DoD INSTRUCTION 6490.16

DEFENSE SUICIDE PREVENTION PROGRAM

Originating Component: Office of the Under Secretary of Defense for Personnel and Readiness

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Under Secretary of Defense for Personnel and Readiness Memorandum, "Guidance for Commanders and Health Professionals in the Department of Defense on Reducing Access to Lethal Means Through the Voluntary Storage of Privately-Owned Firearms," August 28, 2014

Under Secretary of Defense for Personnel and Readiness Memorandum, "Standardized Department of Defense Suicide Data and Reporting," March 14, 2014

Under Secretary of Defense for Personnel and Readiness Memorandum, "Standardized Department of Defense Suicide Data and Reporting," March 11, 2015

Directive-type Memorandum 16-001, "Policy for Reporting Suicides and Attempts of Service Members and Suicides of Service Members' Dependents," January 7, 2016

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Purpose: In accordance with the authority in DoD Directive (DoDD) 5124.02, this issuance:

- Establishes policies and assigns responsibilities for the DoD Suicide Prevention Program, pursuant to Section 533 of Public Law (PL) 112-81, Sections 580 through 583 of PL 112-239, and Section 567 of PL 113-291.

- Establishes procedures for the oversight and reporting of the DoD Suicide Prevention Program.
- Establishes policies for reporting suicides and suicide attempts of Service members, both Active Component and Selected Reserve (SELRES), and suicides of Service members' dependents, in accordance with Section 567 of PL 113-291.
- Establishes the Suicide Prevention General Officer Steering Committee (SPGOSC) and the Suicide Prevention and Risk Reduction Committee (SPARRC).
- Assigns responsibilities and prescribes procedures for the evaluation of effectiveness and outcomes of non-clinical suicide prevention activities.

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SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY. This issuance applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the National Guard Bureau (NGB), the Combatant Commands, the Office of Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this issuance as the "DoD Components").

1.2. POLICY. It is DoD policy that the DoD:

a. Protects the privacy of personnel seeking or receiving treatment relating to suicidal behavior, consistent with applicable standards, including DoD Instruction (DoDI) 5400.11, DoD 5400.11-R, DoD Manual (DoDM) 6025.18, and DoDIs 6490.04 and 6490.08. This includes data collected over the course of suicide prevention, intervention, and postvention activities.

b. Provides DoD Components with a training competency framework on suicide prevention.

c. Collects and consolidates surveillance data of suicides and suicide attempts for reporting and analysis for members of Active Component and SELRES, and for suicides by Service members' dependents using consistent collection, reporting, and analysis of suicides and suicide attempts. This includes suicide-related behaviors data from the Department of Defense Suicide Event Report (DoDSER) and the Annual Suicide Report (ASR) submitted by the DoD Components in a timely manner to support suicide prevention efforts.

d. Encourages unit memorial ceremonies and services when a Service member dies by suicide.

e. Implements the Department of Defense Strategy for Suicide Prevention (DSSP), which is modeled after the National Strategy for Suicide Prevention and encompasses the comprehensive policy on prevention of suicide among Service members, as required by Section 582 of PL 112-239.

1.3. INFORMATION COLLECTION. The Quarterly Suicide Report (QSR) and the DoDSER referred to in this issuance do not require licensing with an Office of Management and Budget (OMB) control number in accordance with Volume 2 of DoDM 8910.01.

1.4. SUMMARY OF CHANGE 3. The changes to this issuance are made in accordance with Section 726 of PL 117-81 requiring the use of standardized definitions of terms related to suicide, and implements actions informed by the Government Accountability Office Report 21-300 on evaluating program effectiveness through evaluation.

SECTION 2: RESPONSIBILITIES

2.1. EXECUTIVE DIRECTOR, FORCE RESILIENCY (EDFR). Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), the EDFR:

a. Oversees all suicide prevention programs, other than clinical programs under the purview of the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

b. Provides policy direction to, and oversight of, the DSSP.

c. Coordinates with the Director, DoD Human Resources Activity (DoDHRA), to ensure the Defense Suicide Prevention Program is adequately resourced.

d. Develops and issues policy and implementation guidance for suicide surveillance and reporting within the DoD, and recommends changes or revisions to the USD(P&R), the ASD(HA), the Director of the Defense Health Agency (DHA), or the Office of the Armed Forces Medical Examiner (AFMES).

e. Through the Director, Defense Suicide Prevention Office (DSPO), serves as the DoD point of contact for all OSD-level reports to Congress primarily concerning Service member and dependent suicide events.

f. Through the Director, DSPO, coordinates with the Secretaries of the Military Departments; the Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD(M&RA)); the Director, DHA; and the Director, DoDHRA, to receive data required for implementing DoD suicide prevention programs and monitoring existing surveillance data.

g. In coordination with the Director, DoDHRA, select for appointment a general officer/flag officer (GO/FO) or a member of the Senior Executive Service (SES) as the Director, DSPO.

h. Co-chairs or appoints a GO/FO or SES-equivalent to co-chair the SPGOSC, with a GO/FO or SES-equivalent appointed by the ASD(HA). May invite ad-hoc members as needed.

i. Through the Director, DSPO, oversees compliance with the requirements in this issuance, as outlined in DoDI 6400.09.

2.2. ASD (M&RA). Under the authority, direction, and control of the USD(P&R), the ASD(M&RA):

a. Directs the Deputy Assistant Secretary of Defense for Civilian Personnel Policy to obtain guidance from the DSPO on developing and executing non-clinical suicide prevention education and training for DoD civilian personnel, including civilian employees deployed in support of military operations and employees assigned outside the continental United States.

b. Reviews policies and procedures that affect suicide prevention and involve risk factors common to those associated with suicide, and coordinates these policies and procedures with the DSPO before they are issued.

c. Coordinates with the Director, DSPO; the Secretaries of the Military Departments; and the Chief, NGB, to ensure suicide prevention programs are implemented in accordance with Component's structure, demographics, and needs across the Active Component and SELRES.

d. Identifies unique issues of the Reserve Component and their members' dependents, communicates those needs to the Director, DSPO, and the Secretaries of the Military Departments, and works to bridge gaps to meet the needs of the Reserve Component and their members' dependents.

e. Designates, in writing, a primary and alternate GO/FO, SES, or equivalent level person with direct access to senior leadership and an understanding of the Reserve Component's suicide prevention needs, to actively serve as a member of the SPGOSC.

f. Designates, in writing, a subject matter expert who is a military member or full-time or part-time Federal employee to actively serve as a member of the SPARRC and its working groups.

2.3. DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR MILITARY COMMUNITY AND FAMILY POLICY. Under the authority, direction, and control of the ASD(M&RA), the Deputy Assistant Secretary of Defense for Military Community and Family Policy:

a. Collaborates with the DSPO on issues related to the prevention of suicide for family members and dependents of Service members, including:

(1) Any policies, procedures, or guidance related to family members and suicide prevention and awareness.

(2) Military Community and Family Policy efforts that address risk factors common to those associated with suicide.

b. Incorporates evidence-based suicide prevention programs or content into family and youth programs, when appropriate.

c. Oversees suicide prevention training and resources to families.

d. Provides the DSPO with family programs data, when requested, to help assess the effectiveness of the DoD's suicide prevention efforts.

2.4. DIRECTOR, DODHRA. Under the authority, direction, and control of the USD(P&R), the Director, DoDHRA:

a. Coordinates with the EDFR on the operational responsibilities of the Director, DSPO.

b. Supports the DSPO with human resources matters, budgetary matters, civilian personnel policy, and legal matters.

c. Through the Director, Defense Manpower Data Center (DMDC), compiles available data on suicides by military dependents and provides information to the DSPO from the Defense Enrollment Eligibility Reporting System (DEERS).

