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Effective 4 October 2024

Personnel–General

Army Suicide Prevention Program

By Order of the Secretary of the Army:

RANDY A. GEORGE
General, United States Army
Chief of Staff

Official:

MARK F. AVERILL
Administrative Assistant to the Secretary of the Army

History. This publication is a mandated revision. The portions affected by this mandated revision are listed in the summary of change.

Authorities. The authorities for this regulation are DoDI 6490.03, DoDI 6400.09, and DoDI 6490.16.

Applicability. This regulation applies to the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated.

Proponent and exception authority. The proponent of this regulation is the Deputy Chief of Staff, G–9. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific requirements.

Army internal control process. This regulation contains internal control provisions in accordance with AR 11–2 and identifies key internal controls that must be evaluated (see app M).

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) via email directly to usarmy.pentagon.hqda-dcs-g-9.mbx.publishing-team@army.mil.

Committee management approval. AR 15–39 requires the proponent to justify establishing/continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the Office of the Administrative Assistant to the Secretary of the Army, Special Programs Directorate at email usarmy.pentagon.hqda-hsa.mbx.committee-management@army.mil. Further, if it is determined that an established "group" identified within this regulation, later takes on the characteristics of a committee, as found in the AR 15–39, then the proponent will follow all AR 15–39 requirements for establishing and continuing the group as a committee.

Distribution. This regulation is available in electronic media only and is intended for the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

*This regulation supersedes AR 600-92, dated 8 August 2023.

SUMMARY of CHANGE

AR 600–92
Army Suicide Prevention Program

This mandated revision, dated 4 October 2024—

- Updates responsibilities (paras 1–25 through 1–28, 1–31, 1–32, and 1–34).
- Updates time requirements for report submissions (paras 2–4*b*(3), 2–4*b*(4), and 5–9*d*).
- Updates unit training policy (para 4–2*d*).
- Updates Ask, Care, Escort–Suicide Intervention course policy (para 4–5*f*(1)).
- Updates U.S. Army Reserve specific responsibilities (para 5–2*b*(2)
- Incorporates Army Directive 2018–07–7 (Prioritizing Efforts-Readiness and Lethality (Update 7) (throughout).

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Section I

General

1–1. Purpose
This regulation implements Department of Defense Instruction (DoDI) 6490.16 and incorporates DoDI 6400.09, prescribes policies and procedures, and assigns responsibilities for the Army Suicide Prevention Program (ASPP). The policy directs activities to prevent suicide and self-harm using a comprehensive and proactive three-phased approach (prevention, intervention, and postvention). Promoting health, well-being, and prevention of harmful behaviors are linked efforts that encompass physical, mental, and social health dimensions. Prevention is a shared effort that is distributed across the Army enterprise, commands, and communities at all echelons. The policy establishes oversight of the ASPP through continuous assessments and establishes requirements for reporting Soldier suicide deaths, attempts, ideations, and dependent suicide deaths.

1–2. References, forms, and explanation of abbreviations
See appendix A. The abbreviations, brevity codes, and acronyms (ABCAs) used in this electronic publication are defined when you hover over them. All ABCAs are listed in the ABCA database located at https://armypubs.army.mil.

1–3. Associated publications
This section contains no entries.

1–4. Responsibilities
Responsibilities are listed in Section II.

1–5. Records management (recordkeeping) requirements
The records management requirement for all record numbers, associated forms, and reports required by this publication are addressed in the Records Retention Schedule–Army (RRS–A). Detailed information for all related record numbers, forms, and reports are located in Army Records Information Management System (ARIMS)/RRS–A at https://www.arims.army.mil. If any record numbers, forms, and reports are not current, addressed, and/or published correctly in ARIMS/RRS–A, see DA Pam 25–403 for guidance.

1–6. Overview and the Army Suicide Prevention Program
a. Leaders establish a culture of trust that results in the early identification of risk and protective factors and applies multiple targeted actions to achieve suicide prevention outcomes. Leaders who apply consistent and systematic whole-of-person and whole-of-unit strategies will positively affect individual and unit resilience outcomes.

b. Suicide is a result of a complex interaction of many factors–environmental, psychological, biological, and social. Because there is no one, single solution, this challenge requires a comprehensive public health approach to suicide prevention, which includes coordinated efforts for an integrated prevention approach. The Army's approach operationalizes the public health approach, which includes defining the problem, identifying influencing risk and protective factors to describe the problem, then identifying, implementing, and evaluating helping agencies, programs, and services.

c. The ASPP aligns policies, practices, and programs that promote positive behavioral change, strengthen personal and collective bonds, and build readiness and resilience through collaborative partnerships and evidence-based programs that are replicable, scalable, and sustainable. Specific elements include stigma reduction, help-seeking behaviors, and proactive activities (for example, financial literacy and skill building) before the point of crises, while supporting activities and services intended to improve the quality of life of Soldiers, Department of the Army (DA) Civilians, their Families, and installations.

1–7. Army Suicide Prevention Program goals and objectives

a. Goal. The Army's ultimate goal is to prevent suicides and self-harm behaviors. This is accomplished by building a culture of resilience, reducing risk, and strengthening Soldiers by increasing protective factors, such as coping skills and help-seeking behavior through a combination of prevention, intervention, and postvention activities.

b. Objectives.

(1) Increase the visibility and timeliness to identify patterns of suicidal behaviors and associated risk and protective factors by using reporting systems to inform and improve mitigation strategies and activities in a timely manner. Documented actions to support commanders using the results of assessment tools.

(2) Foster a culture of trust within organizations by enabling help-seeking behaviors without fear of stigmatization or unwarranted actions that adversely impact one's career. Soldiers must be given protection and command support to defer promotion and stabilize to seek behavioral health (BH) assistance. This may be extended to a spouse or child, at the Soldiers request, to allow Soldiers to focus on Family care (see AR 600–8–11 for deferment or reassignment criteria).

(3) Ensure Soldiers are provided with opportunities to gain education and skills to develop and build on existing protective factors (for example, financial security through financial management). Actions include reinforcing the activities and documenting that Soldiers received training and education. Documentation of those activities helps to assure continued mentorship and informs strategy assessment.

(4) Reduce access and increase proper storage skills to a broad range of lethal means. Documented actions include the provision of lethal means toolkits or other resources (distribution of gun locks and education on storage options). See chapter 2 for guidance on reducing risk from lethal means.

(5) Direct the integration, synchronization, and evaluation of programs, practices, and policies. Documented actions include tracking multiple reinforcing activities (trainings and events) and outputs (evidence of delivery, such as attendance counts or materials distributed) along with at least short-term outcomes (knowledge or skill gain) (see chap 7 for assessment).

(6) Communicate and coordinate prevention efforts to increase knowledge and understanding of available resources. Documented actions include resource guides and a comprehensive communications and marketing plan (see chap 2 regarding developing key communication messaging). Additionally, leaders should seek to identify non-military support networks that may exist with their Soldiers and incorporate or leverage as appropriate.

1–8. The components of the Suicide Prevention Program

a. The ASPP has three components: prevention, intervention, and postvention. Commanders and leaders play an integral role in all aspects of the program to protect and preserve individuals, units, and installations. Strong relationships between installation and community partners from garrison, medical personnel, and commanders improve the overall effort.

b. The ASPP is built on a foundation of prevention and depends on empathetic and proactive unit leaders and supervisors who make the effort to know their personnel and build a culture of trust and cohesive teams.

c. Prevention focuses on the range of educational, training, and outreach activities to equip Soldiers, DA Civilians, and Family members with knowledge and skills to strengthen abilities to prevent becoming overwhelmed with life circumstances (see para 2–5).

d. Intervention includes alteration of the conditions that produced the current crisis, development of a care plan and potential treatment of underlying conditions that may have contributed to suicidal behaviors, and follow-up care to assure positive outcome (see para 2–9).

e. Postvention refers to a range of activities following suicide behaviors and is a part of the overall spectrum of suicide prevention. After an event, commanders, noncommissioned officers (NCOs), and installation personnel will take steps to secure and protect individuals (see para 2–12).

1–9. Suicide prevention overview

a. Suicide prevention seeks to enable protective factors (unit cohesion, financial readiness, and BH care access) and prevent self-harm among those identified as at-risk through command visibility tools or individual warning signs. Prevention refers to all efforts that build resilience, reduce stigma, and build understanding of suicide and related behaviors. Effective suicide prevention efforts (education, outreach, crisis intervention, training, and policy) are dependent upon the existence of a command culture that

fosters trust, accountability, caring, and engaged individuals focused on prevention and early intervention (non-clinical or clinical counseling) as opposed to crisis management alone.

b. There are four tiers of suicide prevention activities—

(1) Tier one (Sustain): actions that create environments of emotional, psychological, and physical safety for all. These activities are foundational and universal (unit and communitywide) and are intended to be applied to the entire population through various means. A prevention approach focuses on individual, interpersonal, and organizational elements through holistic means to address risk and protective factors for harmful acts, leveraging, where possible and appropriate, existing prevention efforts. The actions here are referred to as primary prevention because they intend to prevent before a problem develops, such as health promotion, asset-building, or activities that eliminate risk factors before they cause harm. These actions address the conditions in the places where Soldiers, Families, and DA Civilians work, live, and learn.

(2) Tier two (Protect): actions to address individual knowledge, skills, beliefs, and behaviors. This tier focuses on learning coping skills for life stressors and how to take action across a variety of areas (financial skills, relationship skills, and so forth). Individuals are supported and skills are reinforced at the peer and unit level. Commanders must consistently assess their personnel's ability to handle stress and foster a positive and inclusive environment that develops life-coping skills and protective factors. Commanders must also assess the workplace environment to assess any barriers that may decrease reinforcement of positive coping skills.

(3) Tier three (Engage): actions to identify and support people that may be at risk of suicide. Training can be provided to improve intervention skills, increase knowledge, and build confidence in Soldiers to identify and respond appropriately to suicidal behaviors. Prevention also includes reducing access to lethal means by knowing what options are available for securing lethal means and putting time and space between someone with suicidal intent and lethal means.

(4) Tier four (Act): actions in support of crisis response and to support people known to be at risk of suicide. Tier four is often referred to as intervention and focuses on preventing a life crisis from stressors (financial, domestic, legal, and law enforcement) leading to suicidal behavior for those identified with risk. Identification of at-risk Soldiers should be made in collaboration with the highly specialized professionals assigned or designated to support commands. These nonclinical (chaplains and military Family life counselors (MFLCs)) and clinical (BH) providers can support leaders with the management of at-risk Soldiers.

1–10. Army Suicide Prevention Program

a. The ASPP incorporates the Department of Defense (DoD) Suicide Prevention Strategy, DoDI 6400.09, and the Centers for Disease Control and Prevention's (CDC) seven evidence-based prevention strategies for suicide prevention. The CDC strategies are intended to work in combination with socio-ecological model and reinforce each other to prevent suicide. The seven primary strategies designed to mitigate suicide are—

(1) Strengthen financial readiness.

(a) Improve financial readiness (Army Financial Readiness Program).

(b) Increase household economic stability (credit monitoring).

(2) Strengthen access and delivery of care.

(a) Reduce stigma by modeling help-seeking behaviors.

(b) Increase care access through referring at-risk Soldiers.

(3) Create protective environments.

(a) Reduce access to lethal means through increasing safe storage behaviors (medicines and firearms) and providing lethal means counseling.

(b) Promote unit cohesion through building resilience and life skills that results in measurable skill development.

(c) Promote family advocacy and relationship programs (Army Community Service (ACS), chaplains, and MFLCs).

(d) Ensure newly arriving Soldiers and their Families orient to the unit in accordance with AR 600–8–8.

(4) Promote connectedness by implementing policies and activities that increase support, reduce stress, foster camaraderie, and creating a positive environment.

(a) Increase peer support for care-seeking (resilience skills; ask, care, escort (ACE); and ask, care, escort-suicide intervention (ACE–SI)).

(b) Build pro-social (bystander) skills (Engage).

(c) Build unit cohesion (physical fitness training, master resilience trainer (MRT), ACE, Better Opportunities for Single Soldiers, and Building Strong and Ready Teams).

(5) Teach coping and problem-solving skills (performance experts and MRT).

(a) Enhance parenting skills (ACS).

(b) Increase use of resilience techniques (performance experts and MRT).

(c) Build financial management knowledge (ACS).

(d) Develop relationship skills (chaplains and ACS).

(e) Prevent and reduce substance misuse (Army Substance Abuse Program (ASAP)).

(6) Identify and support people at risk.

(a) Optimize use of visibility tools (BH Pulse and Commander's Risk Reduction Toolkit (CRRT)) to identify and refer to clinical and non-clinical services.

(b) Identify signs of suicide risk and refer peers (ACE, ACE–SI, and Engage).

(7) Lessen harm and prevent future risk by—

(a) Use of suicide prevention program coordinator (SPPC) and installation assets in support of commanders and units.

(b) Improve safe reporting and messaging about suicide to support help-seeking efforts and privacy when discussing, responding to, and reporting self-directed harm and prohibited abusive or harmful acts through the media, including social media platforms (Soldiers, Families, and DA Civilians) (public affairs officer (PAO)).

(c) Improve Soldier knowledge of reducing access to lethal means (firearms, ropes and asphyxiation devices, and medications).

b. Implementing an integrated ASPP requires prevention personnel to use supportive planning tools, such as logic models, to identify and support people at risk.

c. Table 1–1 illustrates these linkages between suicide prevention initiatives discussed above and their associated CDC strategies. Managing the ASPP involves developing objectives (see app D and chap 7) and associated actions in accordance with the appropriate CDC strategies.

Table 1–1
Suicide Prevention Initiatives and Centers for Disease Control Strategies

Types of suicide prevention initiatives (tools, education, and training)	Centers for Disease Control strategies (DoDI 6400.09)
Army Financial Readiness Program	*Strengthening economic supports*
BH Pulse; CRRT, BH Teams in brigade (BDE) footprints	*Strengthening access and delivery of care*
Building Strong and Ready Teams, ACE; ACE–SI; Army Family Programs	*Creating protective environments*
Chaplains, ACE; ACE–SI; Engage; MRT	*Promoting connectedness*
Army Family Programs; MRT; Reception, Staging, Onward Movement, and Integration (RSOI) Training for New Soldiers arriving to Installation and Deployment or Redeployment	*Teaching coping and problem-solving skills*
Visibility tools-BH Pulse; CRRT ACE; ACE–SI	*Identifying and supporting people at risk*
Soldier counseling; counseling to reduce access to lethal means; Postvention Toolkit	*Lessening harm and preventing future risk*

d. The purpose of a logic model is to articulate a program's theory of action, showing linkages between activities and expected changes (attitudes, knowledge, and behaviors) aligned with strategies such as promoting connectedness or lessening harm and preventing future risk. The range of initiatives in table 1–1 produce respective resiliency outcomes (improved sense of belonging and decreased stigma) which prevention specialists can measure as part of implementing the ASPP. See chapter 7 for information on assessment of suicide prevention programs (SPPs).

e. Several suicide prevention activities, such as ACE trainings or commanders' use of visibility tools, have distinct but related outcomes. For example, the mid-term outcomes of suicide prevention trainings, include the trainee's (Soldier's) application of learned concepts in life, such as stress management,

conflict resolution, or care-seeking. These behaviors mitigate known risk factors such as the ones listed in appendix B.

Section II

Responsibilities

1–11. Chief of Staff, Army

The CSA, through the Vice Chief of Staff of the Army, will oversee implementation and alignment of Army primary prevention efforts consistent with DoDI 6400.09, DoDI 6490.16, the Defense Suicide Prevention Strategy, and this regulation.

1–12. Assistant Secretary of the Army (Manpower and Reserve Affairs)

The ASA (M&RA) will—

a. Develop and oversee policy for the ASPP to ensure Army policy, programs, processes, systems, and resources are effectively targeted to promote and optimize Total Army readiness and resiliency.

b. Develop suicide prevention training and education requirements for DA Civilian leadership courses.

c. Prepare budget submissions, direct allocation of funds, monitor execution of resources, and serve as the functional budget program manager for the ASPP.

d. Review, approve, and publish the list of programs that comprise the suicide prevention portfolio.

e. Develop suicide prevention oversight, to include measures and reporting procedures.

1–13. Chief, National Guard Bureau

The CNGB will—

a. Prescribe Army National Guard (ARNG) policies and programs for prevention, intervention, and postvention of self-harm and prohibited harmful behaviors consistent with this regulation, DoD, and statutory requirements.

b. Oversee execution of the data-informed suicide prevention actions through a command governance process.

c. Appoint personnel to participate in Headquarters, Department of the Army (HQDA) suicide prevention governance and associated working groups and ensure personnel provide data, information, analysis, recommendations, and evaluation results.

d. Identify, collect, share, and evaluate innovative practices across the States, Territories, and District of Columbia (DC).

e. Recommend measures, systems, processes, and procedures to increase efficiencies within the ASPP.

f. Ensure ARNG unit compliance with suicide prevention requirements outlined in this regulation and advise the Director, Prevention, Resilience, and Readiness (DPRR) regarding the challenges associated for the ARNG.

g. Manage all ARNG suicide prevention training requirements and ensure suicide prevention training is documented.

h. Provide initial training and professional development for suicide prevention program managers (SPPMs).

i. Establish procedures for reporting suicidal behaviors and other harmful behaviors by ARNG personnel in accordance with requirements outlined in this regulation—

(1) Ensure submission of DA Form 7747 (Commanders Suspected Suicide Event Report) to the Army SPPM for every suicide or suspected suicide.

(2) Ensure an AR 15–6 investigation is completed for every suspected or confirmed suicide. The initial serious incident report (SIR) listing the mechanism of death (based on command or police information) should be the impetus for beginning the AR 15–6 investigation.

(3) Ensure commanders initiate a line of duty (LOD) investigation for all Soldiers who die by suicide while serving in a duty status under authority of Title 10 U.S. Code, or Title 32 U.S. Code. In cases where Soldiers who die by suicide are not serving in a duty status under Federal law, it is recommended that an LOD be initiated in cases where the Soldier has deployed. Contributing factors caused by the deployment may exist such as post-traumatic stress disorder (PTSD), traumatic brain injury, and depression.

(4) Ensure Families, unit members, and coworkers who experience loss due to suicide are offered long-term assistance including the resources listed in appendix J.

(5) Establish and charter a Suspected Suicide Fatality Review and Analysis Board (S2FRAB) at each State, Territory, and DC and provide a summary report to the Army SPPM, at usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil within 45 days of convening the S2FRAB.

j. Conduct continuous monitoring to assess performance across prevention, intervention, and postvention and share evaluation results to the Deputy Chief of Staff (DCS), G–9.

k. Form strategic partnerships at the Federal, State, and local level to develop networks of providers and expand access to care. Key stakeholders include other military services, Federal agencies, non-governmental organizations, and public and private entities.

l. Ensure SPPMs administer, coordinate, and manage the ARNG SPP, to include developing policy and regulatory guidance, managing program funding to include establishing requirements and submitting budget requests, developing and overseeing internal controls, and coordinating or conducting evaluations.

m. Ensure ARNG Soldiers in medical military occupational specialties to receive training on suicide prevention and related behaviors.

n. Ensure a full-time Director of Psychological Health is appointed within each State, Territory, and DC Joint Forces Headquarters (JFHQ) to provide BH subject matter expertise to commanders, Soldiers, and Families, such as, but not limited to—

(1) Conduct command-directed BH evaluations.

(2) Support LOD investigations.

(3) Deliver BH readiness limiting profiles.

(4) Assist Servicemembers and Families obtaining timely access to quality care and resources.

(5) Respond to referrals regarding Soldiers at risk of harming themselves or others.

(6) Support Commanders Critical Incident Report.

(7) Conduct health assessment screenings.

(8) Conduct readiness screenings.

(9) Coordinate, assess, and evaluate prevention and wellness education programs with military and community partners.

o. Provide emphasis, resources, policy, and implementation guidance to each State and Territory Adjutant General and the Commanding General (CG), DC for the execution of suicide prevention activities which include—

(1) Establish and chair a Commander's Ready and Resilient Council (CR2C) and appoint a community Ready and Resilient integrator (CR2I) when practical for the ARNG. When a CR2C is not practical, develop and implement strategies to accomplish similar goals to that of the CR2C (see glossary for definition of CR2C).

(2) Publish a health promotion policy supporting healthy behaviors including risk reduction and suicide prevention efforts.

(3) Ensure Soldiers identified with high-risk symptoms and behaviors are managed in a consistent manner.

(4) Ensure Soldiers are encouraged to seek assistance if they are experiencing challenges or have been identified with BH or substance abuse symptoms.

(5) Ensure policies are in place for crisis management, weapons profiles, and other unit-related procedures that relate to high-risk symptoms or suicide-related events.

(6) Ensure Soldiers are referred who are undergoing multiple disciplinary actions or with multiple risk factors to appropriate BH, substance misuse, and Family support services, as available.

(7) Provide the opportunity for Servicemembers not living on DoD-owned or operated property, and the immediate Family members in their household, to voluntarily store privately owned firearms in the unit arms rooms in armories pursuant to State, Territory, and DC law, in consultation with their servicing staff judge advocates (SJAs). Commanders from National Guard States that do not allow firearm storage in armories will work through their SPPM to coordinate with local community resources for safe storage and share innovative practices with other States.

(8) Ensure there is a process to share information with qualified and cleared medical providers, investigators, and command leadership, including but not limited to behavioral problems, family or relationship problems, financial problems, and any other information relating to the Soldier's or Soldier's Family's physical or BH. All efforts should be made to ensure confidentiality rights are not violated. Professional

discretion should always be exercised in identifying what information is required to fulfill necessary functions.

(9) Establish a Soldier and State, Territory, or DC-centric year-long strategic messaging plan for suicide prevention, intervention, and postvention that promotes a holistic approach to suicide prevention.

(10) Ensure all NCOs are trained as gatekeepers for suicide prevention and mentor their Soldiers in basic suicide prevention and use of ACE.

(11) Work with the risk reduction program coordinator (RRPC) or equivalents to review risk data, identify units with potential issues, and target these units with evidence-informed interventions.

(12) Emphasize destigmatization of help-seeking behavior. Ensure annual BH screenings and additional post-deployment health reassessment screenings at 180/365 days' post demobilization to promote long-term post-deployment surveillance of potential at-risk Soldiers.

(13) Oversee and monitor demobilization and annual BH screenings to provide early identification and treatment of potential at-risk indicators; reduce stigma; and preempt mild traumatic brain injury (mTBI), PTSD, and substance misuse issues.

(14) Ensure that personnel more likely to come in contact with Soldiers at increased risk of suicide or self-directed harm are aware of their roles, responsibilities, and mutual referral functions. These personnel include but are not limited to chaplains, religious affairs specialists, sexual assault response coordinators, victim advocates, suicide intervention officers, Soldier and Family Programs personnel, Inspector General personnel, and leaders. Formalize the process for chaplains to refer Soldiers or Family members to caregivers for issues beyond the chaplain's scope of expertise and experience.

(15) Oversee and maintain records of all suicide prevention, intervention, and postvention training and ensure commanders are advised if training is not conducted as specified in chapter 4.

(16) Ensure a suicide intervention officer, E–6 or above, is appointed on an additional duty basis via a memorandum for record at the company, troop, or battery level as the commander's primary advisor on all suicide prevention requirements, trainings, and campaigns, and State and local community level suicide prevention, intervention, and postvention resources. Ensure the suicide intervention officer participates their ready and resilient (R2) forums (see chap 3 of this regulation for additional guidance on R2 forums).

(17) Direct ARNG ASPP personnel coordinate with the Department of Defense Suicide Event Report (DoDSER) program manager to ensure DD Form 2996 (Department of Defense Suicide Event Report) is accurate and complete.

1–14. Chief, Public Affairs

The CPA will—

a. Advise and support the proponent to develop and implement a communication plan in support of ASPP. This includes articles in Army and DoD internal print and broadcast media, public affairs guidance and strategic messages, and release of information about Army suicide prevention to the public through the media and community relations channels.

b. Ensure a shift to proactive and positive messaging, which strengthens Soldier protective factors.

c. Ensure personnel participate in suicide prevention working groups (SPWGs) at echelon. Personnel will provide data, information, analysis, recommendations, and evaluation results.

d. Ensure personnel conduct responsible reporting of suicide deaths to reduce risk and encourage help-seeking behavior.

e. Ensure installation PAOs—

(1) Provide advice and counsel on effective communication planning and execution.

(2) Collaborate, integrate, and synchronize the community awareness needs for health promotion and Army Senior Leader R2 Council initiatives (see chap 3) with other ongoing communication efforts.

(3) In conjunction with ASPP subject matter experts (SMEs), develop campaigns and products (for example, Bugle Notes) that inform units, Family members, and community members on components of the integrated ASPP.

(4) Incorporate safe messaging practices when reporting on suicide, to include safe language, safe storage, and current links to the United States and outside the United States crisis lines.

1–15. Deputy Chief of Staff, G–1

The DCS, G–1 will—

a. Ensure the CG, U.S. Army Human Resources Command will support commanders with the deletion and deferment of orders and deferment of promotion in support of stabilizing Soldiers and Families per AR 600–8–11.

b. Ensure RRPCs or equivalents—

(1) Identify high-risk units and populations through review of RRPC data.

