

Army Regulation 600-63

Personnel-General

Army Health Promotion

**Headquarters
Department of the Army
Washington, DC
14 April 2015**

UNCLASSIFIED

SUMMARY of CHANGE

AR 600-63
Army Health Promotion

This major revision, dated 14 April 2015--

- o Incorporates information about the Ready and Resilient Campaign (para 1-5).
- o Adds and/or updates responsibilities for the following: Assistant Secretary of the Army (Manpower and Reserve Affairs); Deputy Chief of Staff, G-1 (Director, Army Resiliency Directorate); Program Manager, Army Suicide Prevention Program; Health Promotion Policy Officer; and Program Manager, Deployment Health Assessment (chap 1, sect II).
- o Adds the requirement for commanders to appoint a Suicide Prevention Program Manager, in writing, to manage the suicide prevention program (para 1-26c).
- o Implements changes throughout to clarify the role of the senior commander relative to the Community Health Promotion Council (para 1-27b).
- o Implements the use of DD Form 2996 (Department of Defense Suicide Event Report) as an official Department of Defense form and replaces the use of the term "DODSER", when referencing the report itself, with the DD Form 2996 (para 1-30j and throughout).
- o Revises the Commander's Suspected Suicide Event reporting procedures and implements the use of DA Form 7747 (Commander's Suspected Suicide Event Report) to incorporate concerns derived from the Department of Defense Suicide Report and additional data elements to better access and analyze suicide events. Additionally, replaces the use of the term "CSSER (Commander's Suspected Suicide Event Report)" with the DA Form 7747 (para 1-31w and throughout).
- o Clarifies roles and responsibilities for chaplains relative to suicide prevention (para 1-32).
- o Provides roles and responsibilities for the Installation Health Promotion Officer (para 1-33).
- o Clarifies roles and responsibilities for the Installation Suicide Prevention Program Manager (para 1-34).
- o Introduces the Specialized Suicide Augmentation Response Team/Staff Assistance Team process and establishes the team as a Headquarters, Department of the Army Deputy Chief of Staff, G-1 led, multidisciplinary team to provide intervention to suicide event clusters (para 4-4e(3)).
- o Updates and clarifies suicide prevention training requirements and command responsibilities for the Suicide Prevention Program (para 4-7).
- o Removes the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention self-assessment and compliance program requirement from this regulation (throughout).

Effective 14 May 2015

Personnel-General

Army Health Promotion

By Order of the Secretary of the Army:

RAYMOND T. ODIERNO
General, United States Army
Chief of Staff

Official:



GERALD B. O'KEEFE
Administrative Assistant to the
Secretary of the Army

History. This publication is a major revision.

Summary. This publication prescribes policy and sets forth responsibilities for all aspects of the Army Health Promotion Program and implementation of 32 CFR 85.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. The provisions of chapter 7 also apply to all visitors and personnel from other agencies or businesses that operate within or visit Army workplaces.

Proponent and exception authority. The proponent of this regulation is the

Deputy Chief of Staff, G–1. 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 a 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 guidance.

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 appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from Office of the Deputy Chief of Staff, G–1 (DAPE–AR), 300 Army Pentagon, Washington, DC 20310–0300.

Suggested improvements. Users are invited to send comments and suggested

improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of Staff, G–1 (DAPE–AR), 300 Army Pentagon, Washington, DC 20310–0300.

Committee management. AR 15–1 requires the proponent to justify establishing/continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the U.S. Army Resources and Programs Agency, Department of the Army Committee Management Office (AARP–ZA), 9301 Chapek Road, Building 1458, Fort Belvoir, VA 22060–5527. 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 15–1, then the proponent will follow all AR 15–1 requirements for establishing and continuing the group as a committee.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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Chapter 1 Introduction

Section I General

1–1. Purpose

This regulation prescribes policies and responsibilities for the Army Health Promotion Program.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

See responsibilities in Section II of this chapter.

1–5. Army Ready and Resilient Campaign

The Ready and Resilient Campaign (R2C) guides the Army's efforts in cultivating a holistic, multidisciplinary approach to health promotion and includes the efforts of the Army Health Promotion Program. Additional information regarding R2C and related resources may be accessed on the R2C website (<http://www.army.mil/readyandresilient/>).

a. R2C is a far-reaching and comprehensive campaign to enhance individual and collective resilience in order to improve readiness across the Total Army - Soldiers (Active, National Guard and Reserve), Army Civilians and Family members. The Campaign integrates and synchronizes Army programs aimed at health promotion. Specifically, it integrates and synchronizes the multiple Armywide efforts that are designed to improve physical, psychological and emotional health in order to enhance individual performance and increase overall unit readiness.

b. The R2C objectives will be achieved when:

(1) The Army's culture has embraced resilience as part of its profession and as a key and critical component to readiness.

(2) Leaders, Soldiers, Army Civilians and Family members receive quality assistance through the coordinated efforts of Army programs and services, thus reinforcing a command climate of trust, mutual respect, dignity, and self-discipline.

(3) Soldiers enter the Army strong and become stronger during their service, and the campaign's efforts are incorporated into the Army Campaign Plan's processes and management activities producing enduring change for the institution.

(4) Ultimately, the Army maintains its capability to rapidly deploy and sustain ready and resilient forces to prevent conflict, shape the security environment, and win the nation's wars.

1–6. Army Health Promotion

a. Army health promotion is a leadership program defined as any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental changes conducive to the health and well-being of the Army community. Health promotion encompasses the assets of educational, environmental, and medical support services, enabling people to increase control over and improve their quality of life, health, wellness, and well-being. Army health promotion focuses on the integration of primary prevention and public health practice into community and organizational structure to ensure that health and well-being are part of the way in which the Army does business. Health is the product of many personal, environmental, and behavioral factors. Health promotion programs must consider a broad range of health-related factors and should address the following functional areas:

(1) Health education.

(2) Behavioral health (BH).

(3) Physical health.

(4) Spiritual health.

(5) Environmental and/or social health.

b. Army health promotion involves—

(1) Identifying community health needs, conducting risk assessments and setting priorities for health promotion services and programs.

(2) Conducting risk communication and involving stakeholders in the decision-making process.

(3) Developing and implementing health promotion programs to meet identified needs while enhancing resiliency, overall quality of life, and well-being.

(4) Evaluating the effectiveness of these programs.

c. Health promotion utilizes a five-step public health process which is similar to the composite risk management (CRM) process described in Army Techniques Publication (ATP) 5–19. CRM is defined in a similar process by identifying, assessing, and controlling risk arising from operational factors and making decisions that balance risk costs with mission benefits. The public health process includes the following five steps:

(1) Identifying the problem through surveillance from which priorities can be generated.

(2) Determining the cause of the problem and associated risk and protective factors or behaviors that lead to or limit the problem.

(3) Evaluating intervention value through a systemic review of the literature.

(4) Developing (if needed), analysis, and implementation of evidence-based programs and policies to address the problem.

(5) Monitoring the effectiveness of the program or policy through deliberate monitoring techniques.

d. One may apply the principles used in the Public Health Process to reduce health risks and improve medical readiness in much the same way as the CRM process is used in managing risk in unit operations. Identification and prioritization of hazards to health are followed by the development and implementation of programs and policies that are designed to make a difference among the Army's beneficiary population.

e. Command supervision and enforcement of interventions is critical. Reassessment enables evaluation of success or the need for adjustments.

f. Health promotion is a leadership program that encompasses the assets of educational, environmental, and medical support services that enable people to increase control over, and improve their health in support of Army well-being.

1–7. Objective of the Army Health Promotion Program

a. The objective of the Army Health Promotion Program is to implement programs and services at the community level in support of the National Prevention Strategy (NPS), which are designed to meet the needs of Army beneficiary population while collaborating with other departments and agencies. These health promotion programs and services address:

(1) NPS strategic directions for healthy and safe community environments, clinical and community preventive services, empowered people, and the elimination of health disparities among the Army's beneficiary population.

(2) NPS priorities for tobacco-free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, injury and violence-free living, reproductive and sexual health, and mental and emotional well-being.

(3) The Surgeon General specific health promotion programs that include physical and dental examinations, self-reported health information, and initiatives to promote social and emotional well-being.

b. The objectives will be monitored through actions of the public health process that:

(1) Gather and electronically store data.

(2) Measure data against established standards accepted by the Army to include key indicators outlined in the National Prevention Strategy (NPS).

(3) Educate and provide intervention for individuals within the Army community.

(4) Reevaluate the program and revise appropriately.

c. In addition to The Surgeon General of the Army derived objectives, health promotion programs include physical and dental examinations, self-reported health information, and initiatives to promote social and emotional well-being.

d. Operationally, health promotion is implemented and enhanced at the community level through a Community Health Promotion Council (CHPC), as provided for in this regulation.

Section II Responsibilities

1–8. Assistant Secretary of the Army (Manpower and Reserve Affairs)

The ASA(M&RA) will—

a. Provide supervision and oversight to ensure Army Policy, programs, processes, systems and resources are effectively targeted to promote and optimize total Army readiness.

b. Incorporate and adapt customer and stakeholder feedback systems.

c. Identify portfolios of complementary programs to assess gaps and redundancies.

d. Ensure integration across the Army to leverage cost effective strategies to sustain the All-Volunteer Force.

e. Monitor trend data to inform Army's performance in achieving strategic objectives.

1–9. Deputy Chief of Staff, G–1

The DCS, G–1, as the Army staff proponent for the Army Health Promotion Program and the R2C, will—

a. Establish R2C governance structure.

b. Appoint a Program Portfolio Manager.

- c. Develop Army Health Promotion Program policy and ensure implementation of Part 85, Title 32 Code of Federal regulations (32 CFR 85).
- d. Develop policy for, and implement the Army Substance Abuse Program (ASAP).
- e. Develop policy for, and implement the Army Body Composition Program.
- f. Develop policy for, and implement Deployment Health Assessment Program (DHAP) administration in accordance with DODI 6490.03.
- g. Develop policy for, and implement the Army Suicide Prevention Program (ASPP).
- h. Act as the policy proponent for Comprehensive Soldier and Family Fitness (CSF2).

1-10. Director, Army Resiliency Directorate

The Director, Army Resiliency Directorate will—

- a. Conduct mission analysis of R2C requirements and develop a concept plan for the governance process.
 - (1) Conduct analysis of Headquarters Department of the Army (HQDA) forums related to R2C content and develop recommendations for elimination, retention, or merging of the various forums.
 - (2) Incorporate the R2C into the Army Campaign Plan as a major objective and ensure that ready and resilient is fully addressed by Army Capstone and resourcing documents.
 - (3) Develop recommendations for a process/means to regularly review and validate the R2C governance process and campaign plan metrics and outcomes.
- b. Provide guidance and leadership on all suicide prevention policy issues.
 - (1) Exercise staff leadership and supervision over the ASPP.
 - (2) Ensure that the ASPP is coordinated and consistent with the Department of Defense Instruction (DODI) that governs suicide prevention efforts throughout Department of Defense (DOD).
 - (3) Ensure that the ASPP is represented on the Defense Centers of Excellence Suicide Prevention and Risk Reduction Committee.
- c. In partnership with the Office of The Surgeon General/U.S. Army Medical Command (OTSG/MEDCOM), provide program management support and monitoring for the DHAP across all components in accordance with DODI 6490.03.
- d. Develop policy to provide DHAP and health promotion, risk reduction and suicide prevention program policies for noninstallation-based commands and geographically-dispersed Soldiers and Army Civilians, to include the Reserve Components (RCs) (Army National Guard [ARNG] and U.S. Army Reserve [USAR]).

1-11. Program Manager, Army Suicide Prevention Program

The Program Manager, ASPP will—

- a. Direct the operations of the ASPP and serve as Department of the Army's (DA's) lead on all issues related to suicide prevention.
- b. Develop ASPP goals and policies.
- c. Review, assess, and recommend policy changes as appropriate.
- d. Interpret ASPP policy in response to inquiries from Army commands (ACOMs), Army service component commands (ASCCs), and direct reporting units (DRUs), their subordinate commands, other uniformed Services, DOD, and other Federal agencies.
- e. Prepare budget submissions, direct allocation of funds, monitor execution of resources, and serve as the functional budget program manager for the ASPP.
- f. Maintain liaison between the Army and other uniformed Services, other Federal agencies, and the private sector.
- g. Consolidate all suicide-related statistics and provide periodic reports to the Director of Human Resources Policy, the Army Staff, ACOMs, ASCCs, DRUs, DOD, and Suicide Prevention Program Managers (SPPMs).
- h. Establish and maintain program-level evaluation plans, measures, data collection, analyses, and reporting procedures for implementation at Army, U.S. Army Installation Management Command (IMCOM), ACOM, ASCC, DRU, and installation levels.
- i. Provide technical assistance in the use of automation and other emerging technologies in suicide prevention programs.
- j. Be responsible for integration, coordination, and approval of all policies pertaining to the ASPP.
- k. Exercise general staff responsibility for plans, policies, programs, budget formulation, and related research and program for suicide prevention and awareness in the Army.
- l. Serve as the lead staff agent for the Specialized Suicide Augmentation Response Team (SSART) and Staff Assistance Team (SAT).
- m. Develop, establish, administer, and evaluate suicide prevention, education, and training programs.
- n. Conduct program oversight and suicide prevention staff assistance visits to installations, states, territories, and regional support command units on a continuous basis per SSART and SAT requirements and DCS, G-1 guidance.

- o.* Provide services such as marketing, training, data processing, analysis, evaluation, guidebooks, operational guidance products, and reports to DOD, ACOMs, ASCCs, DRUs, and installations.
- p.* Collect data and analyze suicide-related data for risk factors surrounding suicidal behavior to assist in the development and/or sustainment of effective strategies to reduce suicidal behavior.
- q.* Review and evaluate suicide prevention programs and their implementation.
- r.* Serve as the primary source for reporting of official Army suicide rates.
- s.* Lead the SSART and SAT visits upon request from commanders (ACOM, ASCC, and DRU).

1–12. Health Promotion Policy Officer

The Health Promotion Policy Officer (HPPO) will—

- a.* Facilitate, synchronize, and support execution of health promotion programs in support of improving the health and well-being of Soldiers, Army Civilians and Families while maximizing Army Readiness.
- b.* Assist in the development of health promotion policies, procedures, and programs.
- c.* Provide health promotion subject matter expertise (SME) to R2C, functional working groups and in support of this regulation, AR 600–110 and AR 600–9.

1–13. Program Manager, Deployment Health Assessment

The Program Manager, Deployment Health Assessment (DHA) will—

- a.* Oversee/Monitor the administration of Deployment Health Assessment Program (DHAP) for Army components and Army Civilians in accordance with DODI 6490.03 and DODI 6490.12
- b.* Develop, integrate, and execute DHAP metrics in support of senior leader reporting requirements and actions which assist in the early identification and treatment of physical and behavioral conditions to maximize Army readiness.
- c.* Ensure DHAP alignment with health promotion systems, processes, and policies across the Army.
- d.* Partner with critical stakeholders (OSD–HA, OTSG/MEDCOM, VA, USARC, ARNG, and HRC) to address issues that affect Health Promotion and prevent maximizing deployment health assessment participation across the Army.
- e.* Develop and leverage an enduring DHA strategic communications plan that educates and promotes the importance of DHAP participation in support of Soldier and Army Civilian well-being.

1–14. Deputy Chief of Staff, G–3/5/7

The DCS, G–3/5/7 will serve as the Army proponent, and have Army Staff responsibility, for the Army Physical Readiness Training Program.

1–15. Deputy Chief of Staff, G–4

The DCS, G–4 will serve as the proponent for development and implementation of policies and programs concerning nutrition in troop dining facilities and commissaries.

1–16. The Surgeon General

The Surgeon General (TSG) will—

- a.* Provide guidance in accordance with AR 350–1 in medical, physiological, and health areas including BH, nutrition, oral health, cardiovascular risk-factor reduction, and stress management. TSG establishes and reviews policy development in other areas, to include Army health promotion, DHAP execution/outcomes, medical aspects of substance abuse diagnosis and treatment, suicide prevention, tobacco-free living, active living, healthy eating, body fat standards, and injuries related to physical fitness and exercise.
- b.* Implement policy, standards, and education for medical and dental programs; for example nutrition, early identification of hypertension, psychological and BH, and oral health promotion.
- c.* Appoint a representative with an appropriate health care background to serve along with the representative from DCS, G–1 as a member of the DOD Prevention Safety and Health Promotion Council.
- d.* Advise the DCS, G–1 with respect to all medical and BH aspects of health promotion, to include the epidemiological aspects of suicide.
- e.* Oversee the medical and dental aspects of all Army training programs.
- f.* Assist the Army Medical Department in providing—
 - (1) Training for health care providers in suicide-risk identification, intervention, and treatment for patients who may be at increased risk of suicide.
 - (2) Education materials that promote responsible consensual sexual behavior in Army populations.
- g.* Appoint a representative with an appropriate health promotion background to serve on a working group, as warranted, to address issues related to the integration of health and fitness within the Army along with representatives from IMCOM G–9; United States Army Public Health Command (USAPHC); DCS, G–1; DCS, G–3/5/7; U.S. Army

Combat Readiness/Safety Center; Assistant Chief of Staff for Installation Management; U.S. Army Recruiting Command; U.S. Cadet Command; and the Training Support and Schools Directorate, Physical Readiness Division.

h. Provide support to the DCS, G-1 for SSART and SAT initiatives.

i. Provide Medical Operational Data System (MODS) subject matter expert (SME) support that enables the development/use of performance metrics that assist in the monitoring of critical outcomes and program performance at every echelon within all Army components.

j. Provide mission support for tobacco prevention, control and cessation programs including—

(1) Coordinating Army tobacco prevention and control policy; developing and recommending changes to G-1 and ASA M&RA.