2.5. DIRECTOR, DSPO.

a. Policy Responsibilities. Under the authority, direction, and control of the Director, DoDHRA, and with guidance on policy implementation from the EDFR, the Director, DSPO:

(1) Assists the EDFR in the development of DoD non-clinical suicide prevention programs that promote and enhance suicide prevention, intervention, and postvention with the goal of reducing stigma and increasing the awareness to facilitate help-seeking behaviors.

(2) Oversees the Military Services and NGB's compliance of non-clinical suicide prevention activities in accordance with this issuance and DoDI 6400.09.

(3) Serves as the DoD's primary point of contact for DoD-wide responses to Congressional hearings, reports, and other mandates, as well as other inquiries concerning non-clinical suicide prevention.

(4) Fosters, in accordance with applicable law and DoD regulations, collaboration and cooperation among external stakeholders, such as other Federal Agencies (e.g., Department of Veterans Affairs, Department of Health and Human Services); non-governmental organizations (nonprofit organizations and private organizations); international entities; and institutions of higher education to develop suicide prevention through activities such as conferences, working groups, and other collaborative mechanisms.

(5) In collaboration with the Secretaries of the Military Departments, develops and implements a comprehensive strategic communications plan to promote effective suicide prevention messaging within the DoD.

(6) Analyzes and assesses DoD-wide surveillance data (by using information through established data systems, research studies, and pilot programs) and research activities related to suicidal and other high-risk behaviors to identify risk factors and key outcomes and inform suicide prevention policies and programs. Evaluates and incorporates suicidal behavior-related research into suicide prevention policies and programs. Research efforts include:

(a) Participating in other organizations' working groups, committees, and panels tasked with identifying and funding research in this field, with the aim of avoiding redundancies.

(b) Funding research gaps identified by the Military Services and other DoD stakeholders, to the extent feasible within the DSPO's budget.

(c) Collaborating with the Uniformed Services University of the Health Sciences on DoD standards and procedures for collection of suicide-related data.

(7) Oversees the development and distribution of the ASR. Publishes the ASR each calendar year to internal and external stakeholders.

(8) Serves as the Executive Secretary of the SPGOSC.

(9) Designates, in writing, the chair of the SPARRC.

(10) Develops policy guidance for DoD suicide prevention, competencies, and education for DoD personnel.

(11) Develops, publishes, monitors, and disseminates a comprehensive DSSP.

(12) Uses the public health approach to address suicide prevention.

(13) Serves as the USD(P&R)'s point of contact for receiving suicide data, analysis, and reports from the Director, DHA, and the DoD Components.

b. Operational Responsibilities. Under the authority, direction, and control of the Director, DoDHRA, and in coordination with the EDFR, the Director, DSPO:

(1) Leads, guides, and oversees the Defense Suicide Prevention Program.

(2) Provides technical assistance to DoD stakeholders to build or identify suicide prevention program requirements, and funding to minimize program gaps and to review and reduce duplication and redundancies.

(3) With the Department of Veterans Affairs and Centers for Disease Control and Prevention, creates, implements, and maintains an interagency suicide data repository, Military Mortality Database in accordance with the procedures in Volume 1 of DoDM 8910.01, to ensure the comprehensive surveillance and analysis of suicide across the Military Services.

(4) Establishes minimum standardized data elements for collecting, reporting, and disseminating data about suicidal behaviors, and sets standards consistent with DoDI 5400.11, DoD 5400.11-R, and DoDM 6025.18 for publically releasing data across the DoD quarterly, annually, and as needed.

(a) Provides guidance to the Secretaries of the Military Departments on the analysis and reporting of validated data on confirmed and pending cases of suicidal behaviors.

(b) Works with the Director, AFMES, to receive validated data on confirmed and pending cases of death from suicide by Service members.

(c) Collaborates with the Secretaries of the Military Departments to obtain information on and report deaths by suicide when not in a duty status.

(5) Provides non-clinical suicide prevention and resource information to the OSD Military-Civilian Transition Office for incorporation into transition goals, plans, and success programming for eligible Service members, pursuant to Section 1142 of Title 10, United States Code (U.S.C.) and provides representation to the OSD Military-Civilian Transition Office councils and working groups, as necessary.

(6) Provide oversight of the evaluation of DoD non-clinical suicide prevention activities in accordance with this issuance.

(7) Use the "Guidance Questions" section of Table 1 to review submitted evaluation plans for non-clinical suicide prevention activities.

(8) Annually convene a meeting for the Military Departments and NGB to share progress and results from ongoing and completed evaluations of non-clinical suicide prevention activities.

(9) Coordinates with the Secretaries of the Military Departments and Chief, NGB on the evaluation of DoD non-clinical suicide prevention activities to:

(a) Identify metrics, and data sources when relevant, to be used for DoD-wide evaluation of non-clinical suicide prevention activities.

(b) Share results with the DoD Prevention Collaboration Forum as identified in DoDI 6400.09, and other DoD stakeholders to inform policy and program decisions.

(c) Identify and support other means of oversight to include site visits in collaboration with the DoD Prevention Collaboration Forum.

2.6. DIRECTOR, DMDC. Under the authority, direction, and control of the Director, DoDHRA, the Director, DMDC:

a. Provides suicide-related data and analytic support to the Director, DSPO, as requested.

b. Manages the Military Mortality Database to track deaths and causes of deaths of DoD military personnel and maintains a data repository for dependent deaths, to enable thorough analysis and inform policies on the prevention of suicides. The database will include deaths during the Service member's period of service and deaths after separation or retirement, to the extent such information is available.

c. Provides Service-specific and aggregate personnel end strength, demographic, and other Service-related information to the Director, AFMES, to complete and standardize the data files required to calculate annual suicide rates.

d. Compiles available data on suicides by military dependents and provides information to the DPSO and the Services' suicide prevention offices from DEERS, in accordance with Section 567 of PL 113-291.

2.7. ASD(HA). Under the authority, direction, and control of the USD(P&R), and in accordance with DoDD 5136.01 and DoDI 1010.10, the ASD(HA):

a. Supports the EDFR on healthcare-related aspects of suicide prevention policies and programs.

b. In coordination with the EDFR and the Director, DSPO, supports DoD-wide suicide prevention, intervention, postvention, surveillance, investigative activities, and research.

c. Supports disseminating and messaging for adopting core education and training guidelines on preventing suicide and suicide-related behaviors by all health professions, including graduate and continuing education entities developed by the DSPO and DHA.

d. Ensures that the Military Departments provide uniformed behavioral health professionals suicide prevention training as part of internship, residency, fellowship, and continuing medical education programs.

e. Appoints a GO/FO or SES-equivalent to co-chair the SPGOSC with EDFR and may invite ad-hoc members as needed.

2.8. DIRECTOR, DHA. Under the authority, direction, and control of the USD(P&R) through the ASD(HA), and in accordance with DoDD 5136.13, the Director, DHA:

a. Integrates the use of evidence-based programs and strategies related to suicide prevention and clinical intervention across the Military Health System.

b. Coordinates and collaborates with the DSPO to promote suicide prevention, non-clinical and clinical intervention, and postvention efforts.

c. Evaluates DoD clinical suicide prevention programs.

d. Designates, in writing, a subject matter expert to actively serve as a member of the SPARRC and its working groups.

e. Requires the Department of Veterans Affairs and DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide to be widely distributed within the Military Health System, and for related clinical support tools and training to be readily available to providers.

f. Monitors and evaluates the Military Health System's effectiveness of current evidence-informed diagnostic tools and treatment methods as outlined in the Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide.

g. Requires DHA-administered warrior care programs to:

(1) Incorporate suicide prevention into the care of wounded warriors and submit suicide-related data collected in the Disability Evaluation System to the Director, DSPO, as requested.

(2) Provide:

(a) The suicide prevention training framework to recovery care coordinators, quarterly.

(b) A copy of all suicide-related training curricula and materials to the Director, DSPO, annually.

