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PERSONNEL AND
READINESS

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MEMORANDUM FOR DEPUTY ASSISTSANT SECRETARY OF THE ARMY FOR
MILITARY PERSONNEL/QUALITY OF LIFE
DEPUTY ASSISTANT SECRETARY OF THE NAVY FOR
MILITARY PERSONNEL POLICY
DEPUTY ASSISTANT SECRETARY OF THE AIR FORCE FOR
RESERVE AFFAIRS AND AIRMEN READINESS

SUBJECT: Suicide Prevention Training Competency Framework

The Defense Suicide Prevention Office (DSPO), in collaboration with the Services, and a host of other partners, has developed the attached Suicide Prevention Training Competency Framework (SPTCF). The framework supports the standardization in suicide prevention gatekeeper training and education across the DoD, informs DoD policy on suicide prevention training and education activities, and increases suicide prevention capabilities among all stakeholders in the DoD community.

To better support the needs of the Department and Services, the framework identifies core knowledge, skills, abilities and other characteristics for suicide prevention training and education across DoD components and the Services. It also serves as a baseline for Suicide Prevention Program Managers and training developers to create or update existing competency models or training curricula for the targeted populations as listed in the SPTCF. Please ensure your current and future suicide prevention training curricula is congruent with the SPTCF.

K Franklin

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Director
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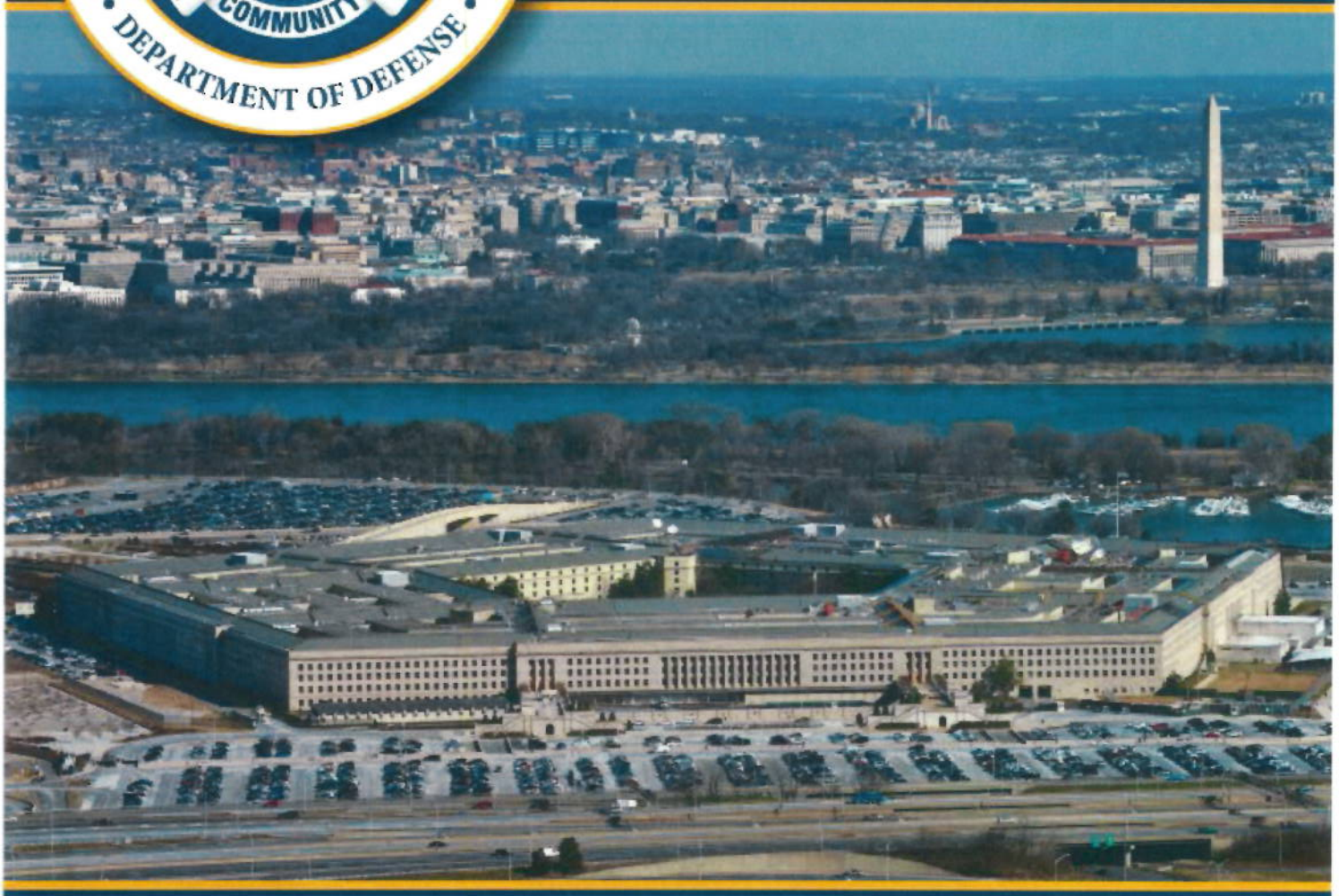
Attachment:
As stated

DEFENSE SUICIDE PREVENTION OFFICE

Under Secretary of Defense for Personnel and Readiness

August 2016



Suicide Prevention Training Competency Framework

A Competency Framework for all Members and Targeted Sub-Groups Across the Department of Defense

HOPE • COMMUNITY • CARE

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1 Purpose

In adherence with Department of Defense (DoD) Directive Number 6490.14, "Defense Suicide Prevention Program," June 18, 2013 and the Defense Strategy for Suicide Prevention, the Defense Suicide Prevention Office (DSPO) has established the Suicide Prevention Training Competency Framework to support the following outcomes:

1. Ensure training content consistency in suicide prevention education and training across the DoD.
2. Inform DoD policy on suicide prevention education and training activities.
3. Increase suicide prevention capabilities among all stakeholders in the DoD community.

This framework identifies core knowledge, skills, abilities, and other characteristics (KSAOs) for suicide prevention training and education across DoD components and the Services. The intended audiences for this framework are all appropriate DoD organizations and staff, such as Suicide Prevention Program Managers, training designers/developers, and other suicide prevention leaders. The framework serves as a baseline for the intended audience to create or update existing competency models or training curricula for the targeted populations throughout the stakeholders' military lifecycle as determined by the Services. The competencies will inform the development of training, education, outreach, assessment materials, and instructional activities targeted to each population's specific suicide prevention requirements. As such, this framework is intended as an initial phase or precursor to a more developed competency framework that would include, mapping to specific training learning objectives, and developing measures of performance expected by the individual once the training is completed.

2 Background

2.1 History

Department of Defense Directive (DoDD) 6490.14, "Defense Suicide Prevention Program," published June 18, 2013, issued the following guidance:

> The Director of the DSPO establishes core competencies for and oversees the effectiveness of suicide prevention training and shares best practices that comprehensively address all groups involved in prevention, intervention, postvention, and surveillance activities across the DoD (Enclosure 2, p.5, "Responsibilities," 4. Director of the DSPO, (f).

In addition to the guidance cited above regarding the development of competencies, DoDD 6490.14 (Enclosure 2, p.7, 5. Assistant Secretary of Defense for Health Affairs (ASD(HA)) (d.))

and two other documents—(1) the National Defense Authorization Act for Fiscal Year 2013, Section 581, Subsection 10219, and (2) "The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives," Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, August 2010, Recommendation 17—together provide that DoD must target primarily three specific populations for suicide prevention education and training in addition to Service members: healthcare professionals, chaplains, and families of Service members.

2.2 *Need for Population-Specific Competencies*

In response to the guidance above, it was determined that along with the core competencies, population-specific competencies should be standardized across DoD. To help accomplish this goal, the DSPO Director appointed a Suicide Prevention Training Evaluation Working Group to serve in an advisory capacity to identify other populations (in addition to health care professionals, chaplains, and family members) to be targeted for education and training, and to provide input into developing the related competencies.