(2) Coordinate appropriate suicide prevention, intervention, and postvention services in conjunction with commanders, SPPC, and CR2I.

(3) Participate in CR2Cs and working groups.

(4) Support ASPP governance by providing aggregate level data, analysis, and recommendations to the SPWG, unit R2 forum processes, and the CR2C.

(5) Support the ASPP in reviewing risk data, identifying units with potential issues, and target these units with evidence-informed interventions.

(6) Evaluate and share lessons learned from prevention activities to reduce risk.

1–16. Deputy Chief of Staff, G–3/5/7

The DCS, G–3/5/7 will advise the CSA and the ASA (M&RA) on suicide prevention training requirements originating from HQDA that affect Soldiers and Army units. The DCS, G–3/5/7 will—

a. Ensure that professional military education (PME), ranging from basic training to senior Army 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 Soldiers.

b. Develop strategies and resource prioritization for HQDA mandatory suicide prevention training requirements which affect Soldiers and Army units.

c. Ensure the Director, Manpower, Accounting and Force Structure Division—

(1) Develops and distributes core-curriculum content to Service schools to support professional military and civilian education and professional development requirements.

(2) Assists in developing Soldier and DA Civilian suicide prevention training and education programs that promote help-seeking behaviors, identifying risk factors, resilience, and coping methodologies; strengthen Soldiers; and enable interventions to DA Civilian supervisors that focus on referral techniques and protocols for their employees.

(3) Develops, reviews, and validates training seat requirements for suicide prevention courses via the Structure and Manning Decision Review and Training Resources Arbitration Panel processes.

d. Ensure, as the Army prevention integrator, the integration of suicide prevention throughout the force.

1–17. Deputy Chief of Staff, G–9

As the Army prevention staff lead, the DCS, G–9 will—

a. Exercise staff supervision and administer the ASPP in accordance with DoDI 6490.16, DoDI 6400.09, and the Defense Suicide Prevention Strategy.

b. Assist in determining suicide prevention training and education requirements for DA Civilian leadership courses.

c. Ensure the DPRR—

(1) Provides strategic guidance and supervision for prevention policies, plans, training, capabilities, and governance nested with the Defense Suicide Prevention Strategy and reduces self-harm and prohibited harmful acts.

(2) Assists in planning and supervising the execution of Army policies and programs for suicide prevention. Provides senior leadership visibility of enterprise suicide trends and patterns and develops recommendations for a process to regularly review suicide trends, metrics, and outcomes.

(3) Serves as the functional budget program manager and prioritizes suicide prevention training and education resource requirements during the year of execution, the budget year, and the program objective memorandum years.

(4) Designates in writing a SPPM, in accordance with DoDI 6490.16, to serve as the DA-level manager to facilitate accurate and impactful interpretation of data, evidence-based programs and policy, meaningful execution of those programs and policies, and continuous evaluation of their effectiveness towards the goal of creating and implementing best practices in the area of military suicide prevention.

(5) Facilitates the development of responses to suicide prevention inquiries from all internal and external government agencies.

(6) Designates in writing a general officer, flag officer, member of the senior executive service, or equivalent level person to serve as a primary and alternate member for the Resilience Executive Forum and DoD Suicide Prevention General Officer Steering Committee and ensure they have direct access to Army senior leadership in accordance with DoDI 6490.16.

(7) Ensures periodic visits to all Army commands (ACOMs), Army service component commands (ASCCs), direct reporting units (DRUs) to ensure compliance with established policies and procedures, recommend corrective actions, if needed, and provide technical assistance.

d. Appoint personnel to participate in HQDA suicide prevention governance and associated working groups. Personnel will provide data, information, analysis, recommendations, and evaluation results.

e. Ensure the Army SPPM—

(1) Collects and analyzes suicide-related data for risk factors pertaining to suicidal behavior to assist in the development or sustainment of effective strategies to reduce suicidal behavior and align data-informed suicide prevention actions into DA governance process.

(2) Interprets ASPP policy in response to inquiries from ACOMs, ASCCs, ARNG, and DRUs, their subordinate commands, other uniformed Services, DoD, and other Federal agencies.

(3) Establishes, publishes, and maintains program-level evaluation plans, data collection, and analyses for implementation at Army Staff, U.S. Army Installation Management Command (IMCOM), ACOM, ASCC, ARNG, DRU, and installation levels. Provides ACOMs, ASCCs, and DRUs with evaluation and oversight results.

(4) Represents the ASPP and serves as a member of the Defense Suicide Prevention Office's (DSPO) Suicide Prevention and Risk Reduction Committee, its working groups, other DoD and HQDA boards and committees as appropriate, and the private sector.

(5) Verifies and consolidates all suicide-related statistics, to include incidences of suicide clusters, and provides periodic reports to the Army Staff, ACOMs, ASCCs, ARNG, DRUs, DoD, SPPMs, and SPPCs.

(6) Chairs HQDA SPWG.

(7) Coordinates with Family Advocacy Program (FAP) manager to ensure suicides related to domestic abuse and child abuse, including children and adults, victims and offenders, Regular Army (RA) Soldiers, and dependents, are reviewed in the annual HQDA, FAP Fatality Review Committee.

(8) Assesses feasibility in the use of emerging technologies in SPPs.

(9) Assists in developing the installation suicide prevention personnel workforce training requirements for initial and professional development training.

(10) Establishes a 1 to 5-year evaluation plan for at least one new or ongoing non-clinical ASPP activity and submit that plan to DSPO by 30 September each year.

f. Provide program management for the Army DoDSER Program. The Army DoDSER Program Manager supports the enterprise by monitoring completion and timeliness of DD Form 2996 on suicides and suicide attempts by Army Soldiers. The DoDSER Program Manager assists in the completion of an annual DoDSER Report published by the DSPO. The Army DoDSER Program Manager will—

(1) Coordinate with RA, U.S. Army Reserve (USAR), and U.S. Army Recruiting Command ASPP personnel to ensure DD Forms 2996 are accurate and complete.

(2) Respond to ad hoc requests for information from commanders and prevention personnel; completing quality assurance reviews on submitted DD Forms 2996; tracking completed and delinquent DD Forms 2996; completing transfers on required DD Forms 2996; resolving duplicate DD Forms 2996; assisting in obtaining information for DD Forms 2996 (for example, AR 15–6 reports, DA Form 7747, and others); and submitting improvement recommendations to Psychological Health Center of Excellence and the Army SPPM.

(3) Publish guidance for the identification of local DoDSER points of contact (POCs).

(4) Send follow-up messages for all events for which DD Form 2996 is not received in the required 60 days of notification of the Armed Forces Medical Examiner System (AFMES) confirmation of suicide or within 30 days of an identified suicide attempt.

1–18. Chief, Army Reserve

The CAR will—

a. Ensure regional and major subordinate commands (MSCs) use the initiative evaluation process (IEP) for developing initiatives to prevent suicides.

b. Oversee execution of the data-informed suicide prevention actions through a command governance process.

c. Appoint personnel to participate in HQDA suicide prevention governance and associated working groups and ensure personnel provide data, information, analysis, recommendations, and evaluation results.

d. Identify the requirements for the distribution of suicide prevention training materials.

e. Ensure USAR units' compliance with requirements prescribed in this regulation and advise DPRR regarding the challenges associated with suicide prevention for the Reserve.

f. Recommend policies and operational tasks to DPRR regarding the tailored requirements for suicide prevention within the USAR.

g. Establish procedures for reporting suicidal and other harmful behaviors in accordance with requirements prescribed in this regulation.

h. Conduct an AR 15–6 investigation on all suspected Soldier suicides.

i. Ensure submission of DA Form 7747 and DD Form 2996 to the Army SPPM for every suicide or suspected suicide.

j. Oversee execution of the suicide prevention data-informed actions through a command governance process.

k. Monitor suicide prevention efforts across prevention, intervention, and postvention. Conduct annual evaluation of the ASPP to assess performance and share results.

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

m. Require USAR Soldiers in medical military occupational specialties to receive training on suicide prevention and related behaviors.

1–19. The Surgeon General

TSG will—

a. Ensure Army healthcare providers, including Army behavioral and mental health providers, meet the Assistant Secretary of Defense for Health Affairs policies, guidelines, and requirements for suicide prevention competency and training.

b. Coordinate with Director, Defense Health Agency (DHA) in the assignment of the installation directors of psychological health (IDPHs) to—

(1) Participate in unit R2 forums and S2FRABs.

(2) Provide consultation to commanders on the management of high-risk Soldiers and the results of the Behavioral Pulse tool.

(3) Provide Army BH epidemiological consultation services.

(4) Support data requests to ensure complete and quality DoDSERs.

c. Advise the DCS, G–9 with respect to all medical and BH aspects of suicide prevention, to include the epidemiological aspects of suicide prevention, intervention, and postvention.

d. Provide recurring data to the Army SPPM on suicide deaths, attempts, and ideations.

e. Provide support that enables the development of performance metrics that assist in the monitoring of critical outcomes and program performance.

f. Ensure Army personnel participate in suicide prevention governance and associated working groups. Personnel will provide data, information, analysis, recommendations, and evaluation results.

g. Designate an Army Director of Psychological Health to serve as the Chief BH staff officer for the Army and U.S. Army Medical Command (MEDCOM); SME to the Army Surgeon General; and senior BH consultant to ACOM, ASCC, and DRU commanders; and to manage the Army BH System of Care, Army behavioral health officers (BHOs) who are assigned to and under the command and control of an Army operational commander, and the Army clinical suicide prevention officer. The Army Director of Psychological Health will—

(1) Ensure appointment of a BH officer to serve as the MEDCOM clinical suicide prevention officer.

(2) Ensure each garrison has a designated IDPH and Army BHOs are assigned to and under the command and control of U.S. Army Forces Command unit commanders.

(3) Ensure policy development and metrics monitoring and education (for example, lethal means) pertaining to the management of Soldiers at risk for suicide occurs at the installation and regional levels, to include Army BHOs who are assigned to and under the command and control of an Army operational commander.

h. The Army MEDCOM clinical suicide prevention officer will—

(1) Serve as the Army clinical suicide prevention officer and SME to the Office of The Surgeon General (OTSG), BH Division Chief, Behavioral Health Service Line (BHSL) and DoD officials.

(2) Manage the MEDCOM quarterly clinical suicide prevention review; interfacing with Army regional directors of psychological health and IDPHs to provide a multidisciplinary clinical review of cases of suicide to share best practices, develop BH policy recommendations, and mitigate risk of suicide of beneficiaries.

(3) Collaborate with numerous individuals, organizations, and working groups: Office of the DCS, G–9, DHA Public Health Division, MEDCOM Army Recovery Program and G–9 SPWG meeting designed to enhance communication and bridge gaps in services.

(4) Provide MEDCOM trend analysis reports on BH access to care and recommendations to OTSG, medical readiness commands, regional directors of psychological health and IDPHs and BHSL on current policy, mitigation strategies, and evidenced-based clinical practice.

i. Ensure commanders of medical readiness commands—

(1) Meet established postvention requirements and participate in the MEDCOM postvention processes and Fatality Review Board.

(2) Provide personnel to participate in CR2Cs and associated working groups. Personnel will provide data, information, analysis, recommendations, and evaluation results.

(3) Collaborate with garrison commanders (GCs) and key stakeholders on the integration of services to achieve ASPP goals and objectives.

(4) Provide suicide behaviors data and participate in installation and command S2FRAB and installation SPWG.

j. Coordinate with Director, DHA to provide Army BH epidemiological consultation services to the Army—

(1) Provide quarterly reports on suicide studies, evaluations, consultations, and other findings with relevance.

(2) Support suicide prevention research and evaluation efforts.

(3) Conduct implementation program evaluation of proponent program of instruction and instruct individual readiness training on an as-needed basis and focused on priorities determined by the U.S. Army Training and Doctrine Command (TRADOC) and the U.S. Army Combined Arms Center.

k. Publish quarterly reports to HQDA, DCS, G–9, DPRR, ACOMs, ASCCs, and DRUs on studies, evaluations, consultations, and other findings with relevance to the suicide prevention enterprise at usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil.

1–20. The Judge Advocate General

TJAG will provide advice for the interpretation of laws and regulations in support of the ASPP.

1–21. Chief of Chaplains

The CCH will—

a. Support planning, implementation, and evaluation of suicide prevention activities and training with the DCS, G–9, to include promoting community and professional awareness of chaplain confidential counseling to all Soldiers and Family members for purposes of either self-reporting or reporting others at risk for harm to self or others.

b. Assist in the development of spiritual readiness initiatives, policies, and programs as part of the spiritual domain.

c. Provide support to senior commanders (SCs) for planning, implementing, and evaluating of spiritual readiness and suicide prevention activities and training.

d. Identify personnel to participate in suicide prevention governance and associated working groups at echelon. Personnel will provide data, information, analysis, recommendations, and evaluation results.

e. Share evaluation results of spiritual readiness and suicide prevention activities (for example, healthy relationships).

f. Assist in the execution of suicide prevention training to the force per AR 165–1.

g. Provide personnel to participate in SPWG at echelon, to include the suicide response team (SRT) and S2FRAB.

h. Encourage and promote concepts of religiously informed spiritual well-being and good health among Soldiers and Family members.

i. Ensure chaplains—

(1) Seek advice of supporting BH professionals.

(2) Collaborate with combat and operational stress control teams, MFLCs, and other prevention specialist to provide multidisciplinary support, normalize referrals, and reduce stigma associated with help-seeking behavior.

(3) Advise commanders on moral and ethical issues and other factors that may result in an increased risk for suicide behaviors and overall risky behaviors.

(4) Receive training to identify individuals who may be at increased risk of suicide and make appropriate referrals.

(5) Provide the suicide prevention training expertise to assist the commander in the education awareness training process.

(6) Advise and assist other staff and working group members (for example, FAP manager and MRTs) to meet identified training needs.

(7) Function as secondary gatekeepers for at-risk personnel.

(8) Lead the spiritual fitness components for suicide prevention and share data, trends, analysis, recommendations, and evaluation results with the SPPC and the CR2I.

j. Ensure religious affairs specialists—

(1) Collaborate with combat and operational stress control teams, MFLCs, and other prevention specialists to provide multidisciplinary support, normalize referrals, and reduce stigma associated with help-seeking behavior.

(2) Advise Soldiers on moral and ethical issues and other factors that may result in an increased risk for suicide behaviors and overall risky behaviors.

(3) Receive training to identify individuals who may be at increased risk of suicide and make appropriate referrals.

(4) Provide the suicide prevention training expertise to assist the commander in the education awareness training process.

(5) Advise and assist other staff and working group members (for example, FAP manager and MRTs) to meet identified training needs.

1–22. Provost Marshal General

The PMG will—

a. Provide policy guidance to Provost Marshal Director of Emergency Services (DES) to support suicide prevention governance at echelon.

b. In coordination with the Director, U.S. Army Criminal Investigation Division (USACID), provide suicide ideation data to commander and CR2Cs on topics that support suicide prevention efforts to identify at-risk behavior.

c. Provide personnel to participate in SPWG at echelon and associated working groups. Personnel will provide data, information, analysis, recommendations, and evaluation results.

d. Provide the Director, DSPO, through the Army SPPM, the criminal investigation report of a Soldier's death by suicide and access to the criminal investigation files within 30 days of the report being completed (see DoDI 6490.16).

e. Establish installation-level protocols for law enforcement response to potential suicide situations that are discreet and avoid increasing stress for the personnel in suicidal crisis.

f. Reinforce instruction presented at the U.S. Army Military Police School concerning identification of persons at risk for suicide and emphasize that actions taken by law enforcement in the LOD may cause some people to be at increased risk of suicide.

g. Ensure designated installation personnel coordinate with SPPC and SPWG to assess utilization and capacity of installation and off-post firearms storage and develop recommendations for execution.

1–23. Director, U.S. Army Criminal Investigative Division

The Director, USACID will—

a. Provide criminal data analysis on topics that support suicide prevention efforts to identify high-risk behavior.

b. Provide personnel to participate in SPWGs at echelon and associated SPWGs. Personnel will provide data, information, analysis, recommendations, and evaluation results.

(1) Ensure USACID offices provide personnel to participate in the S2FRAB.

(2) Investigate noncombat deaths in accordance with DoDI 5505.10 and AR 195–2.

c. Ensure personnel support SPWG. Personnel will provide data, information, analysis, recommendations, and evaluation results.

d. Provide the Director, DSPO and the Army SPPM the criminal investigation report of a Soldier's death by suicide and access to the criminal investigation files within 30 days of the report being completed (see DoDI 6490.16).

e. Ensure supervisors in USACID and special agents in charge of the supporting USACID element—

(1) Investigate noncombat deaths in accordance with DoDI 5505.10 and AR 195–2.

(2) Establish liaison with local civilian law enforcement agencies, coroners, and medical examiners, as appropriate, to obtain information regarding suicide-related events involving military personnel, their Families, or DA Civilians, which may have occurred off-post, and provide such information to the SPPC and AR 15–6 investigating officer (IO).

(3) As allowed by appropriate regulations, provide the SC, DC, SPWG, and AR 15–6 IO extracts from the USACID reports of investigation (including psychological autopsy), which may be useful in understanding the reasons for a suicide and in formulating future prevention plans.

(4) Provide information to SPPC, SPPMs, and the Army DoDSER program manager for the timely completion of DoDSERs in accordance with DoDI 6490.16.

(5) Coordinate with commanders regarding suspected suicide death investigations to ensure commanders take appropriate, timely actions (for example, AR 15–6 and LOD investigations), in the event that the suspected suicide death is afterward determined to be a suicide. The USACID element investigating the event assists commanders by providing data in support of completing DA Form 7747.

1–24. Director of Army Safety

The Director of Army Safety will—

a. Appoint representatives to support safety initiatives to prevent suicide, such as lethal means safety.

b. Ensure personnel participate in SPWG at echelon and associated working groups. Personnel will provide data, information, analysis, recommendations, and evaluation results.

1–25. Commanding General, U.S. Army Training and Doctrine Command

The CG, TRADOC will—

a. Implement suicide prevention training developed in coordination with the DCS, G–9 for all levels of PME, to include incorporating ACE–SI Tier 1 for select PME courses.

b. Coordinate the integration of all components of holistic suicide prevention into Army school curriculum.

c. Implement functions as the Army Prevention Force Modernization Proponent in accordance with AR 5–22 with responsibility to integrate doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy for ASPP-enabling functions.

1–26. Commanding General, U.S. Army Materiel Command

The CG, AMC, through the CG, IMCOM, will—

a. Implement ASPP policies.

b. Appoint or assign SPPM duties in writing to—

(1) Provide installation assistance for execution and monitoring of the ASPP and to serve as a liaison to the Assistant Chief of Staff for Personnel and ACOM, ASCC, and DRU SPPMs.

(2) Provide data, analysis, training compliance, outcomes, and recommendations to commands in support liaison officer roles.

c. Coordinate, monitor, and report on the execution of the Army's and installations' ASPP efforts.

d. Deliver HQDA-approved initial training and professional development for installation SPPCs.

e. Provide a roster each quarter of assigned suicide prevention personnel at installations, camps, and stations to the Army SPPM.

f. Conduct installation army operational procedure inspections on the SPP based on the procedures designated.

g. Ensure personnel participate in HQDA SPWGs. Personnel will provide data, information, analysis, recommendations, and evaluation results.

h. Provide Army survivor outreach services to Families who experience losses.

i. Provide and evaluate educational opportunities for Soldiers, DA Civilians, and Families to develop and sustain resilience.

j. Deliver capabilities in support of prevention, intervention, and postvention.

k. Ensure SPPCs complete initial training, attend appropriate professional development training, and provide annual report to the Army SPPM.

1–27. Commanders of Army commands, Army service component commands, and direct reporting units

Commanders of ACOMs, ASCCs, and DRUs will—

a. Monitor the administration of the ASPP through the CR2C to ensure compliance with policies and mandatory tasks established by this regulation. Requirements for installation R2 council are outlined in AR 600–63.

b. Ensure ACOM, ASCC, and DRU SPPM oversee suicide prevention metrics and monitor suicide prevention efforts across prevention, intervention, and postvention.

c. Embed suicide prevention education in command strategic documents, such as campaign plans and training guidance, to ensure consistent, regular, and comprehensive delivery of information and support at the appropriate frequency, duration, and intensity.

d. Establish and charter S2FRAB and provide summary report to the Army SPPM at usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil no later than 45 days of the S2FRAB.

e. Assess execution of suicide prevention, intervention, and postvention through staff assistance visits (SAVs) to subordinate commands.

f. Ensure submission of DA Form 7747 to the DCS, G–9 and ACOM, ASCC, or DRU SPPM in accordance with published timelines for every suicide or death that is being investigated as a possible suicide.

g. Ensure that Soldiers report their dependent's suicide death to nearest installation Defense Enrollment Eligibility Reporting System (DEERS) office within 30 days of receiving death certificate.

h. Ensure subordinate units implement approved suicide prevention training effectively. Ensure trainers at all levels are properly trained to enable effective training delivery.

i. Ensure SCs consult with their supporting medical providers for—

(1) Advice on the ASPP and medical capabilities.

(2) Collaboration with operational leadership and key stakeholders on the integration of BH and medical services.

(3) Coordination with the Army BHOs who are assigned to and under the command and control of an Army operational commander to provide command consultation on all aspects of the psychological health of Soldiers and their Families.

(4) Advice on protocols for the identification and management of at-risk Soldiers.

j. Ensure SCs arrange uninterrupted Army-provided BH care for transitioning Soldiers through risk screenings and warm handoffs.

k. Ensure that geographically-dispersed commanders have access to supporting medical providers to facilitate and implement suicide prevention policies.

l. Ensure that Army BHOs are assigned on orders to Army operational commands to provide command consultation on at-risk Soldiers and other BH trends within the unit and to coordinate with supporting BH providers (for example, combat operational control stress units) on the early identification, triage, and disposition of individuals.

1–28. Commanding General, U.S. Army Reserve Command

The CG, USARC will—

a. Provide oversight and strategic guidance for implementing the ASPP and address suicide prevention using a multidisciplinary approach (see chap 3).

b. Appoint SPPMs for each geographic and functional USARC.

c. Manage suicide prevention quota allocations for all courses in USAR schools.

d. Coordinate suicide prevention efforts with United States Army Forces Command.

e. Ensure USAR Soldiers in medical military occupational specialties receive annual training on suicide prevention and related behaviors.

f. Establish command procedures for reporting suicidal behaviors in accordance with requirements prescribed in this regulation.

g. Establish and charter a S2FRAB at geographic and functional commands and provide report to the Army SPPM at usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil within 45 days of convening.

h. Conduct an AR 15–6 investigation on all suspected Soldier suicides.

i. Ensure submission of DA Form 7747 in accordance with published timelines to the Army SPPM for every suicide or equivocal death that is being investigated as a possible suicide.

j. Monitor suicide prevention efforts across prevention, intervention, and postvention.

k. Conduct annual assessment of the ASPP.

l. Provide initial training and professional development for SPPMs.

m. Provide recurring data to the Army SPPM on suicide deaths, attempts, and ideations.

n. Establish command policy and procedures for implementation of Reserve Component (RC) SRTs.

o. Provide personnel to complete DoDSER in coordination with Army DoDSER Program Manager.

p. Ensure Soldiers report their dependent's suicide death to nearest installation DEERS office within 30 days of receiving death certificate.

q. Ensure the USARC SPPM—

(1) Administers, manages, and provides direction to the USAR ASPP.

(2) Serves as the POC for information and advisor to the CAR on suicide prevention, including promoting awareness, prevention, intervention, postvention, and training and education. Annually reports on compliance and outcomes.

(3) Develops a command suicide prevention plan that addresses the public health approach to suicide.

(4) Implements ASPP goals, objectives, operating procedures, and policies.

(5) Reviews, assesses, and recommends policy changes as appropriate.

(6) Interprets ASPP policy in response to inquiries from USARC MSCs and DRUs and their subordinate commands.

(7) Prepares budget submissions, directs allocation of funds, monitors execution of resources, and serves as the functional budget program manager for the ASPP.

(8) Maintains liaison between the USARC, HQDA, ARNG, and other Federal agencies.

(9) Compiles, analyzes, and shares suicide prevention data to monitor and evaluate prevention, intervention, and postvention initiatives. Recommends measures, symptoms, processes, and procedures to increase efficiencies with the ASPP.

(10) Obtains copies of all submitted DA Forms 7747; consolidates and analyzes all suicide-related statistics to inform prevention strategies and provide periodic reports to the Director of Services and Support Division, MSCs, and SPPMs.

(11) Inputs data about suicide deaths to the DoDSER for all confirmed and suspected suicide and suicide attempt regardless of hospitalization in accordance with DoDI 6490.16. Provides guidance to USAR Operations regarding the DoDI 6490.16 reporting requirements and timeline of suicide ideations, attempts, and suicide deaths.

(12) Processes, tracks, and reports on all AR 15–6 investigations and submits all completed documents to HQDA as directed by policy. Serves as the advisor to the IO in AR 15–6 investigations.

(13) Establishes and maintains program-level evaluation plans. Incorporates SAVs, measures, data collection, analyses, and reporting procedures for implementation at MSCs. Identifies and distributes information to the MSCs regarding best practices in suicide prevention.