(2) Collaborating with national organizations promoting tobacco control and cessation to the extent authorized by rules and regulations governing interaction with non-Federal entities.

(3) Collaborating with other military services and outside agencies on tobacco initiatives and policy.

(4) Representing DA on DOD level tobacco prevention and control working groups as appropriate.

(5) Collaborating with Army agencies on issues related to tobacco policy and interventions.

(6) Issuing orders and MEDCOM regulations as TSG deems necessary to establish and enforce tobacco-free medical campuses (TFMCs) as provided in chapter 7 of this regulation.

1-17. The Chief of Public Affairs

The Chief of Public Affairs will advise and support the proponent to develop and implement a communication plan in support of the Army R2C. This includes articles in Army and/or DOD internal print and broadcast media, and release of information about Army R2C to the public through the media and through community relations.

1-18. Chief of Chaplains

The Chief of Chaplains will—

a. Provide Army special staff responsibility for the garrison Chaplain Family Life Center program, spiritual fitness that is religiously informed, and deployment-related stress ministry.

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

c. Coordinate suicide prevention activities and training with the DCS, G-1 and TSG.

d. Provide support to DCS, G-1 for SSART and SAT initiatives.

1-19. The Judge Advocate General

The Judge Advocate General will—

a. Provide staff assistance and advice for the interpretation of laws and regulations in support of the Army Health Promotion Program and the R2C.

b. Review the liability implications of non-health professionals providing health promotion programs.

c. Ensure that Judge Advocate officers are not detailed as SPPMs, in accordance with AR 27-1.

1-20. Chief, National Guard Bureau

The chief, NGB will—

a. Prescribe ARNG policies and programs for health promotion and suicide prevention consistent with this regulation.

b. Encourage State Adjutants General to develop health promotion programs, including suicide prevention, tobacco-free living and oral health.

c. Identify the requirements for the distribution of training materials to support suicide-intervention skills and training for gatekeepers (see glossary).

d. Identify the requirements for carrying out train-the-trainer workshops to support suicide-intervention training for gatekeepers (see DA Pam 600-24), junior leaders and first-line supervisors

e. Establish task forces and committees to facilitate health promotion initiatives to reduce high-risk behaviors and build resiliency.

f. Attend meetings of health promotion, risk reduction, suicide prevention program councils, committees, task forces, and so on, as applicable.

g. Enforce the conduct of periodic or event driven health assessments (for example, Periodic Health Assessment (PHA), Deployment Health Assessment Program (DHAP), Mental Health Assessments, and so on) to enable the early identification and treatment of physical and behavioral health issues.

1-21. Chief, U.S. Army Reserve

The Chief, Army Reserve will—

- a. Prescribe USAR policies and programs for health promotion and suicide prevention for the United States Army Reserve consistent with this regulation.
- b. Ensure Regional and Major Subordinate Commands develop programs for health promotion, suicide prevention, tobacco-free living and oral health.
- c. Identify requirements for the distribution of training materials to support suicide-intervention skills training for gatekeepers (see glossary).
- d. Identify requirements for carrying out train-the-trainer workshops to support suicide-intervention training for gatekeepers (see DA Pam 600–24), unit leaders, junior leaders, and first-line supervisors.
- e. Establish task forces and committees to facilitate health promotion initiatives to mitigate high-risk behaviors and build resiliency.
- f. Attend meetings of health promotion, risk reduction, suicide prevention program councils; committees; task forces; and so on, as applicable.
- g. Enforce the conduct of periodic or event driven health assessments (for example, Periodic Health Assessment (PHA), Deployment Health Assessment Program (DHAP), Mental Health Assessments, and so on) to enable the early identification and treatment of physical and behavioral health issues.

1–22. Commanding General, United States Army Public Health Command

The Commanding General (CG), United States Army Public Health Command (USAPHC) will—

- a. Centrally manage Health Promotion Officers (HPOs) through portfolio management oversight of health promotion, risk reduction, and suicide prevention efforts across the Army to ensure standardization.
- b. Recommend Army Health Promotion Program policy implementation and change to HQDA, DCS, G–1.
- c. Define the role of, and identify training requirements and training opportunities for, HPOs in support of CHPCs.
- d. Develop and disseminate standardized, evidence-based guidelines, programs, and tools for health promotion.
- e. Identify and develop population-based, comprehensive, and integrated military health information systems. Regularly monitor these systems to recommend proactively evidence-based health promotion initiatives where the needs are greatest.
- f. Develop evidence-based metrics for program evaluation and health promotion outcomes.
- g. Coordinate with community-level stakeholders to ensure that all health promotion activities conform to high standards of evidence-based practice for health promotion.
- h. Provide SME consultation, education, and training for Army Health Promotion Program efforts to CHPCs and health promotion teams.
- i. Provide SME consultation, education, oversight of leader training, curriculum updates and evaluation support for Army Pregnancy Postpartum Physical Training Program.
- j. Maintain a centralized repository of readily accessible, evidence-based best practices for health promotion initiatives.
- k. Provide recommendations for population- and community-based research.
- l. Establish a CHPC network and report best practices, training, and outcomes throughout CHPC network.
- m. Direct USAPHC to act as SME and provide technical oversight for Army Wellness Center (AWC) operations.
- n. Develop and implement AWC standardization criteria; define the role and responsibilities of AWC personnel; and integrate process as an extension of Patient Centered Medical Home using technical advice from U.S. Army Medical Command (MEDCOM).
- o. Coordinate the development and implementation of AWCs.
- p. Provide program management for the Army Department of Defense Suicide Event Report (DODSER) program.
- q. Represent DA on DOD level tobacco working groups and with national organizations promoting tobacco prevention, control, and cessation activities as appropriate.
- r. Provide support to DA G–1 for SSART initiatives and coordinate responses on CHPC activities and effectiveness.
- s. Provide continuing education for health promotion professionals.
- t. Develop and disseminate standardized evidence based suicide prevention educational products in order to support ASPP efforts.
- u. Provide SME consultation, education, and support of the ASPP.

1–23. Assistant Chief of Staff for Installation Management

Assistant Chief of Staff for Installation Management will—

- a. Provide Army staff oversight and policy development in support of Installation Management Command (IMCOM) execution of this regulation.
- b. Support and participate in the R2C initiatives in accordance with HQDA guidance.

1–24. Commanding General Installation Management Command

Commanding General Installation Management Command will—

- a. Designate, as appropriate, garrison commanders (GCs) to serve as representatives on installation CHPCs.
- b. Define the role of, and train, Army Community Service (ACS) personnel, using DCS, G-1 approved training materials in support of suicide-risk identification efforts, using technical assistance from BH officers.
- c. Ensure that suicide prevention information is integrated into all ACS training plans and briefings given to Family members.
- d. Provide survivor outreach services (SOS) to Families who experience loss, to include those who experience a loss due to suicide.
- e. Provide referral services to unit members and coworkers who experience loss due to suicide.
- f. Promote instructional opportunities for Soldiers, Army Civilians, and Families to develop and sustain personal relationships, team dynamics, conflict management, and problem solving.
- g. Promote tobacco-free living on Army installations and support tobacco control policies to reduce tobacco use on Army installations.
- h. Appoint or assign SPPM duties (if a SPPM manpower authorization does not exist) to provide installation assistance for execution of the ASPP and to serve as a liaison to the Assistant Chief of Staff for Personnel and ACOM, ASCC, and DRU SPPMs.
- i. Develop and implement an IMCOM suicide prevention program execution plan.
- j. Develop and implement an integrated Family Member Suicide Prevention Program.
- k. Identify the requirements for the distribution of training materials to support suicide-intervention skills training for gatekeepers.
- l. Identify the requirements to carry out train-the-trainer workshops to support suicide-intervention training for gatekeepers (refer to DA Pam 600-24).
- m. Provide support to DCS, G-1 for SSART and SAT initiatives and, as requested, coordinate on all training to ensure the needs of Family members are addressed.
- n. Ensure the establishment of a Family Advocacy Program (FAP) Fatality Review Committee to review all known or suspected domestic violence or child abuse related fatalities homicides or suicides, in accordance with AR 608-18.
- o. Ensure installation resources and control systems are in place to support and track the completion of health assessments for all deploying/redeployed Soldiers from all Army components and for Army Civilians.
- p. Ensure in and out processing systems identify Soldiers during the transition process that are receiving treatment, and procedures are in place that ensure coordination with installation and/or gaining command medical activities to ensure continuity of health care.

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

The CG, TRADOC will serve as the functional proponent for Army Physical Readiness Training Program. The Commander, U.S. Army Training Center and Fort Jackson will serve as the specified proponent for physical fitness and will—

- a. Coordinate the inclusion of all components of Army health promotion into Army school curricula.
- b. Exercise responsibility for Army physical fitness doctrine.
- c. Develop training support packages for suicide-risk identification for unit leaders.
- d. Provide suicide-risk identification training for leadership courses.
- e. Implement Army policy to control use of tobacco products during initial military training and all other Army schools.
- f. Develop instruction and associated training materials on prevention of, and response to, sexual assault for use in the accession and/or initial entry training base, professional military education courses throughout the Army, proponent schools and/or functional courses, and units in accordance with AR 600-20.
- g. Ensure that current and appropriate substance abuse awareness training and information on the ASAP occurs at initial entry and pre-commissioning and is integrated into all other Army professional development courses in accordance with AR 600-85.

1-26. Army command, Army service component command, and direct reporting unit commanders ACOM, ASCC, and DRU commanders will—

- a. Monitor data and develop, implement, and evaluate programs designed to achieve Army health promotion.
- b. Appoint a fulltime, dedicated HPO to serve as special staff to the senior commander for the coordination of the CHPC.
- c. Appoint a SPPM (or assign duties to existing personnel) to provide assistance for, and staff supervision of the ASPP. ACOM, ASCC, and DRU commanders will appoint SPPMs through a written memorandum of appointment. The memorandum will specify the SPPM's chain of command, period of appointment or specify that it is indefinite, and place of duty or office location. It will cite this regulation and DA Pam 600-24 as the governing guidance that define SPPMs' duties, reference sources of training of local information on SPPM duties beyond the referenced sources and describe any local duties.

- d.* Develop and implement a suicide prevention action plan appropriate for their command.
- e.* Utilize, whenever possible, existing and standardized best practices to facilitate relevant outcome measurements across the Army and DOD.

1–27. Senior commanders

Senior commanders will—

- a.* Have the overall responsibility for health promotion/R2C at the installation/regional level.
- b.* Establish and preside over the installation CHPC. (See chap 2.)
- c.* Consult DCS, G–1 for employment of SSART and SAT, as needed, for assistance with integration and/or assessment of policies, programs, and resources.
- d.* Enforce the execution of periodic and event driven health assessments (for example, Periodic Health Assessment (PHA), Deployment Health Assessment Program (DHAP), annual dental examination, Mental Health Assessments, and so on) to enable the early identification and treatment of physical and behavioral health issues.
- e.* Appoint a HPO to facilitate the CHPC process.

1–28. Garrison commanders

Garrison commanders will—

- a.* Serve as primary provider of installation services and facilities to senior commanders and tenant organizations; integrate installation capabilities and resources with requirements to achieve strategic objectives of Army health promotion; provide a mechanism for senior commanders and tenant organizations to communicate their needs, assist in prioritizing local requirements; and highlight issues for elevation to senior leaders.
- b.* Ensure the effective and efficient delivery of a broad range of programs and services to Soldiers, Army Civilians, Families, and units that build and strengthen their resilience, increase their professionalism, and equip them with the knowledge, skills, abilities, and support they need to maintain physical and emotional health. Programs include, but are not limited to, Army Community Service; Child, Youth and School Services; Army Sports Program; First Sergeant's Barracks Program; Sponsorship; Exceptional Family Member Program; Suicide Prevention; Sexual Harassment and Assault Prevention Program; Soldier and Family Assistance Centers; and Survivor Outreach Services.
- c.* Coordinate with MEDCOM to implement health promotion programs, to include providing facilities support and staff assistance for unit health promotion events.
- d.* Be a member of the CHPC.
- e.* Implement evidence-based health promotion programs at their installations in accordance with this regulation.
- f.* Appoint a SPPM (or appoint duties to existing personnel) to provide assistance for, and staff supervision of the ASPP. This appointment must be done through a written memorandum of appointment and meet all the requirements specified in para 1–26c.
- g.* Coordinate with union organizations representing Army Civilians, as applicable.
- h.* Ensure installation resources and control systems are in place to support and track the completion of health assessments for all deploying/redeployed Soldiers from all Army components and for Army Civilians.
- i.* Ensure in and out processing systems identify Soldiers during the transition process that are receiving treatment, and procedures are in place that ensure coordination with installation and/or gaining command medical activities to ensure continuity of health care.

1–29. State Adjutants General and Army Reserve direct reporting unit and/or major subordinate command commanders

State Adjutants General and commanders will—

- a.* Be responsible for all aspects of the health promotion, risk reduction, and suicide prevention/R2C program for their state or command.
- b.* Establish and chair a CHPC and appoint a HPO when practical for their organization. When a CHPC is not practical, develop and implement strategies to accomplish similar goals to that of the CHPC.
- c.* Ensure the appointment of a SPPM or assign duties to existing personnel.

1–30. Medical Command and/or medical treatment facility commanders and/or senior theater medical commanders

MEDCOM and/or medical treatment facility (MTF) commanders and/or senior theater medical commanders will—

- a.* Serve as principal advisers to the installation and/or senior commander with respect to the Army Health Promotion Program.
- b.* Provide equipment and health care personnel to administer and interpret the self-reported health information tools, teach classes, and compile statistics to support the health promotion program and review and assess PHA, and DD Form 2795 (Pre-Deployment Health Assessment); DD Form 2796 (Post-Deployment Health Assessment (PDHA)); and

DD Form 2900 (Post-Deployment Health Re-Assessment (PDHRA)) in accordance with DODI 6490.03 and DODI 6490.12.

- c.* Use process action teams to address specific issues involving health promotion at the MTFs.
- d.* Coordinate with installation and garrison staff in their areas of operation to prioritize health promotion services from the installation and community perspective.
- e.* Develop and implement evidence-based health promotion programs for installations, geographically dispersed Active Army, ARNG, USAR, and the community in partnership with the installation and appropriate staff through the CHPC.
- f.* Develop and implement protocols for the identification and management of high-risk patients in each patient care unit of the MTF, and provide in-service suicide prevention training for health care providers.
- g.* Ensure sufficient staff is trained as gatekeepers and the availability of trainers to support training mission.
- h.* Provide a fellowship-trained forensic psychiatrist or psychologist when required to conduct a psychological autopsy in cases of equivocal death.
- i.* Provide advice and assistance to the geographically dispersed Active Army and the RC commanders to facilitate and implement health promotion policies.
- j.* Appoint a designated Behavioral Health provider to serve as the point of contact for completion of the DD Form 2996 (Department of Defense Suicide Event Report) on every suicide, suicide attempt and suicidal ideation resulting in hospitalization or evacuation from theater. Specific details regarding the DD Form 2996 are outlined in DA Pam 600–24.
- k.* Resource personnel and technical support for AWC implementation according to guidance from USAPHC.
- l.* Promote and use risk communication tools and techniques when working with stakeholders and provide opportunities for two-way dialogue to strengthen credibility and trust between stakeholders and leaders.
- m.* Coordinate activities with unit commanders to successfully complete the DD Form 2996.
- n.* Ensure medical staffs are aware of and advise commanders regarding Soldiers access to privately owned and Government weapons when at risk of suicide.
- o.* Implement policies and programs to increase MTF tobacco-free campuses and MTF tobacco-free workforce.
- p.* Ensure that oral disease prevention principles and education are incorporated into all appropriate patient care, including but not limited to obstetrics, pediatrics, diabetes, medical nutrition therapy, and so on.
- q.* Serve as a member of the CHPC.

1–31. Commanders

Commanders at all levels will—

- a.* Publish a health promotion policy that includes suicide prevention efforts. This policy includes a full scope of evidence-based prevention activities as listed in this regulation to promote a community of healthy behaviors.
- b.* Support Army health promotion/R2C initiatives and meet established reporting requirements.
- c.* Remain sensitive and responsive to the needs of Soldiers, Army Civilians, Family members, and retirees.
- d.* Encourage all Soldiers, Army Civilians, and Family members to practice a lifestyle that improves and protects physical, behavioral, and spiritual well-being: including maintaining an active and tobacco-free lifestyle, a healthy body-mass composition, and adequate sleep.
- e.* Enhance unit readiness and maximize human resources by implementing the health promotion program within their units.
- f.* Implement and enforce the PHA process and the DHAP to enable the early identification and treatment of physical and behavioral health issues at critical stages within the deployment cycle.
- g.* Understand the conditions that drive execution and make DHAP a command priority within the deployment cycle. The DHAs (DD Form 2795, DD Form 2796, and DD Form 2900) are required for all outside the continental United States (OCONUS) deployments (for example, operational deployments, training events, humanitarian missions, and so on) greater than 30 days to locations not supported by a fixed US MTF. Moreover, commanders are required to determine the environmental risks and the need for DHAs for all deployments of 30 days or less to any location, continental United States or OCONUS. See DODI 6490.03.
- h.* Ensure that Soldiers identified with suicide-risk symptoms and/or behaviors are not belittled, humiliated, or ostracized by other Soldiers and are not identified through special markings or clothing (for example, having Soldiers wear reflective training vests with signs identifying them as high-risk individuals).
- i.* Promote the battle buddy system throughout the Army Force Generation cycle for all Soldiers regardless of rank, position, and organizational affiliation.
- j.* Ensure that Soldiers are treated with dignity and respect and are encouraged to seek assistance if they are experiencing challenges or have been identified with suicide-risk symptoms.
- k.* Ensure that policies are in place for Unit Watch (protective measures for at-risk Soldiers), weapons profiles, and other unit-related procedures that relate to suicide-risk symptoms or suicide-related events.