(3) Support and assist Service members and their families with suicide prevention, intervention, and postvention.

2.9. CHIEF, PSYCHOLOGICAL HEALTH CENTER OF EXCELLENCE (PHCOE). Under the authority, direction, and control of the Director, DHA, the Chief, PHCoE:

a. When requested, provides data to the DSPO for data surveillance and evaluation of non-clinical suicide prevention efforts, in accordance with DoDM 6025.18.

b. Oversees all DoDSER inputs and requires data to be thoroughly checked for accuracy and submitted in accordance with timelines established by the USD(P&R).

c. Disseminates the annual DoDSER by July 31 for each calendar year to internal and external stakeholders.

d. Reports to the DoD Components on populations at risk and other key demographic information on a quarterly basis.

e. Maintains the DoDSER to collect, store, and report all suicide and identified suicide attempt information for all Service members, including Reserve Component members.

f. In coordination with the EDFR, collects demographic information from the DMDC on Service members who attempt suicide as reported by the Military Services through the AFMES.

g. Consolidates data for all Service member suicide attempts on a quarterly basis and provides aggregate count information to the DSPO on a quarterly basis before the last business day of the month after the quarter ends.

h. Designates, in writing, a subject matter expert to actively serve as a member of the SPARRC and its working groups.

2.10. DIRECTOR, AFMES. Under the authority, direction, and control of the Director, DHA, the Director, AFMES:

a. Verifies and reports deaths by suicides for the Active Component and, to the extent applicable, the Reserve Component, to the Military Services, the Chief, PHCoE, the DMDC, and the Director, DSPO.

b. Provides suicide-related data to the DSPO.

c. Designates, in writing, a subject matter expert to actively serve as a member of the SPARRC.

d. Completes and standardizes the data files required to calculate annual suicide rates.

2.11. DIRECTOR OF THE DOD EDUCATION ACTIVITY (DODEA). Under the authority, direction, and control of the USD(P&R) through the ASD(M&RA), the Director, DoDEA:

a. Oversees and delivers an evidence-based suicide prevention training to students and staff in DoDEA schools and annually submits a copy of all training curriculum and materials to the Director, DSPO.

b. Submits the number of suicide attempts and suicides by DoDEA students to the DSPO annually.

2.12. ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS (ATSD(PA)). In coordination with the USD(P&R), the ATSD(PA):

a. Develops guidance and tools for DoD leadership for engaging with media on suicides in accordance with DoDD 5122.05.

b. Publicizes DoD efforts for suicide prevention (e.g., suicide prevention month).

c. Supports the Director, DSPO, in developing, coordinating, and disseminating messages focused on suicide prevention, intervention, postvention, and surveillance to support stigma reduction and reduce the potential for suicide contagion.

d. Assists the Director, DSPO, in addressing media inquiries on DoD suicide prevention, intervention, and postvention efforts.

e. Coordinates with the Director, DSPO, before releasing any messages concerning suicide policies, programs, and statistics.

2.13. DIRECTOR OF THE DEFENSE MEDIA ACTIVITY. Under the authority, direction, and control of the ATSD(PA), the Director, Defense Media Activity:

a. Trains all new public affairs officers on effective suicide prevention messaging to reduce suicide events.

b. In coordination with the DSPO, provides a wide variety of information on suicide prevention to the entire DoD family (i.e., Active Component, National Guard, and Reserve Service members, dependents, retirees, and DoD civilians) as well as to external audiences through all available media.

c. Communicates messages and themes on suicide prevention from DoD senior leaders (i.e., Secretary of Defense, Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff, Military Service Chiefs, and Combatant Commanders) in order to support and improve quality of life and morale, promote situational awareness, provide timely and immediate force protection information, and sustain readiness.

d. Provides broadcast, written, and multi-media information related to suicide prevention to:

(1) Active Component, National Guard, and Reserve Service members.

(2) DoD civilians.

(3) DoD dependents.

(4) Individuals assigned, attached, or embarked aboard U.S. Navy vessels.

2.14. GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE. The General Counsel of the Department of Defense provides legal advice and assistance on all matters affecting the mission and responsibilities of the Defense Suicide Prevention Program.

2.15. UNDER SECRETARY OF DEFENSE FOR INTELLIGENCE AND SECURITY. The Under Secretary of Defense for Intelligence and Security establishes DoD policy regarding the safeguarding and protection of firearms on military installations.

2.16. ASSISTANT SECRETARY OF DEFENSE FOR SPECIAL OPERATIONS AND LOW INTENSITY CONFLICT. The Assistant Secretary of Defense for Special Operations and Low Intensity Conflict:

a. Directs the Commander, United States Special Operations Command to implement suicide prevention policies and programs that address prevention, intervention, and postvention, in accordance with this issuance and the DSSP.

b. Directs the Commander, United States Special Operations Command to develop a special operations forces-specific suicide prevention policy and program that addresses prevention, intervention, and postvention, in accordance with this issuance and the DSSP.

c. Coordinates with the Secretaries of the Military Departments to promote and assist in suicide prevention, intervention, and postvention efforts.

d. Designates, in writing, a primary and alternate GO/FO, SES, or equivalent level person with direct access to senior leadership to actively serve as a member of the SPGOSC.

e. Designates a subject matter expert to actively serve as a member of the SPARRC and its working groups.

f. Develops evaluation plans for special operations forces-specific non-clinical suicide prevention activities in accordance with Section 7 of this issuance.

g. Ensures that prevention personnel at the command level are empowered and supported by military leaders to implement data-informed actions, as described in DoDI 6400.09.

2.17. DOD COMPONENT HEADS. The DoD Component heads ensure all DoD issuances, regulations, policies, guidance, trainings, resources, manuals, and reports use the standardized definitions for suicide, suicide attempt, and suicide ideations as noted in the Glossary of this issuance.

2.18. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

a. Implement a suicide prevention policy and program that addresses prevention, intervention, and postvention, in accordance with this issuance and the DSSP.

b. Oversee Military Department implementation of the guidance in this issuance and the DSSP for the Active and Reserve Components.

c. In accordance with DoDI 6400.09, adequately staff, fund, and maintain a Service-level suicide prevention program that includes a designated military or civilian person at the command or installation level, whose duties include implementation and oversight of the command or installation suicide prevention program.

d. Provide guidance for collecting suicide-related event data.

e. Allow military criminal investigative organizations to investigate noncombat deaths, in accordance with DoDI 5505.10.

f. Designate, in writing, a primary and alternate GO/FO, SES, or equivalent level person with direct access to senior leadership to actively serve as a member of the SPGOSC.

g. Designate representatives, at least one per Service, to actively serve as members of the SPARRC and its working groups.

h. Establish policies and procedures to ensure the deaths of dependents of Active and Reserve Component Service members are accurately reported and documented in DEERS.

i. Ensure Service members, and civilians are aware of resources for suicide prevention, intervention, and postvention available on military installations. Ensure commanders (or civilian equivalents) are prepared to refer individuals who are not entitled to use military treatment facilities to appropriate suicide prevention, intervention, and postvention resources.

j. Support DSPO's annual suicide death review by providing data elements to the Director, DSPO, within 90 days post AFMES confirmation. Data elements include personnel file,

contingency tracking system deployment file, medical files, social media data (if available), and a criminal investigation report. The criminal investigation report will be provided within 30 days of the report being completed by the military criminal investigative organization concerned.

k. Develop evaluation plans for non-clinical suicide prevention activities in accordance with Section 7 of this issuance.

l. Ensure that prevention personnel at the command and installation level are empowered and supported by military leaders to implement data-informed actions as described in DoDI 6400.09.

m. Annually establish a 1 to 5-year evaluation plan for at least one new or ongoing non-clinical suicide prevention activity. Such plans must be submitted to DSPO within 90 days of issuance publication and by September 30 annually thereafter.

n. Ensure that evaluation plans adhere to the procedures outlined in this issuance.

o. Submit changes to a previously submitted plan to DSPO within 90 days of change.

p. Participate in an annual meeting with the DSPO, Military Departments, and NGB to share progress and results from ongoing and completed evaluations of non-clinical suicide prevention activities.