(14) Provides guidance on suicide prevention training changes. Coordinates and implements ACE–SI train-the-trainer workshops at Reserve support commands.

(15) Maintains record of all certified ACE–SI trainers.

(16) Provides USAR Soldiers with State and local resources at the community level.

(17) Serves as a member of CR2C and associated working groups as designated, representing suicide prevention issues and providing input on MSC and USARC suicide prevention.

(18) Works with the RRPC or equivalents to review suicide-risk data and identifies units with potential issues.

(19) Facilitates the SPWG, SRT, and the S2FRAB.

(20) Conducts annual review of the USAR SPPM onboarding training and updates the curriculum as needed.

(21) Receives and monitors all commander's critical information requirements (CCIRs) and provides support to commanders, leaders, and Soldiers as needed.

(22) Conducts annual inspection program and organizational inspection program for MSCs to ensure program effectiveness.

1–29. Commanders of corps and divisions

Corps and division commanders will—

a. Be responsible for the overall operations, execution, and assessment of suicide prevention efforts across the command.

b. Ensure compliance with regulations and policies established for the conduct of effective prevention activities.

c. Attend and inform higher S2FRAB through data, information, analysis, recommendations, and evaluation results.

d. Actively participate and support the SC in the suicide prevention mission, goals, and objectives.

e. Ensure reporting, awareness, and visibility of suicide and risk are reported through both mission and senior command channels.

1–30. Senior commanders

SCs will—

a. Oversee the ASPP and leverage the garrison command-appointed installation SPPC as the ASPP SME. Consult with the IDPH before taking any BH actions.

b. Conduct reviews of suicide prevention, intervention, and postvention activities.

c. Establish installation policy for the SRT and the S2FRAB.

1–31. Garrison commanders

GCs will—

a. Integrate suicide prevention training as part of in and out processing and RSOI.

b. Ensure the provision of services and assistance to Families, unit members, and coworkers who experience loss due to suicide.

c. Appoint a full-time SPPC or appoint duties to existing personnel whose duties include implementation of the installation ASPP and recurring reporting and updates on ASPP to the SC.

d. Coordinate with medical authorities and staff for suicide prevention activities.

e. Inform DA Civilians of support resources at their location.

f. On Joint installations, conduct review of memorandum of agreement with their counterparts from other military Services' installations when the Army and the other Service enter a joint basing agreement where common services are provided by one Service for both bases.

g. Inform Soldiers through the Casualty Assistance Office on requirement to report their dependent's suicide death to nearest installation DEERS office within 30 days of receiving death certificate.

h. Ensure in and out processing systems identify Soldiers during the transition process who are receiving treatment. Ensure procedures are in place that ensure coordination with installation and gaining command medical activities.

i. Support suicide prevention training for Family members and ACS staff.

j. Appoint on orders personnel to serve as the DoDSER POC for at least 1 year. The DoDSER POC will complete required training and submit record to the IMCOM SPPM within 30 days of appointment.

k. Resource the professional development training of all ASPP installation positions.

l. Ensure the installation SPPC—

(1) Serves as the POC for information and advisor to SC on suicide prevention, including promoting awareness, prevention, intervention, postvention, training, and education. Provide a status on the ASPP to the SC.

(2) Compiles, analyzes, and shares data to identify high-risk populations and monitors and evaluates awareness and prevention initiatives and suicide prevention training.

(3) Develops an annual installation suicide prevention plan and reports annual compliance and outcomes. Reviews and reports on suicide prevention, intervention, and postvention activities, training, resources, outcomes, and capabilities at least annually, through the CR2C.

(4) Serves as a member of CR2C and working groups as designated, representing suicide prevention issues and providing input into related programs, initiatives, and pilots.

(5) Maintains inventory of installation and command suicide prevention, intervention, and postvention resources available to assigned units to enable integration across installation.

(6) Oversee all suicide prevention training and provide support to commanders for planning suicide prevention training events and maintain records of all ACE–SI trainers. Advise commanders on fidelity of

training. Serve as the singular authority for certification of all ACE–SI trainers upon completion of the ACE–SI tier two course of instruction.

(7) Completes the HQDA ASPP online suicide prevention personnel training within the first 120 days of assuming SPPC responsibilities.

(8) Integrates suicide primary prevention and postvention into unit R2 teams, community, Family, and Soldier support programs (for example, sponsorship, BH, sexual assault, substance misuse, and domestic violence) as appropriate.

(9) Communicates suicide prevention messages and ensures suicide awareness materials are readily available to commanders.

(10) Administers the SPWG and S2FRAB (see chap 3). Develops charters, minutes, and tracks action items.

(11) Facilitates and coordinates the SRT and postvention activities within 48 hours of a death by suicide.

(12) Obtains copies of submitted DA Form 7747. Consolidates and analyzes all suicide-related statistics to inform prevention strategies and provide status at the SPWG.

(13) Serves as a member of the installation FAP Fatality Review Committee, presenting suicide prevention issues and providing input into related programs. Works with the installation FAP manager to identify suicides that may be related to domestic abuse and child abuse, including children and adults, victims and offenders, RA Soldiers and dependents, for review.

m. Ensure the Director, ACS—

(1) Coordinates the Family member suicide prevention training.

(2) Conducts appropriate in-service training (ACE–SI, counseling on access to lethal means safety, and so forth) of ACS staff members, including volunteers who routinely assist Soldiers, DA Civilians, and Family members who might be at risk of suicide.

(3) Empowers Family members with knowledge, training (if desired), and actions for how to contact and communicate a suicide attempt, ideation, or behavior change to the Soldier's team, squad, or unit chain of command after hours, over weekends, during holidays, and leave.

(4) Shares evaluation results, data, trends, analysis, and recommendations with the SPPC, the SPWG, and the CR2C for Family member and dependent programs that reduce risk and strengthen protective factors for suicide prevention.

n. Ensure the Director, Family, Morale, Welfare and Recreation (FMWR)—

(1) Integrates suicide prevention into FMWR programs, such as firearm storage, as appropriate.

(2) Supports suicide prevention efforts by providing data, trends, analysis, and evaluation results at the SPWG and CR2C.

1–32. Brigade and battalion commanders

BDE and battalion commanders will—

a. Publish a command policy that operationalizes and describes unit activities to promote resilience, protective factors, and positive behaviors; prevent harmful behaviors (to include procedures for management and tracking of Soldiers at risk for suicide); and implement the three components of suicide prevention (prevention, intervention, and postvention). Monitor efforts across prevention, intervention, and postvention.

b. Establish a unit R2 forum process to provide early detection of risk behavior through systematic assessment; use visibility tools (see para 2–3) and understanding of local resources; implement timely, local, and targeted responses for prevention, intervention, and postvention; and enhance readiness and resilience of unit Soldiers and their Families and DA Civilians. Coordinate with supporting medical and BH providers, unit ministry team, and MFLC for support.

c. Consult with supporting BH provider and unit chaplain to establish procedures to identify and manage high-risk Soldiers to procure suicide risk factor data. Actively participate to address and mitigate at-risk Soldiers.

d. Incorporate annual face-to-face suicide prevention training into the overall unit training plan. Retain records of Soldier suicide prevention training. Provide records to installation SPPC upon request. Virtual training may be approved at battalion commander level if Soldiers are at a remote location and face-to-face is unavailable. Virtual and online training may be coordinated for geographically dispersed units or teams by installation SPPC upon request.

e. Serve as a member of CR2C. Report on unit R2 forum status and share results of suicide prevention, intervention, and postvention activities.

f. Implement SRT and postvention activities within 24 hours and no later than 48 hours of a death by suicide.

g. Record and report all suicides, to include deaths being investigated as suspected suicides, using DA Form 7747 in accordance with timelines outlined in chapter 2. For visibility, notify ACOM, ASCC, or DRU SPPM and installation SPPC of DA Form 7747 submission to the Army SPPM.

h. Implement and enforce the periodic health assessment process and the Deployment Health Assessment Program to enable the early identification and treatment of physical and BH issues at critical stages in the deployment cycle.

i. Regulate privately owned weapons in accordance with this regulation (see para 2–7).

1–33. Commanders of companies, detachments, and equivalent units

The commanders of companies, detachments, and equivalent units will—

a. Establish a R2 forum process that includes how to identify and manage high-risk Soldiers. Actively participate in meetings in which at-risk Soldiers are addressed and mitigation plans are put into place.

b. Implement and monitor suicide prevention, intervention, and postvention activities.

c. Incorporate annual suicide prevention training into the overall unit training plan. Retain records of Soldier suicide prevention training and record in the Digital Training Management System (DTMS). Provide records to installation SPPC upon request.

d. Ensure Soldiers are encouraged to seek assistance if they are experiencing challenges or have been identified with suicide-risk symptoms (see para 2–6).

e. Implement health and welfare checks system with first-line leaders in barracks and in residence especially for higher risk Soldiers and given any potential life changing situations (for example, death, divorce or break up, legal actions, demotion, or not being promoted).

f. Participate in SRT meetings.

g. With the support of suicide prevention stakeholders (SPPCs, chaplains, supporting BH providers, RRPCs, R2 personnel, performance experts, ACS, SJA, or DES) assess unit risk and develop tailored and systematic training, assess outcomes, and share lessons learned as part of the unit R2 forums.

h. Use DA Form 7747, Section 3, in the conduct of AR 15–6 investigations on all suspected Soldier suicides, to include timelines; and record and report all suicides, to include deaths being investigated as suspected suicides, using DA Form 7747. For visibility, notify ACOM, ASCC, or DRU SPPM and installation SPPC of DA Form 7747 submission to the Army SPPM.

i. Assess Soldier and Family continuity of care and consider requesting U.S. Army Human Resources Command support to adjust, delete, or defer orders for medical reason to provide Soldiers and Family members struggling with mental health greater stability and consistent mental health care with the same provider.

1–34. Community Ready and Resilient Integrator

The CR2I appointed by the SC (RA) or regional readiness commander (USAR) will—

a. Develop, design, and implement the SC Community R2 Plan, including capability and resource requirements. Ensure the SC Community R2 Plan addresses the public health approach to suicide prevention.

b. Integrate ASPPs, policies, and practices effectively and in collaboration, as appropriate, with individuals or entities responsible for prevention programming.

c. Develop a process to oversee the implementation of ASPP, activities, and policies through the CR2C.

d. Promote awareness of community resources for all prevention areas, including suicide prevention.

e. Coordinate with internal and external organizations to share information, trends, innovative practices, and lessons learned.

Chapter 2
Suicide Prevention, Intervention, and Postvention

2–1. Overview
The Army's public health approach to suicide prevention, per DoDI 6400.09, promotes a positive environment and prevents harmful behaviors. Integrated prevention targets risk and protective factors (see app B) and the environment to set the conditions to promote positive behaviors and outcomes (for example, trust, cohesion, purpose, belonging, adaptability, self-awareness, self-development, and self-discipline).

2–2. Army Integrated Suicide Prevention Program framework and program elements
The Army Integrated Prevention Program will leverage the suicide prevention framework of visibility, continuous assessment, and targeted actions to institute a comprehensive and proactive policy to address suicidal behavior.

a. Visibility. Visibility involves the identification, collection, and integration of data to deliver a more holistic picture across the individual, unit, leader, Family, and community levels. This increased visibility will enable leaders to be more proactive in increasing positive behaviors and intervene, thereby reducing at-risk behaviors. The intent is to have sufficient information to monitor and guide efforts for improved resilience and readiness.

(1) Visibility tools are available to assist leaders with early identification of at-risk Soldiers and overall unit risk propensity to inform prevention strategies. Visibility tools include, but are not limited to the CRRT, Azimuth Check, and Defense Organizational Climate Survey (DEOCS) (see para 2–7).

(2) Use of periodic and systematic review of individual and trend data can help determine the gaps between the current and desired end state for the ASPP. Baseline data describes the conditions that exist in the organization before implementation of prevention initiatives. Analysis and reporting that keeps senior leaders aware of suicidal behavior and tracks demographic trends is helpful in developing or refining ASPP objectives and immediately identifies events that could potentially raise the level of risk for a segment of the Army.

b. Continuous monitoring and local outcomes evaluation. Continuous monitoring and evaluation efforts refer to the investigation, exploration, and analysis of suicide prevention activity (PA) outputs and outcomes to identify deviations from standards, emerging trends, and monitoring progress toward meeting objectives. Assessment is a key component of the process and is directed to achieving desired outcomes or end states. The assessment process entails three distinct tasks: continuously monitoring the situation and the progress of the operations; evaluating the operation against measures of effectiveness and measures of performance to determine progress relative to the mission, objectives, and end states; and developing recommendations and guidance for improvement. Improving communications between leaders and Soldiers, gathering objective evidence, and sharing promising practices are actions that will promote improvement that brings readiness value to the Army.

c. Data-informed targeted actions. Targeted actions are the suicide prevention inputs and will be nested within the ASPP goals and identified through a combination of leader observations, visibility tools, and continuous assessments. Actions are planned and implemented for maximum effectiveness.

2–3. Visibility tools
The Army routinely collects and analyzes suicide-related data on the risk factors surrounding suicidal behavior to inform the development and sustainment of effective strategies to reduce suicides and suicide attempts. It is important that commanders have access to this timely and accurate information to identify or mitigate emerging situations before they become critical. Surveillance data may be used in conjunction with local level evaluation efforts (see chap 7). Commanders and prevention personnel should strive to define the problem and create a common operating picture. Commanders and the suicide prevention workforce can identify prevention actions (see app B) to build and maintain resilience based on the information and analysis from these tools. There are multiple visibility tools that identify risk and protective factors that impact readiness. Commanders will formulate a data-informed prevention approach using reports from these risk reduction tools and other assessments to improve or sustain unit readiness.

a. The Behavioral Health Pulse. The BH Pulse is a voluntary and anonymous survey tool that assesses the BH needs of a unit.

(1) The tool provides aggregate unit-wide data and is optimal if at least 70 percent of personnel in selected units participate. The tool should be reserved for use only when indicated, for example if there is a

specific problem identified in a unit or if aggregate data is required to identify general concerns. The BH Pulse contains aspects of a visibility tool, whereby commanders can assess how a unit functions in terms of resilience as compared to the Army. Metrics allow for trends analysis of how a unit changes over time (in response to a training event, deployments, or other significant events). To maximize utility of the tool and data over time, the tool should be administered no more frequently than every 12–18 months. The tool is administered at the request of the commander. Commanders will consult with their supporting BH provider for the analysis and recommendations.

(2) The core survey is 15 minutes and covers four main areas to indicate resilience: work environment (morale, role overload, unit cohesion, or garrison stressors); social relationships (loneliness, social integration, or marriage issues); risk factors (family violence, sexual harassment and sexual assault, and risky behaviors); and BH (anxiety, alcohol use, or stigma about seeking help).

(3) Commanders will consult with their supporting BH provider to determine if a BH Pulse assessment will be valuable in guiding command decisions. Commanders will request support in the selection of units and interpretation of data to guide the commander in making appropriate decisions to address BH concerns conveyed by the unit's data. Commanders will request consultation from supporting BH providers on the findings and recommendations from the assessment.

b. Current version. The most current version of the BH Pulse tool can be requested from the Army SPPM at usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil.

c. The Commander's Risk Reduction Toolkit.

(1) Use of the CRRT can help commanders assess suicide risk within their units.

(2) The CRRT will facilitate unit command officials' ability to develop suicide prevention and intervention strategies and ensure Soldiers receive the assistance they need.

(3) Authorized battalion and company unit command officials should at a minimum access the CRRT when they receive a new Soldier and when notified that a Soldier had a risk event either from or in the Vantage Platform or from an external agency (for example, ASAP, Blotter, e-profile, and so forth) to assess suicide risk.

(4) Authorized staff and officials at the BDE and above should access the CRRT at least monthly to monitor suicide risk trends and patterns that may warrant resource re-allocation. Authorized unit command officials should contact their installation or USAR command or ARNG State/Territory RRPC or RRPC equivalent for all CRRT questions related to system access, platform issues, and data interpretation or to request training on the system.

d. The Defense Organizational Climate Survey and Defense Organizational Climate Pulse. The DEOCS and Defense Organizational Climate Pulse (DOCP) is a confidential, command-requested organization development survey that measures cross-cutting 19 risk and protective factors to help leadership and unit and organization leaders understand problematic behaviors in their organization. The voluntary DEOCS 5.0 survey contains roughly 100 questions based on leading social and military research. Commanders and leaders can also add up to 10 multiple choice and 5 short answer questions from a list of over 600 questions covering 50 topic areas to customize the DEOCS 5.0 for their unit or organization. DEOCS results are provided to commanders in a new interactive dashboard that includes a breakdown by various categories. The DOCP is a customizable, short survey on organizational climate, including questions that are selected based on topics that are relevant to the unit or organization.

e. The Azimuth Check. The Azimuth Check is an annual requirement for Soldiers (see AR 350–53). The Azimuth Check is a confidential self-assessment tool comprised of a survey that assesses a Soldier's level of overall fitness across the five R2 dimensions: physical, emotional, social, spiritual, and family. In addition, it provides tailored self-development resources to Soldiers. Commanders can receive aggregate unit-level results that indicate protective and risk factors.

f. Tool-supported suicide prevention decision making. Leaders may refer to scientifically-based, field-tested tools that provide tactics, techniques, and procedures to facilitate the identification, management, resourcing, and readying of Soldiers that may be at risk for suicide or negative BH outcomes. These tools and associated processes begin with leader engagement at team, squad, and platoon leader level.

2–4. Suicide reporting and surveillance

Commanders will ensure the following suicide surveillance and reporting procedures are in place:

a. Army surveillance of suicidal behavior is a critical activity which includes the collection of information about suicidal behavior among all Soldiers. The DoDSER program standardizes suicide surveillance across the Services to support the DoD suicide prevention mission. The Army provides input to the

DoDSER database in accordance with protocols established by DoD. The DoDSER program monitors a suicide-related risk and contextual factors for suicide events that occur among Servicemembers. DD Form 2996 standardizes the data collected on suicide events and is an integral part of the ASPP. DD Form 2996 is required for each suicide and suicide attempt regardless of hospitalization occurring among all Servicemembers, to include the Soldiers serving on active duty, Soldiers in active status with the USAR, and Selected Reserve members.

(1) DD Form 2996 is used to report all suicides and suicide attempts regardless of hospitalization for all RA and RC Soldiers, to include the Selected Reserve (see DoDI 6490.16). DD Forms 2996 for suicides are due within 60 days from notification of death has been confirmed as a suicide by the AFMES. DD Forms 2996 for suicide attempts are due within 30 days of the event. See DoDI 6490.16 for mandatory procedures for providing required DoDSER data.

(2) The ASAP program manager will appoint a DoDSER POC for at least 1 year. If there is not an ASAP program manager at a location outside the continental United States (OCONUS), the senior medical commander will appoint on orders an individual who is not assigned or attached to a medical treatment facility (MTF) or other DHA organization to serve as the DoDSER POC. The DoDSER POC will coordinate with unit and installation medical personnel to complete DoDSERs for suicides and suicide attempts. For DD Forms 2996 of RC Soldiers, completion is assigned to the DoDSER POC assigned to that Army component. The POC ensures that the completed DD Form 2996 is submitted via https://dodser.health.mil/ within 60 days from notification that the death has been confirmed as a suicide by the Armed Forces medical examiner (AFME), and for suicide attempts, within 30 days of the event.

(3) The SPPC will monitor the completion of DD Form 2996. If a commander has any questions regarding who has a need to know, he or she should contact the servicing judge advocate before sharing any information.

(4) For all deaths by suicides and suicide attempts, ensure the disclosure of medical information conforms to privacy laws and regulations and appropriate protocols for disclosure of information are followed.

(5) DD Form 2996, as a reporting tool, is not intended to replace the psychological autopsy, which is limited to fatalities in which the manner of death is uncertain. Psychological autopsies may be requested by the AFME or USACID on active duty deaths under special circumstances. Additionally, the SC may instead request a behavioral analysis review through USACID. The psychological autopsy is a forensic investigative tool that is used to confirm or refute the death of an individual by suicide. It is not to be confused with gathering of information for suicide event surveillance for epidemiological purposes. Specifically, psychological autopsies assist in ascertaining the manner of death and are primarily used to resolve cases where there is an equivocal cause of death; that is, death cannot be readily established as natural, accidental, a suicide, or a homicide. Some examples might include a single vehicle accident or incidents involving unusual or suspicious circumstances, such as deaths due to substance abuse or resulting from apparently unintentional, self-inflicted gunshot wounds. Subjects for investigation include all Soldiers serving on active duty and members of other Armed Forces of the United States serving on active duty and assigned or attached to an Army unit or installation.

(6) The DoDSER POC will provide updates upon request from HQDA DoDSER POC on status of open DoDSERs (DD Form 2996).

b. AR 15–6 investigations are required and are intended to support suicide surveillance efforts, including the collection of informational data about suicide behavior; and provide the command, DA, and DoD with information helpful to developing policies, creating and funding SPPs and training events, and producing multimedia suicide prevention products.

(1) Commanders will conduct an AR 15–6 investigation on all suspected or confirmed Soldier suicides.

(2) The commander exercising general court-martial convening authority (GCMCA), or responsible general officer assigned to a command billet with a servicing SJA, is the appointing authority for all suicide investigations. This authority will not be delegated. The commander will appoint an IO in the rank of O–4 or above, in writing, within 15 days of notification of suspected suicide or death.

(3) The investigating command must submit the report of investigation to the SPPC within 90 days of the date of the suspected suicide. In each case, the IO will complete the investigation within 75 days of the date the CCIR reporting the suspected suicide was submitted. The investigating command then has 10 days to complete the legal review, appointing authority's action, and, if necessary, obtain a GCMCA ratification of findings and recommendations. The investigating command will submit the completed investigation to the SPPC within 1 business day of the approval authority's action or GCMCA ratification.

(4) Notice of the granting of an extension to the 75-day suspense for the investigation will be provided by the GCMCA in the investigating command's chain to the ACOM, ASCC, DRU, or USARC commander through the SPPC immediately upon issuance of such an extension. Such notice will identify the new suspense and include a timeline of investigative work completed to date, an explanation of the reasons for the extension, and a description of the intended course of action (COA) to ensure prompt completion of the investigation.

(5) All interviews with the Army or other military service personnel will be sworn statements. Although interviews of non-military personnel, including Family members, generally should be documented in writing (for example, written statement and IO summary of the interview), such interviews are not required to be sworn.

(6) The IO will consult DoDI 6490.16 and AR 638–34 for conduct of investigations into suspected suicides and requirements for suicide incident Family briefs.

(7) The IO will use DA Form 7747 and DD Form 2996 to help develop questions and guide their investigation.

(8) Include a copy of the Soldier's orders or certificate of performance to verify his or her duty status at the time of death.

c. Commanders are required to complete and submit DA Form 7747 on every suicide or suspected suicide. The form initially arose from a need to capture suicide event information in a formal location since it was previously not being entered into a consolidated database for analysis. DA Form 7747 is used in the determination and in future statistical analysis of Army suicides. The data obtained in the Commander's Suspected Suicide Event Report (CSSER) is intended to accomplish multiple purposes outlined below, to include streamlined and accurate data tracking and detailed analysis. The CSSER—

(1) Standardizes the collection of data across the Army.

(2) Simplifies the Army's current process for collecting information related to suspected deaths by suicide (circumstances, methods, and contributing factors surrounding the event).

(3) Facilitates the Army's ability to collect information for longitudinal analysis and policy decisions.

(4) The CSSER facilitates accuracy in tracking data from SIR through AR 15–6 investigation and is not intended to supplant the current SIR and commander's inquiry processes. Suicide-related reports are sent to senior leadership through multiple operational channels (email, SIR, phone calls, and so forth) with several inconsistencies that, at times, prompted a series of communications and requests for information to clarify. Capturing the data in one location is an effort to ensure accuracy, consistency, and viability of data for use in analysis.

d. Investigations are conducted to inform determination of death and to support data gathering for analysis. The AFMES makes suicide determinations for Soldiers serving on active duty. Suicide determinations for Soldiers not serving on active duty are made by local coroners as recorded on the formal death certificate. Commanders will conduct an AR 15–6 investigation into all suspected Soldier suicides.

e. USACID investigates noncombat deaths within its jurisdiction in accordance with DoDI 5505.10 and AR 195–2. Investigations of non-combat deaths with no DoD nexus are conducted by law enforcement agencies outside the DoD. USACID agents can leverage professional relationships with local authorities where appropriate under the guidelines of AR 195–2 to support local commanders in obtaining police reports, coroner's reports, and death certificates. LOD investigations are conducted on all deaths of Soldiers who, at the time of death, were on active duty, in an inactive duty training status, or where the death is suspected to be connected to a previous duty incident. The LOD investigations are conducted in accordance with AR 600–8–4.

f. The CSSER is composed of three sections: (I) Serious Incident Report; (II) Preliminary Inquiry (Commander's Initial Report); and (III) Commander's Final Report. The CSSER establishes timelines for submission for Soldiers in active duty status in three sections—

(1) *Section I Serious Incident Report.* The SIR is to be completed by the commander with help of law enforcement (for example, USACID, Provost Marshal Office, or DES) and casualty affairs. A suicide event SIR is submitted through operational reporting within 24 hours of the incident, in accordance with AR 190–45.

