

# Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention and Response Independent Review Committee

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# Table of Contents

## Contents

Table of Contents .....	2
Foreword .....	5
Executive Summary .....	6
SPRIRC Recommendations .....	7
Acknowledgements .....	17
Dedication .....	17
Chapter One: Introduction .....	18
SPRIRC Activities and Approach .....	20
Understanding Suicide as a Wicked Problem .....	21
The Public Health Approach to Suicide Prevention .....	23
Current Sociocultural Trends .....	25
Fluctuations in the U.S. Labor Market May Contribute to Increased Suicide Risk in the Military .....	25
Newer Generations of Workers have Different Motivations to Work and Expectations of their Employers .....	26
What Constitutes an American ‘Family’ Continues to Evolve .....	27
Chapter 2: Points of Strength in the U.S. Military .....	29
Healthy and Empowered Individuals, Families, and Communities .....	29
Clinical and Community Preventive Services .....	31
Treatment and Support Services .....	32
Surveillance, Research, and Evaluation .....	32
Chapter 3: Overarching Department of Defense Issues .....	35
The Military Promotion System .....	35
Organizational Instability Caused by Frequent Moves .....	37
Slow Hiring Processes and Outdated Approaches to Filling Job Vacancies .....	38
Poorly Functioning Systems and Aging Infrastructure .....	39
Lack of Collaboration and Synchronization of Efforts .....	40
Chapter 4: Healthy and Empowered Individuals, Families and Communities .....	42
Suicide Prevention Training .....	43

Personnel Under Investigation.....	45
Postvention Response .....	46
Chapter 5: Clinical and Community Preventative Services.....	49
Prevention Workforce.....	49
Training Management.....	51
Leadership.....	53
Housing.....	56
Limiting or Reducing Access to Highly Lethal Methods of Suicide.....	57
Reducing Non-Firearm Lethal Means .....	62
Social Relationships.....	63
Family Support.....	64
Sleep Quality.....	65
Alcohol Availability and Consumption .....	68
Financial Readiness .....	70
Chapter 6: Treatment and Support Services .....	73
Behavioral Health Personnel Shortages.....	73
Improve Pay and Benefits to Attract and Retain Talent .....	74
Expand the Pool of Available Candidates .....	76
Improve Efficiencies in Hiring Practices.....	77
Expand and Optimize Behavioral Health Technicians .....	77
Administrative Barriers that Interfere with Care Delivery .....	78
Reduce Administrative Burdens on Behavioral Health Care Providers .....	79
Improve the Behavioral Health Information Technology Infrastructure .....	80
Expand the Evidence-Based Practices .....	82
Limited Engagement with Community-Based Agencies and Providers.....	86
Expand Use of Technology-Based Solutions for Scalable Treatment Delivery.....	88
Integrated Disability Evaluation System .....	89
Chapter 7: Surveillance, Research and Evaluation.....	91
Leadership Issues .....	91
Program Evaluation .....	92
Service Members Under Investigation.....	93
Service Member Well-Being and Morale .....	94

Behavioral Health Interventions and Services .....	94
Chapter 8: Moving Forward.....	96
Congressional Oversight.....	96
Implementation .....	96
References.....	97
Appendix A: Charter for Suicide Prevention and Response Independent Review Committee..	108
Appendix B: Policies, Programs and Materials Review.....	111
Policies Reviewed by the SPRIRC .....	111
Programs, Materials and Research Reviewed by the SPRIRC .....	113

# Foreword

A Letter to Service Members of the U.S. Military,

It is with gratitude and appreciation that we submit to you our report, “Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention and Response Independent Review Committee.” We undertook this task with you as our primary stakeholder. We never lost sight of your dedication, passion, courage, and commitment to service as we developed our recommendations.

We heard your voices loud and clear. During our visits, we invited you to identify what is and is not working, and what needs to change when it comes to suicide prevention and response in the Armed Forces. We asked what you would specifically recommend to the Secretary of Defense to prevent suicide. Your candor and compassion were most impressive. You overwhelmingly supported the DoD’s efforts to prevent suicide as the right thing to do. While some current efforts were not seen as effective, you did not hesitate to reinforce the importance of suicide prevention practices and helped us consider different options to decrease the risk of suicide among those in uniform.

You and your families sacrifice every day for us. You deserve excellence, dignity, and respect, and to have your voices heard. Our freedom and national security depend on each and every one of you, and we endeavor to work equally hard to support you in the ways we can. We are grateful and honored for the opportunity to serve you and thank you for sharing your voices for this important effort.

Sincerely,



Dr. Gayle Y. Iwamasa    Dr. Rebecca K. Blais    Dr. Craig J. Bryan    Dr. Jerry Reed



Dr. Stephanie Gamble    Dr. Rajeev Ramchand    LTG Nadja West (ret.)



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## Executive Summary

At the Direction of Congress, Secretary Austin established the Suicide Prevention and Response Independent Review Committee (SPRIRC) on May 17, 2022 to conduct a comprehensive review of clinical and non-clinical suicide prevention and response programs. The SPRIRC was led by Dr. Gayle Iwamasa, who was joined by nine highly qualified subject matter experts external to the Department of Defense (DoD), with experience in the public health approach to suicide prevention, mental health services, epidemiology of suicide, sexual assault, lethal means safety, service member and family support services, and civilian employment within the Services, including several Veterans with extensive military leadership at multiple levels.

The SPRIRC attended numerous briefings by the Services' Suicide Prevention leads, and met with a variety of, external partners, and stakeholders. SPRIRC members also conducted a comprehensive examination of DoD and Service-level policies and programs related to suicide prevention and response, reviewed current clinical and non-clinical military suicide prevention research, and received input from additional stakeholders via email. Most importantly, the SPRIRC met with thousands of service members, military family members, and civilian support and service providers at nine military installations representing all US Armed Services, both CONUS and OCONUS.

In December 2022, the SPRIRC presented Secretary Austin with this report and ten recommendations addressing overarching issues within the military that the SPRIRC believe will improve service member well-being by improving operations and infrastructure. An additional 117 recommendations are provided within the four strategic directions of the Defense Strategy for Suicide Prevention: Healthy and Empowered Individuals, Families, and Communities; Clinical and Community Preventive Services; Treatment and Support Services; and Surveillance, Research, and Evaluation.

In this report, the SPRIRC emphasized that effectively preventing and responding to suicide will require a multifactorial approach, as deaths by suicide among service members are complex; thus, simple or singular strategies will not work. The recommendations are listed in the table below, where the SPRIRC also provided priority ratings based on our expertise and experience in determining what strategies could have the most impact at reducing suicide in the military. Context and rationale for the recommendations are provided within each section. The SPRIRC acknowledges that the 2023 NDAA was pending signature as this report was being finalized, and that many of the recommendations in this report align with initiatives proposed by Congress.

## SPRIRC Recommendations

Rubric to determine each recommendation's priority rating:

<b>3: High</b>	<b>2: Moderate</b>	<b>1: Low</b>
SPRIRC considers these recommendations to be "necessary" or "must" changes. These recommendations should receive the greatest amount of the DoD's priority, attention, and resources because they are most likely to result in the largest reductions in suicide and have an overall benefit to service members and the DoD.	These recommendations may have a moderate impact on suicide rates or only have an impact if one or more of the high priority recommendations are implemented.	These recommendations primarily serve to amplify the effects of high and moderate priority recommendations. By themselves, these recommendations may not have a meaningful impact on suicide rates but may serve to strengthen protective factors and supports for service members and their families.
<b>Number</b>	<b>Recommendation</b>	<b>Priority Rating</b>
3.1	Create a Task Force to modernize and reform the military promotion system to better reward and select the right people for the right positions at the right time based on demonstrated leadership skills and abilities.	<b>3</b>
3.1.1	Provide greater flexibility in military career trajectories in the military promotion system.	<b>2</b>
3.2	Reduce the frequency of reassignments.	<b>2</b>
3.3	Extend the length of command assignments.	<b>2</b>
3.4	Offer new assignments to military personnel before they reenlist or extend their military service.	<b>2</b>
3.5	Eliminate legal and bureaucratic barriers to efficient hiring and onboarding processes.	<b>3</b>
3.6	Create a task force charged with improving the usability and reliability of military information technology systems while balancing its various security needs.	<b>2</b>

3.7	Ensure military installations and units are properly resourced with computers, printers, internet connectivity, and other hardware and systems necessary to complete military requirements.	2
3.8	Centralize responsibility for core suicide prevention activities that are common to all Services.	3
3.9	Improve data sharing across DoD offices and Services.	2
4.1	Modernize the content, delivery, and dosage of suicide prevention education and skill building across the career cycle of military personnel.	3
4.1.1	Separate training should be developed for different audiences and for intended effect.	3
4.1.2	Training should be delivered in small groups of service members with similar rank and/or positions instead of mass “one-size-fits-all” training.	3
4.1.3	The DoD should vary training duration and frequency to maximize engagement and efficacy.	2
4.1.4	The DoD should allow service members to select from a range of complementary topics and educational materials to meet training requirements.	2
4.2	Centralize suicide prevention training curriculum.	2
4.3	Require Military Exchange personnel to complete skills-based training designed to recognize indicators of elevated emotional distress and effective methods for interacting with and responding to acutely distressed customers.	1
4.4	Expand the Limited Privilege Suicide Prevention (LPSP) Program to all service members undergoing investigation in all Services.	2
4.5	Implement the Air Force’s Commander/First Sergeant Checklist for Airmen and Guardians Under Investigation across all Services.	2
4.6	If DoD program evaluation and research find that some investigations and offenses are associated with especially increased risk of suicide, the DoD should develop policies requiring a specially trained behavioral health professional to be present at the initial notification of the subject.	3
4.7	Amend DoDI 6490.16 to reference DoDI 1300.15.	2



4.8	Leadership focused suicide training should include how to implement postvention following a suicide or suicide attempt.	2
4.8.1	Enhance implementation of the Postvention Toolkit for a Military Suicide Loss.	2
4.8.2	Improve implementation of the Leaders Suicide Prevention Safe Messaging Guide.	2
4.9	Develop an automated system to proactively push postvention resources to commanders and other key support personnel when a suicide occurs.	1
4.10	The Office of the Assistant Secretary of Defense for Sustainment and its counterparts within the Services should own a centrally funded contract(s) to ensure that all military installations have access to professional trauma scene cleaning and biohazard removal companies.	1
5.1	Integrate All Prevention Efforts under One Operational Office within the Department of Defense	2
5.1.1	Create Enduring Oversight Mechanisms for the Prevention Workforce.	2
5.1.2	Develop Substance Misuse Prevention Policy.	2
5.1.3	Transform the current Violence Prevention Cell into the Integrated Prevention Resource Center of Excellence.	1
5.1.4	Enhance Communication and Buy-in for Prevention Workforce.	1
5.2	Form a task force to review required training and make recommendations to reduce training requirements that are not specific to maintaining military occupational competencies.	2
5.3	Empower leaders to enact “set schedule” policies for unit training.	2
5.4	Ensure that all military workplaces have a sufficient inventory of computers and access to high-speed internet for personnel to efficiently complete mandated trainings.	2
5.5	Integrate curriculum that teaches transformational leadership skills in all professional military education and formal leadership development courses.	2

5.6	The Services should integrate skills training in navigating difficult conversations into early leadership training courses and professional military education.	2
5.7	Establish leadership guidelines for official after-hours communications with subordinates.	1
5.8	Reward steward leadership.	1
5.9	DoD should create improved and prescriptive guidance on how to effectively manage housing on-base.	1
5.10	DoD should engage stakeholders in property management.	1
5.11	DoD should ensure adequate transportation between work and on-base living quarters for junior enlisted service members.	1
5.12	Repeal Public Law 112-239 Section 1057 and replace with procedural due process regarding the collection and recording of information relating to the lawful acquisition, possession, ownership, carrying, or other use of a privately owned firearm or weapon by military personnel and civilian employees of the DoD.	3
5.13	Direct the Office of General Counsel to issue guidance that outlines how information about firearm acquisition, possession, ownership, carrying, or other use of a privately owned firearm or weapon by military personnel and civilian employees of the DoD can be legally collected by program evaluators.	2
5.14	Establish standards for DoD-approved firearm safety training requirements.	3
5.14.1	Require DoD-approved firearm safety training, including refresher and sustainment training every five years.	2
5.15	Implement a 7-day waiting period for any firearm purchased on DoD property.	3
5.16	Develop a national database for recording serial numbers of firearms purchased on DoD property.	2
5.17	Implement a 4-day waiting period for ammunition purchases on DoD property to follow purchases and receipt of firearms purchased on DoD property.	3
5.18	On DoD property, raise the minimum age for purchasing firearms and ammunition to 25 years.	3

5.19	Incentivize the acquisition and use of firearm locking devices by providing discounts for firearm locking devices purchased at a Military Exchange.	2
5.20	Establish command notification procedures when a service member or family member who lives on DoD property purchases a firearm on DoD property.	2
5.21	Require anyone living on DoD property in military housing to register all privately owned firearms with the installation's arming authority and to securely store all privately owned firearms in a locked safe or with another locking device.	3
5.22	Establish DoD policy restricting the possession and storage of privately owned firearms in military barracks and dormitories.	3
5.23	Prohibit the possession of privately owned firearms that are not related to the performance of official duties on DoD property by anyone who does not live on DoD property.	2
5.24	Develop and implement a multimedia public education campaign to promote secure firearm storage.	2
5.25	Ensure that all shower curtain rods, window curtain rods, and closet rods installed in barracks, dormitories, and military housing can "break away" with excessive load.	2
5.26	Partner with local communities in collaborative efforts to limit or restrict access to sites or locations commonly used for suicide.	2
5.27	The DoD should fully fund MWR programs that support service members and families and allocate funds based on community needs. Particular attention should be paid to smaller and remote installations where alternatives to MWR programs do not exist.	2
5.28	The DoD and Services need to be fully supported in their efforts to recruit and retain staff, increase access or capacity to child care on and off the installation, expand the Family Child Care program, collaborate with community-based assistance programs, and support public/private partnership initiatives.	2
5.29	Increase funding and support for the Spouse Education and Career Opportunities (SECO) program and the Military Spouse Education Partnership (MSEP).	2

5.30	Provide funding to furnish barracks, dorms, and military housing with light-blocking window coverings.	2
5.31	Ensure that operational air conditioning units are installed in all barracks, dorms, and military housing.	2
5.32	Ensure duty schedules allow for 8 hours of sleep and minimize the frequency of shift changes.	3
5.33	Provide education in healthy sleep habits during military training and regularly scheduled unit formations.	2
5.34	Raise the minimum purchase price and ban price discounting of energy drinks sold on DoD property.	1
5.35	Ban the promotion of energy drinks on DoD property.	1
5.36	Display signs on vending machines and retail outlets where energy drinks are sold about responsible energy drink consumptions.	1
5.37	Address excessive alcohol use and the risks it poses in existing training requirements including suicide prevention training, sexual harassment and assault prevention training, and other safety-focused trainings.	3
5.38	Ban the promotion of alcohol on DoD property.	2
5.39	Fund safe transportation programs for service members living on-base.	1
5.40	Establish a 24/7 sobriety program for service members arrested for or convicted of alcohol-related offenses.	2
5.41	Increase the purchase price of alcohol sold on DoD property.	2
5.42	Limit when alcohol is sold on DoD property.	2
5.43	The Office of the Inspector General should conduct a comprehensive review of the magnitude of unpaid and delayed payments to service members and their families and provide recommendations for improving efficiencies.	3
5.44	The pay scale for junior enlisted service members should be reviewed and reassessed for competitiveness with non-military wages.	2

5.45	Pay systems must be fixed so that service members do not experience delays in pay.	3
6.1	Eliminate budget and statutory limitations that hinder the Services' ability to increase incentive pay and retention bonuses for DoD behavioral health clinicians.	3
6.2	Provide greater legal flexibility in civilian pay structure and plans.	2
6.3	Create DoD loan forgiveness programs for DoD behavioral health clinicians.	2
6.4	Amend DoD policy to allow longer assignments and extensions for civilian behavioral health professionals assigned to duty stations outside the United States.	2
6.5	Fully and centrally fund the Joint Travel Regulation allowance for civilian employee relocation.	2
6.6	Expand DoD behavioral health training programs to civilian candidates.	2
6.7	Expand the Health Professions Scholarship Program (HPSP) to civilian behavioral health students and trainees.	2
6.8	Create DoD behavioral health training programs for a broader range of behavioral health disciplines.	2
6.9	Broaden the range of accreditations accepted for the hiring and credentialing of qualified behavioral health providers.	2
6.10	Expedite the hiring process for behavioral health professionals.	3
6.11	Include national clinical credentialing approval in DHA's efforts to standardize credentialing review processes for behavioral health professionals.	2
6.12	Utilize behavioral health technicians as behavioral health care extenders.	2
6.12.1	Increase the number of active-duty behavioral health technicians.	2
6.13	Provide behavioral health technicians with advanced training in evidence-based practices that can be delivered within their scope of practice.	2

6.14	Hire more administrative support personnel to work in behavioral health clinics.	2
6.15	Implement a process improvement initiative to identify burdensome processes and procedures that can be eliminated or reduced.	1
6.16	Better align behavioral health clinician scheduling templates and workload benchmarks with local MTF and community needs.	1
6.17	Implement episodes of care scheduling within behavioral health clinics.	2
6.18	Improve the reliability, usability, and interoperability of the Behavioral Health Data Portal (BHDP) and Genesis.	2
6.19	Improve the reliability, usability, and interoperability of email and digital communications systems.	1
6.20	Identify information technology issues and processes that degrade the performance of behavioral health services computer systems.	1
6.21	Review and amend Defense Health Agency Administrative Instruction 6025.06 to ensure alignment of this policy with the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (VA/DoD CPG).	1
6.22	Provide skills-based training in evidence-based suicide prevention treatments to behavioral health clinicians across the Military Health System.	3
6.23	Provide advanced training in evidence-based suicide prevention treatments to TRICARE behavioral health clinicians.	3
6.24	Screen for unhealthy alcohol use in primary care clinics.	2
6.25	Ensure the availability of evidence-based care for those seeking treatment or support for unhealthy drinking.	2
6.26	Align substance use treatment programs with behavioral health treatment programs.	2
6.27	Expand opportunities to treat common mental health conditions in primary care, with a priority to adopt Collaborative Care models.	2
6.28	Amend DoDI 6490.06 to clarify when the delivery of evidence-based suicide-focused interventions falls within the scope of non-medical counseling.	2

6.29	Develop and implement post-discharge support for service members at risk of suicide recently discharged from health care.	2
6.30	Implement caring communications.	2
6.31	Fund and create interdisciplinary case management billets within behavioral health clinics.	2
6.32	Increase TRICARE payment rates for behavioral health services.	2
6.33	Ensure TRICARE payments to behavioral health professionals are made as directed by TRICARE policy.	3
6.34	Expand the types of licensed behavioral health providers accepted by TRICARE	2
6.35	Update TRICARE provider rosters at least twice annually.	2
6.36	Expand collaborations with academic affiliations offering evidence-based services and offer internships to students interested in learning evidence-based treatments for services members.	2
6.37	Expand the availability of telebehavioral health services.	2
6.38	Clarify language regarding the limits of telebehavioral health practice across jurisdictions.	1
6.39	Establish partnerships between MTFs and regional healthcare systems that can deliver evidence-based telebehavioral health services.	2
6.40	Allow unit commanders to backfill positions at the initiation of a medical evaluation board.	2
6.41	The DoD should fully fund and staff wounded, ill, and injured programs at 100%.	2
6.42	The DoD should identify a process and a set of criteria for service members to maximize convalescent leave while engaged with the Integrated Disability Evaluation System.	1
7.1	Conduct research to identify early career risk factors that predict leader removal from office or relief of duty and identify predictors of good military leadership that demonstrate positive outcomes.	1

7.2	Enhance program evaluation efforts to continuously monitor how policies, programs, and initiatives impact risk and protective factors for suicide.	2
7.3	Establish formal partnerships between the Office of People Analytics (OPA) and academic institutions to provide consultation and support for ongoing program evaluation efforts.	2
7.4	Conduct a DoD-wide MWR program evaluation to identify activities and programs that appeal to today's service members.	1
7.5	Conduct research to clarify the types of offenses and charges confer increased suicide risk among service members.	2
7.6	Conduct research to determine if fluctuations in the US labor market are correlated with service member suicide.	1
7.7	The DoD should review the IT capabilities within Service Medical Departments and leverage the Telemedicine and Advanced Technology Research Center (TATRC) under the U.S. Army Medical Research and Development Command (USAMRDC); and the Defense Health Agency Virtual Health Clinical Integration Office (VH CLIO) to coordinate research focused on provision of behavioral health services in virtual formats.	1
7.8	Fund research focused on the development and testing of mobile health technologies to improve mental health and well-being.	2



## Acknowledgements

The SPRIRC would like to acknowledge the many individuals who helped make this report possible. We thank the numerous installation military and civilian staff who coordinated our site visits and additional onsite personnel for their hospitality and assistance, including coordinating our meetings with local community agencies and leaders. We also were fortunate to have had helpful consultative and subject matter experts from DoD, who patiently responded to our questions and shared their knowledge. We thank Secretary of Defense Lloyd Austin for establishing the SPRIRC and entrusting us with this important task. You have made instrumental changes within the DoD during your tenure as Secretary of Defense, illustrating your unwavering commitment to our service members. Our recommendations are extensive and comprehensive, and we entrust them to you as a function of your steadfast commitment to them. We concur that one death by suicide is one too many. Most importantly, we are grateful to the thousands of service members, family members, and providers who took time from their schedules to share their experiences and observations with us.

## Dedication

This report is dedicated to the U.S. service members we lost to suicide, their friends, colleagues, and family members. Our recommendations were built in their honor to help ensure that all service members feel that their lives are worth living.

The veterans who served on the SPRIRC wish to convey our deepest gratitude to our brothers and sisters in arms for their daily service to our nation and their continuing efforts to prevent suicide in our ranks. We, too, experienced many of the challenges documented in this report first-hand in our roles as military leaders and advocates, as well as from being family of service members throughout our careers, and recognize that while we cannot change the past, we can and must change the future if we are to prevent suicide in our military. It is our hope that by listening to you -- every Soldier, Sailor, Marine, Airman, and Guardian -- we can create an environment where you can thrive and remain ready and capable to defend our nation.

Our non-veteran SPRIRC members also have deep connections to the military. Some have directly shared the challenges and joys of the military lifestyle, living through the training cycles, military moves, and deployments of our spouses, sons, daughters, and siblings. Many of us have dedicated our careers to serving this community. We will continue our efforts to serve you.

From all of us, it has been an honor and privilege to serve on this committee. We share the strong conviction that we can and must do all we can to help our military strengthen its resiliency and strive to help service members recognize their lives are worth living and saving.



## Chapter One: Introduction

Pursuant to the National Defense Authorization Act (NDAA) for Fiscal Year 2022 (section 738), on March 22, 2022, Secretary of Defense (SECDEF) Austin established the Suicide Prevention and Response Independent Review Committee (SPRIRC, See Charter in Appendix A). The SPRIRC, chaired by Dr. Gayle Y. Iwamasa, was charged with conducting a comprehensive review of Department of Defense (DoD) efforts to address and prevent suicide. In addition to Dr. Iwamasa, Secretary Austin appointed nine other subject matter experts and special consultants from outside of DoD with expertise in mental health, suicide epidemiology, lethal means safety, public health, policy, and the overlap of sexual assault and suicide prevention to serve on the SPRIRC. Expert consultants had prior experience as military officers, senior and non-commissioned enlisted leaders, and civil servants, with content knowledge in the areas of health care, military family life, community support, public policy, leadership, and spirituality.

The establishment of the SPRIRC and the recommendations the Committee represent one of the DoD's most recent efforts to prevent suicide among service members. Though not a comprehensive list, other notable milestones in DoD suicide prevention preceding the SPRIRC's formation include:

**2008:** The Department of Defense Suicide Event Report (DoDSER) program is established, providing greater standardization of DoD suicide surveillance across the Services. That same year, the number of service members who died by suicide surpassed the number of service members who died in combat during the Global War on Terrorism.

**2009:** The DoD Task Force on the Prevention of Suicide by Members of the Armed Forces is established to study suicide in the military and provide recommendations.

**2010:** The DoD Task Force publishes its report of 76 recommendations, including a recommendation calling for the establishment of a DoD Suicide Prevention Policy Office.

**2011:** The Defense Suicide Prevention Office (DSPO) is established to provide comprehensive enterprise-wide policy on non-clinical suicide prevention and serve as the DoD's official source for reporting on data related to suicides and suicide attempts among service members in both the Active Component and Selected Reserve.

**2015:** The DoD Office of the Inspector General (OIG) publishes DODIG-2015-182, *Assessment of DoD Suicide Prevention Processes*, identifying the need for multiple process changes to improve suicide prevention and response policies and programs within the DoD. A major concern was a lack of structure and planning of suicide prevention programs and tasks across the DoD.

**2015:** The DoD publishes the Department of Defense Strategy for Suicide Prevention (DSSP) outlining its mission, vision, goals, and objectives for suicide prevention. The DSSP aligns with the Surgeon General's 2012 National Strategy for Suicide Prevention (NSSP) while providing for the needs of the Department and remaining consistent with existing Service suicide prevention programs.

**2017:** Department of Defense Instruction (DoDI) 6490.16, *Defense Suicide Prevention Program* is published, establishing policies, assigning responsibilities, and outlining oversight procedures for the DoD Suicide Prevention Program. The DoDI also establishes the Suicide Prevention General Officer Steering Committee and the Suicide Prevention and Risk Reduction Committee.

**2020:** DoDI 6400.09, *DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm*, is published, establishing and integrating policies and responsibilities to mitigate self-directed harm and abusive or harmful acts. The DoDI also adapts and applies the Centers for Disease Control and Prevention's framework for sexual violence prevention.

**2021:** The United States Government Accountability Office (GAO) publishes GAO-21-300, *DOD Needs to Fully Assess Its Non-Clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness*, recommending improved collaboration between DSPO and the Services on non-clinical suicide prevention efforts and improved collaboration between DSPO and the Psychological Health Center of Excellence.

**2021:** The White House releases the *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-sector, Evidence-informed Public Health Strategy* highlighting five key components of suicide prevention: improving lethal means safety, enhancing crisis care and care transitions, increasing access and quality of mental health care, addressing risk and protective factors, and increasing research coordination, data sharing and evaluation.

**2021:** The Independent Review Commission on Sexual Assault in the Military also releases its report with 82 recommendations to address sexual assault, an important risk factor for suicide among military personnel.

**2022:** The national 988 Suicide and Crisis Lifeline is launched, facilitating easier access to the National Suicide Prevention Lifeline, which encompasses the Military Crisis Line and Veterans Crisis Line.

**2022:** The United States Government Accountability Office publishes GAO-22-105108, *DoD Should Enhance Oversight, Staffing, Guidance, and Training Affecting Certain Remote*

*Installations*, providing 14 recommendations to improve suicide risk assessment and oversight at outside the continental U.S. (OCONUS) locations and improve guidance and training for commanders.

Most of these prior efforts resulted in recommendations, some of which have been enacted and others which have not. For this reason, many SPRIRC recommendations are similar to or even duplicative of recommendations made previously by multiple other independent reviewers. To that end, one conclusion of the SPRIRC is that persistently elevated suicide rates in the DoD result in no small part to the DoD’s limited responsiveness to multiple recommendations that have been repeatedly raised by independent reviewers and its own experts. If suicide rates among military personnel continue to increase or remain unchanged in the years following the release of this report, the SPRIRC recommends that the Secretary of Defense review our recommendations and the recommendations contained in prior reports to ensure all recommendations were addressed and implemented before forming another review committee. If the recommendations that have been repeatedly raised by multiple groups are not implemented, there is little reason to expect that suicides among military personnel will drop.

*One conclusion of the SPRIRC is that persistently elevated suicide rates in the DoD result in no small part to the DoD’s limited responsiveness to multiple recommendations that have been repeatedly raised by independent reviewers and its own experts.*

## SPRIRC Activities and Approach

The SPRIRC officially convened on May 17, 2022, to begin reviewing: DoD and Service policies and programs (Appendix B); receiving briefings from DoD offices and Services; DoD suicide and unit climate

survey data; previous reports from the OIG, GAO, the Services, and other sources internal and external to the DOD; published research studies; and industry standards of practice.

The SPRIRC identified several key data points from the DoD’s

Table 1.11

	Active Duty	National Guard	Reserve
<b>Number of suicides in 2021</b>	328	117	74
<b>% of suicides...</b>			
using a firearm	67.1%	76.1%	74.3%
with known relationship difficulties in the preceding months	44.2%	41.8%	31.8%
with known legal/administrative stressors in the preceding months	23.1%	20.9%	13.6%
with known work-related stressors in the preceding months	12.5%	11.9%	9.1%
with a known death of friend/family member in the preceding months	14.5%	13.4%	13.6%
with known financial difficulties in the preceding months	7.6%	10.4%	9.1%
with a behavioral health diagnosis	43.9%	32.8%	40.9%
with prior self-harm	15.5%	16.4%	9.1%
receiving outpatient mental health services in the preceding months	41.6%	22.4%	22.7%
occurring in the barracks/berthing	15.5%	4.5%	No data available
occurring in another location on-post/base	22.1%	32.8%	18.2%

most recent Annual Report on Suicide in the Military, released on October 20, 2022 (Table 1.1). Though specific to calendar year 2021 only, these patterns reflect overall trends within the DoD over the past decade.

The SPRIRC also met with representatives from partnering federal agencies, community organizations, Military Service Organizations (MSO), and Veterans Service Organizations (VSO), and conducted nine installation site visits from August 8, 2022, and November 4, 2022. Installations were selected to ensure representation of all Services, National Guard and Reserve units, and Outside the Continental U.S. (OCONUS) locations (see Table 1.1). During these site visits, the SPRIRC met with command leadership, officers, senior enlisted leaders, non-commissioned officers, junior enlisted service members, active-duty and civilian healthcare providers, community support staff members and program managers, community leaders, and family members. The SPRIRC also received input from a range of stakeholders via an email “suggestion box” created to collect information from service members, families, and the public. Finally, a SPRIRC member attended the National Military Suicide Survivor Seminar coordinated by the Tragedy Assistance Program for Survivors to meet with family members, service members, veterans, and others

who had lost loved ones to suicide. In sum, the SPRIRC met with 2939 individuals, including 2106 military personnel and 692 civilian employees and family members. These sources of information were combined and served as the basis for the findings summarized in this report and the recommendations.

Table 1.2

Installation	Location	No. of Military	No. of Civilians
Joint Base Elmendorf Richardson	Alaska	316	72
Fort Wainwright	Alaska	260	99
Eielson Air Force Base	Alaska	126	26
Naval Air Station North Island	California	342	41
Camp Humphreys/Camp Casey	Korea	163 *	53
Fort Campbell	Kentucky	192	151
Nellis Air Force Base/Creech Air Force Base	Nevada	224	52
North Carolina National Guard	North Carolina	273	16
Camp Lejeune	North Carolina	373	160

\* Includes 3 Korean Augmentation to the US Army (KATUSA) personnel

## Understanding Suicide as a Wicked Problem

Suicide prevention efforts within and external to the DoD often seek to identify and employ "solutions" intended to target suicide's presumed causes. Although this cause-and-effect approach is sufficient to solve many conventional problems, it is ill-suited for "wicked problems" like suicide (Churchman, 1967; Bryan, 2021, Rittel & Webber, 1973; Skaburskis, 2008). As used here, the term “wicked” is not intended to imply any moral or ethical qualities but rather to convey that suicide is an especially difficult and elusive problem to solve. Wicked problems are difficult to solve because they involve complex interdependencies. Influenced by a growing number of studies highlighting the complexity of suicide (Goddard et al., 2022; Huang et al., 2020a, 2020b), suicide researchers have increasingly embraced this perspective. A key hallmark of wicked problems is

the tendency for efforts aimed at solving one aspect of the problem to create or uncover new problems.

As applied to suicide, expansion of suicide risk screening across the DoD provides an illustrative example. Intended to improve the detection of high-risk service members and provide early interventions to avert suicidal behavior, this strategy has led to increased referrals to behavioral health clinics, as intended. However, the resulting increase in demand for behavioral health services was not accompanied by an increase in behavioral clinicians.<sup>1</sup> On the contrary, the number of behavioral health professionals in the DoD has actually decreased over time, resulting in a significant and still-growing demand-supply imbalance.