- l.* Refer Soldiers who are undergoing disciplinary action and have multiple risk factors present to appropriate support services, such as ASAP, social work services, or the FAP, to mitigate risk.
- m.* Ensure that Families, unit members, and coworkers who experience loss due to suicide are provided and/or offered long-term assistance. See DA Pam 600–24 for a specific list of available prevention, intervention, and post-intervention resources.
- n.* Demonstrate positive efforts to deglamorize the use of all forms of tobacco products, illegal drugs, prescription drug abuse and irresponsible use of alcohol.
- o.* Initiate proactive measures to prevent loss of life within their units due to suicide and to reduce the impact on survivors if a suicide takes place.
- p.* Use risk communication tools and techniques when working with stakeholders and provide opportunities for two-way dialogue to strengthen credibility and trust between stakeholders and leaders.
- q.* Enhance unit readiness and maximize human resources by encouraging Soldiers to attain and maintain dental wellness or dental readiness classification (DRC) 1 and referring Soldiers in DRCs 3 and 4 for examination and treatment with a goal of attaining at least DRC 2. (See AR 40–35 for description of DRCs.)
- r.* Ensure that all Soldiers and Family members are aware of the lack of availability of dental care for Family members at post facilities and understand how to enroll in and use the Family member dental insurance plan for treatment at civilian facilities.
- s.* Conduct an AR 15–6 investigation on all suspected Soldier suicides in accordance with Army Directive 2010–01. Completed AR 15–6 investigations for active duty Soldiers will be forwarded to USAPHC. Completed AR 15–6 investigations for the ARNG and USAR will be forwarded to their respective headquarters-level SPPM.
- t.* Share information on Title 10 Reserve Component Soldiers, as appropriate, with parent ARNG and USAR component units (for example: belligerence, depressive symptoms, hygiene, obsessive behavior, family and relationship problems, financial problems, and any other information relating to the Soldier’s physical or BH, well-being, or readiness).
- u.* Share a Soldier’s information only with those who have a need to know. If a commander or health care professional has any questions regarding who is authorized to receive a Soldier’s information, they should contact the servicing judge advocate or legal advisor and Protected Health Information guidance before sharing any information.
- v.* Proactively work with Soldiers who have permanent profiles (especially BH) to ensure that appropriate assignments, schools, educational opportunities, training, temporary duty, promotions, and accommodations are made when needed.
- w.* Develop and submit a DA Form 7747 (Commander’s Suspected Suicide Event Report) for every suicide or equivocal death which is being investigated as a possible suicide. Active duty units are required to submit an initial report within 5 days following a death and all units (to include ARNG and USAR) are required to submit a completed report within 30 days.
- x.* Provide annual suicide prevention and awareness training to all personnel, including Active Army and RC Soldiers and Army Civilians. Commanders must also ensure the availability of training for Family members.
- y.* Incorporate suicide prevention training into the yearly training plan.
- z.* Keep records of Soldiers’ annual suicide prevention awareness training and track and assess mandatory suicide prevention training of individual Soldiers in accordance with AR 350–1.
 - aa.* Provide command support for unit participation in suicide awareness and prevention activities.
 - bb.* Support stigma reduction by building a command climate that encourages and enables Soldiers and Army Civilians to seek help.
 - cc.* Support stigma reduction by training leaders, Soldiers, Army Civilians, and contractors on an individual’s positive decision to seek behavioral health care should not, in and of itself, adversely impact the individual’s ability to obtain or maintain a national security position or security clearance. Commanders must ensure security managers and supervisors, are trained and understand their roles and responsibilities to support an individual’s wellness and recovery.
 - dd.* Manage at-risk Soldiers, to include processing for separation as appropriate in a timely manner.
 - ee.* Refer individuals who are identified as having personal or emotional problems to an appropriate source for help.
 - ff.* Use the unit risk inventory (URI), the reintegration URI, DD Form 2795, DD Form 2796, and DD Form 2900 to identify Soldier issues that need command attention and additional resources.
 - gg.* Inquire as to whether or not a Soldier owns or has plans to acquire privately owned weapons if the commander has reasonable grounds to believe the Soldier is at risk of harming self or others.
 - hh.* If the Soldier at risk has privately owned weapons on-post, restrict that Soldier’s access to those weapons in accordance with AR 190–11.
 - ii.* If the Soldier at risk has privately owned weapons off-post, request that the Soldier bring the weapons to the unit for storage in the unit arms room.
 - jj.* If the Soldier at risk is unwilling to voluntarily surrender his/her off-post privately owned weapons, will not order him/her to do so.

1–32. The U.S. Army Garrison, State Joint Forces Headquarters, and U.S. Army Reserve Command Chaplain

The Garrison, State JFHQ, and USAR Command Chaplain will—

- a.* Serve as members of the CHPC and provide input regarding religiously informed spiritual health into health promotion programs.
- b.* Ensure that all chaplains and chaplain assistants are trained as gatekeepers.
- c.* Ensure all chaplains and chaplain assistants are trained to conduct the Army-approved gatekeeper training workshops.
- d.* Ensure that all chaplains and chaplain assistants are trained to conduct Army-approved, suicide awareness, prevention, and intervention training.
- e.* Ensure that Chaplains are not detailed as SPPMs, in accordance with AR 165–1.
- f.* Provide support to DCS, G–1 for SSART and SAT initiatives.

1–33. Installation Health Promotion Officer

The HPO will—

- a.* Provide SME support to the senior commander on the CHPC process and input for health promotion policy.
- b.* Coordinate the CHPC for the senior commander to include a strategic plan for installation health promotion.
- c.* Monitor and advise the senior commander on the status of the CHPC and working groups.
- d.* Integrate CHPC members to include installation, medical, mission personnel, and community stakeholders that serve as SMEs.
- e.* Serve as liaison between the CHPC membership and USAPHC.
- f.* Coordinate with SMEs to advise senior commanders on strategies for effective and efficient health promotion initiatives.
- g.* Support execution of the tenets of this regulation for the senior commander by conducting ongoing assessments of CHPC activities through the working group action plans.

1–34. Installation Suicide Prevention Program Manager

The SPPM will—

- a.* Administer the suicide prevention program for both military and civilian members with a goal to reduce suicidal behavior.
- b.* Serve as the presiding officer of the Suicide Prevention Task Force (SPTF) and coordinate the efforts of task force members.
- c.* Serve as a member of the CHPC representing suicide prevention issues and providing input into related programs.
- d.* Complete the HQDA ASPP online SPPM training (when available) within the first sixty days after appointment by commander.
- e.* Oversee all Ask, Care, Escort (ACE), ACE–Suicide Intervention (SI) and gatekeeper training and advise the commander if training is not conducted as specified in this regulation.
- f.* Maintain record of all certified ACE–SI and gatekeeper trainers and provide this information to the respective Army Component SPPM quarterly.
- g.* Serve as the point of contact for program information and advice to the commander and to major subordinate commands.
- h.* Integrate suicide prevention into community, Family, and Soldier support programs as appropriate.
- i.* Coordinate with internal and external organizations to share information, trends, best practices, lessons learned, and training developments.
- j.* Report actions of the SPTF through the CHPC to the senior commander.
- k.* Participate in inter-Service Family Assistance Committees.
- l.* Provide direct support to commanders for planning suicide prevention training events.
- m.* Ensure suicide awareness materials are readily available to commanders for use in their programs.
- n.* Serve as a point of contact with headquarters-level SPPMs for issues related to suicide monitoring.
- o.* For the Active Army, work in ASAP and report directly to the ASAP Manager. For the USAR major subordinate commands (MSCs), work under the DCS, G–1 and report to the human resources officer. For USARC level SPPMs, report to the Chief, Programs Branch under the USAR G–1, Services and Support Division.
- p.* Coordinate and execute ACE–SI suicide intervention, train-the-trainer workshops at the installation, territory and/or state and Reserve Support Commands.

1–35. Ready and Resilient Program Portfolio Manager

The Ready and Resilient Program Portfolio Manager will—

- a.* Refine and execute a process for program evaluation and promote evidence-based practices.

- b. Provide advice to Army senior leaders to inform decisions regarding Ready and Resilient programs.
- c. Identify requirements for future programs and evaluation efforts.
- d. Facilitate collaboration among portfolio program managers.
- e. Maintain a balanced portfolio.

Chapter 2

Community Health Promotion Program

2–1. Implementation guidance

a. The senior commander will establish and preside over the CHPC. Noninstallation-based commands, including USAR DRU and/or MSC, will establish a CHPC where practical. When supporting elements and resources are too geographically dispersed to support a CHPC, noninstallation-based commands will develop and implement strategies to accomplish similar goals.

(1) The CHPC will be organized to provide a comprehensive approach to health promotion/R2C.

(2) All tenant organizations are members of the CHPC for health promotion policy and programs. The senior commander, through the CHPC, will provide comprehensive health promotion/R2C policy that is applicable to all members of the command.

(3) A formal charter will be established and signed for all health promotion, risk reduction, and suicide prevention councils, teams, and committees in accordance with AR 15–1. The primary signature authority will be the senior commander or designee, The Adjutant General, or the USAR DRU and/or MSC commander. These charters must clearly outline—

- (a) Organization and membership.
- (b) Mission.
- (c) Scope and objective (integration with other councils and/or committees).
- (d) Meeting schedule.
- (e) Standard products and/or services.
- (f) Metrics, assessment, and outcome reporting protocols.
- (g) A marketing and/or outreach plan.

(4) The CHPC will identify and recommend strategies to eliminate redundancies and voids in programs and services by evaluating population needs, assessing existing programs, and coordinating targeted interventions.

(5) The CHPC will ensure health promotion programs comprise the following functional areas:

- (a) Public health process to raise individual and community awareness.
- (b) BH interventions to improve psychological health and reduce self-destructive behaviors.
- (c) Physical programs directed towards achieving optimal physical wellness.
- (d) Spiritual programs to foster spiritual awareness and enrichment.
- (e) Environmental and social programs that promote and sustain healthy lifestyles, strengthen community action, and encourage proactive public health policies.

b. Health promotion initiatives to address community needs may include media awareness campaigns, classes, seminars, workshops, activities and health interventions, policy changes, resource coordination and/or reorganization, and other initiatives to accomplish required goals. Existing programs may be used to meet these needs.

c. The CHPC will initiate preventive interventions that directly impact the total population (Soldiers, Army Civilians, Family members, and retirees).

d. The CHPC will develop and implement means to allow commanders to monitor program goals and objectives.

2–2. Community Health Promotion Council membership

a. The presiding officer of the CHPC is the senior commander.

b. The senior commander will ensure the goals, objectives, and purposes of the Health Promotion Program are well-publicized throughout the command to keep Soldiers, Army Civilians, Family members, and retirees aware of program benefits. This includes the relationship and interaction with CHPC members and overall program components.

c. The HPO organizes and synchronizes CHPC activities and outcomes in support of established senior commander, ACOM/ASCC/DRU, and DA performance goals and objectives.

d. The CHPC will be a multidisciplinary team appointed on orders by the senior commander. The CHPC members act as advisors to the installation commander on health promotion programs.

e. Council members will—

- (1) Assess community needs.
- (2) Develop, implement, and evaluate courses of action to address identified community needs.
- (3) Attend the CHPC meetings as the SME in area of knowledge.

- (4) Contribute to council process to find solutions to multidisciplinary issues that face the well-being and readiness of the post, camp, or station and constituents.
 - (5) Participate in or chair process action teams and/or working groups as assigned by the appropriate CHPC leader where expertise is required.
 - (6) Take responsibility for respective areas of education.
 - (7) Utilize the public health process to report progress to the CHPC and senior commander and other appropriate leaders at MEDCOM, IMCOM, U.S. Army Forces Command, and USAPHC.
 - (8) Assist the HPO by providing documentation of requirements upon request.
 - (9) Analyze data resulting from program assessments or evaluations.
 - (10) Keep an inventory of resources. Integrate all existing installation health promotion programs.
 - (11) Develop a comprehensive marketing plan based on existing resources and demographics.
 - f. The HPO will provide logistical and advisory support to the senior commander and the CHPC.
 - g. CHPC members will identify appropriate chairs for their respective working groups.
 - h. CHPC members will serve for a minimum of 1 year, subject to reappointment at the end of the year. Members should have authority and responsibility to provide resources to assist with achievement of CHPC goals. The CHPC membership will include the following:
 - (1) Senior Commander.
 - (2) GC.
 - (3) Senior Commander's Command Sergeant Major.
 - (4) HPO.
 - (5) SPPM.
 - (6) Major tenant commanders.
 - (7) Garrison Command Sergeant Major.
 - (8) Director, Human Resources Policy Directorate (Civilian Personnel Advisory Center, Military Personnel Services, Education).
 - (9) Provost Marshal.
 - (10) Family Advocacy Program Manager.
 - (11) Commander, MTF.
 - (12) Director of Logistics.
 - (13) Director for Plans, Training, and Mobilization.
 - (14) Commander, Dental Activity and/or Director of Dental Services.
 - (15) Comprehensive Soldier and Family Fitness Program Manager.
 - (16) Installation senior Chaplain or delegated representative.
 - (17) Public Affairs Officer.
 - (18) Risk Reduction Program Coordinator.
 - (19) Alcohol Drug Control Officer.
 - (20) Sexual Assault Response Coordinator.
 - (21) Staff Judge Advocate.
 - (22) Consultants, as needed. For example, this category could include representatives from the Provost Marshal, Director of Emergency Services, civilian personnel offices, ASAP, BH, MTF, dental clinic, veterinary services, environmental science, American Red Cross, fitness, food services, RC advisors, the Inspector General, or other selected community members.
 - i. CHPC members are encouraged to attend the Military Health Promotion Course. See <http://phc.amedd.army.mil/Pages/Training.aspx> for Military Health Promotion Course description and registration information.
- 2-3. Community Health Promotion Council administration**
- a. The CHPC will convene at least quarterly. The presiding officer will identify a recorder to assist during council sessions.
 - b. The CHPC will implement a health promotion improvement program.
 - c. USAPHC, U.S. Army Institute of Public Health, Epidemiology and Disease Surveillance Portfolio will provide program evaluation consultation.
 - d. USAPHC, U.S. Army Institute of Public Health, Epidemiology and Disease Surveillance Portfolio will provide SMEs to the CHPC, as needed.
- 2-4. The Suicide Prevention Task Force**
- a. Each installation, USAR DRU, MSC, and state JFHQ will establish a SPTF to plan, implement, and manage the local ASPP. The membership of this task force will be tailored to meet local needs.
 - b. Commanders may assign the suicide prevention mission to the SPPM, who serves as the chair of the SPTF and a

member of the CHPC, or may elect to establish a separate SPTF to function as a subcommittee of the CHPC. When using the CHPC to manage the ASPP, care must be taken to ensure that suicide prevention remains a primary responsibility. Responsibilities of the task force members, with respect to suicide prevention, must be clearly established. Specific details regarding the SPTF are outlined in DA Pam 600–24.

c. The SPTF will—

(1) Coordinate program activities and the suicide prevention activities of the command, interested agencies, and persons.

(2) Evaluate program needs and make appropriate recommendations to the commander.

(3) Review, refine, add, or delete items to the program based on an ongoing evaluation of needs.

(4) Develop awareness training for suicide prevention activities and identify appropriate forums for training.

(5) Evaluate the impact of the pace of training and military operations on the quality of individual and Family life in the military community.

(6) Recommend command policy guidance for training and operations issues to assure that Soldiers and their leaders have sufficient opportunity for quality Family life.

(7) Be aware of publicity generated with respect to suicides in the community and develop public awareness articles, in coordination with the Public Affairs Officer, for publication.

(8) Meet at the discretion of the task force presiding officer.

(9) In the event of a suicide, review the results of the behavioral analysis review, psychological autopsy and/or the DD Form 2996 (as applicable) to look for possible causes of the suicide and, if necessary, evaluate prevention efforts and make recommendations to the commander.

(10) Coordinate with civilian support agencies, as necessary.

(11) Implement an integrated Family member suicide prevention program.

2–5. Collaboration and health promotion integration

a. Collaboration and integration among community agencies enhance knowledge, experience, and resources and have the potential of minimizing duplication of efforts. Collaboration extends beyond services available on military installations to include potential partners, such as state, tribal, local, and territorial governments, businesses, health care systems and clinicians, early learning centers, schools, colleges and universities, and various community, non-profit, and faith-based organizations (American Red Cross, American Heart Association, and so forth).

b. The GC is responsible for synchronizing, integrating, and linking services, infrastructure, and operational support to Soldiers, Families, and senior commanders to enable a ready and resilient Army. This support extends from garrisons to encompass comprehensive communication and outreach to local communities to engage and encourage community leaders and programs in collaborative partnerships to support all Components.

c. Other potential collaborative resources include, but are not limited to—

(1) The U.S. Army Public Health Command at <http://phc.amedd.army.mil>.

(2) The Centers for Disease Control and Prevention at <http://www.cdc.gov>.

(3) The Department of Health and Human Services at <http://www.hhs.gov>.

(4) The Defense Centers of Excellence at <http://www.dcoe.health.mil/>.