(2) *Section II Commander's Initial Report.* The Commander's Initial Report is completed by the commander with direct inputs from law enforcement (for example, USACID, Provost Marshal Office, or DES), casualty affairs, BH, unit medical, RRPC, and other SMEs (for example, Family Advocacy and financial readiness). Much of the information is available within the CRRT. Submit within 5 days of the incident.

(3) *Section III Commander's Final Report.* The Commander's Final Report entails the baseline questions for the IO to include in the investigation and should be submitted through the command within the allotted timeframe without compromising the integrity of the investigation. This section also meets the requirements outlined in AR 15–6 about conducting in-depth interviews and investigations (submitted within regulations, usually within 60 days of the event). In most cases, the form should be fit for submission even if the investigation is still incomplete. Section III should be completed by the IO and submitted by the commander within 60 days of the incident.

g. There are no timelines established for USAR commanders given the uncertainty of drill periods and ability to complete the required reports. The CAR will establish timelines that best fit USAR training and drill schedules and inform the Amy SPPM through the DPRR.

h. The Commander's Initial and Final CSSER reports (Sections II and III) are currently submitted directly to the Army SPPM via encrypted email at usarmy.pentagon.hqda-dcs-g-9.list.csser@army.mil. Army SPPM will forward the form to the Army DoDSER Program Manager, who will forward it to the POC completing the DD Form 2996. The coordination process will include the IMCOM SPPM and ACOM, ASCC, and DRU commanders.

2–5. Prevention

Prevention in the Army targets the internal (individual), external (Family, peers) and environment (unit, community) to set the conditions that reinforce readiness and resilience in all Five Dimensions of Strength (see AR 350–53) and consistent adherence to high professional standards. Prevention includes building resilience, support networks, removal from exposure, encouraging professional conduct and training, and ensuring conduct and fidelity of required training.

a. Suicide prevention efforts (education, outreach, crisis intervention, training, and policy) seek to reduce suicide risk while increasing factors (connectedness, financial readiness, reduced access to lethal means, and referral to care systems) that protect people from suicide.

b. A prevention approach focuses on individual, interpersonal, and organizational elements through a holistic approach to address risk and protective factors for self-directed harm and prohibited abusive or harmful acts, leveraging, where possible and appropriate, existing prevention efforts.

c. ASPP policies and programs foster healthy behaviors and climates, life skills, and stress management early on and reinforce these behaviors and skills using appropriate educational strategies to maintain proficiency throughout one's military career or civilian employment cycle.

2–6. Protective factors

a. Effective prevention efforts require a combination of risk reduction and strengthening of protective factors against self-harm and associated thoughts and behaviors. Enhancing protective factors allows for the mitigation of risk at the earliest stages, at times before intervention, is necessary.

b. Certain protective factors may help prevent or mitigate suicidal thoughts and behaviors and build resilience and include—

(1) Coping and problem-solving skills, including stress reduction techniques.

(2) Cultural and spiritual beliefs that encourage connecting and help-seeking behaviors, mitigate and discourage suicidal ideations, or create a strong sense of purpose or self-esteem.

(3) Connections to friends, family, unit, and broader community support.

(4) Supportive relationships with care providers, unit, and Family members.

(5) Availability of physical and mental health care and increased care access through referral to BH services.

(6) Safe storage of lethal means.

(7) Peer support for care-seeking and bystander intervention.

(8) Increased financial readiness and household economic stability.

(9) Postvention support.

(10) Safe reporting and messaging about suicide aligned with knowledge and needs.

(11) Sense of purpose.

(12) Asking for help or demonstrated request for assistance.

(13) Stable and consistent mental health care with the same provider can enable higher quality of care and result in sustained attendance. Changing BH care professionals may increase the risk to Soldiers and Family members. Commanders may request U.S. Army Human Resources Command support to

adjust, delete, or defer orders for medical reasons to provide Soldiers and Family members struggling with mental health greater stability and consistent mental health care with the same provider.

2–7. Lethal means

a. Time-based prevention.

(1) Lethal means safety is the process of ensuring that highly lethal means of suicide are out of timely reach during times of increased stress and when the risk of suicide is heightened. Since suicide is frequently an impulsive act, the goal of lethal means safety is to make suicide methods or means more difficult to access, particularly when someone is believed to be at risk for suicide. Lethal means are objects (for example, firearms, medications, sharp objects, and ligatures) that can be used to engage in suicidal self-directed violence, including suicide attempts. Creating time and space between and individual and a lethal means through safe storage behaviors can prevent suicides.

(2) Prevention policies and practices for lethal means will—

(a) Promote and educate on the voluntary use of safe storage methods, to include gun locks and safes, and safe storage for medications.

(b) Raise awareness and provide education on time-based prevention for individuals at risk.

(c) Identify community partnerships for lethal means safety and storage options.

(d) Target time-based prevention activities to units identified as higher risk for self-harm.

(3) Time-based prevention or lethal means safety is an essential component of effective suicide prevention.

(4) Prevention professionals and commanders will promote the voluntary use of gun locks and other safe storage methods for privately owned firearms on property that is not on a military installation or other DoD-owned or operated property.

(5) Medications and poisons, including prescription and nonprescription medicines, alcohol, chemicals, poisons, and gas should not be used in a way other than directed. Prevention professionals and commanders will promote safe storage of medications, discuss the negative impacts of alcohol and medications, and promote proper disposal of outdated or no longer needed medications.

b. Response.

(1) For situations involving Soldiers who are a danger to themselves or others, immediate actions will be taken to ensure care and reduction of risk, in accordance with applicable laws and DoD and Army policies and regulations, including making necessary notifications to authorities.

(2) Unit arms room storage of privately owned weapons. Commanders may order on-post privately owned weapons be stored in a unit arms room, in consultation with healthcare professionals, when a Soldier is a potential threat to self or others.

(a) Privately owned weapons may be maintained in the unit arms room until the commander, in consultation with healthcare professionals, determines that the risk has been effectively mitigated.

(b) Commanders will consult with their servicing SJA for advice on the law and regulations governing privately owned weapons.

(c) Commanders will consult with supporting healthcare providers to help identify potential risks and coordinate care requirements and assist in determining if or when the identified risk has been successfully mitigated.

(3) Off-post storage of privately owned weapons. A commander's ability to regulate the privately owned weapons of Soldiers who reside off-post is limited pursuant to Public Law 111–383. This statute prohibits the DoD from issuing any requirement or collecting or recording any information relating to the otherwise lawful acquisition, possession, ownership, carrying, or other use of a privately owned firearm, ammunition, or another weapon by a member of the U.S. Armed Forces not kept on a military installation. There are three stated exceptions to this prohibition.

(a) The first two exceptions apply when Soldiers are engaged in official duties or are in uniform.

(b) The third exception allows commanders to regulate privately owned weapons when a Soldier is under investigation, prosecution, or adjudication of an alleged violation of law, including matters related to whether a member of the armed forces constitutes a threat to the member or others. Within this exception, commanders who come to a reasoned conclusion (based on direct observation or reports from friends, Family, or healthcare providers) that a Soldier is a threat to self or others may initiate an investigation into the potential threat of violence. Upon initiation of an investigation, the commander is authorized to ask the Soldier whether he or she possesses any privately owned weapons that are kept off-post.

(4) If the Soldier has privately owned weapons off-post, the commander may request that the Soldier bring the weapons to the unit to be stored in the unit arms room.

(a) Commanders should seek the advice of their servicing SJA prior to taking any action or collecting any information concerning privately owned weapons maintained off-post.

(b) If the Soldier is unwilling to voluntarily surrender his or her off-post privately owned weapons, the Soldier cannot be ordered to comply with the request.

(c) A Soldier who is unwilling to voluntarily surrender his or her off-post privately owned weapons may be ordered to temporarily reside on and be restricted to post.

(d) If a commander believes a Soldier is a risk to self or others and is considering an order to restrict the Soldier to post, the commander should initiate a command-directed BH evaluation through BH specialty care or emergency services. Commanders or supervisors must be clear as to the reason for the emergent evaluation and inform the BH evaluator of concerns prior to the directed evaluation. This process would assess the Soldier's current risk level to further inform the commander's decision. Command consultation findings will be documented on DA Form 3822 (Report of Mental Status Evaluation).

(e) Commanders should develop a unit coordinated care plan in coordination with Army unit medical assets and supporting BH providers to address root causes of the risk behaviors and establish support for any Soldier directed to secure privately owned weapons.

2–8. Communicating suicide prevention messages

a. An essential foundation to the ASPP is communicating key suicide prevention messages to Soldiers, leaders, DA Civilians, and Families throughout the entire year. Commanders have a legitimate need to know about the BH and physical capabilities of their Soldiers to safely and efficiently carry out their mission. However, Soldiers may feel they cannot acknowledge the need for help without negatively impacting their careers. To combat the belief that seeking help is a sign of weakness, commanders are encouraged to reinforce the personal courage it takes to seek BH help through their communications.

b. Commanders and the Army suicide prevention workforce not assigned or attached to an MTF or other DHA organization should disseminate awareness communication regularly. A large selection of materials is available through the DPRR and the DHA Public Health and the Suicide Prevention Resource Center (see app J).

c. Commanders at all levels may wish to produce their own materials, especially for inclusion in unit newsletters, digital media and social media, or newspapers. It is important to coordinate with SMEs, installation SPPC, public affairs offices, and local community health services for accuracy and appropriateness of content of the information in unit newsletters. Media items may be published prior to periods or events that are likely to produce a higher-than-normal incident of suicide (for example, the summer moving months of July and August have a higher incidence of suicide).

d. Printed media may include posters, brochures, tip cards, command newsletters and newspapers, and magazines. Briefings, trainings, stand downs, chain teachings, and command messages given during formations are great ways for leaders to communicate key suicide prevention messages. Other methods include static displays; films; day, week, and month observances; media events; opportunities to participate in local events; and strategic communication plans.

e. The Army routinely observes Suicide Prevention Month in conjunction with the National Suicide Prevention Week and the World Suicide Prevention Day. The Army usually observes Suicide Prevention Month in the same month in which the national observance falls (September).

f. A marketing plan that includes a communication plan will increase awareness regarding programs, training, and resources available to assist in suicide prevention and building resilience and should be part of a uniform and consistently applied marketing plan that creates awareness of the existence, nature, and availability of all Army health promotion, risk reduction, and suicide prevention products and services. This includes using metrics in process evaluations to measure increased awareness of products and services by Soldiers, DA Civilians, and their Families (see chap 7).

g. A suicide prevention marketing plan should be done in coordination with the organizations that deliver capabilities in support of the program. To reduce redundancy, CR2Is should consider coordinating with public affairs to develop a comprehensive, multidisciplinary approach to increasing awareness of resources and organizations in an all-year round campaign to strengthen Soldier, Family member, DA Civilian, and community resilience.

h. If a SPPC develops a suicide prevention marketing program, it will include—

(1) Public service-type announcements or commercials using leaders or celebrities with a message encouraging help-seeking behaviors and suicide intervention practices.

(2) Publication and promotion of existing military and civilian crisis hotline numbers in local media and resource materials.

(3) Publication and internet availability of articles on stress, depression, family violence and abuse, substance abuse, and the identification of agencies that can help.

(4) Formally scheduled, regular prevention observances or activities.

2–9. Intervention

Commanders play an integral part during intervention, as it is their responsibility to ensure access to appropriate health care and safety of assigned personnel. Intervention focuses on preventing a life crisis or stressor (financial, domestic, legal, and law enforcement) from leading to suicidal behavior. Chaplains, FAP workers, and health care personnel whose primary duties involve assisting people who are more susceptible to suicidal ideation are highly involved in intervention efforts, which includes helping Soldiers managing suicide ideation through BH care. Other personnel (law enforcement, inspector general, and Red Cross) with Soldier and Family interaction also intervene when needed.

a. The Army provides assistance and intervention as a response function to facilitate constructive care. Intervention starts with individuals and organizations understanding how to recognize and take action to stop, mitigate, or assist Soldiers and DA Civilians to access resources to strengthen personal resilience. Intervention is a crucial factor in suicide-risk reduction and proactive resilience strengthening. Commanders and Army prevention personnel will work together to—

(1) Address the conditions that produced the current crisis, treat the underlying BH conditions that contributed to suicidal behavior, and provide follow-up care to assure positive treatment outcome.

(2) Identify suicide risk through medical channels (profile or command-directed evaluation) or command channels (CRRT, identified risk factors like substance use, violence, previous attempts, a Soldier involved in a Uniform Code of Military Justice (UCMJ) proceeding or who is experiencing financial pressures or relationship issues) or through individual or community notification (self-identification, leader, or Family or battle buddy concerns). Screening is an important part of both prevention and intervention. Since areas such as sexual assault, substance abuse, domestic violence, depression, and PTSD are significant contributors to suicide ideation, collaboration with SMEs in these fields is crucial, especially when screening Soldiers.

(3) Mitigate identified suicide risk through established command-driven and SME-informed processes at all levels of command from company and detachment level through BDE. Intervention may be clinical or non-clinical, including education (financial and legal), training (resilience), and referrals (on-post and off-post), each with a goal of strengthening and building protective factors in affected individuals. Actions may also include inspecting and modifying a person's environment, such as temporarily removing items that an individual may use to harm himself or herself when residing on post, ordering off-post Soldiers to reside in the barracks until risk is mitigated, or requesting surrender of items when off post, close monitoring, and BH care.

(4) Determine disposition, to include return to full duty, return to duty with limitations, medical board, administrative separation, or others as deemed appropriate and consistent with regulation. Disposition is a SME-informed command determination.

b. Use of social networking technologies are popular means used today to communicate important personal information. Leaders may become aware of a Soldier's social networking content through the chain of command, anonymous calls, or personal observation. Leaders receiving such information should consult with their servicing legal advisor on how to proceed. Through a Soldier's social networking content, leaders may become aware of the warning signs that someone may be in crisis. Leveraging these types of communications may help to accelerate identification and response time to prevent suicide.

c. Widespread promotion of suicide prevention and general crisis hotlines provides a confidential means for Soldiers, DA Civilians, and Family members to reach out for help in a non-threatening way. The Military Crisis Line and 988 Suicide and Crisis Lifeline offer free, confidential, 24-hour access services, 365 days per year to assist members in crisis or concerned friends and Families. For the continental United States, contact the Military Crisis Line or the 988 Suicide and Crisis Lifeline by dialing 988. For OCONUS, dial 00–800–1273–8255, for Korea dial 00–808–555–118, and Military Crisis Line, 1–800–273–8255, press 1, offer free, confidential, 24-hour access services, 365 days per year to assist

members in crisis or concerned friends and Families. The following are ways that the crisis line can be promoted as a resource.

2–10. Crisis management

Crisis management for high-risk Soldiers is only to be implemented as a last resort to protect at-risk Soldiers from self-harm and harm to others. The emphasis is on getting the at-risk individual into a safe environment immediately and commanders must be acutely aware it can be seen as stigmatizing.

a. Crisis management, formerly known as unit watch, should only be used under the consultation of and in addition to medical or psychiatric recommendations or in austere conditions where BH assessment is not readily available to ensure the safety of the Soldier and mission. Commanders must not implement crisis management on Soldiers who have not been clinically evaluated by a BH provider.

b. The following should be considered:

(1) Positive control of the Soldier, especially during periods of transition to appointments.

(2) That those entrusted to support crisis management are thoroughly briefed on the importance of being with the Soldier at all times and to respect Soldier's privacy, ensuring Soldier is not identified to other unit Soldiers through observable means that would stigmatize help-seeking.

(3) The Soldier receives follow-up by BH.

2–11. Assessing Soldiers under investigation

For Soldiers pending UCMJ action and for Soldiers who are interviewed by USACID, commanders and military law enforcement personnel, in consultation with their supporting legal advisors, should develop procedures to mitigate risk factors during investigations, adjudication, and other adverse actions. Soldiers pending UCMJ action may become high risk and they should be supported during and after proceedings.

a. Soldiers who are under investigation may be at elevated risk for harmful behaviors such as substance misuse and suicide. Investigations of any type increase Soldier stress due to the uncertain outcomes, potential embarrassment, and the potential consequences for individual reputation and career.

b. To reduce risk for harmful behaviors, commanders must actively address the unique risk factors of Soldiers who are facing legal stressors. Commanders and senior enlisted should use the following to reduce risk for those under investigation:

(1) Engage in dialogue with civilian law enforcement officers. Soldiers must be handed directly to their commanders or designated representative immediately following an investigative interview.

(2) Implement a hand-off procedure that places the Soldier in a protective environment and allows time for Soldier and command to respond to the investigation requirements.

(3) Prevent social isolation.

(4) Encourage behavioral and emotional support. An encounter with an at-risk person can be a deeply emotional experience, especially when someone is not trained to provide assistance or has limited experience with people in crisis. In these situations, it is important to process the experience with someone trained and knowledgeable such as chaplains, MFLCs, and BH providers.

(5) Mentor Soldiers on available support options such as legal and financial assistance. Care should be taken when referring both active duty and non-active duty Soldiers to civilian resources. This could set them up for increased financial stress due to medical bills they may not have resources to cover. Caution should be exercised to ensure that Soldiers do not incur a financial hardship from a referral action.

2–12. Postvention

a. Postvention occurs after an individual has attempted suicide or died by suicide and includes support provided to individuals impacted following these actions. Essential elements to an effective postvention process include commanders following postvention guidance in the Commanders Handbook to Postvention (https://www.armyresilience.army.mil/) and the DSPO Postvention Toolkit (https://www.dspo.mil/) and search for Postvention Toolkit. Commanders will consult with BH, spiritual, and community support services to develop their postvention actions. It is also important that commanders promote help-seeking behaviors of Soldiers within the unit which might include seeking support from Family, friends, unit personnel, BH, spiritual, and community support services. Postvention consists of three objectives—

(1) Set a foundation for healthy grieving and facilitate healing of individuals and the unit.

(2) Prevent other negative effects of exposure to suicide through identification and referral of those most at risk for BH concerns, including suicide behaviors. Similar to grieving the loss of a Soldier in

combat, the primary, long-term objective of the postvention process is to return the unit to its state of readiness prior to the event.

b. Commanders and SPPCs will implement mandatory postvention procedures in accordance with DoDI 6400.09, AR 600–20, AR 638–8, AR 638–34, and this regulation.

(1) Promote recovery and healing among those affected.

(2) Include support to the bereaved, but also assistance to anyone whose risk of suicide might increase in the aftermath of suicide behaviors.

(3) Provide community support services (for example, BH, spiritual, and so forth) to individuals affected by addressing all Five Dimensions of Strength.

c. Commanders will consult their IDPH or supporting BH provider for specific support and approaches after a suicide attempt. Proactive postvention can help confront and stabilize any suicide-specific issues among Soldiers.

d. Every interaction with a Soldier affected by suicide behaviors is an opportunity to support and advance their healing and provide them hope. Leaders need to actively engage Soldiers early within 48 hours of the event and throughout the postvention process so that they receive the support they need.

e. S2FRABs are conducted at the installation and ACOM, ASCC, and DRU levels. Commands can benefit from analyzing the decedent's behaviors to identify system gaps and opportunities to improve prevention through policy, procedures, and practices and identify how to better equip and train leaders at all levels and improve leadership development before tragedies occur and how to better support leaders and units after a tragedy occurs. S2FRABs contribute to the suicide prevention goals and objectives by providing comprehensive, objective, standardized, and big picture analysis of individual, systemic, and other environmental factors. See chapter 3 for guidance.

2–13. Family member suicide prevention

a. Family member suicide prevention activities are voluntary and based on existing military and civilian family and social service resources and emerging programs. Efforts expand across the spectrum of the ASPP and the DoDI 6400.09 prevention strategies discussed in this section. Family members, as defined by DEERS, are entitled to and receive the same services and treatment as their military sponsor. Among these resources are military community-based chaplaincy, social work and prevention counseling services (ACS), civilian community-based agencies, and clinical BH and medical care, along with other tri-service medical care (TRICARE) services. SMEs in various disciplines and organizations provide suicide prevention support. Family members may seek help independently or use their sponsor's chain of command to initiate their request for suicide prevention resources, services, and assistance. See appendix J for additional resources.

b. Family members can help prevent suicide or suicide attempts by being alert and engaged before life stressors and risk events build up. Family members are encouraged to participate in resilience building and suicide prevention training and activities.

2–14. The Army suicide prevention workforce

a. The Army suicide prevention workforce works in support of the SC (includes, but is not limited to SPPM, SPPC, RRPC, CR2I, ACS personnel, and so forth) and is comprised of Army personnel who are not assigned or attached to MTFs, DHA Public Health, or other DHA organization, that conduct the following activities:

(1) Identify and develop a plan to address individual, interpersonal, organizational, and installation or community risk and protective factors.

(2) Implement targeted prevention, intervention, and postvention activities such as practices, procedures, and policies that are evidence-based and produce changes in knowledge, beliefs, attitudes, and behaviors.

(3) Have mechanisms in place to monitor the degree to which progress is being made.

(4) Consult and collaborate with leaders and other stakeholders within the installation and community to optimize access and usage of resources.

(5) Share information, practices, and outcomes among leaders and stakeholders.

b. Prevention activities are planned (that is, determine how and when the activity will be implemented, by whom it will be implemented, and what outcomes are expected) and delivered as planned.

c. Installation leadership and organizations resource and participate in prevention activities.

d. Installation leadership and organizations support a collaborative, integrative, and inclusive approach to the delivery of prevention activities (that is, time to implement, leadership engagement, and vocal support for participation).

e. Continually assess the quality and impact of prevention activities and use monitoring and evaluation findings to inform improvement, planning, and resourcing.

f. Discontinue prevention activities that are not data-informed, evidence-based, or not meeting objectives.

Chapter 3
Suicide Prevention Governance

3–1. Overview
The suicide prevention governance process establishes the framework to inform commanders and stakeholders on the progress of efforts to sustain and build resilience and foster a culture of trust throughout their respective organizations. The suicide prevention governance process will use forums at the HQDA, ACOM, ASCC, DRU, USAR, installation, and unit level.

3–2. Army Suicide Prevention governance process
The governance process presents suicide prevention information and analysis to ensure capabilities, resource synchronization, integration, and focus on outcomes to inform leader decisions.

a. Headquarters, Department of the Army Suicide Prevention Working Group.

(1) At the HQDA level, the SPWG provides leadership with the ability to oversee the ASPP. The HQDA SPWG will highlight issues and recommend solutions. The working group is chaired by the Army SPPM. Members include but are not limited to command and component SPP personnel and action officers from Army Staff with roles and responsibilities in support of the ASPP.

(2) Inputs: Task action plans (TAPs), information briefs on special topics, measures of performance, and measures of effectiveness from command CR2Cs.

(3) Outputs: Establish quarterly meetings, TAP reporting timelines and status, coordinate information across members, guidance on TAPs, review of policy, structure, process, program, and resources, and reporting on measures of performance and measures of effectiveness.

b. Charter. The Army SPPM will publish a charter in accordance with AR 15–39.

3–3. Unit Ready and Resilient forum
The unit R2 forum is a BDE-level process that extends down to the company level to synchronize and monitor standards for a safe, healthy environment that supports suicide prevention. Unit commanders will focus on positive behaviors and protective factors, reducing at-risk behaviors, and promoting an environment of trust through leadership and management systems. The unit R2 forum provides leadership at multiple levels through continuous assessment and individual and unit targeted actions directed within their formation. The R2 forum is facilitated by a unit coordinator designated by the commander. Unit commanders can choose to incorporate aspects of the R2 process within already existing meetings or can establish new meetings.

a. Commander and sergeant major of the unit chair R2 teams.

b. Commanders of MSCs will monitor, participate, and provide oversight for subordinate BDE and battalion commanders' R2 forums.

c. Commanders will consult with their supporting BH provider for management of high-risk Soldiers.

d. The Chair will publish a unit R2 forum charter in accordance with AR 15–39 (see app K for a charter template).

e. R2 forum membership will include BDE and battalion command team; MRT; safety officer; BDE surgeon or physician's assistant; chaplain; S–1, S–2, and S–3 representatives; Army medical personnel not assigned or attached to an MTF or other DHA organization; equal opportunity officer; sexual assault response coordinator or victim advocate; Soldier Family Readiness Group (SFRG) advisor; and others at the discretion of the commander (for example, Provost Marshal or DES). Commanders should ask their supporting legal advisor and supporting BH provider to attend the R2 forum as needed.

f. RC R2 teams may include representatives from the Readiness Division (RD).

g. Unit R2 teams implement the ASPP framework and will—

(1) Identify risks, health concerns, and protective factors and provide timely and trend data on individuals and the unit using visibility tools (see app B).

(2) Ensure the effective distribution of resources and monitor progress.

(3) Institute techniques, practices, and a climate that build and foster early identification of risk, help-seeking behaviors, and resilience.

(4) Implement targeted, timely, and specific data-informed prevention actions.

(5) Monitor progress and share visibility and lessons learned through the CR2C and associated working groups.