Offices and Agencies Represented in the Suicide Prevention Training Evaluation Working Group

- Assistant Secretary of Defense for Health Affairs
- Defense Suicide Prevention Office
- DoD/Services' Chaplains
- DoD/Services' Suicide Prevention Programs
- Joint Chiefs of Staff, J1
- Navy Bureau of Medicine and Surgery
- Office of the Deputy Assistant Secretary of Defense, Military Community and Family Policy
- Office of the Under Secretary of Defense for Personnel and Readiness
- Department of Defense Education Agency
- Service Components

According to Recommendation 33 of the 2010 Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, "family members should be educated and trained to recognize the signs of stress and distress, to know whom to call for advice, and to understand how to respond in emergencies." Therefore, this competency framework identifies competencies to help shape the education and training that should be made available to families. However, families cannot be held to workplace performance standards in the competency areas developed. Rather, all DoD components should encourage families to attend and have access to training, education, and information regarding Competency Component Supporting Elements below (see Appendix A for a complete list of target populations and sample subpopulations). Access to training, education, and information is the responsibility of local leader based on mission and resources available. All targeted populations include both military and civilian personnel.

3 Process and Overview

DSPO's mission to reduce suicide among Service members and their families requires all members of the DoD community to have the KSAOs necessary to achieve that goal. These KSAOs form part of the competencies individuals need to successfully perform in the functional area of suicide prevention, intervention, and postvention. DSPO views this framework as applicable in developing, validating, and implementing suicide prevention competencies across the DoD community.

Reducing suicide also requires a full spectrum approach, which is holistic and integrative. Historically, the Services have responded to the threat of suicide with training focused on prevention and awareness, with varying results. Reducing the threat of suicide requires more than training programs and awareness to combat it; we must ensure DoD's Service members, civilians and families are building resilience and protective factors. Additionally, emphasis on leader/supervisor engagement, connectedness among Service members, civilians and families as well as taking a multidisciplinary approach are a few key elements needed to reduce the threat of suicide. However, providing the necessary KSAOs will remain foundational to suicide prevention.

3.1 Development of the Suicide Prevention Competency Framework

The competency framework provided here is based on professional practice guidelines, extensive research of DoD-endorsed suicide prevention resources, and subject matter expertise (see Appendix C for a comprehensive list of resources used to create the framework and Appendix D for more discussion on the framework development process). Table 1 below describes the two types of core competencies developed by the Suicide Prevention Training Evaluation Working Group: core and population-specific.

Table 1. Competency Types

Competency Type	Definition
Core competencies	Apply to the entire DoD community. These competencies are relevant to all DoD members regardless of their population group, role, or position.
Population-specific competencies	Apply to a specific population group and are shared across roles and positions (subpopulations) within similar functional requirements or role responsibility.

3.2 *Application of the Suicide Prevention Competency Framework*

The core and population-specific competencies listed below should be tailored to the specific function and/or performance requirements of the many members of the DoD community. The various DoD populations may apply each competency differently, based on their respective suicide prevention responsibilities. As such, this Competency Framework should be incorporated primarily into the annual training conducted by the Services and/or at specific points within the member's lifecycle (i.e., initial/recurring training, upon inprocessing at a new organization, professional military education, deployment cycle phases, transitions, etc.), as deemed appropriate by the DoD component. The core and population-specific competencies complement and inform each other. Ultimately, the general and specific populations should work together in recognizing, caring, and assisting those individuals who may be at-risk of suicide. Table 2 depicts an example of how one competency, "Crisis Response and Prevention," may be addressed across different target populations.

Table 2. Population-Specific Application of the Crisis Response and Prevention Competency (Example)

Population	Crisis Intervention/Response Supporting Content Focus	Strategy/Approach
Families	Be aware of resources for responding to a crisis situation	Newsletters (electronic and hard copy); public service announcements; Family Readiness Group meetings, and other tailored and developmentally appropriate manner that accounts for the age of the intended recipient. All such resources can be used to educate families on local and national crisis response resources including telephone and internet hotlines that are available 24/7.
Organizational Leaders/Unit Command Teams	Ensure that personnel understand how to respond when a crisis situation arises	Leadership or organization-wide meeting(s) to discuss crisis response; provide training opportunities, and/or guidance to personnel for how to respond to a crisis situation based on the organization's current crisis management protocols and

		approved training support curricula (e.g. ASIST, ACE-SI, ACT, etc.)

3.3 Suicide Prevention-Related Terminology

This competency framework fosters consistency of competency development across the DoD, including consistency in the use of suicide prevention-related terminology. The DoD will use the Centers for Disease Control and Prevention (CDC) Self–Directed Violence Classification system updated in 2011. Appendix B, Other Commonly Used Self-Directed Violence Terms, lists the terms, definitions, and sources from the 2011 report.

4 Core Competencies

4.1 Core Competency Overview

The core competency framework (Table 4.1.1) is organized according to three major suicide prevention areas that apply to the entire DoD community and stakeholders:

1. Prevention Education (Primary Prevention)
2. Crisis Intervention/Response (Secondary Prevention)
3. Postvention Education (Tertiary Prevention)

Each major suicide prevention area includes the following:

- Core competency areas for suicide prevention (numbered titles in each chart heading, (e.g., "1-Prevention Education").
- Components that describe and help define the KSAOs for suicide prevention activities (Column 1—lettered items, (e.g., "a. Knowledge about the topic of suicidal ideation")).
- Competency supporting content elements, which help explain or demonstrate the competency, presented in Column 2 in bulleted lists. NOTE: These elements do not constitute a comprehensive list for all populations, but are representative of relevant actions/concepts.

This competency framework is a baseline for the DoD community to shape existing or develop suicide prevention competency supporting content elements, as needed. To the extent possible, these competency supporting content elements will need to contain measureable behavioral indicators (observable behaviors that individuals employ when they are demonstrating a particular competency); competency models may include specific performance measures.

Appendix A defines the key words and terms used in the framework, Suicide Prevention Competency Framework Terms and Definitions.

4.1.1 Core Competency Framework

CORE COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
1-Prevention Education	
a. Knowledge of suicidal ideation	Suicidal ideation can include: • Thinking about killing him/herself • Planning for ways to kill him/herself • Feeling trapped or hopeless • Hoping not to wake up in the morning • Thinking the world would be better off without him/her • Sense of hopelessness and helplessness *(Appendix C, 66.i)*
b. Knowledge of applicable suicide trends within the military and the impact that suicide events may have on the DoD community/stakeholders* ***Note:** Knowledge of such trends in the military related to suicide and knowledge of potential impacts of suicide events can be helpful in preventing other suicide events. However individuals at risk for dying by suicide may not necessarily fit into these categories.	Applicable suicide trends can include the following facts: • Death by suicide is a low base-rate event, but one suicide event can have a large impact (e.g., on family, coworkers, and peers) when it does occur. • A suicide event may trigger additional suicide events. However, providing effective, supportive responses to the initial suicide event may reduce the likelihood of this happening. • Firearms are the most frequently used means/method by Service members who die by suicide. • Mental disorders and substance abuse are risk factors for suicide. Since these conditions may be under-reported or unknown about an individual, one cannot assume "lack of risk" if the status of an individual is unknown with respect to these risk factors. • Stressors and triggering events such as relationship problems are more strongly associated with Service member suicide than is deployment status. • The majority of suicides for Service members occur in non-deployed settings. • While the majority of Service members who have died by suicide were Caucasian, non-Hispanic males (most commonly enlisted, active component), deaths by suicide span all demographics and ranks. *(Appendix C, 55)*

CORE COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
c. Knowledge of the risk factors for suicidal ideation and behavior	Risk factors for suicidal ideation and behavior can include: • Prior ideation, planning, or suicide attempts • History of sexual and/or physical abuse • Experiencing sexual harassment or assault • Easy access to lethal means/methods of suicide • Social alienation (e.g., hazing, bullying, public humiliation) • Ostracism (e.g., exclusion from social acceptance, activities, or interactions; denying privilege of friendship) • Mental illness, (e.g., Post-Traumatic Stress Disorder (PTSD), traumatic brain injury (TBI) depression, anxiety disorders) • Substance abuse (legal and/or illegal) • Chronic pain • Rage, anger, desire for revenge • Restlessness, agitation, insomnia • Sleeping all the time • Dramatic changes in mood • Anniversary and birthday dates/events • Degree of exposure to death (desensitization) • Perceiving burdensomeness to others *(Appendix C, 47)*