*“I really need mental health services right now but I am not going because I would be taking a spot that my E3 needs. With one provider on the ship, we can’t all access care.”*  
--Navy E8

The growing demand-supply imbalance results in longer wait times for service members to initiate behavioral health treatment and extended gaps between scheduled appointments, reducing treatment efficacy, prolonging symptoms, and decreasing well-being. The demand-supply imbalance also increases work demands for behavioral health clinicians, contributing to burnout and attrition, further exacerbating the demand-supply imbalance already straining the DoD’s behavioral healthcare system. Although the precarious nature of the DoD behavioral healthcare system is not attributable only to expanded suicide risk screening, expanded screening has nonetheless revealed and worsened a different problem: behavioral health professional shortages.

This is not to say that suicide risk screening as a suicide prevention strategy is inherently “wrong.” Rather, this example highlights key differences between wicked problems like suicide and other more conventional problems. Critically, wicked problems like suicide have complex interdependencies among multiple components or factors. Making a change in one area therefore often leads to second- and third-order effects that can, in some cases, counteract or neutralize the original intervention. Similarly, there are no “right” or “wrong” solutions for wicked problems, although some strategies will sometimes be better or worse than others under some circumstances. To address a wicked problems like suicide, the DoD must reduce its reliance on solutions-oriented thinking and adopt process-oriented thinking instead. Several core assumptions underlying this approach include the following:

1. **Multiple strategies are necessary to effectively prevent suicide.** There is no “one thing” that will prevent all suicides. Multiple strategies must therefore be implemented in concert to address multiple aspects of the problem at the same time.
2. **A strategy that prevents suicide under certain conditions may nonetheless have little effect, or maybe even make things worse, under other conditions.** One-size-fits-all approaches will almost always have negligible impact.

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<sup>1</sup> This outcome is not unique to the Department of Defense; schools that have initiated depression screening for youth have similarly disbanded these programs because of inability to meet demand (Hallfors et al., 2006).

3. **Even when a strategy works, different strategies will probably be needed in the future to maintain these initial gains.** Feedback systems are necessary to continuously monitor strategy effects and guide decisions about adapting or changing strategies accordingly. The principles of continuous process improvement must be part of the comprehensive approach.

## The Public Health Approach to Suicide Prevention

As stated in the White House Strategy (2021), DoD has adopted a comprehensive public health approach to reduce suicide rates, which incorporates the recently updated Center for Disease Control and Prevention’s seven Strategies for Action (Figure 1.1). These complementary strategies align with the perspective of suicide as a wicked problem because they seek to address suicide from multiple directions and at multiple levels rather than focusing solely on the individual experiencing suicidal thoughts and engaging in suicidal behaviors. The public health approach further recognizes that there are risk and protective factors at all levels of a system. Reducing modifiable risks and increasing protection at multiple levels is therefore essential; focusing only on the individual without regard for the systems and context that surround the individual are unlikely to be effective. This public health approach, combined with the view of suicide as a wicked problem, served as the foundation for the SPRIRC’s findings and recommendations, which are organized around the four pillars of the National Strategy for Suicide Prevention adopted by the DoD in 2015 (Figure 1.2):

### Center for Disease Control and Prevention’s Strategies for Action

1. Strengthen economic impacts
2. Create protective environments
3. Improve access and deliver of interventions
4. Promote healthy connections
5. Teach coping and problem-solving skills
6. Identify and support those at risk
7. Decrease risk by lessening harms and preventing future risk

Figure 1.1





*Figure 1.2 The four pillars of the National Strategy for Suicide Prevention that serve as the foundation for the SPRIRC’s recommendations*

- **Healthy and Empowered Individuals, Families, and Communities.** This pillar focuses on creating environments that reduce the risk for suicidal behaviors by promoting the health and well-being of all community members and integrating suicide prevention activities across settings and sectors. A core assumption is that suicide can be prevented when communities collaborate and coordinate activities.
- **Clinical and Community Preventive Services.** This pillar focuses on the availability of support services, systems, and resources within the community that help people solve problems and challenges that can increase their vulnerability to suicidal behaviors. A core assumption is that suicide can be prevented by creating and supporting lives that are worth living.
- **Treatment and Support Services.** This pillar focuses on the availability of evidence-based healthcare services, especially behavioral health treatments, that have been shown to reduce the risk of suicidal behaviors. A core assumption is that suicide can be prevented when people are able to quickly receive effective and early interventions and treatments.
- **Surveillance, Research, and Evaluation.** This pillar focuses on the importance of continual and systematic efforts to collect, analyze, and use data to guide decision-making and future efforts, as well as the importance of continual engagement in efforts to examine the



effectiveness and utility of various strategies. A core assumption of this pillar is that suicide can be prevented when strategies are based on reliable and easily accessible data.

## Current Sociocultural Trends

Because suicide is influenced by social factors and cultural norms, suicide prevention strategies must account for sociocultural trends to maximize their effectiveness. The SPRIRC identified three especially salient sociocultural trends that likely affect suicide risk among military personnel and corresponding prevention strategies: (1) fluctuations in the U.S. labor market; (2) generational differences in employment motives and expectations; and (3) changing definitions of what constitutes a family.

### Fluctuations in the U.S. Labor Market May Contribute to Increased Suicide Risk in the Military

Fluctuations in the United States labor market correlate with changes in the rates of suicide in the general United States population. For example, during the Great Recession of 2008, evidence suggests a 1% increase in unemployment was associated with a 1% increase in suicide rates (Reeves et al, 2012).<sup>2</sup> Shifts in the United States labor market are similarly associated with military enlistment and retention. The Eleventh Quadrennial Review of Military Compensation published in 2012 found that across studies, a 10% decrease in civilian unemployment will “reduce high-quality enlisted recruiting by 2-4%,” and that although retention is also associated with civilian unemployment, it is less sensitive than recruiting. These associations are important to consider when examining suicide risk in the Armed Forces.

Aside from a spike in unemployment in the spring of 2020 associated with the COVID-19 pandemic that persisted until November 2021, the U.S. unemployment rate has been under 4 percent since the fall of 2018 (Bureau of Labor Statistics, 2022). Ample employment opportunities in the civilian sector may be contributing to the military’s current recruiting crisis, with each service branch unable to meet its 2022 recruiting goals. Without modifications to the military’s “mission readiness” goals, this translates to more work being done by fewer people or “more with less,” an adage SPRIRC heard routinely from service members and command at every installation. If, as we contend in this report that operations tempo (OPTEMPO) contributes to suicide risk, monitoring and adapting to labor market fluctuations will be important for sustaining the military’s most important asset—its people.

More jobs and low unemployment also suggest that filling positions typically held by civilians to support service members will be a challenge. This includes behavioral health professionals, but also child care providers, dining facility staff, teachers, support program staff, and others who are critical to supporting military personnel and their families. We identified these issues across

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<sup>2</sup> There is also some evidence to dispute this association based on certain statistical modeling assumptions (Harper & Bruckner, 2017).

installations and recommend key strategies that the DoD will need to implement to ensure its military personnel are adequately supported for mission readiness.

## Newer Generations of Workers have Different Motivations to Work and Expectations of their Employers

Like most large enterprises, the military is not unique in that its most senior leaders are older than its newest recruits. Across the DoD, the average age of the enlisted corps is 27 years old, whereas the average age of the officer corps is 34 years old (ODASD (MC&FP), 2020). More telling, nearly 73% of enlisted personnel but only 37% of officers are under age 30 (ODASD (MC&FP), 2020). These age differences represent significant variances in birth cohorts, with the junior enlisted corps being raised in a different sociocultural context than their leaders. These differences have produced generational tensions between leaders and enlisted that extend beyond mere differences in developmental maturity.

Among the enlisted corps, nearly half are 18-25 years old, having been born between 1995 and 2002, encompassing a cohort known as ‘millennials.’ A key difference between millennials and older generations is that they are the first cohort to be born into homes with personal computers, 24-hour access to online news and entertainment, and social network platforms. According to one RAND study (Weinbaum et al., 2016), these contextual factors have affected their expectations of the workplace. For example:

1. Millennials “prefer open communication and continuous feedback throughout the organizations and teams in which they participate;”
2. Millennials prefer “quick responses to questions, have an urgent sense of immediacy, and get impatient with the slow pace of organizations that are less than cutting edge in their usage of technology;”
3. Once they have information, Millennials “want to share and discuss it;”
4. Millennials are “unlikely to readily accept organizational policies that limit the sharing of information.”

Millennials in the military are no exception. A recent article in NCO Journal interviewed 20 junior enlisted soldiers about their expectations of leaders; these junior enlisted soldiers reported that “they wanted NCOs to be fair in the way they led, empathetic to their concerns, confident in the way they led, and honest in their interactions.” (Hanks, 2020).

The most pronounced generational tension observed by the SPRIRC during site visits surrounded expectations and beliefs about communication between leaders and their subordinates. According to a 2019 article in the NCO journal, “today's staff NCOs need to move away from the ‘Do As I Say Or Else’ style of leadership and instead become effective communicators” (Miller, 2019). The SPRIRC heard these sentiments repeatedly from junior enlisted personnel and officers across

Services. Younger personnel, both enlisted and officer, expressed frustration with older personnel for being overly rigid in their thinking and “not listening” to suggestions or input. Younger personnel also displayed more openness towards help-seeking and self-disclosure of their struggles, behaviors, and attitudes that have been promoted and reinforced within and external to the DoD for over a decade as part of anti-stigma efforts. Older personnel, by comparison, were more likely to view help-seeking and self-disclosure of struggles as indicators of low resilience. In the words of one senior enlisted leader, “Junior enlisted need to stop asking questions and just do their jobs. They have no resilience or coping skills.” Other senior NCOs and officers similarly expressed frustration with younger personnel for “not listening” or “always asking for an explanation.” This sentiment was not shared by all senior leaders, though. In the words of one senior enlisted leader, “We can’t do today’s Army like the old days; we need to adjust or get out.” Another senior officer observed that because younger personnel “think differently” they can solve some problems better and faster than older personnel, “The problems are all the same but our young Soldiers have all the answers to the test; they are the solution.” Improving communication across generations will be critical for the DoD to maximize the effectiveness of its suicide prevention efforts as well as mission readiness overall. People want to understand how what they are doing contributes to the big picture and matters.

*“We can’t do today’s  
Army like the old  
days; we need to  
adjust or get out”  
--Army E8*

## What Constitutes an American ‘Family’ Continues to Evolve

The SPRIRC repeatedly heard the adage “if the service member’s family isn’t happy, the service member isn’t happy.” Supporting service members’ families is a critical element of well-being and effective suicide prevention in the armed forces. What constitutes a “family” has evolved over time and in many ways, DoD policies and practices have not kept up with these changes. Several statistics illustrate the heterogeneity of the modern military family:

- **Single parents:** Since 2000 the number of single parents in the military has decreased, but in 2020, close to 53,000 active-duty service members were single parents, representing nearly 4% of all active-duty service members (ODASD (MC&FP), 2020). Unpredictable work schedules, long work shifts, deployments, and field exercises can have disproportionately adverse effects on these service members as they try to balance work and family demands.
- **Working spouses:** In 2020, 90,755 active-duty service members were in dual military marriages, representing 6.8% of active-duty service members. Among these, 32,478, just over one-third, had children. In fact, between 2003-2014, 179,252 live births were reported to women actively serving in the US military (Romano et al., 2022). Among those not in dual-military families, 78% of spouses are employed. These families must contend with negotiating child care and other familial responsibilities in addition to their work responsibilities, whether to the military or civilian employers (ODASD (MC&FP), 2020). Further, the impact of permanent changes of station (PCS) has a different impact on dual-

career families, especially when both service members face deployment or geographic separation because of a lack of a joint assignment availability.

- **Families with children have more than one child:** In 2020, active-duty service members with children had, on average, two children (ODASD (MC&FP), 2020). Balancing the competing schedules of multiple children, often across different age groups with different needs, requires more flexibility than caring for one child.
- **Cohabitation:** In 2018, nearly 8% of active-duty service members were cohabiting, defined as living together but not married. Those who cohabit often experience similar familial stressors as those who are living together and married but are not eligible for the same benefits (Meadows et al., 2021).
- **Sexual orientation:** In 2018, across the Military Branches just over 6% of active-duty service members identified as lesbian, gay, or bisexual (Meadows et al., 2021). A portion of these may be married or cohabit with same-sex partners and some also have children. While these family members may be eligible for services offered to all spouses, some may feel unwelcome from accessing such support.

The U.S. military and its service members exist in the context of current sociocultural trends and patterns. Global conditions have changed vastly just in the last decade, and readiness in today's armed forces requires vision, agility, and clear understanding of the context in which service members live and work so to ensure that our nation's warriors are prepared and ready to fight.

## Chapter 2: Points of Strength in the U.S. Military

The DoD continues to take steps to address many of the areas which we assessed. For example, on September 22, 2022, Secretary Austin disseminated a memo to increase Basic Allowance for Housing (BAH) in 28 Military Housing Areas that experienced an increase of more than 20 percent above this year's BAH, as well as actions to support families including enhancing spouse employment. The SPRIRC acknowledges these efforts. The SPRIRC identified several promising practices or programs that highlight the Service's ongoing commitment to enhancing service member well-being and morale and reducing harmful behaviors.

While not a complete list of all "wins," the committee observed or learned about these examples which could serve as groundwork for further development and implementation of programs and initiatives that improve service member readiness and well-being and/or achieve a desired outcome with greater cost savings. That said, not all programs have been formally evaluated, which represents an area of growth to ensure maximum effectiveness and the ability to replicate things that are working well. The DoD and Services should implement routine and systematic program evaluation for wider implementation.



### Healthy and Empowered Individuals, Families, and Communities

- **The Battalion Command Assessment Program (Army).** The Battalion Command Assessment Program (BCAP), recently implemented by the Army, focuses not only on physical and cognitive requirements for effective leadership, but also integrates assessment of written and verbal communication skills, feedback from peers and subordinates, and results of interviews with psychologists.
- **Eagle Family Time (Fort Campbell).** Eagle Family Time entails scheduled "white space" that has been protected by leadership to allow all service members to spend time with their families. Similar programs have been established at other installations. However, the benefits of these programs are susceptible to failure over time if and when this scheduled "white space" is filled with work duties and operational tasks.
- **Strong Bonds Program (Air National Guard).** Strong Bonds focuses on building readiness by enhancing relationships with intimate partners/spouses. The program attempts to reduce divorce, increase marriage and family harmony, build resiliency, demonstrate relational skills, and minimize the possibility of suicides secondary to family stress.
- **Coral Academy (Nellis Air Force Base).** Coral Academy appears to be a successful way that Services can ensure high quality education for children of service members. The program incorporates Military and Family Life Counselors (MFLCs) into the education team and has identified a recruitment process

for family member spouses who are educators, providing one option to mitigate the longstanding stressor of military spouse unemployment.

- **Partnerships to address child care capacity (Naval Air Station North Island).** The Navy partnered with the City of Coronado to lease an underutilized community property for a Child Development Center (CDC). Locating the CDC off DoD property provided a solution to quickly address limited child care space on base.
- **Partnerships to improve quality of life (Camp Lejeune).** Camp Lejeune is part of a Cooperative Planning Group that focuses on making the surrounding community of Jacksonville, NC, a better place to live for Marines and their families. This partnership resulted in effective resolution of community issues involving Marines.
- **Eaglewerx Program (Fort Campbell).** This innovative program is a collaboration between the Army, academic institutions, and industry. Eaglewerx's dedicated staff work with service members, often junior enlisted soldiers, experiencing practical problems in their work. Service members request a consultation by describing the problem, breaking down the process underlying the problem, and proposing a solution. Full time active-duty and industry staff collaboratively review projects, brainstorm solutions, and work with Soldiers to develop prototype products to solve the problem.
- **Partnerships with privatized housing (Nellis Air Force Base).** Strong partnerships between installation commanders and privatized property management companies appeared to foster healthier and more connected communities, and quicker resolution of housing-related concerns (e.g., maintenance requests) as compared to installations without these collaborative relationships. Privatized housing communities that encourage family or community activities were identified as having more value to the military population.
- **UNITE (Air Force).** UNITE funds are available for activities and meals designed to enhance group cohesion and team building; meals must be provided in conjunction with the activity. The availability of funding, albeit limited, was perceived by military personnel to benefit connections among peers and to promote good order and discipline.
- **Better Opportunities for Single Soldiers (BOSS; Army).** The mission of BOSS is to enhance the morale and welfare of single soldiers, increase retention, and sustain combat readiness. The program's target demographic is the 18–24-year-old junior enlisted soldier on their first or second duty assignment. Some notable BOSS programs and initiatives include:
  - The Fort Wainwright BOSS program sponsors Soldiers Against Drunk Driving, a volunteer program that provides transportation for Soldiers who are under the influence of alcohol.
  - The Fort Campbell Warrior Zone provides free Wi-Fi, gaming computers, movie rooms, and other entertainment or activities, as well as a support staff that actively engage with service members utilizing their services. Facilities are collocated with a food vendor, which appeared to increase engagement by service members.

- The Camp Humphreys BOSS activities are identified and led by the Soldiers, providing them with a voice and opportunity to impact their peers' well-being.



## Clinical and Community Preventive Services

- **The Warrior's Keeper Program (Fort Campbell).** This volunteer mentorship program targets Soldiers experiencing difficulty in their personal or professional lives. Soldiers match with mentors (Warrior Keepers) who have experienced similar challenges to serve as a role model and to provide support to the soldier. Volunteer Warrior Keepers receive suicide prevention training and command allows flexibility for Warrior Keeper's schedules.
- **Comfort Dogs (Nellis Air Force Base).** Comfort Dogs bring dogs to visit service members in dorms every other week. Having the animals within an easily accessible location promotes morale and provides comfort.
- **School Liaison Officers (Nellis Air Force Base).** School Liaison Officers (SLOs) serve as points of contact for incoming families of school aged children. They often assist the families with stressors related to moving and engage in prevention services. While most installations have a SLO, the SLO at Nellis Air Force Base also engages in community prevention efforts, consistent with the "no wrong door" concept.
- **Community suicide prevention coalitions (multiple installations).** Although most communities surrounding military installations have community suicide prevention councils, some installations did not engage with their community council. Participation in community suicide prevention councils were helpful for identifying current community trends in suicide as well as identifying alternative treatment resources in the community.
- **Suicide prevention recognition programs (multiple installations).** Recognizing individual service members' proactive engagement in suicide prevention efforts increased morale and reinforced peer support.
- **Your Safe Place (Naval Air Station North Island).** Your Safe Place (YSP) supports survivors of intimate partner and family violence in San Diego County, CA. YSP reported positive collaborations with the Family Advocacy Program and New Parent Support Program, providing access to services that complement those available on base.



## Treatment and Support Services

- **Partnerships with community mental health providers (multiple installations).** Multiple installations established effective partnerships with local mental community health agencies who provide culturally competent and evidence-based behavioral health services to military personnel. Six of nine installations visited by the SPRIRC, for example, had collaborative relationships with local Cohen Veterans Network clinics. Culturally competent services increased the military community's willingness to access services.
- **Community intervention teams (Fort Campbell and Naval Air Station North Island).** Clarksville, TN, and San Diego County, CA, have crisis intervention teams that work closely with law enforcement to respond to mental health crises. These teams' connections with military law enforcement and support agencies are considered essential to their success in serving military-connected clients.
- **Human Performance Teams (Creech Air Force Base).** Human Performance Teams (HPTs) embed behavioral health technicians, chaplains, and other support personnel conduct outreach and targeted interventions within military units and workplaces. At Creech Air Force Base, HPT personnel undergo top security clearance review to allow them to meet with service members "behind the door" in secured work areas, thereby improving access and reducing concerns about help-seeking.
- **True North (Air Force).** The True North program embeds behavioral health clinicians and chaplains into military units to augment clinic-based behavioral health services. Research examining the effects of True North supports the program's effects on reducing stigma, increasing help-seeking behaviors, and improving access to care. Despite its demonstrated benefits, the True North program has been discontinued or severely scaled back at most installations because of insufficient funding.
- **Wellness Coordinators (Fort Campbell).** Wellness coordinators embedded with Criminal Investigation Division (CID) units are behavioral health clinicians who meet with CID agents to discuss life problems and stressors without triggering a behavioral health referral. The program has reportedly increased the willingness of CID agents to address issues and problems earlier.



## Surveillance, Research, and Evaluation

- **Suicide prevention research funding.** The DoD has dramatically advanced suicide prevention research efforts within the U.S., resulting in several key findings that have advanced scientific and public understanding of suicide. The DoD has become one of the nation's leading funders of suicide prevention research.



- **Millennium Cohort Study.** The Millennium Cohort Study is a DoD research project created in 2001 in response to growing concern about the potential impact of military deployments. Since 2001, the project has enrolled over a quarter of a million service members from multiple generations, making it largest and longest-running health study in military history.
- **Creation and support of multidisciplinary research collaboratives.** DoD-sponsored research has stimulated the creation of multiple large, multi-institution research collaboratives focused on conducting research to prevent suicide, reduce suicide risk factors, and promote psychological health and well-being among military personnel. Some of these collaboratives include the Army Study to Assess Risk and Resilience in Service members (Army STARRS), the Military Suicide Research Consortium (MSRC), the South Texas Research Organizational Network Guiding Studies on Trauma and Resilience (STRONG STAR), the Consortium to Alleviate PTSD (CAP), the Chronic Effect of Neurotrauma Consortium (CENC), the INjury & TRAumatic STress (INSTRUST) PTSD/TBI Clinical Consortium, and the Augmenting Suicide Prevention Interventions for Service members (ASPIS). Many of these collaboratives involve partnerships among academic institutions, the Services, and military installations. The outcomes include critical information about improving medical and psychological treatments for at-risk military personnel.
- **Publicly available research data.** Data collected as part of the Army Study to Assess Risk and Resilience in Service members (Army STARRS), a large epidemiological study of suicide risk and protective factors among Army personnel, and the Military Suicide Research Consortium (MSRC), a collection of studies focused on developing novel assessment and intervention methods to prevent suicide, are available for public use by researchers who receive appropriate regulatory approvals. Publicly available research data rapidly accelerates the ability of researchers to better understand suicide among military personnel.
- **Improving the effectiveness suicide prevention treatments and interventions.** DoD-sponsored research supported the development of brief cognitive behavioral therapy for suicide prevention (BCBT), an outpatient psychological treatment that reduces suicide attempts among active-duty military personnel by 60% as compared to usual behavioral health treatment (Rudd et al., 2015), and crisis response planning (CRP), a brief intervention that reduces suicide attempts among military personnel by 76% as compared to usual crisis management methods (Bryan et al., 2017). BCBT and CRP have since been adapted for use in other populations. The DoD has not yet funded training efforts to implement BCBT, CRP and other evidence-based treatments across the Military Health System, however (see Chapter 6).
- **Improved suicide risk screening and assessment methods.** DoD-sponsored research has resulted in the identification and refinement of novel suicide risk screening and assessment methods. The DoD-sponsored PRimary care Screening Methods (PRISM) study, for example, has revealed important information about optimal ways to screen for suicide risk in Medical Treatment Facilities (MTFs). Results of these studies have led to the refinement of the Suicide Cognitions Scale (SCS), a self-report scale that improves the identification of military personnel who will attempt suicide. These findings have not been translated into clinical practice across the DoD, however.
- **Developing effective upstream suicide prevention strategies.** DoD-sponsored research has led to the development of universal peer-to-peer interventions to prevent suicide. The Wingman Connect

program has been found to significantly reduce suicidal ideation and depression among military personnel (Wyman et al., 2020) and the Airman's Edge program demonstrated the feasibility of CRP training and use among non-healthcare professionals (Baker et al., 2021).



## Chapter 3: Overarching Department of Defense Issues

The DoD's suicide rate remains elevated despite considerable investment in a variety of strategies. When asked about stressors service members face, we heard of institutional practices, procedures, and cultural norms that increase work demands, reduce the availability of down time, contribute to hopelessness and perceptions of entrapment, and degrade psychological health and well-being. The DoD's complex and strict hierarchical organizational structure further impedes its ability to implement effective strategies and quickly adapt to community needs. Other practices steeped in historical precedent and tradition lag modern expectations and social norms about career progression and meaningful employment, creating tensions that increase psychological and social strain for military personnel and their families. The DoD therefore struggles to prevent suicide in part because many of its own systems, rules, and cultural norms get in the way of well-intentioned efforts that inadvertently create stress in the daily lives of service members and family. This stress reduces military readiness, can lead to premature separation, and contributes to recruitment challenges as the system strains to adequately support its members. To better prevent suicide, the DoD should therefore seek to remove institutional practices, procedures, and norms that impede the implementation of evidence-based practices and strategies that could save lives. Reflected in this chapter, the overarching issues outlined here are integrated throughout this report and in specific recommendations.

### The Military Promotion System

The military's promotion system was identified by many military personnel of all ranks as problematic and outdated. Because military leaders have such a strong influence on the well-being of their subordinates, greater care in the promotion and leadership selection process at all levels of the military could create a culture and environment that reduces vulnerability to suicide. Rather than focusing on characteristics and behaviors that are conducive to effective leadership, however, the military's promotion system overemphasizes the quantification and rank-ordering of work-related activities that have little to no bearing on leadership potential (e.g., number of jumps, number of patients seen), encouraging unproductive competition and zero-sum thinking. Current standards for promotion do little to evaluate a service member's ability to lead and inspire people as well as manage complex systems, resulting in the promotion of individuals with good technical skills but poor personnel management abilities. Military personnel also pointed to the "up or out" institutional norm wherein people are discharged from or "forced out" of the military if they do not promote on schedule, even when promotion is not in the best interest of the service member or the military. One military officer talked about how the military's stratification practice encourages officers to "push their people to the limits" so they can have better numbers than other officers.

The promotion system also encourages excessive focus on self-preservation as military leaders achieve greater rank, prompting leaders to increasingly make “safe” decisions that are “good for their career” even when such decisions come at the expense of subordinates’ well-being.

**3.1 Create a Task Force to modernize and reform the military promotion system to better reward and select the right people for the right positions at the right time based on demonstrated leadership skills and abilities.** Across the Services, the military promotion system places too much emphasis on longevity and stratification of work-related activities while de-emphasizing leadership qualities and potential. In some Services, promotion selections for junior personnel are also based in part on service members’ performance during “boards,” which are highly vulnerable to bias. The SPRIRC heard concerns about promotion processes at every level of leadership including at the most junior levels, such as for the non-commissioned officer corps. The Army’s Battalion Commander Assessment Program (BCAP) for senior leaders provides a potential model for this reform. Although the BCAP’s scope may not be feasible for implementation at all levels of the military, the core principles that underlie BCAP could be implemented more broadly across the DoD.

**3.1.1 Provide greater flexibility in military career trajectories in the military promotion system.** The “up or out” promotion mindset needlessly increases the risk of underqualified or underprepared military personnel being placed in positions of responsibility and authority and encourages high-performing and talented military personnel to prematurely leave military service. These norms often cause significant relationship strain, which in 2021 was documented in almost half of military suicides. Some military personnel also described feeling “trapped” by these decisions, resulting in significant emotional distress. Military personnel further described feeling as if the military forced them to choose between their careers or their families because of rigid institutional norms about career progression. Many of these individuals reported that this tension leads to pre-planned exits from the military despite strong service records and likelihood of promotion. Creating greater flexibility in military career trajectories and more autonomy over one’s career progression could significantly reduce emotional stress and avert relationship strain for many military personnel in addition to improving sustainment of current service members. The task force should consider how to provide opportunities for high performing service members to continue working in their technical specialty indefinitely.

*“I have a soldier who likes to turn wrenches. The military says he needs to promote or get out, though, even though he has no desire to be in a leadership position and everyone knows he wouldn’t be good at that. Why can’t he just turn wrenches? He’s really good at that and he likes it, but that’s not good enough in the military, so he’ll probably get out.”*  
--Army E7

## Organizational Instability Caused by Frequent Moves

An institutional practice that serves as a common source of stress for many military personnel and families is frequent PCSs that typically occur every 2–4 years. Frequent moves can indirectly increase suicide risk by increasing stress, creating instability in social support networks, and introducing financial strain. Frequent turnover in military commanders—typically occurring every two years—also contributes to enormous instability within the system and the reticence of many leaders to take on complicated problems because of time limitations and concerns that these changes will be abandoned by subsequent leaders. Military personnel also reported having to PCS against their wishes, even when they had volunteered to stay in difficult-to-recruit locations. For example, multiple military personnel stationed in Alaska reported having to “fight” with their Service leadership to stay in place even though these locations were understaffed and historically unappealing to other military personnel. In most cases, these service members were told that staying in place for too long would be “bad for their career.”

Service members also reported lengthy delays in receiving travel reimbursements, recurring problems with the DoD’s electronic voucher system, frequent damage to household goods, and confusing and complicated claims systems that often resulted in lost time and finances. Multiple senior military personnel and families who had moved multiple times during their careers reported that these PCS-related problems had become increasingly common over time, especially since the consolidation of Defense Travel Management Office functions. Consolidation of this office reduced the availability of travel management office representatives at local military installations who could support military personnel and their families during these stressful transition periods. Dual military couples also reported out-of-sync PCSs that were particularly burdensome for those expecting children or those with children. Such disruptions and burdens create challenges for equal employment opportunities. Several service members, typically women, in dual career marriages stated that they planned to end their service earlier than initially planned because continuing to serve was not possible with their family constellation. This results in poor retention of service members with strong service records. Military personnel also noted that frequent moves disincentivized the formation of new relationships with peers and the local community, contributing to isolation and disconnectedness, two leading risk factors for suicide. Reducing the frequency of reassignments without impacting career progression may reduce suicide risk by helping military personnel and families establish and maintain strong social networks, minimize frequent disruptions to routine, and reduce financial strain.

- 3.2 Reduce the frequency of reassignments.** Less frequent moves can increase social stability, promote unit cohesion, and provide greater financial stability, particularly impactful for dual military families. It would also reduce burden on already strapped DoD business operations that are understaffed and difficult for service members to navigate.
- 3.3 Extend the length of command assignments.** Military commanders are expected to move frequently, often every two years. High turnover among military leaders creates and sustains instability within the system. Service members and families repeatedly described difficulty wading through a confusing multitude of programs and services that are continually started and stopped when leadership changes, even when programs are anecdotally beneficial. Other programs are only partially implemented or under resourced,

preventing them from operating as intended. Some programs are “sunset” when leadership changes, the program’s champion leaves, the contract is terminated, or the budget is cut. Alternatively, some ineffective programs continue because there is no oversight when leadership turns over. Rapid leader turnover disrupts the military’s ability to address complicated problems that require more time to fully understand and target. Major problems that adversely impact service member well-being therefore persist for longer than necessary. Lengthening the duration of military command assignments could improve the military’s ability to effectively address complex problems like suicide.

- 3.4 Offer new assignments to military personnel before they reenlist or extend their military service.** Military personnel repeatedly expressed a desire to have more input in the assignment selection process, explaining that they often felt “trapped” in undesirable locations or career lines when reassignments were issued after they had already committed to additional service. Military personnel recommended that assignment options be made available to them and confirmed *before* they decide to extend their service commitment. Research shows that choice availability reduces the stressfulness of consequent situations by increasing perceptions of control (Paterson & Neufeld, 1995). Perceived control over stressors is also associated with reduced psychological distress (Fassett-Carman et al., 2020). Changing the reassignment selection process to provide service members with greater input and control could improve well-being and reduce emotional stress and feelings of being trapped, an especially strong risk factor for suicide (Taylor et al., 2011).

## Slow Hiring Processes and Outdated Approaches to Filling Job Vacancies

DoD hiring practices are cumbersome and inefficient. The length of time it takes to hire a person in the DoD system often results in many civilian applicants giving up and finding employment elsewhere. This issue contributes to organization-wide staffing shortages, contributing to increased workloads and stress across the entire organization. In meetings with multiple programs and offices, the SPRIRC was informed of numerous instances where job candidates received no communication from the DoD about their application until a year or more after they applied, at which point they were notified that they were approved for hire. Many candidates accepted competing offers well before this notification is received, resulting in significant waste of time and effort by the DoD. Further, there exists a large untapped resource of military spouses (professional and non-professional) who could fill much needed positions at installations who are prevented from service because of bureaucratic barriers and limited child care options. Current regulations also prevent many well-qualified and appropriately trained individuals from applying for jobs within their scope because of historical hiring processes and policy guidance. As will be discussed in Chapter 6 of this report, slow hiring processes also contribute to behavioral health staffing shortages, limiting access to behavioral health care and undermining its effectiveness.