2.19. CHAIRMAN OF THE JOINT CHIEFS OF STAFF. The Chairman of the Joint Chiefs of Staff:

a. Supports Combatant Command coordination efforts with the Services to promote and assist in suicide prevention, intervention, and postvention efforts.

b. Designates, in writing, a primary and alternate GO/FO, SES, or equivalent level person with direct access to senior leadership to actively serve as a member of the SPGOSC.

c. Designates, in writing, a subject matter expert to actively serve as a member of the SPARRC and its working groups.

2.20. MILITARY SERVICE CHIEFS. Under the authority, direction, and control of the Secretaries of the Military Departments, the Military Service Chiefs:

a. Promote total force fitness and resilience in accordance with Chairman of the Joint Chiefs of Staff Instruction 3405.01.

b. Promote opportunities for the families of Service members to participate in suicide prevention activities.

c. Ensure the Military Services' suicide prevention efforts are implemented and in alignment with the DSSP.

d. Provide resources for combatting stigma, training and programs for suicide prevention, intervention, and postvention.

e. Ensure Service healthcare providers (including behavioral and mental health providers) meet ASD(HA) policies, guidelines, and requirements for suicide prevention competency and training requirements.

f. Ensure that professional military education, ranging from basic training to senior Service schools, develops leaders with the interpersonal and leadership skills required to fulfill their leadership and mentoring responsibilities relative to suicide prevention, and promotes the well-being and total fitness of the Service members. Develop and distribute core-curriculum content to Service schools to support professional military education requirements.

g. Oversee suicide prevention education and training that promotes help-seeking behaviors, identifying risk factors, resilience and coping methodologies, strengthens Service members, and enables interventions to Service civilian supervisors that focuses on referral techniques and protocols for their employees.

h. Oversee policies that encourage family members to seek help and to attend suicide prevention training.

i. Direct commanders at all levels to:

(1) Provide suicide prevention training to all members of the organization at a frequency determined by the Military Service concerned.

(2) In accordance with DoDI 6400.09, develop and implement postvention guidance for subordinate organizations to follow after a suicide.

j. For Military Departments that have different training requirements by Component, direct the commanders of Reserve Component organizations, through the direction and control of the Secretaries of the Military Departments and the NGB, to implement a suicide prevention program comparable to the Active Component, as directed by the Secretaries of the Military Departments:

(1) Develop strategic messaging on suicide prevention, intervention, and postvention efforts that promote a holistic approach to suicide prevention.

(2) Require Reserve Component clinical service providers to receive training on suicide prevention and related behaviors.

k. Provide a Service-wide suicide prevention education and training program as a separate or combined part of an overall training program.

l. Inform civilian employees and those civilian employees deployed of support resources at their present and deployed locations outside the continental United States.

m. Ensure a DoDSER is submitted for each suicide event occurring among their respective Service members. DoDSERs for suicides will be due within 60 days from notification that the death has been confirmed as a suicide by AFMES. DoDSERs for suicide attempts will be due within 30 days of the event.

n. Support DSPO's research initiatives by ensuring, in accordance with law and DoD regulations, access to criminal investigation files after a suicide, including, but not limited to, personnel file, contingency tracking system deployment file, medical files, and social media data. The criminal investigation files that include all information available will be provided within 30 days of the report being completed by the military criminal investigative organization concerned.

o. Through their Suicide Prevention Program Manager (SPPM):

(1) Represents the Service suicide prevention program at internal DoD and external meetings.

(2) Promotes and fosters suicide prevention, intervention, and postvention efforts within each Service.

(3) Serves as a member of the SPARRC and its working groups.

(4) Verifies the accuracy of all Service suicide data (confirmed and pending suicides) for the QSR and ASR.

2.21. CHIEF, NGB. The Chief, NGB:

a. Establishes policies for providing National Guard members with State and local suicide resources at the community level.

b. In collaboration with State Adjutant Generals, ensures National Guard members receive training on suicide prevention and the availability of DoD, State, and local resources.

c. Monitors the appointment of coordinators at the State and local levels to promote and foster suicide prevention, intervention, and postvention efforts.

d. Designates, in writing, a primary and alternate GO/FO, SES, or equivalent level person with direct access to senior leadership and an understanding of the National Guard's suicide prevention needs to actively serve as a member of the SPGOSC.

e. Designates, in writing, an SPPM to:

(1) Actively serve as a member of the SPARRC and its working groups. While the NGB has one vote, SPPMs from both the Army National Guard and Air National Guard are welcome to serve as non-voting members.

(2) Coordinate with the Director, DSPO and the Secretaries of the Military Departments to identify metrics and feasible data sources to be used for DoD-wide evaluation efforts.

f. On behalf of and in coordination with the Secretaries of the Army and Air Force, develops evaluation plans for non-clinical suicide prevention activities in accordance with Section 7 of this issuance.

g. Ensures that prevention personnel at the command and installation level are empowered and supported to implement data-informed actions as described in Paragraph 3.2 of DoDI 6400.09.

2.22. COMBATANT COMMANDERS. In coordination with the Chairman of the Joint Chiefs of Staff and the Military Service Chiefs, the Combatant Commanders:

a. Support Military Service suicide prevention programs and training.

b. Incorporate suicide prevention considerations into joint planning efforts.

c. To the maximum extent practicable, make integrated services (e.g., chaplain support, medical services, family support services) available to all members in their respective areas of responsibility, including deployed locations.

SECTION 3: STANDARDIZED DOD SUICIDE DATA AND REPORTING

3.1. PURPOSE. Standardized data for the reporting of suicides by Service members is extremely important when reporting suicide rates. This section establishes the guidance and procedures for standardized DoD Component data and reporting within the Military Services and the DoD.

3.2. GUIDANCE.

a. The Military Services and the DoD must report all suicide data in accordance with the procedures contained in this issuance. AFMES is the official DoD-wide entity responsible for confirming active duty suicides. For the purpose of DoDSER reporting, include all suicide attempts that occurred during the period of Military Service. Nothing in this issuance affects the Military Services' obligation to make line-of-duty determinations for purposes under Sections 1447 through 1455 of Title 10, U.S.C. and Military Service regulations.

b. AFMES makes a determination on a pending suicide case after reviewing available investigative reports and any available incident information that is entered into the Defense Casualty Information Processing System by Military Service casualty case managers.

(1) If little or no information is provided, AFMES contacts its medical examiners or other personnel to obtain additional information. If a Service member died in a civilian jurisdiction, AFMES contacts the local coroner's office to obtain further information.

(2) If a discrepancy occurs between AFMES and the Military Services, the two parties will share information and identify the reliability of the source to determine whether to confirm the suicide. Adjudication will take place between the Military Service and AFMES.

c. The AFMES medical examiner autopsy report determines a confirmed suicide for members of the Active and Reserve Components and National Guard members on active duty.

(1) SELRES not on active duty suicides will be counted and reported in conjunction with the Military Service's mortuary affairs office.

(2) Reconciliation between AFMES and the Military Services is conducted using autopsy reports as the primary means to determine cause and manner of death.

d. The Military Services will obtain DoD Component strength figures exclusively from the DMDC to ensure consistent inclusion and exclusion criteria of Service members. This allows comparison of suicide rates among Service Components. The Military Services will obtain population data monthly from the DMDC with month-end strength. Each DoD Component population for the prior calendar year will be averaged to obtain the average DoD Component population during the calendar year. This population data will be used to calculate the calendar year annual rate.

e. National Guard and Reserve suicide rates will include only the SELRES and will not include the Individual Ready Reserve and the Inactive National Guard.

f. Service member suicides that occur within 120 days after a Service member is placed on Temporary/Permanent Disability Retired List status or the Temporary/Permanent Disability Retired List population at large will not be included when calculating the DoD Component rates, because the Department of Veterans Affairs may report these statistics.

g. The DSPO will publish the QSR within 90 days of the end of the quarter and the ASR each year.