(5) Navy Marine Corps Public Health Center at <http://www.nmcpbc.med.navy.mil/>.

(6) The National Institutes of Health at <http://www.nih.gov/>.

(7) The National Institute of Mental Health at <http://www.nimh.nih.gov/index.shtml>.

(8) The Substance Abuse and Mental Health Services Administration at <http://www.samhsa.gov>.

(9) The Department of Veterans Affairs at <http://www.va.gov>.

(10) Tri-Service Medical Care, Mental Health Resource Center at <http://www.tricare.mil/mentalhealth/>.

(11) Department of Justice at <http://www.justice.gov>.

(12) Office of National Drug Control Policy at <http://www.whitehouse.gov/ondcp>.

(13) Environmental Protection Agency at <http://www.epa.gov>.

(14) Department of Education at <http://www.ed.gov>.

d. See DA Pam 600–24, for specific resources and outreach programs for geographically dispersed Soldiers, Army Civilians, and Family members.

Chapter 3 Health Promotion

3–1. General

Health promotion uses the public health process to promote, maintain and improve individual, family and community

health and well-being by raising awareness, changing policy and providing educational and intervention strategies improving standards that increase the readiness of the total force.

3–2. Framework

Public health is most successful when a standardized framework is used. The CHPC will recommend, coordinate, and ensure the integration of the following processes in the framework of public health promotion programs: assessment, planning, implementation, evaluation, and communication of health information needs and resources.

- a.* Assessment is the appraisal of individual and community needs for public health in order to determine—
 - (1) Health knowledge, perceptions, attitudes, motivation, and practices.
 - (2) Priority areas, nature, and emphasis needed for public health based on results of collected data.
 - (3) Appropriate public health activities for the designated target population.
 - (4) The selection of valid sources of information about health needs utilizing existing computer resources, databases, or other appropriate data-gathering instruments. Members of the CHPC will provide necessary information for community assessment.
- b.* Planning is a comprehensive approach to preparing and developing an effective public health program, and begins by establishing specific behavioral goals and learning objectives that are realistic and measurable. Planning also requires recruitment and commitment of personnel and decision-makers, selection of educational methods and strategies appropriate to the target population, procurement of resources, inclusion of program evaluations, and communication with the CHPC.
- c.* Implementation is the execution of the planned public health program. The program implementer will deliver a series of planned learning activities designed to achieve changes in health awareness, knowledge, attitude, skills, and behavior. These activities involve setting up, managing, and executing instructional sessions, methods, strategies, wellness activities, interventions, and promotion measures that address program objectives.
- d.* Evaluation is the review of the program to determine the effectiveness of the public health program and whether program objectives were met. Evaluation requires the collection and examination of appropriate data. It documents the strengths and weaknesses of program planning and execution, and monitors participant performance, quality control, and fiscal accountability.
- e.* Communication is the sharing of public health needs, concerns, and resources with the target population and program stakeholders (persons or groups that are interested in the success of the program).
 - (1) Communication should include increasing awareness, illustrating skills, reinforcing knowledge, affecting attitude and behavior changes, supporting risk reduction and disease prevention health policies, and reporting program effectiveness to stakeholders.
 - (2) Communication services should incorporate the sharing of community resources, responding to requests for health information, referring requesters to valid health information sources, and assisting with marketing and public relations. The CHPC fosters networking among stakeholders and health care personnel, and should coordinate between the target population and health care providers. The CHPC will coordinate with the Public Affairs Office to support health education efforts through media partnerships and mass media.
 - (3) Risk communication tools and techniques should be incorporated into the strategic communication process and provide opportunities for two-way dialogue to strengthen credibility and trust between stakeholders and leaders.

Chapter 4 Healthy Behavior

4–1. General

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 psychiatric and psychological treatment, as well as improving overall well-being and often improving the outcomes of other medical conditions.

- a.* The three cornerstones of effective strategies to promote optimal BH include—
 - (1) Strengthening individuals.
 - (2) Strengthening communities.
 - (3) Reducing structural barriers to health.
- b.* CHPCs will ensure initiatives are established that address each of the three cornerstones and ensure preventive activities are carried out to reduce the risk and impact of BH illness on the installation.
 - (1) Programs that strengthen individuals should focus on increasing the number and quality of resources available to Soldiers, Army Civilians, Family members and retirees. Examples of such programs include efforts to improve housing, stress interventions, installation newcomer briefings, relationship enhancement programs, and so on.
 - (2) Programs that strengthen communities should strive to enhance connections between individuals and community

organizations, as well as improve communication and cooperation between community organizations. Such programs could include community health fairs, partnerships between medical activities (MEDDACs) and units, between Child and Youth Services and BH services, and between MEDDACs and DOD schools.

(3) Programs that reduce structural barriers to BH should promote access to sources of BH care and reduce the stigma traditionally associated with BH services. Examples include establishing after-duty hours for BH services; public awareness campaigns designed to educate the community on the availability of BH services; and campaigns to de-stigmatize BH services. Health care providers should adhere to the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the standard for BH diagnoses and definitions nomenclature.

c. BH professionals, enlisted BH specialists, and registered nurses normally perform BH promotion activities; therefore, CHPCs will ensure that installation BH activities are conducting preventive services, in addition to clinical services. Prevention activities may include depression and anxiety screening programs, targeted interventions aimed at high-risk populations, or preclinical interventions to prevent emergent problems from reaching a diagnosable condition.

d. The CHPCs will encourage a culture of lifelong learning to strengthen personal, interpersonal, and on-the-job competence; and to integrate cognitive, behavioral, emotional, social, and spiritual health. To maximize this effort, the strategy involves—

- (1) Identifying high-risk individuals early.
- (2) Providing psychosocial programs to improve self-management skills and to develop appropriate behaviors.
- (3) De-stigmatizing BH care and promoting the normalization of help-seeking behaviors and working to eliminate stigma in language, attitudes and actions.
- (4) Increasing awareness of individual strengths and group capabilities.
- (5) Shifting the focus from tertiary care to primary prevention.
- (6) Using community resources.

e. In addition to general BH promotion and prevention activities, the CHPC will ensure that specific programs are properly implemented in councils, teams, and committees related to specific programs listed here report information and status of trends to the CHPC on a quarterly basis:

- (1) Stress management (para 4-2).
- (2) Combat and operational stress control (para 4-3).
- (3) Suicide prevention and surveillance (para 4-4).
- (4) Responsible sexual behavior (para 4-12).
- (5) ASAP (para 4-13).
- (6) Tobacco Control Program (para 4-14).
- (7) Domestic violence prevention (para 4-15).

4-2. Stress management

a. BH stress management includes assistance provided to Soldiers and Family members so they may cope with the demands, real or perceived, from stress related to work, home, and within them. BH services will do the following:

- (1) Implement treatment programs to cope with work and Family-related stress.
- (2) Develop and conduct training programs to teach commanders and supervisors how to counteract the effects of work and Family-related stress.
- (3) Partner with other community services to support a multifaceted approach to reduce the incidence and prevalence of BH problems.
- (4) Assist commanders in developing and implementing comprehensive stress prevention efforts designed to increase Soldiers' and Army Civilians' ability to cope positively with stress, in coordination with unit ministry team (UMT) personnel.

b. The senior commander, USAR DRU and/or MSC commander, JFHQ commander, and/or CHPC may designate a process action team to review and evaluate stress management activities for the community. If a process action team is designated, care must be taken to ensure that its membership reflects a cross-section of the CHPC membership as a whole and is not limited solely to BH and chaplaincy assets.

(1) The process action team approach will encompass the full range of methods available for identifying risk factors, and promoting protective elements that can help individuals become resilient in the face of adversity, thereby moderating the impact of stress on an individual's social and emotional well-being.

(2) The process action team will collaborate with local BH services, other consumer agencies, and caregivers to ensure supportive and sensitive interventions are provided as necessary in the community.

c. Health care providers will implement health education programs for individuals affected by stress.

4-3. Combat and operational stress control

The stress of active combat operations often leads to a combat and operational stress reaction (COSR). The prevention and treatment of COSR is often done by BH teams that are deployed to provide combat and operational stress control (COSC) interventions. The purpose of COSC efforts is "to preserve the fighting strength" of the force; COSC efforts

are preventive in nature. In order to reduce stigma, practice "expectancy," and return Soldiers to duty as quickly as possible, three levels of primary prevention service are provided:

a. Combat and operational stress control universal prevention. Surveillance and mitigation activities to reduce or avoid stressors and increase Soldiers' tolerance and resilience to severe stress. Services include unit surveillance and/or screening, educational classes and/or briefings, incident debriefings, and so on.

b. Combat and operational stress control indicated prevention. Surveillance and mitigation activities involving contact by BH personnel with individual Soldiers identified as having possible warning signs or pre-diagnostic COSRs. Such cases can be aided by their unit, brief visits, or by restoration treatment for 1 to 3 days in Combat Stress Control (CSC) Team-type medical facilities. The COSC case information is recorded as a patient encounter but classified by one or more COSR codes rather than "diagnosed" with current DSM codes.

c. Combat operational stress reaction treatment prevention. Prevention consists of activities that mitigate and/or stabilize the effects of stress to reduce long-term morbidity and complications in Soldiers with one or more DSM diagnosable psychiatric and/or BH disorders. A Soldier with COSR whose condition persists and prevents return to effective duty within 4 days, or requires more invasive clinical follow-up and/or a patient record of continuing BH treatment, should be tracked through normal medical channels.

d. Commanders, staff officers, and proponent agencies. Commanders, staff officers, and proponent agencies should be aware how—

(1) The UMTs provide preventive, immediate, and replenishing spiritual and emotional support and care to Soldiers experiencing combat stress.

(2) The CSC Teams—

(a) Implement the BH recovery aspects of combat stress.

(b) Develop and implement Soldier and leadership training on coping with the demands of deployment and combat-related stressors.

(c) Record work activities during deployment using the USAPHC COSC Work Activity Recording System.

e. Stress management. Stress management is a concern for leaders at every level. Techniques and considerations for the management of stress in Army operations can be found in Field Manual (FM) 6–22.5, *Combat and Operational Stress Control Manual for Leaders and Soldiers*.

f. Training. The CHPC will support and assist CSC Teams to promote and advertise COSC training activities to all leaders, organizations, and tenant units.

4–4. Army Suicide Prevention Program

The success of the ASPP is predicated on the existence of proactive, caring, and courageous Soldiers, Army Civilians and Family members who recognize imminent danger and take immediate action to save a life.

a. Army Suicide Prevention Program's purpose.

(1) Supports the Army's goal to minimize suicidal behavior by reducing the risk of suicide for Active Army and RC Soldiers, Army Civilians, and Family members. Suicide prevention programs implement control measures to address and minimize risk factors for suicide while strengthening the factors that mitigate those risks.

(2) Establishes a community approach to reduce Army suicides through the function of the CHPCs. The CHPC integrates multidisciplinary capabilities to assist commanders in implementing local suicide prevention programs, and establishes the importance of early identification of, and intervention with, problems that detract from personal and unit readiness.

(3) The ASPP proponent of DCS, G–1 has an Army-wide commitment to provide resources for suicide-intervention skills, prevention, and follow-up in an effort to reduce the occurrence of suicidal behavior across the Army. The ASPP develops initiatives to tailor and target policies, programs, and training in order to mitigate risk and behavior associated with suicide. A function of the ASPP is to track demographic data on suicidal behaviors to assist Army leaders in the identification of trends. See DA Pam 600–24 for additional information regarding the ASPP.

b. Army Suicide Prevention Program applicability. The ASPP applies to all Soldiers (Active Army and RC) and Army Civilians. CHPCs will direct the implementation of suicide prevention programs on installations and for noninstallation based commands where establishment of a CHPC is practical. For noninstallation-based commands without CHPCs, the program will be implemented by the SPTF under the direction of the SPPM. Suicide prevention programs at this level will—

(1) Secure the safety of individuals at risk for suicide.

(2) Minimize the adverse effects of suicidal behavior on unit cohesion and other military personnel.

(3) Preserve mission effectiveness and war fighting capability.

c. Army Suicide Prevention Program strategy and supporting elements. The strategy and supporting elements of ASPP are based on the premise that suicide prevention will be accomplished by leaders through command policy and action. The key to the prevention of suicide is positive leadership and deep concern by supervisors of military personnel and Army Civilians who are at increased risk of suicide.

d. Army Suicide Prevention Program goal. It is the Army's goal to prevent suicide for Soldiers, Army Civilians and

Family members. However, it must be recognized that in some people, suicidal intent is very difficult to identify or predict, even for a BH professional. Some suicides may still occur even in units with the best leadership climate and most efficient crisis intervention and suicide prevention programs. Therefore, it is important to redefine the goal of suicide prevention as being suicide-risk reduction. Suicide-risk reduction consists of reasonable steps taken to lower the probability that an individual will engage in acts of self-destructive behavior.

e. Army Suicide Prevention Program responsibilities. Suicide prevention is a commander's program and is the responsibility of every leader. Leaders care for their personnel and create an environment that encourages help-seeking behaviors. Commanders at all levels are responsible for integrating and administering suicide prevention programs for their organization.

(1) Program administration on installations is vested with the senior commander, who requires the Director of Human Resources to manage the program and community initiatives, in conjunction with the CHPC. The CHPC will ensure a proactive, coordinated, and synchronized local program. It is the responsibility of each CHPC to ensure that suicide prevention activities are carried out in accordance with guidance provided in this chapter. The CHPC presiding officer may designate a subcommittee of CHPC members to manage suicide prevention activities, or the CHPC may elect to have the SPTF manage suicide prevention activities.

(2) Program administration for noninstallation-based organizations without a CHPC is managed by the SPTF under the supervision of the SPPM or other official designated by the senior commander. The SPTF will develop a proactive, coordinated, and synchronized program that spans all geographically dispersed Soldiers and builds relationships to leverage local agencies to meet needs normally met by installation-based services.

(3) Another resource that is available to commanders is the SSART and SAT. The DCS, G-1 is the lead agent for the SSART and SAT. The purpose of this team is to assist and support commanders by providing pertinent and timely intervention to suicide event clusters and responding to the needs of the requesting commander using a multidisciplinary approach. Teams are composed with representation from DCS, G-1; Office of the Surgeon General; Office of the Chief of Chaplains; IMCOM; and DCS, G-3, and other agencies based on the requesting command's needs.

4-5. Suicide prevention and surveillance

a. Army suicide prevention focuses on maintaining individual readiness through five overarching strategies.

(1) Developing positive life coping skills.

(a) All leaders must encourage and support various life coping skills programs available at the installation and within the local community. These programs should focus on developing life resiliencies, such as improving personal relationships, managing finances, dealing with stress or conflict, and preventing alcohol and drug abuse.

(b) The CHPC and SPTF will ensure that these programs are promoted and well-advertised to all leaders, organizations, and tenant units.

(2) Encouraging help-seeking behavior.

(a) All leaders will create a command climate which emphasizes and encourages help-seeking behavior. The senior commander will send periodic messages of concern, announcements, or statements promoting the health, welfare, and readiness of the military community, encouraging help-seeking behaviors, and providing support for those who seek help.

(b) Commanders at all levels will eliminate any policy that inadvertently discriminates, punishes, or discourages any Soldier or Army Civilian from seeking out or receiving professional counseling.

(c) All commanders will promote access to services and programs that support the resolution of BH, Family, and personal problems that underlie suicidal behavior.

(d) The CHPC and SPTF will increase visibility and accessibility to all local helping agencies, to include promotional campaigns, to publicize various services and the proper protocols for their use.

(e) The CHPC and SPTF will monitor usage trends of such helping agencies to ensure prompt and easy access while protecting the privacy of those seeking treatment in accordance with Health Insurance Portability and Accountability Act (HIPAA) rules.

(f) The CHPC and SPTF will coordinate with various local civilian health and/or social services outreach programs that incorporate BH services and suicide prevention.

(3) Raising awareness of, and vigilance towards, suicide prevention.

(a) Commanders will ensure suicide awareness and suicide prevention training is provided to all Soldiers and offered to Army Civilians.

(b) Commanders will coordinate training events for all noncommissioned officers (NCOs), officers, and Army Civilian supervisors on recognizing symptoms of BH disorders and potential triggers or causes of suicide and other harmful, dysfunctional behavior.

(c) MEDCOM and TRADOC will develop programs of instruction to educate all Army health care providers in suicide-risk surveillance to assist them in determining when injuries are self-inflicted.

(d) Leaders will ensure all UMT members and Family Life chaplains within their command receive suicide

prevention training which includes recognizing potential danger and warning signs, suicidal risk estimation, confidentiality requirements, how to conduct unit suicide prevention training, and intervention techniques to employ when it is known that a person they are counseling is at risk for suicide.

(e) The CHPC and SPTF will ensure all installation gatekeepers are properly trained on recognizing behavioral patterns that place individuals at risk for suicide. Gatekeepers will be trained on suicide-intervention techniques to effectively reduce the immediate risk (see table 4–1 for examples of primary and secondary gatekeepers) and assist individuals in crisis with access to definitive care.

**Table 4–1
Gatekeepers**

Primary Gatekeepers	Secondary Gatekeepers
Chaplains & Chaplain Assistants	Military Police
ASAP Counselors	Trial Defense and Legal Assistance Attorneys
Family Advocacy Program Workers	Inspectors General
Army Emergency Relief Counselors	DOD School Counselors
Emergency Room Medical Technicians	Red Cross Workers
Medical/Dental Health Professionals	

(f) The CHPC and SPTF will identify any installation-wide events that might increase the risk of suicide and take appropriate measures to reduce or eliminate risk. These events may include a major deployment or redeployment, or a highly publicized suicide on the installation or in the local community.