CORE COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
d. Knowledge of the role of stressors and triggering events in suicidal ideation and behavior	Triggers and stressors may not *cause* suicide but are influential when combined with risk factors. Stressors and triggering events can include: • Career threatening change in fitness for duty • Adverse deployment experience • Suicide or loss of relative, someone famous, or a peer • Relationship problems (e.g., divorce, separation, break-up with significant other) • Workplace conflict • Pending deployment • Failure to be promoted • Loss of status/respect/rank (e.g., public humiliation, being bullied or abused, failure at work/task) • Transitions (e.g., Permanent Change of Station (PCS), retirement, change of unit/squadron) • Financial distress (e.g., a large credit card debt, inability to make a car payment, or taking out payday loans) • Legal issues (e.g., Uniform Code of Military Justice actions, Driving Under the Influence citations/arrests, and traffic violations) • Combat / Operational Stress; Post-Traumatic Stress Disorder *(Appendix C, 28)*

e. Skills to recognize warning signs for suicidal behaviors	Warning signs for suicidal ideation and behavior can include: • Expressing hopelessness: Feelings that nothing can be done to improve the situation • Isolation and Alienation - Withdrawing from family, friends, peers, co-workers, or society • Showing self-pity, negative ruminations, blame or remorse • Showing inhibited aggression turned toward the self (auto-aggression) • Taking steps toward implementation of a suicide plan (e.g., making arrangements to divest responsibility for dependent others such as children, pets, elders; obtaining the means to die by suicide) • Expressing purposelessness: No reason for living, dissatisfaction with life, no sense of purpose, decreased self-esteem • Showing somatic symptoms such as sleep problems, fatigue, and loss of appetite • Increasing use of alcohol or drug • Acting recklessly or engaging impulsively in risky behavior • Expressing feelings of being trapped with no way out, or being in unbearable pain • Expressing anxiety: Agitation, irritability, angry outbursts, feeling like wants to "jump out of my skin" • Writing or talking about suicide, wishing to die, or death • Dramatic lack of interest in usual activities or habits • Threatening to kill self or intention to act on such ideas • Updating wills and/or life insurance unexpectedly • Saying goodbye to loved ones • Giving away possessions, putting affairs in order, tying up loose ends *(Appendix C, 28 & 52)*

CORE COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
f. Knowledge of protective factors that build resilience and support suicide prevention efforts	Protective factors* can include: • Strong interpersonal relationships • Sense of competence with prior problem solving and/or crisis resolution • Social/emotional abilities • Sense of belonging to a group and/or organization (e.g., Peer support groups and activities) • Models of healthy coping; coping skills (e.g., cognitive flexibility) • Willingness to ask for help • Physical fitness • Religious and/or spiritual identity • Strong personal resiliency • Relevant training/education and stress-inoculation programs and materials • Stress-relieving activities, such as yoga, exercise, proper sleep, use of mood logs and journals, and counseling * Military-related programs and personnel that are associated and available to support protective factors are essential to build resilience and support suicide prevention efforts.

CORE COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
g. Knowledge of benefits of participating in peer support groups and other activities that build resilience, as appropriate	Benefits of participating in peer support groups and similar activities can include: • Realization he/she is not alone; support is available • Suggested new ways to deal with particular problems/issues • Provided emotional support • Improved coping skills (e.g., cognitive flexibility, social engagement, physical activity as stress relief) • Improved understanding of alternative paths to recovery (e.g., spiritual counseling, clinical treatment, participation in community activities) • Increased satisfaction with health status • Increased social networking • Improved quality of life • Improved wellness • Supported acceptance of illness/situation *(Appendix C, 15)*

2-Crisis Intervention / Response	
a. Knowledge of the similarities and differences in the Services' common models or approaches for crisis support in joint environments (e.g., bases that include members from multiple Services)	Services' models or approaches include: • ACE (Army & Air Force: Ask, Care, Escort) • ACT (Navy: Ask, Care, Treat) • RACE (Marine Corps: Recognize distress (or change in behavior), Ask, Care, Escort)
b. Ability to identify and execute an appropriate response within a specific adverse situation, incorporating risk mitigation strategies	Risk mitigation strategies can include: • Responding to all suicidal thoughts with empathy and understanding • Increasing safety contacts with individuals demonstrating warning signs • Connecting the individual with appropriate crisis response personnel • Communicating with the individual in a way that reserves judgment and demonstrates compassion and respect *(Appendix C, 52)*
c. Ability to recognize suicidal situations as an emergency (just as other medical emergencies)	Indicators of suicidal situations can include: • Well-formed suicidal plans, preparations, and/or rehearsals • Demonstration of distress • Experienced sense of entrapment • Expressed feelings of failure • Withdrawal from friends, family, and/or society • Demonstration of pain, both emotional and physical • Noticeable change in the accumulation and/or rate of change of risk factors *(Appendix C, 47)*
d. Ability to intervene with someone who may be at risk for suicide or an adverse outcome for appropriate intervention and support (e.g., treatment options)	Appropriate intervention and support can include: • Contacting appropriate emergency responders (i.e., Police, Emergency Medical Services) • Contacting appropriate healthcare providers • Contacting appropriate spiritual professionals • Referring the individual to suicide support resources • Walking or transporting the individual to the provider's location • Respecting confidentiality within legal limitations

e. Knowledge of Veterans/Military Crisis Line and other applicable DoD-specific resources	Crisis intervention resources include: • National Suicide Prevention Lifeline: 800-273-8255 • Veterans/Military Crisis Line: 800-273-8255, Press 1 • Military OneSource: 800-342-9647 • Real Warriors Live Chat: 866-966-1020 • DoD Safe Helpline: 877-995-5247
3-Postvention Education	
a. General knowledge of the grieving process, and grief	The grieving process and grief can be characterized by: • Numbness or detachment • Trouble carrying out normal routines • Preoccupation with own sorrow • An extreme focus on the loss and reminders of departed loved ones • A long-term process and not an event *(Appendix C, 55 & 65)*
b. Ability to provide appropriate intervention or support to those affected by suicide	Resources or support for those affected by suicide include: • Support groups • Individual counseling – particularly if a person continues to be affected by grief over time with no apparent improvement • Increased social support and the reduction of isolated environments • Respect and support for the affected individual's need to grieve • Mindfulness of holidays and anniversaries • Knowledge of organizational suicide prevention plan policies, procedures, and protocols *(Appendix C, 60)*
c. Skills to communicate with friends and family members of the deceased in a clear and supportive way regarding hope, healing, and wellness	Supportive communication with those affected by suicide can be characterized by: • Empathy • Compassion • Nonjudgmental support • Respect • Safe environment • Opportunity to talk about the loss and grief repeatedly over time

5 Population-Specific Competencies

5.1 Population-Specific Competency Overview

In addition to the 3 specific populations primarily targeted for suicide prevention education and training, DSPO has developed eight population-specific competency frameworks that address additional competencies for DoD Military and Civilian Public Affairs Personnel, DoD Support Services Specialists, Legal Personnel, Organization Leaders/Unit Command Teams, and Other Crisis Support Professionals. The above mentioned populations have been identified as gatekeepers whom, in the performance of their duties, are in the best position to assist at-risk individuals throughout a continuum of care and support. They also fit into an overall strategy to support suicide prevention, intervention, and postvention efforts. All of these groups, with the exception of Families, are expected to demonstrate both the core and their respective population-specific competencies. Command Support Staff is also identified as a target population; however, the requisite competencies for Command Support Staff are covered in the Core Competency Framework (4.1.1) as well as in the related population-specific competencies. See Appendix A for examples of subpopulations within the target populations. The specific populations listed above are key staff who routinely come in contact with individuals who may be at risk of suicide. Identifying suicide prevention role-specific competencies for these groups will allow an increased number of at-risk individuals to be identified at an earlier stage in order to provide the necessary resources to mitigate the stressors afflicting the individual.

The framework serves as a baseline to create or update existing competency models or to develop training curricula for targeted populations throughout the stakeholders' lifecycle as determined by the DoD Components. The competencies will inform the development of training, education, outreach, assessment materials, and instructional activities targeted to each population's specific suicide prevention requirements. Competency Supporting Content Elements within the core competencies framework above will need to be further targeted to meet the population-specific requirements.

Each population-specific competency framework contains titles and supporting definitions that describe the KSAOs required for suicide prevention activities within a given population. Each supporting content element demonstrates how the components might look when incorporated into training curricula. Any elements without a citation were created by the DSPO and vetted with subject matter experts.