- 3.5 Establish a task force to eliminate legal and bureaucratic barriers to efficient hiring and onboarding processes.** Personnel shortages across the DoD were reported by multiple stakeholder groups, resulting in excessive workload for military personnel and DoD civilian employees. Unfilled positions in DoD support programs like the Child Development Centers (CDCs) and substance use programs hamper the DoD’s ability to

effectively target common sources of stress within the military community whereas unfilled behavioral health positions delay access to care for at-risk military personnel, prolonging symptom resolution and recovery from high-risk states. Across the board, slow and inefficient hiring and onboarding processes were frequently cited as barriers to filling these vacant positions. Identifying and eliminating legal and bureaucratic barriers to efficient hiring and on-boarding processes would allow the DoD to quickly fill vacant positions, reducing workload demands across the DoD and strengthening services that could reduce stress and improve well-being among military personnel. The task force will develop policies to allow dual-encumbered positions to quickly address vacancies, establish shortened timelines for each step of the hiring process, standardize and classify all position descriptions for clinically licensed behavioral health practitioners and determine responsible program offices for each hiring component.

## Poorly Functioning Systems and Aging Infrastructure

Across the DoD, multiple stakeholder groups reported significant frustration and stress surrounding poorly functioning systems, inadequate resourcing, and dated infrastructure. Computers routinely take over 30 minutes to boot up, email systems take over 10 minutes to load, computers frequently freeze or lock up when multiple work-essential programs and systems are running simultaneously, and printers do not routinely function. Furthermore, despite the DoD's expanded use of digital and computer-based methods to complete required trainings and workflows, many enlisted personnel do not have access to DoD computers in their duty locations, causing competition for access to the limited number of functional computers and workstations available for use in the workplace. To compensate, military personnel at many bases use computers and printers at Morale Welfare and Recreation (MWR) facilities to meet mandatory training requirements and other administrative tasks. Compensatory strategies reduce overall productivity and create added work stress.

Military personnel also reported recurring work stoppages and delays because of flooding, plumbing problems, and electrical problems resulting from aging infrastructure. "It's mind-blowing what standards we tolerate in the military," one officer said when discussing infrastructure and equipment problems. *Of greatest concern, poorly functioning systems sometimes cause and/or sustain risk factors that increase risk for suicide.* The Air Force's myEval, myDec, and myFSS systems, for example, reportedly lock up and crash frequently, creating disruptions in Airman pay, reimbursements, awards, and promotions. The Navy's eNavFit system, deployed within the past month, has experienced similar technical "glitches" and problems. The Defense Finance and Accounting Service's SmartVoucher system was another system that reportedly creates unnecessary stress and financial strain for military personnel because of repeated voucher denials and delayed reimbursements. One finance officer estimated that approximately half of the in-bound service members at their installation experienced a SmartVoucher rejection, adding that repeated rejections were common. These systems problems are compounded by personnel shortages, limiting the military's capacity to quickly resolve problems and develop strategies to avert their recurrence. The combination of poorly functioning systems with downsized workforce reduces productivity, increases work-related stress, and creates financial strain across the entire



force. Personnel must also work extended hours to compensate for these deficiencies, disrupting social support networks and creating relationship strain within military families.

- 3.6 Create a task force charged with improving the usability and reliability of military information technology systems while balancing its various security needs.** Slow and unreliable computer systems and information technology networks were cited as a leading workplace stressor that frequently interfered with routine work demands, extended work hours, and degraded well-being. Because some of these issues are caused by cybersecurity measures that consume significant computer processing requirements and interfere with the interoperability of computers with printers, scanners, and other external devices, the task force should review existing DoD cybersecurity processes. This review will help identify ways to reduce their impact on mission achievement. The DoD should also ensure its computer equipment can handle such security measures.
- 3.7 Ensure military installations and units are properly resourced with computers, printers, internet connectivity, and other hardware and systems necessary to complete military requirements.** In some units, the number of computers available to complete mandatory training and access DoD systems is insufficient. This problem is especially pronounced in National Guard and Reserve units, requiring personnel to complete military requirements while off-duty, interfering with social and family relationships. The lack of reliable connectivity also prevents medical and non-medical providers from effectively communicating with one another and delays command from successfully and efficiently implementing change from established feedback systems aimed at improving mission readiness. The DoD should properly resource all military installations and units with functioning computers, printers, and internet connectivity for military personnel to complete work-related tasks while on-duty.

## Lack of Collaboration and Synchronization of Efforts

DoD suicide prevention efforts are hampered by stove-piping and limited collaboration across DoD offices and Services, resulting in duplicative efforts and programmatic silos that have impaired the ability to develop a holistic approach to suicide prevention and response. For example, numerous assessment tools and surveys with overlapping content and focus are used by the Army to assess unit climate, psychological health, and organizational risk factors: DEOCS, Behavioral Health Pulse, Unit Risk Inventory, Army Readiness Assessment Program, Azimuth Check, and Soldier Risk Assessment. Because each tool is managed by a different office and was developed to meet a specific need that could not be achieved through effective cross-organization collaboration and data sharing, military personnel and leaders perceive they are constantly being surveyed. Collaboration and data sharing with researchers and entities outside the DoD is even more difficult, hamstringing DoD efforts to quickly develop innovative strategies. Restricting collaboration and the flow of information and ideas from all sources stifles the very innovation the DoD desires to effectively prevent and respond to suicide and creates needlessly redundant work, increases cost and time, increases stress and degrades well-being for military personnel.



- 3.8 Centralize responsibility for core suicide prevention activities that are common to all Services.** Certain suicide prevention activities like annual awareness trainings and post-suicide death investigations are conducted by all Services but are not standardized, impeding the DoD's ability to evaluate program impact. Responsibility and authority for these activities should be centralized within DSPO, operationalized to the Prevention Workforce, and DoD policy should be updated accordingly to ensure the Services are required to comply with suicide prevention activities.
- 3.9 Improve data sharing across DoD offices and Services.** Military program leads and researchers reported numerous bureaucratic, policy, and legal roadblocks surrounding data ownership and data sharing. Staffing shortages further hinder data sharing by serving a bottleneck for responding to data requests. As a result, DoD offices and Services often create and field their own surveys, knowing that this practice contributes to survey fatigue and frustration for military personnel. The DoD should review data sharing policies and remove barriers that impede rapid, efficient data sharing and dissemination across DoD offices and programs.



## Chapter 4: Healthy and Empowered Individuals, Families and Communities

The DoD Strategy for Suicide Prevention (DSSP) was published in 2015. Efforts to implement this strategy lack consistency because responsibility for suicide prevention initiatives and efforts are delegated to the Services. Although this allows each Service to customize suicide prevention efforts to their unique needs, limited collaboration, and synchronization of efforts—noted in the section on Overarching Issues have resulted in redundant programs that consume limited resources. In other areas, this has created asymmetric efforts that create inefficiencies and double work, resulting in confusion and frustration across DoD. Within each Service, suicide prevention initiatives are sometimes implemented without evidence of effectiveness, and without integrating program evaluation or long-term sustainment plans. Thus, programs and initiatives “come and go” quickly, precluding the opportunity to meaningfully assess their impact and limiting the potential for widespread implementation even when effective in reducing suicide.

This pattern is sustained by the way DoD is funded, with an annual budget that is regularly plagued by continuing resolutions, leading to unstable funding for programs and contracts necessary for ongoing effective suicide prevention strategies. This pattern is also reinforced by cultural norms and promotion practices that expect military personnel, especially officers in leadership positions, to frequently change positions for career progression (see Chapter 3). High turnover of suicide prevention program leaders hampers the effectiveness of DoD’s suicide prevention efforts and results in lost opportunities for impact. The DoD’s general lack of an actionable and evolving strategy for suicide prevention implementation also contributes to a general perception that suicide prevention is not taken seriously by the organization. Emphasizing this point, one enlisted service member stated, “we are just waiting for the next one to die; they don’t care.”

The absence of a comprehensive suicide prevention strategy is also reflected in reactive decision-making by military leaders who feel pressured to “do something” quickly whenever a suicide occurs. Reactive decision-making is further reinforced by external sources that focus on suicide counts during inappropriately narrow timeframes that are divorced from broader trends and context. Comparing suicide numbers from one year to the previous year, for example, has become routine practice even though this strategy typically cannot provide useful or meaningful information about the impact (or lack thereof) of a given program or initiative. Programs are then stopped or replaced before their full impact can be assessed with new programs hastily deployed before they have been fully and thoughtfully developed. This focus on immediacy has pressured

program leads to develop products designed to meet compliance requirements but often do not address the underlying issues that contribute to military suicide. Personnel shortages across the DoD compound these issues. Collectively, these forces have impeded the DoD's ability to develop and sustain a long-term enterprise-wide suicide prevention strategy. Furthermore, it contributes to an exaggerated overemphasis on compliance standards, resulting in a "check-the-block" approach, experienced by service members as leadership not valuing their lives. The DoD must improve coordination of suicide prevention programming and activities across the Services.

## Suicide Prevention Training

The SPRIRC identified significant concerns regarding DoD suicide prevention training efforts. Most service members shared that the discussions of suicide were typically limited to annual required suicide prevention training or following a suicide death. In many cases, service members reported trainers had limited interest, experience, or preparation in providing suicide prevention training. This was particularly salient in the National Guard, where personnel reported being handed a script mere minutes before a training started and directed to deliver the suicide prevention training to their peers.

At all installations, service members from every Service and at all ranks agreed that the content, frequency/dosage, and means of delivering suicide prevention training are ineffective and serve only to "check the block."

Service members also complained of overreliance on poorly designed PowerPoint presentations, conducted in large groups in dark auditoriums as part of back-to-back mandatory training. During these "death by PowerPoint" presentation marathons, many service members reported falling asleep or being on their cell phones. Self-directed computer-based training provided little improvement because, as described in Chapter 3, many service members do not have access to computers in their work areas, and the functioning computers that are available run very slow and/or cannot connect with local printers, preventing them from printing their training completion certificates. Finally, and perhaps most disturbing, some service members expressed concern that excessive focus on suicide "warning signs" may inadvertently teach at-risk service members which behaviors to avoid reporting to evade detection by others. Overall, the DoD's current approach to annual suicide prevention training is redundant and unengaging, leads to exhaustion with the topic, and does not build primary prevention skills or encourage desired behavior change.

**4.1 Modernize the content, delivery, and dosage of suicide prevention education and skill-building across the career cycle of military personnel.** To maximize effectiveness, suicide prevention training practices should be tailored to different settings, development levels, roles within the organization (e.g., supervisor duties), and diverse populations. Training updates should attend to four key dimensions and should provide sufficient variety to better match the needs of different groups, situations, and intended effects: Content, delivery method, dosage, and variety.

**4.1.1** With respect to **content**, separate training should be developed for different audiences and for intended effect. For example, training designed to encourage service members experiencing severe distress and/or suicidal thoughts to access

treatment or support services should be distinguished from training designed to help service members recognize and respond to peers in distress, and also distinguished from training designed to help supervisors and leaders recognize and respond to service members or peers in distress. Training intended to encourage learners to take action to help others should emphasize skills training methods proven to develop behavioral competencies. Because resources and services can vary across installations, training should be accompanied by installation-specific information and materials (e.g., “handouts” or electronic equivalents).

- 4.1.2** To maximize interaction and discussion of the material, with respect to **delivery method**, training should be delivered in small groups of service members with similar rank and/or positions instead of mass “one-size-fits-all” trainings. Groups larger than 20 will dilute prevention effectiveness and hamper interactive engagement. Training instructors should be selected based on their interest in the topic and demonstrated ability to present or teach. Instructors should receive sufficient training and preparation in advance to effectively communicate the information and facilitate discussion.
  - 4.1.3** With respect to **dosage**, the DoD should vary training duration and frequency to maximize engagement and efficacy. Whereas some content and effects may be better delivered with high frequency but brief methods (e.g., disseminating information about support services), other content and effects may be better delivered using longer methods delivered infrequently (e.g., supervisor training in recognizing and responding to personnel in distress).
  - 4.1.4** With respect to **variety**, the DoD should allow service members to select from a range of complementary topics and educational materials to meet training requirements. For example, training focused on intervening with peers could include separate modules focused on active listening skills, crisis response planning, and lethal means safety. Service members could select one of these modules to meet their training requirements. Increased variety and decision-making autonomy could increase interest and engagement and reduce perceptions of redundancy.
- 4.2 Centralize suicide prevention training curriculum.** As noted in the previous sections of this report, responsibility for developing and implementing suicide prevention training is delegated to the Services, resulting in duplicative efforts. Responsibility and authority for suicide prevention training should be centralized within DSPO and operationalized through the Prevention Workforce, and DoD policy should be updated accordingly to ensure the Services are required to comply with suicide prevention training assigned to the selected office. DSPO, in coordination with the Prevention Workforce, should collaborate with the Services to ensure that Service-specific needs and issues can be appropriately addressed and incorporated into the training components that are general to all branches, such as uniform risk and protective factors. As part of this change, a centralized training management system should be created to improve the tracking of training implementation and completion. Regular and ongoing program evaluation of suicide prevention training

should be incorporated into DSPO and operationalized within the Prevention Workforce responsibilities.

- 4.3 **Require Military Exchange personnel to complete skills-based training designed to recognize indicators of elevated emotional distress and effective methods for interacting with and responding to acutely distressed customers.** Military Exchange personnel who sell firearms and ammunition may be ideally positioned to identify and intervene with at-risk military personnel experiencing acute emotional distress. DSPO should create and implement customized suicide prevention training for Military Exchange personnel who sell firearms and ammunition. The training should include content focused on observable indicators of emotional distress and skills training focused on approaching and effectively responding to distressed customers.

## Personnel Under Investigation

In 2021, 23% of service members who died by suicide were experiencing or had experienced legal or administrative challenges during the preceding year. Over half of these service members were under investigation (DSPO, 2021). Being the focus of an ongoing investigation creates a combination of individual and occupational stressors that can increase risk for suicide compounded by poor handling by investigators or command. During SPRIRC site visits, military lawyers and investigators reported that service members under investigation are often ostracized by their peers, increasing their sense of isolation and undermining a core source of social support. Although public health models of suicide prevention would suggest these statistics signal a high-risk subgroup warranting targeted prevention, the Air Force was the only Service to have any suicide prevention initiative directly targeting this high-risk subgroup.

- 4.4 **Expand the Limited Privilege Suicide Prevention (LPSP) Program to all service members undergoing investigation in all Services.** The Air Force's LPSP Program provides increased confidentiality during behavioral health treatment to service members at risk for suicide who are undergoing legal action. The program removes a barrier to help-seeking in this high-risk group and protects information service members under investigation share with a behavioral health clinician during treatment. Such information cannot be used in existing or any future UCMJ action. A behavioral health clinician can place an Airman or Guardian in the program after they have been evaluated as having elevated risk for suicide. The DoD should create a DoD-wide version of this program that is available to all service members undergoing investigation in all Services.
- 4.5 **Implement the Air Force's Commander/First Sergeant Checklist for Airmen and Guardians Under Investigation across all Services.** In accordance with AFI 90-5001, *Integrated Resilience*, the Commander/First Sergeant Checklist for Airmen and Guardians Under Investigation or Involved in the Military/Civilian Criminal Justice/Legal Systems was implemented in the Department of the Air Force in April 2021. The checklist outlines actions to be taken within the first 24 and 72 hours of an Airman or Guardian being notified they are under UCMJ or Command Directed investigation, or a civilian jurisdiction for a criminal offense. The checklist outlines actions including handoff procedures from investigators to the unit, reinforcing the service member's value to the unit, informing the service member of available resources including the LPSP program, and taking steps to

maximize their physical safety. The DoD should create a DoD-side version of this checklist and ensure it is available to all unit commanders and senior enlisted leaders. The current Air Force checklist and future DoD checklist should include provisions on “need to know” within units, with a goal of helping to ensure that details of crimes for which people are under investigation are not widely discussed within units.

- 4.6 If DoD program evaluation and research find that some investigations and offenses are associated with especially increased risk of suicide, the DoD should develop policies requiring a specially trained behavioral health professional to be present at the initial notification of the subject.** Military investigators, lawyers, and law enforcement personnel at many installations said that crimes against children, specifically child sexual assault and child pornography, anecdotally, were the types of charges most associated with suicidal behavior among service members under investigation. These informants were unaware of any DoD databases or tracking systems that could provide quantitative data to confirm their impressions. If DoD program evaluation and research identifies specific types of charges and offenses that significantly increase the risk of suicide among service members (see Recommendation 7.5 in Chapter 7), the DoD should require specially-trained behavioral health professionals to be present when a service member is first notified that they are under investigation for one of these offenses. Co-response models in which behavioral health professionals accompany law enforcement to certain types of events such as those mentioned above are becoming increasingly common in the United States. Such models could help to de-escalate incidents (and thus police use of force) and link those at risk to available resources. The behavioral health professional could conduct a suicide risk assessment, provide targeted interventions like Crisis Response Planning to reduce acutely elevated risk, and provide consultation to unit leadership and investigators to connect the service member to indicated support agencies and resources.

## Postvention Response

The suicide death of a service member can negatively impact the well-being and psychological health of their families, friends, and peers (Pac et al., 2021). The negative effects of suicide loss are especially pronounced in close-knit communities like military installations. How the community responds to a suicide—also known as *postvention*—can influence the magnitude of the loss on others. The DoD provides instruction and toolkits to assist unit commanders, but our site visits revealed limited awareness of these resources and uncertainty about how and when to use them, leading to inconsistent responses across installations and even across units within installations. Inconsistent use of these resources could result in unhelpful messaging that inadvertently reinforces stigma and discourages help-seeking. In addition, we heard from service members at every installation that failure to provide a sincere postvention response left them wondering if they mattered. If command can overlook the death of a service member to suicide than it will be just as easy to overlook the death and contribution of any service member to the unit. Some commanders and senior

*“We shouldn’t have to fight  
command to have a  
memorial. It helps us  
grieve.”*

*-Enlisted Soldier, Army*

leaders reported they refused to hold memorials for suicide decedents because of concern that doing so would “glamorize” suicide or encourage additional suicide attempts. One commander explained, “If we have memorials, there will be copycat suicides because now they know they have our attention.” This perspective was shared by some chaplains, who are frequently called upon to assist with casualty response. Improved implementation of existing postvention protocols could promote healing among suicide loss survivors, minimize the negative effects of suicide loss, and enhance the effectiveness and consistency of the DoD’s response to suicide loss.

**4.7 Amend DoDI 6490.16 to reference DoDI 1300.15.** Section 5 of DoDI 6490.16, *Defense Suicide Prevention Program*, provides guidance and recommendations for unit memorial ceremonies and services following the suicide death of a service member. Section 5.2 states that “Commanders (and equivalent leaders) are strongly encouraged to conduct a memorial event for every service member who dies while assigned to their unit, regardless of the cause and manner of death.” Inconsistent application of this guidance to suicide decedents, has created the perception that suicide decedents are valued less than others. Guidance regarding military funeral honors ceremonies and eligibility for these services are provided by DoDI 1300.15, *Military Funeral Support*. To clarify eligibility and procedures for memorial ceremonies and services following a suicide death, DoDI 6490.16 Section 5 should be amended to reference DoDI 1300.15. Updated DoD policies and guidance specific to suicide deaths should also be communicated to commanders during professional military education and leadership training courses.

**4.8 Leadership focused suicide training should include how to implement postvention following a suicide or suicide attempt.** Such training should be designed to help commanders, senior enlisted leaders, and other leaders effectively and proactively respond to suicides and suicide attempts.

**4.8.1 Enhance implementation of the Postvention Toolkit for a Military Suicide Loss.** The *Postvention Toolkit for a Military Suicide Loss*, available on the DSPO website, provides guidance and resources for responding to suicide loss. The toolkit includes customized recommendations for multiple key individuals involved in responding to suicide loss (e.g., unit commanders and leaders, first responders, chaplains). These postvention strategies and recommendations are not used systematically by individuals from these key groups across installations because of limited awareness of the toolkit. The toolkit should be integrated into the suicide prevention training for leaders described above.

**4.8.2 Improve implementation of the Leaders Suicide Prevention Safe Messaging Guide.** The *Leaders Suicide Prevention Safe Messaging Guide*, also available on the DSPO website, provides guidance for how to notify personnel about the suicide of a peer, how to communicate with external audiences via social media and traditional media, and common misconceptions about suicide. Some military leaders and commanders expressed uncertainty about how to talk about suicide loss with their units and the media, especially when multiple suicides occurred in a short period of time. The guide should be integrated into the suicide prevention training for leaders described above.

- 4.9 Develop an automated system to proactively push postvention resources to commanders and other key support personnel when a suicide occurs.** To support implementation of postvention protocols, the DoD should develop an automated system that proactively pushes information and resources from the *Postvention Toolkit for a Military Suicide Loss* and *Leaders Suicide Prevention Safe Messaging Guide* to commanders, senior enlisted leaders, and other key individuals involved in casualty assistance processes as soon as a self-inflicted death is reported<sup>3</sup>. This approach would increase the likelihood of commanders and other support personnel implementing recommended response strategies.
- 4.10 The Office of the Assistant Secretary of Defense for Sustainment and its counterparts within with Services should own a centrally funded contract(s) to ensure that all military installations have access to professional trauma scene cleaning and biohazard removal companies.** The SPRIRC heard reports of surviving family members, roommates, and peers having to clean up suicide scenes because of the limited availability of professional cleaning services or inadequate cleaning jobs (e.g., blood stains still being visible after cleaning). Service members and other DoD connected employees, especially those who knew the service member who died, should not be involved in cleaning death scenes.

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<sup>3</sup> The manner of death, suicide, can take weeks or months to be determined after the death. However, other characteristics of the death are available sooner, and could be used to prompt a response.





## Chapter 5: Clinical and Community Preventative Services

This section focuses on recommendations to improve the well-being of entire military communities with the goal of reducing vulnerability to suicide among service members. Well-being includes how a person subjectively feels, including how they think their life is going, whether they think their life has meaning, and whether they experience positive states like happiness and joy. These feelings of well-being can protect against severe emotional distress in the face of a stressor (Bryan et al., 2020) and reduce suicide risk in military personnel. An individual's well-being is also influenced by a variety of external objective factors such as one's educational attainment, housing, work, and neighborhood. Our recommendations are focused on boosting well-being by affecting individual behaviors (sleep quality, excessive and hazardous alcohol use, and financial management) as well as external factors like workplaces cultures (training management and leadership), the social environment (housing, access to highly lethal means of suicide), and family life. Many of these recommendations have already been raised in previous DoD and external reviews.

### Prevention Workforce

An important component for enhancing well-being across the military community is to ensure prevention prepared communities are a focus of command. If we can prevent harmful behaviors from beginning in the first place, we can save lives by emphasizing prevention and early intervention rather than waiting until the service member is in crisis. Arming the newly established DoD Prevention Workforce (DODI 6400.11) to achieve success is important. Primary prevention includes strategies, programs and initiatives that reduce both direct and indirect adverse personal, social, health and economic consequences. Integrating already existing, albeit siloed prevention programs, such as family advocacy, substance misuse, sexual assault/harassment, suicide prevention, EEO, etc., under one umbrella is imperative. These challenges share many risks and protective factors, and addressing the commonalities between these challenges will prepare our service members for a variety of concerns they may face in their careers. The Prevention Workforce is well suited to address all of these issues in a cohesive manner. To maximize the robust investment already occurring in mobilizing the DoD's Prevention Workforce, the following recommendations are made.

#### **5.1 Integrate All Prevention Efforts under One Operational Office within the Department of Defense.** Primary prevention of harmful behaviors remains siloed under

the current integrated primary prevention guidance with programs impacting harmful behaviors falling under different commands. Currently, integration of prevention at the OSD level occurs within the Prevention Collaboration Forum (PCF) that meets quarterly to provide governance. The focus of the integrated prevention model on secondary and tertiary prevention also functions as a silo in which prevention is lost in the levels of bureaucracy. Primary, secondary, and tertiary prevention will be successful when collaboration and sharing of resources and strategies occur. Cost savings brought about by reduction in duplication of efforts, faster implementation of innovative and effective strategies, and improved communication will result in better utilization of prevention supports by service members and their families. The SPRIRC recommends that the Family Advocacy Program (FAP) be placed under the Office of Force Resiliency (OFR), where it can be better aligned with related programs that currently exist under OFR: Defense Suicide Prevention Office (DSPO), the DoD Sexual Assault Prevention and Response Office (SAPRO), and the Office of Diversity, Equity and Inclusion (ODEI). Further, the USD(P&R) is currently identifying a non-clinical OSD-level Office of Primary Responsibility for Alcohol Policy (OPRAP), as recommended by the IRC for Sexual Assault Prevention in the Military. This office should also be aligned under OFR to ensure collaboration and integration with DSPO, SAPRO, ODEI, and FAP. All efforts should be made to integrate the programs at the Department level to truly impact all three levels of prevention, develop integrated prevention models, engage in program evaluation activities, and combine efforts at all echelons to maximize the impact of the workforce. A similar approach should be taken at the base/post/facility level.

- 5.1.1 Create Enduring Oversight Mechanisms for the Prevention Workforce.** For sustained oversight to ensure standardized implementation of the Prevention Workforce, twice annually the Services including the National Guard Bureau will provide briefings to the PCF. Such briefings must include: Number and location of positions posted and filled; percent of personnel participating in the workforce evaluation; projected locations for hiring; summary of barriers and successes; and status of prevention plans developed.
- 5.1.2 Develop Substance Misuse Prevention Policy.** As part of the Department's integrated primary prevention efforts, OUSD(P&R) Office of Drug Demand Reduction and Violence Prevention Cell, in collaboration with Health Affairs, will develop and issue substance misuse prevention policy as part of the Integrated Primary Prevention Policy. Such policy will provide key actions leaders at all levels will take to mitigate the role of substance misuse in suicide and other harmful behaviors. This effort should include OPRAP and be conducted in collaboration with the realignment of substance use services and mental health services as discussed in Chapter 6.
- 5.1.3 Transform the current Violence Prevention Cell into the Integrated Prevention Resource Center of Excellence.** To establish the DoD Prevention Workforce as a national model for prevention practitioners, USD(P&R) should establish an Integrated Prevention Resource Center of Excellence (IPRCOE) that is managed by a Tier-1 SES as the director. This CoE will host an annual

leadership/training Summit, maintain the prevention research clearinghouse required in DoDI 6400.11, assemble and disseminate evidence informed practices in prevention and provide expertise and additional resources/materials to support the standardization, professionalization, and full implementation of the Prevention Workforce across DoD. The IPRCOE should be resourced to support the expanded mission to include personnel.

- 5.1.4 Enhance Communication and Buy-in for Prevention Workforce.** The Prevention Workforce is a necessary and critical investment to enhance prevention effectiveness across the Force. While the establishment of the workforce is currently in a nascent stage, the SPRIRC found that leadership understanding and buy-in varied significantly across the sites visited. The workforce’s benefits will be limited if leaders at every level do not fully understand and embrace this capability. To address this implementation challenge, OUSD(P&R) should develop and implement a communications campaign and convene annual Cross-Service Workforce Summits of leaders who are “early adopters” and “influencers” to foster clear understanding, leverage lessons learned, and promote clear, direct, and consistent communication on the nature, role, and value of the Prevention Workforce.

## Training Management

Over the last two decades, the DoD was primarily focused on the Global War on Terrorism. Accordingly, garrison operations focused on continuous readiness in preparation for frequent deployments, leaving little time for rest or reset. During this time, traditional “peacetime” garrison-based functions and activities not directly related to overseas deployments (e.g., infrastructure maintenance) became less of a priority. Although withdrawal of U.S. military forces from Afghanistan could be viewed as the symbolic end to the Global War on Terrorism, because of ongoing tensions in Eastern Europe and East Asia, the DoD has not shifted back to “peacetime” garrison operations. Changing national security priorities have instead maintained the DoD’s high operations tempo (OPTEMPO) levels at many installations as the military shifts its readiness and preparedness to better meet these new priorities. Despite ongoing high OPTEMPO, the DoD and the Services continue to add new training requirements without removing or eliminating older training requirements. Across installations visited by the SPRIRC, training demands and requirements were identified as primary sources of stress, burnout, and demoralization. In the words of one officer, “It’s physically impossible to do everything I’m asked. At the end of the day, it’s the paperwork and number of requirements and inspections. So you have a pattern of things that are impossible. That creates toxicity.” This issue arises in part from the stove piping and limited collaboration across DoD offices and programs and is magnified by an undersupply of

*“It’s physically impossible to do everything I’m asked. At the end of the day, it is the paperwork and number of requirements and inspections. So you have a pattern of things that are impossible. That creates toxicity.”*

*--Army Officer*

computers, slow information technology systems, and limited access to high-speed internet— issues discussed in previous sections of this report. Improving training management practices and access to reliable computers and information technology systems would reduce vulnerability to suicide by reducing occupational stress and improving well-being.

**5.2 Form a task force to review required training and make recommendations to reduce training requirements that are not specific to maintaining military occupational competencies<sup>4</sup>.** Across military personnel of all ranks and Services, a resounding message heard by the SPRIRC was that the number of training requirements are unreasonable and exceed workload capacity. The primary source of stress comes from DoD-required training that are not essential to maintaining most job competencies (e.g., human trafficking training, cybersecurity training). These trainings create undo stress for military leaders, who often feel stuck in a “Catch-22,” responsible for ensuring the readiness of their personnel but also expected to ensure compliance with an ever-growing list of training requirements that impedes readiness training. In collaboration with the Services, this task force should consider how training purpose, content, delivery format, duration, timing, and frequency can be adjusted to reliably obtain the intended effect.

**5.3 Empower leaders to enact “set schedule” policies.** Across sites, a leading source of stress involved near-constant yet unpredictable changes to training and mission schedules. Because of this perpetual state of uncertainty, military personnel said they often have little idea what they will be doing on a day-to-day basis. “There’s no point in planning ahead,” one NCO commented, “because something always comes up. You can pour weeks or months of effort into something, then one night you get a text message that things have changed, so all that time and work was wasted.” This unpredictability creates significant disruptions in military families, leading to tension, relationship conflict, and financial strain. Examples of how family members are impacted when schedules abruptly change include having to problem solve transportation to and from school and other activities, arrange child care, and cancel family activities and plans made months previously. Service members who try to plan ahead, quickly find out that trying to arrange activities involving travel or coordination with their family and friends may result in financial hardship and hurt feelings. “Because we don’t schedule anything in advance, I can’t plan leave or travel far in advance. By the time my leave is approved, flights are really expensive. If we could just plan ahead and keep things fixed, it would save us all so much time and money.” This issue was reported

*“Because we don’t schedule anything in advance, I can’t plan leave or travel far in advance. By the time my leave is approved, flights are really expensive. If we could just plan ahead and keep things fixed, it would save us all so much time and money.”*

*--Junior Enlisted Service Member*

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<sup>4</sup> The SPRIRC endeavored to not add training requirements. However, we recommend modifying trainings and we discuss ways to integrate new content into existing training. We do recommend new training requirements for service members who possess or are required to use firearms, behavioral health clinicians, and military exchange personnel who sell firearms and ammunition.

at all levels, even by the most senior leaders. “Everyone has a boss,” one commander noted, adding, “I try as hard as I can to protect my people from these last-minute changes but my hands are tied by the expectations of my boss.” Increasing predictability throughout the DoD could prevent suicide by strengthening protective factors like social support, family relationships, and leisure time. The DoD should empower leaders to establish “set schedule” policies to reduce stress, anxiety, and frustration related to unpredictability.