3.3. PROCEDURES.

a. The Military Services will designate personnel to provide quarterly and annual data on confirmed and pending cases of suicides to the Director, AFMES, in accordance with the procedures in this issuance. The Military Services will:

(1) Designate trained personnel to complete a DoDSER entry for all confirmed and suspected suicides and suicide attempts.

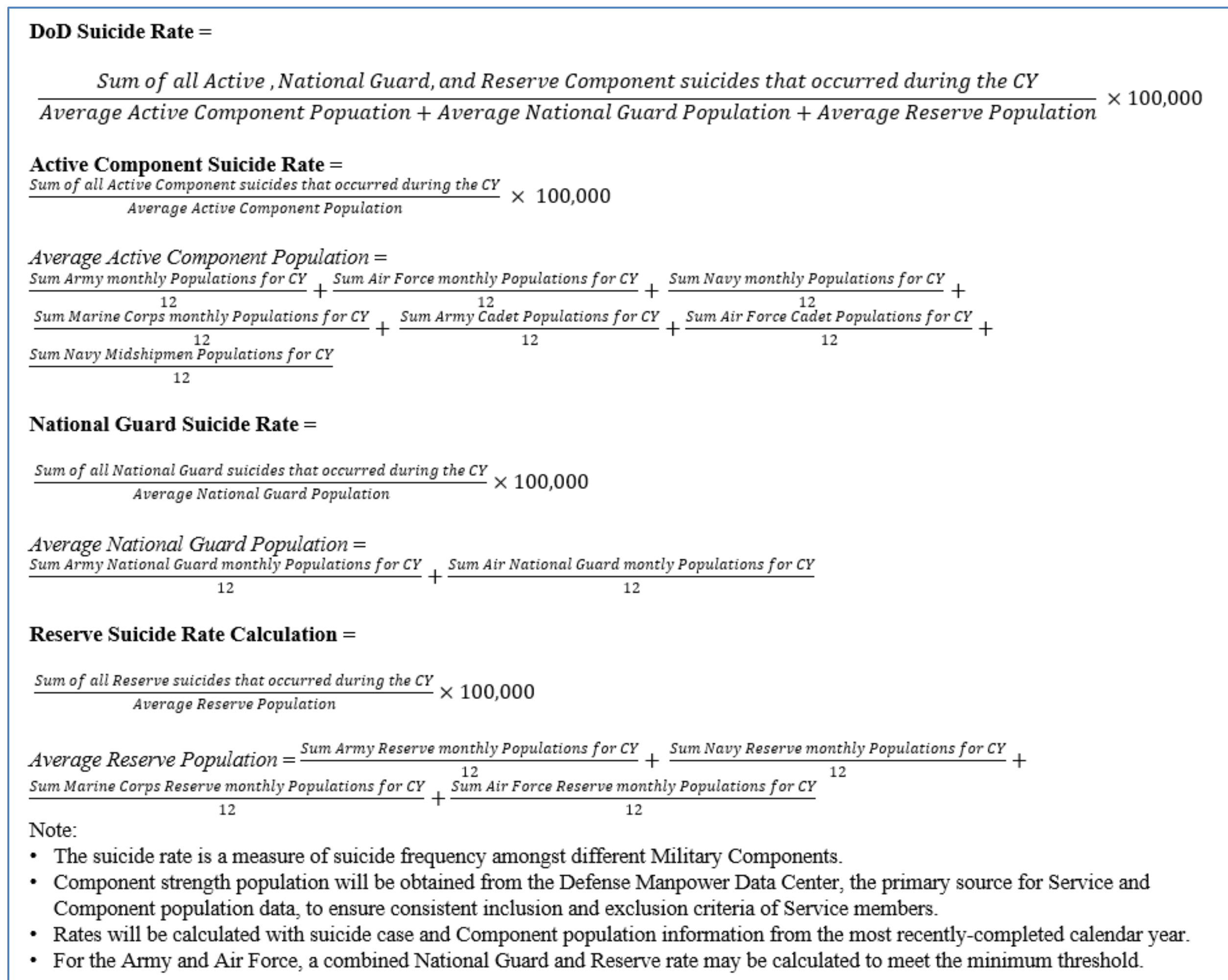
(2) Direct the establishment of a suicide event board at the command or installation level.

(3) Designate personnel to update the cause and manner of death in the Defense Casualty Information Processing System within 15 days after the AFMES makes a final determination.

b. AFMES will calculate annual suicide rates for the Active and Reserve Components and provide DSPO with finalized suicide counts and rates no later than June 30 each year. The Active Component suicide rate includes active members and cadets and midshipmen at the designated military academies.

c. How to calculate each rate is described in Figure 1.

Figure 1. Suicide Rate Calculation



DoD Suicide Rate =

$$\frac{\text{Sum of all Active, National Guard, and Reserve Component suicides that occurred during the CY}}{\text{Average Active Component Popuation} + \text{Average National Guard Population} + \text{Average Reserve Population}} \times 100{,}000$$

Active Component Suicide Rate =

$$\frac{\text{Sum of all Active Component suicides that occurred during the CY}}{\text{Average Active Component Population}} \times 100{,}000$$

Average Active Component Population =

$$\frac{\text{Sum Army monthly Populations for CY}}{12} + \frac{\text{Sum Air Force monthly Populations for CY}}{12} + \frac{\text{Sum Navy monthly Populations for CY}}{12} + \frac{\text{Sum Marine Corps monthly Populations for CY}}{12} + \frac{\text{Sum Army Cadet Populations for CY}}{12} + \frac{\text{Sum Air Force Cadet Populations for CY}}{12} + \frac{\text{Sum Navy Midshipmen Populations for CY}}{12}$$

National Guard Suicide Rate =

$$\frac{\text{Sum of all National Guard suicides that occurred during the CY}}{\text{Average National Guard Population}} \times 100{,}000$$

Average National Guard Population =

$$\frac{\text{Sum Army National Guard monthly Populations for CY}}{12} + \frac{\text{Sum Air National Guard montly Populations for CY}}{12}$$

Reserve Suicide Rate Calculation =

$$\frac{\text{Sum of all Reserve suicides that occurred during the CY}}{\text{Average Reserve Population}} \times 100{,}000$$

$$\text{Average Reserve Population} = \frac{\text{Sum Army Reserve monthly Populations for CY}}{12} + \frac{\text{Sum Navy Reserve monthly Populations for CY}}{12} + \frac{\text{Sum Marine Corps Reserve monthly Populations for CY}}{12} + \frac{\text{Sum Air Force Reserve monthly Populations for CY}}{12}$$

Note:
- The suicide rate is a measure of suicide frequency amongst different Military Components.
- Component strength population will be obtained from the Defense Manpower Data Center, the primary source for Service and Component population data, to ensure consistent inclusion and exclusion criteria of Service members.
- Rates will be calculated with suicide case and Component population information from the most recently-completed calendar year.
- For the Army and Air Force, a combined National Guard and Reserve rate may be calculated to meet the minimum threshold.