5.1.1 Chaplains Competency Framework

CHAPLAINS COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
1-Pastoral Prevention	
a. Ability to establish rapport and relationships with Service members, DoD Civilians, and their families to facilitate help-seeking behavior and aid suicide prevention efforts	Ways to establish rapport and relationships of this nature can include: • Demonstrating trustworthiness • Participating in Command events • Demonstrating a ministry of presence within the command • Demonstrating genuine interest in others' well-being • Withholding judgment • Publically disseminating contact information
b. Ability to assist in the development and implementation of strategies that reduce the stigma and discrimination associated with seeking help	Stigma reduction efforts can include: • Publically advocating the benefits of help-seeking behavior and the strength it takes to get help • Publically recognizing and discrediting the stigma associated with help-seeking • Developing community-based strategies that target at-risk relevant subgroups • Developing or supporting communication efforts that highlight the complete confidentiality that Chaplains* can provide • Networking with other helping professionals to provide training and education • Active participation in working groups established by both DoD and individual Services addressing the issue from a system-wide perspective * Note: Other entities have some level of confidentiality, including mental health providers and some of the crisis lines that allow anonymous help (e.g., Veterans/Military Crisis Line, National Suicide Prevention Lifeline)

2-Pastoral Intervention	
a. Skills to implement the role of the ministry team as attendant (including conducting risk assessments and developing safety plans) **NOTE:** The risk assessment/safety plan should not be confused with or substitute for those performed by a licensed and privileged health care provider	Attendant duties for a ministry team can include: • Conducting risk assessments • Developing safety plans • Comprehensive review of current and historical command climate surveys • Participating in Service-specific suicide prevention training on emerging developments in the field; serving as a trainer/facilitator, as needed (see RAND report on Gatekeeper Training for Suicide Prevention, 2015) • Answering spiritual questions related to suicide and resilience with an understanding of the medical implications involved in suicide • Taking a proactive role in collaborating with professional help providers for the purpose of identifying when to refer individuals to Chaplains
b. Ability to collaborate with interdisciplinary teams to provide appropriate care to those at risk, considering both the limits of privacy and the mandate for confidentiality	Collaboration with an interdisciplinary team can include: • Coordinating with doctors, mental health personnel, substance abuse counselors, or caretakers • Learning appropriate medical terminology • Learning about mental health services and emergency resources • Learning referral processes to connect Service members to appropriate healthcare personnel for crisis management including due regard for informed consent and Service member willingness • Taking an active role in connecting the individual with appropriate professional help, as appropriate and within limits of confidentiality/privacy • Collaborating substantively with Command without compromising the inviolability of confidentiality • Consulting with appropriate healthcare providers to develop and implement intervention strategies that do not necessarily require a hand-off to healthcare personnel* *NOTE: This element is part of the Chaplains Corps practice and policy. When members will not release chaplains from confidentiality, chaplains should have previously consulted with healthcare providers regarding strategies for care and interventions that might assist the member in accepting a referral.

c. Ability to apply pastoral counseling skills to help reduce risk for suicide	Pastoral counseling can include: • Discussing the purpose and meaning of life • Emphasizing the individual's importance to his or her family, organization, or community • Providing a safe environment for the individual to speak openly and share their immediate concerns • Utilizing references from relevant religious traditions or the individual's world view to emphasize the value of life itself • Helping the individual realize that he or she is not alone • Helping the individual work through any thoughts or emotions related to suffering *(Appendix C, 66. b)*
d. Application of pastoral visitation and follow-up activities	Follow-up activities can include: • Checking in with family members and friends on the individual's health status • Supporting the person's reintegration into society after a traumatic event, (e.g., calling or writing a letter of support) • Creating a specific plan for the next meeting with the individual • Demonstrating genuine care for well-being by visiting the individual's home, workplace, or other appropriate meeting place • Visiting at a Service-specific remote location both in times of crisis/need and in times of stable mental health
3-Pastoral Postvention	
a. Skills to provide pastoral care related to grief and loss, with an awareness of cultural differences within an organization and among family members	People of divergent cultures can differ in the way they experience grief and loss: • In the emotions experienced • In the display and processing of emotions • In their beliefs about death and after-life • In their rituals to address the death • In their comfort discussing the deceased *(Appendix C, 39)*

b. Ability to support Casualty Assistance Representatives after Service members have died by suicide	Support to Casualty Assistance Representatives can include: • Accompanying the representative to bear news • Following up with the family after the initial notice and provide ongoing support, to include deciding on any memorial services • Organizing support systems for those directly affected by the suicide • Discussing any information with the Casualty Assistance Representatives that might aid their efforts
c. Knowledge of Service-specific policies and practices surrounding memorial ceremonies/services	Policies and practices can include: • Funeral traditions, practices, and customs • Common burial sites • Cremation facilities catering to Services • Appropriate settings for a service/ceremony • Allowance of religious symbols at the service/ceremony • Service-specific guidelines regarding Command Memorial Services and/or funerals for those who died by suicide • Incorporation of postvention message into services. *(Appendix C, 26)*
4-Pastoral Communication with Command	
a. Ability to advise the Command on the climate related to suicide and suicide prevention efforts	Information to share with Command regarding the suicide-related climate can include: • Patterns of negative morale (e.g., hopelessness) across multiple individuals • Patterns of unaddressed grief or complicated grief following the loss of fellow warriors • Patterns of stigma related to help-seeking behavior, preventing troubled individuals from receiving proper support • Widely experienced secondary-trauma events or other widely experienced stressors or triggering events • Data from command climate survey

5-Pastoral Support and Mentorship	
a. Ability to mentor, guide, and support other chaplains during and after crisis situations (includes being able to provide care for the caregiver and to practice self-care)	Supporting/mentoring other chaplains can include: • Providing pastoral care for the caregiver • Practicing self-care to ensure personal fortitude in order to provide proper support to others • Serving as a sounding board for chaplains who are helping individuals through crisis situations • After crisis situations, debriefing with chaplains to evaluate strategies chosen and employed during the crisis situation • Providing additional support for chaplains and Unit Ministry Teams/Religious Ministry Teams who have provided care for individuals who died by suicide
b. Ability to help other chaplains develop suicide prevention skills through the sharing of resources, networks, and best practices	Contributing to other chaplains' suicide prevention skill development can include: • Connecting chaplains with survivors of suicide and/or suicide attempt survivors networks and support groups • Informing chaplains of relevant Service-specific suicide prevention training programs • Ensuring chaplains' understanding of suicide prevention evidence-based best practices as indicated by relevant professional organizations • Ensuring unit ministry/religious ministry teams receive adequate training in the latest evidence-based practices • Sharing with other chaplains useful sources of information regarding suicide prevention *(Appendix C, 45)*
c. Ability to provide oversight of chaplains' participation in Command suicide prevention programs	Chaplains' participation in Command suicide prevention programs can include: • Regularly checking in with supporting personnel, such as other chaplains, and with local program managers • Providing insight regarding trends, themes, and delivery methods related to suicide prevention • Acting as a liaison to disseminate information regarding, or to gain support for, suicide prevention programs for target populations • Providing feedback from target populations regarding attitudes toward suicide prevention efforts

5.1.2 DoD Military & Civilian Public Affairs Personnel Competency Framework

DoD Military and Civilian Public Affairs Personnel Framework	
Competency Components	**Competency Supporting Content Elements**
1-Suicide-Related Message Development and Dissemination	
a. Knowledge of DoD, Services, and Substance Abuse and Mental Health Services Administration (SAMHSA)/Suicide Prevention Resource Center (SPRC) Public Affairs Guidance on safe and effective messaging of suicide	Public Affairs Guidance for Suicide Event and Suicide Prevention Messaging includes tips such as: • Avoid referring to suicide in headlines; report the cause of death in the body of the story. • Describe the deceased as "having died by suicide" rather than as "a suicide" or having "committed suicide" • Avoid detailed descriptions regarding the circumstances surrounding or information about the location and means used to die by suicide • Avoid glorifying or romanticizing suicide or people who have died by suicide • Do not present suicide as an inexplicable act or explain it as a result of stress only • When appropriate, refer to a "rise" in suicide rates rather than calling such a rise an "epidemic," which implies a more dramatic and sudden increase Note: Research has shown that the use in headlines of the word "suicide" or referring to the cause of death as "self-inflicted" increases the likelihood of contagion. *(Appendix C, 19, 66. j, 66. m, 66. n)*

DoD Military and Civilian Public Affairs Personnel Framework	
Competency Components	**Competency Supporting Content Elements**
b. Ability to craft messages that drive help-seeking behavior, reduce stigma, and reduce the potential for suicidal contagion	Messages that may help reduce stigma and the potential for suicidal contagion can include: • Use of strength-based messaging • Promotion of protective factors and resilience skills • Provision of contact information for the Military Crisis Line and/or other resources available to those in crisis • Reference to peer support successes and recent treatment advances for behavioral health problems including depression, anxiety, Post-Traumatic Stress Disorder, and substance abuse • Sharing of individual stories of resilience, successful treatment, support services, and other life-saving interventions that enabled individuals to overcome feelings of despair without resorting to suicide • Listing warning signs of suicide and self-harming behavior • Emphasizing suicide prevention messages *(Appendix C, 19, 66. m, 66. n)*
c. Skills to coordinate, when necessary, with local suicide prevention subject matter experts before releasing messages concerning suicide policies, programs, and statistics	When additional validation of information is required, consider obtaining guidance from the following agencies prior to release: • American Association of Suicidology • American Foundation for Suicide Prevention • Centers for Disease Control and Prevention • Defense Suicide Prevention Office • Department of Veterans Affairs • National Institute of Mental Health • Office of the Surgeon General • Substance and Mental Health Services Administration • Service level Suicide Prevention Program Managers • Suicide Prevention Resource Center *(Appendix C, 19)*

5.1.3 DoD Support Services Competency Framework

Each target population listed below includes many groups from the DoD community. These lists of subpopulations are not meant to be exhaustive (as it is not feasible to call out all members of each population), but rather to show a sampling of the types of groups within the major identified populations.