(4) Synchronizing, integrating, and managing the ASPP. Army suicide prevention is managed at the installation and/or community level by the CHPC and SPTF. To integrate all available resources within an installation and local community and synchronize these resources throughout the unit, suicide prevention programs require a central controlling agency, the CHPC and SPTF. The agency’s primary responsibilities related to suicide prevention are to establish, plan, implement, and manage the installation ASPP. It will maximize and focus available resources and ensure unit ASPPs operate within the overall installation plan.

(a) The CHPC and SPTF will implement suicide prevention strategies and objectives for all assigned or attached Army installation tenant units, regardless of location or unit of assignment.

(b) Risk Management Team (RMT) - formerly, the Suicide Risk Management Team.

1. Army divisions and other large activities with adequate support should consider establishing a RMT. This is an optional element of the ASPP. The RMT will actively monitor the progress of Soldiers identified as at risk. The team is charged with the responsibility of addressing the medical and administrative needs presented by high risk cases.

2. The RMT will not become involved in rescue or emergency lifesaving operations with respect to suicide attempts. These activities will be left to appropriate personnel who are trained in emergency procedures. It is the role of the RMT to address those problems and issues that precipitated the suicide attempt and to expeditiously deal with them.

(c) In managing installation suicide prevention activities, the CHPC and SPTF may choose to create one or more subcommittees that meet on a more frequent basis. Separate subcommittees should take responsibility for training programs, monitoring and reporting requirements, and unit and community outreach.

(5) Conducting suicide surveillance, analysis, and reporting that keeps senior leaders aware of the problem of suicidal behavior, tracks demographic trends that could be 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. See DA Pam 600–24, *Health Promotion, Risk Reduction, and Suicide Prevention*, for details on information sharing.

b. Leaders will ensure those within their command that are experiencing a major life crisis or that have experienced a significant loss will have an appropriate level of supervision and assistance.

4–6. Suicide prevention phases

The ASPP consists of three principal phases or categories of activities to mitigate the risk and impact of suicidal behaviors: prevention, intervention, and “postvention.”

a. Prevention focuses on preventing normal life stressors from turning into life crises. Prevention Programming focuses on equipping the Soldiers, Army Civilians, and Family members with coping skills to handle life circumstances that might otherwise become overwhelming. Prevention includes early screening to establish baseline BH and to offer specific remedial programs before dysfunctional behavior occurs. Prevention is dependent upon caring and proactive small unit leaders who make the effort to know their subordinates, including estimating their ability to handle stress, and who offer a positive, cohesive environment which nurtures and develops positive coping skills.

b. Intervention attempts to prevent a life crisis or BH disorder from leading to suicidal thoughts or behavior by helping someone manage suicidal thoughts and by taking action to intervene when a suicide appears imminent. It encourages and/or mandates professional assistance to handle a particular crisis or treat a BH illness. Early involvement

is a crucial factor in suicide-risk reduction. Intervention includes addressing the conditions that produced the current crisis, treating the underlying psychiatric disorder(s) that contributed to suicidal thoughts, and providing follow-up care to assure problem resolution. This may also include inspecting and modifying a person's environment, such as removing items that an individual may use to harm him or herself when residing on post, or requesting surrender of items when off post, and providing close monitoring and care from a buddy. Commanders play an integral part during this phase, as it is their responsibility to ensure a particular problem or crisis has been resolved before assuming the threat has passed.

c. Postvention is required when an individual has attempted or completed a suicide. After an attempt, commanders, NCOs, supervisors, and installation gatekeepers must take steps to secure and protect such individuals before they cause additional harm to themselves and/or others. Postvention activities also include unit-level interventions following a completed suicide to minimize adverse psychological reactions to the event, prevent or minimize the potential for suicide contagion, strengthen unit cohesion, and promote continued mission readiness. For more information on developing a good postvention response, see chapter 4 of DA Pam 600–24.

4–7. Suicide prevention training

The Army conducts suicide prevention and awareness training for all Soldiers, Army Civilians, and Family members to increase awareness of suicide-risk factors and warning signs and available resources, and to encourage intervention with at-risk individuals. The DCS, G–1 ASPP Manager will issue annual supplemental guidance on training content and methods. See AR 350–1, Army Training and Leader Development, for frequency of training and refer to DA Pam 600–24 for additional guidance.

a. Annual suicide prevention and awareness training is required for those serving in the Active Army, ARNG, USAR, and Army Civilians. ACE training modules are located on the Army Suicide Prevention website at <http://www.preventsuicide.army.mil>.

b. ACE is the Army-approved suicide prevention and awareness training model for all Soldiers, leaders, Army Civilians, and Family members. The key learning objective of ACE is awareness training (risk factors, warning signs, and resources).

c. In addition to the ACE training curriculum, the following topics will be included in the annual training: the importance of BH, stress reduction, life-coping skills, alcohol and/or drug abuse avoidance, financial responsibility, conflict management, and marriage and Family-life skills. Training products to support the ACE training model include the 'Beyond the Front' and 'Home Front' interactive videos, 'Shoulder-to-Shoulder' video series, and future products approved by the DCS, G–1. For more information, visit <http://www.preventsuicide.army.mil>. Training must be conducted in person and in small groups, to the extent possible, rather than using large groups, video teleconference, or Web-based training.

d. Annually, all Soldiers and leaders (to include Army Civilian leaders) will receive the appropriate ACE training. Completion of training will be documented in the Digital Training Management System and the Individual Training Record. All Army leaders will receive training on the current Army policy toward suicide prevention, suicide-risk identification, and early intervention with at-risk personnel. This includes how to properly refer subordinates to the appropriate helping agency, and how to create an atmosphere within their commands that reduces stigma and encourages help-seeking behavior.

e. Commanders will ensure that Army Civilians are provided annual suicide prevention and awareness training. Civilian supervisors will also receive training that focuses on referral techniques and/or protocols for their employees. Commanders and/or supervisors will ensure that all applicable labor relations requirements are complied with in implementing the suicide prevention training for Army Civilians. Employees may be excused from the Army suicide prevention training by their immediate supervisor if the employee feels that the training is emotionally or psychologically too stressful. Commanders who excuse employees from scheduled training will offer alternative training opportunities (for example, one-on-one review of the training materials, ACE card, and Suicide Prevention Training Tip cards with the assistance of chaplains and ACE or other Army-approved suicide prevention trainers). Training should be coordinated with the local civilian personnel advisory center and completion documented in the Defense Civilian Personnel Data System.

f. 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, Family Readiness Group meetings, spouses meetings, pre and post deployment briefings, and so on). The Army-approved training for Family members is the ACE Suicide Prevention Training for Family members.

g. Specific training modules exist for medical personnel focusing on the review of clinical protocols for responding to crisis situations involving Service members who may be at high risk for suicide, and clinical tracking requirements and protocols for those known to be at increased risk of suicide. Commanders should seek assistance from the SPTF, UMTs, brigade or division BH sections, combat stress control units, or local community BH organizations.

h. ACE–SI is a 4-hour training module for all company-level junior leaders and first-line supervisors to include squad and section leaders, platoon sergeants, platoon leaders, first sergeants, executive officers, company commanders, and Army Civilians assigned at the company level. They are the target audience for ACE–SI. This is a one-time training requirement. The key learning objective is to train the skills required to intervene in a suicide situation.

Documentation of completion of training will be annotated on the Individual Training Record. There is a 6-hour ACE-SI train-the-trainer module for company-level junior leaders and first line supervisors who are command-selected to train the 4-hour module. It consists of the same 4-hour module that all junior leaders and first line supervisors receive as well as a 2-hour module on small group facilitation. Those attending the 6-hour training are selected by commanders from among the population of junior leaders and first line supervisors defined above. Successful completion of the 6-hour module qualifies attendees to train all company-level junior leaders and first line supervisors. Availability of the 6-hour training will be announced periodically by HQDA, G-1 (ASPP).

i. Gatekeepers are individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and Army Civilians in need.

(1) Gatekeepers will receive advanced suicide intervention skills training in recognizing and helping individuals with suicide-related warning signs or risk factors. This is a one-time training requirement, separate from ACE, and its curriculum is determined and authorized by DCS, G-1. Gatekeepers are designated by their commanders and must receive advanced suicide intervention skills training from a qualified gatekeeper trainer. Gatekeepers can be identified either as "primary gatekeepers" (whose primary duties involve assisting those in need who are more susceptible to suicide ideation) or "secondary gatekeepers" (who may have a secondary opportunity to come in contact with a person at risk). See table 4-1 for examples of primary and secondary gatekeepers.

(2) Qualified advanced suicide intervention skills trainers will receive an additional skill identifier (ASI). Individuals may receive an ASI of 1S upon completion of the train-the-trainer course for suicide intervention skills and execution of three workshops in suicide intervention skills.

(3) All officers, second lieutenant through major; all warrant officers; and NCOs up through sergeant first class, are eligible to be awarded the suicide intervention skills trainer ASI 1S (see DA Pam 611-21 for procedural guidance).

j. Chaplains and their assistants in UMTs will assist commanders in providing suicide prevention and awareness training for Soldiers, Army Civilians, and Family members in their respective units and communities. All chaplains and chaplain assistants will receive basic and advanced suicide prevention and/or awareness training as determined by the Chief of Chaplains. Chaplains and UMTs will consult with local BH assets to ensure that information provided to units is scientifically and medically accurate.

k. BH professionals provide health promotion, prevention, and clinical services to address suicidal and self-injurious behaviors. BH professionals also provide UMTs and other installation/community organizations with medically and scientifically supported information on suicide and suicide prevention.

(1) BH professionals will receive training on state-of-the-art techniques and information sources pertaining to suicide prevention. MEDCOM will ensure that uniformed BH professionals receive initial training as part of residency and fellowship programs sponsored by MEDCOM and/or as part of the advanced training portion of the Basic Officer Leadership Course. Army Civilians and contract BH providers will ensure they remain current on suicide prevention information.

(2) Army BH officers will provide the technical expertise for all suicide prevention education and/or awareness training. It is the role of BH officers to train-the-trainers in all suicide prevention programs within the medical community.

l. Commanders will provide suicide prevention training to Family members using chaplains as support trainers and Army-approved Suicide Prevention training. ACS personnel may assist as required. In-service training in suicide prevention for the staffs of ACS, Child and Youth Services, and youth activities will be coordinated by the ACS officer and/or director and may be conducted by BH officers or chaplains. ACS personnel will not be used to conduct suicide prevention training for Army units.

4-8. Family Member Suicide Prevention Program

a. Installation-based Family Member Suicide Prevention Program (FMSPP).

(1) FMSPP will be executed by the installation SPPM in coordination with the CHPC. The FMSPP is intended to promote an understanding of the potential for suicide in the community. The garrison chaplain office will conduct an education awareness program in partnership and support of SPPM and CHPC for Family members to help them recognize the signs of increased suicide risk and to learn about referral sources for friends and Family members. Educational programs will focus on three groups: parents, teenagers, and spouses.

(2) Programs that include suicide prevention content will be coordinated with installation and Army suicide prevention SME. Individuals with suicidal thoughts will not receive crisis intervention services by installation supporting agencies. Crisis intervention by ACS for persons who may be having thoughts of suicide is limited to referrals to the MTF or Community Behavioral Health Service. Agencies will not provide counseling or clinical services to any individual where suicide may be a concern. Such Family members will be referred to the MTF or Community Behavioral Health Service. Persons for whom suicide is not an immediate concern may also be referred to the UMT or the Chaplain Family Life Center.

b. Noninstallation-based FMSPPs are unique in that they must address the needs of units, Soldiers, and Families that are geographically dispersed and not normally in close proximity to Army-based services and support.

(1) The noninstallation-based FMSPP will be coordinated at the local unit level between the commander and the unit

Family Program Coordinator. The SPTF, in conjunction with the state or Army Reserve DRU/MSF Family Program, will provide support as requested. The SPTF, with the support of local unit commanders, will develop memoranda of agreement to leverage community services for crisis intervention and referral and ensure that commands are publicizing these resources to their Soldiers and Families.

(2) The SPTF will ensure that training programs tailored to Families are available and that units have access to qualified trainers to conduct the training. At a minimum, training will include suicide awareness to help recognize signs and symptoms of increased suicide risk and information on referral resources.

4-9. Suicide prevention programs for deployments

a. Deployed unit commanders will address suicide prevention efforts for extended deployments greater than 90 days. This includes incorporating suicide prevention training before, during, and after deployment (see DA Pam 600-24, see deployment cycle support). The additional stress on deployed Soldiers and their Families, separation from available community resources, and possible access to firearms places deployed Soldiers at increased risk. Deployed unit commanders should recognize this risk and take appropriate measures that increase awareness and vigilance, and that build resilience among Soldiers and their Families. This could include coordinating with assigned CSC Teams, which offer classes and practical exercises on combat-stress management and other life skills. Classes are taught by CSC unit BH officers and enlisted specialists in a military (not patient care) atmosphere.

b. Deployed commanders also will adapt existing community-based objectives of the ASPP for deployed Soldiers and units. Strategies of the ASPP will be applied to a forward-deployed force through actions in the following areas: designating proponents to manage the suicide prevention program; ensuring leader and Soldier-peer vigilance; conducting training; ensuring surveillance of completed suicides and suicide attempts; and establishing a command climate that encourages appropriate help-seeking behavior by distressed Soldiers.

c. Unit commanders will provide suicide prevention training to Soldiers before and after authorized absences while deployed (for example, mid-tour and rest and recuperation leaves)

d. Deployed commanders will convene quarterly Suicide Prevention Review boards in theaters at the corps, division task force, and/or joint task force-level headquarters, and report findings, initiatives and best practices to Deputy Chief of Staff, G-1, Army Suicide Prevention Program, 300 Army Pentagon, Washington, DC 20310-0300.

4-10. Army suicide behavior surveillance

a. Army suicide surveillance is crucial to understanding the magnitude of various suicidal behaviors and in identifying trends, factors, and reasons for such behaviors that can be applied to preventive measures. Surveillance will be accomplished through the following:

(1) Serious Incident Report as the primary means of initial notification of all deaths, to include possible suicides, will be sent up the chain of command in accordance with AR 190-45, *Law Enforcement Reporting*.

(2) Investigations conducted to inform determination of death and to support data gathering for analysis.

(a) Active duty suicide determination will be made by the Armed Forces Medical Examiner (AFME). Non-active duty suicide determination will be from local coroners as recorded on the formal death certificate.

(b) Commands from all components will conduct an AR 15-6 investigation into all suspected Soldier suicides in accordance with Army Directive 2010-01. See paragraph 1-31 for commander's responsibilities.

(c) The U.S. Army Criminal Investigation Command (USACIDC) conducts investigations on active duty equivocal deaths to determine if criminal activity was involved. For non-active duty deaths, Criminal Investigation Command has limited legal authority to conduct investigations, but can leverage professional relationships with local authorities where appropriate under the guidelines of AR 195-2, *Criminal Investigation Activities*, to support local commanders in obtaining police reports, coroner's reports, and death certificates.

(d) Line of duty 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 line of duty investigations are conducted in accordance with AR 600-8-4, *Line of Duty Policy, Procedures, and Investigations*.

(e) Commanders from all components will develop and submit a DA Form 7747 to the Office of the Provost Marshal General/Law Enforcement Liaison Officer, on every suicide or equivocal death which is being investigated as a possible suicide. Active duty units are required to submit an initial report within 5 days following a death and all units (to include ARNG and USAR) are required to submit a completed report within 30 days. See DA Pam 600-24 for information on the DA Form 7747.

(f) Psychological autopsies will ascertain the manner of death for active duty deaths only in cases where there is an equivocal manner of death, that is, when the cause of death cannot be readily established as natural, accidental, suicide, or homicide. Only at the request of the involved medical examiner, Criminal Investigation Command investigator, or senior commander through the Armed Forces Medical Examiner (AFME), will psychological autopsies be initiated. Fellowship-trained forensic psychiatrists or psychologists will complete psychological autopsies. Those performing psychological autopsies will provide results to the AFME. Responsible offices within these organizations will review

findings, determine trends, pull data points, and capture and distribute lessons learned. See DA Pam 600–24 for complete instructions for psychological autopsies.

b. The DD Form 2996 is the DOD data collection instrument used for monitoring suicides for all branches of the military. The DD Form 2996 was developed to examine the causes and circumstances of suicide behaviors among military personnel. The DD Form 2996 standardizes the data collected on all suicide events and is an integral part of the ASPP. The DD Form 2996 should be completed for all suicides, suicide attempts, and suicidal ideations which result in hospitalizations. This includes evacuations from theater where the injury or injurious intent is self-directed.

(1) The DODSER project manager is responsible for administering the program for the Army. The DODSER project manager functions within the Behavioral and Social Health Outcomes Program (BSHOP) DODSER cell, which is located within the Army Institute of Public Health, USAPHC. The DODSER project manager is responsible for monitoring both the timeliness and quality of the DD Form 2996s submitted.

(2) Formal requests to complete the DD Form 2996 are sent by the DODSER project manager to DODSER points of contact (MTF commanders) for each AFME confirmed event. Follow-up messages are sent for all events for which a DD Form 2996 is not received within the required 60-day time frame.

(3) For suicide attempts and suicidal ideations resulting in hospitalization, the MTF commander is responsible for ensuring a DD Form 2996 is submitted within the required 30 days time frame.