- 5.4 Ensure that all military workplaces have a sufficient inventory of computers and access to high-speed internet for personnel to efficiently complete mandated trainings.** As discussed in the multiple sections of this report, many military units have an undersupply of functioning computers in the workplace, creating bottlenecks for personnel to complete computer-based trainings (CBTs) in a timely manner. These bottlenecks are compounded by slow computer processing speeds and limited or absent high-speed internet connectivity. Many service members reported having to leave their workplace to find computers to complete required CBTs, which sometimes interferes with mission requirements, or they stay after the duty day to complete these trainings, cutting into their personal and recuperation time. Morale, Welfare and Recreation (MWR) facility staff at many installations, reported their computer stations are regularly filled during lunch and after work hours with service members completing required CBTs. Several senior leaders added that young service members express disappointment with the military because they thought they would be working with cutting edge technology, and quickly grow disillusioned with poorly maintained, slow, antiquated information technology systems incapable of meeting basic work requirements. This problem is especially severe for National Guard and Reserve units. At one National Guard facility visited by the SPRIRC, 60 personnel were required to share 8 computers, of which only 4 worked. Sailors on ships often have no ready access to computers yet are expected to complete all required CBTs. Given the reliance of computers for meeting training requirements, the DoD should ensure that all military units have enough computers and peripheral devices for personnel to efficiently complete computer-based trainings and other work-related tasks. The DoD should also ensure that all military workplaces have access to high-speed internet connections.

## Leadership

Military leaders are uniquely positioned to shape the environment and conditions to promote the health and well-being of service members. Military personnel who positively view their leadership report better physical and mental health, reduced mental health stigma, and increased engagement in help-seeking behaviors (Dupre & Day, 2007; Jones et al., 2012; Jones et al., 2018), as well as lower suicidal ideation (Trachik et al., 2022). Military units with leaders who are favorably rated also display higher performance (Bass et al. 2003). Research shows that certain leadership behaviors can promote well-being, mitigate risk factors for suicide, and reduce suicidal ideation. For example, making decisions that allow subordinates to obtain better sleep is correlated with improved sleep quality and reduced depression among military personnel (Gunia et al., 2015). Spending time discussing the purpose of military service with subordinates is also associated with

less severe suicidal ideation because this behavior increases belongingness (Trachik et al., 2020; Trachik et al., 2021). Military personnel from units with leaders who approved leave requests without obstruction, provided autonomy in decision-making, and displayed consideration for how mission demands and decisions might impact the well-being of subordinates also displayed reduced stress and higher morale, conditions known to be associated with reduced suicide risk (Bryan et al, 2020). Notably, the SPRIRC was provided with recent DEOCS data for all the installations we visited and supportive and transformational leadership were noted to be top protective factors at each installation. When transformational leadership was absent, service members felt vulnerable and experienced low morale and self-worth, which are associated with higher suicide risk. One service member stated “my first sergeant held my naturalization papers to a lighter. He didn’t care about me. And it was clear I couldn’t report him because I don’t matter.”

According to the DEOCS data provided to the SPRIRC, *supportive and transformational leadership* were noted to be top protective factors at each installation visited.

DEOCS data for the installations visited by SPRIRC also consistently showed themes of racial and sexual harassment and stress as the top risk factors associated with increased risk for suicide. Several service members stated that reporting harassing incidents did not appear to reduce the harassment, which they interpreted as being tolerated by leadership. The SPRIRC heard about problematic leadership behaviors including active discouragement of help-seeking (e.g., “My first sergeant told me to go to the mental health appointment and say that nothing was wrong so I could be back to work in 10 minutes.”), contacting subordinates after hours for non-emergency work-related matters, making frequent last-minute changes to work or training schedules, and regular denial of leave and sick day requests (e.g., “My leave was denied because I didn’t provide enough reason for why I needed to take three days off to attend my child’s graduation”). Leader knowledge and inexperience about policy and regulation was also reported. The SPRIRC heard about some leaders not knowing about or refusing to implement DODI 1350.02, which was updated on September 4, 2020, to ensure that pregnant service members would be free from discrimination. Some pregnant service members described their leaders as lacking in compassion and understanding when they were experiencing pregnancy complications, while other pregnant service members described having supportive leaders who gave them time off for appointments and flexibility with scheduling, especially when part of a dual-military couple. Encouraging and promoting positive leadership behaviors could prevent some suicides by mitigating risk factors like stress and burnout, enhancing well-being and purpose, and promoting connectedness and belonging.

**5.5 Integrate curriculum that teaches transformational leadership skills in all professional military education and formal leadership development courses.** A transformational leadership style is one in which leaders inspire and motivate followers in ways that go beyond typical incentive systems. Transformational leadership involves four key behavior patterns (Judge & Piccolo, 2004): (1) engaging in admirable behavior, displaying conviction, and appealing to subordinates’ emotions; (2) articulating an inspiring vision, setting high standards, communicating optimism about goal attainment,



and providing meaning for assigned tasks; (3) challenging traditional assumptions, taking risks, and soliciting feedback from subordinates; and (4) attending to subordinates' needs, acting as a mentor or coach, and listening to the needs and concerns of subordinates. Transformational leadership styles are especially effective in systems that are marked by close functional proximity between supervisors and workers (Howell & Hall-Merenda, 1999) like the military, and training across the leadership life cycle could improve morale, well-being, retention, and cohesion within military units, leading to reductions in suicide. Research suggests transformational leadership can improve worker morale, well-being, and performance, especially when leaders clarify their expectations, establish rewards for meeting expectations, and proactively take steps to correct anticipated problems before those problems affect the workplace (Judge & Piccolo, 2004; Yin et al 2019). This training should be introduced as early as possible into Professional Military Education (PME) to ensure the impact of transformational leadership reaches all levels of the military.

**5.6 The Services should integrate skills training in navigating difficult conversations into early leadership training courses and professional military education.** As noted in a brief presented to the SPRIRC by the RAND Corporation regarding a research study currently under DoD security review, this training should include skills training in successfully navigating difficult conversations: “NCOs need to be taught how to have difficult conversations, with opportunity to practice and apply these skills through interaction (e.g., small group discussions, role-plays).” RAND identified a desire for difficult conversations skills within the Army, which was also echoed in SPRIRC focus groups across the Services. This training should be conducted in-person whenever possible and should only be web-based if in-person training is not feasible. The training should be included in early leadership training and PME courses.

**5.7 Establish leadership guidelines for official after-hours communications with subordinates.** Guidelines that restrict work- and mission-related text messaging and phone calls with service members while off-duty unless necessary (e.g., genuine emergency, loss of life or equipment) should be implemented DoD-wide. Such guidelines provide leaders with a framework for determining which situations or circumstances justify contacting personnel after-hours. Service members across the Services reported that they regularly received after-hour tasks through text, phone calls, or e-mails from their immediate leadership that were often routine matters, neither immediate nor critical. Unmarried service members who lived in the barracks also reported that they were the “go to” personnel after-hours because they were “already on base and didn’t have family schedules to disrupt.” These off-duty interruptions of personal time interfere with service members’ ability to decompress and undermines personal agency over personal time, leading to frustration, burnout, and degradation of well-being. Guidelines implemented at Fort Drum could serve as a model for the rest of the Services.

**5.8 Reward steward leadership.** Steward leadership involves a proactive desire to create a better future for others while balancing the needs of one’s subordinates, people outside of the organization, society, and future generations. Steward leadership is characterized by behaviors that seek to achieve success by addressing the needs of different stakeholders. One unit leader stated that he openly recognized a handful of soldiers who assisted him in preventing a suicide. He reported that this open acknowledgment increased morale and gave his soldiers the sense they could reduce suicide risk by being appropriately vocal.

Across Services and all ranks, military personnel reported that the DoD rewards performance metrics that emphasize workload and compliance metrics (e.g., graduation rates, number of jumps, number of patients seen) but not leadership qualities like trust, ability to motivate change, team building, empathy, and vision. As part of promotion reform (Recommendation 1 from Overarching Issues), the DoD should incorporate tracking and rewarding leadership behaviors that promote trust, cohesion, equity, inclusion and well-being—qualities associated with improved well-being, enhanced performance, and reduced suicide risk.

## Housing

Poor housing quality is correlated with a range of risk factors for suicide, including chronic disease, injury, and behavioral health issues like depression (Evans et al., 2000; Krieger & Higgins, 2002; Office of the Surgeon General, 2009). Poorly maintained housing has also been shown to negatively impact behavioral health and well-being. Comfortable living conditions, by contrast, can elevate well-being and provide opportunities for social connection. On-base housing conditions for service members of all ranks is highly variable across the DoD, with barracks and dormitories for junior enlisted service members typically being in the worst shape, contributing to the perception that military commanders and the DoD more broadly do not care about the well-being of junior enlisted service members. At many installations, military leaders expressed concern about isolation among junior enlisted personnel because they “hide in their rooms” and do not interact much with others. However, in many locations the aging barracks and dorms in which junior enlisted live lack common areas for service members to socialize and interact with others. Complicating matters, some on-base housing is located far away from workplaces, support agencies, and MWR facilities, creating geographic barriers to protective factors that could reduce suicide risk. Improving housing conditions on- and off-base could reduce suicide risk by increasing well-being, improving access to protective factors, and reducing several risk factors for suicide.

**5.9 DoD should create improved and prescriptive guidance on how to effectively manage housing on-base.** Several installations had barracks/dorms in notable disrepair with poor housing administration and ineffective repair management and plans. SPRIRC site visits revealed that the Air Force employed an effective housing subcontract that resulted in faster moves in between tenants, quicker responses to repair requests, and housing that was well-maintained. At Nellis and Eielson Air Force Bases, the housing management companies were well-staffed, organized, committed to housing upkeep, and responsive to tenant needs. Junior enlisted housing at these locations were noticeably cleaner than installations where unit leadership were responsible for overall maintenance. Other military branches may benefit from adopting the Air Force’s approach to mitigate their own housing challenges.

**5.10 DoD should engage stakeholders in property management.** Engaging stakeholders in decision-making contributes to a sense of value and inclusion. Part of the success of housing on Air Force Bases was its inclusion of service members in decision-making related to design and space needs. The dorm council at Eielson AFB was active and engaged, which also contributed to a sense of purpose and belonging while in a remote and isolated location. This inclusion resulted in housing and living quarters that reflected the



lifestyle of its tenants, including clean and well-maintained common areas that were utilized for socializing.

**5.11 DoD should ensure adequate transportation between work and on-base living quarters for junior enlisted service members.** Service members at several installations reported that some living quarters were located far from work locations, commissaries, and common social areas, which restricted their ability to engage with others and routinely buy basic necessities. This challenge was notably heightened when individual transportation was not possible because of installation regulations or personal finances, or when installations were in areas with harsh weather conditions, precluding service members from walking to these locations. Camp Humphreys had free routine bus routes supplemented by onsite mopeds that service members could rent, and another installation was piloting an individual motorized transportation system. Past pilots of adding bus routes were underutilized, but smaller scale measures, such as scooters, mopeds, or e-bikes, may be beneficial, decreasing social isolation and enhancing service members' abilities to purchase basic living items.

## Limiting or Reducing Access to Highly Lethal Methods of Suicide

Research shows that limiting or reducing access to highly lethal methods for suicidal behavior—a strategy sometimes referred to as lethal means reduction—are correlated with reductions in suicide mortality. Reducing access to highly lethal methods can prevent suicide in two ways. First, limiting or reducing access to suicide attempt methods can avert some suicide attempts by thwarting a service member's ability to make a suicide attempt. Second, limiting or reducing access to the most dangerous or most lethal methods can prevent some suicide deaths by improving the survivability of suicide attempts. Though a suicide attempt may occur, the act is much less likely to result in death.

Lethal means reduction efforts are most effective when they focus on methods that are both highly lethal and commonly used (Mann et al., 2005). Within the military, firearms meet both criteria. With respect to lethality, suicide attempts with a firearm are fatal over 90% of the time (Conner et al., 2019). With respect to frequency, DoD data indicate approximately 66% of active-duty suicides, 72% of Reserve suicides, and 78% of National Guard suicides involve firearms. Several lines of evidence suggest that limiting or reducing firearm availability could dramatically reduce the military's suicide rate. For example, a simple policy change requiring Israeli military personnel to store their military-issued weapons in armories over the weekend led to a 40% reduction in the Israeli military's suicide rate (Lubin et al., 2010). A similar reduction in suicide deaths occurred among District of Columbia residents after the enactment of the Firearms Control Regulations Act of 1975, which included provisions requiring DC residents to securely store personally owned firearms in their homes using a locking device (Loftin et al., 1991). The reductions in suicides among DC residents was not mirrored in neighboring counties, however, suggesting the effect only benefited those who were legally subject to its provisions. Next, epidemiological studies have found that mandatory waiting periods after firearm purchases are correlated with lower suicide rates (Anestis et al., 2017; Luca et al., 2017; Ludwig & Cook, 2000). Finally, a research synthesis conducted by RAND found that among all firearm policies, the evidence was strongest for child access prevention laws - which promote safe firearm storage - on decreasing firearm suicides and

total suicide. Collectively, these studies suggest that policies that encourage (or require) secure firearm storage practices and slow firearm acquisition could prevent some military suicides.

**5.12 Repeal Public Law 112-239 Section 1057 and replace with procedural due process**

**regarding the collection and recording of information relating to the lawful acquisition, possession, ownership, carrying, or other use of a privately owned firearm or weapon by military personnel and civilian employees of the DoD.**

Section 1057 of Public Law 112-239, as amended, also known as the 2011 National Defense Authorization Act (NDAA), prohibits the Secretary of Defense from collecting or recording any information relating to the lawful acquisition, possession, ownership, carrying, or other use of a privately owned firearm or ammunition by a service member or civilian employee of the DoD. Initially developed to prevent the unconstitutional infringement of service members' right to acquire, possess, and use firearms when not on DoD property, multiple policy officials, law enforcement personnel, leaders, and military researchers indicated that legal interpretations of this provision have severely impeded DoD efforts to understand and prevent military suicides. One military lawyer noted, "I used to be able to ask if [fellow service members] have weapons" and that "allowing commander to know if a service member has a firearm off-post would be very useful; I have heard commanders lament that." This provision has subsequently been added to other DoD policies like DODI 6400.09, *DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm*. Congress should repeal this section of the law and replace it with language that allows the Secretary of Defense to collect or record information about the lawful possession, ownership, carrying, or other use of a privately owned firearm or ammunition by service members and civilian employees when such information is necessary for the purposes of injury and mortality prevention. To ensure the Constitutional rights of service members and civilian employees are not infringed by this change, Congress should write and pass new laws that specify the penalties for the unlawful use of such information and records.

*"... we are not allowed to ask service members off-post if they have firearms. I have soldiers returning from complex deployments. I used to be able to ask if they have weapons. When that serious event came up, I used to have the list. That list used to help commanders to take things seriously. Allowing commanders to know if a service member has a firearm off-post would be very useful. I have heard commanders lament that."*

*--Military Officer*

**5.13 Direct the Office of General Counsel to issue guidance that outlines how information**

**about firearm acquisition, possession, ownership, carrying, or other use of a privately owned firearm or weapon by military personnel and civilian employees of the DoD can be legally collected by program evaluators.** Changing and conflicting interpretations of Public Law 112-239 Section 1057 have recently impeded program evaluation efforts

focused on suicide prevention, even when the program evaluations are directed by Congress. The OGC should be directed to develop and issue guidance that outlines how firearm-related information can be collected from military personnel and civilian employees of the DoD for the specific purposes of program evaluation in a manner that meets the intent and requirements of Public Law 112-239 Section 1057.

**5.14 Establish standards for DoD-approved firearm safety training requirements:**

DoDD 5210.56 Section 4.3 specifies the minimum qualifications for government personnel to carry privately owned firearms on DoD property. Firearm safety courses often cover issues such as safely loading and unloading a firearm, keeping one's finger off the trigger until ready to shoot, and being aware of one's intended target and what is behind it. Topics like using secure firearm storage methods and suicide prevention are discussed less (Hemenway et al., 2019). The DoD should establish minimum standards for firearm safety training that include content about (1) suicide prevention, and (2) information about secure firearm storage methods including but not limited to safes, cable locks, trigger locks, and lock boxes, and (3) should require demonstrated proficiency in the operation and use of firearms, and (4) the operation and use of firearm locking devices. DoD-approved firearm safety training should be provided by a firearm safety organization or the Office of the Under Secretary of Defense for Intelligence and Security. Firearm safety curriculum should be updated at least once every 5 years; should be required of all DoD personnel who acquire, possess, own, carry or otherwise use a firearm, whether privately owned or as part of their work-related duties; and should be made available to all DoD beneficiaries who want to attend. These requirements mirror the requirements outlined by DoDI 6055.04 for motorcycle safety training.

**5.14.1 Require DoD-approved firearm safety training, including refresher and sustainment training every five years.** The DoD should establish policies that require individuals who possess a privately owned or work-issued firearm to attend and complete the DoD-approved firearm safety training referenced in 5.14. Refresher and sustainment training should be required at least once every 5 years. This should be required for, at a minimum:

- All military personnel and civilian employees who acquire, own, possess, or carry a firearm
- Those who purchase a firearm on DoD property

**5.15 Implement a 7-day waiting period for any firearm purchased on DoD property.** As stated above, research has found that suicides are reduced in jurisdictions with mandatory waiting periods following the purchase of a firearm. Implementing a waiting period for firearms purchased from a Military Exchange or another vendor on DoD property could prevent some suicides that are rapidly occurring in response to sudden life stressors or intense emotional distress.

**5.16 Develop a national database for recording serial numbers of firearms purchased on DoD property.** Routine collection of serial numbers of firearms purchased on DoD property will allow for the tracking of firearms used in military suicides. This data should be cross-referenced in investigations determining the origin of the firearm purchase.

**5.17 Implement a 4-day waiting period for ammunition purchases on DoD property to follow purchases and receipt of firearms purchased on DoD property.** Coupled with mandatory waiting periods for firearm purchases, implementing a corresponding waiting period for ammunition purchases will further reduce rapidly occurring responses to sudden life stressors or intense emotional distress. Each retailer will be required to develop a system that tracks when a firearm was purchased and when ammunition may be purchased.

**5.18 On DoD property, raise the minimum age for purchasing firearms and ammunition to 25 years.** Approximately half of all military suicides occur among personnel 25 years old or younger. Firearms are used in less than 35% of suicides among military personnel 17-20 years old but become the predominant suicide method starting at 21 years old (Figure 5.1), which corresponds to the minimum purchase age for handguns and ammunition under the Gun Control Act of 1968 and in many U.S. states.

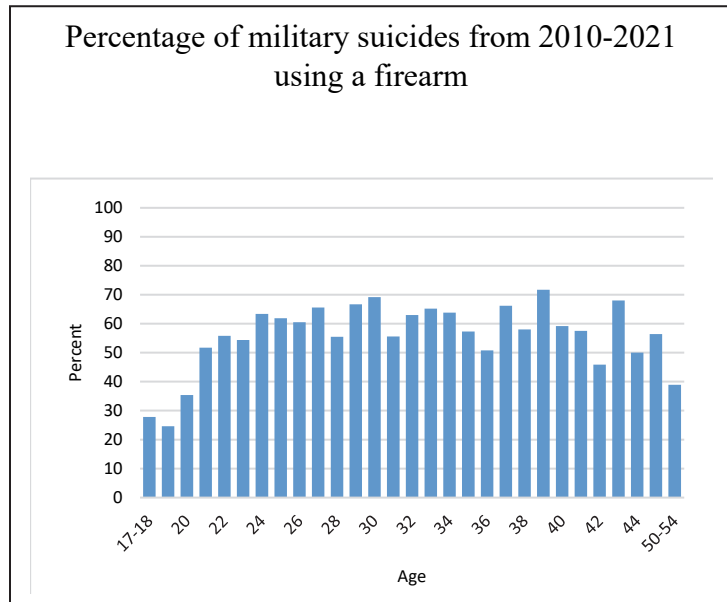


Figure 5.1

Raising the minimum purchase age for buying any firearms or ammunition on DoD property to 25 years could prevent some suicides among younger military personnel by reducing their availability. This policy change would not preclude young service members from legally purchasing firearms from off-base dealer but could reduce firearm availability by delaying the acquisition of a first firearm by younger military personnel.

**5.19 Incentivize the acquisition and use of firearm locking devices by providing discounts for firearm locking devices purchased at a Military Exchange.** Distribution of cable locks has become a common strategy employed by the DoD and VA for encouraging secure firearm storage among firearm-owning service members. Although low cost and scalable, cable locks are disfavored as compared to other locking devices like safes, lockboxes, in-vehicle locks, and clam shell cases. However, these preferred locking devices are more expensive, which can create economic barriers to adoption, especially by younger service members with lower salaries. To circumvent this barrier and encourage wider adoption of secure firearm storage practices, the DoD should fund an incentive program that offers discounts to service members, family members, and civilian employees for the purchase of firearm locking devices at a Military Exchange. A graduated discount rate could be employed to offer larger discounts for lower ranking personnel with lower income levels. This recommendation aligns with Section 595 of the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, which directs the SECDEF to establish a voluntary

pilot program to promote safe storage of personally owned firearms at five installations by furnishing locking devices and/or firearms safes through direct provision, subsidy, or some other method.

- 5.20 Establish command notification procedures when a service member or family member who lives on DoD property purchases a firearm on DoD property.** The DoD should establish new policies that require the Military Exchange and any other vendor to notify the Provost Marshal (or equivalent) and military command when a service member, family member, or civilian employee purchases a firearm on DoD property. Multiple military commanders and senior leaders reported wanting to know when service member purchased firearms so they could review their high-risk tracking systems. “If someone would have told me that my Soldier had bought a gun on-base, I would have gone to that Soldier right away to check on them because I knew they were having a lot of problems,” one senior enlisted leader reported. A military investigator commented that “far too often we learn that a service member bought a gun on base only after they used it to kill themselves.” Upon notification the provost Marshal and military commander should confirm that the service member or civilian employee has completed DoD-approved firearm safety training curriculum. Firearm purchases should not be finalized until firearm safety training can be verified.

*“Far too often we learn that a service member bought a gun on base only after they used it to kill themselves.”*

*--Military Investigator*

- 5.21 Require anyone living on DoD property in military housing to register all privately owned firearms with the installation’s arming authority and to securely store all privately owned firearms in a locked safe or with another locking device.** Nearly half (44%) of military suicides occur on DoD property, most often in personal residences and living quarters. Research shows that storing firearms with a safe or locking device can prevent some suicides in residents of homes with firearms. (Monuteaux et al., 2019; Shenassa et al., 2004). Service members, family members, and anyone else living in base housing other than barracks or dorms should be required to store their privately owned firearms in the armory, in a privately owned gun safe, or another locking device. Minimum requirements for armory storage and procedures for the accountability of privately owned firearms and ammunition should be in accordance with DoD Manual 5100.76. Consistent with DoDD 5210.56, privately owned firearms and ammunition should be stored separate from government arms and ammunition.

- 5.22 Establish DoD policy restricting the possession and storage of privately owned firearms in military barracks and dormitories.** The DoD lacks a policy prohibiting the possession, carrying, or use of any firearm in military barracks or dormitories for reasons that are not related to the performance of official duties. Although secure storage options like armories are available on base, multiple military personnel expressed concern about limited use of this option because of inconsistent enforcement of policy. For example, one safety officer observed that “there are armories on base that can be used [to store privately owned firearms] but they don’t have as many personal firearms as would be expected.”

Multiple military leaders also reported that they too often found out that a barracks resident kept a firearm in their barracks room only after they had died of self-inflicted gunshot wound. The lack of consistent policy across Services and installations hinders consistent enforcement. Establishing a DoD policy that restricts the possession and storage of privately owned firearms in military barracks and dormitories could prevent some military suicides by reducing access and availability during periods of acutely elevated suicide risk. Minimum requirements for armory storage and procedures for the accountability of privately owned firearms and ammunition should be in accordance with DoD Manual 5100.76. Consistent with DoDD 5210.56, privately owned firearms and ammunition should be stored separate from government arms and ammunition.

**5.23 Prohibit the possession of privately owned firearms that are not related to the performance of official duties on DoD property by anyone who does not live on DoD property.** DoDD 5210.56 Section 4 allows DoD personnel to carry privately owned firearms for purposes not related to the performance of official duties on DoD property under certain circumstances. The DoD should amend this policy to prohibit the possession of privately owned firearms by anyone who does not live on DoD property for any purpose not related to the performance of official duties.

**5.24 Develop and implement a multimedia public education campaign to promote secure firearm storage.** DoD-funded research shows that tailored public education messages that encourage secure firearm storage increase service members' willingness to adopt secure firearm storage practices (Anestis et al., 2021). Law enforcement and combat arms professions are perceived as especially credible messengers (Anestis et al., 2021; Anestis et al., 2022; Bandel et al., 2022). Messaging should not be specific to suicide prevention, however; messaging should emphasize responsible firearm ownership and injury prevention in general. The DoD should set aside sufficient funds to develop and implement a coordinated multimedia campaign to encourage safe firearm storage among military personnel and family members. The DoD should collaborate with researchers and marketing professionals to optimize and evaluate the impact of these messages.

## Reducing Non-Firearm Lethal Means

The second most commonly used method to die by suicide among service members is asphyxiation or hanging. As noted above, limiting or reducing access to means may reduce suicide attempts and death. The DoD should mitigate means for asphyxiation and hanging on base and partner with local communities to implement prevention strategies at locations commonly used for suicide.

**5.25 Ensure that all shower curtain rods, window curtain rods, and closet rods installed in barracks, dormitories, and military housing can “break away” with excessive load.** Military leaders reported that some barracks, dormitories, and military housing have shower rods, window curtain rods, and closet rods that are bolted or otherwise securely affixed to the walls, preventing them from collapsing under excessive weight loads. One military officer reported that closet rods were so secure in one barracks that service members joked about using them for pull-ups. Replacing these common ligature points with break-away alternatives could prevent some suicides by hanging and asphyxiation.



**5.26 Partner with local communities in collaborative efforts to limit or restrict access to sites or locations commonly used for suicide.** Some military installations are located near sites with high suicide counts, sometimes referred to as suicide “hot spots.” For example, the Coronado Bridge in San Diego, which serves as the main thoroughfare for service members and DoD civilian employees who work at Naval Air Station North Island (NASNI) is the second deadliest bridge in the U.S. for suicide death. Behavioral health clinicians reported constant concern about their suicidal patients who cross the bridge multiple times per day because service members have died by suicide by jumping from the bridge. Community leaders reported limited engagement from the DoD in collaborative discussions focused on increasing bridge safety to prevent suicide, however. The SPRIRC also learned that jumping was reportedly more common on installations with tall, multi-story buildings without fences, barriers, and other safety features to prevent access to these heights. The DoD should therefore partner with local communities to support efforts aimed at restricting access to sites or locations that are commonly used for suicide. Assisting with funding for the Coronado Bay Bridge Suicide Deterrent Project is one such example of partner potential. The DoD should also ensure that appropriate safety features are installed in multi-story buildings located on DoD property to reduce access to locations that could be used for suicide.

## Social Relationships

Belongingness and social support are well-established protective factors for suicide (Hatcher & Stubbersfield, 2013; Bell et al., 2018; Bryan et al., 2010). Social support received from family members and other people outside the military community are especially protective (Blais et al., 2021). Research shows that suicide risk is reduced among people who regularly experience positive emotions because these experiences “undo” the effects of stress and increase the use of coping strategies and social support networks (Bryan et al., 2021; Bryan et al., 2020). Well-being and morale programs, including those run by MWR including programs like Better Opportunities for Single Soldiers (BOSS), Warrior Zone recreational centers, gaming centers, religious ministry outings, and community relations projects reduce vulnerability to suicide in the military. They do this by providing service members with opportunities to form and sustain meaningful connections with fellow service members, family members, and other members of the local community. The SPRIRC observed several barriers to full implementation of these programs across each installation, including limited funding, and staffing shortages.

**5.27 The DoD should fully fund MWR programs that support service members and families and allocate funds based on community needs. Particular attention should be paid to smaller and remote installations where alternatives to MWR programs do not exist.** Funding and staffing shortages were identified as two primary limits to the reach and scope of MWR programming. At some installations, for example, discounted rates for some MWR-sponsored activities were not large enough to be affordable by junior enlisted personnel and families. Staffing shortages also forced MWR facilities to limit their operational hours, severely restricting access for service members and their families. These challenges were especially pronounced at installations located in small communities or remote locations. The method by which MWR funds are distributed across installations also does not consider regional or local differences in resources. For example, installations

located in rural or remote areas typically require additional transportation funds given limited community resources that may be more common in large cities (e.g., extensive bus, ride share, or subway systems).

## Family Support

Given that the DSPO has been tracking family member and dependent suicides in addition to service member suicide, the SPRIRC engaged with military family members and family support services at every installation we visited. Limited child care options and opportunities for spouse employment were regularly reported as negatively impacting service member well-being in multiple ways including added financial burden, creating relationship strain, and scheduling conflicts with work. At every installation visited by the SPRIRC, the DoD Child Development Center (CDC) reported unfilled staff vacancies, high staff turnover, and long wait lists. At NASNI, for example, the CDC wait list has more than 1000 children. CDC leadership reported that staff recruitment, hiring, and retention is challenging because of lengthy hiring on-boarding processes (see Overarching Issues) and non-competitive wages for qualified staff. Child care options off-base are limited and often much more expensive, especially in geographically remote locations, resulting in spouses being unable to work outside the home. One family member explained how limited child care negatively impacted their lives: “Coming here and not being able to find a career because the pay wouldn’t suffice for the child care costs for 3 young children, and being isolated and your active-duty spouse who is gone a lot, I’ve felt like an insufficient mother and that we were failing as parents.” To compensate for these issues, some military commanders have authorized parents to bring their children to work. Effectively addressing challenging issues experienced by military families would improve well-being and quality of life.

*“Coming here and not being able to find a career because the pay wouldn’t suffice for the child care costs for 3 young children. And being isolated and your active-duty spouse who is gone a lot, I’ve felt like an insufficient mother and that we were failing as parents.”*

*--Military Spouse*

The SPRIRC applauds the Secretary of Defense Memorandum, September 22, 2022, “Taking Care of our Service Members and Families” which directed the Department to invest in Child Development Program (CDP) facilities and infrastructure. The DoD has multiple efforts to increase child care capacity on and off installations via (1) expansion of Family Child Care homes, (2) continued collaboration with community-based assistance and public/private partnerships, (3) construction and renovation of CDCs, and (4) efforts by the Defense State Liaison Office (DSLO) to advance Licensure Exemptions for Military Family Child Care Providers. The following recommendations are offered as additional strategies to improve military family well-being.

- 5.28 The DoD and Services need to be fully supported in their efforts to recruit and retain staff, increase access or capacity to child care on and off the installation, expand the Family Child Care program, collaborate with community-based assistance programs and support public/private partnership initiatives.** Compensation for DoD civilian



personnel is limited by law. The DoD also has less legal flexibility in civilian pay structure and plans than other federal agencies like the Department of Veterans Affairs. Providing greater legal flexibility to the Services over civilian pay structures and plans could improve the recruitment and retention of qualified child care staff. CDC staff and leaders consistently reported that the hiring and onboarding process for child care staff often takes 9-12 months to complete. Given this lengthy process, qualified candidates drop out of the hiring process to accept competing offers. As noted in the Chapter 3, eliminating legal and bureaucratic barriers to efficient hiring and onboarding of DoD employees could alleviate CDC staffing shortages and expand child care to more military families, thereby enhancing well-being and eliminating several risk factors for suicide including relationship and financial strain. DoD and the Services should fully implement the recommendations from the current DoD Child Development Program Recruitment, Retention, and Compensation Task Force addressing staffing, pay bands, and position descriptions for child care providers when finalized in March 2023.

**5.29 Increase funding and support for the Spouse Education and Career Opportunities (SECO) program and the Military Spouse Education Partnership (MSEP).** Expanding spousal employment is a high DoD priority. For military families, having two incomes may be vital to their family's well-being. The opportunity for military spouses to obtain meaningful employment throughout multiple moves and relocation is critical to the retention and readiness of the active-duty service member. As such, the SPRIRC considers spouse well-being and employment a protective factor for service member suicide, as it promotes healthy relationships and financial readiness. SECO and MSEP were developed to enhance military spouses' opportunities for employment through tools and career resources, career coaching, and military friendly employers. SECO career coaches are available to provide support and assistance to military spouses. Leveraging the SECDEF's recent memo that addresses spouse employment by increasing funding and support for these programs, especially in targeted professions of high value and need to the DoD (e.g., child care, behavioral health), would improve the financial readiness of military families, strengthen family relationships, and alleviate staffing shortages in the DoD.