Table 3. Support Services – Target Population

Section	Population Name	Sample Subpopulations
5.1.1	**Chaplains**	• Chaplains • Chaplain Assistants/Religious Program Specialists
5.1.2	**DoD Military and Civilian Public Affairs Personnel**	• Editors • Photographers • Public Affairs/Relations Officers • Reporters
5.1.3	**DoD Support Services Specialists**	• DoD Service and Benefit Support Call Centers • Military OneSource • Peer Counselors
5.1.4	**Families**	• Spouses/Significant Others • Children (Unmarried/Under 21) • Adult children (21 and over) • Dependent Parents/Parents • Dependent Siblings • Other Relatives

5.1.5	**Healthcare Providers**	• Licensed clinical professionals
		  ○ Physicians
		  ○ Psychologists
		  ○ Advanced practice/registered nurses
		  ○ Licensed clinical social workers
		  ○ Health care providers with prescription writing privileges
		• Practitioners Under Supervision of a Licensed Provider
		  ○ Medical Corpsmen
		  ○ Counselors
		  ○ Substance Abuse Counselor (clinical)
		  ○ Medical Interns and Residents
		  ○ Psychology and Clinical Social Work Interns/Residents

5.1.6	**Organization Leaders/Unit Command Teams**	• Command Teams (all levels) • First-line Leaders/Supervisors

Section	Population Name	Sample Subpopulations
5.1.7	**Legal Personnel**	• JAG (Judge Advocate General) Personnel • Legal Assistance Attorneys • Paralegals • Physical Evaluation Board Counsels • Trial Lawyers • Defense Counsel • Victim's Legal Counsel • Legal Assistant Attorneys
5.1.8	**Other Crisis Support Professionals**	• Casualty Assistance Representatives* • Military Firefighters* • Military Police* • Other First Responders as directed by the Military Service
5.1.9	**Command Support Staff**	• Suicide Prevention Program Managers / Coordinators • Department of Defense Civilians • Department of Defense Education Activity Staff • Equal Opportunity Advisors/Equal Employment Advisors • Family Advocacy Program Personnel • Family Readiness Officers • Financial Counselors • Holistic Health (e.g., chiropractic, meditation) • Inspectors General • Military Family Life Consultants • Military Family Readiness Service Providers • Child Care Workers • Counselors (non-clinical) • Family Life Education Providers • Morale, Welfare, and Recreation Staff • Resilience Training Staff • Recovery Care Coordinators • Risk Reduction Staff • Transition to Veterans Program Office/Transition Assistance Program Staff • Sexual Assault Response Coordinators • Sexual Assault Victim Advocates • Staff of organizations that typically house and/or employ transient and/or Limited Duty personnel • Substance Abuse Counselors (non-clinical)

**See definitions for these groups in the Suicide Prevention Competency Framework Terms and Definitions (Appendix A).*

DoD Support Services Specialists Competency Framework	
Competency Components	**Competency Supporting Content Elements**
1- Suicide Risk Assessment	
a. Skills to identify suicidal ideation, intent, and behavior, incorporating understanding of relevant cultural influences	Identifying suicidal ideation, intent, and behavior can include: • Estimating the level of risk • Providing input into clinical decision making as appropriate or requested • Understanding referral processes to clinical mental health providers and emergency services • Determining next steps, including when/where to make referrals • Determining when/how the status of an individual should be monitored • Contributing relevant information to appropriate sources as needed or requested *(Appendix C, 14 & 16)* Incorporating understanding of relevant cultural influences into assessment can include: • Understanding the effects of language, interpersonal styles, behaviors, values, attitudes, and practices • Taking into account various cultural belief systems regarding suicide and related behaviors (e.g., in the Korean culture, suicide can be viewed as a noble end to bringing shame to a family) • Adapting services to language preferences and cultural norms • Promoting diversity among providers, peers, Command, etc. *(Appendix C, 55)*

DoD Support Services Specialists Competency Framework	
Competency Components	**Competency Supporting Content Elements**
b. Knowledge of health systems and societal risk factors	Knowledge of health systems and societal risk factors can include: • **Barriers to accessing health care.** Navigating complex health systems, stigma associated with seeking help for suicide attempts, and mental disorders • **Access to means.** Examples include: Pesticides, firearms, heights, railway tracks, poisons, medications, sources of carbon monoxide • **Inappropriate media reporting and social media use.** Examples include: Gratuitously cover celebrity suicides, report unusual methods of suicide or suicide clusters, show pictures or information about the method used, or normalize suicide as an acceptable response to crisis or adversity • **Stigma associated with help-seeking behavior.** Can be a substantial barrier to people receiving help that they need; can discourage the friends and families from providing the support they need or even from acknowledging their situation *(Appendix C, 61)*
c. Ability to identify risk of suicide	Ability to identify risk of suicide as follows: • **High-Suicidal.** Very low wish to live (WTL); very high wish to die (WTD); high prediction of future suicide attempts, attempts with intent to die, frequent life/death debates. • **Moderate-Suicidal.** High WTD, low WTL; high prediction of future attempts, plans and attempts with intent to die, frequent life/death debates; very frequent suicidal thoughts. • **Low-Suicidal.** Moderate suicidal thoughts, low prediction of future attempts, infrequent life/death debate, moderately high WTL, very low WTD. • **Non-Suicidal.** No internal life/death debate, no thoughts of suicide, prediction of no future suicide attempts. *(Appendix C, 14)*

2-Immediate Crisis Response and Other Interventions	
a. Ability to remain calm in high-stress, crisis situations	High-stress, crisis situations can include: • An emotionally stressful event or traumatic change in a person's life; a time of intense difficulty, trouble, or danger • A situation in which a person is attempting to kill him or herself or is seriously thinking about or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment *(Appendix C, 55)*
b. Ability to respond quickly in crisis situations in a manner that can help reduce the likelihood of suicide	Responding quickly in crisis situations can include: • Immediately recognizing when someone is in suicidal or related crisis • Implementing immediate crisis responses (e.g., referring to emergency services, walking/transporting the individual to the provider's location, calling in resources to provide required services, or calming an irate or hysterical individual) • Memorizing or having easy access to telephone numbers/other contact information for emergency services
c. The ability to employ methods that reduce trauma and agitation among suicidal individuals	Implementing methods that reduce trauma and agitation among potentially suicidal individuals can include: • Speaking in a calm and soothing voice • Effectively listening, posing proper questions, and establishing rapport • Setting appropriate boundaries/expectations
d. The ability to implement strategies for engaging with individuals at risk of suicide	Implementing strategies for engaging with individuals at risk of suicide may include: • Enhanced case management • Promotion of Resilience • Peer Support • Patient-led planning designed to increase safety outside of clinical settings *(Appendix C, 61)*

3-Crisis Response Documentation and Communication	
a. Ability to document and report crisis events in a timely and accurate manner	Documenting and reporting crisis situations can include: • Accessing appropriate suicide prevention guidance, requirements, and processes • Keeping track of all conversations with an individual who expresses any indication that he or she could harm him or herself or is experiencing unique or intense stressors* • Recording the removal of weapons or other harmful means as a precaution* - see DoD Means Reduction memorandum dated August 28, 2014 • Recording referrals made and outcomes, as available* * *As permitted to ensure confidentiality, as applicable.* *(Appendix C, 19)*
4-Suicide Prevention Strategies	
a. Knowledge of evidence-based outreach efforts for suicide prevention	Knowledge of evidence-based outreach efforts for suicide prevention fall in three categories: • **Public Health Approach.** Designed to reach an entire population in an effort to maximize heath and minimize suicide risk by removing barriers to care and increasing access to help, strengthening protective processes such as social support, and altering the physical environment. • **Target Market Groups.** Target vulnerable groups within a population based on characteristics such as age, sex, occupational status or family history. While individuals may not currently express suicidal behaviors, they may be at an elevated level of biological, psychological or socioeconomic risk. • **Outreach to Specific Individuals.** Target specific vulnerable individuals within the population, e.g., those displaying early signs of suicide potential or who have made a suicide attempt. *(Appendix C, 55)*