(4) In the continental United States, each MTF commander will designate and appoint on orders a BH professional to serve as the MTF DODSER point of contact for at least 1 year. Outside the continental United States (ACOM, ASCC, and in forward deployed theaters of operation), the senior medical commander will appoint on orders a BH officer to serve as the DODSER point of contact. For DD Form 2996s completed on RC Soldiers, DD Form 2996 completion is assigned to the nearest MTF at which the Soldier's unit of assignment receives medical care. The point of contact will ensure that the completed DD Form 2996 is submitted to the DODSER project manager via a secure Web site at <https://DODSER.t2.health.mil/>.

(5) In the event an active duty Soldier is admitted to a civilian hospital for serious suicidal ideation or a suicide attempt, the unit commander is responsible for notifying the supporting MTF clinical operations cell during daytime work hours, or the administrative officer of the day during non-duty hours, to inform the leadership of the Soldier's name, rank, social security number, and whether the Soldier was admitted for a suicide attempt or ideation.

(6) In collaboration with the MTF commander, the Chief, BH Services, and the CHPC will monitor the completion of the DD Form 2996. Feedback from the DODSER cell's quality assurance team will be provided to MTF commanders annually or upon formal request. Compliance reports that highlight delinquent DD Form 2996s are issued monthly to MTF command points of contact.

(7) In conjunction with ASPP, data from the preceding investigations and information gathering systems will be collected and maintained by the BSHOP DODSER cell. The BSHOP will analyze the data on a regular basis to provide statistical understanding, identify trends, and formulate lessons learned.

(8) DCS, G–1 will develop strategies to distribute trends and lessons learned back down to commanders in a timely manner. Inputs will be provided to the DODSER database in accordance with protocols established by ASPP and USAPHC.

(9) The 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.

c. In conjunction with ASPP, data from the preceding investigations and information gathering systems will be collected and maintained by the USAPHC BSHOP. The BSHOP will vigilantly study the data for all components on a regular basis to provide statistical understanding, identify trends, and formulate lessons learned. DCS, G–1 will develop strategies to distribute trends and lessons learned back down to commanders in a timely manner. All components will provide input to the database in accordance with protocols established by ASPP and USAPHC.

4–11. Suicide Response Team

a. Each CHPC or SPTF will establish policies and procedures for the implementation of a Suicide Response Team (SRT) for their respective installation or organization. The SRT will consist of chaplains, BH professionals, and other counselors and helping agencies, as appropriate. The SRT will coordinate with any organic BH and chaplaincy assets to respond to any known or suspected suicide occurring in subordinate or tenant organizations by offering additional support to unit commanders, ensuring that proper guidelines are followed for local media coverage, and monitoring completion and submission of appropriate reports as outlined in this regulation. The SRT will never assume tactical control of suicide-response activities for a unit with organic BH or chaplaincy assets.

b. At the discretion of the commander, the SRT will convene within 48 hours of an attempted or completed suicide to support the command and installation affected by a suicide event. As an adjunct to the SPTF, its function is to assist the commander in assessing the situation, determining appropriate courses of action, directing immediate interagency and inter-staff actions, and advising the commander. Team intervention will include taking actions necessary to provide for the immediate welfare of Families who have suffered a suicide or suicide attempt. At a minimum, the SRT should be composed of the following:

(1) The Command Surgeon (for example, brigade, division, and so on).

- (2) The Command Psychiatrist or senior BH officer.
- (3) The battalion or separate company commander.
- (4) A representative of the battalion and/or headquarters Chaplain.
- (5) A representative of the Assistant Chief of Staff, G-1.
- (6) A representative of the Staff Judge Advocate.
- (7) A representative of the Provost Marshal.
- (8) A representative of ASAP.
- (9) A representative of the ACS office.

c. Battalion and separate company commanders will—

(1) Convene the SRT, through the Command Surgeon, when Soldiers within the command are identified as a suicide risk.

(2) Institute procedures within the battalion or company to facilitate the identification, evaluation, and medical evacuation (if necessary), of Soldiers at increased risk of suicide.

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

(4) Coordinate any necessary administrative action required by members of the command who have attempted suicide.

4-12. Responsible sexual behavior

a. Responsible sexual behavior includes—

- (1) The ability to understand and weigh the risks associated with sexual activity.
- (2) Outcomes and impact of sexual actions.
- (3) Being educated on, aware of, and avoiding sexual behaviors that may constitute sexual harassment and/or assault.
- (4) Practicing abstinence when appropriate.

b. Unprotected sexual intercourse places persons at risk for human immunodeficiency virus infection, other sexually transmitted infections, and unintended pregnancy. Unintended pregnancies can be disruptive to unit readiness as well as to the physical, social, and BH of the Soldiers involved. Unintended pregnancy has been identified as a risk factor for child abuse, neglect, low-birth weight, cigarette smoking, alcohol use, and spouse abuse.

c. CHPC will monitor the rates of unintended pregnancies, sexually transmitted infections, and sexual assaults in the community. Using a multidisciplinary approach, CHPC will ensure individuals and groups receive appropriate education and interventions regarding responsible sexual behavior.

d. Commanders and leaders at all levels in all components will—

- (1) Promote and maintain a culture in which responsible sexual behavior is encouraged, supported, and expected.
- (2) Coordinate with the servicing MEDDAC or medical center (MEDCEN) to accomplish education on responsible sexual behavior for personnel under their command.
- (3) Assist the servicing MEDDAC or MEDCEN in developing and implementing responsible sexual behavior education programs for Soldiers, Family members, and other health care beneficiaries in the community.

e. All Soldiers are expected to attend any required training pertaining to responsible sexual behavior.

4-13. Army Substance Abuse Program

ASAP is a comprehensive program conducted to prevent and control substance abuse among Soldiers and their Families through a wide variety of activities, including prevention, identification, education, and rehabilitation services comprised of outpatient treatment. (See AR 600-85.) ASAP interfaces with, and can refer patients to, more intensive resources (for example, hospital treatment programs or residential treatment programs) when the clinical needs of the patient exceed available resources in the outpatient setting.

a. Alcohol and drug abuse are incompatible with Army values and readiness. Commanders will provide the opportunity for rehabilitation to Soldiers identified as alcohol abusers and process them for administrative separation in accordance with AR 600-85 and other applicable administrative regulations.

b. The Risk Reduction Program Coordinator (RRPC) will report Installation Prevention Team meeting results through the CHPC to the senior commander.

c. All levels of the chain of command must take prompt action, regardless of rank or grade of the individual involved, if alcohol or illicit drug use is suspected.

d. Implementation of the ASAP is required for installations, communities, and activities in accordance with AR 600-85.

e. Commanders at every level will ensure that an active and aggressive drug testing program is maintained in their units.

f. Substance abuse policy will be given adequate publicity to ensure that eligible Army Civilians, Family members, and retirees are aware of—

- (1) Command support.
- (2) Available information.
- (3) Referral procedures.
- (4) ASAP rehabilitation services.

g. Enrollment of Army Civilians, Family members, and retirees is voluntary. The commander of the servicing installation or activity is responsible for developing procedures by which Army Civilians may use ASAP facilities and services, namely the Employee Assistance Program.

h. CHPC will assist commanders, supervisors, and health care providers, in coordination with the local ASAP, to provide prevention education for all members of the Total Army Family on the detrimental effects of alcohol and drug abuse on combat readiness and a healthy lifestyle.

i. CHPCs will ensure that ASAP activities are carried out in accordance with guidance provided in this chapter.

4-14. Tobacco Control Program

a. See chapter 7 of this regulation for the Army policy on smoking in the workplace.

b. The use of all forms of tobacco products during initial military training is controlled for Soldiers (see chapter 7).

c. Commanders and supervisors will encourage Family members and retirees to engage in appropriate tobacco-free living activities.

d. As a part of routine physical and dental examinations and at other appropriate times, such as at prenatal and well baby clinics, health care providers will inquire about the patient's tobacco use, including use of smokeless tobacco products, and advise the patient of risks associated with use, the health benefits of abstinence, and where to obtain help to quit, such as the MEDCOM Web site concerning management of tobacco use at <https://www.qmo.amedd.army.mil/smoke/smoke.htm>. This includes the health risks associated with second and third hand smoke. Second hand smoke includes all incendiary effects of burning tobacco, such as the release of carcinogens into the air. Third hand smoke includes the contamination of objects such as skin and clothing caused by the aerosolized release of toxins and other by-products during the burning of tobacco.

e. Installations will provide tobacco cessation programs for all health care beneficiaries and, as resources permit, for Army Civilian employees. If not available through military MTFs, commanders will coordinate programs through local community resources, such as the American Cancer Society and the American Lung Association, after consulting with their appropriate legal advisor. To the extent possible, occupational health clinics will provide tobacco cessation programs for Army Civilians. If such programs are not feasible at a particular installation, the occupational health clinic will refer civilian employees seeking such a program to local community resources.

4-15. Domestic violence prevention

The program aspects of FAP will be addressed through the Family Advocacy Committee and meetings will be scheduled at least quarterly to—

a. Provide recommendations for FAP programs and procedures.

b. Facilitate an integrated community approach through the CHPC.

c. Recommend new resources and programs needed.

d. Identify long-range, intermediate, and immediate FAP needs and initiate action for their implementation, to include addressing corrective action plans to comply with DOD 6400.1-M. CHPCs will ensure domestic violence prevention activities are carried out in accordance with guidance provided in AR 608-18.

Chapter 5 Physical Health

5-1. General

The aspects of physical health and wellness have direct implications on Soldier readiness, warfighting ability, and work performance. The physical dimension encompasses the areas of physical fitness and health, injury prevention, ergonomics, oral health, nutrition, and weight control. CHPC will recommend, coordinate, and ensure the integration of physical health and wellness programs for units, Soldiers, Army Civilians, and Family members in their areas of responsibility.

5-2. Fitness and Health Program

a. *Physical fitness.* Physical fitness is defined as a set of attributes an individual must have or achieve that relates to the ability to perform physical activity. Guidance on Soldier physical fitness is provided in AR 350-1 and FM 7-22.

b. *Physical fitness and performance.* Critical components of physical fitness related to Soldier performance are muscular strength and endurance; aerobic and anaerobic conditioning and endurance; mobility (agility, balance, coordination, flexibility, posture, power, speed, and stability); body composition; and a healthy lifestyle.

c. Department of the Army Civilians.

(1) Civilians employed by the Army are encouraged to engage in a regular program of exercise and in other positive health habits.

(2) For employees in occupations that require physical strength and stamina for satisfactory performance (such as a firefighter), a physical exercise program may be part of their jobs and may be conducted during duty hours.

(3) Subject to mission requirements, commanders and/or supervisors may approve up to 3 hours of administrative leave per week (not to exceed 6 consecutive months) to participate in a command-sponsored formal training program that includes physical fitness, health assessments and/or evaluations, and education on nutrition and exercise principles.

(4) While formal physical fitness training may recur in an organization's schedule, employees will not be given administrative leave for physical exercise training once they have already received such training. This excused absence is limited to one time only and does not apply to other types of training or professional development. (See Employee Wellness Program, Civilian Personnel On-line, <http://cpol.army.mil/library/permis/593.html>.)

(5) Beyond the situations described above, work schedules may be adjusted to permit health promotion education training and exercise where possible and when it is consistent with the workload and mission.

d. Community Health Promotion Councils. CHPCs will assist in coordination efforts for planning, implementing, and evaluating civilian fitness programs.

e. Use of physical fitness and recreation facilities.

(1) Garrison Commanders will establish and sustain programs and infrastructure that enable unit leader initiatives that promote physical fitness and resilience for individual Soldiers, units, and Family members. A comprehensive approach will support robust intramural sports, field training exercises, combatives, foot marches, and fun runs/walks.

(2) Commanders may use appropriated fund contracts for organizational memberships in local commercial or municipal fitness facilities only as prescribed in AR 215-1 and relevant fiscal funding authorities.

(3) Civilians are encouraged to engage in a healthy lifestyle and take advantage of the many opportunities to maximize their physical fitness, health, and well-being.

(4) As an inherent responsibility of command, commanders may establish the priority between Soldiers, Army Civilians, and Family members for the use of physical fitness facilities, consistent with resource availability, mission, and training requirements. Policies discussed in this paragraph apply to those minimally essential facilities whose primary purpose is physical fitness. They do not apply to those designed principally for community recreation activities such as bowling alleys, golf courses, and tennis courts.

f. Fitness and health promotion programs. Integration of fitness and health promotion programs through collaborative efforts enhances the effectiveness and efficiency of physical fitness programs. The CHPC will encourage and assist health professionals and fitness and/or sport personnel in the integration of programming efforts to alleviate duplication and broaden physical fitness opportunities for community personnel.

5-3. Injury prevention

Accidental and overuse injuries to the musculoskeletal system are the single leading cause of lost workdays and physical profiles in the Army and, as such, have a significant impact on the readiness and deployability of the force. The unit commander is the critical agent for injury prevention and is responsible for establishing interventions and monitoring their effect. The CHPC will support commanders by recommending, coordinating, and ensuring the integration of injury prevention programs for units, Soldiers, Army Civilians, and Family members in their area of responsibility. The MTF and safety professionals will provide SME consultation in support of unit leadership, which has decision-making authority over the root causes of injury.

a. Unit commanders will—

(1) Foster a culture of injury risk reduction in all aspects of physical work, physical and military training, and unit mission essential task accomplishment.

(2) Coordinate with the supporting medical officer, safety officer, and the medical and/or dental treatment facility commander to receive SME consultation (such as from physicians and nurse practitioners, physician assistants, physical and occupational therapists, and dentists) regarding all unit staff functions related to injury prevention (such as unit health, medical, and dental readiness meetings; occasional monitoring of physical and military training; appropriate use of mouth guards, and so on).

(3) Identify and assess training and/or mission hazards of physical and occupational training as they relate to musculoskeletal injury, develop and implement prevention interventions, and evaluate their effectiveness in accordance with the risk management process of ATP 5-19.

(4) Ensure Soldiers receive physical training appropriate to their levels of physical conditioning, and follow a gradual progression of physical training as outlined in FM 7-22 and in the Standardized Physical Training (SPT) Program for initial military training in order to avoid injury. Although the SPT program is specific to initial military training, the principles are applicable to operational units conducting physical training.

(5) Assume responsibility for outcomes of physical training programs by monitoring unit injury profiles as well as unit physical fitness.

(6) Focus on achieving greater unit physical readiness by emphasizing improvements in the Army physical fitness test pass rate rather than the unit average.

(7) Monitor physical profiles and enforce activity restrictions imposed.

(8) Ensure Soldiers at high risk for injuries are monitored. Ensure those with musculoskeletal complaints or exhibiting signs of injury receive prompt medical attention and have access to resources that will enable directed or self-treatment of injuries.

b. The MTF commander will support the unit commander by providing medical officers and SMEs who will—

(1) Understand the commander's mission goals relevant to physical performance, and advise the commander on practical alternatives to current physical training practices when they place Soldiers at increased risk for musculoskeletal injury.

(2) Educate unit commanders and other leaders on injury risk factors, potential interventions to reduce them, how to recognize the early signs and symptoms of musculoskeletal injuries, and self-treatment techniques.

(3) Assist commanders in analyzing sick call and profile rates, injury incidence, and trends; advise commanders of changes in the health status of the command and interventions to reduce injury rates.

(4) Provide liaison services between command and medical personnel to interpret or clarify any health care treatment ambiguities and coordinate with health providers issuing physical profiles when uncertainties arise.

(5) Provide direct medical oversight and consultation to unit officers responsible for physical training.

5-4. Ergonomics

a. Ergonomics is the field of study that seeks to prevent work-related injuries by fitting the job to the person, rather than the person to the job. Ergonomics involves the evaluation and design of workplaces, environments, jobs, tasks, equipment, and processes in relationship to human capabilities and interactions in the workplace.

b. An integrated ergonomics program works to prevent work-related musculoskeletal injuries or illnesses of the muscles, tendons, ligaments, peripheral nerves, joints, cartilage (including intervertebral discs), bones and/or supporting blood vessels in the upper or lower extremities, back, or neck. These injuries are associated with exposure to ergonomic risk factors such as repetitive, forceful, or prolonged exertions; frequent heavy lifting; pushing, pulling, or carrying heavy objects; a fixed or awkward work posture; contact stress; localized or whole-body vibration; cold temperatures; and poor lighting. These workplace risk factors can be intensified by work organization characteristics including inadequate work-rest cycles, excessive work pace and/or duration, unaccustomed work, lack of task variability, machine work, and piece rate.

c. Ergonomics programs are included in the installation Safety and Occupational Health Program, in accordance with AR 40-5. At a minimum, ergonomic programs will—

(1) Interface with existing programs

(2) Include a written plan with goals and objectives.

(3) Address the five critical program elements—workplace analysis, hazard prevention and control, health care management, education and training, and program evaluation. The degree of emphasis on each critical program element will vary according to the hazards and concerns at each installation.

(4) Assist in procurement initiatives to ensure ergonomic design criteria are considered.

5-5. Oral health

a. Oral health promotion includes all initiatives to increase the overall fitness and dental readiness of Soldiers, reduce the incidence of dental disease in the community, identify community members in need of dental treatment, and direct them to sources of appropriate care. It expands the traditional dental program by—

(1) Requiring a minimum level of dental health for active duty Soldiers (DRC 2) and encouraging Soldiers to attain and maintain dental wellness (DRC 1).

(2) Providing information to the community concerning the dental insurance program for Family members and RC dental care.

(3) Using the dental data from the Medical Protection System (MEDPROS) and the Corporate Dental System as a tool to help evaluate community oral health.

(4) Integrating hypertension screening and tobacco use counseling into dental examinations and treatment plans.

b. There are three oral health programs: Army Dental Readiness Program, Clinical Oral Health Promotion and Disease Prevention Program, and the Community Oral Health Promotion and Disease Prevention Program.