## Sleep Quality

Sleep disruption is common among service members (Huang et al., 2021; McKeon et al., 2019). The Pentagon's 2021 *Study on Effects of Sleep Deprivation on Readiness of Members of the Armed Forces* concluded that "inadequate sleep appears to be more the rule than exception" (p. 6) among military personnel. Sleep disruption is a well-established risk factor for suicidal ideation and behaviors, possibly because insomnia degrades stress reactivity, emotion regulation, and decision-making processes (McCall & Black, 2013; Woznica et al., 2015). Research shows that service members who report sleep difficulties are nearly 3 times more likely to report suicidal ideation (Vargas et al., 2020). Sleep quality is impacted by multiple factors, some of which can be mitigated by addressing environmental and lifestyle factors including light exposure, climate control, work schedules, and caffeine consumption (Troynikov et al., 2018). Reducing exposure to conditions and discouraging lifestyle choices that disrupt sleep quality could reduce vulnerability to suicide. The following recommendations are in alignment with the risk mitigation strategies summarized in the 2021 DoD study on sleep in the armed forces.

- 5.30 Provide funding to furnish barracks, dorms, and military housing with light-blocking window coverings.** Daylight exposure has a powerful influence on circadian rhythms. Circadian rhythms are especially sensitive to light exposure immediately before and during scheduled sleep time. Service members stationed in Alaska, which has extended periods of sunlight during summer, are especially vulnerable to sleep disruptions during summer months. Service members working evening and overnight shifts are also vulnerable to sleep disruption because their sleep must occur during sunlight hours (i.e., “day sleepers”). Light-blocking window coverings can ensure sufficient darkness in sleeping areas, minimizing circadian sleep disruptions caused by light exposure. Across installations visited by the SPRIRC, light-blocking window coverings for day sleepers were not uniformly available or maintained for all barracks, dormitory, and military housing residents. The DoD should provide funding to ensure that day sleepers living in on-base housing have light-blocking window coverings in bedrooms and access to blackout blindfolds. Funds should also be allocated to ensure installations can maintain this equipment and replace damaged or worn-out equipment as needed. All future military housing projects, including new builds and renovations/modernization efforts, should budget for light-blocking window coverings and blackout blindfolds. Installations located in Alaska should receive priority for this funding.
- 5.31 Ensure that operational air conditioning units are installed in all barracks, dorms, and military housing.** Circadian rhythms are also influenced by core body temperature. Being able to regulate the temperature of one’s sleeping area can improve sleep quality (Haghayegh et al., 2022). At some installations, older military housing facilities do not have air conditioning systems and have poor air circulation, limiting service members’ ability to control the temperature in their bedrooms and creating discomfort during summer months. Some installations had air conditioning units, but a portion were nonfunctional and service members reported overly lengthy repair times. Delays in repair caused by budget problems were echoed by housing staff. The DoD should provide funding to retrofit or modernize all military housing units with climate control systems that allow individual units to control its temperature settings. Air conditioning units should be able to maintain ambient temperatures ranging between 62- and 82-degrees Fahrenheit, as recommended in the DoD’s 2021 *Study on Effects of Sleep Deprivation on Readiness of Members of the Armed Forces*. Funds should also be allocated to ensure installations can maintain and quickly repair damaged or inoperable climate control systems. Installations located in warmer climates should receive priority for this funding.
- 5.32 Ensure duty schedules allow for 8 hours of sleep and minimize the frequency of shift changes.** Based on evidence-based guidelines, the DoD’s 2021 Report to Congressional Armed Services Committees, *Study on Effects of Sleep Deprivation on Readiness of Members of the Armed Forces*, recommends that commanders at all levels should commit to setting duty schedules that allow service members to obtain 8 hours of sleep per 24-hour period, with planned recovery time of 2-3 consistent nights of sleep. For units that must operate 24-hour duty schedules, research shows that forward shift changes (e.g., day to evening to night) is least disruptive to work performance and sleep cycles, with longer intervals between shift changes minimizing disruptions to circadian rhythms and sleep

quality (Goh et al., 2000). Many military personnel in units with 24-hour duty schedules described shift rotations and schedules that do not follow these guidelines, resulting in excessive sleepiness and sleep disruption among military personnel. To aid commanders with designing and implementing optimal rotating shift schedules, the DoD should develop and distribute “shift response maps” based on the relation between the shift start time and circadian phase (Postnova et al., 2014).

- 5.33 Provide education in healthy sleep habits during military training and regularly scheduled unit formations.** Stimulus control is an evidence-based strategy for minimizing insomnia and sleep disruptions. Research shows that stimulus control and other related strategies to improve sleep can be effectively delivered in low intensity group formats. Education in these principles should be implemented within existing military training and reinforced throughout the career life cycle as part of routine unit operations, similar to educational and prevention approaches for other safety issues. A proactive approach includes providing optimal sleep strategies and behaviors specific to the military environment.
- 5.34 Raise the minimum purchase price and ban price discounting of energy drinks sold on DoD property.** Compared to age-matched civilians, military personnel consume much more caffeine (Lieberman et al., 2012; Schmidt et al., 2008), which may exacerbate operational risk as indicated in the 2021 DoD sleep study. Energy drink vending machines are common on military installations, with over 90% of surveyed military personnel saying energy drinks are “readily available” on base and 33% saying they are “readily available” in their work area (Schmidt et al., 2008). Energy drink sales at Army and Air Force Exchange Services (AAFES) have also significantly increased over time (Johnson et al., 2014). Insomnia is the most common adverse event associated with energy drink consumption (Nadeem et al., 2021). Because lower prices on energy drinks are associated with increased sales (Mayima et al., 2021; Temple et al., 2016), raising the minimum purchase price of energy drinks sold on DoD property could reduce overall caffeine consumption, thereby improving sleep quality and reducing vulnerability to suicide.
- 5.35 Ban the promotion of energy drinks on DoD property.** During site visits, the SPRIRC observed strategic advertising of energy drinks in military retail facilities including pallet displays and endcap/end-of-aisle displays. These in-store advertising tactics are known to be effective at increasing product sales (Nakamura et al., 2014). Banning pallet displays, endcap/end-of-aisle displays, and any other in-store advertising of energy drinks in AAFES and other locations on DoD property could reduce overall caffeine consumption, thereby improving sleep quality and reducing vulnerability to suicide.
- 5.36 Display signs on vending machines and retail outlets where energy drinks are sold about responsible energy drink consumptions.** Warning labels are a known strategy for informing consumers about harms associated with products like cigarettes (Strong et al., 2021) and alcohol (Kokole et al., 2021). As energy drinks disrupt quality sleep and may be contributing to suicide risk in military populations, the DoD should post warnings about excessive consumption of these beverages on installations in places where these drinks are sold, including on vending machines. Some research suggests messages should be

"gain-framed" that stress the benefits of not consuming energy drinks (versus loss-framing, which stress the health problems associated with consuming these drinks; Kim, 2020; Temple et al., 2016).

## Alcohol Availability and Consumption

Excessive and problematic alcohol use is a national public health issue that directly impacts suicide risk. In the U.S., approximately one in eight deaths among adults aged 20 to 64 is attributed to excessive alcohol use and an even greater proportion--approximately one in six--of deaths among *men* aged 20 to 64 is attributed to excessive alcohol use (Esser et al., 2022). Research shows that approximately one-third of U.S. suicides with toxicology data were acutely intoxicated<sup>5</sup> at the time of death (Kaplan et al., 2013) and increased risk of suicide among those who meet criteria for an alcohol use disorder (Goldman-Mellor et al., 2022). Trends are similar in the military; in 2021, 18% of service members who died by suicide had an alcohol use disorder diagnosis (DSPO, 2022).

The SPRIRC repeatedly heard reports from multiple stakeholder groups that excessive alcohol use is a serious problem among military personnel. Junior enlisted service members spoke openly about their own excessive use, including how they recognized their own drinking was problematic. Other service members spoke about past alcohol-related convictions, especially driving under the influence (DUI) charges, and military law enforcement at every installation told us that excessive alcohol use is involved in most of the on-base incidents to which they respond.

Research supports these reports; one-third of service members report binge drinking in the past month and 10% report heavy drinking or binge drinking at least once per week in the past month (Meadows et al., 2021). There is also strong agreement that the military promotes a culture of drinking – almost one-third of active-duty service members agreed with at least one of the following statements: it was “hard to fit in” with their command if they did not drink; drinking was part of being in one's unit; everyone was encouraged to drink at social events; or leaders were tolerant of drunkenness when personnel were off-duty (Meadows et al., 2021). At some installations visited by the SPRIRC, military leaders were considering or recommending loosening of restrictions on the quantity of alcohol service members could have in their barracks (Thayer, 2022). Intended to promote healthy drinking and socialization, this approach will probably increase alcohol-related incidents and suicide. To prevent suicides among military personnel, the DoD should implement evidence-based strategies to reduce excessive alcohol use among military personnel. These recommendations should be implemented in conjunction with our recommendations regarding substance use disorder services discussed in Chapter 6.

- 5.37 Address excessive alcohol use and the risks it poses in existing training requirements including suicide prevention training, sexual harassment and assault prevention training, and other safety-focused trainings.** As discussed in Chapter 5, the SPRIRC recommends revisions to the DoD’s suicide prevention training that mirror the recommendations for improved training called for by the Independent Review Commission on Sexual Assault in the Military. Revised training should include modules and information about alcohol use and misuse, the alcohol content of drinks, what constitutes healthy versus

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<sup>5</sup> In this study, acute intoxication was defined as defined as blood alcohol content (BAC)  $\geq 0.08$  g/dl.

unhealthy and excessive drinking, how alcohol impairs judgment and performance as well as increases risk for suicide and perpetrating sexual violence, and strategies for recognizing and addressing harmful drinking in oneself and others.

- 5.38 Ban the promotion of alcohol on DoD property.** During the SPRIRC’s site visits, committee members visited on-base retail establishments. Alcohol was sold at many establishments and strategic advertising of alcohol, similar to energy drinks, including both pallet displays and endcap/end-of-aisle displays. Such in-store advertising has been shown to increase sales across multiple categories of alcoholic beverages (Nakamura et al., 2014). To reduce the incidence and severity of excessive drinking among service members, the SPRIRC recommends that the DoD place a moratorium on pallet, endcap/end-of-aisle, and other in-store advertising for any type of alcohol sold in on-base retail establishments to go into effect.
- 5.39 Fund safe transportation programs for service members living on-base.** Increased security measures since September 11, 2001, have made military installations less accessible to civilians. Unfortunately, this also restricts access to commonly used transportation services like taxis and commercial rideshare options (e.g., Lyft, Uber). The SPRIRC experienced this challenge firsthand at multiple installations. At Fort Wainwright, for example, the community’s primary taxi company had their base access restricted after they installed video cameras in their cars as a strategy to enhance driver safety. At other installations, only pre-registered drivers could drive on-base but it was unclear how those who lived on base could know or request drivers with base access. These security-focused policies inadvertently increased risk to service members because they increase the likelihood of driving while intoxicated. Two installations developed and implemented solutions to this problem. At Fort Wainwright, the BOSS program created a Soldiers Against Drunk Driving (SADD) initiative in which Soldiers volunteered to work shifts to provide safe transportation from off-base establishments to on-base housing with a “no questions asked” approach. According to SADD tracking, 1300 rides were provided during the previous fiscal year. At Camp Humphreys, low-cost transportation was available from an on-base taxi service that could be contacted using a smartphone app designed specifically for that service. Most personnel stationed at Camp Humphreys had this app downloaded on their phones and used it for point-to-point transportation on-base as a supplement to the no-cost bus line. To reduce the occurrence of alcohol-related incidents, the DoD should develop and fund programs that provide safe transportation for service members 24 hours per day, 7 days per week, with a particular emphasis on evenings/nights and weekends. The specific form of transportation provided could vary across installations based on community and local factors.
- 5.40 Establish a 24/7 sobriety program for service members arrested for or convicted of alcohol-related offenses.** Counties in South Dakota, North Dakota, and Montana have recently initiated 24/7 sobriety programs to reduce repeat alcohol-related DUI and domestic violence offenses. Under such programs, those arrested or convicted of such charges must submit to twice-a-day breathalyzer tests or wear a continuous alcohol monitoring bracelet for multiple months.<sup>6</sup> Those who test positive or skip a test are subject

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<sup>6</sup> The duration may be even longer for those with multiple convictions.

to “swift, certain, modest sanctions,” which involves one or two days in jail in most counties. Evidence from the RAND Corporation reveals that these initiatives have reduced arrests for both DUIs and domestic violence incidents (Midgette & Kilmer, 2021). Enacting similar 24/7 programs across the Services could prevent some suicides by reducing alcohol consumption and repeat legal/disciplinary issues among service members. The DoD should base the program on existing models and retain two core components for adaptation in the DoD context: (1) daily monitoring of alcohol consumption, and (2) clear and immediate repercussions following a positive or skipped test. Service members who are in the process of administrative discharge from the military should be included in the program. Finally, any costs associated with implementing and sustaining the program—including purchase and maintenance of equipment used for detecting the presence of alcohol—should be borne by the DoD not the service member.

**5.41 Increase the purchase price of alcohol sold on DoD property.** Most service members, including those who live off-base, reported to the SPRIRC that they primarily purchased alcohol on base because of its convenience and reduced cost. Research shows that drinking volume, morbidity, and mortality reduce as alcohol purchase price increases (Wagenaar et al., 2009, Wagenaar et al., 2010). Increasing the purchase price of alcohol sold at retail outlets on DoD property could similarly reduce alcohol consumption among military personnel. While this would have no impact on alcohol purchases from off-based vendors, this change could nonetheless reduce overall alcohol consumption, especially among younger personnel who live in military housing.

**5.42 Limit when alcohol is sold on DoD property.** Research also suggests that limiting the days and times during which alcohol can be sold reduces heavy drinking and other adverse outcomes associated with alcohol misuse (Middleton et al., 2010). Limiting the days and times in which a service member or their family members can purchase alcohol on DoD property could be another strategy for reducing overall alcohol consumption, especially among younger personnel who live in military housing.

## Financial Readiness

Up to 10% of service members who die by suicide had known financial difficulties. Financial stress, in combination with other factors (e.g., relationship issues, mental health problems), can increase vulnerability for suicide (Goodin et al., 2019). The COVID-19 pandemic and current inflation exacerbated this stressor, with rising housing costs exceeding BAH funds, limited rental options, and increasing prices of everyday items, including groceries, toiletries, and gas. The Secretary of Defense implemented several actions to mitigate these concerns (see *Strengthening Economic Security in the Force*, dated November 2021), and the SPRIRC acknowledges this rapid deployment of resources as one of the many efforts of the current administration to mitigate suicide risk. That said, many of the financial concerns reported to the SPRIRC and observed during site visits pre-dated the pandemic, suggesting additional measures may be needed. Of note, many service members, like their peers taking on their first full-time jobs or going to college, join the military with limited or no prior experience developing a budget and limited understanding of retirement options, saving strategies, or interest rates.

These vulnerabilities are compounded by organizational and bureaucratic processes that result in unacceptably high error rates in pay and long delays in reimbursements for official government travel and purchases. During one SPRIRC site visit, a finance officer estimated that half of all travel reimbursements at his installation were rejected by the Defense Finance Accounting Service (DFAS). When asked what accounted for the high error rate, the finance officer explained that the system was entirely online, but most incoming service members did not have access to internet-enabled devices when receiving instructions for submitting vouchers, the instructions and steps were long and complicated, and the Smart Voucher portal was not designed with automated alert systems or hard-stop algorithms that flagged errors. Centralization of DoD financial services and downsizing of finance personnel at military installations have created barriers for service members to quickly resolve pay and reimbursement issues. “You used to have the finance person sit down with you and complete your travel form from your PCS but now it’s online and it gets kicked back,” one officer explained. “You no longer have that SME or someone that knows this job helping you and guiding you through that stuff.” Although financial planners are available at most military installations, financial planners observed that their services often are not accessed until after a service member is in deep debt or experiencing severe financial strain.

**5.43 The Office of the Inspector General should conduct a comprehensive review of the magnitude of unpaid and delayed payments to service members and their families and provide recommendations for improving efficiencies.** The SPRIRC heard routinely that service members faced financial stressors associated with administrative DoD payment processes. We heard this across all service branches, from the most junior enlisted to the most senior officers. Given the potential magnitude of the problem, we recommend that the Office of the Inspector General conduct a thorough and robust analysis to assess and describe the magnitude of payment problems. Specifically, the report should analyze: (1) the average, median, and lower and upper bounds of non-reimbursed, out-of-pocket costs, and the types of such costs, associated with PCS moves; (2) the average, median, and lower and upper bounds of the time from which a service member submits his/her reimbursement forms and they are fully paid, as well as how this varies by the type of reimbursement and rank; (3) the frequency by which regular payments, scheduled to occur on the 1<sup>st</sup> and 15<sup>th</sup> of each month, are delayed and factors that may be associated with delays (e.g., a recent PCS); 4) the frequency of overpayments and resulting recoupment processes and the average, median and upper bounds of subsequent periods without pay resulting from these errors.

**5.44 The pay scale for junior enlisted service members should be reviewed and reassessed for competitiveness with non-military wages.** In combination with housing and food allowance, as well as pension benefits, the average income after accounting for these latter resources appears to be at least consistent or higher than non-military wages. However, inflation, rising food and gas prices, rising transportation costs, and the housing market create strains that are challenging to navigate for junior enlisted service members, and pension benefits are not immediately tangible resources or available to those serving for shorter periods of time. Moreover, many service members reported non-dependent financial responsibilities that could not be claimed or adjusted for, including needing to support family members. Numerous service members also reported multiple “hidden costs” of military services resulting from having to purchase equipment and gear required for their

jobs to compensate for insufficient inventory at work, poor resource management and oversight, lengthy acquisitions processes, and bureaucratic hurdles. Some service members reported taking on second jobs (e.g., driving for Lyft/Uber, DoorDash) or engaging in other activities to pay bills. Others reported the desire or need for secondary employment but were unable to given their rapidly changing and unpredictable job schedules or lack of personal transportation. The result was often high debt-to-income ratios in a population that has less flexibility to engage in non-military labor and pursue higher wage positions than their civilian peers. These issues are further exacerbated when service members do not get paid or reimbursed, yet are still required to pay rent and transportation, purchase groceries and other items for basic living.

- 5.45 Pay systems must be fixed so that service members do not experience delays in pay.** At every site visit, SPRIRC was informed of consistent and extensive challenges with service members getting paid or reimbursed in a reasonable time frame. For those without spousal and family supports, or other avenues to access hold-over funds, delays in pay create excessive and unnecessary stress. DoD should work with each branch to review pay systems to ensure these systems are fully operational and cause in delays in pay and reimbursement are corrected. This may involve engaging a hybrid finance model that includes both online options and on-site in-person resources to assist service members without computer access or experiencing other challenges with the online system. Additionally, pay services must be available to service members who work outside regular business hours.





## Chapter 6: Treatment and Support Services

Since 2010, approximately half of military personnel who died by suicide were diagnosed with a behavioral health condition, and 30% received behavioral health care at a Military Treatment Facility (MTF) within 90 days of their death. Accessible and effective behavioral health services are critical to prevent suicide. Like the U.S. healthcare system, the military health system considers behavioral health a specialty care service. However, younger service members shared a willingness to talk about mental health issues and to access behavioral health treatment. Correspondingly, this is consistent with recent findings that public stigma, at least for depression, is decreasing and the changes in stigma align with generational cohorts (Pescosolido et al., 2021). Alternatively, more senior military personnel discussed treatment-seeking with stigmatized attitudes that reflected a lower willingness to seek and recommend behavioral health care. As stated in previous sections of this report, several factors combine to stress an already overburdened group of service providers. These factors include (1) siloed and underutilized preventative services and supports available to service members and their families, (2) a culture of fear where leaders are required to immediately send service members to be evaluated by a licensed behavioral health provider when they voice suicidal thoughts, and (3) demand for behavioral health services that exceeds capacity.

In addition to these issues, the SPRIRC highlights five converging factors that have led to a severe behavioral health demand-supply imbalance within the DoD: (1) behavioral health personnel shortages; (2) administrative barriers that interfere with care delivery; (3) institutional barriers that interfere with evidence-based practices; (4) limited collaboration with community-based agencies; and (5) limited adoption of technology-based solutions for scalable treatment delivery. Recommendations across each of these five domains are provided in this section.

### Behavioral Health Personnel Shortages

As with the U.S. in general, the DoD faces a critical personnel shortage in the behavioral health professions. Across installations, billets for behavioral health professionals remain empty, increasing workload demands and expectations that exceed the availability and capacity of remaining providers. At every installation visited by the SPRIRC, at least one-third of the assigned behavioral health positions were unfilled; in some locations, more than half of the behavioral health positions were unfilled. This demand-supply imbalance has resulted in long wait times for service members hoping to initiate behavioral healthcare and even longer gaps between scheduled

appointments. Mental health appointments are considered specialty care appointments thus the acceptable wait time for an initial appointment is 28 days. However, some installations exceed this expectation by using emergency department behavioral health evaluations as same-day visits. After an initial behavioral health appointment, follow-up appointments cannot be scheduled as frequently as needed. At many installations, for instance, psychotherapy appointments are available only every 4–6 weeks instead of every 1–2 weeks. One provider noted, “I can’t even start an evidenced-based treatment protocol because I don’t see them frequently enough. It would do more damage than good.” These observations mirror earlier findings from the Office of the Inspector General (DODIG-2020-112). Many service members are unable to receive an adequate dose of behavioral health treatment, resulting in symptom exacerbation and prolonged recovery time. In the words of one behavioral health provider, “We don’t provide treatment anymore; we manage crises.”

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Given the nationwide undersupply of behavioral health professionals, growing the DoD’s behavioral health force will require a multipronged talent management strategy that should (1) improve pay and benefits to attract and retain talent; (2) expand the pool of eligible candidates; (3) improve efficiencies in hiring practices; and (4) utilize behavioral health technicians more effectively as behavioral health extenders.

## Improve Pay and Benefits to Attract and Retain Talent

- 6.1 Eliminate budget and statutory limitations that hinder the Services’ ability to increase incentive pay and retention bonuses for DoD behavioral health clinicians.** Behavioral health clinicians regularly reported non-competitive pay relative to other agencies and organizations, especially in the private sector, as a key contributor to attrition. This pay discrepancy is supported by GAO Report to Congressional Committees (GAO-20-165), *DoD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists*, which found that cash compensation for military psychiatrists typically falls below the 20<sup>th</sup> percentile compared to civilian psychiatrists. Increasing incentive pay packages and retention bonuses for behavioral health clinicians, both uniformed and civilian, could help reduce attrition in the short-term and increase morale. As noted in the GAO-20-165 report, and in the DoD’s 2020 Report to Congress, *Strategy to Recruit and Retain Mental Health Providers*, budget and statutory limitations hinder the Services’ ability to change the rate of special and incentive pays. Eliminating these limitations could improve the Services’ ability to retain existing behavioral health clinicians.

- 6.2 Provide greater legal flexibility in civilian pay structure and plans.** As noted in the DoD’s 2022 Report to Congress, *Behavioral Health Requirements of the Department of Defense*, unlike other federal agencies, compensation for DoD civilian personnel is limited by law. Providing greater legal flexibility to the Services for civilian pay structures and plans could improve the recruitment and retention of civilian behavioral health professionals to improve access to care for service members in need.
- 6.3 Create DoD loan forgiveness programs for DoD behavioral health clinicians.** The Public Service Loan Forgiveness (PSLF) Program forgives the remaining balance of an individual’s Direct Loans after they have made 120 qualifying monthly payments under an income-driven repayment plan. Although DoD employees are eligible for PSLF, because the program is not DoD-specific, the program cannot be leveraged to maximize benefit to the DoD. A DoD-specific loan forgiveness program modeled on the Indian Health Service (IHS) Loan Repayment Program, which repays up to \$40,000 in eligible health profession education loans in exchange for an initial two-year commitment to practice in health facilities servicing American Indian and Alaska Native communities, could be instituted to incentivize behavioral health clinicians to work for DoD. To incentivize longevity, the program could also provide renewal options like the National Institute of Health (NIH) Loan Repayment Program.
- 6.4 Amend DoD policy to allow longer assignments and extensions for civilian behavioral health professionals assigned to duty stations outside the United States.** DoDI 1400.25, Volume 1230 currently limits overseas assignments for civilian employees to five continuous years and requires the approval of the Head of the DoD Service to grant an extension. Only a single extension not to exceed two years may be granted. An unintended consequence of this policy is that civilian behavioral health professionals must leave their overseas assignment even when they want to remain and their retention is supported by local command. Amending this policy to allow for longer overseas assignments, especially at locations that have historically struggled to recruit qualified behavioral health professionals, would reduce strain on the behavioral healthcare system resulting from personnel shortages.
- 6.5 Fully and centrally fund the Joint Travel Regulation allowance for civilian employee relocation.** Another key barrier to recruiting qualified behavioral health professionals to accept positions is a lack of funds available to defray relocation expenses. This barrier disproportionately affects installations located in remote areas with smaller populations, perpetuating personnel shortages. As one program leader noted, “There aren’t many candidates in this area and it’s hard to attract someone to come here if they have to incur a significant cost to accept the position.” Multiple behavioral health professionals estimated that they spent several thousands of dollars to relocate for their current positions. Many qualified candidates have declined job offers because they could not afford to move. Although the Joint Travel Regulation provides mechanisms for funding civilian employee relocation costs, funds for this purpose are not centralized. As a result, some commanders may be unwilling to provide funds from their local budgets for this purpose. The DoD should fully fund civilian employee relocation programs and centralize the funds to ensure equitable access and distribution for positions across the DoD. The DoD should also adopt

a system that pays directly for relocation instead of reimbursement for relocation expenses, as the latter is taxable as personal income, reducing the attractiveness of this incentive.

## Expand the Pool of Available Candidates

- 6.6 Expand DoD behavioral health training programs to civilian candidates.** The Army, Navy, and Air Force currently have accredited internship and residency programs that serve as important accession points for multiple behavioral health disciplines. Eligibility for many of these training programs requires commissioning and a multiyear active-duty commitment, thus, excluding potential candidates who are ineligible for military service or do not wish to serve in a uniformed capacity. Creating education and training programs for civilian behavioral health professionals could increase the supply of behavioral health professionals within the DoD. DHA and the Services should develop education and training programs for behavioral health professionals that do not require military service. These new opportunities could be integrated into existing military training programs but could also entail the creation of new education and training programs at larger MTFs. Overall workload and productivity standards at participating sites should be adjusted for behavioral health clinicians who provide clinical supervision to trainees.
- 6.7 Expand the Health Professions Scholarship Program (HPSP) to civilian behavioral health students and trainees.** The Army, Navy, and Air Force currently offer scholarship programs for certain behavioral health trainees interested in serving on active duty as a behavioral health provider. These programs offer a monthly allowance for living expenses and cover academic expenses such as tuition, books, and school fees. Scholarships are awarded to eligible behavioral health trainees in exchange for a multiyear active-duty service commitment. Establishing a comparable program wherein scholarships are awarded in exchange for a multiyear civil service commitment could attract students and trainees who are ineligible or not interested in serving on active duty.
- 6.8 Create DoD behavioral health training programs for a broader range of behavioral health disciplines.** The Army, Navy, and Air Force support professional training programs for psychologists and psychiatrists. These programs provide high quality training in behavioral health service delivery and provide opportunities for recruitment of these trainees. These training opportunities should be made available to social workers, licensed professional counselors, mental health counselors, licensed marriage and family therapists, psychiatric nurses, psychiatric physician assistants and other behavioral health professions.
- 6.9 Broaden the range of accreditations accepted for the hiring and credentialing of qualified behavioral health providers.** Given the current difficulties with recruitment and retainment of existing behavioral health providers, the DoD would benefit from expanding the range of accreditations for all currently employed and future behavioral health disciplines to include accreditation by nationally recognized professional accrediting organizations. This would expand the pool of potential behavioral health provider candidates.

## Improve Efficiencies in Hiring Practices

- 6.10 Expedite the hiring process for behavioral health professionals.** Behavioral health professionals and medical leadership consistently reported that the hiring process often takes 9–12 months to complete. Because of this lengthy process, DoD loses many qualified candidates to competing offers. A recent example shared with the SPRIRC is the Congressional query of hiring actions at Walter Reed National Military Medical Center, which found the average time to hire civilian behavioral health professionals was 546 days for psychiatrists, 304 days for psychologists, and 224 days for social workers. That report found that approximately half of psychiatrists declined the position, necessitating a restart of the hiring process at the recruitment stage. Behavioral health professionals described the hiring process as confusing and frustrating, explaining that they often had to repeat tasks and re-create paperwork multiple times for unspecified reasons. Security review processes were frequently cited as a leading cause of delay. “You have to want to work for the DoD really bad to survive the hiring process,” said one behavioral health professional. The slow hiring process further serves to demoralize existing DoD behavioral health professionals. “I keep telling my people that we’ll have more help soon,” one clinic director said, “but they’re tired of me saying that. By the time I hire someone new, I’ve lost another provider due to exhaustion. We won’t ever be able to catch up.” To effectively compete with other agencies and attract talent, DoD hiring processes should be reformed so that qualified candidates can be onboarded within sixty days of accepting a job offer.
- 6.11 Include national clinical credentialing approval in DHA’s efforts to standardize credentialing review processes for behavioral health professionals.** Another commonly cited source of hiring delays was the clinical credentialing review processes. Inconsistencies in credentialing requirements across the Services were noted in the DoD 2022 Report to Congress, *Behavioral Health Requirements of the Department of Defense*. As a result, DHA is conducting a comprehensive review of behavioral health credentialing to standardize credentialing processes across Services and will expand the behavioral health provider types to include psychiatric physician assistants and licensed professional counselors. As part of DHA’s effort to standardize credentialing, the DoD should also implement national credentialing approval so behavioral health professionals already credentialed at one DoD location are not required to be recredentialed when transferring to another DoD MTFs.

National credentialing approval will result in faster onboarding and improve access to care.

## Expand and Optimize Behavioral Health Technicians

- 6.12 Utilize behavioral health technicians as behavioral health care extenders.** As outlined in Defense Health Agency Procedural Instruction 6490.12, active-duty behavioral health technicians are trained to conduct outreach, facilitate psychoeducational groups, conduct brief assessments, and provide targeted interventions. Thus, behavioral health technicians could be deployed as behavioral health care extenders to address the large volume of lower acuity cases presenting to military behavioral health clinics. This would leverage a cost-

effective method for growing the behavioral health workforce and improve access to care for treatment-seeking military personnel. Behavioral health technicians could also be embedded in units to engage in preventive activities and early intervention. The Human Performance Teams developed at Creech Air Force Base could serve as an example for how to use behavioral health technicians to extend the reach of behavioral health services. A model for effectively deploying behavioral health technicians recently provided by the RAND Corporation recommended three key strategies to maximize behavioral health technician contributions to clinical care: (1) provide clinical support tools and templates to behavioral health technicians to structure clinical tasks and ensure task agreement among technicians and licensed behavioral health clinicians; (2) create specific expectations for supervision (e.g., distinguishing activities that should be directly observed by a licensed behavioral health clinician); and (3) expand continuing education opportunities for behavioral health technicians to ensure skill proficiency and continued skill development. More effective use of behavioral health technicians would facilitate the development and implementation of stepped care behavioral healthcare and decrease excessive demand for services from licensed behavioral health providers.

**6.12.1 Increase the number of active-duty behavioral health technicians.** To further maximize impact, the DoD should increase the number of active-duty behavioral health technicians. An internal workforce analysis conducted at Madigan Army Medical Center when the embedded behavioral health model was first implemented at Joint Base Lewis McChord indicated a ratio of one behavioral health professional (inclusive of licensed behavioral health clinicians and behavioral health technicians) for every 400 service members was necessary to maintain a one-week access to care standard. The DoD should set recruitment, retention, and personnel assignment benchmarks to meet this ratio.

**6.13 Provide behavioral health technicians with advanced training in evidence-based practices that can be delivered within their scope of practice.** Several evidence-based practices can be effectively delivered by behavioral health technicians and care extenders. For example, motivational interviewing has been used to help individuals engage in change processes related to problematic health behaviors and was designed to be implemented by lay individuals. Motivational interviewing can be provided by behavioral health technicians and is scientifically supported for a wide range of health issues including ambivalence about treatment engagement. It is also shown to be helpful for suicidal ideation, and lethal means counseling (Anestis et al., 2021; Britton et al., 2020; Michol et al., 2022). Crisis response planning (CRP), a brief strategy that significantly reduces suicidal behavior among military personnel (Bryan et al., 2017), can also be effectively administered by behavioral health technicians. Training programs for motivational interviewing and CRP are available and could increase the reach of effective treatment strategies and interventions to military personnel experiencing non-acute stress.