3.4. RATE CALCULATION AND REPORTING REQUIREMENTS AND TRACKING AND REPORTING RULES.

a. This reporting includes Active Component and drilling and training National Guard and Reserve members, individual mobilization augmentees, and full-time support Active Guard and Reserve personnel.

b. The AFMES reports suicide numbers to DSPO and DMDC on a weekly basis, with inputs from the Military Service suicide prevention programs.

c. The Military Services will report cause and manner of death, if known, for suicide deaths of members not in a duty status to AFMES. Suicide counts will be published in the QSR on the last day of the reporting quarter. Because of the inability to confirm all suspected suicides, and because of potential delays in reporting, the QSR will update the suicide counts by Service Components for previous quarters, as necessary, due to newly received information. Data reported will have appropriate caveats to alert readers to the potential for future updates.

d. Each Military Service will report to AFMES the number of suicide deaths from within the Active Component, SELRES, and members of the Reserve Component not in a duty status no later than 15 calendar days after the end of the quarter, to the extent such information is available.

e. The DSPO will publically disseminate DoD quarterly reports, which summarize quarterly inputs from the Military Services, no later than the end of the quarter following the reporting period.

f. The DSPO will publish in the ASR the official suicide counts and suicide rates for both Active and Reserve Components.

g. Suicides involving National Guard and Reserve Service members while on active duty, actively drilling, or in a civilian status will be included in the respective National Guard and Reserve suicide rates.

h. Military Service component rates will not be calculated when the number of suicides is less than 20. Instead, only the number of suicides will be reported.

i. Each Military Service, NGB, and other Components will ensure reports reflect the standardized definitions for suicide, suicide attempt, and suicide ideation as noted in the Glossary of this issuance.

SECTION 4: REPORTING SUICIDES OF SERVICE MEMBERS' DEPENDENTS

4.1. PURPOSE. The procedures contained in this section will be used to comply with Section 567 of PL 113-291. The DoD employs a comprehensive data collection approach that integrates dependent data from DEERS, the National Death Index, and the Military Services.

4.2. PROCEDURES.

a. Military sponsors must report dependent suicide deaths to the nearest installation DEERS Real-Time Automated Personnel Identification System Office within 30 days of receiving the final death certificate.

b. DEERS verifying officials will scan the death certificate into the DEERS database.

c. Verifying officials will ensure that dependents' suicide deaths are captured accurately by selecting "suicide" from the manner of death drop-down menu in DEERS.

d. DMDC will:

(1) Use data from the DEERS database to access dependent suicide data that will be used to identify the manner of death, and any other data relevant to suicides of dependents.

(2) Provide record-level dependent suicide data (e.g., social security number, full name, and death date) on a quarterly basis no later than 15 calendar days after the end of the quarter to the DSPO, in accordance with Paragraph 2.18.j of this issuance.

e. The Military Services will provide record-level death data (e.g., social security number, full name, and death date) on each dependent captured in a Service-specific database to the DSPO no later than 30 days after the end of each calendar year quarter, if such information is available.

SECTION 5: UNIT MEMORIAL CEREMONIES AND SERVICES

5.1. PURPOSE. Unit memorial ceremonies and services honor the service of Service members who have died and offer support to unit survivors and family members. These memorial events assist survivors and family members in dealing with the realities of death by allowing them a means for expressing their grief, receiving condolences, and beginning the healing process.

5.2. GUIDANCE.

a. 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.

b. A memorial event should offer the opportunity to provide closure for members of the unit organization. Even in the case of a death by suicide, a commander's (or equivalent leader's) remarks can serve to reinforce the value of life, underscore the loss felt by members of the unit organization, encourage others to seek appropriate help, and highlight the ongoing need to care for all. Commanders (or equivalent leaders) are encouraged to ask for professional advice and input from unit-assigned chaplains and other key unit organization leaders.

c. Unit organization commanders (or equivalent leaders) should inform family members of the deceased about any unit organization memorial event that is conducted in a deployed environment, and invite the family to attend unit organization memorial events at the home station as appropriate.

d. Certain types of public communication after a suicide could possibly increase or decrease the suicide risk of those receiving communications. Therefore, the memorial service should avoid idealizing the act or method of suicide. It is appropriate to comment on any positive accomplishments that the Service member may have done while in Service. All public statements will appropriately respect the privacy of family members of the deceased.

(1) If conducted improperly, a memorial service may lead to glorification of the suicide event and potentially trigger contagion events among personnel with identified or unidentified suicide risk. Therefore, memorial services should avoid commenting on method or manner of death, or idealizing any actions that may have contributed to the death by suicide.

(2) A memorial service can help with reducing contagion and help participants cope with guilt and anger. The memorial service should:

(a) Comfort the grieving.

(b) Provide a eulogy appropriate to the Service member, family, and circumstances, in a similar manner as for other Service member deaths; one that reflects any relevant strengths or accomplishments, while not idealizing the manner of death or any traits that might have contributed to the death.

(c) Ensure that there is no public comment on the specific circumstances surrounding the death, such as the manner used in the suicide, or speculation as to the reasons for the suicide. Any comments on the death should be matter-of-fact and general, in a similar manner, for example, as one would talk about the sudden loss of a Service member from a motor vehicle accident.

(d) Encourage Service members or family members to seek help, as appropriate, by listing available resources for help.

e. The Secretaries of the Military Departments may provide additional regulatory guidance as necessary.

SECTION 6: GOVERNANCE STRUCTURE

6.1. SPGOSC.

a. Purpose. The SPGOSC provides oversight and guidance for governance and execution of the Defense Suicide Prevention Program.

b. Guidance. The SPGOSC will:

(1) Serve as an advisor to the USD(P&R) on suicide prevention policies and programs.

(2) Provide guidance and policy priorities for the SPARRC to develop recommendations and action plans for decision.

(3) Approve new or updated policies and programs which address present, emerging and future suicide prevention needs, employing evidence-informed practices.

c. Procedures. The SPGOSC will:

(1) Be co-chaired by EDFR or appoint a GO/FO or SES-equivalent to co-chair the SPGOSC, with a GO/FO or SES-equivalent appointed by the ASD(HA). May invite ad-hoc members as needed.

(2) Meet quarterly or as required by the co-chairs.

(3) Have members appointed and designated in writing.

(4) Comply with DoDI 5105.18.

6.2. SPARRC.

a. Purpose. The SPARRC is an action officer working group of the SPGOSC focused on suicide prevention efforts in the DoD.

b. Guidance. The SPARRC will:

(1) Develop policy recommendations for the SPGOSC, which address present, emerging, and future suicide prevention needs, employing evidence-informed practices.

(2) Implement the priorities of policy and program decisions made by the SPGOSC.

c. Procedures. The SPARRC will:

(1) Be chaired by designation in writing by the Director, DSPO.

(2) Meet quarterly or as required by the chair.

(3) Have members appointed and designated in writing.

(4) Comply with DoDI 5105.18.

SECTION 7: PROGRAM EVALUATION FOR NON-CLINICAL SUICIDE PREVENTION ACTIVITIES

7.1. PURPOSE.

This section outlines the procedures and requirements for the evaluation of the effectiveness and outcomes of non-clinical suicide prevention activities.

7.2. PROCEDURES.

a. Based on the DoD's public health and primary prevention approach to suicide prevention, non-clinical suicide prevention activities that fall under the scope of this guidance include non-medical programs and practices intended to address individual, interpersonal, and organizational risk and protective factors that increase or decrease the risk of self-harm, including suicide.

(1) Non-clinical suicide prevention activities include, but are not limited to, those that directly address suicide (e.g., training to identify and support those deemed to be at higher risk for suicide); efforts to promote total force fitness by targeting protective factors such as skill development (e.g., building healthy relationships, coping skills, emotional intelligence, effective communication, and resilience); efforts to promote protective environments and healthy climates (e.g., safe storage of lethal means); military dependent support programs; financial readiness; and efforts to address institutional and systematic risk factors for suicide.

(2) Postvention activities that provide support for individuals who have lost a loved one or colleague to suicide, or attempted suicide, are also included under the scope of non-clinical suicide prevention.

(3) Non-medical prevention activities are those primarily administered or implemented by non-medical providers operating outside of medical treatment facilities and clinics under the purview of the DHA.

b. Consistent with DoDI 6400.09, the Secretaries of the Military Departments and the Chief, NGB will collaborate with DSPO to ensure that suicide prevention activities are developed from a relevant evidence-base and have an evaluation capability, based on the criteria in this issuance, in place before implementation within their respective organizations. Prevention activities that are not data-informed or evidence-based must be reviewed for improvement and gather program evaluation data.