(1) *Dental Readiness Program.* The Dental Readiness Program described in AR 40-35, is designed to ensure that Soldiers maintain optimum oral health and do not lose valuable personal or unit time due to preventable dental disease or orofacial injuries.

(a) Each active duty Soldier is required to receive an annual dental examination. Results of the examination are used to establish a DRC, which is monitored by the Soldier's unit through the MEDPROS. Commanders will encourage Soldiers to attain and maintain DRC 1 (dental wellness) and ensure that Soldiers receive examinations and required treatment to maintain at least a DRC 2.

(b) A brief description of DRCs follows; the complete description is found in AR 40–35.

1. *DRC 1.* Patients with a current dental examination who do not require dental treatment or reevaluation.
2. *DRC 2.* Patients with a current dental examination who have an oral condition that requires treatment or reevaluation, but is unlikely to cause a dental emergency within 12 months.
3. *DRC 3.* Patients who are likely to have a dental emergency within 12 months.
4. *DRC 4.* Patients who require a dental examination, or whose dental status is unknown. DRC 4 patients normally are not considered to be worldwide deployable.

(c) Unit commanders will require and enforce mouth guard use during the following training: pugil stick, bayonet and/or rifle, obstacle and/or confidence course, and hand-to-hand combat. Commanders will require mouth guard use during physical training or unit sports activities that may involve injury to the face or mouth as a result of head-to-head contact, falls, tooth clenching, or blows to the mouth.

(d) Commanders will emphasize Soldier responsibility for maintaining dental readiness (DRC 1 or 2). In accordance with AR 600–20, chapter 5, a commander may take administrative or punitive action against Soldiers who refuse to have a dental examination or complete treatment for a DRC 3 condition.

(2) *Clinical Oral Health Promotion and Disease Prevention Program.* Clinical preventive services in this program include oral prophylaxis, fluoride prescription, and counseling on individual oral hygiene, nutrition, and tobacco cessation, as appropriate. Dentists should refer Soldiers to a registered dietitian (RD) for nutrition counseling when appropriate. The following screenings will also be incorporated into initial, periodic, and comprehensive evaluations:

- (a) Hypertension screening, referral, and follow-up.
 - (b) Tooth decay, tobacco, periodontal, and oral cancer risk assessment.
 - (c) Skin and lip cancer assessment.
 - (d) Orofacial injury risk assessment and mouth guard fabrication.
 - (e) Detection of signs of Family abuse and neglect.
- (3) *Community Oral Health Promotion and Disease Prevention Program.* Contents of the program include—
- (a) Support for the fluoridation of community water supplies.
 - (b) Alternative fluoride administration (supplement or fluoride varnish) to Family members by health care providers such as physicians and nurses.
 - (c) Community education programs coordinated through partnerships with the local medical and installation communities to promote oral health to a broad audience.
 - (d) School-based programs established through a cooperative arrangement with on- or off-post schools that have a significant proportion of military dependent children in the area of responsibility. Activities may include an oral screening examination (with parental consent) and comprehensive, age appropriate oral health instruction. Instruction should include brushing, flossing, diet counseling, and the appropriate use of fluorides. Sports safety (mouth guards), tobacco interdiction, sealants, and sun safety are also recommended as part of the health promotion message when suitable.
 - (e) Establishment of a system for reporting child neglect or abuse to the local FAP reporting point of contact, in accordance with AR 608–10.
 - (f) Nutrition environment assessment to ensure the availability of healthy food, snack and beverage choices. Access to foods rich in protein, fiber, calcium, magnesium, B vitamins and zinc, and decreased exposure to foods, beverages or snacks that contain refined carbohydrates and polybasic organic acids is essential for maintaining Soldier fitness and oral health.
 - (g) Deployed Environment Dental Readiness Threat Assessment conducted by deployed dentist in coordination with preventive medicine and dietitian to ensure that Soldiers have opportunities to perform oral hygiene at least twice per day, access to healthy food, beverages or snacks, and familiarity with stress management techniques that do not harm oral health.
- c. The proponent for oral health will ensure that community oral health promotion activities are carried out in accordance with guidance provided in this chapter.
- d. The senior commander and/or CHPC may designate a process action team to review oral health promotion activities for the community. If a process action team is designated, care must be taken to ensure that its membership reflects a cross-section of the CHPC membership as a whole and is not limited solely to dental assets.

5–6. Promotion of nutritional fitness.

Proper fueling and healthful eating are crucial elements to ensure Soldier readiness and peak performance.

a. *Good nutrition.* Good nutrition is important for promoting health and reducing chronic disease. Good health involves balancing proper eating habits with physical fitness and activity from an early age to ensure healthy lifestyle habits are inherently prioritized. The CHPC will recommend, coordinate, and ensure the integration of nutrition education programs for units, Soldiers, Army Civilians and Family members in their area of responsibility.

b. *Nutrition professionals.*

- (1) RDs and other qualified personnel develop nutrition education curriculum for military treatment facilities, the

DOD worksite, and military food service occupational specialty curriculum using a variety of applicable applications. RDs are skilled providers, trained and proficient in practical application of nutrition science to individual lifestyles and food choices, and in techniques of nutrition education and medical nutrition therapy.

(2) Other personnel (for example, health care providers, health educators, and nutrition care specialists), when given appropriate training, may provide nutrition education. This will not include nutrition counseling, which is a component of medical nutrition therapy.

c. Standards of practice.

(1) Military Dietary Reference Intakes, prescribed in AR 40–25, provide guidelines and standards for feeding healthy Soldiers. They are intended for use by personnel involved in menu planning, dietary evaluation, nutrition education and research, and food research and development.

(2) The primary care provider and dental care provider will refer Soldiers to a RD for nutrition counseling when appropriate.

(3) CHPCs will utilize approved standardized tools that initiate collaborative efforts to engage stakeholders, assess the eating environment, identify opportunities for improvement, and implement and evaluate targeted interventions on an annual basis. The council will ensure educational programs are offered to meet communities' assessed nutritional health needs, while promoting necessary lifelong behavioral changes to maintain optimal health and wellness.

(4) Food advisors and food service managers will comply with the basic nutritional standards for installation dining facilities, in accordance with AR 30–22, which provides guidance for meeting nutrition standards in dining facilities and ensuring compliance with AR 40–25.

(5) Commanders will ensure that a RD is an active member of the CHPC.

(6) Military Nutrition Environment Assessment Tool (m-NEAT) will be utilized to measure the accessibility to healthy food options Army installations and prioritize changes to improve healthy eating

5–7. Body composition management

a. Weight status categories. Body Mass Index (BMI) is a useful measure of overweight and obesity. It is calculated using height and weight and is a good gauge for determining risk for chronic disease associated with weight. Any BMI not within the normal range increases risk for disease and conditions associated excess weight.

(1) *Underweight.* Adults with a BMI less than 18.5 are at risk for compromised health and performance. This indicates a low weight and has been associated with amenorrhea (women), bone loss, malnutrition, and other conditions.

(2) *Normal weight.* Adults with a BMI ranging from 18.5 to 24.9 are considered at a normal weight.

(3) *Overweight and obese.* Adults with a BMI ranging from 25 to 29.9 are classified as overweight and those with a BMI greater than 30 are considered obese. These individuals have increased risk for Type 2 diabetes, heart disease, high blood pressure, stroke, gallstones, breathing problems, sleep apnea, and certain forms of cancer. The higher the BMI, the higher the risk.

b. Army Body Composition Program.

(1) Soldiers are responsible for complying with body composition standards in accordance with AR 600–9. Soldiers who exceed body fat standards may be subject to adverse administrative action.

(2) Guidance for medical personnel and commanders to assist Soldiers in body composition management is found in AR 600–9.

(3) A standardized, comprehensive body composition management program is available at the MTF to support requirements of AR 600–9.

(4) Soldiers who greatly exceed or fall extremely below body composition standards may be at risk for compromised health, duty performance, and readiness. They should be referred to the appropriate clinic resources for medical and psychological evaluation and/or a RD to provide guidance on energy balance and nutrition requirements to achieve a healthy body composition.

Chapter 6 Spiritual Fitness

6–1. General

A spiritually fit person recognizes that there are multiple dimensions that make up a human being and seeks to develop the total person concept. This includes enhancing spiritual fitness through reflection and practice of a lifestyle based on personal qualities needed to sustain one during times of stress, hardship, and tragedy. When a person's actions deviate from his or her stated values, then the person may experience inner conflict. This person struggles for integrity and congruity, but cannot find inner peace until he or she deals with this struggle. The extent to which this is accomplished is a measure of spiritual fitness.

6-2. Spiritual fitness

a. Commanders at all levels will encourage and provide for human self-development activities leading to increased spiritual fitness in accordance with this regulation, AR 600-20, AR 165-1, Comprehensive Soldier and Family Fitness and other applicable directives.

b. Army leaders should develop an awareness of the lifestyles, cultural backgrounds, stages of development, possible relationships to religious beliefs, and the needs of their Soldiers, Army Civilians, and Family members. The CHPC will recommend, coordinate, and ensure the integration of spiritual fitness programs for units, Soldiers, Army Civilians, and Family members in their area of responsibility.

c. Commanders at the installation, state JFHQ, DRU and/or MSC, and community level will develop Soldier and Family support activities to undergird, reinforce, and implement the enhancement of spiritual fitness. They will ensure time is scheduled for activities, programs, and training to accomplish the goals of spiritual fitness programs.

d. In providing for self-development activities, commanders and other leaders must ensure they do not favor one form of religion over another. The practice of religion, to the extent that it relates to spiritual fitness, must be left to the sole discretion of the Soldier, Army Civilian, and Family member. They must be free to worship or not worship as they choose without fear of being disciplined or stigmatized for their choice.

e. All Soldiers and Army Civilians are expected to live by the tenets of the professional Army ethic and those individual values that support and sustain the Army core values.

f. Chaplains assigned to a unit or MTF are SMEs that can provide religiously informed spiritual guidance to Soldiers, Army Civilians, and Family members upon request.

Chapter 7 Environmental Health

7-1. General

a. The overall mission of environmental health programs is to create and maintain a supportive, safe, and healthy environment. This is accomplished through two primary mechanisms. First, environmental health programs strive to achieve and sustain health-enhancing human environments that are protected from biological, chemical, and physical hazards, and are secure from the adverse effects of environmental threats. Programs in this category include but are not limited to air quality, water quality (including fluoridation), toxic management and pesticide use, and a wide range of workplace health and safety issues. Second, environmental health is promoted through proactive public health policies that reduce risk from environmental exposures and encourage healthy lifestyles. Programs in this category include but are not limited to tobacco control practices and policies governing morale, welfare, and recreational (MWR) facilities, such as hours of operation. Environmental health programs and services will be provided according to detailed implementing instructions and guidance published in DA Pam 40-11.

b. The CHPC will recommend, coordinate, and ensure the development and integration of appropriate environmental health programs and policies for units, Soldiers, Army Civilians, and Family members in their communities.

7-2. Guidance for controlling tobacco use in Department of the Army-controlled areas

a. Using tobacco products (to include cigarettes, cigars, cigarillos, smokeless tobacco and/or electronic cigarettes, inhaled tobacco, and all other tobacco products designed for human consumption) harms readiness by impairing physical fitness and by increasing illness, absenteeism, premature death, and health care costs. Readiness is enhanced by promoting the standard of a tobacco-free environment that supports abstinence from, and discourages the use of, any tobacco product.

b. Full cooperation of all commanders, supervisors, Soldiers, and Army Civilians is expected to ensure people are protected from the harmful effects of tobacco products.

c. All organizational elements, to include Active Army, Reserve Components, and Army Civilian personnel, that occupy space in or on conveyances, offices, buildings, or facilities over which DA has custody and control will comply with Army policy and guidance. This includes space assigned to the Army by the General Services Administration or space contracted from other sources.

d. This policy does not cancel or supersede other instructions that control the use of tobacco products because of fire, explosion, or other safety considerations.

7-3. Policy for controlling tobacco use

a. Tobacco use is prohibited in all DA-occupied workplaces except for designated smoking areas. The workplace includes any area inside a building or facility over which DA has custody and control, and where work is performed by military personnel, civilians, or persons under contract to the Army.

(1) Notices will be displayed at entrances to buildings and facilities over which DA has custody and control that

state that smoking is not allowed except in designated smoking areas. Designated smoking areas must comply with the provisions of the CFR.

(2) If possible, designated outdoor smoking areas will provide a reasonable measure of protection from the elements. However, the designated areas will be at least 50 feet from common points of entry/exit and will not be located in areas that are commonly used by nonsmokers.

(3) Use of all tobacco products is prohibited in all military vehicles and aircraft, and in all official vans and buses.

b. The use of any tobacco products during initial entry training is governed by TRADOC Regulation 350–6. Cadre and faculty of any military school will not use tobacco products in the presence or view of students while on duty. All personnel attending training provided by the Army, regardless of Service, will adhere to Army policy regarding the use of tobacco products.

c. Smoking is not permitted in common spaces of multiple housing areas such as Family housing apartments, unaccompanied personnel housing, unaccompanied personnel housing permanent party, Army lodging, and other Army-operated hotels and recreational lodging. Common space is defined as any space within a building that is common to occupants and visitors. These areas include, but are not limited to, corridors, laundry rooms, lounges, stairways, elevators, lobbies, storage areas, and restrooms.

d. Health care personnel will not use any tobacco products during the duty day or while in uniform. Moreover, in addition to the prohibitions contained in paragraph 7–3a above, use of tobacco products is prohibited on or within medical campuses as established in this regulation.

e. Installation commanders and medical activity commanders will cooperate to establish and enforce tobacco free medical campuses (TFMCs) that include:

(1) Any property or non-residential building that is operated, maintained or assigned to support medical activities, including but not limited to hospitals, medical laboratories, outpatient clinics (including medical, dental, and veterinary facilities), or aid stations operating for the primary purpose of delivering medical care and services for DOD eligible beneficiaries and /or meeting the mission of the Army Medical Command.

(2) All other facilities in which medical activities or administration take place.

(3) All internal roadways, sidewalks and parking lots.

(4) All sidewalks, parking lots and grounds external but adjacent to the building or related to the migratory corridors surrounding the medical facility.

f. Where it represents a change in the past practice or working conditions, full enforcement of this subparagraph must be preceded by compliance with all applicable collective bargaining obligations.

g. Use of tobacco products by students is prohibited on the grounds of DOD Education Activity schools over which DA exercises control, except as provided for by the Director, DOD Education Activity. Visiting adults, faculty, and staff may use tobacco products out of the presence or view of students in tobacco-use areas designated in accordance with this policy.

h. Use of tobacco products is prohibited in and at all Child and Youth Services facilities and sports fields, except in designated areas out of the presence or view of children and youth.

i. Smoking policy specific to MWR and Army lodging facilities is addressed in AR 215–1. MWR facilities include fitness and recreation centers, Armed Forces Recreation Center hotels, cabins and campsites, clubs, and bowling centers.

j. Smoking is prohibited where it presents a safety hazard, such as at firing ranges, ammunition storage areas, fuel dumps, motor pools, and equipment maintenance shops.

k. Users of tobacco products will not be allowed additional time beyond routine breaks to be away from their jobs for tobacco breaks. Supervisors will monitor their workers and initiate appropriate administrative action if workers are noncompliant with applicable regulations and negotiated agreements.

l. If the conditions of employment for bargaining unit members are affected by this policy, installation commanders will begin negotiations as soon as practical with unions. Changes in tobacco use policies that impact on bargaining unit members affect their conditions of employment. Management is obligated to bargain over changes in conditions of employment before implementing this regulation, as it pertains to civilian bargaining unit members.

m. Smoking is permitted in individually-assigned Family and unaccompanied personnel housing living quarters, as long as the quarters do not share a common heating, ventilating, and air conditioning system. Smoking will be allowed in quarters with common heating, ventilating, and air conditioning systems only if an air quality survey can establish that the indoor air quality protects nonsmokers from environmental tobacco smoke. The American Society of Heating, Refrigeration, and Air Conditioning Engineers have established that 20 cubic feet per minute per person of outside fresh air is required. The carbon dioxide level should not exceed 1000 parts per million. When individual living quarters are not required or are not available, and two or more individuals are assigned to one room, smoking preferences will be a determining factor during the assignment of rooms. The installation commander will provide affirmative procedures to reassign nonsmokers to living space that is not occupied by a smoker and, if necessary, reassign smokers to living space where they may smoke without inflicting harm or inconveniencing those who do not smoke.

n. Health education classes regarding the use of tobacco products and its related health problems will be provided

throughout professional military training. Classes will be offered during basic and advanced courses for enlisted and officer (warrant and commissioned) Soldiers.

a. Installations will provide tobacco use cessation programs for all health care beneficiaries. If not available through MTFs, commanders will coordinate programs through local community resources, such as the American Cancer Society and American Lung Association. To the extent possible, occupational health clinics will provide tobacco use cessation programs for Army Civilians. If such programs are not feasible at a particular installation, the occupational health clinic will refer Army Civilians seeking such a program to local community resources.

7-4. Signs for controlling tobacco use

a. Commanders are authorized to continue using locally manufactured signs already reproduced or posted until updated signs are available.

b. If locally manufactured signs are not in use, DA Form 5560 (No Smoking Except in Designated Smoking Areas) and DA Form 5560-1 (Designated Smoking Area) will be used for restricting tobacco use. These forms are available electronically on the Army Publishing Directorate (APD) Web site.

c. DA Form 5560 may be enlarged for use as a highway-type sign at the entrance to installations and activities.