## Administrative Barriers that Interfere with Care Delivery

Burnout is a key contributor to healthcare professional attrition (Willard-Grace et al., 2019) and has also been shown to degrade the quality and effectiveness of healthcare (Tawfik et al., 2019).



Overwhelmingly, DoD behavioral health clinicians reported experiencing the most reliable determinants of clinician burnout (Figure 6.1) to the SPRIRC. To reduce behavioral health clinician burnout, the SPRIRC recommends the DoD reduce administrative burdens, provide greater control over job duties, and improve information technology infrastructure for behavioral health clinicians.

### Reduce Administrative Burdens on Behavioral Health Care Providers

#### Primary Determinants of Burnout among Behavioral Health Professionals

- Increased workload
- High caseloads
- Low control over job duties
- Limited influence on organizational decisions
- Incompatible expectations due to competing job roles
- Uncertainty and unpredictability
- Confusion about job expectations

Figure 6.1

#### 6.14 Hire more administrative

**support personnel to work in behavioral health clinics.** Behavioral health clinicians and personnel routinely reported a lack of administrative support personnel to perform essential day-to-day clinic functions such as answering phones and scheduling appointments. Because of these shortages, uniformed behavioral health technicians often fulfill these roles, reducing the availability of appropriately trained enlisted personnel to provide clinical services described above (e.g., walk-in triage services, intake appointments, psychoeducational groups, outreach) that could positively impact the demand-supply imbalance in behavioral health services. Hiring more administrative support staff for behavioral health clinics would enable behavioral health clinicians and technicians to engage in preventive and response work by allowing them to spend more time engaged in direct patient care.

#### 6.15 Implement a process improvement initiative to identify burdensome processes and

**procedures that can be eliminated or reduced.** Like many other areas of the DoD, systems and processes within the Military Health System include tasks or requirements that needlessly increase the daily workload and burden of behavioral health clinicians. For example, the Behavioral Health Data Portal (BHDP) and Genesis systems cannot communicate directly with each other, requiring clinicians to copy and paste information from BHDP into Microsoft Word, then copy and paste that same information from Word into Genesis. These unnecessary and often duplicative burdens contribute to burnout and impede the delivery of behavioral health services. Although process improvement efforts have been developed within the Military Health System, bureaucratic processes, overly restrictive acquisitions and contracting policies, and limited resourcing

*“You have to do so much extra work just to accomplish the simplest and most basic things necessary to do your job.”*

*--Behavioral Health Clinician*

prolong problematic inefficiencies force process improvement efforts to focus on only a small subset of “the biggest problems” at the expense of “smaller” issues that adversely impact the day-to-day lives of behavioral health professionals. In the words of a behavioral health clinician, “You have to do so much extra work just to accomplish the simplest and most basic things necessary to do your job.” The DoD should form a working group to identify the most burdensome processes that impede the work of behavioral health clinicians and develop solutions to remove or eliminate these burdens within 2 years. The Getting Rid of Stupid Stuff (GROSS) model is one method for identifying and solving these problems (Ashton, 2018).

- 6.16 Better align behavioral health clinician scheduling templates and workload benchmarks with local MTF and community needs.** Behavioral health clinicians and medical leaders expressed concern that standardizing clinician scheduling templates and workload benchmarks by DHA across MTFs does not provide sufficient flexibility for commanders to adapt services to local needs or changing conditions. This perceived mismatch with local demands contributes to clinician burnout and reduces the ability of behavioral health clinics to adjust their services to better meet the assessed needs of their community. DHA should review and revise the clinician scheduling template and workload system to balance standardization across the enterprise with flexibility to meet local needs.
- 6.17 Implement episodes of care scheduling within behavioral health clinics.** Behavioral health treatment is more effective when psychotherapy sessions are scheduled regularly (Fleming et al., 2020; Hoyt & Edwards-Stewart, 2018). Among military personnel, appointment frequency less than once every three weeks has been shown to significantly degrade treatment efficacy (Hoyt & Edwards-Stewart, 2018). As stated above, because of the DoD’s severe behavioral healthcare demand-supply imbalance, behavioral health appointments cannot be scheduled more often than once every 4–6 weeks. To ensure service members can receive behavioral healthcare in a way that maximizes the potential for recovery, the DHA piloted an “episode of care” model at Fort Belvoir wherein multiple behavioral health appointments were scheduled weekly at the outset of care. DHA leadership reported that, as expected, the pilot led to better clinical outcomes, improved follow-up rates and patient satisfaction. The DHA should implement the episode-of-care model within behavioral health clinics. Because of the existing behavioral health demand-supply imbalance, the DHA should institute a phased roll-out, with immediate implementation for patients who recently attempted suicide and patients with severe suicidal ideation.

## Improve the Behavioral Health Information Technology Infrastructure

- 6.18 Improve the reliability, usability, and interoperability of the Behavioral Health Data Portal (BHDP) and Genesis.** As noted previously in this report, poor reliability, usability, and interoperability of information technology systems is a DoD-wide problem that degrades the well-being of all personnel who depend on its usage and functionality. Recurring problems specific to the information technology systems used by behavioral health clinicians were also reported. BHDP and Genesis, two key systems used by behavioral health clinicians, frequently freeze and crash, hindering clinicians’ ability to



efficiently deliver and document care. Clinicians added that BHDP’s unreliability forces them to use paper-and-pencil forms to monitor patients’ clinical status and suicide risk. Manual entry of these data into BHDP is time-consuming such that many clinicians skip this step. Because this problem contributes to the appearance of non-compliance with screening and assessment requirements, clinicians reported feeling they were unjustly blamed for compliance deficiencies. Behavioral health clinicians and medical professionals also expressed frustration with the limited technical support offered by the Enterprise Service Desk, mirroring complaints from across the DoD about the severe deficiencies of centralized support services for DoD systems. One behavioral health clinician explained that “the MHS Genesis project office refuses to even return phone calls...due to their narrow focus on rolling out the new program.” Problems that disrupt the reliability, usability, and interoperability of critical medical systems should be fixed so that clinicians can provide high quality care without unnecessary distraction or time-consuming burdens. The DoD should fund the development and implementation of a solution to enable the interoperability and improve functioning of the BHDP and Genesis systems.

**6.19 Improve the reliability, usability, and interoperability of email and digital communications systems.** Behavioral health clinicians also described an inability to communicate via email or attend virtual meetings on the Microsoft Teams platform, beginning after the @health.mil email changeover initiated within the past year. “We basically can’t interact with the rest of the base,” explained one behavioral health clinician. Another behavioral health clinician said, “It’s been months since I received one of the base commander’s emails,” prompting another clinician in the same group to add, “I can’t even remember when we last received a base-wide notice from our support agencies.” These collective technology-related issues cause behavioral health clinicians to regularly fall behind in their work and directly threaten patient safety by impeding the ability of behavioral health clinicians to appropriately coordinate care with support agencies and behavioral health professionals working outside the DHA (e.g., embedded behavioral health), jeopardizing patient safety. The DoD should ensure that all healthcare professionals are able to communicate via email and other digital platforms with other key stakeholders of the DoD community.

**6.20 Identify information technology issues and processes that degrade the performance of behavioral health services computer systems.** The problems with computer and IT systems discussed earlier in this report also disrupts patient care and interferes with the timely completion of work duties in behavioral health. Behavioral health staff experience the same concerns that service members reported to SPRIRC--Computers routinely take 30 minutes or longer to start-up and email systems can take another 15 minutes to load, delaying the start of patient care preventing providers and staff from entering notes, checking schedules, and completing other routine duties. Clinicians avoid contacting their local Information Technology office, because doing so could result in removal of the computer for extended periods without replacement because of inadequate inventory, causing even greater disruption to their work. The general sense among behavioral health clinicians and military personnel is that behavioral health services computer performance is influenced by cybersecurity systems and processes that consume computer processing speed. The DoD should also ensure that MTFs are adequately funded to maintain a large

enough inventory of computer equipment to prevent work stoppages and disruptions to patient care when a computer requires maintenance or repair.

## Expand the Evidence-Based Practices

Evidence-based treatments exist for behavioral health conditions that contribute to suicide risk but are not uniformly available to service members with such conditions. This includes care for more common mental health conditions such as depression and anxiety, as well as conditions common among service members who die by suicide, such as alcohol use disorders. Indeed, DoD has funded research on evidence-based practices specifically delivered to those who have thoughts of suicide or who have attempted suicide. DoD-funded research also has shown that targeted interventions like crisis response planning (CRP) reduce suicide attempts among military personnel by 76% as compared to traditional risk management practices (Bryan et al., 2017).

Treatments like brief cognitive behavioral therapy for suicide prevention (BCBT) reduces suicide attempts among military personnel by 60% as compared to traditional behavioral health treatments (Rudd et al., 2015), indicating that widespread adoption of BCBT could lead to meaningful reductions in military suicides and significant cost savings (Bernecker et al., 2020).

Implementation of evidence-based practices like BCBT and CRP across the Military Health System has been negligible because of institutional policies and organizational practices that make it difficult, if not impossible, for behavioral health clinicians to provide these treatments with high reliability and integrity. Rigid requirements for screening and documentation were regularly identified as key barriers to patient-centered care. Behavioral health clinicians and leaders also expressed frustration that the DoD has yet to implement system-wide training specific to translate their research investments into clinical practice. To ensure high-risk service members have access to the most effective behavioral health treatments to reduce suicide attempts, institutional practices and organizational barriers that impede the adoption and implementation of effective suicide prevention practices should be eliminated.

- 6.21 Review and amend Defense Health Agency Administrative Instruction 6025.06 to ensure alignment of this policy with the *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* (VA/DoD CPG).** Defense Health Agency Administrative Instruction 6025.06 outlines standardized procedures for suicide risk screening in behavioral health specialty care settings and other healthcare settings including a predetermined decision-making framework for triaging patients based on their responses to the Columbia Suicide Severity Rating Scale (CSSRS) which has been demonstrated to have poor predictive validity (Bjureberg et al., 2022; Gutierrez et al., 2021; Simpson et al., 2021). The Instruction also does not include the VA/DoD CPG recommended risk level assessment. The decision-making framework outlined in Defense Health Agency Administrative Instruction 6025.06 should be revised to align with the

VA/DoD CPG guidelines for screening, evaluation, and assignment of risk level, which will assist clinicians in taking appropriate action.

- 6.22 Provide skills-based training in evidence-based suicide prevention treatments to behavioral health clinicians across the Military Health System.** The *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* recommends the use of suicide-focused cognitive behavioral therapies and safety planning-type interventions with behavioral health patients reporting suicidal ideation or recent suicidal behaviors. Defense Health Agency Administrative Instruction 6025.06 requires online suicide risk care core training that are not skills-based and are likely to result in minimal change in clinical practice. The DHA leadership should fund skills-based training in evidence-based suicide prevention treatments for all DoD behavioral health providers.
- 6.23 Provide advanced training in evidence-based suicide prevention treatments to TRICARE behavioral health clinicians.** Section 749 of the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023 includes a provision requiring behavioral health providers under the TRICARE program to undergo evidence-based and suicide-specific training. Several factors discourage behavioral health clinicians from enrolling in the TRICARE network. To ensure that TRICARE behavioral health clinicians have access to high quality training that aligns with practices recommended by the *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, the DoD should provide funding to support training in evidence-based trainings shown to be effective for suicide prevention for TRICARE behavioral health clinicians.
- 6.24 Screen for unhealthy alcohol use in primary care clinics.** The U.S. Preventative Task Force (USPTF) recommends primary care physicians screen “for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use” (2018). For screening, the USPTF recommends screening instruments that are short (typically 1 to 3 items) that can be administered quickly and in conjunction with other existing screenings in primary care. For patients who screen positive, the USPSTF recommends providing brief behavioral counseling interventions designed to reduce unhealthy alcohol use and increase motivation for treatment (e.g., motivational interviewing).
- 6.25 Ensure the availability of evidence-based care for those seeking treatment or support for unhealthy drinking.** Service members may refer themselves to substance abuse treatment or be referred by commanding officers. Several evidence-based options for treating alcohol use disorders exist, including pharmacologic and behavioral treatments (Witkiewitz et al., 2019), yet these treatments are not routinely offered to service members. The DoD should ensure that providers of substance use treatment are trained in evidence-based treatments and offer those treatments to service members in need at every MTF and military installation. DHA should also consider requiring behavioral health providers to treat co-occurring disorders using evidenced-based care.

- 6.26 Align substance use treatment programs with behavioral health treatment programs.** Although substance use disorders frequently co-occur with mental health conditions, in each service branch the SPRIRC observed that treatment for substance use disorders were siloed from services for mental health conditions. The SPRIRC recommends better integration and coordination between substance abuse services and behavioral health services. Similar models are included in VA, particularly in clinics that provide care to the most frequently co-occurring disorders, such as PTSD. Organizationally, treatment for substance use disorders and mental health conditions should be aligned within treatment facilities, installations, as well as at the DoD-level. Such organizational integration will ensure that service members are consistently able to access treatment demonstrated to be effective for substance use and co-occurring conditions.
- 6.27 Expand opportunities to treat common mental health conditions in primary care, with a priority to adopt Collaborative Care models.** Most service members have greater access to primary care providers than they do to behavioral health care providers. Collaborative Care “focuses on defined patient populations tracked in a registry, measurement-based practice, and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected” (AIMS Center, n.d.). Recent evidence of an Army-based trial of Collaborative Care in the Military Health System found the model both clinically effective and cost-effective (Engle et al., 2016; Lavelle et al., 2018). Additionally, Collaborative Care can work without having a behavioral health clinician physically within the primary care clinic. In the Army trial, for example, each clinic had a nurse care manager, supplemented by a psychiatrist, psychologist, and nurse care manager who remotely assisted sites (Lavelle et al., 2018). Such virtual positions are currently very attractive to behavioral health providers who can be recruited to provide services without having to relocate.
- 6.28 Amend DoDI 6490.06 to clarify when the delivery of evidence-based suicide-focused interventions falls within the scope of non-medical counseling.** To accelerate service member access to behavioral health professionals for low acuity problems of routine day-to-day military life (e.g., relationship problems, financial strain, conflict with coworkers), the DoD created and implemented initiatives such as Military One Source and the Military and Family Life Counseling (MFLC) Program to provide “non-medical” face-to-face counseling services that are short-term, psychoeducational, and solution-focused. Non-medical counseling is distinguished from formal psychotherapy, also referred to as “medical counseling,” even though the procedures used in non-medical and medical counseling are the same. Because suicidal ideation is outside the scope of non-medical counseling, non-medical counselors are expected to refer military personnel needing psychotherapy to the Military Health System. Non-medical counselors reported this expectation often created unintended professional dilemmas when access to care at the MTF was limited. From an ethical standpoint, licensed non-medical counselors should continue to provide services to suicidal service members, but policy limits their activities to administering suicide risk screening tools and reviewing “safety plans.” These activities are repeated over and over again, frustrating the service member, sometimes to the point

that they discontinue services or begin concealing their suicidal ideation. Amend DoDI 6490.06 to allow non-medical counselors to provide evidence-based counseling to military personnel when the primary driver(s) of suicidal ideation are caused by routine problems of day-to-day military life and the assessed level of suicide risk is both low and non-chronic, as defined by the *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*.

- 6.29 Develop and implement post-discharge support for service members at risk of suicide recently discharged from health care.** Risk for suicide death remains elevated for up to 12 months following a suicide attempt. Despite this, the DoD currently has no centralized program or process to monitor and provide support for these high-risk service members. A DHA-wide post-discharge program should specify the person/agency responsible for conducting the follow-up, when the follow-up will occur, how patients will be contacted (e.g., by phone, email, text, or in-person), how follow-up attempts will be documented, and procedures for ensuring patient safety if they are unreachable. These policies should be required for patients who have made suicide attempts and expanded to include discharged patients clinically assessed as benefiting from such support. In addition to ensuring patient safety, the policy should include processes for MTFs to link mortality data to health care delivery data, thus capturing when and how patients may die after being discharged. This recommendation aligns with recommendations made by the Interdepartmental Serious Mental Illness Coordinating Committee’s (ISMICC) 2017 report to Congress as well as the Mental Health & Suicide Prevention National Response to COVID-19 National Response effort led by the National Action Alliance for Suicide Prevention. Such linkages enable MTFs to identify settings and patients at higher risk of suicide and can be used to inform local suicide prevention strategies for targeted high-risk groups. It will also ensure compliance with reporting and investigating suicides that occur within 72 hours of discharge from a hospital, which the Joint Commission classifies as a “sentinel event.”
- 6.30 Implement caring communications.** DoD-sponsored research has found that sending periodic caring communications (e.g., postcards, text messages) to high-risk service members for 12–24 months in addition to usual behavioral healthcare reduces the risk of suicidal behaviors by approximately half, an intervention commonly known as “caring contacts” (Comtois et al., 2019). Similar results have been obtained in civilian populations (Luxton et al., 2013). The *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* recommends this intervention for patients who have been discharged from psychiatric hospitalization for suicidal ideation or a suicide attempt. In addition, the *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* sets in place provisions for those accessing emergency departments for a suicide attempt, or who have made a suicide attempt but miss outpatient treatment sessions. Several Services have implemented post-discharge programs that include and expand upon caring contacts (e.g., the Marine Intercept Program, the Navy Sailor Assistance and Intercept for Life) but these programs are not fully resourced or implemented.
- 6.31 Fund and create interdisciplinary case management billets within behavioral health clinics.** The interdisciplinary case management model exists in multiple varieties

throughout the Department of Veterans Affairs and civilian care networks like the Behavioral Health Interdisciplinary Program. Interdisciplinary case managers provide wrap-around services to those who have attempted suicide including risk monitoring, care coordination, and clinical services. Interdisciplinary case managers function as behavioral health care extenders to ensure that service members at risk for future suicide attempts have ready access to support and services when needed. Additionally, these individuals can help support leadership with more effectively utilizing suicide safety watches through education and instruction. One service member noted, “Suicide watch just makes the problem worse for everyone.” The DoD should fund and assign at least one interdisciplinary case management billet in every DoD behavioral health clinic and embedded behavioral health clinic, with an ideal ratio of one interdisciplinary case manager per 500 military personnel.

### Limited Engagement with Community-Based Agencies and Providers

As part of each site visit, the SPRIRC visited with community-based agencies and providers. These visits revealed that military installations had varied relations with community-based providers. In some instances, a high level of collaboration and cooperation resulted in seamless communication and referrals between installation and community-based providers, but in others, community-based providers complained about wanting to serve the military community but facing access and cost barriers for doing so.

Given the DoD’s current inability to meet behavioral health care demand, leveraging community-based providers to meet the behavioral health needs of service members is a critical strategy for addressing its current demand-supply imbalance.

Further, expanded engagement with community-based agencies that serve as training programs for behavioral health professionals provides the added benefit of exposing early career professionals to military culture, increasing the national supply of military culturally competent behavioral health care providers. Behavioral health trainees who work with military personnel may also be more willing to pursue permanent employment with the DoD, thereby growing the behavioral health workforce. Such programs and agencies could also provide care to family members who cannot receive behavioral health services from the MHS.

**6.32 Increase TRICARE payment rates for behavioral health services.** The DoD’s behavioral health demand-supply imbalance could be partially relieved by referring more service members to TRICARE network providers. However, community behavioral health professionals frequently reported low reimbursement rates from the TRICARE network as a reason for not enrolling as TRICARE providers (GAO, 2011). Numerous community professionals expressed a strong desire to offer behavioral health services to service members but noted that doing so was financially difficult. One potential TRICARE-eligible provider stated, “I withdrew my application after I learned that I would only be reimbursed at 25% of my per session rate. My rate is the average in the community.” A military behavioral health professional further noted, “We have a TRICARE system based on patriotism.” Unfortunately, this may not be solely a TRICARE/DoD issue. In 2014–2016,

almost 27% of psychiatrists nationwide worked in predominantly self-pay practices, a 10% increase since 2007–2009 (Benjenk & Chen, 2020). Thus, while TRICARE Management Activity (TMA) has the authority to adjust reimbursement rates (which are tied to the Medicare Part B Physician Fee Schedule), a joint effort between TMA and the Centers for Medicare & Medicaid Services (CMS) may be more beneficial to identify reimbursement strategies that make TRICARE and Medicare reimbursement more attractive to behavioral health care providers. TMA should initiate discussions with CMS to create a joint, mental health working group and develop a strategic plan to improve reimbursement rates and/or practices to attract more behavioral health care providers who can provide services to service members and their families.

- 6.33 Ensure TRICARE payments to behavioral health professionals are made as directed by TRICARE policy.** Community behavioral health providers and healthcare systems are also reluctant to provide behavioral health services to military beneficiaries because of TRICARE’s lengthy payment process. “It takes forever to get paid a pittance, if you even get paid at all,” explained one community behavioral health professional. The TRICARE Operations Manual Section 6.2.1 requires that “The contractor shall process 98% retained and adjustment claims accurately and to completion within 30 calendar days from the date of receipt” (TRICARE, 2021). TMA should conduct an audit of its contractors to ensure these standards are being met for behavioral health care appointments and create strategies to improve efficiencies if they are not.
- 6.34 Expand the types of licensed behavioral health providers accepted by TRICARE.** Because the TRICARE fee schedule is tied to the Medicare Part B Physician Fee Schedule, TRICARE is unable to cover the costs of behavioral health services provided by licensed behavioral health counselors, licensed marriage family therapists, and licensed professional counselors because these licenses are not accepted by Medicare, shrinking the pool of behavioral health professionals available to DoD beneficiaries. This significantly decreases the amount of potentially available community behavioral health providers for service members. The DoD should initiate discussions with CMS to develop a plan to expand the types of licensed behavioral health providers accepted by Medicare.
- 6.35 Update TRICARE provider rosters at least twice annually.** Family members repeatedly expressed frustration that TRICARE behavioral health provider rosters included clinicians who were no longer accepting new patients, no longer located in the area, no longer accepting TRICARE, or even having disconnected phone lines. Family members also reported rosters including professionals with degrees and credentials that were not accepted by TRICARE which resulted in unexpected fees and discontinuation of services. The DoD should direct TMA to develop a process to ensure provider rosters are reviewed and updated at least twice annually and should clearly designate which providers have licenses that are not eligible for reimbursement.
- 6.36 Expand collaborations with academic affiliations offering evidence-based services and offer internships to students interested in learning evidence-based treatments for services members.** Access to evidence-based treatments can be expanded by establishing collaborations with nearby academic affiliations offering evidence-based treatments to

service members and their families. Likewise, DoD could establish practica for behavioral health training programs and offer supervised training under the guidance and oversight of licensed clinicians working in the DoD. This also could serve as a recruitment tool for these students to seek permanent positions in DoD behavioral health when they graduate. Additionally, access to evidence-based care for service members can be increased if DoD establishes partnerships with academic affiliations who offer massed evidence-based care, often specifically targeting problems and issues experienced by service members. DoD should seek to collaborate with these programs to develop and implement a mutually agreeable partnership such that service members can access these programs.

## Expand Use of Technology-Based Solutions for Scalable Treatment Delivery

Delivery of behavioral health services via remote video- and teleconferencing increases treatment-seeking behaviors (Kauer et al., 2014) without diminishing the effectiveness of behavioral healthcare services (Osenbach et al., 2013; Sloan et al., 2011). Telebehavioral health has also been shown to significantly reduce psychiatric hospitalization utilization (Godleski et al., 2012). Published case reports of BCBT support the safety and feasibility of treating suicide risk via telebehavioral health (Rojas et al., 2022). Guidelines for the clinical care of suicidal patients via telebehavioral health have also been published (Godleski et al., 2008; McGinn et al., 2019) Despite its considerable promise, telebehavioral health is underutilized in the MHS. Behavioral health clinicians and medical leadership identified several organizational and institutional barriers including the absence of videoconferencing equipment, limited training and experience, and liability concerns. Opinions about telebehavioral health varied across military stakeholder groups, with some stakeholders favoring wider implementation and other preferring face-to-face services. However, the latter group of service members reported that they would nonetheless engage in telebehavioral health if it provided quick access to care.

Telebehavioral health can overcome many logistical barriers commonly faced by military personnel like geographic distance and scheduling conflicts.

- 6.37 Expand the availability of telebehavioral health services.** The DHA has developed a plan to stand up three TBH hubs under the DHA medical center to augment behavioral health care for military personnel worldwide. This effort should be fully funded and sufficiently resourced to ensure successful deployment. Remote locations and those that have severe demand-supply imbalances should be prioritized for expanded telebehavioral health services.
- 6.38 Clarify language regarding the limits of telebehavioral health practice across jurisdictions.** Many military behavioral health clinicians are reluctant to offer telebehavioral health services because of confusion regarding federal and state law. 10 USC Section 1094 states that a health-care professional working under the jurisdiction of the Secretary of a military service "...may practice the health profession or professions of the health-care professional at any location in any State, the District of Columbia, or a Commonwealth, territory, or possession of the United States, regardless of where such



health-care professional or the patient are located, so long as the practice is within the scope of the authorized Federal duties.” Behavioral health clinicians noted that this guidance was seemingly contradicted by other DoD guidance (e.g., *Counseling, Advocacy, and Prevention (CAP) Telehealth Program Guidance*) recommending clinicians review telehealth regulations in the jurisdiction in which the patient is located for additional requirements and restrictions. Because most jurisdictions prohibit the practice of telehealth across state lines, clinicians were uncertain which regulations or laws were applicable to their work and reported conflicting information from supervisors and legal counsel. The applicability of 10 USC Section 1094 was especially confusing for Military Family Life Consultant (MFLC) Program counselors, who are contracted employees not federal employees. To clarify this confusion DoD should seek to expand access to behavioral health services by seeking legal authority for “Anywhere-to-Anywhere” telebehavioral health authority like that obtained by the Department of Veterans Affairs. Such authority should allow the provision of behavioral health services via telehealth in any state, irrespective of the service member or DoD professional location and should include trainees supervised by a qualified DoD health care professional. While efforts to establish this authority are underway, the Office of General Counsel should provide guidance regarding the practice of telebehavioral health services by DoD behavioral health clinicians and DoD-contracted behavioral health clinicians providing services to service members across state lines.

- 6.39 Establish partnerships between MTFs and regional healthcare systems that can deliver evidence-based telebehavioral health services.** The DoD should seek to expand access to behavioral health services by establishing partnerships with regional healthcare systems, academic medical centers, and/or university-based behavioral health training programs that offer evidence-based telebehavioral health services. Recommendations for successful partnership models with federally qualified health centers are available and can serve as a guide for this process (Fortney et al., 2019).

## Integrated Disability Evaluation System

A service member who becomes ill or injured can be referred to the DoD’s disability evaluation system. Under the newly created joint DoD/VA process known as the Integrated Disability Evaluation System (IDES), adjudicating boards determine if service members meet medical retention standards and are fit to continue to serve. Historically, completion of the evaluations took significant time (e.g., an average of 400 days in 2012). The DoD has been working to improve the process and as of 2020, the Services are close to achieving a completion goal of 180 days; Rennane et al., 2022). Nonetheless, this period of evaluation may be a time of suicide risk for service members. During its site visits, the SPRIRC met with multiple service members undergoing disability evaluation. These service members reported feeling isolated, disconnected from peers and their civilian communities, and lacking purpose. Moreover, service members being evaluated often experienced hostility and tension from their peers who experienced increased work demands because units cannot backfill positions while service members are under evaluation. Commanders added that because many service members in the process believe they will soon be exiting the military, behavioral and disciplinary problems (e.g., drug use) often occur with increased frequency, complicating the separation process and increasing demand for behavioral health

services. This increase in demand by these service members, many who will eventually leave the military, decreases access to behavioral health care for remaining service members. Thus, the process not only negatively impacts the service member being evaluated, it also increases stress and burnout for that service member's peers and consumes resources from support services and behavioral health professionals, exacerbating strain on the system. The DoD should develop policies and procedures that reduce suicide risk to the departing service member and support those service members who will be impacted by the loss.

- 6.40 Allow unit commanders to backfill positions at the initiation of a medical evaluation board.** Unit commanders raised concerns that they were unable to request replacement personnel until after the medical evaluation board (MEB) process was complete and the service member was separated from military service. Because many service members are placed on a limited duty status during the MEB process, the MEB process functionally exacerbates personnel shortages, increasing workload and stress for others in the unit. Service members undergoing MEB reported this often results in hostility and isolation from peers, increasing their risk for suicide.

Allowing unit commanders to request replacement personnel as soon as an MEB is initiated could reduce strain on the unit and reduce harmful peer relationships that can increase risk for the service member being separated.

- 6.41 The DoD should fully fund and staff wounded, ill, and injured programs at 100%.** Site visits revealed staffing shortages at programs that typically support those in the IDES process as well as limitations on which conditions would confer being admitted. The DoD should fully fund and staff these programs at 100% so that these service members can get timely services and evaluation. This will reduce the burden currently being shouldered by behavioral health providers and improve access to those services for remaining service members.
- 6.42 The DoD should identify a process and a set of criteria for service members to maximize convalescent leave while engaged with the Integrated Disability Evaluation System.** Once service members have reached their medical retention determination point (MRDP) and are engaged in the MEB/PEB, it may be beneficial for the service member to maximize convalescent leave to receive care and services at their home of record. The DoD, in conjunction with the Services, should identify which medical conditions requiring an MEB could be managed at the home of record. The DoD should develop protocols that require those engaging with this option to have established housing and connection to transition resources as well as the ability to attend all required appointments.



## Chapter 7: Surveillance, Research and Evaluation

Reducing suicide risk will require enhanced activity in surveillance, research, and program evaluation to monitor program effects and continually expand our understanding of modifiable and actionable protective and risk factors for suicide among service members. While collecting information for this report, the SPRIRC identified several knowledge gaps that warrant closer examination, thereby strengthening the DoD’s ability to make evidenced-informed decisions. The recommendations included in this section are meant to align with the recommendations made in previous sections of this report.

### Leadership Issues

Earlier in this report, we noted how leadership behaviors can influence suicide by either depleting or enhancing service member well-being. “Toxic leadership” was a recurring theme across all Services and installations, with many stakeholders wondering why and how these leaders had progressed so far in their careers without intervention or removal. Some military personnel speculated that the rules and regulations that govern early dismissal from the military—essentially “firing” or terminating their employment—created barriers that inadvertently reinforced bad behavior. Military personnel added that most toxic leaders had “reputations that precede them,” suggesting problematic leadership could be identified much earlier in the career cycle. As one senior NCO noted, “Instead of getting rid of these obviously problematic people, we just move them over and over again because it’s easier to just move someone to a different location than it is to fire them or get rid of them.” Conducting research focused on identifying early indicators of problematic leadership could improve the DoD’s ability to take preventative steps that could reduce their negative influence on the community.

*“Instead of getting rid of these obviously problematic people, we just move them over and over again because it’s easier to just move someone to a different location than it is to fire them or get rid of them.”*

*--Air Force Senior NCO*

- 7.1 Conduct research to identify early career risk factors that predict leader removal from office or relief of duty and identify predictors of good military leadership that demonstrate positive outcomes.** Military personnel identified an institutional and cultural practice of “playing hot potato” with toxic and abusive leaders. The thinking that toxic leadership traits are detectable from the earliest stages of a leader’s military career was

nearly unanimous. Because of the military's promotion process, these problematic personnel continue to gain rank, adversely impacting the lives of more and more people over time. To improve the identification of problematic leaders earlier in their career trajectory, the DoD should conduct research focused on predictors of leadership behavior that would warrant removal from office or relief of duty for misconduct, as well as the effectiveness of mentoring or coaching for those identified as in need of amelioration. The DoD should also conduct research on predictors of good leadership, including identifying behaviors that demonstrate the ability to achieve mission accomplishments while being respected by those they lead. Such research could reveal essential clues regarding potential preventative and proactive actions that could be taken early in a leader's career development to reduce negative leadership outcomes.