(1) Evaluation plans for each suicide prevention activity must be based on a theory of change that is specifically created for that activity. The theory of change must portray the notions of desired outcomes (short-, intermediate-, and long-term) of a program, activity, intervention, or initiative.

(2) Prevention activities must have mechanisms and resources in place to monitor the degree to which they meet intended outcomes, and to conduct process evaluation to inform enhancements, planning, and resourcing.

(3) Evaluation plans must specify:

(a) Clear steps for implementation and responsibilities for those involved in implementation.

(b) The intended connections between inputs; activities; outputs; short-, intermediate-, and long-term outcomes; and programmatic improvements expected as a result of implementing the activity with fidelity.

(c) A process of continued assessment or reassessment of the activity.

(4) Evaluation plans should be practical, feasible, and tailored in a way that produces accurate and actionable findings; for example, evaluation plans should account for and provide the resources and time required to conduct sufficient evaluation.

(5) Evaluation plans must include assessment of short- and intermediate-term outcomes, using established methods to evaluate the risk and protective factors that the program aims to mitigate. Activities that may be effective in one unit or at one installation may not be effective in other locations; therefore, evaluation plans must assess both process metrics (including fidelity monitoring) and outcome metrics, to account for different needs, and be able to assess for effectiveness among the intended target population.

(6) Evaluation plans must incorporate appropriate methodologies, to include: Use of quantitative (e.g., standardized pre- and post-outcome measures, where possible) or qualitative (e.g., focus group feedback or written comments and feedback from assessments) methods to assess implementation, reach, engagement, organizational support, and effectiveness; an evaluation plan may include both qualitative and quantitative data methods. Consistent with guidance provided in DoDI 6400.09, evaluation practices must adhere to DoD policies concerning privacy, ethics, human subjects, data-sharing, and other applicable laws and regulations.

c. The Secretaries of the Military Departments and Chief, NGB will use the DoD Suicide Prevention Standards of Practice Framework for Evaluation at Table 1 to develop evaluation plans for non-clinical suicide prevention activities in accordance with standards of practice established in OMB Memorandum M-20-12, and to ensure that requirements set-forth in DoDI 6400.09 are adequately met, and consistently reported.

(1) Evaluation plans must take into account resources needed, review processes, and other contextual factors.

(2) Data collection, storage, and analysis will be conducted according to Military Department or NGB policies on records collection and management.

(3) The evaluation plan must address these 'considerations' for each standard in accordance with Table 1:

(a) Plan. This category addresses preparations required for conducting evaluation.

(b) Prepare. This category addresses the steps needed for effective data collection.

(c) Execute. This category addresses key actions that leaders must be mindful of to generate evaluations results that provide value.

(d) Assess. This category addresses feedback mechanisms to ensure actions occur to foster improvement.

Table 1. DoD Suicide Prevention Standards of Practice Framework for Evaluation

Standard of Practice	Considerations	Guidance Questions
Relevance and Utility Must address questions of importance and serve the information needs of stakeholders. Evaluations should present findings that are actionable and available in time for use. Information should be presented in ways that are understandable and can inform activity improvement.	• Plan – Identify Stakeholders • Prepare – Information Scope and Selection • Execute – Report Clarity • Assess • Report Timeliness and Dissemination	• Is there transparency to stakeholders in reporting and review of evaluation findings to enable decisions about improvement? • Are findings presented in a clear manner? • Is the evaluation timely to inform implementation? • Are evaluation findings used in decision-making? • Is there ongoing data collection to measure effectiveness? Does data collection measure effectiveness across different sub-groups (e.g., groups with different risk factors) and demographic groups, as well as measuring whether changes in implementation techniques or target audience alter efficacy?

Table 1: DoD Suicide Prevention Standards of Practice Framework for Evaluation, Continued

Standard of Practice	Considerations	Guidance Questions
Rigor Evaluations must produce findings that stakeholders can confidently rely upon, while providing an understanding of limitations. Evaluations should be planned, implemented, and interpreted by qualified evaluators with relevant education, skills, and experience for the methods undertaken. Evaluations must adhere to widely accepted scientific principles and employ methods most appropriate for the evaluation's objectives, within constraints of timeline, feasibility, and available resources.	• Plan – Program Documentation • Prepare – Defensible Data Sources – Valid Information – Reliable Information – Systematic Information • Execute – Qualitative Analysis – Quantitative Analysis – Impartial Reporting • Assess – Context Analysis	• What are the goals of the activity? • What are the specific, measurable, achievable, realistic, time-bound objectives or outcomes? • What are the data sources for the outcomes? • Does it include process and outcome metrics that are aligned with expected outputs and outcomes (short and intermediate), which are in turn clearly aligned with the goals and objectives of the suicide prevention activity (long-term)?[1] Articulate short-term outcomes of interest (e.g., changes in knowledge, skill, attitudes) and expected long-term impacts (e.g., reduced suicides) • What is the data analysis methodology? • What are the findings?
Independence and Objectivity Evaluations must be independent, objective, inclusive, and engage a broad range of stakeholders. Evaluators should have the necessary authority to protect their independence and objectivity in the design and conduct of evaluations, and in the interpretation and dissemination of findings.	• Plan – Identify potential conflicts to objectivity • Prepare – Develop procedures to avoid potential conflicts to objectivity • Execute – Enact procedures to avoid potential conflicts to objectivity • Assess • Final product is independent and objective	• Is the evaluator free of any conflict of interest, such as the need to demonstrate effectiveness to continue receiving funding? • Does the approach garner buy-in from the target audience (e.g., are materials culturally responsive?)? • Are evaluators free from bias and can they reach objective conclusions?

[1] Evaluation plans should allow for realistic expectations with some programmatic impacts (e.g., some may show short-term impacts, but depending on how quickly evaluation plans are developed, enough data is gathered and enough time has lapsed, some of the intermediate or long-term outcomes that the activity is intended to impact within the evaluation time frame may not yet be available).

Table 1: DoD Suicide Prevention Standards of Practice Framework for Evaluation, Continued

Standard of Practice	Considerations	Guidance Questions
Transparency Evaluations must be transparent in planning, implementation, and completion phases to enable accountability and help ensure they are not tailored to generate specific findings.	• Plan – Described Purposes and Procedures • Prepare – Practical Evaluation Process • Execute – Cost-effective • Assess – Scalable	• How is the activity implemented? • Does it reach the intended audience? • Is the cost of the evaluation sustainable? • Is the activity scalable to meet demands of different military communities?
Ethics Evaluations must be conducted with the highest ethical standards. Ethical evaluations are planned and conducted to safeguard the dignity, rights, safety, and privacy of participants and other stakeholders.	• Plan – Alignment to Program/Initiative • Prepare – Data collected in accordance with Institutional Review Board and OMB requirements • Execute – Fiscal Responsibility • Assess – Requirements for evidence-building activities, open government data, and confidential information protection, and statistical efficiency in accordance with law and OMB guidance.[2]	• Are evaluation methods tailored to the status or maturity of an activity? • Are evaluation methods facing any barriers for data collection? • Does evaluation comply with Institutional Review Board and OMB requirements, including protecting confidential information? • Are evaluation findings being used to inform improvement?

[2] Foundations for Evidence-Based Policy Making Act: PL 115-435, 132 Statute 5529.

GLOSSARY

G.1. ACRONYMS.