3–4. Suicide Prevention Working Group

a. Each SC and commander of a USAR geographic or functional command will establish a SPWG to plan, implement, and manage the local integrated ASPP, the installation suicide prevention action plan, the SRT, and the S2FRAB. The frequency will be determined based on alignment with the CR2C. The SPWG will be an enduring subcommittee of the CR2C. The SPPC will facilitate the SPWG. The SPPC will lead the development of a plan to implement objectives, review data as directed by the SC, and track progress on objectives. The SPPC will synchronize suicide prevention, intervention, and postvention activities into the SPWG.

b. The SC may designate an O–6 as the co-lead. The SPPC will publish a SPWG charter in accordance with AR 15–39 (see app K for a charter template). The SPPC will develop an action plan and submit to the CR2I. The minimum standards required for working group action plans are—

(1) Link the priority to a specific objective and establish baseline data and assessments.

(2) Outline the outcome objectives.

(3) Frame the priority area with a problem statement.

(4) Identify measures of performance and measures of effectiveness for activities and actions.

(5) Identify actions and activities that are required for success and associated timelines and milestones.

(6) Identify items needing higher headquarters assistance.

(7) Brief status to the CR2C on a quarterly basis.

c. The SPWG will—

(1) Identify inadequacies and gaps in systems or policies to support the development of focused solutions nested with the suicide program elements in paragraph 2–2.

(2) Align suicide prevention strategies and related trainings, plans to address policy and systems gaps, and measures used to evaluate the adequacies of their community resources.

(3) Oversee and monitor the implementation and evaluation of suicide prevention awareness, education, and training activities.

(4) Recommend and oversee, in coordination with public affairs, safe messaging with respect to suicides in the community and commands and develop public awareness campaigns for publication and evaluation.

(5) Conduct a holistic and broad review by gathering and reviewing information to identify the strengths and weaknesses of community-level helping services; policies that promote or hinder access to services; and the misalignment of or gaps between HQDA, DoD, and local policies, suicide prevention resources, and related agencies.

(6) Compile, analyze, and share data to monitor and evaluate prevention, intervention, and postvention initiatives.

(7) Implement a S2FRAB (see para 3–6) and oversee the SRT (see para 3–5).

(8) The membership of this committee should be tailored to meet local needs.

d. Activities in a suicide prevention marketing program will include—

(1) Public service-type announcements or commercials using leaders or celebrities with a message encouraging help-seeking behaviors and suicide intervention practices.

(2) Publication and promotion of existing military and civilian crisis hotline numbers in local media and resource materials.

(3) Publication and internet availability of articles on stress, depression, Family violence and abuse, substance abuse, and the identification of agencies that can help.

(4) Formally scheduled, regular prevention observances or activities.

(5) Inventory of programs and services. Publish a consolidated single inventory of programs and services from garrison, medical, and mission organizations that, at a minimum, identifies the provider, a description of the service, who is eligible to use the service, and the hours of operation.

(6) Results and outcomes (measures of performance and measures of effectiveness) and share lessons learned.

3–5. Suicide response team purpose, objective, and membership

a. The SRT purpose is to assist and advise the commander after a suspected suicide in assessing the situation, determining appropriate COAs, and directing immediate interagency and inter-staff actions. The SRT supports the suicide prevention objective to increase the timeliness and usefulness of suicide behavior surveillance and associated risk and protective factors in the reporting system to improve preventive actions.

b. The SC will convene the SRT no later than 48 hours of a suspected suicide to support the affected command and installation affected by a suicide event. The SC should select SRT members to attend and be appropriately advised and informed by the SPPC.

c. SRT members may be required to sign non-disclosure agreements and should consult with their supporting legal advisors before doing so. Members include, at a minimum, Division Chief of Staff or G–1, division command sergeant major or Senior Enlisted Advisor, GC, SPPC, unit medical officer not assigned or attached to an MTF or other DHA organization, unit chaplain, installation chaplain, USACID Special Agent in Charge, Provost Marshal or DES, PAO, CR2I, survivor outreach services representative, equal opportunity officer, and Casualty Assistance Center chief. Additional team members may include FAP, ASAP, or Sexual Harassment/Assault Response and Prevention Program Manager. The SC should ask his or her supporting legal advisor and supporting BH provider to attend the SRT, as needed.

d. SRT members will coordinate actions to support immediate unit recovery processes informed by the trauma event model and develop recommendations for medium and long-term postvention activities. See paragraph 2–12 for postvention.

e. COAs will also include taking actions necessary to provide for the immediate welfare of Families who have suffered a death by suicide.

f. Commanders will confer with their supporting BH provider and chaplain to determine the actions necessary after a suicide attempt. Commanders must be mindful of supporting the Soldier and balancing privacy and personally identifiable information while identifying and mitigating risk within the unit.

g. SRT actions in support of suicide behaviors.

(1) The SRT should support commanders in the identification, evaluation, and medical evacuation (if necessary) of Soldiers at increased risk of suicide as a result of a suicide event.

(2) SRT members should be prepared to review the following facts:

(a) Decedent's background, demographics, and unit or organizational affiliation.

(b) Circumstances of the event.

(c) Status of the decedent's family and affected unit members as reported by chaplain or casualty assistance officer.

(3) SRT members should be prepared to—

(a) Review and complete suicide event data reporting and information requirements. See appendix H for suicide event data reporting.

(b) Review casualty assistance protocols.

(c) Review postvention phases.

(d) Identify barriers that may hinder the SRT and strategies to mitigate.

h. SRT inputs and outputs.

(1) The following information is recommended as inputs into the SRT:

(a) Unit command team (commander and senior enlisted).

(b) SRT members and other identified personnel to support the completion of outputs.

(c) Reporting requirements.

(d) Information gathering.

(2) Initiate postvention process. The following are recommended outputs from the SRT:

(a) Assign SRT roles and responsibilities.

(b) Establish reporting timelines and responsible persons.

(c) Short, medium, and long-term postvention activity planning and transition.

(d) Out-brief to commander.

i. Battalion and company commanders will—

(1) Initiate an investigation of suspected suicide pursuant to AR 15–6.

(2) Institute procedures to facilitate the identification, evaluation, and medical evacuation (if necessary) of Soldiers at increased risk of suicide as a result of the suicide event.

(3) Maintain liaison with other members of the SRT on matters affecting members of the command.

3–6. Installation Suspected Suicide Fatality Review and Analysis Boards

a. The installation S2FRAB will convene in a timely manner and no later than 60 days after a suspected suicide to provide a comprehensive, objective, standardized, and big picture analysis of individual, systemic, and other environmental factors that may have contributed to or enabled death by suicide. The SC at the installation level has oversight and responsibility for the S2FRAB. The SC will publish a S2FRAB charter in accordance with AR 15–39 (see app K for a charter template).

b. Installation S2FRAB membership will include members from units, chaplains, command medical officer not assigned or attached to an MTF or other DHA organization, USACID representative, CR2I, SPPC, FAP representative, and PAO. Additional personnel may participate in S2FRAB upon advice from legal counsel to maintain privacy and avoid unintended disclosures of personal information.

c. The S2FRAB objectives are to—

(1) Describe and record any trends, data, or patterns that are observed surrounding suicide fatalities.

(2) Recommend local rules and procedures for review of suicide fatalities, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and recordkeeping of the causes of suicide fatalities (DoDSER and DA Form 7747).

(3) Recommend improvements to promote improved and integrated services, programs, and policies.

(4) Recommend components for prevention and education programs.

(5) Recommend training to improve the identification and investigation of suicide fatalities.

(6) Determine and provide informed solutions.

d. Installation S2FRAB inputs and outputs.

(1) The following information is recommended as inputs into the S2FRAB:

(a) Unit command team (commander and senior enlisted).

(b) S2FRAB members and other identified personnel to support the completion of outputs.

(c) Information for DA Form 7747.

(d) Information for the DoDSER.

(e) Informative data and information sources. See appendix H for these sources.

(2) The following are recommended outputs from the S2FRAB:

(a) Completed DA Form 7747.

(b) Completed DoDSER.

(c) Completed suicide reports. See appendix G for the required suicide reports.

(d) Memorandum on the findings of the S2FRAB.

(e) Screen captures from the deceased Soldier's CRRT file.

(f) Transfer of findings and COAs to appropriate installation governance body (unit R2 forum, SPWG, or CR2C).

e. Installation S2FRAB reporting.

(1) The installation S2FRAB will generate a memorandum on the findings of the S2FRAB to support higher headquarters.

(2) At a minimum, the memorandum should include the following information on the Soldiers who died by suicide:

(a) Brief summary of the S2FRAB that generally characterizes the demographics, stressors, method or means, if Soldier was under BH or chaplain care, any administrative and legal actions, and other significant demographic data.

(b) Notable findings on possible gaps in services, programs, and policies.

(c) Recommendations for improvements in services, programs, and policies at the unit, installation, and headquarters (ACOM, ASCC, and DRU) levels.

(d) Recommendations for internal process improvements on local suicide reporting requirements.

f. Special interest items requested from SC or ACOM, ASCC, or DRU commander.

3–7. Army command, Army service component command, direct reporting unit, and U.S. Army Reserves Suspected Suicide Fatality Review and Analysis Board

a. ACOM, ASCC, and DRU commanders will conduct S2FRABs for suicide deaths within their area of responsibility based on the decedent's home station. ACOM, ASCC, and DRU commanders are encouraged to coordinate with other ACOM, ASCC, and DRU commanders when a suicide death occurs during temporary duty, training, or while away from their home station. ACOM, ASCC, and DRU commanders will publish a S2FRAB charter in accordance with AR 15–39 (see app K for a charter template). The S2FRAB objectives are to—

(1) Assess subordinate command suicide reporting and surveillance through review of DoDSER and DA Form 7747 submission.

(2) Describe trends or patterns that are observed surrounding suicide fatalities.

(3) Analyze subordinate command findings and recommendations.

(4) Recommend improvements to subordinate commands.

(5) Monitor recommendations through CR2C processes.

(6) Recommend informed solutions to the CR2C and HQDA suicide prevention governance process.

b. Inputs and outputs.

(1) The following information is recommended as inputs into the S2FRAB:

(a) Unit command team (commander and senior enlisted).

(b) S2FRAB members and other identified personnel to support the completion of outputs.

(c) DA Form 7747.

(d) Findings and recommendations from installation and subordinate command S2FRABs.

(2) The following are recommended outputs from the S2FRAB:

(a) Memorandum on the findings of the S2FRAB (see app I for an example of the memorandum for reporting findings of the S2FRAB). Memorandum must be formatted in accordance with AR 25–50.

(b) Transfer of findings and recommendations to appropriate governance body (CR2C or HQDA governance).

(c) CRRT reports on unit trends and rates in comparison to DA levels.

(d) Assessment of findings.

c. Reporting. The S2FRAB will annually generate a memorandum on the findings or report on the findings at the R2 governance process and submit to usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil. Appendix I contains a template. At a minimum, the information should include the following on the Soldiers who died by suicide:

(1) Brief summary of the S2FRAB that generally characterizes the demographics, stressors, method or means, if Soldier was under BH or chaplain care, any administrative and legal actions, and other significant demographic data.

(2) Notable findings on possible gaps in services, programs, and policies.

(3) Recommendations for improvements in services, programs, and policies at the unit, ACOM, ASCC, DRU, and HQDA levels.

(4) Recommendations for internal process improvements on local suicide reporting requirements.

(5) Special interest items requested from HQDA.

d. ACOM, ASCC, and DRU S2FRAB membership will include members from units, command BH or medical officer not assigned or attached to an MTF or other DHA organization, USACID representative, chaplains, CR2I, SPPM, FAP representative, Casualty Assistance Center representative, PAO, and GC. Additional personnel may participate in S2FRAB upon advice from legal counsel to maintain privacy and avoid unintended disclosures of personal information.

e. The command SPPM will facilitate the meeting, to include scheduling, coordinating agenda and members, meeting logistics, compiling the S2FRAB report, and any administrative requirements that support the information-sharing.

Chapter 4
Training and Education

4–1. Overview

a. Suicide prevention training and education provides a foundation for Soldiers, DA Civilians, and Family members to build and sustain personal readiness and resilience. Readiness and resilience must remain a priority to ensure personnel are prepared to fight and win our nation's wars.

b. Suicide prevention and resilience training and education will be integrated within the institutional, operational, and self-development domains.

c. The overarching goals are to increase and promote positive behaviors and protective factors that lead to sustained personal readiness and resilience. The objective of suicide prevention training is to support the development of knowledge on suicide-related help-seeking behaviors and stigma, protective and risk factors, stressors, and warning signs, early and crisis intervention, and postvention principles.

d. Suicide prevention training objectives will—

(1) Implement targeted evidence and outcome-based training and education that improve knowledge, behaviors, and performance skills.

(2) Build protective factors and promote positive behaviors to support personal readiness and resilience and optimize human performance.

e. Suicide prevention training must be delivered with fidelity and achieve all identified objectives to have an effect. Commanders will set time on the training schedule and enable trainers to deliver effective and interactive training.

4–2. Unit training

a. Commanders will use evidence-informed visibility tools (see para 2–3) and unit R2 forums (see para 3–4) to implement prevention activities, suicide prevention training, and unit education.

b. The commander's assessment is informed by visibility tools at his or her disposal and are intended to aid in early identification harmful behaviors. Leaders will incorporate tactical prevention strategies within the command climate assessment action plan. The plan will include goals for prevention activities, training, and education to maximize unit readiness, resilience, culture of respect, trust, and optimized human performance. Commanders will select suicide prevention training based on their assessment of the unit's requirements and will accept risk where deemed prudent.

c. Commanders will record completed training in DTMS.

d. Commanders may meet suicide prevention training requirements by either meeting the requirements as outlined in paragraphs 4–4 through 4–6 or through an alternative evidence-informed training approved by SC or their designee.

(1) Approved alternative training plans developed using the format in appendix K will be forwarded to usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil.

(2) At a minimum, alternate training must meet the DoD Core Competency Framework requirements available at https://www.dspo.mil/portals/113/documents/final%20signed%20competency%20framework%202016.pdf?ver=2018 – 02 – 07 – 111806 – 747 to—

(a) Provide personnel with the skills to identify and achieve an appropriate response within a specific adverse situation.

(b) Incorporate risk mitigation strategies.

(c) Recognize suicidal ideations as an emergency (just like other medical emergencies).

(d) Intervene by contacting appropriate providers and transporting the individual to the provider.

(e) Include knowledge of crisis lines and other DoD-specific resources.

(3) Alternative training plans must be evidence-based with measurable learning objectives that align with the DoD suicide prevention training and include evaluation methods. Training plans should be developed in partnership with the SPPC, to include an evaluation component.

4–3. Suicide prevention institutional training

Integrated training and education will be incorporated within institutional training and PME in appropriate progressive increments as for Soldiers and DA Civilians. Resilience and suicide prevention training and education will be fully integrated into the institutional initial military training (IMT) and PME with concepts and performance skills, targeting the appropriate level of career maturity and requirements of the leadership requirements model (see AR 350–1).

a. ACE Base+1 is a one-time requirement at IMT for officers and enlisted Soldiers. IMT units will record training within the individual training record (ITR). Training is conducted in person and in small groups with a ratio of 1 instructor per 10 Soldiers (1:10). Unit commanders can use ACE Base+1 to satisfy the personal readiness training requirement listed in AR 350–1. Note that ACE Base+1 has three 30-minute modules attached to the base. However, if the trainer can only teach the base which is 30 minutes long counts as the annual suicide prevention training.

b. Suicide prevention and resilience training and education during IMT, basic combat training, advanced individual training, Basic Officer Leader Course (BOLC)-A (pre-commissioning/pre-appointment) and BOLC–B (officer initial entry and branch qualification), Warrant Officer Candidate School, Warrant Officer Basic Course focuses on R2 skills that assist new Soldiers with assimilating into the Army culture.

c. PME training and education within NCO Education System, to include distributed learning courses, focuses on developing suicide prevention and resilience skills and human performance optimization that support leader development that will reinforce the Army profession; a culture of respect, trust, and cohesion; and upholding the standards and ethics associated with the Army profession.

d. PME training and education within Officer Education System, not including BOLC–A or BOLC–B, focuses on developing suicide prevention and R2 skills, human performance optimization, and leadership development that will reinforce the Army profession, a culture of respect, trust and cohesion, and upholding the standards and ethics associated with the Army profession.

e. Company Commander/First Sergeant Pre-Command Course and Battalion and BDE Pre-Command Course focus on developing and accessing suicide prevention and R2 skills, performance optimization, and leadership development that have an immediate impact on the leader's ability to lead his or her unit. Commanders will be trained on visibility tools and unit R2 forums.

f. Suicide prevention and R2 training and education are incorporated within the Civilian Education System to complement the learning continuum. The training and education integrate resilience and performance skills targeting the appropriate level of career maturity and requirements with the Army Civilian workforce.

4–4. Ask, Care, Escort: The Army Suicide Prevention Training Model

a. ACE Base+ 1 is an Army-approved suicide prevention and awareness training for Soldiers, leaders, DA Civilians, Family members, and civil partners. All individuals can benefit from attending ACE Base+1 training. The ACE Base+1 training should be implemented in full, ensuring trainees receive all content as intended. Note that ACE Base+1 has three 30-minute modules attached to the base. However, if the trainer can only teach the base which is 30 minutes long counts as the annual suicide prevention training.

b. The objective of ACE Base+1 is to support the development of knowledge on suicide-related help-seeking and stigma, protective and risk factors, stressors, and warning signs, early and crisis intervention, and postvention principles.

c. Due to the multiple areas of training content outlined below, ACE providers and trainers are encouraged to use a fidelity checklist (see app E for examples of information to develop a checklist) to monitor implementation of the training activity.

d. Learn to never force someone to get help. Law enforcement and medical personnel should be summoned to the scene if the individual declines assistance.

e. Commanders will provide DA Civilian supervisors with suicide prevention and awareness training that includes referral techniques and protocols for their employees. Commanders and supervisors will ensure that applicable labor relations requirements comply with implementing the suicide prevention training for DA Civilian supervisors. DA Civilians will attend suicide prevention and awareness training. (ACE for DA Civilians).

f. Commanders will ensure that suicide prevention training (ACE Circle of Support) is available to Family members. This is not a mandatory requirement; however, commanders should encourage Family member participation at appropriate venues (for example, SFRG meetings, spouses' meetings, and pre and post-deployment briefings). The Army-approved training for Family members is the ACE Circle of Support.

g. Use and distribute suicide prevention materials from https://www.armyresilience.army.mil/, as appropriate.

4–5. Ask, Care, Escort–Suicide Intervention

a. The goals of the ACE–SI course are foremost to recognize the early identification of suicide warning signs and know when and how to take action, understand ways to combat stigma related to help-seeking, use emergency and non-emergency resources, recognize how risk factors and protective factors impact suicide risk, and understand how to support reintegration and postvention.

b. The ACE–SI course, also referred to as end-user training (ACE–SI Tier 1) is intended for Army leaders E–5 and above, DA Civilian supervisors, Family members, Soldier and Family Readiness Groups, unit ministry teams, military police, and USACID agents. ACE–SI is also available for other professional

support staff to include Resiliency and Wellness Center Staff, ACS staff, emergency room medical technicians, Army Medical Department personnel, DoD school counselors, Employee Assistance Program coordinators, victim witness liaisons, and others as deemed necessary by commanders. Family member specific training can be scheduled through SPPC, ACS, and commanders.

c. Commanders will ensure that the following attributes are avoided in Soldiers selected for ACE–SI training: inattentive, unempathetic, unmotivated, and rigid. This type of instructor doesn't care for others. They are unmotivated to train the material. When they are training, they do not engage the students. The instructor is rigid in their teaching and in their beliefs about suicide and BH.

d. Commanders will use DTMS to record training completion.

e. ACE–SI master trainers (Tier 3) will deliver the ACE–SI Train-the-Trainer (Tier 2) module for identified SPP personnel, chaplains, and command-selected organizational leaders. The Tier 2 training consists of the ACE–SI course and a training module on small group facilitation.

f. ACE–SI Train-the-Trainer (Tier 2) is the Army's 16-hour suicide intervention train-the-trainer course for Army leaders and prevention professionals who plan to deliver the ACE–SI Tier 1 course. This training consists of the ACE–SI course and a module on small group facilitation and includes practice teaching. Attendees who complete the 16-hour course are qualified to train the ACE–SI course; therefore, ACE–SI is not a prerequisite for ACE–SI Tier 2. Commanders will maintain a record of training completion in the Soldier's ITR.

(1) Those attending the Tier 2 are selected by commanders from among the population of E–6 to E–8, chief warrant officer 2 to chief warrant officer 3, and O–2 to O–4 with at least 1 year left on installation. Successful completion of the Tier 2 is dependent upon the individual conducting a teach-back that verifies ability to conduct the ACE–SI requirement. Certification qualifies the attendees to conduct end-user training. Commanders should look for the following positive attributes and traits that are essential for effective training and leadership in Tier 2 instructors: attentive and engaging, empathetic, motivated, flexible and open-minded, positive beliefs about BH and prevention, desire to train and develop others, compassionate leadership, and active involvement in Soldiers' lives. Soldiers with the grade of E–5 with the military occupational specialty of 56M, 68X, and 68W can attend ACE–SI Tier 2 workshop without a signed exception to policy.

(2) Installation R2 Performance Centers personnel will provide master trainer (Tier 3) capabilities and will deliver ACE–SI Tier 2 upon request and in coordination with identified SPPM/SPPC. Master trainer (Tier 3) capabilities will be transitioned to component POCs in fiscal year 2024.

(3) Installation ASAP program manager will identify a single POC at the installation level to fulfill the requirements for coordinating and tracking ACE–SI training requirements. The POC will—

(a) Oversee all ACE–SI training and ensure there are sufficient trainers.

(b) Advise commanders on training issues, to include coordinating and executing ACE–SI Tier 2, approving ACE–SI Tier 2 candidates, certifying ACE–SI trainers upon completion of ACE–SI Tier 2 instruction course, and approving ACE–SI Tier 2 candidates, obtaining exceptions to policy for E–5s attending ACE–SI Tier 2.

(c) Maintain a roster of all certified ACE–SI trainers.

4–6. Training and education courses

a. ACE Base+1 is the primary tool for training on suicide prevention across all Army components.

b. Commanders will incorporate face-to-face suicide prevention annual training for Soldiers and civilians into the overall training plan for the unit. Training will be made available for Family members at times and locations that promote attendance.

c. Commanders will determine the duration, location, and means for conducting training. Given the sensitive nature of certain topics and the possibility that such topics could be triggering events, use discretion to ensure the class size is appropriate.

d. Unit leaders will lead the training and may use assets such as chaplains, legal representatives, MRTs, SPPC, ASAP prevention coordinator, Safety, PMG, or other SMEs.

e. One-time training will be entered into the Soldier's ITR. Commanders will use DTMS to record training completion of annual suicide prevention training.

f. Training will inform and explain to Soldiers and Family members the availability of confidential counseling services (for example, chaplains and MFLCs) to discuss and self-report or report concern for others who are at risk of harm to self or others without risk of stigma.

g. Commanders are authorized to use Engage with the suicide prevention infographic and vignette as authorized training to meet the annual suicide prevention requirement.

h. The following is the required suicide training. Commanders can select from ACE Base+ 1 or Engage. Units should be aware that Engage training has to be requested through the Performance Centers.

(1) *Ask, Care, Escort.* ACE Base+1 is an Army-approved, integrated, and modular suicide prevention and awareness training for Soldiers, leaders, civilians, and Family members. The objective of ACE Base+1 is to support the development of knowledge on suicide-related help-seeking behaviors and stigma, protective and risk factors, stressors and warning signs, and early crisis intervention and postvention principles.

(2) *Ask, Care, Escort–Soldiers and leaders.* ACE Base+1 is a one-time requirement at IMT for officers and enlisted Soldiers. IMT units may record training within the ITR. Training is conducted in person and in small groups. Unit commanders can use ACE Base+1 to satisfy the personal readiness training requirement listed in AR 350–1.

(3) *Ask, Care, Escort–Department of the Army Civilians.* Commanders will provide DA Civilian supervisors with suicide prevention and awareness training that includes referral techniques and protocols for their employees. Commanders and supervisors will ensure that applicable labor relations requirements comply with implementing the suicide prevention training for DA Civilian supervisors.

(4) *Engage.* Commanders have discretion in applying skills found in the Engage training module. The Engage skill is designed to teach all Soldiers and DA Civilians to recognize a potentially harmful situation or interaction and the skills to choose to respond in a way that could positively influence the outcome. Engage training is requested through the Performance Centers.

(5) *Ask, Care, Escort Circle of Support.* Commanders will ensure that suicide prevention training is available to Family members. This is not a mandatory requirement; however, commanders should encourage Family member participation at appropriate venues (for example, SFRG meetings, spouses' meetings, pre- and post-deployment briefings, and so forth). The Army-approved training for Family members is the ACE Suicide Prevention Training for Family members (ACE Circle of Support).

i. Commanders will ensure that personnel are trained in advanced suicide prevention training.

(1) *Ask, Care, Escort–Suicide Intervention.* ACE–SI is the Army's Tier One Suicide Intervention course. The goals of the ACE–SI course are foremost to enable prevention through identification of suicide warning signs and know when and how to take action, understand ways to combat stigma related to seeking help, use emergency and non-emergency resources, recognize how risk factors and protective factors impact suicide risk, and understand how to support reintegration and postvention. The ACE–SI Tier One course is intended for Army leaders E–5 and above, DA Civilian supervisors, Family members, family advocacy personnel, unit ministry teams, and family life chaplains. ACE–SI is also available for other professional support staff, to include Resiliency and ACS staff.