## Program Evaluation

Earlier in this report, we described multiple existing military structures that inadvertently increase risk for suicide including stove piping and limited collaboration across program offices and Services. The DoD would be more effective if it systematically evaluated existing programs and terminated or modified programs that do not work or are not sustainable. Unfortunately, program evaluation is rarely built into many DoD initiatives and efforts. When programs do demonstrate success, however, implementation across the DoD is rare. An example of this specific to reducing suicide is the absence of formal training processes for Brief Cognitive Behavior Therapy and Crisis Response Planning for DoD service providers despite their demonstrated effectiveness for preventing suicidal behavior among military personnel. Requiring program evaluation for all suicide prevention and well-being efforts should be required.

- 7.2 Enhance program evaluation efforts to continuously monitor how policies, programs, and initiatives impact risk and protective factors for suicide.** The DoD regularly enacts policy changes and stands up programs intended to impact well-being, suicide risk, and other risk and protective factors. For example, beginning January 1, 2023, service members will receive an 11% increase in their monthly Basic Allowance for Subsistence (BAS), which could alleviate financial strain among service members. Previous research shows that wage increases are associated with decreases in suicide, especially for those with lower income levels (Gertner et al., 2019, Kaufman et al., 2020, Stack, 2021). Recent changes to the Joint Travel Regulations allow service members to ship empty gun safes up to 500 pounds. This strategy could incentivize the purchase and use of firearm locking devices, which is correlated with reduced suicides in firearm-owning homes (Monuteaux et al., 2019; Shenassa et al., 2004). These changes could similarly prevent some military suicides and thus, should be evaluated for their effect on suicide within DoD. We recommend the DSPO use existing data systems to engage in regular program evaluation efforts for these efforts as well as other DoD-wide suicide prevention strategies, thereby providing insights regarding the effects of these policy changes on outcomes of relevance to suicide.
- 7.3 Establish formal partnerships between the Office of People Analytics (OPA) and academic institutions to provide consultation and support for ongoing program evaluation efforts.** OPA lacks the resources and personnel to engage in dissemination and implementation efforts. Subsequently, the results of internal evaluations often have limited reach and remain largely unknown to the public and the larger community of researchers.

Moreover, they are not well-utilized in decision-making about which programs and initiatives DoD should sustain and which should be sunset. Partnering OPA with external subject matter experts could enhance the DoD's ability to conduct unbiased assessments of its current practices, programs and policy effects and facilitate the dissemination and implementation of findings by publishing results in peer-reviewed outlets, presenting results at scientific meetings, and communicating results through the media and other public communication methods. Such findings will improve DoD's ability to make data-based decisions about which of the myriad of programs to continue to support and which efforts should not be continued.

- 7.4 Conduct a DoD-wide MWR program evaluation to identify activities and programs that appeal to today's service members.** Utilization of MWR activities and programs was variable across the installations visited by the SPRIRC. Higher attendance and participation were reported at locations where physical facilities had been renovated with gaming centers, where a mobile gaming trailer was implemented, and when input and feedback were solicited from stakeholders. Poorly attended events were often scheduled when most service members were at work or were repeated multiple times throughout the year. The SPRIRC also were informed that high OPTEMPO often interrupted their ability to participate in MWR trips that require reservations and planning, as field exercises or additional duties were regularly added during weekends and evenings. MWR should conduct a DoD-wide program evaluation and sunset poorly attended programs and activities and invest resources in new programming commensurate with the needs and wishes of the service members who are serving today.

## Service Members Under Investigation

As noted earlier in this report, effective suicide prevention requires multiple approaches. At present, individuals under investigation are at heightened risk to engage in behaviors (e.g., alcohol misuse) that elevate their risk for suicide attempts and death by suicide, yet specific details about which charges and disciplinary actions are most strongly correlated with these outcomes are not well understood. Anecdotal reports provided to the SPRIRC by Service investigative offices (CID, NCIS, and OSI) suggest service members under investigation for crimes against children may account for a large share of suicides among service members under investigation and/or may be at increased risk of suicide. However, to date SPRIRC did not identify empirical work that has examined whether specific offenses increase suicide risk. If differences between specific charges are found, such research could allow the DoD to develop and implement more targeted interventions to improve safety for this subgroup of service members.

- 7.5 Conduct research to clarify the types of offenses and charges confer increased suicide risk among service members.** Current DoDSER data provide information about the percentage of suicide decedents who were currently or recently under administrative or legal investigation, but no details are available about the types of charges or offenses this category includes, hindering efforts to develop targeted preventative strategies for this group of service members. The DoD should use existing data to calculate and report the types of offenses and charges for which service members were being investigated; the number and percentage of service members under investigation who die by suicide,

separated by offense or charge type; and how these numbers and rates vary by rank. The DoD should specifically examine suicide risk among those under investigation for crimes against children, including child sexual assault and child pornography.

## Service Member Well-Being and Morale

Current sociological factors greatly influence suicide risk and must be accounted for in current suicide prevention efforts. That said, these efforts must be bolstered by research on real-time changes that directly impact our service members.

- 7.6 Conduct research to determine if fluctuations in the US labor market are correlated with service member suicide.** Some economic forecasts suggest job opportunities in the civilian sector are expected to increase until 2031 but other economists are predicting a recession in 2023. While a recession may increase military recruitment, without adequate unemployment support external to DoD, economic conditions may also contribute to an increase in the U.S. suicide rate. How macroeconomic factors might influence suicide risk in military populations is unknown. Research should be conducted to understand how trends in civilian markets and in military accessions and retentions interact and impact military suicides. Such research could reveal clues to develop and implement targeted preventive interventions for service members who join the military or remain in the military while experiencing financial strain.

## Behavioral Health Interventions and Services

As noted earlier in this report, mental health services are severely understaffed, creating access barriers to those wanting and willing to seek mental health care.

- 7.7 The DoD should review the IT capabilities within Service Medical Departments and leverage the Telemedicine and Advanced Technology Research Center (TATRC) under the U.S. Army Medical Research and Development Command (USAMRDC); and the Defense Health Agency Virtual Health Clinical Integration Office (VH CLIO) to coordinate research focused on provision of behavioral health services in virtual formats.** These modalities have shown to be particularly attractive to younger service members under 25 years of age who account for nearly half of all military suicides.

The DoD would benefit from leveraging existing resources to examine the benefits of potential increased availability of behavioral health supports to service members whenever and wherever they may need them.

- 7.8 Fund research focused on the development and testing of mobile health technologies to improve mental health and well-being.** Mobile health technologies (e.g., smartphone apps) can potentially assist service members experiencing distress, overcome barriers to care and supplement behavioral health care. The Virtual Hope Box is a mobile app developed by the DoD's National Center for Telehealth and Technology (T2) that provides



access to guided digital activities (e.g., relaxation exercises, coping cards) and has been shown to significantly improve veterans' ability to cope with unpleasant emotions (Bush et al., 2017). Similarly, engagement in Vets Prevail, a 100% online therapy platform, resulted in clinically meaningful reductions in mild-to-moderate PTSD and depressive symptoms (Hobfoll et al., 2016). Digital adaptations of Brief Cognitive Behavior Therapy, a psychological treatment that significantly reduces suicide attempts among military personnel (Venkatesan et al., 2020), is currently undergoing scientific evaluation. Scientific evidence demonstrating the potential benefits of free mobile mental health apps developed by the Department of Veterans Affairs is accumulating (Owen et al., 2018). These free mobile health apps address many of the concerns identified in this report as risks for suicide—sleep problems (CBT-I Coach), stress (PTSD Coach), and relationship issues (PTSD Family Coach). Funding additional research focused on the benefits of these and other mobile health technologies for service members could identify widely available and inexpensive suicide prevention and wellness resources for military personnel.



## Chapter 8: Moving Forward

The SPRIRC sought to demonstrate the need for a multifaceted approach to preventing suicide among service members. DoD leaders and Congress have all stated the need to effectively address suicide. In order to do this, we have outlined recommendations addressing the underlying issues causing the most distress for service members. Some recommendations will result in quick wins while others require resourcing and significant system changes in how the DoD operates. Some recommendations will likely result in more efficient operations and potential cost savings because of reductions in the duplication of programs and services. Service members must be prepared and ready to fight for our country when called upon to do so, and the recommendations made in this report are designed to strengthen their ability to complete this mission. If implemented, our recommendations will enhance the well-being of service members and their families, build morale, and reduce morbidity and mortality associated with suicidal behavior.

### Congressional Oversight

The SPRIRC recognizes the efforts and actions that the DoD and the Services have been implementing to reduce suicide risk, many of which are highlighted at the beginning of this report. The SPRIRC also acknowledges that the DoD and Congress have implemented and put forth new initiatives and programs during the course of this work that could positively impact suicide rates over the long term. A number of actions and initiatives included in the 2023 NDAA align with recommendations in this report. We encourage Congress to further leverage this momentum to facilitate the changes needed to support service member well-being and reduce factors that contribute to suicide risk. Several SPRIRC recommendations require legislative action, all recommendations will require genuine and coordinated effort. As with the IRC on Sexual Assault in the Military, the SPRIRC urges Congress to consider reasonable timeframes for implementation of the recommendations and importantly, evaluation of new provisions necessary for effective implementation.

### Implementation

The SPRIRC recommends that the DoD quickly develops an implementation plan to address the recommendations. The SPRIRC recognizes that some recommendations will require Congressional action and we encourage the DoD to be forthright and honest about the requirements for those recommendations. For recommendations that may be implemented quickly, the SPRIRC encourages the DoD to take immediate action.



## References

- Aims Center. (2022). *Collaborative Care*. University of Washington, Psychiatry and Behavioral Sciences Division of Population Health. <https://aims.uw.edu/collaborative-care>
- Anestis, M. D., Selby, E. A., & Butterworth, S. E. (2017). Rising longitudinal trajectories in suicide rates: The role of firearm suicide rates and firearm legislation. *Preventive Medicine, 100*, 159-166. <http://mikeanestis.weebly.com/publications.html>
- Anestis, M. D., Bond, A. E., Bryan, A. O., & Bryan, C. J. (2021). An examination of preferred messengers on firearm safety for suicide prevention. *Preventive Medicine, 145*, 106452. <https://doi.org/10.1016/j.ypmed.2021.106452>
- Anestis, M. D., Bryan, C. J., Capron, D. W., & Bryan, A. O. (2021). Lethal means counseling, distribution of cable locks, and safe firearm storage practices among the Mississippi National Guard: A factorial randomized controlled trial, 2018–2020. *American Journal of Public Health, 111*(2), 309-317. <https://doi-org.mrhc.idm.oclc.org/10.2105/AJPH.2020.306019>
- Anestis, M. D., Bryan, C. J., Capron, D. W., & Bryan, A. O. (2022). Evaluation of safe firearm storage messaging in a sample of firearm-owning US military service members. *JAMA Network Open, 5*(10), e2235984. <https://doi:10.1001/jamanetworkopen.2022.35984>
- Ashton, M. (2018). Getting rid of stupid stuff. *New England Journal of Medicine, 379*(19), 1789-1791.
- Baker, J.C., Bryan, C.J., Bryan, A.O., & Button, C.J. (2021). The Airman’s Edge Project: A peer-based, injury prevention approach to preventing military suicide. *International Journal of Environmental Research and Public Health, 18*(6), 3153. <https://doi.org/10.3390/ijerph18063153>
- Bandel, S. L., Bond, A. E., Bryan, C. J., & Anestis, M. D. (2022). Public perception of gun violence-related headline accuracy and the credibility of media sources. *Health Communication, 1*-6. <https://doi.org/10.1080/10410236.2022.2037199>
- Bass, B. M., Avolio, B. J., Jung, D. I., & Berson, Y. (2003). Predicting unit performance by assessing transformational and transactional leadership. *Journal of Applied Psychology, 88*(2), 207–218. <https://doi.org/10.1037/0021-9010.88.2.207>
- Bell, C. M., Ridley, J. A., Overholser, J. C., Young, K., Athey, A., Lehmann, J., & Phillips, K. (2018). The role of perceived burden and social support in suicide and depression. *Suicide and Life-Threatening Behavior, 48*(1), 87-94. <https://ouci.dntb.gov.ua>
- Benjenk, I., & Chen, J. (2020). Trends in self-payment for outpatient psychiatrist visits. *JAMA Psychiatry, 77*(12), 1305–1307. <https://doi:10.1001/jamapsychiatry.2020.2072>
- Bernecker S. et al. (2020). Economic Evaluation of Brief Cognitive Behavioral Therapy vs Treatment as Usual for Suicidal US Army Soldiers. *JAMA Psychiatry, 77*(3), 256–264. [doi:10.1001/jamapsychiatry.2019.3639](https://doi:10.1001/jamapsychiatry.2019.3639)
- Bjureberg, J., Dahlin, M., Carlborg, A., Edberg, H., Haglund, A., & Runeson, B. (2022). Columbia-Suicide Severity Rating Scale Screen Version: Initial screening for suicide risk in a psychiatric emergency department. *Psychological Medicine, 52*(16), 3904-3912. <https://doi.org/10.1017/s0033291721000751>
- Blais, R.K., Tirone, V., Orłowska, D., Lofgreen, A., Klassen, B., Held, P., Stevens, N., & Zalta, A.K. (2021) Self-reported PTSD symptoms and social support in U.S. military service

- members and veterans: a meta-analysis, *European Journal of Psychotraumatology*, 12(1).  
<https://doi.org/10.1080%2F20008198.2020.1851078>
- Britton, P. C., Conner, K. R., Chapman, B. P., & Maisto, S. A. (2020). Motivational interviewing to address suicidal ideation: A randomized controlled trial in veterans. *Suicide and Life-Threatening Behavior*, 50(1), 233-248. <https://doi.org/10.1111/sltb.12581>
- Bryan, C. J., Morrow, C. E., Anestis, M. D., & Joiner, T. E. (2010). A preliminary test of the interpersonal-psychological theory of suicidal behavior in a military sample. *Personality and Individual Differences*, 48(3), 347-350. <https://doi.org/10.1016/j.paid.2009.10.023>
- Bryan, C., Burch, T., Clemans, T., Leeson, B., Maney, E., Mintz, J., Rudd, M., & Williams, S. (2017). Effect of crisis response planning vs. contracts for safety on suicide risk in US Army soldiers: a randomized clinical trial. *Journal of Affective Disorders*, 212, 64-72. <https://doi.org/10.1016/j.jad.2017.01.028>
- Bryan, C. J., Bryan, A. O., Rugo, K., Hinkson, K., & Leifker, F. (2020). Happiness, meaning in life, and PTSD symptoms among national guard personnel: A multilevel analysis. *Journal of Happiness Studies*, 21(4), 1251-1264. <https://doi.org/10.1007/s10902-019-00129-3>
- Bryan, C. J., Bryan, A. O., & Kopacz, M. S. (2021). Finding purpose and happiness after recovery from suicide ideation. *The Journal of Positive Psychology*, 16(1), 46-53. <https://doi.org/10.1080/17439760.2019.1676460>
- Bureau of Labor Statistics. (November 2022). *The Employment Situation*. [News Release]. <https://www.bls.gov/news.release/pdf/empisit.pdf>
- Bush, N.E., Smolenski, D., Denneson, L.M., Williams, H.B., Williams B.A., Thomas, E.K., & Dobscha, S.K. (2017). A virtual hope box: Randomized controlled trial of a smartphone app for emotional regulation and coping with distress. *Psychiatric Services*, 68(4), 330-336.
- Churchman, C.W. (1967). "Wicked Problems". *Management Science*, 14(4), B-141–B-146. <https://doi.org/10.1287/mnsc.14.4.B141>
- Comtois, K. A., Kerbrat, A. H., DeCou, C. R., Atkins, D. C., Majeres, J. J., Baker, J. C., & Ries, R. K. (2019). Effect of augmenting standard care for military personnel with brief caring text messages for suicide prevention: a randomized clinical trial. *JAMA Psychiatry*, 76(5), 474-483. <https://doi.org/10.1001/jamapsychiatry.2018.4530>
- Conner, A., Azrael, D., & Miller, M. (2019). Suicide case-fatality rates in the United States, 2007 to 2014: A nationwide population-based study. *Annals of Internal Medicine*, 171(12), 885-895. <https://doi.org/10.7326/m19-1324>
- Defense Suicide Prevention Office. (2015). Department of Defense Strategy for Suicide Prevention. [https://www.dspo.mil/Portals/113/Documents/TAB%20B%20-%20dssp\\_final%20USD%20PR%20signed.pdf](https://www.dspo.mil/Portals/113/Documents/TAB%20B%20-%20dssp_final%20USD%20PR%20signed.pdf)
- Department of Defense. (2010). *Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces*. <https://www.health.mil/Reference-Center/Reports/2010/12/01/Task-Force-of-the-Prevention-of-Suicide-by-Member-of-the-Armed-Forces>
- Department of Defense. (2021). *Department of Defense Annual Report on Suicide in the Military*. <https://www.dspo.mil/Portals/113/Documents/2021%20ASR/FY21%20ASR.pdf?ver=1F9QARTc2gfXMGIoqum0Mw%3d%3d>

- Department of Defense. (2020). *Strategy to Recruit and Retain Mental Health Providers*.  
<https://www.health.mil/Reference-Center/Reports/2020/11/04/Strategy-to-Recruit-and-Retain-Mental-Health-Providers>
- Department of Defense. (2022). *Behavioral Health Requirements of the Department of Defense*.  
<https://www.health.mil/Reference-Center/Reports/2022/01/20/Behavioral-Health-Requirements-of-the-DoD>
- Department of Defense. (2022, November 10). *Disability Evaluation System* (DoD Instruction 1332).
- Dupre, K. E., & Day, A. (2007). The effectiveness of supportive management and job quality on the turnover intentions and health of military personnel. *Human Resource Management, 46*(2), 185–201. <https://doi.org/10.1002/hrm.20156>
- Engel, C., Jaycox, L., Freed, M., Bray, R., Donald Brambilla, D., Zatzick, D., Litz, B., Tanielian, T., Novak, L., Lane, M., Belsher, B., Olmsted, K., Evatt, D., Vandermaas-Peeler, R., Unützer, J., & Katon, W. (2016). Centrally assisted collaborative telecare for posttraumatic stress disorder and depression among military personnel attending primary care: A randomized clinical trial. *JAMA Internal Medicine, 76*(7), 948–956. doi:10.1001/jamainternmed.2016.2402
- Esser, M., Leung, G., Sherk, A., Bohm, M., Liu, Y., Lu, H., & Naimi, T. (2022). Estimated deaths attributable to excessive alcohol use among US adults aged 20 to 64 years, 2015 to 2019. *JAMA Network Open, 5*(11):e2239485. doi:10.1001/jamanetworkopen.2022.39485
- Evans, J., Hyndman, S., Stewart-Brown, S., Smith, D., & Petersen, S. (2000). An epidemiological study of the relative importance of damp housing in relation to adult health. *Journal of Epidemiology and Community Health, 54*(9), 677–686. <https://doi.org/10.1136/jech.54.9.677>
- Fassett-Carman, A., DiDomenico, G., von Steiger, J., & Snyder, H. (2020). Clarifying stress-internalizing associations: Stress frequency and appraisals of severity and controllability are differentially related to depression-specific, anxiety-specific, and transdiagnostic internalizing factors. *Journal of Affective Disorders, 260*, 638-645. <https://doi.org/10.1016/j.jad.2019.09.053>
- Fleming, C., Hawrilenko, M., Wachen, J., Peterson, A., Yarvis, J., Borah, A., Litz, B., Young-McCaughan, S., Hale, W., Mintz, J., Resick, P., & STRONG STAR Consortium. (2020). It's about time: Examining the role of session timing in Cognitive Processing Therapy in active duty military personnel. *Journal of Behavioral and Cognitive Therapy, 30*(3), 231-239. <https://doi.org/10.1016/j.jbct.2020.04.001>.
- Fortney, J. C., Veith, R. C., Bauer, A. M., Pfeiffer, P. N., Valenstein, M., Pyne, J. M., Dalack, G. W., Kramer, T. L., Ferro, L. J., Metzger, K., Shore, J. H., Carlo, A. D., Coates, S., Ward-Jones, S., Larkins, E., Hafer, E., Shushan, S., Weaver, D. L., & Unützer, J. (2019). Developing telemental health partnerships between state medical schools and federally qualified health centers: Navigating the regulatory landscape and policy recommendations. *The Journal of Rural Health, 35*(3), 287–297. <https://doi.org/10.1111/jrh.12323>
- Gertner, A. K., Rotter, J. S., & Shafer, P. R. (2019). Association between state minimum wages and suicide rates in the US. *American Journal of Preventive Medicine, 56*(5), 648-654. <https://doi.org/10.1016/j.amepre.2018.12.008>

- Goddard, A. V., Xiang, Y., & Bryan, C. J. (2022). Invariance-based causal prediction to identify the direct causes of suicidal behavior. *Frontiers in Psychiatry*, 2598. <https://doi.org/10.3389/fpsy.2022.1008496>
- Godleski, L., Darkins, A., & Peters, J. (2012). Outcomes of 98,609 US Department of Veteran Affairs patients enrolled in telemental health services, 2006–2010. *Psychiatric Services*, 63(4), 383-385. <https://doi.org/10.1176/appi.ps.201100206>
- Godleski, L., Nieves, J. E., Darkins, A., & Lehmann, L. (2008). VA telemental health: Suicide assessment. *Behavioral Sciences & The Law*, 26(3), 271-286. <https://doi.org/10.1002/bsl.811>
- Goh, V. H., Tong, T. Y., Lim, C. L., Low, E. C., & Lee, L. K. (2000). Circadian disturbances after night-shift work onboard a naval ship. *Military Medicine*, 165(2) 101-5. <https://doi.org/10.1093/milmed/165.2.101>
- Goldman-Mellor, S., Olfson, M., & Schoenbaum, M. (2022). Acute injury mortality and all-cause mortality following emergency department presentation for alcohol use disorder. *Military Medicine* 165(2) 101-105. <https://doi.org/10.1093/milmed/165.2.101>
- Goodin, C. A., Prendergast, D. M., Pruitt, L. D., Smolenski, D. J., Wilson, N. Y., Skopp, N., & Hoyt, T. (2019). Financial hardship and risk of suicide among U.S. Army personnel. *Psychological Services*, 16(2), 286–292. <https://doi.org/10.1037/ser0000201>
- Gunia, B. C., Sipos, M. L., LoPresti, M., & Adler, A. B. (2015). Sleep leadership in high-risk occupations: An investigation of soldiers on peacekeeping and combat missions. *Military Psychology*, 27(4), 197-211. <https://doi.org/10.1037/mil0000078>
- Gutierrez, P. M., Joiner, T., Hanson, J., Avery, K., Fender, A., Harrison, T., Kerns, K., McGowan, P., Stanley, I. H., Silva, C., & Rogers, M. L. (2021). Clinical utility of suicide behavior and ideation measures: Implications for military suicide risk assessment. *Psychological Assessment*, 33(1), 1–13. <https://doi.org/10.1037/pas0000876>
- Government Accountability Office. (2011). *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra* (GAO-11-500). GAO.
- Government Accountability Office. (2020). *DOD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists* (GAO-20-165). GAO.
- Haghighayegh, S., Khoshnevis, S., Smolensky, M. H., Hermida, R. C., Castriotta, R. J., Schernhammer, E., & Diller, K. R. (2022). Novel temperature-controlled sleep system to improve sleep: a proof-of-concept study. *Journal of Sleep Research*, 31(6), e13662. <https://doi.org/10.1111/jsr.13662>
- Hallfors, D., Brodish, P. H., Khatapoush, S., Sanchez, V., Cho, H., & Steckler, A. (2006). Feasibility of screening adolescents for suicide risk in "real-world" high school settings. *American Journal of Public Health*, 96(2), 282–287. <https://doi.org/10.2105/AJPH.2004.057281>
- Hanks, R. (2020, February 28). What soldiers want: the Gen Z perspective. *NCO Journal*. <https://www.armyupress.army.mil/Journals/NCO-Journal/Archives/2022/February/What-Soldiers-Want/#>
- Hatcher, S., & Stubbersfield, O. (2013). Sense of belonging and suicide: A systematic review. *The Canadian Journal of Psychiatry*, 58(7), 432-436. <https://doi.org/10.1177/070674371305800709>
- Harper, S. & Bruckner, T.A. (2017). Did the Great Recession increase suicides in the USA: Evidence from an interrupted time-series analysis. *Annals of Epidemiology*, 27(7). 409-414. <https://doi.org/10.1016/j.annepidem.2017.05.017>

- Hemenway, D., Rausher, S., Violano, P., Raybould, T. A., & Barber, C. W. (2019). Firearms training: What is actually taught? *Injury Prevention, 25*(2), 123-128. <https://doi.org/10.1136/injuryprev-2017-042535>
- Hobfoll, S. E., Blais, R. K., Stevens, N. R., Walt, L., & Gengler, R. (2016). Vets prevail online intervention reduces PTSD and depression in veterans with mild-to-moderate symptoms. *Journal of Consulting and Clinical Psychology, 84*(1), 31-42. <https://doi.org/10.1037/ccp0000041>
- Howell, J. M., & Hall-Merenda, K. E. (1999). The ties that bind: The impact of leader-member exchange, transformational and transactional leadership, and distance on predicting follower performance. *Journal of Applied Psychology, 84*(5), 680-694. <https://doi.org/10.1037/0021-9010.84.5.680>
- Hoyt, T., & Edwards-Stewart, A. (2018). Examining the impact of behavioral health encounter dose and frequency on posttraumatic stress symptoms among active-duty service members. *Psychological Trauma: Theory, Research, Practice, and Policy, 10*(6), 681. <https://doi.org/10.1037/tra0000350>
- Huang, X., Ribeiro, J. D., & Franklin, J. C. (2020). The differences between individuals engaging in nonsuicidal self-injury and suicide attempt are complex (vs. complicated or simple). *Frontiers in Psychiatry, 11*, 239. <https://doi.org/10.3389/fpsy.2020.00239>
- Huang, X., Ribeiro, J. D., & Franklin, J. C. (2020). The differences between suicide ideators and suicide attempters: Simple, complicated, or complex? *Journal of Consulting and Clinical Psychology, 88*(6), 554. <https://doi.org/10.1037/ccp0000498>
- Huang, Y., Xu, J., Zheng, S., Xu, S., Wang, Y., Du, J., Xiao, L., Zhang, R., Wang, H., Tang, Y., & Su, T. (2021) The risk factors for insomnia and sleep-disordered breathing in military communities: A meta-analysis. *PLoS One, 16*(5): e0250779. <https://doi.org/10.1371/journal.pone.0250779>
- Johnson, L. A., Foster, D., & McDowell, J. C. (2014). Energy drinks: review of performance benefits, health concerns, and use by military personnel. *Military Medicine, 179*(4), 375-380. <https://doi.org/10.7205/MILMED-D-13-00322>
- Jones, N., Campion, B., Keeling, M., & Greenberg, N. (2018). Cohesion, leadership, mental health stigmatisation and perceived barriers to care in UK military personnel. *Journal of Mental Health, 27*(1), 10-18. <https://doi.org/10.3109/09638237.2016.1139063>
- Jones, N., Seddon, R., Fear, N. T., McAllister, P., Wessely, S., & Greenberg, N. (2012). Leadership, cohesion, morale, and the mental health of UK Armed Forces in Afghanistan. *Psychiatry: Interpersonal & Biological Processes, 75*(1), 49-59. <https://doi.org/10.1521/psyc.2012.75.1.49>
- Judge, T. A., & Piccolo, R. F. (2004). Transformational and transactional leadership: A meta-analytic test of their relative validity. *Journal of Applied Psychology, 89*(5), 755-768. <https://doi.org/10.1037/0021-9010.89.5.755>
- Kaufman, J. A., Salas-Hernández, L. K., Komro, K. A., & Livingston, M. D. (2020). Effects of increased minimum wages by unemployment rate on suicide in the USA. *Community Health, 74*(3), 219-224. <https://doi.org/10.1136/jech-2019-212981>
- Kaplan, M. S., McFarland, B. H., Huguet, N., Conner, K., Caetano, R., Giesbrecht, N., & Nolte, K. B. (2013). Acute alcohol intoxication and suicide: A gender-stratified analysis of the National Violent Death Reporting System. *Journal of the International Society for Child and Adolescent Injury Prevention, 19*(1), 38-43. <https://doi.org/10.1136/injuryprev-2012-040317>

- Kauer, S. D., Mangan, C., & Sanci, L. (2014). Do online mental health services improve help-seeking for young people? A systematic review. *Journal of Medical Internet Research*, *16*(3), e3103. <https://doi.org/10.2196/jmir.3103>
- Kim, J. (2020). The interplay of message framing and consideration of future consequences on energy drink consumption: Focusing on the underlying emotional mechanism, *Health Communication*, *35*(9), 1081-1090. <https://doi.org/10.1080/10410236.2019.1613477>
- Kokole, D., Anderson, P., & Jané-Llopis, E. (2021). Nature and potential impact of alcohol health warning labels: A scoping review. *Nutrients*, *13*(9), 3065. <https://doi.org/10.3390/nu13093065>
- Krieger, J., & Higgins, D. L. (2002). Housing and health: Time again for public health action. *American Journal of Public Health*, *92*(5), 758–768. <https://doi.org/10.2105/ajph.92.5.758>
- Lavelle, T. A., Kommareddi, M., Jaycox, L. H., Belsher, B., Freed, M. C., & Engel, C. C. (2018). Cost-effectiveness of collaborative care for depression and PTSD in military personnel. *The American Journal of Managed Care* *24*(2), 91-98. <https://www.ajmc.com/view/costeffectiveness-of-collaborative-care-for-depression-and-ptsd-in-military-personnel>
- Lieberman, H.R., Stavinoha, T., McGraw, S., White, A., Hadden, L., & Marriott, B.P. (2012). Caffeine use among active duty US Army soldiers. *Journal of the Academy of Nutrition and Dietetics*, *112*(6), 902-912.e9124. <https://doi.org/10.1016/j.jand.2012.02.001>
- Loftin, C., McDowall, D., Wiersema, B., & Cottey, T. J. (1991). Effects of restrictive licensing of handguns on homicide and suicide in the District of Columbia. *New England Journal of Medicine*, *325*(23), 1615-1620. <https://doi.org/10.1056/nejm199112053252305>
- Lubin, G., Werbeloff, N., Halperin, D., Shmushkevitch, M., Weiser, M., & Knobler, H. Y. (2010). Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. *Suicide and Life-Threatening Behavior*, *40*(5), 421-424. <https://doi.org/10.1521/suli.2010.40.5.421>
- Luca, M., Malhotra, D., & Poliquin, C. (2017). Handgun waiting periods reduce gun deaths. *Proceedings of the National Academy of Sciences*, *114*(46), 12162-12165. <https://doi.org/10.1073/pnas.1619896114>
- Ludwig, J., & Cook, P. J. (2000). Homicide and suicide rates associated with implementation of the Brady Handgun Violence Prevention Act. *The Journal of the American Medical Association*, *284*(5), 585-591. <https://doi.org/10.1001/jama.284.5.585>
- Luxton, D. D., June, J. D., & Comtois, K. A. (2013). Can post discharge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *34*(1), 32. <https://doi.org/10.1027/0227-5910/a000158>
- Mamiya, H., Moodie, E.E.M., Schmidt, A.M., Ma, Y., & Buckeridge, D.L. (2021). Price discounting as a hidden risk factor of energy drink consumption. *Canadian Journal of Public Health*, *112*(4) 638-646. [Doi:10.17269/s41997-021-00479-7](https://doi.org/10.17269/s41997-021-00479-7).
- Mann, J.J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mehlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schmidtke, A., Shaffer, D., Silverman, M., Takahashi, Y., Varnik, A., Wasserman, D., Yip, P., & Hendin, H. (2005). Suicide prevention strategies: a systematic review. *JAMA*, *294*(16), 2064-2074.