7-5. Enforcement for controlling tobacco use

Failure to comply with the prescribed policy subjects all Soldiers, Family members, retirees, and Army Civilian personnel to a variety of penalties, dependant on the nature of the violation, the status of the offender, and other relevant factors. Violation of Army policies subjects military personnel to a variety of possible administrative or disciplinary actions and it subjects civilian personnel to possible disciplinary actions. Repeat violations may result in the removal of personnel from activities or barring them from activities' MWR facilities and youth activity centers or installations.

Chapter 8 Survivor Outreach Services

8-1. General

Survivor Outreach Services (SOS) is under the auspices of the IMCOM G-9. SOS is an Army-wide program designed to provide dedicated, ongoing, comprehensive support to survivors of deceased Soldiers, to include those who experience loss due to suicide. The program is a joint effort, with collaboration among IMCOM, the Casualty and Mortuary Affairs Operation Center, the ARNG and USAR, Office of the Chief of Chaplains, DCS, G-1, Office of The Judge Advocate General, and Office of The Surgeon General.

8-2. Framework

a. SOS standardizes casualty services and policies across the Army and provides additional staffing at Casualty Assistance Centers and Active Army and RC Family programs. SOS responds to the need for specialized staff at Casualty Assistance Centers to help Casualty Assistance Officers support survivors, as well as adding additional staff whose sole mission is to provide continuing support to survivors.

b. An advisory panel acts as the advocate for survivors and advises senior leadership on the resolution of issues impacting surviving Families. The panel is chaired by the IMCOM G-9. SOS services are available to all survivors and are available until the survivor desires to discontinue services. Furthermore, the SOS Advisory Panel will partner with nonprofit agencies to augment services, assist with legislative issues, and increase awareness of issues impacting surviving Families.

Appendix A References

Section I Required Publications

Unless otherwise stated, all publications are available at <http://www.apd.army.mil/>.

AR 30-22

Army Food Program (Cited in para 5-6c(4).)

AR 40-5

Preventive Medicine (Cited in para 5-4c.)

AR 40-25

Nutrition and Menu Standards for Human Performance Optimization (Cited in paras 5-6c(1), 5-6c(4).)

AR 40-35

Dental Readiness and Community Oral Health Protection (Cited in paras 1-31q, 5-5b(1), 5-5b(1)(b).)

AR 165-1

Army Chaplain Corps Activities (Cited in paras 1-32e, 6-2a.)

AR 215-1

Military Morale, Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities (Cited in paras 5-2e(2), 7-3i.)

AR 350-1

Army Training and Leader Development (Cited in paras 1-16a, 1-31z, 4-7, 5-2a.)

AR 600-20

Army Command Policy (Cited in paras 1-25f, 5-5b(1)(d), 6-2a.)

AR 600-85

The Army Substance Abuse Program (Cited in paras 1-25g, 4-13, 4-13a, 4-13d.)

AR 608-10

Child Development Services (Cited in para 5-5b(3)(e).)

ATP 5-19

Risk Management (Cited in paras 1-6c, 5-3a(3).)

DA Pam 600-24

Health Promotion, Risk Reduction, and Suicide Prevention (Cited in paras 1-20d, 1-21d, 1-24l, 1-26c, 1-30j, 1-31m, 2-4b, 2-5d, 4-4a(3), 4-5a(5), 4-6c, 4-7, 4-9a, 4-10a(2)(e), 4-10a(2)(f).)

FM 7-22

Army Physical Readiness Training (Cited in paras 5-2a, 5-3a(4).)

HQDA EXORD 110-13

Ready and Resilient Campaign Plan (Available at <http://www.army.mil/readyandresilient> (common access card required).) (Cited in para 1-23.)

Section II

Related Publications

A related publication is a source of additional information. The user does not have to read a related reference to understand this publication. DOD publications are available at <http://www.dtic.mil/whs/directives/>.

Army Directive 2010-01

Conduct of AR 15-6 Investigations into Suspected Suicides and Requirements for Suicide Incident Family Briefs

AR 11-2

Managers' Internal Control Program

AR 15-1

Committee Management

AR 15-6

Procedures for Investigating Officers and Boards of Officers

AR 25-30

The Army Publishing Program

AR 40-501

Standards of Medical Fitness

AR 190-45

Law Enforcement Reporting

AR 195-2

Criminal Investigation Activities

AR 385-10

The Army Safety Program

AR 600-8-4

Line of Duty Policy, Procedures, and Investigations

AR 600-8-101

Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing)

AR 608-1

Army Community Service Center

DA Pam 40-11

Preventive Medicine

DA Pam 40-21

Ergonomics Program

DA Pam 600-8-101

Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing)

DA Pam 611-21

Military Occupational Classification and Structure

DODD 1010.10

Health Promotion and Disease/Injury Prevention

DODD 6025.18

Privacy of Individually Identifiable Health Information in DOD Health Care Programs

DODI 6055.1

DOD Safety and Occupational Health (SOH) Program

DODI 6490.03

Deployment Health

DODI 6490.12

Mental Health Assessments for Service Members Deployed in Connection with Contingency Operations

DSM

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

National Prevention Strategy

America's Plan for Better Health and Wellness, June 2011 (Available at <http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf>.)

TRADOC Regulation 350–6

Enlisted Initial Entry Training Policies and Administration (Available at <http://www.tradoc.army.mil/tpubs/regndx.htm>.)

Veterans Affairs/DOD Clinical Practice Guideline

Treating Tobacco Use and Dependence (Available at <http://www.oqp.med.va.gov/cpg/cpg.htm>.)

2012 National Strategy for Suicide Prevention

Goals and Objectives for Action (Available at <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html>.)

Section III

Prescribed Forms

Unless otherwise indicated, DA Forms are available on the APD Web site (<http://www.apd.army.mil>), and DD Forms are available on the Office of the Secretary of Defense Web site (<http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm>).

DA Form 5560

No Smoking Except in Designated Smoking Areas (Prescribed in para 7–4.)

DA Form 5560–1

Designated Smoking Area (Prescribed in para 7–4.)

DD Form 2996

Department of Defense Suicide Event Report (Prescribed in para 1–30*j*.)

Section IV

Referenced Forms

Unless otherwise indicated, DA Forms are available on the APD Web site (<http://www.apd.army.mil>), and DD Forms are available on the Office of the Secretary of Defense Web site (<http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm>).

DA Form 11–2

Internal Control Evaluation Certification

DA Form 2028

Recommended Changes to Publications and Blank Forms

DA Form 7747

Commander's Suspected Suicide Event Report

DD Form 2795

Pre-Deployment Health Assessment (The form is completed on-line in Service-specific systems. Individuals will receive instructions and gain access to the appropriate system at the time of their assessment.)

DD Form 2796

Post-Deployment Health Assessment (PDHA) (The form is completed on-line in Service-specific systems. Individuals will receive instructions and gain access to the appropriate system at the time of their assessment.)

DD Form 2900

Post-Deployment Health Re-Assessment (PDHRA) (The form is completed on-line in Service-specific systems. Individuals will receive instructions and gain access to the appropriate system at the time of their assessment.)

Appendix B Internal Control Evaluation

B-1. Function

The function covered by this evaluation is the Army Health Promotion Program.

B-2. Purpose

The purpose of this evaluation is to assist commanders and program managers at all levels and their staffs in evaluating the key internal controls outlined below. It is intended as a guide and does not cover all controls.

B-3. Instruction

Answers must be based on the actual testing of key 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. These key internal controls must be formally evaluated every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2 (Internal Control Evaluation Certification).

B-4. Test questions

- a.* Has the proponent collaborated with the Chief Public Affairs for advice and support in developing the Communication Annex (or Appendices) to the base plan?
- b.* Has the proponent consulted with the Public Affairs Office to integrate and synchronize plan execution with other Public Affairs activities?
- c.* Has a SPPM been appointed at the IMCOM, ARNG, and USAR levels, to provide assistance for the execution of ASPP, and to serve as a liaison to the DCS, G-1 and supported ACOM, ASCC, and DRU SPPMs?
- d.* Has a SPPM been appointed by the ACOM, ASCC, and DRU commanders to provide assistance for, and staff supervision of, the ASPP?
- e.* Has a suicide prevention plan been developed and implemented by ACOM, ASCC, and DRU commanders?
- f.* Has each senior commander established a CHPC?
- g.* Have commanders at all levels developed a health promotion policy that includes suicide prevention?
- h.* Have provisions been implemented by commanders to ensure that Soldiers identified with suicide-risk symptoms and behaviors are not belittled, humiliated, or ostracized by other Soldiers?
- i.* Does the SPPM administer suicide prevention for both military and Army Civilians, serve as the presiding officer of the SPTF, and track suicide prevention training?
- j.* Is the appropriate ACE suicide prevention training administered annually to all Soldiers, leaders, and Army Civilians and made available to Family members?
- k.* Is a DA Form 7747 developed for every suicide or equivocal death which is being investigated as a possible suicide?

B-5. Supersession

This evaluation is the initial internal control evaluation for the Army Health Promotion Program.

B-6. Comments

Help make this a better test for evaluating internal controls. Submit comments to Deputy Chief of Staff, G-1 (DAPE-HRI), 300 Army Pentagon, Washington, DC 20310-0300.

Glossary

Section I Abbreviations

ACE

Ask, Care, Escort

ACOM

Army Command

ACS

Army Community Service

AFME

Armed Forces Medical Examiner

ARNG

Army National Guard

ARNGUS

Army National Guard of the United States

ASA (M&RA)

Assistant Secretary of the Army (Manpower and Reserve Affairs)

ASAP

Army Substance Abuse Program

ASI

additional skills identifier

ASPP

Army Suicide Prevention Program

ATP

Army Techniques Publication

AWC

Army Wellness Center

BH

behavioral health

BMI

Body Mass Index

BSHOP

Behavioral and Social Health Outcomes Program

CFR

Code of Federal Regulations

CG

Commanding General

CHPC

Community Health Promotion Council

COSC

combat and operational stress control

COSR

combat and operational stress reaction

CRM

composite risk management

CSC

Combat Stress Control

DA

Department of the Army

DCS, G-1

Deputy Chief of Staff, G-1

DCS, G-3/5/7

Deputy Chief of Staff, G-3/5/7

DCS, G-4

Deputy Chief of Staff, G-4

DHA

Deployment Health Assessment

DHAP

Deployment Health Assessment Program

DHAPM

Deployment Health Assessment Program Manager

DOD

Department of Defense

DODD

Department of Defense Directive

DODI

Department of Defense Instruction

DODSER

Department of Defense Suicide Event Report

DRC

dental readiness classification

DRU

direct reporting unit

DSM

Diagnostic and Statistical Manual of Mental Disorders

FAP

Family Advocacy Program

FM

field manual

FMSPP

Family Member Suicide Prevention Program

GC
garrison commander

HPO
Health Promotion Officer

HPPO
Health Promotion Policy Officer

HQDA
Headquarters, Department of the Army

IMCOM
Installation Management Command

JFHQ
Joint Force Headquarters

M-NEAT
Military Nutrition Environment Assessment Tool

MEDDAC
Medical Department Activity

MEDCEN
medical center

MEDCOM
U.S. Army Medical Command

MEDPROS
Medical Protection System

MODS
Medical Operational Data System

MSC
major subordinate command

MTF
medical treatment facility

MWR
morale, welfare, and recreation

NCO
noncommissioned officer

NPS
National Prevention Strategy

OCONUS
Outside the Continental United States

OTSG
Office of the Surgeon General

R2C
Ready and Resilient Campaign

RC

Reserve Component

RD

registered dietitian

RMT

Risk Management Team

RRP

Risk Reduction Program

SAT

Staff Assistance Team

SME

subject matter expert

SOS

survivor outreach services

SPPM

Suicide Prevention Program Manager

SPT

Standardized Physical Training

SPTF

Suicide Prevention Task Force

SRT

Suicide Response Team

SSART

Specialized Suicide Augmentation Response Team

TFMC

tobacco free medical campus

TRADOC

Training and Doctrine Command

TSG

The Surgeon General

UMT

Unit Ministry Team

USACIDC

U.S. Army Criminal Investigation Command

USAPHC

U.S. Army Public Health Command

USAR

U.S. Army Reserve

Section II

Terms

Army Substance Abuse Program

A comprehensive program designed to eliminate substance abuse, including prevention, identification, education, and rehabilitation services.

Battle buddy system

A cultural support mechanism in the Army in which two people operate together as a single unit, both for improved functioning and increased safety. Each may be able to prevent the other from becoming a casualty or rescue the other in a crisis.

Behavioral health provider

Trained BH clinician who is credentialed or licensed as a psychiatrist, clinical or counseling psychologist, social worker, or psychiatric nurse practitioner and/or psychiatric nurse specialist.

Body composition

The quantification of the major structural components of the human body (fat and lean body mass).

Equivocal death

Cases where the available facts and circumstances do not immediately distinguish the mode of death. Ambiguity or uncertainty existing among any of the four identified modes of death makes it equivocal. See Mode (manner) of death, below.

First-line supervisors and junior leaders

For the purpose of suicide prevention training, includes officers in the grade of O-3 and below, to include company commanders, and NCOs in the grade of E-6 and below.

Fitness coordinator

A civilian health and fitness individual that, under the supervision of the installation commander, is responsible for managing and coordinating the installation health fitness program(s).

Flexibility

The ability of a joint to bend easily within the normal range of motion. Flexibility is highly specific and dependent on the muscles and connecting tissue surrounding a joint. Good flexibility is characterized by a freedom of movement, which contributes to ease of movement and economy of muscular effort.

Gatekeeper

Individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and Army Civilians in need.

Geographically dispersed

Organizations or individuals who are not centrally located on a post or installation are considered to be geographically dispersed. This primarily refers to USAR and ARNG units and personnel whose cohesion is disrupted by distance but also includes Active Army Soldiers who live and work more than 50 miles from an installation, such as recruiters.

Health

The general condition of the body. Good health is normally characterized by optimal functioning and freedom from disease and abnormality.

Health care providers

Physicians, nurse practitioners, physician assistants, registered nurses, mental health specialists, occupational and physical therapists, and RDs under the supervision of the unit surgeon or the commander of the MTF. For the purpose of this regulation, this term includes comparable personnel of U.S. Armed Forces and host nations.

Health promotion

Any combination of health education and related organizational, social, economic, or health care programs designed to improve or maintain health.

Hypertension identification

Actions to identify early those health risk factors for high blood pressure, including smoking, cholesterol level, weight,

family history, nutrition, and inactivity. These actions include early identification, provision of information regarding control and lifestyle factors, and treatment referral.

Military Nutrition Environment Assessment Tool

A standardized tool used to measure accessibility to healthy food options. m-NEAT appraisals assess environmental factors and policies at the community level that support healthy eating. The tool was developed to help health promotion professionals, commanding officers, and others in the DOD community measure accessibility to healthy food options.

Mode (manner) of death

Five categories: natural, accidental, suicide, homicide, unknown. These categories are distinguished from the cause of death (for example, gunshot wound, and heart disease).

Muscular endurance

The ability of a muscle or muscle group to perform repetitive functions for an extended period of time.

Muscular strength

The maximum force exerted in a single, voluntary contraction of a muscle or muscle group. Both muscular strength and endurance are related to age, selected general health factors, genetics, level of training, and level of effort.

Nutrition

An appropriate intake of food that meets nutritional needs for calories and the macro- and micro-nutrients that are essential for health, and are indispensable for individual well-being and productivity.

Physical fitness

A set of attributes that an individual must have or achieve that relates to the ability to perform physical activity. It is the general state of good health that enables an individual to cope with the physical demands of a job and to use physical reserves to cope with emergencies. Components of physical fitness include cardio respiratory endurance, muscular strength and endurance, flexibility, and body composition.

Psychological autopsy

A procedure designed to clarify the nature of an individual's death by focusing on the psychological aspects of the person. The primary purpose of the autopsy is to reconstruct and understand the circumstances, lifestyle, and state of mind of the individual at the time of death. MEDCOM and/or MEDCEN commanders must provide a credentialed BH officer, in accordance with paragraph 1-30h above, to conduct a psychological autopsy when required by regulation.

Public health

The aggregate of interventions and policies that are concerned with improving health and quality of life of the community through the promotion of healthy behaviors.

Self-harm

A self-inflicted, potentially injurious behavior for which there is evidence (either explicit or implicit) that the person did not intend to kill himself or herself (that is, had no intent to die). Persons engage in self-harm behaviors when they wish to use the appearance of intending to kill themselves in order to attain some other end (for example, to seek help, punish others, to receive attention, or to regulate negative mood).

Spiritual fitness

The development of the personal qualities needed to sustain a person in times of stress, hardship, and tragedy. These qualities come from religious, philosophical, or human values and form the basis for character, disposition, decision-making, and integrity.

Stress management

Assistance provided to individuals so they may cope with real or perceived demands from the environment and from within themselves.

Suicide

Self-inflicted death with evidence (either explicit or implicit) of intent to die.

Suicide attempt

A self-inflicted potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or

implicit) of intent to die. A suicide attempt may or may not result in injury. Therefore, this category includes behaviors where there is evidence that the individual intended to die, but the event resulted in no injuries.

Suicidal ideation

Any self-reported thoughts of engaging in suicide-related behaviors (without an attempt).

Suicide prevention

Initiatives and activities designed to reduce the incidence of suicide and improve the identity ratio of at-risk individuals.

Suicide prevention task force

A committee responsible for planning, implementing, and managing the local ASPP.

Unit ministry team

The chaplain and chaplain assistant who provide direct religious support for the religious needs of a unit.

Section III

Special Abbreviations and Terms

This section contains no entries.

UNCLASSIFIED

PIN 062880-000