(2) *Ask, Care, Escort–Suicide Intervention Train-the-Trainer Tier Two.* ACE–SI Tier Two is the Army's suicide intervention train-the-trainer course for Army leaders and prevention professionals who plan to deliver the course. The training consists of the ACE–SI course and a module on small group facilitation and includes practice teaching. Attendees who complete the course are qualified to train the ACE–SI course; therefore, ACE–SI is not a prerequisite for ACE–SI Tier Two.

4–7. Exceptions to policy

a. Requests for exception to policy for ACE–SI training will be forwarded through the ACOM, ASCC, or DRU SPPM to the Chief of Training at usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil. This allows the inclusion of additional quality, evidence-based training from national, community, and non-governmental agencies that fits the needs of the proponent.

b. The DCS, G–9 may designate courses as advanced suicide intervention skills training upon request from Army Reserve proponent program managers. This allows the inclusion of additional quality, evidence-based training from national, community, and non-governmental agencies that fits the needs of the proponent.

c. Requests for alternate training will be submitted to the Chief of Training at usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil. At a minimum, alternate training must meet the DoD Core Competency Framework requirements to—

(1) Provide personnel with the skills to identify and achieve an appropriate response within a specific adverse situation.

(2) Incorporate risk mitigation strategies and evaluation framework.

(3) Recognize suicidal ideations as an emergency (just like other medical emergencies).
(4) Intervene by contacting appropriate providers and transporting the individual to the provider.
(5) Have knowledge of crisis lines and other DoD-specific resources.

Chapter 5
U.S. Army Reserve

5–1. Policies and procedures
The ASPP policies and procedures in this regulation apply to the USAR. Pursuant to laws and conditions that affect Army Reservists when they are on reserve and active duty, some additional ASPP policies and procedures also apply. This chapter establishes policies, responsibilities, and specific procedures for implementing and managing the ASPP within the USAR.

5–2. U.S. Army Reserve specific responsibilities
a. Commanding General, U.S. Army Reserve Command. In addition to responsibilities outlined in paragraph 1–28, the CG, USARC will—
(1) Provide program management and operational supervision of the USAR ASPP within their locality.
(2) Ensure that local policies and standards are clearly understood and adhered to by all USAR members.
(3) Ensure the appointment of a SPPM or assign duties to existing personnel.
(4) Be responsible for all aspects of the health promotion, risk reduction, and suicide prevention and R2 programs for their locality or command.
b. Commanders of major subordinate commands and the readiness division commands. Commanders of MSCs and the RD commands will—
(1) Establish an ASPP within their headquarters.
(2) Appoint a senior leader (E–7 or above) to serve as the principal staff officer, who can be an Active Guard Reserve Soldier, troop program unit member, or a civilian corps member, for coordinating and managing the command's ASPP, if no DA Civilian SPPM is available.
c. U.S. Army Reserve Command Suicide Prevention Program Manager. The USARC SPPM and MSC SPPMs will—
(1) Analyze suicide trends, research studies, and other applicable Army and USARC policies and guidance that support command suicide prevention efforts and forward recommendations for implementation through ASPP channels for visibility.
(2) Develop a suicide prevention plan that addresses the public health approach to suicide prevention (see para 2–2).
(3) Publish program goals, objectives, and operating policies and procedures.
(4) Prepare budget submissions, direct allocation of funds, monitor execution of resources, and serve as the functional budget program manager for the ASPP.
(5) Serves as a member of CR2C Work Groups as designated, representing suicide prevention issues and providing input on local and national-level suicide prevention-related programs.
(6) Establish and maintain program-level evaluation plans. Incorporate SAVs, measures, data collection, analyses, and reporting procedures for implementation.
(7) Analyze potential factors in relation to ideation, attempt, and suicide data and provide trend analysis reports.
(8) Provide Soldiers with local and national suicide resources.
(9) Inform Soldiers of requirement to report their dependents' suicide deaths to nearest installation DEERS office within 30 days of receiving death certificate.
(10) Conduct annual assessment of the prevention, intervention, and postvention aspects of the ASPP to assess performance.
(11) Identify units with potential issues (risk and protective factors) in coordination with RRPCs.
(12) Recommend measures, systems, processes, and procedures to increase efficiencies within the ASPP.
(13) Facilitate the SPWG and support the SRT and S2FRAB.
d. U.S. Army Reserve Command Surgeon. The USAR Command Surgeon will—
(1) Designate BH professionals not assigned or attached to an MTF or other DHA organization to support the treatment and referral service in support of ASPP.

(2) Ensure post-deployment health reassessment screenings are conducted post demobilization to promote long-term post-deployment surveillance of potential at-risk Soldiers.

(3) Designate resources for case coordination (non-clinical) to provide improved monitoring of referrals, treatment processes, and care integration of traditional Soldiers between drills.

(4) Coordinate with supporting BH providers to ensure early identification and treatment of potential at-risk indicators; reduce stigma; and preempt mTBI, PTSD, and substance abuse issues.

(5) Assist commanders in identifying, managing, and referring Soldiers in need of substance misuse and BH treatment and any follow-on monitoring.

(6) Provide information and awareness on potential indicators of high-risk or at-risk behavior observed by medical personnel or unit leadership, including forms of self-mutilation or cutting or any examples of potential self-inflicted wounds.

e. U.S. Army Reserve Director of Psychological Health. The USAR Director of Psychological Health will—

(1) Participate in the quarterly CR2C briefings.

(2) Track all CCIRs events with suicide ideations, attempts, and deaths.

(3) Ensure all Soldiers with suicide ideations and attempts are assigned a case manager to support the Soldier through their treatment plan.

(4) Provide subject matter expertise on BH matters and procedures, including command-directed behavior health evaluation profiles.

(5) Provide postvention and provider support for units after a loss of a Soldier.

(6) Offer clinical assessment and referrals for mental health, employment, housing, finances, and other critical needs required to minimize suicide incidents.

(7) Serve as a liaison for civilian providers.

(8) Advocate for care coordination and continuity of service.

(9) Assist with profile management and LOD investigations.

f. Unit leadership. Unit leadership will—

(1) Ensure resilience, risk reduction, and suicide prevention training is integrated into training schedules with focus on initial and sustainment training for all Soldiers as applicable.

(2) Use assessments and command climate surveys to plan training and prevention efforts to promote resilience, coping, and life skills.

(3) Appoint a suicide prevention liaison (SPL), E–6 or above, on an additional duty basis via a memorandum for record at the company, troop, or battery level. The SPL should be the primary suicide prevention trainer and serve as the command liaison to the MSC/RD SPPMs. SPLs should be trained in advanced suicide intervention skills and should receive additional command specific training as determined by their MSC/RD SPPM.

(4) Use Army combat medics (military occupational specialty 68W) not assigned or attached to an MTF or other DHA organization to reinforce unit intervention capabilities promote resilience and monitor BH issues following the proper training or certification in these processes.

(5) Ensure training documentation is completed based on guidance from the CAR.

(6) Commanders should incorporate prevention training into Short Range Training Guidance and Yearly Training Calendar planning.

(7) Consult the MSC/RD SPPM for additional training materials, guidance, and support for annual suicide prevention training.

g. Suicide prevention liaison. The SPL will—

(1) Serve as the commander's primary advisor on all suicide prevention requirements, trainings, campaigns, and events.

(2) Provide guidance on annual suicide prevention training requirements.

(3) Coordinate with training NCOs to ensure all suicide prevention trainings are accurately captured in DTMS.

(4) Assist commanders by facilitating annual ACE briefing at unit level and submit the roster of all Soldiers in attendance to unit and SPPC.

(5) Maintain a suicide prevention resource board within the unit common areas, including the 988 Suicide and Crisis Lifeline by dialing **988**.

(6) Advise commander of Suicide Prevention Month requirements and events and support local suicide prevention events as available.

(7) Work with the SFRG leaders and chaplain or religious affairs specialist to maintain a list of Federal, State, and local service agencies, clinics, and hotlines for Soldier and Family member referrals.

(8) Serve as primary POC at the unit level to assist with coordination of postvention activities and as needed to fulfill requirements post suicide.

5–3. Behavioral health care

Primary prevention and BH promotion are strategic opportunities to influence overall well-being and promote a healthy, ready force. Effective prevention strategies build awareness, increase efficiency, and reduce the need for prolonged BH treatment, improving overall well-being and often improving the outcomes of other medical conditions.

5–4. Geographically-dispersed Soldiers

a. Geographically-dispersed Soldiers are defined as those who do not live within the 50-mile radius catchment area of a military installation. Geographically-dispersed Soldiers and their Families have challenges to access services related to health promotion, risk reduction, and suicide prevention. Soldiers serving on active duty and their Families who cannot easily access an installation are in danger of becoming isolated from critical support services normally available to them. Lack of entitlements for USAR and ARNG Soldiers not in a duty status limits access to many services readily available to the active force.

b. It is important for commands of geographically-dispersed Soldiers to implement strategies to leverage community-based services available at the national, state, and local levels to ensure Soldiers have appropriate support regardless of their location. Some of these resources are as follows:

(1) *Tri-service Reserve Select.* Soldiers on active duty orders for more than 30 days and their Families can use benefits at approved local clinics. Information is available at https://www.tricare.mil. Respective TRICARE representatives can clarify benefits and help locate appropriate services.

(2) *Military OneSource.* Specifically geared to serve geographically-dispersed Soldiers and Families, Military OneSource, at https://www.militaryonesource.mil/, provides resources and support 24 hours a day, 7 days a week, on a wide variety of subjects. Among available services are consultations on childcare and relocation, translation services in more than 140 languages, up to 12 professional counseling sessions, educational materials, and interactive media. Services are provided by DoD at no cost to all Soldiers (RA, ARNG, and USAR) and their Families. Military OneSource is not a crisis line and does not provide clinical counseling.

(3) *Family Assistance Centers.* Family Assistance Centers provide a variety of referral-based services to geographically-dispersed families and retirees. They are strategically placed in local communities in every state for use by military members and their Families, regardless of Service or component.

(4) *Veterans Affairs Centers.* Veterans Affairs (VA) Centers should be noted as an additional resource. These confidential in-person and tele-BH counseling centers are available to members of the RA and the USAR.

(5) *State and county behavioral healthcare.* Many state and county BH organizations can provide services to Soldiers and their Families free of charge or on a sliding fee scale through memorandums of agreement established with state JFHQs.

(6) *Online resources.* These resources provide another avenue to reach geographically-dispersed Soldiers and their Families. Web-based services that support health promotion, risk reduction, and suicide prevention are accessible from any geographical location with an internet connection. A partial list of important websites is in appendix J.

5–5. Collaboration

a. RA and RC commanders should collaborate to take care of Soldiers and Families in geographically remote areas. RA recruiters may be located far from installation-based services and yet be within easy reach of services available to RC Soldiers. The opposite may also be true.

b. Just as the USAR is regionally based and the ARNG is state-based, so also are many of the community services that would benefit Soldiers. The USAR and the ARNG should work together to leverage these resources. The ACOMs, ASCCs, and DRUs work to harness regionally-based services that would be available to all Soldiers, and the state JFHQs can, in return, do the same for state-based services. Developing memorandums of agreement to expand availability of services across components ensures maximum coverage for all Soldiers.

5–6. National, state, and local support

a. There are many national, state, and local services available for geographically-dispersed Soldiers and their Families. The SPWGs should develop a well thought-out and deliberate strategic communications plan to communicate important suicide prevention messages and provide listings of available services and how to access them.

b. The geographically-dispersed live outside of exposure to installation-based mass media campaigns. To effectively reach them, communication should be through means relevant to the location and situation of the target audience. Communication channels may include email, unit newsletters, mass mailings, armory bulletin boards, command letters, organizational websites, and printed media.

5–7. Suicide incident reporting

There are challenges in suicide incident reporting for geographically-dispersed Soldiers, especially those in the RCs. State and local ordinances vary regarding release of police reports, coroner's reports, and vital statistical records such as death certificates. These ordinances can be very restrictive and have the potential to limit the Army's ability to gather data and confirm means of death. Confusion on applying Health Insurance Portability and Accountability Act and privacy laws also can restrict information gathering. Implementing the following strategies can help to alleviate some of these situations. The SPWG chair should—

a. Consult with the special agent in charge of their supporting USACID office regarding entering into memoranda of agreement with local authorities for sharing documents and information when a Soldier dies.

b. Acquire death certificates from the military personnel office which processes Soldier Group Life Insurance claims for survivors.

c. Integrate the SPPM to build and leverage professional contacts.

d. Initiate a relationship with the state coroner's office to solicit aid in acquiring documentation.

e. Interface with local law enforcement, coroners, and medical examiners to document the death determination and to collect epidemiological data regarding off-post suspected suicides of RC Soldiers.

5–8. U.S. Army Reserve suicide investigations

a. Priority. The investigation information and data capture from suicide and suicide-related events continue to be a priority for the Army Reserve. Suicide surveillance efforts, including the collection of informational data about suicide behavior, provide the USAR, DA, and DoD with information helpful to developing policies, creating and funding SPPs and training events, and producing multimedia suicide prevention products.

b. Serious incident report.

(1) MSC commanders will submit a SIR to the USARC Watch within 24 hours of discovery or notification of a Soldier's death, regardless of his or her duty status at the time of death.

(2) Equivocal deaths are defined as deaths which cannot be readily established as natural, accidental, a suicide, or a homicide. When an equivocal death occurs, an updated SIR should be sent to the USARC Operations Center once the local coroner or medical examiner determines the cause of death.

c. Investigations. Suicides will be investigated in accordance with AR 15–6 to identify factors that contributed to the Soldier's suicide, identify lessons learned, and provide recommendations for Soldier care solutions and best practices. The purpose is not to make a determination of death, lay blame for the Soldier's death, nor supersede the local coroner's determination of death assessment.

(1) An AR 15–6 investigation will be conducted for all suspected or confirmed suicides.

(2) The commander exercising GCMCA or responsible general officer assigned to a command billet with a servicing SJA is the appointing authority for all suicide investigations. This authority will not be delegated. The commander will appoint an IO in the rank of O–4 or above, in writing, within 15 days of notification of death.

(3) The investigating command must submit the report of investigation to the USARC SPPM within 70 days of the date of the suspected suicide. In each case, the IO will complete the investigation within 60 days of the date the CCIR reporting the suspected suicide was submitted. The investigating command then has 10 days to complete the legal review and approval authority's action. The investigating command will submit the completed investigation to the USARC SPPM via email or DoD Secure Access File Exchange upload within 1 business day of the approval authority's action.

(4) Notice of the granting of an extension to the 60-day suspense for the investigation will be provided by the GCMCA in the investigating command's chain to the CG, USARC through the USARC SPPM immediately upon issuance of such an extension. Such notice will identify the new suspense and include a timeline of investigative work completed to date, an explanation of the reasons for the extension, and a description of the intended COA to ensure prompt completion of the investigation.

(5) All interviews with Army personnel will be documented on sworn statements. Interviews of other military personnel and non-military personnel, including Family members, generally should be documented in writing (for example, written statement or IO summary of the interview), even if the interviewee does not provide a sworn statement.

(6) The IO will consult AR 638–34 for requirements for suicide incident Family briefs. Questions should be tailored to what is appropriate for the individual being interviewed and limited to the interviewee's scope of knowledge. Investigative interviews around suicide are sensitive in nature and can be emotionally charged due to the tragic loss. Consultation is encouraged with the Psychological Health Program.

(7) The IO will use DD Form 2996 to help develop questions and guide their investigation. No witness will be compelled to incriminate themselves, to answer any question the answer to which could incriminate them, or to make a statement or produce evidence that is not material to the issues being investigated or that might tend to degrade them (see AR 15–6 for more information). The IO will use DA Form 3881 (Rights Warning Procedure/Waiver Certificate) to explain the rights and to memorialize the explanation and the witness' decision (see AR 15–6).

(8) Include a copy of the Soldier's orders or certificate of performance to verify his or her duty status at the time of death.

(9) Information from the AR 15–6 investigations conducted for suicides are subject to release in accordance with the requirements of AR 15–6, AR 25–22, AR 25–55, and AR 638–34.

(10) In accordance with AR 381–10, if during the course of the investigation, the IO discovers the deceased exhibited behaviors that may be associated with espionage or international terrorism, the IO should report this expeditiously to the Intelligence and Security Directorate and annotate it in the AR 15–6 report.

5–9. Suicide reporting

a. Within 24 hours of notification of a suicide death—

(1) The MSC notifies USARC Watch of death for all confirmed and suspected suicide death reports.

(2) The USARC SPP office will send the report to the designated list and add the case into the database for tracking.

b. Within 24–48 hours of notification of a suicide death—

(1) The unit commander will initiate Section I of the CSSER.

(2) USARC SPP officer will send the data from section 1 of the CSSER to HQDA (usarmy.pentagon.hqda-dcs-g-9.list.csser@army.mil).

c. Within 5 days of notification of a suicide death—

(1) The commander exercising GCMCA or responsible general officer assigned to a command billet with a servicing SJA in the MSC will appoint an IO to complete an AR 15–6 investigation.

(2) The appointed AR 15–6 IO will contact their MSC SPPM for guidance.

d. Within 90 days from date of death, for all suicides or suspected suicides, the commander of the deceased Soldier's geographic or functional command will complete a CSSER. Send the initial CSSERs to the USARC SPP (usarmy.usarc.usarc-hq.list.suicidepreventionprogram@army.mil) no later than 90 days from the date of the Soldier's death. Submit an update every 30 days until the AR 15–6 is complete.

5–10. Reporting suicidal ideations and attempts

a. Information on Soldiers with suicidal ideations or attempts is strictly on a need-to-know basis. The distribution list for CCIR will be limited to those individuals who are required to take an action to assist the Soldier.

b. The following procedures will be used to track suicidal ideations and attempts:

(1) The reporting commander will submit a CCIR to the MSC commander using the G–3 channels.

(2) Required information on suicidal ideations and attempts will be limited to the SIR input.

(3) The CSSER report will not be generated for ideations and attempts.

c. The Director of the Psychological Health Program will assign a case manager to assist the commander in the treatment plan of the Soldier. They will provide subject matter expertise on BH matters and

procedures. Commanders and leaders may contact the Psychological Health Program office at https://www.usar.army.mil/php/ or via email at usarmy.usarc.usarc-hq.mbx.psychological-health-program@army.mil.

d. The reporting commander will submit add-on CCIR reports when additional information is available. When the Soldier's treatment plan is complete and the Soldier no longer requires support from the Psychological Health Program case manager, the commander must submit a close-out CCIR.

5–11. Suicide prevention training

The USARC SPP staff are ACE–SI Tier 3 trainers and will coordinate and implement ACE–SI Tier 2 instruction courses and maintain records of all certified ACE–SI trainers.

Chapter 6
Suicide Prevention Records and Reporting Requirements

6–1. Overview

This chapter outlines the reporting and records requirements necessary to provide Army leaders information to assess the effectiveness of and inform decisions regarding policies, initiatives, and resources that sustain personal readiness and resilience. This chapter further describes the Army systems used to record training, education, and prevention and intervention data.

6–2. Records and reports for suicide prevention training

Commanders will retain local records of Soldier's suicide training completion. Army schools will continue to use DTMS course manager to manage and record Soldier training completion while attending Army schools.

a. Unit individual training. Completion of one-time suicide prevention training (ACE–SI) is documented in the ITR. The ITR is governed by AR 350–1. Unit commanders maintain ITRs to assist in Soldier readiness and facilitate the electronic transfer of Soldier training records during reassignment.

b. Institutional individual training. Completion of all institutional suicide prevention training courses (IMT and PME) will be recorded and entered into the Army Training Requirements and Resource System.

c. Department of the Army Civilians. Defense Civilian Personnel Data System (DCPDS) houses and processes all of DoD's civilian human resources data (see DoDI 1400.25). The system is designed to support appropriated funds, nonappropriated funds, and local national human resources operations. Each organization employing DA Civilian personnel will maintain suicide prevention training records in DCPDS.

6–3. Records and reports for suicide prevention program

a. Suspected Suicide Fatality Review and Analysis Board Review Report. The annual report will include the S2FRAB's evidence-informed trends and findings and policy and resource recommendations for HQDA R2 governance. The report will not include personally identifiable information (for example, names, social security numbers, or electronic data interchange personal identifier), privileged or other information protected by the Privacy Act, and other regulatory and statutory requirements. See chapter 3.

b. Department of Defense Suicide Event Report. See chapter 2.

c. DA Form 7747. See chapter 2.

d. Army Suicide Prevention Program performance management indicators. These indicators will be published in HQDA memorandums and monitored through the SPWG and the CR2Cs at echelon. See chapter 7.

6–4. Records and reports for suicide prevention and governance

The installation reports provide the foundation to assess achievement of conditional changes in support of prevention efforts. The annual installation suicide prevention plan will outline the SC's suicide prevention goals, be evidence-based, culturally sensitive and data-driven, and address prevention using a multidisciplinary, integrated approach.

a. ASPP measures will be published in HQDA memorandums and monitored through the CR2Cs at echelon.

b. ASPP policy compliance will be assessed through the program status report and published annually in HQDA memorandum and monitored through CR2Cs at echelon.

Chapter 7
Assessments

7–1. Overview
This chapter outlines a framework for assessing ASPP efforts through the processes of monitoring and evaluation. The results will inform decision making to either sustain or improve upon certain aspects of the program. Focused evaluation is evaluation at the enterprise-level on a common program or outcome type (for example, financial readiness, gatekeeper training, or resiliency building).

7–2. Monitoring
Monitoring consists of routine data collection and analysis of an ongoing program to assess the degree of implementation around key processes needed to generate outcomes. This section addresses the generation of performance measurement indicators (PMIs) to support local program monitoring efforts. In addition, discussion on monitoring of external data as indicators of BH, financial readiness, and other risk and protective factor data is included.

a. Installation-level monitoring. PMI reports and dashboards advise program stakeholders (deliverers, planners, coordinators, and leaders) on the degree of policy compliance and progress made toward achieving intended outcomes. PMIs show evidence of program delivery and may include materials distributed, number of attendees, and the number of sessions.

(1) The Army SPPM will create, distribute, collect, and update performance PMI collection tools (checklists, rosters, and trackers) to demonstrate policy implementation through suicide prevention activities.

(2) Working with stakeholders within their respective organizations, program implementers such as SPPMs will collect and track PMIs (evidence of program delivery) generated from prevention activities (trainings and events).

(3) Program stakeholders, such as prevention personnel at installation and ACOMs, ASCCs, DRUs, and SCs, may refine and create measures (checklists, rosters, and trackers) for outputs suited to their activities.

(4) The Army SPPM and their stakeholders will leverage PMIs to assess progress made toward their suicide prevention goals and specific, measurable, achievable, relevant, and timely (SMART) objectives. Army SPPM, stakeholders, and leadership will then undertake action to either adjust or sustain activities impacting progress on those measures. Monitoring PMI results facilitates the execution of local evaluations (see para 7–3) or inform focused evaluations (see para 7–4) and other investigations (research studies).

(5) Army SPPM, stakeholders, and leadership will use PMI results as part of local-level assessment of proximal (short and medium term) outcomes (increased knowledge, skill, intention to use information, and behavioral change).

b. External monitoring. Monitoring also includes a continuous analytical assessment of data points by the DCS, G–9 and the Chief, Assessment Division, Prevention, Resilience, and Readiness Directorate or authoritative data systems to identify behavioral trends or promising activities that facilitate action at either the strategic, operational, or tactical echelon levels. Data points used in external monitoring may include DoDSER risk factor data and DA Form 7747 submissions, annual suicide report suicide rate data, and external program data such as financial readiness, stress management, BH indicators, or community-based results.

7–3. Installation-level evaluations
a. Evaluation looks at specific aspects of the program's activities, outputs, or outcomes to determine whether goals and objectives were achieved or identify opportunities for program improvement. Local-level evaluations of programs producing proximal to distal outcomes will demonstrate opportunities for program improvement and to what degree intended outcomes were achieved. Evaluations also ascertain whether progress toward SMART goals and objectives is achieved.

b. Prevention professionals and commanders at installations will perform evaluations of their respective ASPPs to determine whether outcomes were achieved or identify areas for process improvement. The IEP guide provides frameworks and tools for local-level logic modeling, creation of SMART objectives, and other resources. Prevention personnel (for example, SPPC and CR2Is) and commanders should use the IEP to support effective planning and evaluation.

7–4. Focused evaluations

a. A focused evaluation will assess the impact of the enterprise ASPP and center on key processes and outcomes to ascertain if progress toward goals and objectives is achieved.

b. The DPRR, through the Army SPPM, in coordination with the CG, AMC, is responsible for performing evaluations of their respective ASPP functions to determine whether outcomes were achieved or identify areas for process improvement. Evaluators will provide or receive specific guidance and will perform a process or outcome evaluation. Consultation with the Army SPPM and relevant stakeholders will occur prior to the initiation of this action to identify and codify objectives. Results of the effort will enable the development of a TAP that will require activities to be monitored to ensure the integrity of continuous improvement efforts.

c. The IEP guide identifies the necessary planning and evaluation activities to generate an evidence-based innovative emerging initiative. Prevention personnel and commanders will use the IEP to support effective planning and evaluation. The IEP will be leveraged by ACOM, ASCC, and DRU commanders and HQDA principal officials to evaluate if a proposal or promising practice has the potential to influence activities across the enterprise.