5.1.4 Families Competency Framework

FAMILIES COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
1- Family Transitions and Reintegration Support	
a. Knowledge of how the military lifecycle (e.g., accession, permanent change of station, deployment, separation, retirement) contributes to levels of stress	Events in the military lifecycle can contribute to levels of stress in the following ways: • Potential repeated episodes of time away from families • Long hours and tasks that are physically, mentally, and/ or emotionally demanding • Frequent mandatory moves, which present career and social challenges for the family as a whole • Strict and sometimes changing codes of conduct • Exposure to danger • Injury/Illness or long-term disability • Temporary guardianship by non-biological parents, non-custodial parents, or extended family or friends • Shifting family structure, roles and responsibilities. *(Appendix C, 36)*
b. Knowledge of how risk factors (e.g., secondary trauma, combat / operational stress, Post-Traumatic Stress Disorder, or chronic pain) impact the individual and his or her family	Risk factors can impact the Service member and his or her family in the following ways: • Lack of trust between family members • Suicide contagion, although rare • Relationship problems leading to separations, divorce, or custody battles • Financial and/or legal problems that impact family unit • Changes in personality and behavior • Power struggles over treatment *(Appendix C, 10)*

c. Ability to respond to different emotional states with empathy as a means to help an individual in distress and protect others from becoming vulnerable	Techniques for responding with empathy can include: • Establishing trust and unconditional regard • Repeating, rephrasing, and summarizing to show that you have heard the other person • Establishing stable and reliable environments and systems of support • Looking someone in the eye (be aware of cultural nuances relative to this approach), and listening actively • Acknowledging symptoms of distress • Asking questions that show care and concern • Offering physical affection (be aware of cultural nuances or other factors, (e.g., victim of sexual harassment, assault or abuse, relative to this approach))

Note: While families cannot be directed to adhere to workplace competency expectations, core and population-specific frameworks should be used to develop education and outreach programs for families.

5.1.5 Healthcare Providers Competency Framework

"Healthcare Providers" in the DoD community is a broad term encompassing licensed and trained clinical professionals (e.g., physicians, psychologists, psychiatrists, advanced practice nurses, and licensed clinical social workers).

This section identifies Healthcare Providers as a target population for suicide prevention training. ASD(HA) is responsible for establishing requirements for healthcare providers, as per DoDD 6490.14:

> Encl 2, 5, d. "Establishes training programs and procedures for healthcare professionals in collaboration with the Director of the DSPO to ensure competency in the delivery of evidence-based care for the assessment, management, and treatment of suicide-related behaviors."

Accordingly, ASD(HA) has an established, rigorous set of policies, clinical practice guidelines (e.g. "VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide" found at http://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_full.pdf), and certification/licensing requirements for guiding healthcare providers in suicide risk assessment, clinical intervention and treatment, as well as command communication and collaboration as outlined in DoDI 6490.08 "Command Notification to Dispel Stigma in Providing Mental Health Care to Service Members." Therefore, this Suicide Prevention Competency Framework defers to existing ASD(HA) policies, guidelines, and requirements for suicide prevention competency and training requirements for healthcare providers.

5.1.6 Legal Personnel Competency Framework

LEGAL PERSONNEL COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
1-Suicide-Related Legal Processes	

a. Knowledge of laws and military policies and procedures that apply to suicide prevention, intervention, and postvention activities	Resources for suicide-related laws and military policies and procedures include:
	• Uniform Code of Military Justice
	• American Bar Associations
	  o Project Home Front
	  o Legal Assistance to Military Personnel
	• Military Pro Bono Assistance
	• Local bar associations

2-Justice System Treatment Options	
a. Knowledge of and ability to refer to treatment service options for at-risk Service members within the justice system	Justice system treatment options for at-risk Service members (to include National Guard and Reserves) include: • Veterans Treatment Court • Service Members Justice Outreach Program • Veterans Justice Outreach Program

5.1.7 Organization Leaders/Unit Command Teams Competency Framework

ORGANIZATION LEADERS/UNIT COMMAND TEAMS COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
1-Suicide Prevention-Related Policy, Guidance, and Surveillance	
a. **Knowledge of policies and procedures that apply to leadership's role in suicide prevention, intervention, and postvention activities**	Policy that applies to leadership's role in suicide prevention should address: • Increased awareness among members of the U.S. Armed Forces about mental health conditions and the stigma associated with mental health conditions and care • Command team's awareness of the standard of care for suicide prevention to be used throughout the Department • The standards for responding to attempted suicides and deaths by suicide, including guidance and training to assist commanders address these incidents • The means to ensure the protection of the privacy of members seeking or receiving treatment relating to suicide • Service- or installation-level responsibilities for responding to suicide *(Appendix C, 57)*

b. Ability to create a Command climate that enables implementation of suicide prevention, intervention, and postvention activities	Creating a safe Command climate can include: • Demonstrating understanding of suicide prevention, intervention, and post-vention policies • Encouraging help-seeking behavior by communicating support and disseminating resources • Developing protocol that addresses needs identified by command climate surveys • Taking proactive measures to address at-risk behaviors • Reducing access to lethal means (i.e., weapons, per Section 1062 (c) of the Ike Skelton National Defense Authorization Act for Fiscal Year 2011 (Public Law 111-383; 124 Stat. 4363), ammunition, drug take back) • Educating individuals about the practices of safe gun ownership • Assist Service member in their transition to a new organization or as they move into civilian life • Supporting access to care (i.e., behavioral health, pastoral counseling, crisis intervention) • Educating about the benefits of treatment • Encouraging access to behavioral health care with assurance that doing so will not necessarily affect their career and how it can improve long-term goals • Engaging organization members, particularly leaders, who have benefitted from behavioral health support to share their stories and mentor others • Developing/adhering to practices that prohibit repercussions (i.e., belittling, hazing, humiliating, or ostracizing members who need care) for seeking behavioral health help or other support • Establishing an "open-door, penalty-free" policy to inform leaders about potential behavioral health issues • Involving key personnel (e.g., chaplains, healthcare providers) in key training events to demonstrate their support for the well-being of the organization

	• Involving key personnel (e.g., chaplains, EO/EEO Advisors, Inspector General, counselors) to assess data obtained from command climate surveys • Providing leaders/supervisors tools on how to get to know their battle buddies / co-workers with the goal of being aware of situations that might make them feel stressed, overwhelmed, or hopeless • Providing Postvention education and skills-based training to re-establish unit resilience and cohesion while supporting healthy grieving
2-Suicide Prevention Training and Education	
a. **Knowledge of the principles, methods, and tools used to implement suicide prevention training and education programs**	Principles, methods, and tools used to implement suicide-related training and education programs can include: • Incorporating suicide prevention-specific caveats into each step/phase of executing the training process, such as: o Awareness of terms to use/avoid o Knowledge of messaging that reduces the likelihood of contagion o Ensuring suicide prevention and resilience skills are conducted at all levels of an organization and supported by key leaders

5.1.8 Other Crisis Support Professionals Competency Framework

See Table 3 for a listing of the subpopulations within Other Crisis Support Professionals.