AFMES	Armed Forces Medical Examiner System
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
ASR	Annual Suicide Report
ATSD(PA)	Assistant to the Secretary of Defense for Public Affairs
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DMDC	Defense Manpower Data Center
DoDD	DoD directive
DoDEA	DoD Education Activity
DoDHRA	DoD Human Resources Activity
DoDI	DoD instruction
DoDM	DoD manual
DoDSER	Department of Defense Suicide Event Report
DSPO	Defense Suicide Prevention Office
DSSP	Department of Defense Strategy for Suicide Prevention
EDFR	Executive Director, Force Resiliency
GO/FO	general officer/flag officer
NGB	National Guard Bureau
OMB	Office of Management and Budget
PL	Public Law
PHCoE	Psychological Health Center of Excellence
QSR	Quarterly Suicide Report
SELRES	Selected Reserve
SES	Senior Executive Service
SPARRC	Suicide Prevention and Risk Reduction Committee
SPGOSC	Suicide Prevention General Officer Steering Committee
SPPM	Suicide Prevention Program Manager
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

AFMES. The system within the DHA that provides worldwide comprehensive medico-legal services and investigations; tracks all deaths subject to its jurisdiction (active duty status deaths), their determination, and other relevant information.

ASR. An annual report that provides official suicide counts and suicide rates for the DoD, including both Service members and military dependents. The ASR also describes DoD's initiatives to combat suicide among Service members and their families.

commander. Anyone with authority and responsibility for effectively using available resources and planning the employment of organizing, directing, coordinating, and controlling military forces for the accomplishment of assigned missions. A commander also has responsibility for the health, welfare, morale, and discipline of assigned personnel as it relates to suicide prevention.

contagion. A situation where knowledge of another person's suicidal act influences others to think about or attempt suicide.

dependent. With respect to a Service member, a dependent is a person described in Section 1072(2) of Title 10, U.S.C. In the case of a parent or parent-in-law of the Service member, the income requirements of Subparagraph (E) do **not** apply. See also the definition of "family" contained in this Glossary.

Disability Evaluation System. Used to determine if Service members coping with wounds or illness are fit to perform their duties and continue to serve in the Armed Forces.

DoDSER. A report that characterizes Service member suicide data through a coordinated, web-based data collection system.

DoDSER system. A web-based application with functionality to collect the core set of standardized DoD suicide surveillance points, as well as a limited number of Military Service-specific suicide surveillance data points. The software collects calendar year data that have been defined in collaboration with the SPPMs of each Military Service and the SPARRC.

data-informed. Decisions based on the collection and analysis of available data.

evidence-based. A conclusion based on rigorous research or evaluation that has demonstrated effectiveness in achieving the outcomes that it is designed to achieve.

family. 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. See also the definition of "dependent" contained in this Glossary.

intermediate-term outcome. Intermediate-term outcomes are behavioral changes expected to occur between 6 months and 2 years following exposure to an activity (e.g., change in action, behaviors, practices, and policies).

intervention. A strategy or approach that is intended to prevent an outcome or alter the course of an existing challenge or stress; also known as "secondary prevention."

lethal means. Method for suicide that has a high likelihood of resulting in death (e.g., firearms, drugs, and poisons).

long-term outcome. Long-term outcomes are functional changes 2 years and beyond (e.g., change in conditions, environment, and culture).

military criminal investigative organizations. The U.S. Army Criminal Investigation Command, the Naval Criminal Investigative Service, and the Air Force Office of Special Investigations.

Military Health System. The DoD medical and dental programs, personnel, and facilities through which the DoD provides healthcare services and support to the Military Services during military operations, and healthcare services and support under TRICARE to members of the Military Services, their family members, and others entitled to DoD medical care.

National Death Index. A centralized database of death record information on file in State vital statistics offices.

non-clinical suicide prevention. Activities including, but not limited to, those that directly address suicide (e.g., training to identify and support those deemed to be at higher risk for suicide); efforts to promote total force fitness by targeting protective factors such as skill development (e.g., building healthy relationships, coping skills, emotional intelligence, effective communication, and resilience); efforts to promote protective environments and healthy climates (e.g., safe storage of lethal means); military dependent support programs; financial readiness; and efforts to address institutional and systematic risk factors for suicide.

Office of the Armed Forces Medical Examiner. The office charged with the execution of Section 1471 of Title 10 U.S.C. and DoDI 5154.30, and makes cause of death and manner of death determinations for all active duty deaths, including suicides.

PHCoE. A division of the J-9 (Research and Development) Directorate of DHA responsible for work on the healthcare related aspects of the DoD's suicide prevention programs and policies. It is also responsible for the operation and sustainment of the DoDSER system, as well as the analysis and communication of DoDSER data and findings. Its mission is to improve the lives of Service members, veterans, and families by advancing excellence in psychological healthcare and prevention of psychological health disorders.

postvention. Response activities that should be undertaken in the immediate aftermath of a suicide that has impacted the unit. Postvention has two purposes: to help suicide attempt survivors cope with their grief, and to prevent additional suicides. It also may provide an

opportunity to disseminate accurate information about suicide, encourage help-seeking behavior, and provide messages of resilience, hope, and healing. Also known as "tertiary prevention."

postvention activity. An intervention or efforts designed to provide support to individuals who have lost a loved one or a colleague to suicide.

prevention. 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. Also known as "primary prevention."

prevention activity. An intervention, or efforts designed to affect a specific outcome(s), or the direct provision of services, and has a target audience. A prevention activity is not routine care, screening tools, passive information (websites, brochures), policies, working groups, or a department, center, or office.

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), external, or environmental (e.g., strong relationships, particularly with family members).

public health approach. A prevention approach that impacts groups or populations of people versus treatment of individuals. Public health focuses on preventing suicidal behavior before it ever occurs (primary prevention), and addresses a broad range of risk and protective factors. The public health approach values multi-disciplinary collaboration, which brings together many different perspectives and experience to enrich and strengthen the solutions for the many diverse communities.

record-level data. Data reflective of individual records that includes at minimum social security number, full name, and date of death, but may also include data reflecting incident details and other related information (if such information is available).

resilience. The ability to withstand, recover from, and grow in the face of stressors and changing demands.

risk factors. Factors caused by stress, trauma, or other circumstances that cause a schism in protective factors. Factors that make it more likely those individuals will develop a disorder or pre-dispose one to high-risk for self-injurious behaviors. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

risk reduction. Methods for reducing the threat for suicidal ideation or behaviors. Examples include, but are not limited to, mental health screenings, counseling, and means reduction.

SELRES. Those units and individuals within the Ready Reserve designated by their respective Services and approved by the Chairman of the Joint Chiefs of Staff as so essential to initial wartime missions that they have priority over all other Reserves.

short-term outcome. Short-term outcomes are those seen immediately to 6 months following exposure to an activity (e.g., change in knowledge, attitude, intention).

SPARRC. 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; part of the DSPO governance structure.

SPGOSC. A collaborative forum made up of GO/FO and SES members who facilitate the review, assessment, integration, standardization, implementation, and resourcing of suicide prevention policies and programs; part of the DSPO governance structure.

SPPM. A DoD Component-level military or civilian program manager funded and appointed to establish, maintain, and implement the DoD Components' suicide prevention policy and program. May also be called a "program manager" or "coordinator," and may be appointed solely as a SPPM or coordinator or in conjunction with other appointed duties as appropriate. The SPPM represents a Components' program at internal DoD and external meetings; promotes and fosters suicide prevention, intervention, and postvention efforts; and serves as a member of the SPARRC and its working groups.

stigma. Negative perception by individuals that seeking mental healthcare or other supportive services will negatively affect or end their careers.

suicidal behaviors. Behaviors related to suicide, including preparatory acts, as well as suicide attempts and death.

suicidal ideation. Thinking about, considering, or planning suicide.

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

suicide attempt. A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior.

suicide attempt survivor. An individual who attempts to die by suicide, but does not die.

suicide data repository. An integrated mortality data repository from the DoD, the Department of Veterans Affairs, and the Centers for Disease Control and Prevention, and includes information on all causes and manners of death to include suicide-related data for Service members and veterans.

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