Appendix A

References

Section I

Required Publications

Unless otherwise indicated, all Army publications are available on the Army Publishing Directorate website at https://armypubs.army.mil. DoD publications are available on the Executive Services Directorate website at https://www.esd.whs.mil.

AR 15–6
Procedures for Administrative Investigations and Boards of Officers (Cited in para 1–13*i*(2).)

AR 15–39
Department of the Army Intergovernmental and Intragovernmental Committee Management Program (Cited in title page.)

AR 25–22
The Army Privacy and Civil Liberties Program (Cited in para 5–8*c*(9).)

AR 25–50
Preparing and Managing Correspondence (Cited in para 3–7*b*(2)(*a*).)

AR 25–55
The Department of the Army Freedom of Information Act Program (Cited in para 5–8*c*(9).)

AR 165–1
Army Chaplain Corps Activities (Cited in para 1–21*f*.)

AR 190–45
Law Enforcement Reporting (Cited in para 2–4*f*(1).)

AR 195–2
Criminal Investigation Activities (Cited in para 1–23*b*(2).)

AR 350–1
Army Training and Leader Development (Cited in para 4–3.)

AR 350–53
Comprehensive Soldier and Family Fitness (Cited in para 2–3*e*.)

AR 381–10
The Conduct and Oversight of U.S. Army Intelligence Activities (Cited in para 5–8*c*(10).)

AR 600–8–4
Line of Duty Policy, Procedures, and Investigations (Cited in para 2–4*e*.)

AR 600–8–8
The Total Army Sponsorship Program (Cited in para 1–10*a*(3)(*d*).)

AR 600–8–11
Reassignment (Cited in para 1–7*b*(2).)

AR 600–20
Army Command Policy (Cited in para 2–12*b*.)

AR 638–8
Army Casualty Program (Cited in para 2–12*b*.)

AR 638–34
Army Fatal Incident Family Brief Program (Cited in para 2–4*b*(6).)

DA Pam 25–403
Army Guide to Recordkeeping (Cited in para 1–5.)

DoDI 5505.10
Criminal Investigations of Noncombat Deaths (Cited in para 1–23*b*(2).)

DoDI 6400.09
DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm (Cited in title page.)

DoDI 6490.16
Defense Suicide Prevention Program (Cited in title page.)

Section II

Prescribed Forms

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate website at https://armypubs.army.mil/. DD forms are available on the Executive Services Directorate website at https://www.esd.whs.mil/dd.

DA Form 7747
Commanders Suspected Suicide Event Report (Prescribed in para 1–13*i*(1).)

Appendix B

Suicide Prevention Program Activities and Outcomes by Risk and Protective Factors

B–1. General

For planning purposes, suicide prevention activities will be aligned to risk and protective factors known to influence rates of harmful behaviors. Activities (A), such as use of commander visibility tools, lethal means counseling, or advocacy and relationship programs, lead to Outcomes (O), such as increased care access through referrals, reduced access to lethal means, or improved Family connections, respectively. Activities (A) and Outcomes (O) are linked to a range of risk and protective factors that can support program and planning. See table B–1.

B–2. Scope

Leaders and the Army suicide prevention workforce should select activities and their respective outcomes aligned with risk and protective factors for suicide and self-harm identified by the CDC and DoD. These should be used to inform development and monitoring of suicide prevention performance management indicators. See table B–1 for examples.

Table B–1
Suicide Prevention Program activities and outcomes by risk and protective factors

Army SPP Activities (A) and Outcomes (O)	Risk and protective factors
Improve financial readiness (O) through the Army Financial Readiness Program (A) Increase household economic stability (O) through credit tracking (A)	**Risk:** Financial problems **Protective:** Increased financial readiness and household economic stability
Reduce stigma (O) through modeling help-seeking behaviors in ACE–SI trainings (A) Increase care access (O) through referring at-risk Soldiers to BH services from commander's utilization of visibility tools and engaged leadership (A)	**Risk:** Barriers to health care Stigma associated help-seeking **Protective:** Supportive relationships with care providers, unit, and Family members Availability of physical and mental health care, and increased care access through referral to BH services Peer support for care-seeking and bystander intervention
Reduce access to lethal means (O) through policy reinforcement, like AR 600–92, and providing lethal means counseling (A) Improve unit cohesion (O) through gatekeeper trainings like ACE and ACE–SI (A) Improve Family connections (O) through MFLC advocacy and relationship programs (A) Improve newly-arriving Soldier connectedness (O) through unit orientations (A) per guidance in AR 600–8–8	**Risk:** Easy access to lethal means among people at risk (firearms or medications) Social isolation or poor social skills Relationship problems, such as strain, a breakup, violence, or loss Transitions (retirement, permanent change of station (PCS), discharge, and so on) **Protective:** Limited access to lethal means among people at risk Connections to friends, Family, and community support
Increase peer support for care-seeking (O) through ACE and ACE–SI (A)	**Risk:** Barriers to health care

Table B–1
Suicide Prevention Program activities and outcomes by risk and protective factors—Continued

Army SPP Activities (A) and Outcomes (O)	Risk and protective factors
Increase bystander intervention skills (O) through Engage trainings (A)	Stigma associated with help-seeking Social isolation or poor social skills **Protective:** Connections to friends, Family, and community support
Improve unit cohesion (O) through MRT and ACE trainings (A)	Cultural and spiritual beliefs that encourage connecting and help-seeking, discourage suicidal behavior, or create a strong sense of purpose or self-esteem Peer support for care-seeking and bystander intervention
Enhance parenting skills (O) through MFLCs (A) Increase use of stress reduction techniques (O) as a result of MRT (A) Increase financial management knowledge (O) through ACS (A)	**Risk:** Adverse childhood experiences such as child abuse and neglected Mental illness (depression or PTSD) Severe, prolonged, or perceived unmanageable stress Financial problems **Protective:** Connections to friends, Family, and community support Coping and problem-solving skills Increased financial readiness and household economic stability (Army Financial Readiness Program)
Create Protective Environments (O) through commanders' use of BH Pulse and CRRT, and identifying and referring high-risk Soldiers to clinical and/or non-clinical services (A) Identify signs of suicide risk and refer peers (O) after receiving ACE and ACE–SI training (A)	**Risk:** Barriers to health care Criminal, Financial, Job, or Legal Problems Illicit drug use and alcohol abuse Stigma associated with help seeking **Protective:** Cultural and spiritual beliefs that encourage connecting and help-seeking, discourage suicidal behavior, or create a strong sense of purpose or self-esteem Peer support for care-seeking and bystander intervention
Improve safe reporting and messaging about suicide (O) through effective communications plan (A) Improve Soldier knowledge of reducing access to lethal means like firearms, ropes/ asphyxiation devices, medications (O) through lethal means training (A)	**Risk:** Previous suicide attempt Exposure to another person's suicide, or sensationalized accounts of suicide or significant loss Sexual violence Cultural and/or spiritual beliefs (suicide is a noble resolution of a personal problem) Stigma associated with mental illness or help-seeking Easy access to lethal means among people at risk (firearms or medications)
	Protective: Coping and problem-solving skills

Table B–1
Suicide Prevention Program activities and outcomes by risk and protective factors—Continued

Army SPP Activities (A) and Outcomes (O)	Risk and protective factors
	Cultural or spiritual beliefs that encourage connecting and help-seeking, discourage suicidal behavior, or create a strong sense of purpose or self-esteem Supportive relationships with care providers, unit, and Family members Limited access to lethal means among people at risk Postvention support Safe reporting and messaging about suicide aligned with knowledge and needs

Appendix C

Suspected Suicide Fatality Review and Analysis Boards

C–1. General

S2FRABs are one of the multiple efforts to improve suicide prevention, intervention, and postvention policies, practices, programs, and procedures. S2FRABs meet the DoD requirement to establish suicide event boards as directed in DoDI 6490.16.

C–2. Scope

The retrospective analysis of suspected suicide deaths serves to provide an objective and comprehensive analysis of individual, systemic, and other environmental factors to identify gaps and opportunities to prevent suicide deaths and to identify how to better equip leaders and Soldiers before tragedies occur. The S2FRAB is founded on the principle that the standard collection and discussion of the events and factors will identify opportunities for future prevention.

C–3. Facilitation of the Suspected Suicide Fatality Review and Analysis Board

a. Information associated with suicide events is often incomplete. The S2FRAB should attempt to collate the diverse data sources and information. The S2FRAB requires an effective facilitator to manage time, collect the information, and guide members to identify themes and system (policy, procedures, protocols, education, and training) level barriers and changes at the tactical/unit, operational/community, and strategic level. The facilitator should aim to answer the following questions:

(1) What intervention should have happened and didn't?

(2) Who knew something?

(3) What was the feasibility of the individual seeking help?

(4) What were the barriers at the individual, unit, and installation?

(5) How could this event have been mitigated?

b. Command team involvement does not indicate blame or fault. The S2FRAB process is non-punitive. Command team participation in S2FRABs should be limited to discussing only their respective cases.

c. Members of the S2FRABs should have strong interpersonal skills who understand the sensitivity of engaging with personnel who have lost someone to suicide. It is recommended that S2FRAB members receive an orientation that includes recognizing and mitigating bias and an overview of the S2FRAB process and outcomes.

d. The following personnel have a key role and support the facilitator of the S2FRAB:

(1) The S2FRAB chair will consult with the supporting BH provider to review significant points, takeaways, gaps, key findings, and lessons learned. The S2FRAB chair must consult the IDPH or supporting BH provider for assistance understanding key information and BH indicators of risk.

(2) The PAO will review the information management process, to include messaging strategies, external communication, and social media platforms.

C–4. Collecting information on the circumstances of the event

a. Individual's name and organization.

b. Leader assessment of individual's background history.

(1) Leader assessment of Soldier risk level and what tool was used in determination.

(2) Review of CRRT information of the deceased Soldier. List events that were visible in CRRT at time of death.

(3) List all PCS moves, tours, and pertinent promotions or demotions.

c. Accounts of the event.

d. Retrospective indicators of intent and observations gained from observations and investigation.

e. Contributing factors.

(1) Access to lethal means.

(2) Relationship issues: failure or perceived loss of a relationship (intimate or other) through divorce, separation, or break up.

(3) Military work stress: job loss (expiration term of service or PCS), job instability, supervisor or coworker issues, poor work evaluation, and unit or workplace hazing.

(4) Legal issues: Court-martial, Article 15, administrative separation absent without leave, or civil legal problems.

(5) Shame event: Personal and professional actions that result in a profound sense of letting others down or feelings of guilt or failure. This includes, but is not limited to perpetrator of abuse (physical, emotional, or sexual), mission-related errors in judgement, lapses in ethical or values-based behavior often contradictory to Army values, loss of security clearance or credentials, body composition or Army Combat Fitness Test failure, or demotion or relieved from duty.

(6) Financial stress: Excessive debt and inability to meet current financial obligation, large debt to income ratio, or command or self-referred for financial issues.

(7) Illness or injury: Any physical health problem naturally occurring or exacerbated by service, for which a Servicemember is seen on or off-post (outpatient, inpatient, emergency department, and so forth); any chronic pain, permanent profiles, or medical chapters.

(8) Sleep issues: Insomnia, poor sleep habits or short sleep durations, sleep apnea, or prescribed sleep medication.

(9) Family or friend death: Recent death of a spouse, Family member, or friend.

(10) Family or friend suicide: Recent suicide of a spouse, Family member, or friend.

(11) Victim of bullying, hazing, or sexual harassment. Male or female victim of current or past emotional, physical, sexual, or verbal abuse at home or in the workplace. Abuse can include harassment and gang-related violence and hazing.

(12) Indictors of increased substance use or abuse. Substance abuse service use, either self-referred or command-referred, on-post or off-post, or untreated perceived substance abuse.

(13) Indications of isolating behaviors.

f. Protective factors.

(1) Supportive and connected relationships with care providers, unit, and Family members.

(2) Financial stability.

(3) Limited access to lethal means.

(4) Cultural and spiritual beliefs that encourage connecting and help-seeking, discourage suicidal behavior, or create a strong sense of purpose or self-esteem.

(5) Coping and problem-solving skills.

(6) Support services used by the individual.

(7) Social media platforms used by the individual.

(8) Additional findings.

C–5. Postvention response update

Leadership may provide an update on the status of postvention activities with the unit in general and affected unit and Family members specifically. This will serve to inform lessons learned. The following are recommended areas to cover in this update:

a. Postvention progress.

b. Services provided to date.

c. Affected Family members (pending notification).

d. Affected unit members (for example, witnessed the event).

e. Additional findings.

f. Way ahead.

C–6. Review and status of reporting requirements

The installation S2FRAB should include time on the agenda to review and assess the following reporting requirements associated with the suspected suicide:

a. DoDSER.

b. CSSER.

c. LOD investigation.

d. AR 15–6.

e. Casualty report.

f. SIR.

Appendix D

Specific, Measurable, Achievable, Realistic, and Time-Bound Objectives Template

D–1. General

SMART objectives allow prevention planners to create specific, measurable, achievable, realistic, and time-bound statements around accomplishing suicide prevention activities, such as trainings and events. SMART objectives will clearly state the type of activity, such as training; how the activity will be measured (for example, end of session survey or focus group); the available resource (trainers) and time (monthly) that will allow the activity to occur; how realistic the objective is given the outputs and outcomes that the activity produces; and the timeline by which the objective will be met. See table D–1.

a. S–How specific is the objective related to your prevention activities? Does your objective define what activities will be completed and who will complete them?

b. M–How measurable is the objective related to what you are trying to achieve, to show proof of achievement? Does the objective state how much change is expected?

c. A–How achievable is the objective (reasonable given available resources and time)?

d. R–How realistic is the objective (related to the program goal and typical outcomes)? Will the objective lead to the desired end state?

e. T–Does your objective have a set deadline or completion date?

D–2. Scope

SMART objectives should be used by leaders and the suicide prevention workforce to identify the specific steps that lead to the successful completion of goals. Completion of the objectives result in specific, measurable outcomes that directly contribute to the achievement of the goals. It is important to get input from leaders, stakeholders, and the CR2C before setting specific PA objectives and to obtain information in support of accurate SMART objective development and buy-in. See table D–1.

Table D–1
Specific, Measurable, Achievable, Realistic, and Time-bound Objectives template

CDC Strategy	Example ASPP Initiative	S-pecific; M-easurable; A-chievable; Realistic; T-imebound (SMART) Objectives
Creating protective environments	Lethal means Training for chaplains	Increase by 50 percent the number of chaplains receiving lethal means training by month, year (S), with over 50 percent of training chaplains using a comprehensive lethal means checklist (M) during sessions (A) to screen and then advise Soldiers who own firearms. 30 percent of active duty clients of chaplain services (R) will adopt new safe firearms storage practices within 3 months of receiving chaplain-based counseling (T).

Appendix E

Fidelity Monitoring (Trainings and Events)

E–1. General

Fidelity monitoring is a component of process evaluation where the focus is on whether the program, activity, or initiative appears to be achieving outcomes (rather than whether outcomes were actually achieved). Fidelity specifically refers to operating as planned, where core, critical elements of a training or event need to be upheld for any planned outcomes to occur. The checklist below can be adapted to observe, during the training session itself, whether attendees actually received key, planned areas of the presentation (for example, ways to identify signs or symptoms or the importance of bystander intervention).

E–2. Scope

A PA involves an intervention, or efforts designed to affect a specific outcome, or the direct provision of services (for example, Engage training) and has a target audience. A PA is not routine care, screening tools, passive information (websites or brochures), policies, working groups, or a department, center, or office. Fidelity monitoring tools can be used by facilitators during practice and content mastery to ensure they are prepared to deliver the activity with maximum effectiveness. Fidelity tools can be used by others to assess the facilitator's level of preparedness and to communicate feedback. Fidelity tools should be developed, tailored, tested, and used for suicide prevention activities. One fidelity tool may not be used for all activities (that is, there may be a fidelity tool for ACE and a fidelity tool for ACE–SI). Use the following components as parts of the fidelity tool:

a. Indicate the date, event title, attendees and recipients, observer title, start time, and end time.

b. Mark level of completion the person who delivers the activity (training, education, session, outreach, and so forth) each rated area as compared with implementation plans (lesson plans and agendas). The level of implementation is connoted as—

(1) Zero–None.

(2) One–Partial implementation (less than 100 percent).

(3) Two–Complete implementation of all components.

c. Rated areas should include, at a minimum, the following planned program (training, education, and outreach):

(1) Knowledge items.

(a) Facilitator reads directly from the notes, manual, or PowerPoint. Does not know the content.

(b) Facilitator uses notes, manual, or PowerPoint about half the time.

(c) Facilitator uses notes, manual, or PowerPoint very minimally or not at all. Knows content very well.

(2) Delivery items.

(a) Facilitator reads content or uses the same tone throughout. Facilitator comes off as boring or emotionally disconnected for some of the presentation.

(b) Facilitator changes tone, volume, or pace sometimes. Facilitator needs improvement on emotional connection to content.

(c) Facilitator changes tone, volume, and pace regularly and appropriately. Facilitator is emotionally connected to the content and uses emotional variation throughout.

(3) Interactive items.

(a) Facilitator does not make the session interactive and primarily talks at the participants.

(b) Facilitator asks questions throughout but does not use motivational interviewing skills to steer the conversation or draw participants into the discussion.

(c) Facilitator effectively draws participants into the discussion and uses motivational interviewing skills to stimulate an engaging conversation throughout the session.

Appendix F

Logic Model Template

F–1. General

A logic model portrays the theory of action (notions of cause and effect) of a program, activity, intervention, or initiative. Components specify inputs, activities, outputs, and outcomes (short-term, intermediate, and long-term). In the ASPP, a logic model shows how an initiative (education, training, or outreach) leads to increased resilience that may impact Army suicide rates. When followed, a logic model helps to achieve SMART objectives and serve as a roadmap for process and local-level (installation or regional) impact evaluation. See table F–1.

F–2. Scope

Leaders and the Army suicide prevention workforce should use planning and evaluation tools like the logic model for each suicide PA. This will also support communicating any adaptations made within the PA and help connect the dots.

Table F–1
Logic model template

Inputs	Activities	Outputs	Short-term outcomes	Mid-term outcomes	Long-term outcomes
-ASPP -AR 600–92; DoDI 6400.09 -Surveillance data; needs assessment data -Training decks, materials -Announcements/ Registration -Commanders -Suicide prevention workforce	Deliver lethal means training to Soldiers as planned, including critical components	-# sessions delivered in full versus partial --# registered versus actual attendees -# completed fidelity checks	-Knowledge gain around safe storage intention to use information at home -Confidence in reducing lethal means access	-Increase in safe storage practices -Reduced access to lethal means (guns or medications)	-Reduced suicide rates -Reduced suicide attempts

Appendix G

Suicide Reporting Requirements Checklist

G–1. General

There are multiple reporting requirements for suspected suicides. This checklist contains the reporting requirement, the regulation, point of contact, and timeline for reporting. See table G–1.

G–2. Scope

The most current list of regulations and requirements are in table G–1.

Table G–1
Suicide Reporting Requirements Checklist

Report	Requirements	Point of contact	Timeline
SIR Per AR 190–45 Form: See AR 190–45	See AR 190–45	See AR 190–45	Within 24 hours of discovery or notification at the installation level
Casualty Report Per AR 638–8 Form: See AR 638–8	See AR 638–8	Casualty Assistance Center	12 hours to collect data
CSSER Section I–SIR Per AR 600–8–4; AR 600–92 Form: DA Form 7747	Completed for every suicide or equivocal deaths investigated as a possible suicide	Commander	Within 24 hours of the incident
CSSER Section II-Commander's Initial Report Per AR 600–8–4; AR 600–92 Form: DA Form 7747	Completed for every suicide or equivocal deaths investigated as a possible suicide All data points are contained within the CRRT	Commander	Within 5 days after the incident
CSSER Section III-Commander's Final Report Per AR 600–8–4; AR 600–92 Form: DA Form 7747	Completed for every suicide or equivocal deaths investigated as a possible suicide	Commander	Within 60 days after the incident
AR 15–6 report Per AR 15–6 Form: See AR 15–6	Appointed by the unit commander	SJA	See requirements
DoDSER Per AR 600–92 Form: DD Form 2996	Completed for all suicides and suicide attempts, regardless of hospitalization	SPPC	60 days after AFMES confirms death by suicide
LOD investigation Per AR 600–8–4; AR 190–45; AR 15–6 Form: See ARs	Appointed by the special court-martial convening authority		

Appendix H

Suicide Reporting Information Data and Sources

H–1. General

To conduct effective information gathering, commanders and supporting personnel will need to collect, review, and analyze available information (as appropriate). Table H–1 provides examples of informative data and information sources to consider. The SRT and S2FRAB should not be centered on just identifying individual characteristics of the suicide death but should begin to aggregate factors to a system-level perspective that may require a systematic response and support an upstream approach to suicide prevention. See table H–1.

H–2. Data sources

Information can be obtained from the following sources:

a. Completed DA Form 7747.
b. Completed DoDSER.
c. Completed suicide reports. See appendix G for the required suicide reports.

Table H–1
Suicide reporting information data and sources

Individual	Environment, climate, or leadership	Systems	Sources to consider (as appropriate)
Medication or substance use or misuse	Climate	Directives or policies (both explicit and implicit)	Policy
Medical concerns (physical pain)	Culture	Procedures	Procedures
Interpersonal relationships (peers and Family)	Morale	Processes	Records
Emotional state	Supervision	Programs and services effectiveness and accessibility	Documentation
Personality, attitudes, and motivation	Performance expectations and counseling	Training (knowledge and skills)	Spouses and significant others
Spirituality and religious practices or struggles	Leadership modeling, mentoring, and training	Resources	Friends and peers
Job performance or qualifications			Coworkers
Workload			Subordinates
Life stressors			Supervisors
Disciplinary actions			Instructors
Fitness			Commanders
Fatigue or sleep			SMEs
			Roommates

Appendix I

Army Command, Army Service Component Command, Direct Reporting Unit Suspected Suicide Fatality Review and Analysis Board Sample Reporting Memo

I–1. General

ACOM, ASCC, and DRU commanders should use this template when completing the annual S2FRAB reporting memorandum. Commanders will ensure that no personally identifiable information is provided in the reporting memorandum.

I–2. Sample Memo

See figure I–1 for a template.

DEPARTMENT OF THE ARMY
GENERAL OFFICER ORGANIZATION
STREET ADDRESS
CITY, STATE ZIP CODE

OFFICE SYMBOL (ARIMS Record Number) DATE

MEMORANDUM FOR Director, Army Resilience Directorate, ATTN: Ready and Resilient and Training Division (DAPE-AR-ART), 300 Army Pentagon, Washington, DC 20310-0111

SUBJECT: Suspected Suicide Fatality Review and Analysis Board Report FY 2020

1. Overview. ACOM reviewed 22 suicides that impacted three Commands at five installations as part of an annual Suspected Suicide Fatality Review and Analysis Board Report for FY2020.

1.a 80% Male, 20% Female	1.b. 90% enlisted, 10% Officer
1.c 40% Under investigation before suicide	1.d 20% Received behavioral health services
1.e 10% Separating from the Army	1.f 60% Personal Firearm, 40% Hanging

2. Findings. ACOM identified the following significant and/or notable findings.

a. Prevention.
• Unit leaders indicated lack of awareness of risk and protective factors and associated resources and programs (include details).

b. Intervention.
• Unit leaders were unaware of Soldier prior behavioral health history (include details).

c. Postvention.
• Unit leaders indicated they did not feel prepared to manage after the suicide death (include details).

3. Recommendations. Based on the findings, ACOM recommends the following for further review and application to the Total Force.

a. Prevention.
• Equip leaders at all levels with knowledge and understanding how applying resources to identified risk and protective factors. (include details).

Figure I–1. Sample reporting memo

OFFICE SYMBOL (ARIMS Record Number)
SUBJECT: Suspected Suicide Fatality Review and Analysis Board Report FY 2020

b. Intervention.
• Improve communication between Behavioral Health providers in the appropriate sharing of information with Commands (include details).

c. Postvention.
• Develop institutional training for leaders at all levels on Postvention.

4. Special Interest Items. N/A

Signature Block

Figure I–1. Sample reporting memo—continued

Appendix J

Resources

J–1. General

The following are samples of available resources for Soldiers, DA Civilians, and Family members.

J–2. Hotlines

a. Call or text 988 for the Suicide and Crisis Lifeline sponsored by the U.S. Department of Health and Human Services. Chat is available at https://988lifeline.org/. Military callers have an option of pressing 1 to connect to the Military Crisis Line to speak with a veteran's representative or a crisis center in their local area. For Europe, dial 00–800–1273–8255. For Korea, dial 00–808–555–118. The veteran's representative has access to U.S. Department of Veterans Affairs records and can work with the caller on VA registration and ensures a warm hand-off to VA services.

b. The Veterans Crisis Line/Military Crisis Line (dial 988, then Press 1) offers free, confidential, 24-hour access services, 365 days per year to assist members in crisis or concerned friends and families. For Europe, dial 00–800–1273–8255. For Korea, dial 00–808–555–118.

c. The Wounded Soldier and Family Hotline (1–800–984–8523) is hosted by the ARNG and provides support to Soldiers and Families. During hurricanes, floods, and other declared emergencies, services are expanded to become a 24 hours a day, 7 days a week resource.

d. A comprehensive listing of hotlines by State is available at https://sprc.org/states/ by searching for "Suicide Prevention Hotlines."