OTHER CRISIS SUPPORT PROFESSIONALS COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
1-Immediate Crisis Response	
a. Ability to remain calm in high-stress, crisis situations	High-stress, crisis situations can include: • An emotionally stressful event or traumatic change in a person's life; a time of intense difficulty, trouble, or danger • A situation in which a person is attempting to kill him or herself or is seriously thinking about or planning to do so, and/or to harm others. This is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment. *(Appendix C, 57)*
b. Ability to quickly respond in crisis situations in a manner that can help reduce the likelihood of suicide	Responding quickly in crisis situations can include: • Immediately recognizing when someone is in suicidal and/or related crisis • Implementing immediate crisis responses (e.g., referring to emergency services, calming an irate or emotionally-escalated individual) as long as it is safe to do so
c. Knowledge of and the ability to employ methods that reduce trauma and agitation among individuals who are thinking about suicide	Implementing methods that reduce trauma and agitation among potentially suicidal individuals can include: • Speaking in a calm and soothing voice • Effectively listening, posing proper questions, and establishing rapport • Setting appropriate boundaries • Being able to inquire directly and non-judgmentally regarding the individual's intentions • Validating concerns and difficulties

OTHER CRISIS SUPPORT PROFESSIONALS COMPETENCY FRAMEWORK	
Competency Components	**Competency Supporting Content Elements**
2-Crisis Response Documentation and Communication	
a. Ability to document and report crisis events in a timely and accurate manner	Documenting and reporting crisis situations can include: • Accessing appropriate suicide prevention guidance, requirements, and processes • Keeping track of all conversations with an individual who expresses any indication that he or she could harm him or herself or is experiencing unique or intense stressors • Recording the removal of weapons or other harmful means as a precaution • Recording referrals made and outcomes, as available *(Appendix C, 19)*
b. Knowledge of appropriate information to share with Command structure to aid suicide prevention efforts	Knowing what is appropriate to share with Command structure can include: • Knowing privacy and confidentiality laws and guidelines • Identifying "need-to-know" data
c. Ability to identify risk of suicide	Ability to identify risk of suicide as follows: • **High-Suicidal.** Very low wish to live (WTL); very high wish to die (WTD); high prediction of future suicide attempts, attempts with intent to die, frequent life/death debates. • **Moderate-Suicidal.** High WTD, low WTL; high prediction of future attempts, plans and attempts with intent to die, frequent life/death debates; very frequent suicidal thoughts. • **Low-Suicidal.** Moderate suicidal thoughts, low prediction of future attempts, infrequent life/death debate, moderately high WTL, very low WTD. • **Non-Suicidal.** No internal life/death debate, no thoughts of suicide, prediction of no future suicide attempts. *(Appendix C, 14)*

Appendix A: Terms and Definitions

Below is a glossary of terms that are used in the Competency Framework. Definitions below without a citation have been created by the Defense Suicide Prevention Office and vetted with subject matter experts. Additional commonly-used suicide prevention/self-directed violence-related terms from CDC are listed and defined in Appendix B.

Term	Definition
Casualty Assistance Representatives	Personnel responsible for notifying family members when a Service member has died. They may be called by different titles in different services: Casualty Assistance Officer (Army), Casualty Assistance Representative (Air Force), Casualty Assistance Calls Officer (Navy, Marines, and Coast Guard).
Combat / Operational Stress	The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of an individual who has been exposed to stressful events in war or stability operations. *(Appendix C, 16)*
Complicated Grief	When the symptoms of grief linger and become increasingly unbearable, the condition turns into what is now being called unresolved, protracted, traumatic, or complicated grief (adapted from Harvard Medical School Family Health Guide). About 10 percent of bereaved people develop complicated grief, a condition with a unique constellation of symptoms, unique risk factors, and a course of illness that requires a specific targeted treatment. *(Appendix C, 48)*
Continuity of Care	The degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context. *(Appendix C, 31)*
Family (Dependent)	A Service member's spouse; children who are unmarried and under age 21 years or who, regardless of age, are physically or mentally incapable of self-support; dependent parents, including step and legally adoptive parents of the Service member's spouse; and dependent brothers and sisters, including step and legally adoptive brothers and sisters of the Service member's spouse who are unmarried and under 21 years of age or who, regardless of age, are physically or mentally incapable of self-support. *(Appendix C, 16)*
Family (Inclusive)	Parents, spouses, significant others, children, caregivers, and all extended family who provide support to the Service member, as well as the families of Service members who have died serving. *(Appendix C, 23)*

Term	Definition
Grief/ Grieving Process	The anguish that a person will experience after a significant loss, like the death of a beloved person. The grieving process does not necessarily happen in a predictable fashion; sad thoughts and feelings often come and go. *(Appendix C, 66. a)*
Intervention	A strategy or approach that is intended to prevent an outcome or to alter the course of an existing challenge or stress; also known as secondary prevention.
Military Firefighters	Generic term for firefighters connected with the military. Employees may have different titles across the Services, (e.g., Damage Control (Navy)).
Military Police	Generic term for police organizations connected with the military. Employees may have different titles across the Services, such as Military Police (Army), Shore Patrol (Navy and Coast Guard), and Security Forces (Air Force).
Pastoral Care	An approach to care that includes the spiritual and emotional components that influence and shape the identity, interior life, and essence of the human person. This is care provided by a religious professional. Pastoral care incorporates the training, knowledge, and experience drawn from various spiritual disciplines and practices.
Pastoral Counseling	A unique form of counseling that uses spiritual resources as well as psychological understanding for healing and growth. Certified pastoral counselors are licensed mental health professionals who also have in-depth religious and/or theological education or training. *(Appendix C, 66 b.)*
Peer Support	Groups of colleagues, co-workers, or para-professionals who might share similar experiences around a common topic or issue, creating opportunities for seeking help and sharing information about relevant resources and positive coping strategies. *(Appendix C, 15)*
Post-Traumatic Growth	Positive change after enduring a trauma or adversity. Such change can include relating to others, exploring new possibilities and choices, developing personal strength, developing spiritual strength, and developing a newfound appreciation of life. *(Appendix C, 5)*
Post-Traumatic Stress Disorder (PTSD)	This condition is described as occurring when a person has been exposed to a traumatic event in which both of the following are present: (1) experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self (for example, combat, friendly fire) or others (for example, seeing anyone who has been killed or injured), and (2) signs of re-experiencing, avoidance, negative cognitions and mood, and arousal are present. *(Appendix C, 3)*

Term	Definition
Postvention	Also known as tertiary prevention, postvention includes those response activities that should be undertaken in the immediate aftermath of a suicide that has impacted the unit. Postvention has two purposes: to help survivors of suicide and suicide attempt survivors cope with their grief and to prevent additional suicides. It also may be an opportunity to disseminate accurate information about suicide, encourage help-seeking behavior, and provide messages of resilience, hope, and healing. *(Appendix C, 30)*
Prevention	Also known as primary prevention; it is a strategy or approach that reduces the risk or delays the onset of adverse health problems, or reduces the likelihood that an individual will engage in harmful behaviors. *(Appendix C, 53)*
Protective Factors	Skills, strengths, or resources that help people deal more effectively with stressful events. Protective factors enhance resilience and help to counterbalance risk factors. Protective factors may be personal (e.g., attitudes, values, and norms prohibiting suicide) or external/environmental (e.g., strong relationships, particularly with family members). *(Appendix C, 53)*
Resilience	The ability to withstand, recover, and grow in the face of stressors and changing demands. *(Appendix C, 23)*
Risk Factors	Issues that make it more likely that an individual may attempt suicide. Factors could be biological, psychological, or social regarding the individual, family, or environment. Examples include, but are not limited to, history of one or more prior suicide attempts, exposure to the suicidal behavior of others, relationship problems/divorce, and drug and alcohol abuse. *(Appendix C, 54 and 66. e)*
Risk Mitigation	Reducing threat for suicidal ideation or behaviors. Examples include, but are not limited to, mental health screenings, counseling, and means reduction.
Secondary Trauma	Stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than direct exposure to the event itself. *(Appendix C, 66. l)*
Stigma (Suicide)	Negative perception by individuals that seeking mental health care or other supportive services will negatively affect or end their careers. *(Appendix C, 66. d)*
Stressors/ Triggering Events	Something that happens emotionally or in one's environment that causes stress. Examples include pending deployment, pending legal action, financial distress, failed relationship, military transitions, and death in the family. *(Appendix C, 66. d)*

Term	Definition
Suicide Attempt Survivor	An individual who attempts to die by suicide, but does not die. *(Appendix C, 55)*
Suicidal Contagion	A situation where knowledge of another person's suicidal act influences others to think about or attempt suicide. *(Appendix C, 55)*
Suicidal Ideation	Thinking about, considering, or planning for suicide. *(Appendix C, 66. e)*
Suicidal Intent	Evidence (obvious and/or implied) that at the time of injury the individual meant to kill himself or herself or wished to die and that the individual understood the probable consequences of his or her actions. *(Appendix C, 62)*
Suicide Prevention and Risk Reduction Committee (SPARRC)	DSPO established the SPARRC for the purpose of collaborating, communicating, and documenting suicide prevention best practices across the Department through members and participants. The SPARRC shall (a) serve as a collaborative forum of subject matter experts to facilitate the flow of information between the DSPO, Military Services, and other stakeholders for the exchange of best practices and lessons learned; (b) report to and advises the Director, DSPO on suicide prevention issues; identifies policy and program changes required to improve suicide-related programs; submits recommendations to the Director, DSPO for approval; and facilitate and implement action items approved by the Suicide Prevention General Officer Steering Committee; and (c) facilitate collaboration between federal partners such as the Department of Veterans Affairs (VA), Department of Health and Human Services, including the Substance Abuse and Mental Health Administration, Centers for Disease Control and Prevention, and National Institute of Mental Health.
Survivor of Suicide	A family member, friend, or immediate organizational member of a person who died by suicide. *(Appendix C, 66. c)*
Warning Signs	Noticeable behaviors that indicate a person may intend to engage in suicidal behavior very soon (minutes or days). *(Appendix C, 28)*

Appendix B: Other Commonly Used Self- Directed Violence Terms

Self-Directed Violence Classification System (Centers for Disease Control and Prevention, 2011)**

**On October 11, 2011, the Office of the Under Secretary of Defense issued a policy memorandum, subject: Standardized Suicide Nomenclature (Self-Directed Violence Classification System) Policy, implementing the use of the Self-Directed Violence Classification System developed by the Centers for Disease Control (CDC) and Prevention for future data collection, reporting, and/or system-wide comparisons between the Department of Defense and the Department of Veterans Affairs (See Appendix C). The referenced CDC document also lists prohibited terms relative to suicide.