- Middleton, J., Hahn, R., Kuzara, J., Elder, R., Brewer, R., Chattopadhyay, S., Jonathan Fielding, J., S. Naimi, T., Toomey, T., & Lawrence, B. (2010). Effectiveness of policies maintaining or restricting days of alcohol sales on excessive alcohol consumption and related harms. *American Journal of Preventative Medicine*, 39(6) 575–589. <https://doi.org/10.1016/j.amepre.2010.09.015>
- Midgette, G., & Kilmer, B. (2021). Can novel, 'swift-certain-fair' programs work outside of pioneering jurisdictions? An analysis of 24/7 sobriety in Montana, USA. *Addiction*, 116(12), 3381-3387. <https://doi.org/10.1111/add.15584>
- Meadows, S.O., Engel, C.C., Collins, R.L., Beckman, R.L., Breslau, J., Bloom, E.L., Dunbar, M.S., Gilbert, M., Grant, D., Hawes-Dawson, J., Holliday, S.B., MacCarthy, S., Pedersen, E.R., Robbins, M.W., Rose, A.J., Ryan, J., Schell, T.L., Simmons, M.M. (2021). *Health related behaviors survey: Substance use among the active component*. RAND Corporation. [https://www.rand.org/pubs/research\\_briefs/RB10116z3.html](https://www.rand.org/pubs/research_briefs/RB10116z3.html).
- McCall, W. V., & Black, C. G. (2013). The link between suicide and insomnia: Theoretical mechanisms. *Current Psychiatry Reports*, 15(9), 1-9. <https://doi.org/10.1007/s11920-013-0389-9>
- McGinn, M. M., Roussev, M. S., Shearer, E. M., McCann, R. A., Rojas, S. M., & Felker, B. L. (2019). Recommendations for using clinical video telehealth with patients at high risk for suicide. *Psychiatric Clinics*, 42(4), 587-595. <https://doi.org/10.1016/j.psc.2019.08.009>
- McKeon, A.B., Stocker, R. P. J., & Germain, A. (2019). Traumatic brain injury and sleep disturbances in combat-exposed service members and veterans: Where to go next? *NeuroRehabilitation*, 45(2), 163-185. <https://doi.org/10.3233/NRE-192804>
- Micol, V. J., Prouty, D., & Czyz, E. K. (2022). Enhancing motivation and self-efficacy for safety plan use: Incorporating motivational interviewing strategies in a brief safety planning intervention for adolescents at risk for suicide. *Psychotherapy*, 59(2), 174-180. <https://doi.org/10.1037/pst0000374>
- Miller, C. (2019). Preparing the millennial generation for leadership. *NCO Journal*. <https://www.armyupress.army.mil/Journals/NCO-Journal/Archives/2019/September/Preparing-the-Millennial-Generation-for-Leadership/>
- Monuteaux, M.C., Azrael, D., & Miller, M. (2019). Association of increased safe household firearm storage with firearm suicide and unintentional death among US youths. *The Journal of the American Medical Association*, 173(7), 657– 662. doi:10.1001/jamapediatrics.2019.1078
- Nadeem, I.M., Shanmugaraj, A., Sakha, S., Horner, N.S., Ayeni, O.R., & Khan, M. (2021). Energy drinks and their adverse health effects: A systematic review and meta-analysis. *Sports Health*, 13(3), 265-277. doi:10.1177/1941738120949181
- Nakamura, R., Pechey, R., Suhrcke, M., Jebb, S.A., & Marteau, T.M. (2014). Sales impact of displaying alcoholic and non-alcoholic beverages in end-of-aisle locations: an observational study. *Social Science and Medicine*, 108(100), 68-73. doi: 10.1016/j.socscimed.2014.02.032.
- O'Connor, K., Neff, D. M., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, 53, 74-99. <https://doi.org/10.1016/j.eurpsy.2018.06.003>
- Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy (ODASD (MC&FP)) (2020). *Demographics: Profile of the Military Community*.

- <https://download.militaryonesource.mil/12038/MOS/Reports/2020-demographics-report.pdf>
- Office of the Surgeon General (US), & National Action Alliance for Suicide Prevention. (2012). *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*. US Department of Health & Human Services (US).  
<https://www.ncbi.nlm.nih.gov/books/NBK109917/>
- Office of the Surgeon General. (2009). *The surgeon general's call to action to promote healthy homes*. U.S. Department of Health and Human Services.  
<https://health.gov/healthypeople/tools-action/browse-evidence-based-resources/surgeon-generals-call-action-promote-healthy-homes>
- Osenbach, J. E., O'Brien, K. M., Mishkind, M., & Smolenski, D. J. (2013). Synchronous telehealth technologies in psychotherapy for depression: A meta-analysis. *Depression and Anxiety, 30*(11), 1058-1067. <https://doi.org/10.1002/da.22165>
- Owen, J. E., Kuhn, E., Jaworski, B. K., McGee-Vincent, P., Juhasz, K., Hoffman, J. E., & Rosen, C. (2018). VA mobile apps for PTSD and related problems: Public health resources for veterans and those who care for them. *MHealth, 4*, 28. doi: 10.21037/mhealth.2018.05.07
- Pak, K., Lee-Tauler, S.Y., Ferreira, K.E., Perera, K., Ghahramanlou-Holloway, M. (2021). *Military Behavioral Health, 9*(1).
- Paterson, R.J., & Neufeld, R.W. (1995). What are my options?: Influences of choice availability on stress and the perception of control. *Journal of Research in Personality, 29*(2), 145-167. <https://doi.org/10.1006/jrpe.1995.1009>.
- Pescosolido, B. A., Halpern-Manners, A., Luo, L., & Perry, B. (2021). Trends in public stigma of mental illness in the US. *The Journal of the American Medical Association, 4*(12).  
<https://doi.org/10.1001/jamanetworkopen.2021.40202>
- Postnova, S., Postnov, D., Seneviratne, M., Robinson, P. (2014). Effects of rotation interval on sleepiness and circadian dynamics on forward rotating 3-shift systems. *Journal of Biological Rhythms, 29*(1), 60-70.
- RAND Corporation. (2022). *Gun Policy in America*. <https://www.rand.org/research/gun-policy.html>
- RAND Corporation. (2022). *Effects of Child-Access Prevention Laws on Suicide*.  
<https://www.rand.org/research/gun-policy/analysis/child-access-prevention/suicide.html>
- RAND Corporation. (2022). "24/7 Sobriety Program." <https://www.rand.org/health-care/projects/24-7.html>
- Reeves, A., Stuckler, D., McKee, M., Gunnell, D., Chang, S., Basu, S. (2012). Increase in state suicide rates in the USA during economic recession. *The Lancet, 380*(9856), 1813-1814.  
[https://doi.org/10.1016/S0140-6736\(12\)61910-2](https://doi.org/10.1016/S0140-6736(12)61910-2).
- Rennane, S., Asch, B.J., Mattock, M.G., Krull, H., Ligor, D.C., Dworsky, M., & Kempf, J. (2022). *Fit for duty: Alternative approaches for determining Department of Defense disability compensation*. RAND Corporation.
- Rittel, H. W., & Webber, M. M. (1973). *Dilemmas in a general theory of planning. Policy Sciences, 4*(2): 155–169. doi:10.1007/bf01405730
- Rojas, S. M., Gold, S. D., Bryan, C. J., Pruitt, L. D., Felker, B. L., & Reger, M. A. (2022). Brief cognitive-behavioral therapy for suicide prevention (BCBT-SP) via video telehealth: a case example during the COVID-19 outbreak. *Cognitive and Behavioral Practice, 29*(2), 446-453. <https://doi.org/10.1016%2Fj.cbpra.2020.12.001>



- Romano, C. J., Hall, C., Bukowinski, A. T., Gumbs, G. R., & Conlin, A. M. S. (2022). Pregnancy-associated and pregnancy-related deaths in the United States military, 2003-2014. *American Journal of Obstetrics and Gynecology*, 227(3), 508.e1–508.e9. <https://doi.org/10.1016/j.ajog.2022.04.020>
- Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., Williams, S.R., Arne, K.A, Breitbach, J., Delano, K., Wilkinson, E. & Bruce, T. O. (2015). Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. *American Journal of Psychiatry*, 172(5), 441-449. <https://doi.org/10.1176/appi.ajp.2014.14070843>
- Rugo, K. F., Leifker, F. R., Drake-Brooks, M. M., Snell, M. B., Bryan, C. J., & Bryan, A. O. (2020). Unit cohesion and social support as protective factors against suicide risk and depression among national guard service members. *Journal of Social and Clinical Psychology*, 39(3), 214-228. [doi.org/10.1521/jscp.2020.39.3.214](https://doi.org/10.1521/jscp.2020.39.3.214)
- Schmidt, R.M., McIntire, L.K., Caldwell, J.A., & Hallman, C. (2008). Prevalence of energy-drink and supplement usage in a sample of Air Force personnel. Interim report for October 2007 to May 2008. Wright-Patterson AFB, Air Force Research Laboratory. <http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA514723>.
- Shenassa, E., Rogers, M., Spalding, K., & Roberts, M. (2004). Safer storage of firearms at home and risk of suicide: A study of protective factors in a nationally representative sample. *Journal of Epidemiology and Community Health*, 58, 841-848. <https://doi.org/10.1136%2Fjech.2003.017343>
- Skaburskis, A. (2008). "The origin of "wicked problems"". *Planning Theory & Practice*, 9(2), 277-280. [doi:10.1080/14649350802041654](https://doi.org/10.1080/14649350802041654)
- Sloan, D. M., Gallagher, M. W., Feinstein, B. A., Lee, D. J., & Pruneau, G. M. (2011). Efficacy of telehealth treatments for posttraumatic stress-related symptoms: a meta-analysis. *Cognitive Behaviour Therapy*, 40(2), 111-125. <https://doi.org/10.1080/16506073.2010.550058>
- Simpson, S. A., Goans, C., Loh, R., Ryall, K., Middleton, M. C., & Dalton, A. (2021). Suicidal ideation is insensitive to suicide risk after emergency department discharge: Performance characteristics of the Columbia-Suicide Severity Rating Scale Screener. *Academic Emergency Medicine*, 28(6), 621-629. <https://doi.org/10.1111/acem.14198>
- Stack, S. (2021). Contributing factors to suicide: Political, social, cultural and economic. *Preventive Medicine*, 152, 106498. DOI: 10.1177/0748730413516837
- Stavinoha, T., McGraw, S., White, A., Hadden, L., & P. Marriott, B.P. (2012). Caffeine use among active duty us army soldiers. *Journal of the Academy of Nutrition and Dietetics*, 112(6), 902-912.e4 <https://doi.org/10.1016/j.jand.2012.02.001>
- Strong, D.R., Pierce, J.P., Pulvers, K., Stone, M.D., Villasenor, A., Pu, M., Dimofte, C.V., Leas, E. C., Oratowski, J., Brighton, E., Hurst, S., Kealey, S., Chen, R., & Messer, K. (2021). Effect of graphic warning labels on cigarette packs on US smokers' cognitions and smoking behavior after 3 months: A randomized clinical trial. *JAMA Network Open*, 4(8). [doi:10.1001/jamanetworkopen.2021.21387](https://doi.org/10.1001/jamanetworkopen.2021.21387)
- Stephens, M. B., Attipoe, S., Jones, D., Ledford, C. J., & Deuster, P. A. (2014). Energy drink and energy shot use in the military. *Nutrition Reviews*, 72(suppl 1), 72-77. <https://doi.org/10.1111/nure.12139>

- Tawfik, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., Sexton, J. B., & Ioannidis, J. P. A. (2019). Evidence relating health care provider burnout and quality of care: A systematic review and meta-analysis. *Annals of Internal Medicine*, *171*(8), 555–567. <https://doi.org/10.7326/M19-1152>
- Taylor, P. J., Gooding, P., Wood, A. M., & Tarrrier, N. (2011). The role of defeat and entrapment in depression, anxiety, and suicide. *Psychological Bulletin*, *137*(3), 391. <https://doi.org/10.1037/a0022935>
- Temple, J.L., Ziegler, A.M., & Epstein, L.H. (2016). Influence of price and labeling on energy drink purchasing in an experimental convenience store. *Journal of Nutrition Education and Behavior*, *48*(1), 54-59. <https://doi.org/10.1016/j.jneb.2015.08.007>
- Thayer, R.L. (2022, July 27). Army looks at easing rules for alcohol in barracks to help reduce suicides and sexual assaults. *Stars and Stripes*. <https://www.stripes.com/branches/army/2022-07-27/army-barracks-alcohol-assaults-suicides-6787929.html>
- Trachik, B., Tucker, R. P., Ganulin, M. L., Merrill, J. C., LoPresti, M. L., Cabrera, O. A., & Dretsch, M. N. (2020). Leader provided purpose: Military leadership behavior and its association with suicidal ideation. *Psychiatry Research*, *285*, 112722. <https://doi.org/10.1016/j.psychres.2019.112722>
- Trachik, B., Oakey-Frost, N., Ganulin, M.L., Adler, A.B., Dretsch, M.N., Cabrera, O.A. & Tucker, R.P. (2021). Military suicide prevention: The importance of leadership behaviors as an upstream suicide prevention target. *Suicide and Life-Threatening Behavior*, *51*, 316-324. <https://doi.org/10.1111/sltb.12707>
- Trachik, B., Moscardini, E., Ganulin, M.L., McDonald, J.L., McKeon, A.B, Dretsch, M.N., Tucker, R.P, & Sowden, W.J. (2022). Perceptions of purpose, cohesion, and military leadership: A path analysis of potential primary prevention targets to mitigate suicidal ideation. *Military Psychology*, *34*(3), 366-375. <https://doi.org/10.1080/08995605.2021.1962184>
- Troynikov, O., Watson, C. G., & Nawaz, N. (2018). Sleep environments and sleep physiology: A review. *Journal of Thermal Biology*, *78*, 192–203. <https://doi.org/10.1016/j.jtherbio.2018.09.012>
- U.S. Preventative Services Task Force. (2018). *Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions*. <https://www.uspreventiveservicestaskforce.org/>
- Vargas, I., Perlis, M. L., Grandner, M., Gencarelli, A., Khader, W., Zandberg, L. J., Klingaman, E. A., Goldschmied, J. R., Gehrman, P. R., Brown, G. K., & Thase, M. E. (2020). Insomnia symptoms and suicide-related ideation in U.S. army service members. *Behavioral Sleep Medicine*, *18*(6), 820–836. <https://doi.org/10.1080/15402002.2019.1693373>
- Venkatesan, A., Rahimi, L., Kaur, M., & Mosunic, C. (2020). Digital cognitive behavior therapy intervention for depression and anxiety: Retrospective study. *JMIR Mental Health*, *7*(8). <https://doi.org/10.2196/21304>
- Wagenaar A. C., Salois M. J., & Komro K. A., (2009). Effects of beverage alcohol price and tax levels on drinking: A meta-analysis of 1003 estimates from 112 studies. *Addiction*, *104*(2), 179-90. doi:10.1111/j.1360-0443.2008.02438.x

- Wagenaar, A. C., Tobler, A. L., & Komro, K. A. (2010). Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. *American Journal of Public Health*, 100(11), 2270-8. doi: 10.2105/AJPH.2009.186007.
- White House. (2012). *Report of the Eleventh Quadrennial Review of Military Compensation*. [https://militarypay.defense.gov/Portals/3/Documents/Reports/11th\\_QRMC\\_Main\\_Report\\_FINAL.pdf](https://militarypay.defense.gov/Portals/3/Documents/Reports/11th_QRMC_Main_Report_FINAL.pdf)
- White House. (2021). *Reducing military and veteran suicide: advancing a comprehensive, cross-sector, evidence-informed public health strategy*. <https://www.whitehouse.gov/wp-content/uploads/2021/11/Military-and-Veteran-Suicide-Prevention-Strategy.pdf>
- Willard-Grace, R., Knox, M., Huang, B., Hammer, H., Kivlahan, C., & Grumbach, K. (2019). Burnout and Health Care Workforce Turnover. *Annals of Family Medicine*, 17(1), 36–41. <https://doi.org/10.1370/afm.2338>
- Weinbaum, C., Girven, R., & Oberholtzer, J. (2016). *The Millennial Generation: Implications for the Intelligence and Policy Communities*. RAND Corporation. [https://www.rand.org/pubs/research\\_reports/RR1306.html](https://www.rand.org/pubs/research_reports/RR1306.html).
- Witkiewitz, K., Litten, R. Z., & Leggio, L. (2019). Advances in the science and treatment of alcohol use disorder. *Science Advances*, 5(9). <https://doi.org/10.1126/sciadv.aax4043>
- Woznica, A. A., Carney, C. E., Kuo, J. R., & Moss, T. G. (2015). The insomnia and suicide link: toward an enhanced understanding of this relationship. *Sleep Medicine Reviews*, 22, 37-46. DOI: 10.1016/j.smrv.2014.10.004
- Wyman P. A., Pisani A. R., Brown, & C. H. (2020). Effect of the wingman-connect upstream suicide prevention program for air force personnel in training: A cluster randomized clinical trial. *JAMA Network Open*. 3(10), e2022532 doi:10.1001/jamanetworkopen.2020.22532
- Yin, J., Ma, Z., Yu, H., Jia, M., & Liao, G. (2019). Transformational leadership and employee knowledge sharing: explore the mediating roles of psychological safety and team efficacy. *Journal of Knowledge Management*. 24(2), 150-171. <https://doi.org/10.1108/JKM-12-2018-0776>

## Appendix A: Charter for Suicide Prevention and Response Independent Review Committee

A. Official Designation: This committee shall be known as the Suicide Prevention and Response Independent Review Committee (SPRIRC).

B. Mission: In accordance with section 738 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2022, the SPRIRC will provide its report containing its findings and recommendations for preventing suicide in the military to the Secretary of Defense (SecDef) no later than 270 days, and to the Committees on Armed Services of the Senate and the House of Representatives no later than 330 days, from the establishment of the SPRIRC. The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this committee in accordance with section 738(h).

C. Scope and Focus of Activities: The SPRIRC will conduct a comprehensive review of both clinical and non-clinical suicide prevention and response programs and factors that may prevent suicide, focusing on the specific locations designated by the SecDef for this review (see Attachment). The SPRIRC will review the suicide prevention and response programs and other factors that may contribute to the incidence or prevention of suicide at the military installations selected for review, and make recommendations to adapt policies and programs to the emerging needs of the total force. Methods for this review include policy review, installation visits, focus groups, individual interviews, and a confidential survey of Service members stationed at the designated locations. The SPRIRC will review relevant suicide prevention and response activities at the designated locations, as well as actions underway to address related recommendations of the Independent Review Commission on Sexual Assault in the Military, to ensure SPRIRC recommendations align, where possible, with current and developing prevention activities and capabilities. This review will include:

- Evaluation of military policies, programs, and processes related to suicide prevention and response;
- Review previous DoD and external efforts (e.g., studies, assessments, reports), including prior and recent recommendations from academic research, industry best practices, interagency partnerships, Military Service Organizations, and Veterans Service Organizations; and
- Recommendations to improve policies, programs, processes, and resources to reduce the incidence of suicide and improve suicide prevention and response efforts at the designated locations and potential enterprise-wide recommendations and actions.

The Director of the Office of People Analytics and the Executive Director, Force Resiliency will coordinate and cooperate with the SPRIRC.

D. Deliverables: In addition to the final report, at the discretion of the SPRIRC, it will provide periodic updates on interim findings to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)). The final report will be released publicly.

E. Governance and Management: A member of the SPRIRC will be designated by the SecDef as the Chair. The Chair will oversee the work of the SPRIRC and establish the agenda for meetings.

The Military Departments and the National Guard Bureau, as appropriate, will identify a designated point of contact at each specified installation in the Attachment. This point of contact will be an officer in the grade of O-5 or higher who will assist the SPRIRC in coordinating the details of the installation visits, as well as ensure that visit dates do not unreasonably interfere with operational and training requirements for units stationed at the specified installations.

F. Membership: Pursuant to section 738 of the NDAA for FY 2022, the SPRIRC members shall be appointed by the SecDef, none of whom may be members of the Armed Forces or DoD civilian employees. Members may be compensated for their work related to the SPRIRC through reimbursable agreements with their affiliated external organizations pursuant to the Intergovernmental Personnel Act in accordance with 5 U.S.C. §§ 3371-3375. The members will be subject matter experts with backgrounds and experiences collectively representing the public health approach to suicide prevention, clinical services for mental health, epidemiology with regard to suicide, the overlap between sexual assault and suicide behavior, and lethal means safety.

The USD(P&R), according to DoD policies and procedures, may select experts or consultants as subject matter experts under the authority of 5 U.S.C. § 3109 to advise the SPRIRC. Such experts or consultants are not members of the SPRIRC. These individuals will not vote on recommendations of the SPRIRC. They may, however, participate in site visits, interviews, and briefings, and may offer advice within their respective subject matter expertise, upon the request of the SPRIRC.

G. Support: The DoD, through the Office of the Under Secretary of Defense for Personnel and Readiness, shall provide staffing and resources as deemed necessary for the performance of the SPRIRC.

H. Recordkeeping: Records of the SPRIRC shall be handled according to applicable DoD policies and procedures. These records may be subject to the Freedom of Information Act of 1966 (5 U.S.C. § 552, as amended).

I. Meetings: The SPRIRC will convene at the call of the Chair, and will meet a minimum of eight times during the year. The Chair will schedule meetings as often as needed. The meetings generally will be in person. At the discretion of the Chair, meetings may be conducted virtually. Regular SPRIRC meetings will be scheduled until completion of the mission. The Committee Chair will oversee SPRIRC meetings.


J. Estimated Annual Operating Costs and Staff Years: The estimated annual operating cost of the SPRIRC, to include compensation of members through reimbursable agreements (5 full-time equivalents (FTEs)), compensation of consultants (5 FTEs), travel, meetings, and contract support (approximately 3 FTEs), is approximately \$1.8 million.

K. Duration: This charter is effective upon signature.

L. Termination Date: March 25, 2023

M. Charter Modification: The USD(P&R) reserves the authority to modify this charter in writing.

N. Approval:

Signature:  Date: MAY 17 2022

## Appendix B: Policies, Programs and Materials Review

### Policies Reviewed by the SPRIRC

Department of Defense. (2017, November 6). Defense Suicide Prevention Program (DODI 6490.16) <https://www.gao.gov/assets/gao-22-105108.pdf>

Department of Defense. (2020, September 11). DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm (DODI 6400.090) <https://www.militaryonesource.mil/leaders-service-providers/child-abuse-and-domestic-abuse/family-advocacy-program-defense-department-policies/>

Department of Defense. (2018, August 31) DoD Housing (DODI 4165.63) <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/416563p.pdf?ver=2019-04-15-094501-830>

Department of Defense. (2015, October 16) Commercial Travel Management: Uniformed Services and Station Allowances (DODI 5154.31) [https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/515431\\_vol01.pdf](https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/515431_vol01.pdf)

Department of Defense. (1989, August 14). Equal Opportunity in Off-Base Housing (DODI 1100.16) <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/110016p.pdf>

Department of Defense. (2008, March 20) Establishment, Management, and Control of Nonappropriated Fund Instrumentalities and Financial Management of Supporting Resources (DODI 1015.15) <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/101515p.pdf?ver=2019-04-08-125317-820>

Department of Defense. (2018, August 31). Real Property Management (DODI 4165.70) <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/416506p.pdf>

Department of Defense. (2020, September 4). DoD Military Equal Opportunity Program (DoDI 1350.02) <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/135002p.pdf>

Department of Defense. (2014, April 28). Health Promotion and Disease Prevention (DODI 1010.10) <https://www.esd.whs.mil/portals/54/documents/dd/issuances/dodi/101010p.pdf>

Department of Defense. (2018, August 31). Real property management. (DODI 4165.70) <https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/416570p.pdf>

Defense Health Agency. (2022, August 9). Suicide Risk Care (6025.06) <https://www.health.mil/-/media/Files/MHS/Policy-Files/Signed-DHAAI-602506-Suicide-Risk-Care.ashx>

DHA-PI 6490.12 Military Behavioral Health Technician (BHT) Management and Utilization

Department of the Air Force. (2019, January 25). Integrated Resilience (AF 90-5001) <https://www.acc.af.mil/Portals/92/Docs/ACC%20Bridge/Resilience/AFI%2090-5001%20Integrated%20Resilience%2025%20Jan%202019.pdf?ver=TRnyzRIaIzuD99VRHZgJ4w%3D%3D>

Department of the Air Force. (2015, March 17). Mental Health (Air Force Directive 44-172). [https://static.e-publishing.af.mil/production/1/af\\_sg/publication/afi44-172/afi44-172.pdf](https://static.e-publishing.af.mil/production/1/af_sg/publication/afi44-172/afi44-172.pdf)

Department of the Air Force. (2019, January 18). Administration of Military Justice (DAFI 51-201) [https://media.defense.gov/2019/Apr/11/2002115350/-1/-1/0/B\\_0159\\_JAG\\_MILITARY\\_COMMANDER\\_AND\\_THE\\_LAW\\_.PDF](https://media.defense.gov/2019/Apr/11/2002115350/-1/-1/0/B_0159_JAG_MILITARY_COMMANDER_AND_THE_LAW_.PDF)

Department of the Air Force. (2022, March 8). Air Force Housing Management (AFI 32-6000). <https://www.familialstatus.org/housing-policies>

Department of the Army. (2020, July 24). Army Command Policy (AR 600-20). <https://www.armyresilience.army.mil/ard/images/pdf/Policy/600-20%20Army%20Command%20Policy.pdf>

Department of the Army. (2015, April 15). Army Health Promotion (AR 600-63). <https://www.armyresilience.army.mil/ard/images/pdf/Policy/AR%20600-63%20Army%20Health%20Promotion.pdf>

Department of the Army. (2014, June 19). Comprehensive Soldier and Family Fitness Program (AR 350-53). <https://www.armyresilience.army.mil/ard/images/pdf/Policy/AR%20350-53%20Comprehensive%20Soldier%20and%20Family%20Fitness.pdf>

Department of the Army. (2014, March 11) Army Substance Abuse Program (AR 600-85). [https://armypubs.army.mil/epubs/DR\\_pubs/DR\\_a/ARN30190-AR\\_600-85-001-WEB-3.pdf](https://armypubs.army.mil/epubs/DR_pubs/DR_a/ARN30190-AR_600-85-001-WEB-3.pdf)

Department of the Army. (2020, May 12). Army Public Health (AR 40-5). [https://armypubs.army.mil/epubs/DR\\_pubs/DR\\_a/pdf/web/ARN16450\\_R40\\_5\\_FINAL.pdf](https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/ARN16450_R40_5_FINAL.pdf)

Department of the Army. (2012, August 24). Army Facilities Management (AR 420-1). [https://armypubs.army.mil/epubs/DR\\_pubs/DR\\_a/pdf/web/ARN15517\\_R420\\_1\\_admin\\_FINAL.pdf](https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/ARN15517_R420_1_admin_FINAL.pdf)

United States Marine Corps. (2021, August 2). Suicide Prevention System. (MCO 1720.2A). Department of the Navy. [https://www.marines.mil/Portals/1/Publications/MCO%201720.2A.pdf?ver=QPxZ\\_qMS-X-d037B65N9Tg%3d%3d](https://www.marines.mil/Portals/1/Publications/MCO%201720.2A.pdf?ver=QPxZ_qMS-X-d037B65N9Tg%3d%3d)

Department of the Navy. (2016, April 20). Community Counseling Program. (MCO 1754.14). Department of the Navy. <https://www.marines.mil/portals/1/MCO%201754.14.pdf>

United States Marine Corps. (2013, February 23). Combat and Operational Stress Control (COSC) Program (MCO 5351.1). Department of the Navy. <https://www.marines.mil/portals/1/Publications/MCO%205351.1.pdf>



United States Marine Corps. (2020, December 10). Combat operational stress control doctrine. (MCTP 3-30E). Department of the Navy.  
<https://www.marines.mil/portals/1/Publications/MCTP%203-30E%20Formerly%20MCRP%206-11C.pdf?ver=2017-09-28-081327-517>

United States Marine Corps. (2016, January 24). Embedded Preventative Behavioral Health Capability (EPBHC). (MCO 1700.41). Department of the Navy.  
<https://www.marines.mil/portals/1/MCO%201700.41.pdf>

The Chief National Guard Bureau. (2018, November 18). National Guard Warrior Resilience and Fitness Program. (CNGBI 0300.01). Department of Defense National Guard Bureau.  
[https://www.ngbpmc.ng.mil/Portals/27/Publications/cngbi/CNGBI%200300.01\\_20181116.pdf?ver=nYmZ5PwH0gLlyeCwBu7nig%3d%3d](https://www.ngbpmc.ng.mil/Portals/27/Publications/cngbi/CNGBI%200300.01_20181116.pdf?ver=nYmZ5PwH0gLlyeCwBu7nig%3d%3d)

Noncommissioned Officer Leadership Center of Excellence. (2020, March 9). *Developing the NCO Corps through Education: NCO Common Corps Competencies*. (NCOLCoE Bulletin No. 1-19) <https://www.ncolcoe.army.mil/Portals/71/publications/ref/1-19-NCOC3.pdf?ver=2020-03-09-111137-160>

Office of the Chief of Naval Operations. (2018, September 18). *Suicide Prevention Program*. (OPNAVINST 1720.4B). Department of the Navy. <https://www.spirit-filled.org/documents/1720.4B.pdf>

*Sailor Assistance and Intercept for Life Update*. (NAVADMIN 021/21).

NAVADMIN 208/16 Suicide Prevention and Response: Sailor Assistance and Intercept for Life

NAVADMIN 263/14 Guidance for Reducing Access to Lethal Means through Voluntary Storage of Privately Owned Firearms

## Programs, Materials and Research Reviewed by the SPRIRC

- DoD
  - Resources Exist, Asking Can Help (REACH), 20221101
  - Lethal Means Safety Toolkit
  - Health of the Force
- Air Force
  - Air Force Suicide Prevention Program
  - Task Force True North
  - SF Investigation Process Map
  - Airman And Family Readiness Center Key Spouse Program
  - True North and Operation Support Team Staffing – site visit installations
- Army
  - Army Suicide Prevention Program (including ACE)
  - Behavioral Health Readiness and Suicide Risk Reduction Review (R4)
  - Azimuth Check (formerly the GAT)
  - Senior Commander’s Guide to Suicide Prevention

- Unit Leader's Guide to Suicide Prevention
- Marine Corps
  - Force Preservation Council (FPC)
  - Embedded Preventative Behavioral Health Capability (EPBHC)
  - UMAPIT 3.0/OSCAR GEN III
- Navy
  - Sailor Assistance and Intercept for Life (SAIL)
  - Navy Suicide Prevention Program
  - Project 1 Small ACG (Every Sailor, Every Day)
  - NG/Reserve: NGB SP TF Final Report

#### Reports

- DoD
  - DODIG-2002-030 DoD IG Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Service Members, 20191119
  - Fort Hood Independent Review Report
  - Independent Review Commission on Sexual Assault in the Military Report
  - On-Site Installation Evaluation Report
  - Sleep Deprivation Report
  - CY21 Annual Suicide Report
  - DODSER 2019 Annual Report and Items
  - The Challenge and the Promise: 2010 Report
- Partnership Reports
  - Zero Suicide Systems Approach Pilot Project Evaluation Report
  - RAND: of Programs for Care System Transitions in Mental Health
  - Suicide Postvention in the Department of Defense: Evidence, Policies and Procedures, and Perspectives of Loss Survivors | RAND
- External Reports
  - GAO Suicide Prevention: DOD Should Enhance Oversight, Staffing, Guidance, and Training Affecting Certain Remote Installations, 20220428
  - DOD IG Hearing Statement: "Suicide Prevention and Related Behavioral Health Interventions in the Department of Defense", 20220406
  - Military Suicide: Preliminary Observations on Actions Needed to Enhance Prevention and Response Affecting Certain Remote Installations, 20220406
  - GAO DOD AND VA HEALTHCARE: Suicide Prevention Efforts and Recommendations for Improvement, 20211117
  - DoDIG-2002-030 Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members, 20211112
  - GAO Defense Health Care: DOD Needs to Fully Assess Its Non-Clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness, 20210426
  - Assessment of DoD Suicide Prevention Processes, 20150930
- Congressional Reports
  - Sleep Deprivation Report to Congress, March 2021

#### Research Articles

- Dilemmas in a General Theory of Planning by Rittel & Webber (1973)

- Suicide Among Males Across the Lifespan: An Analysis of Differences by Know Mental Health Status by Fowler, Kaplan, Stone, Zhou, Stevens & Simon (2022)
- Those Left Behind: A Scoping Review of the Effects of Suicide Exposure on Veterans, Service Members, and Military Families by Amanda Peterson, Melanie Bozzay, Ansley Bender, and Jason Chen (2022), *Death Studies*, 46:5, 1176-1185

#### Memos

- DoD
  - Memo 052722 DoD Prevention Plan of Action, 20220527
- Air Force
  - Memo 032217 Airmen Under Investigation Checklist

#### Other

- Living Works