J–3. Other national resources

a. Military OneSource (1–800–342–9647; https://www.militaryonesource.mil/) is a source for a wide array of call-in services. The phone is always answered by an individual who is a professional counselor with master's degree-level qualifications.

b. TRICARE Mental Health Resource Center provides information on how to secure medical assistance for military members and their Families. The services are not limited to BH issues but extend across the full spectrum of TRICARE services. The website is https://www.tricare.mil/.

c. The Substance Abuse and Mental Health Services Administration (https://www.samhsa.gov/) helps leaders locate BH resources in the communities in which Soldiers live. The state locater maps out resources by state and provides contact information.

d. Centers for Disease Control and Prevention: A technical package for preventing Suicide Strategies: https://www.cdc.gov/; search for Technical Packages for Violence Prevention and select the Preventing Suicide Technical Package.

e. Suicide Prevention Resource Center: https://sprc.org/.

f. Defense Suicide Prevention Office: https://www.dspo.mil/.

g. Defense Centers for Public Health: https://ph.health.mil/.

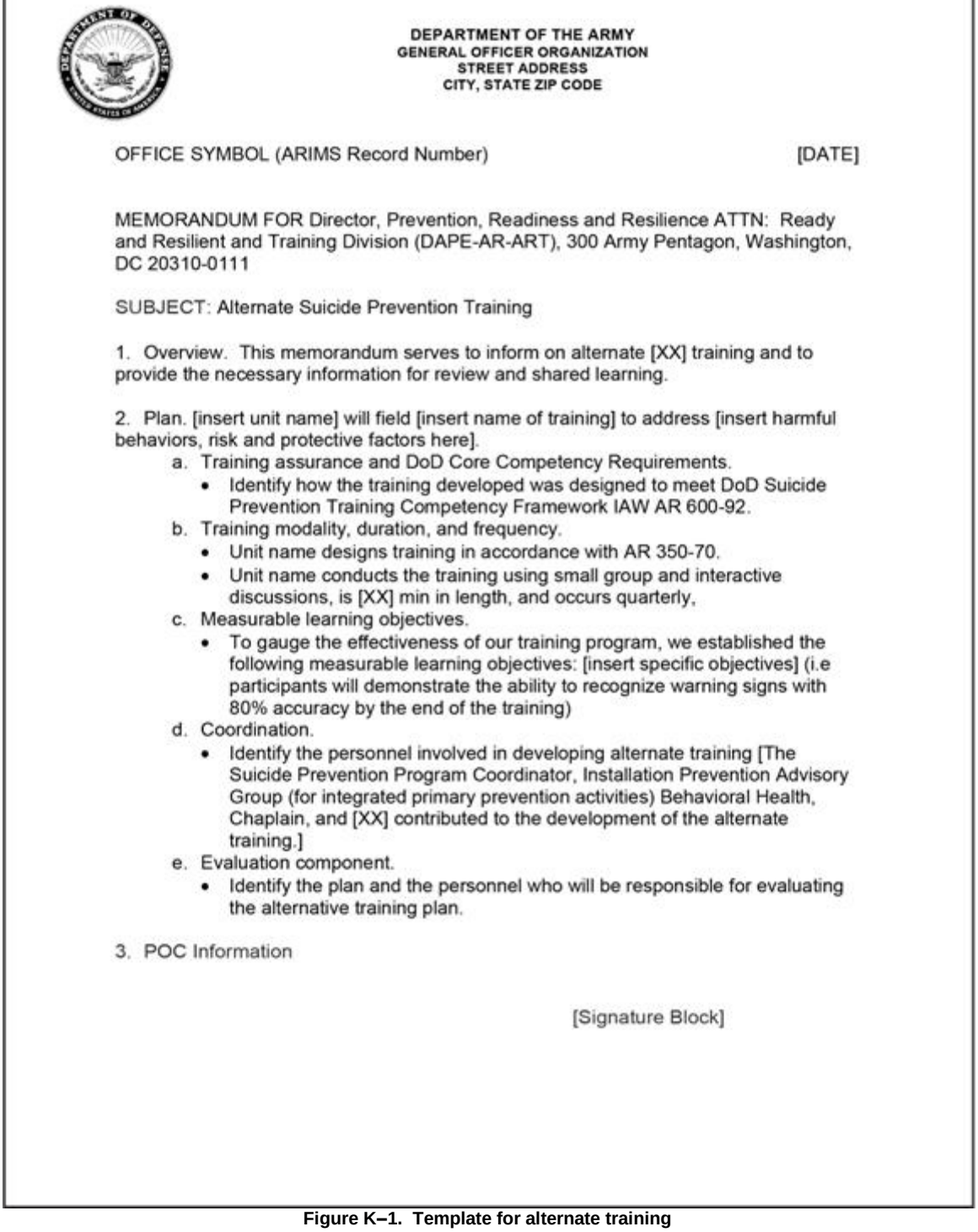
J–4. Director, Prevention, Resilience, and Readiness

The DPRR website is a valuable resource and is located at: https://www.armyresilience.army.mil/.

Appendix K

Alternate Training Request

See figure K–1 for a sample template for alternative training plans.



DEPARTMENT OF THE ARMY
GENERAL OFFICER ORGANIZATION
STREET ADDRESS
CITY, STATE ZIP CODE

OFFICE SYMBOL (ARIMS Record Number) [DATE]

MEMORANDUM FOR Director, Prevention, Readiness and Resilience ATTN: Ready and Resilient and Training Division (DAPE-AR-ART), 300 Army Pentagon, Washington, DC 20310-0111

SUBJECT: Alternate Suicide Prevention Training

1. Overview. This memorandum serves to inform on alternate [XX] training and to provide the necessary information for review and shared learning.

2. Plan. [insert unit name] will field [insert name of training] to address [insert harmful behaviors, risk and protective factors here].

a. Training assurance and DoD Core Competency Requirements.
   - Identify how the training developed was designed to meet DoD Suicide Prevention Training Competency Framework IAW AR 600-92.

b. Training modality, duration, and frequency.
   - Unit name designs training in accordance with AR 350-70.
   - Unit name conducts the training using small group and interactive discussions, is [XX] min in length, and occurs quarterly,

c. Measurable learning objectives.
   - To gauge the effectiveness of our training program, we established the following measurable learning objectives: [insert specific objectives] (i.e participants will demonstrate the ability to recognize warning signs with 80% accuracy by the end of the training)

d. Coordination.
   - Identify the personnel involved in developing alternate training [The Suicide Prevention Program Coordinator, Installation Prevention Advisory Group (for integrated primary prevention activities) Behavioral Health, Chaplain, and [XX] contributed to the development of the alternate training.]

e. Evaluation component.
   - Identify the plan and the personnel who will be responsible for evaluating the alternative training plan.

3. POC Information

[Signature Block]

Figure K–1. Template for alternate training

Appendix L

Charter Templates for Committees Associated with the Army Suicide Prevention Program

L–1. General

In accordance with AR 15–39, committees are defined as any committee, board, commission, council, conference, panel, task force, integrated process team, or other similar group or any subcommittee or subgroup thereof. The councils, working groups, and unit processes established for the ASPP in this policy meet the requirements to be considered a committee, and therefore must have an approved charter. This appendix contains sample template charters that can be tailored for specific command, installation, and unit needs, membership, and resources.

L–2. Template charter for installation Suicide Prevention Working Group

1. Name: Installation Suicide Prevention Working Group

2. Category and Type of Committee:
Intra Army

3. Date Established:
New committee or insert the original establishment date “DDMMYYYY”

4. Authority:
AR 600–92

5. References:
a. DoDI 5105.18 (DoD Intergovernmental and Intragovernmental Committee Management Program).
b. AR 15–39.
c. (If applicable, former charter and approved date).

6. Date to Be Terminated:
Enter the expected overall duration for the committee, no longer than 3 years.

7. Purpose:
The SPWG will—
a. Identify inadequacies and gaps in systems or policies to support the development of focused solutions nested with the Suicide Program elements in paragraph 2–2.
b. Recommend to the SC alignment of suicide prevention strategies and related trainings, plans to address policy and systems gaps, and measures used to evaluate the adequacies of their community resources.
c. Monitor the implementation and evaluation of suicide prevention awareness, education, and training activities.
d. Recommend, in coordination with public affairs, safe messaging with respect to suicides in the community and commands. Recommend public awareness campaigns for publication and evaluation.
e. Conduct a holistic and broad review by gathering and reviewing information to identify the strengths and weaknesses of community-level helping services, policies that promote or hinder access to services, and the misalignment of or gaps between HQDA, DoD, and local policies, suicide prevention, resources and related agencies.
f. Compile, analyze, and share data to monitor and evaluate prevention, intervention, and postvention initiatives.
g. Implement a S2FRAB and monitor the work of the SRT.

8. Governance/Direction and Control:
Title of official or name of the organization the committee provides its advice to and receives it from.

9. Committee Structure and Membership:
The committee will be comprised of the following members:

10. Estimated Number of Meetings:
The committee will meet six times a year.

11. Estimated Annual Operating Costs and Staff Years:
a. The number of work years annually required for the attendance of board participants (all board members and any participating staff), including any requirements for formal action officer meetings, councils of colonels, and any other preliminary or shaping sessions leading to the board, is (example: 1.52) full time equivalents (FTEs) at an estimated cost of $ (cost in dollars).
b. The number of FTEs annually required to support the board (including partial FTEs) is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars). 1. The number and grade of any full-time Government (civilian or military) support staff or members whose duties are exclusive to the board is zero. 2. The size, source, and estimated cost of any contract support staff is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars).
c. The cost of meeting space is $ (cost in dollars) (if zero, insert this language if applicable: because the board will use existing Government facilities).
d. The annual travel costs are $ (cost in dollars). Insert if applicable: Organizations of members will fund the travel and per diem associated with meeting attendance. If more than two committees or subcommittees are involved, use a table.

12. Administrative Support:
Provide the name of the office or directorate responsible for providing administrative support. For example, the Office of the (agency or directorate) will provide staff support and services to the board, including the financial, administrative, logistical, and other support services necessary to carry out the functions of the board.

13. Other Data:
Enter any other information that may be pertinent to the operations of the committee or subcommittee, such as rotation of chairperson assignment, when applicable; existence of similar committee operations under another name; or any special reporting requirements.

14. Correspondence:
Explain correspondence or communications channels to and from the committee, to include responsible office, pertinent email or mailing addresses, website address, and so forth.

Endorsing Official
Date Approved:

L–3. Template charter for unit ready and resilient forums

1. Name:
[Unit Name] R2 forum (Sample names: Health of the Force, Resilience Committee, Health Promotion Team).

2. Category and Type of Committee:
Intra Army

3. Date Established:
New committee or insert the original establishment date “DDMMYYYY”

4. Authority:
AR 600–92

5. References:
a. DoDI 5105.18 (DoD Intergovernmental and Intragovernmental Committee Management Program).
b. AR 15–39.
c. (If applicable, former charter and approved date).

6. Date to Be Terminated:
Enter the expected overall duration for the committee, no longer than 3 years.

7. Purpose:
The unit R2 forum is a BDE-level process that extends down to the company level to synchronize and monitor standards for a safe, healthy environment that supports suicide prevention. Units will focus on positive behaviors and protective factors, reducing at-risk behaviors, and promoting an environment of trust through leadership and management systems. The unit R2 forum objectives are to—
a. Identify risks, health concerns, and protective factors and provide timely and trend data on individuals and the unit using visibility tools.
b. Measure the effective distribution of resources and monitor progress.
c. Recommend to the BDE commander techniques, practices, and a climate that build and foster early identification of risk, help-seeking behaviors, and resilience.
d. Recommend targeted data-informed prevention actions that are timely.
e. Monitor progress and share visibility and lessons learned through the CR2C and associated working groups.

8. Governance/Direction and Control:
Title of official and name of the organization the committee provides its advice to and receives it from.

9. Committee Structure and Membership:
The committee will be comprised of the following members:

10. Estimated Number of Meetings:
The committee will meet six times a year.

11. Estimated Annual Operating Costs and Staff Years:
a. The number of work years annually required for the attendance of board participants (all board members and any participating staff), including any requirements for formal action officer meetings, councils of colonels, and any other preliminary or shaping sessions leading to the board, is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars).
b. The number of FTEs annually required to support the board (including partial FTEs) is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars). 1. The number and grade of any full-time Government (civilian or military) support staff or members whose duties are exclusive to the board is zero. 2. The size, source, and estimated cost of any contract support staff is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars).
c. The cost of meeting space is $ (cost in dollars) (if zero, insert this language if applicable: because the board will use existing Government facilities).
d. The annual travel costs are $ (cost in dollars). Insert if applicable: Organizations of members will fund the travel and per diem associated with meeting attendance. If more than two committees or subcommittees are involved, use a table.

12. Administrative Support:
Provide the name of the office or directorate responsible for providing administrative support. For example, the Office of the (agency or directorate) will provide staff support and services to the board, including the financial, administrative, logistical, and other support services necessary to carry out the functions of the board.

13. Other Data:
Enter any other information that may be pertinent to the operations of the committee or subcommittee, such as rotation of chairperson assignment, when applicable; existence of similar committee operations under another name; or any special reporting requirements.

14. Correspondence:
Explain correspondence or communications channels to and from the committee, to include responsible office, pertinent email or mailing addresses, website address, and so forth.

Endorsing Official
Date Approved:

L–4. Installation Charter for Suspected Suicide Fatality Review and Analysis Board

1. Name:
Suspected Suicide Fatality Review and Analysis Board

2. Category and Type of Committee:
Intra Army

3. Date Established:
New committee or insert the original establishment date “DDMMYYYY”

4. Authority:
AR 600–92

5. References:
a. DoDI 5105.18 (DoD Intergovernmental and Intragovernmental Committee Management Program).
b. AR 15–39.
c. (If applicable, former charter and approved date).

6. Date to Be Terminated:
Enter the expected overall duration for the committee, no longer than 3 years.

7. Purpose:
The S2FRAB objectives are to—
a. Describe and record any trends, data, or patterns that are observed surrounding suicide fatalities.
b. Recommend operating rules and procedures for review of suicide fatalities, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and recordkeeping of the causes of suicide fatalities (DoDSER and DA Form 7747).
c. Recommend improvements to promote improved and integrated services, programs, and policies.
d. Recommend components for prevention and education programs.
e. Recommend training to improve the identification and investigation of suicide fatalities.
f. Recommend informed solutions.

8. Governance/Direction and Control:
Title of official or name of the organization the committee provides its advice to and receives it from.

9. Committee Structure and Membership:
The committee will be comprised of the following members:

10. Estimated Number of Meetings:
The committee will meet four times a year. Each subcommittee (working groups) will meet an estimated 11 times a year.

11. Estimated Annual Operating Costs and Staff Years:

a. The number of work years annually required for the attendance of board participants (all board members and any participating staff), including any requirements for formal action officer meetings, councils of colonels, and any other preliminary or shaping sessions leading to the board, is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars).

b. The number of FTEs annually required to support the board (including partial FTEs) is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars). 1. The number and grade of any full-time Government (civilian or military) support staff or members whose duties are exclusive to the board is zero. 2. The size, source, and estimated cost of any contract support staff is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars).

c. The cost of meeting space is $ (cost in dollars) (if zero, insert this language if applicable: because the board will use existing Government facilities).

d. The annual travel costs are $ (cost in dollars). Insert if applicable: Organizations of members will fund the travel and per diem associated with meeting attendance. If more than two committees or subcommittees are involved, use a table.

12. Administrative Support:

Provide the name of the office or directorate responsible for providing administrative support. For example, the Office of the (agency or directorate) will provide staff support and services to the board, including the financial, administrative, logistical, and other support services necessary to carry out the functions of the board.

13. Other Data:

The installation S2FRAB will generate a memorandum on the findings of the S2FRAB to support higher headquarters. At a minimum, the memorandum should include the following information on the Soldiers who died by suicide:

a. Brief summary of the S2FRAB that generally characterizes the demographics, stressors, method or means, if Soldier was under BH or chaplain care, any administrative and legal actions, and other significant demographic data.

b. Notable findings on possible gaps in services, programs, and policies.

c. Recommendations for improvements in services, programs, and policies at the unit, installation, and headquarters (ACOM, ASCC, and DRU) levels.

d. Recommendations for internal process improvements on local suicide reporting requirements.

e. Special interest items requested from SC or ACOM, ASCC, and DRU.

Enter any other information that may be pertinent to the operations of the committee or subcommittee, such as rotation of chairperson assignment, when applicable; existence of similar committee operations under another name; or any special reporting requirements.

14. Correspondence:

Explain correspondence or communications channels to and from the committee, to include responsible office, pertinent email or mailing addresses, website address, and so forth.

Endorsing Official
Date Approved:

L–5. Army command, Army service component command, and direct reporting unit charter for Suspected Suicide Fatality Review and Analysis Board

1. Name:

Suspected Suicide Fatality Review and Analysis Board

2. Category and Type of Committee:

Intra Army

3. Date Established:
New committee or insert the original establishment date “DDMMYYYY”

4. Authority:
AR 600–92

5. References:
a. DoDI 5105.18 (DoD Intergovernmental and Intragovernmental Committee Management Program).
b. AR 15–39.
c. (If applicable, former charter and approved date).

6. Date to Be Terminated:
Enter the expected overall duration for the committee, no longer than 3 years.

7. Purpose:
ACOM, ASCC, and DRU commanders will conduct S2FRABs for suicide deaths within their area of responsibility based on the decedent’s home station. ACOM, ASCC, and DRU commanders are encouraged to coordinate with the commanders of other ACOMs, ASCCs, and DRUs in which a suicide death occurs during temporary duty, training, or while away from their home station. The ACOM, ASCC, and DRU S2FRAB will—
a. Assess subordinate command suicide reporting and surveillance through review of DoDSER and DA Form 7747 submission.
b. Describe trends or patterns that are observed surrounding suicide fatalities.
c. Analyze subordinate command findings and recommendations.
d. Recommend improvements to subordinate commands.
e. Monitor recommendations through CR2C processes.
f. Recommend informed solutions to the CR2C and HQDA suicide prevention governance process.

8. Governance/Direction and Control:
Title of official or name of the organization the committee provides its advice to and receives it from.

9. Committee Structure and Membership:
The committee will be comprised of the following members:

10. Estimated Number of Meetings:
The committee will meet four times a year. Each subcommittee (working groups) will meet an estimated 11 times a year.

11. Estimated Annual Operating Costs and Staff Years:
a. The number of work years annually required for the attendance of board participants (all board members and any participating staff), including any requirements for formal action officer meetings, councils of colonels, and any other preliminary or shaping sessions leading to the board, is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars).
b. The number of FTEs annually required to support the board (including partial FTEs) is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars). 1. The number and grade of any full-time Government (civilian or military) support staff or members whose duties are exclusive to the board is zero. 2. The size, source, and estimated cost of any contract support staff is (example: 1.52) FTEs at an estimated cost of $ (cost in dollars).
c. The cost of meeting space is $ (cost in dollars) (if zero, insert this language if applicable: because the board will use existing Government facilities).
d. The annual travel costs are $ (cost in dollars). Insert if applicable: Organizations of members will fund the travel and per diem associated with meeting attendance. If more than two committees or subcommittees are involved, use a table.

12. Administrative Support:
Provide the name of the office or directorate responsible for providing administrative support. For example, the Office of the (agency or directorate) will provide staff support and services to the board, including the financial, administrative, logistical, and other support services necessary to carry out the functions of the board.

13. Other data: Army commands/Army service component commands/direct reporting units
S2FRAB will annually generate a memorandum on the findings or report on the findings at the R2 governance process and submit to usarmy.pentagon.hqda-dcs-g-9.list.suicide-prevention@army.mil. At a minimum, the information should include the following on the Soldiers who died by suicide:

a. Brief summary of the S2FRAB that generally characterizes the demographics, stressors, method or means, if Soldier was under BH or chaplain care, any administrative and legal actions, and other significant demographic data.

b. Notable findings on possible gaps in services, programs, and policies.

c. Recommendations for improvements in services, programs, and policies at the unit, ACOM, ASCC, DRU, and HQDA levels.

d. Recommendations for internal process improvements on local suicide reporting requirements.

e. Special interest items requested from HQDA.

Enter any other information that may be pertinent to the operations of the committee or subcommittee, such as rotation of chairperson assignment, when applicable; existence of similar committee operations under another name; or any special reporting requirements.

14. Correspondence:
Explain correspondence or communications channels to and from the committee, to include responsible office, pertinent email or mailing addresses, website address, and so forth.

Endorsing Official
Date Approved:

Appendix M

Internal Control Evaluation

M–1. Function
This internal control evaluation assesses the execution of the ASPP.

M–2. Purpose
The purpose of this evaluation is to assist Army organizations and personnel responsible for the execution of the ASPP in evaluating key internal controls listed in paragraph M–4. It is intended as a guide and does not cover all controls.

M–3. Instructions
Answers must be based on the actual testing of internal controls (for example, document analysis, direct observation, sampling, simulation, or other). Answers that indicate deficiencies must be explained and the corrective action indicated in supporting documentation. The key internal controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2 (Internal Control Evaluation Certification).

M–4. Test questions
a. Are personnel assigned to perform suicide prevention, intervention, postvention, and integration responsibilities?

b. Does the current community R2 plan include SMART goals, objectives, and performance metrics for suicide prevention?

c. Are performance measures in place and reported illustrating progress on the SMART goals and objectives?

d. How does the community R2 plan address strengthening financial readiness and strengthening access and delivery of suicide prevention care, create protective environments, promote connectedness, teach coping and problem-solving skills, identify and support people at risk, and lessen harm and prevent future risk?

e. How do policies address suicide prevention training, reporting, stigma, seeking help, lethal means safety, training compliance, and leader engagement?

f. How are visibility tools used to inform targeted suicide prevention initiatives?

g. What are prevention personnel roles in the R2 governance process? What are the evidence of suicide trends, initiatives, and targeted actions being addressed within the R2 governance process?

h. Do prevention personnel administer activities for both military and DA Civilians?

M–5. Supersession
This evaluation replaces the evaluation previously published in AR 600–92, dated 8 August 2023.

M–6. Comments
Help make this a better tool for evaluating internal controls. Submit comments via email to usarmy.pentagon.hqda-dcs-g-9.mbx.publishing-team@army.mil.

Glossary of Terms

Commander's Ready and Resilient Council
An installation-based process that serves as the SC's primary mechanism to operationalize readiness, resilience, and the ASPP and implement a data-informed integrated prevention system. This multidisciplinary forum allows community members to collaborate and address the health and well-being of the installation or community by integrating, mission, garrison, and medical R2 efforts.

Connectedness
The feeling of support and willingness to help. Involves the quality and number of connections one has with other people in a social circle of family, friends, and acquaintances (see DoDI 6400.09).

Gatekeeper
Members of a community who are trained to counsel Servicemembers on access to lethal means, such as chaplains, front-line supervisors, legal personnel, schoolhouse instructors, and medical personnel (see DoDI 6400.09).

Intervention
A strategy or approach that is intended to prevent an outcome or alter the course of an existing challenge of stress; also known as "secondary prevention" (see DoDI 6490.16).

Lethal means
Method for suicide that has a high likelihood of resulting in death (for example, firearms, drugs, and poisons) (see DoDI 6490.16).

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" (see DoDI 6490.16).

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" (see DoDI 6490.16).

Prevention activities
Policies, programs, or practices that aim to prevent self-directed harm and prohibit abusive or harmful acts (see DoDI 6400.09).

Prevention personnel
Military members or DoD civilian personnel whose official duties (to include collateral and additional duties) involve the prevention of self-directed harm or prohibited abusive or harmful acts and who attain and sustain prevention-specific knowledge and skills (for example, chaplains, SPPMs, and command climate specialists) (see DoDI 6400.09).

Primary prevention
Stopping a self-directed harm and prohibited abusive or harmful act before it occurs. Can be implemented for an entire group or population without regard to risk (universal primary prevention) or can be implemented for individuals, groups, or a population that is at risk (selected primary prevention) (see DoDI 6400.09).

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 (for example, attitudes, values, and norms prohibiting suicide) or external or environmental (for example, strong relationships, particularly with family members) (see DoDI 6490.16).

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 multidisciplinary

collaboration, which brings together many different perspectives and experiences to enrich and strengthen the solutions for the many diverse communities (see DoDI 6490.16).

Resilience
The ability to withstand, recover from, and grow in the face of stressors and changing demands (see DoDI 6490.16).

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 predispose one to high risk for self-injurious behaviors. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment (see DoDI 6490.16).

Self-harm
Behavior directed toward oneself that deliberately results in injury or the potential for injury to oneself. Also called “self-directed harm” (see DoDI 6400.09).

Suicide
Death caused by self-directed injurious behavior with an intent to die as a result of the behavior (see DoDI 6490.16).

Suicide attempt
A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior (see DoDI 6490.16).

Suicide ideation
Thinking about, considering, or planning suicide (see DoDI 6490.16).