Uniform Definitions

Term	Definition
Self-Directed Violence (Analogous to Self-Injurious Behavior)	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. This does not include behaviors such as parachuting, gambling, substance abuse, tobacco use, or other risk taking activities, such as excessive speeding in motor vehicles. These are complex behaviors, some of which are risk factors for SDV, but are defined as behavior that while likely to be life-threatening is not recognized by the individual as behavior intended to destroy or injure the self. These behaviors may have a high probability of injury or death as an outcome but the injury or death is usually considered unintentional. Self-directed violence is categorized into the following: • **Non-suicidal** (as defined below) • **Suicidal** (as defined below) *(Appendix C, 28 and 32)*
Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. Please see appendix for definition of implicit and explicit.
Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.
Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based on the available evidence.

Term	Definition
Suicide Attempt	A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
Interrupted Self-Directed Violence – by Self or by Other	**By self (in other documents may be termed "aborted" suicidal behavior).** A person takes steps to injure self but is stopped by self, prior to fatal injury. **By other.** A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act such as after the initial thought or after onset of behavior. *(Appendix C, 44)*

Additional Key Terms

Additional terms that may appear in other documents discussing self-directed violence or be important to know are defined below.

Term	Definition
Act	The performance of any function or the bringing about of any effect (e.g. A suicidal act may result in death (suicide), injuries, or no injuries) *(Appendix C, 58)*
Death of Undetermined Intent	A death whose manner is unclear when all available information is considered. *(Appendix C, 11)*
Direct	Pertaining to an association between a factor and a condition where the factor occurs prior to the condition, the change in the factor is correlated with a change in the condition and the correlation is not itself the consequence of the factor and the condition being correlated with some prior factor. *(Appendix C, 40)*
Distal Risk Factor	The underlying vulnerability that potentiates a characteristic, variable, or hazard which increases the likelihood of development of an adverse outcome which is measurable and precedes the outcome. *(Appendix C, 42)*

Term	Definition
Episode	A developed situation that is integral to but separate from a continuous narrative. *(Appendix C, 34)*
Explicit	Fully revealed or expressed without vagueness, implication, or ambiguity; leaving no question as to meaning or intent. *(Appendix C, 46)*
Fatal	Causing death. *(Appendix C, 58)*
Immediate Cause of Death	The final disease, injury, or complication directly causing death. *(Appendix C, 11)*
Implicit	Being without doubt or reserve, implied though not directly expressed; inherent in the nature of something. *(Appendix C, 46)*
Impulsivity	**Cognitive Impulsivity.** The intellectual or mental process which results in an act performed without delay, reflection, voluntary direction, or obvious control in response to a stimulus. **Behavioral Impulsivity.** An act performed without delay, reflection, voluntary direction, or obvious control in response to a stimulus. *(Appendix C, 2)*
Indirect	Pertaining to an association between a factor and a condition because both are related to some common underlying condition. *(Appendix C, 46)*
Inferred	To derive as a conclusion from facts or premises. *(Appendix C, 37)*

Term	Definition
Injury	A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical, and medical care. Psychological harm is excluded in this context. *(Appendix C, 34)*
Institution	An established organization or corporation, such as a hospital/urgent care center (emergency facility), mental health facility, clinic. *(Appendix C, 34)*
Intentional Self-Harm	Purposely self-inflicted poisoning or injury. *(Appendix C, 62)*
Non-Fatal	Not causing death. *(Appendix C, 58)*
Physical Injury	A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical, and medical care. Psychological harm is excluded in this context. *(Appendix C, 34)*
Precipitating Event	Factors associated with the definitive onset of a disease, illness, accident, behavioral response, or course of action(e.g. exposure to specific disease, circumstance, condition, or agent). *(Appendix C, 37)*

Term	Definition
Proximal Risk Factor	A measurable characteristic, variable, or hazard that increases the likelihood of development of an adverse outcome and is more immediately antecedent to the outcome, acting as a precipitant. *(Appendix C, 42)*
Rescueability	A term used in assessing a suicide act that indicates that the situation allowed for the possibility of intervention by others to prevent death. *(Appendix C, 59)*
Self-Harm Behavior/Self-Inflicted/ Self Injurious	The act of injuring oneself intentionally by various methods such as self-laceration, self-battering, taking overdoses, or exhibiting deliberate recklessness but with no intent to die. *(Appendix C, 55)*
Self-Harm Ideation	Any thought of or communication regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of intent to die. *(Appendix C, 50)*
Suicidal Ideation	Thoughts of engaging in suicide-related behavior. *(Appendix C, 55)*
Suicidal Intent	There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill self or wished to die and that the individual understood the probable consequences of his or her actions. *(Appendix C, 61)*
Suicidal Plan	A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; this will often include an organized manner of engaging in suicidal behavior such as a description of a time frame and method. *(Appendix C, 50)*
Underlying Cause of Death	The disease, injury, or complication, if any, that gave rise to the immediate cause of death. *(Appendix C, 11)*

Term	Definition
Undetermined Injury Incident	Events where available information is insufficient to enable a medical or legal authority to make a distinction between unintentional, self-directed, and assault. *(Appendix C, 61)*
Victim-Precipitated Assault or Homicide	An act in which a person engages in actual or apparent danger to others in an attempt to get oneself killed or injured. *(Appendix C, 49)*

Appendix C: References

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66. Partner Resources

Certain content and definitions were obtained from or informed by information on websites of the following organizations:

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b. American Association of Pastoral Counselors - http://www.aapc.org/
c. American Association of Suicidology - http://www.suicidology.org/
d. American Psychological Association Glossary - http://www.apa.org/research/action/glossary.aspx
e. Centers for Disease Control and Prevention - http://www.cdc.gov/
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Appendix D: Competency Development Process

The graphic on the following page depicts, at a high-level, the timeline and process through which this competency framework was developed. The effort began in August 2013 with a working group formed to serve as subject matter experts to provide input and vetting across all phases of the initiative. The working group included suicide prevention and resilience program managers and other key stakeholders and subject matter experts from several federal, non-federal and academia organizations.

The working group provided initial input regarding the competencies to be included in the competency framework as well as the target populations to be identified and addressed in the framework. DSPO training and competency modeling subject matter experts then conducted further research to update and refine this list of competencies and to identify competency components. This research included reviewing resources related to suicide prevention competencies. Appendix C includes resources. The working group reviewed and vetted the resulting competency framework.

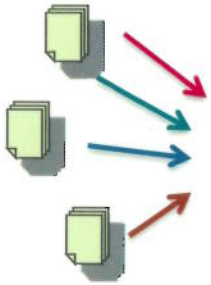
Since May 2014, DSPO coordinated with the suicide prevention working group to develop competency supporting content elements to support training curricula development. Since July 2014, the suicide prevention competency framework has been shared with SPARRC for review/feedback. Director, DSPO provided comments and approved the document to be formally staffed in March 2015.

Suicide Prevention (SP) Training - Competency Framework Development

Key Driver

Department of Defense Directive (DoDD) 6490.14:
The Director of the DSPO establishes core competencies for and oversees the effectiveness of suicide prevention training and shares best practices that comprehensively address all groups involved in prevention, intervention, postvention, and surveillance activities across the DoD

Data Call for Service-specific SP Training Competencies



Development and Vetting of Competencies and Target Populations (via Working Group)

Content Elements Research

Development and Vetting of Content Elements (via SPARRC & DSPO)

DoD Suicide Prevention Training Competency Framework

August 2013 — **May 2014** — **Dec 2014** — **March 2016**