CALL TO ACTION

Suicide Prevention

Reducing Suicide in Army Formations
BDE and BN Commander's Handbook

ARMY RESILIENCE DIRECTORATE

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PUBLICATIONS

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Executive Summary

The purpose of this handbook is to thoroughly examine, from a leadership perspective, the fundamental concepts and engagement necessary to develop and execute an effective suicide prevention program. The suicide prevention framework utilizes visibility tools, which assess risk and protective factors. The suicide prevention framework also establishes a unit forum to operationalize the suicide prevention program through the operations process.

There is no single action that can prevent suicide. However, leaders who apply consistent and systematic whole-of-person approaches can positively impact individual and unit readiness. This handbook presents a vision of an Army built on a culture of trust. Soldiers can build strength and confidence in each another through the application of these principles, practices, and qualities.

- Suicide results from complex, interrelated factors, and therefore prevention must be comprehensive. This handbook describes the strengthening influence of recognized protective factors in many facets of Soldiers' and Army families' lives.
- In suicide prevention, active engagement is important in identifying early indicators of risk propensity. Early identification can prevent destructive outcomes through graduated assistance, building protective factors, and intervening before the risk behavior is acted out.
- Many risk behaviors can have severe personal, family, and mission readiness impacts, and result in legal and administrative actions. This handbook provides guidance on managing the effects of some of these risk behaviors, and mitigating where possible.
- This handbook also identifies the unit resources and community prevention workforces that are associated with risk and protective factors. Leaders need to be aware of the available resources to maintain the highest unit readiness, personnel readiness, and the individual Soldiers' ability to perform their duties.

The Army community of prevention professionals stands ready to address concerns and provide the necessary resources to assist leaders in meeting the daily challenges they face while managing the Army's most incredible resource, its people.

This handbook is intended to be a user friendly "living document." It is geared toward offering leaders evidence-supported insight into the identification of the risk and protective factors that affects Soldiers' lives, their readiness and resiliency, unit-level readiness, and the unit's ability to accomplish its mission. When this handbook is used in conjunction with the Center for Army Lessons Learned (CALL) handbook, *Building Cohesive Teams*, 6 April 2021, command teams can establish a culture of trust. This can help identify and address risk and protective factors, and significantly reduce the possibility of a catastrophic outcome.

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CHAPTER 1

Command Team Handbook to Implementing the Integrated Suicide Prevention Program

This guide is based on the premise that suicide prevention begins with positive actions by unit leaders. These leaders execute effective policies and create a command climate that is conducive to trust and cohesion. Engaged leaders are a fundamental component of the suicide prevention program. An engaged leader is one who demonstrates an honest concern for Soldiers, their families, and Army Civilian Professionals, and provides the appropriate assistance for all personnel to mitigate risk and build protective factors.

Leaders should know their subordinates, and provide timely assistance when needed. Unit commanders must emphasize suicide prevention through actions and examples, and the publication of command letters, directives, and instructions. Unit leaders should provide opportunities for Soldiers to attend support programs, training, and education to build connections and resilience. An ideal unit climate is one where Soldiers trust their leaders, are informed about available resources, and feel empowered to take action. Unit-specific events, a climate of help-seeking and value of life, and traditional suicide prevention education are ways leaders can promote and promulgate the program.

FRAMING THE PROBLEM

Suicide prevention involves a complex set of environmental factors at the individual, peer, unit, community, and society level. Leaders must be able to identify and assess the factors that contribute to the prevention of suicides.

Describing the current state of suicide prevention will define and characterize the current conditions, and when compared to the desired end state, can identify the tactics, procedures, and protocols required to get there.

The Connection between Cohesive Teams and Suicide Prevention: An Upstream Approach

Leaders should actively engage in practices that encourage and motivate individuals to build their personal resilience and enhance their readiness. Some examples of engaging leadership practices include:

- Showing interest in knowing the team and what matters to them;
- Expressing concern for the team, and reaching out when necessary, particularly during off-duty time or to those in transition;

- Assisting them in managing family and professional responsibilities; and
- Mentoring to improve team member skill sets, and solving problems professionally and personally.

An upstream approach looks at identifying and strengthening the protective factors, and creating a safe environment for collaborative and interconnected ways to positively influence outcomes. This is done by persistent and systematic tactics, tools, and procedures to build resilience, increase connection, change unhealthy norms around help-seeking, and teach healthy coping strategies. It is more than keeping people alive. It is about helping them to live healthy and productive lives.

HOW THIS GUIDE IS ORGANIZED

Purpose and Intended Audience. This handbook is for leaders, and contains information on recognizing protective factors and mitigating risk factors against the interplay of interpersonal, intrapersonal, culture, and climate to prevent self-harm behaviors. This book is intended to demonstrate how leaders can synchronize suicide prevention into the operations process and integrate it into daily activities, instead of treating it as an additional duty.

Application of the Operations Process. This command team guide provides the framework to assist commanders and DA civilian supervisors with lowering the risk of suicide and building protective factors. It is organized along the operations process, with added nuances to ensure effective methods for applying the elements of the suicide prevention program. These elements are obtaining visibility data, assessing risk behavior, developing and executing prevention activities, managing at-risk individuals, sharing lessons learned, and monitoring outcomes. The audience for this guide are leaders from brigades and battalions to the company-level command teams.

CHAPTER 2

Planning: Setting the Conditions

Leadership serves to build high-performing teams, and is based on the tenets that the team must be cohesive, trained, disciplined, and fit. The critical components for team success are outlined in Army Doctrine Publication (ADP) 6-22, *Army Leadership and the Profession*, 31 July 2019, and lay the foundation for clearly set standards. Leaders build trust through positive actions, which include communicating and enforcing standards through policy and associated procedures and team activities.

Objectives

- Understand and address risk and protective factors for individuals and units.
- Understand the effects of unit climate and culture on help-seeking behaviors.
- Identify available unit, community, and medical resources (i.e., personnel).

LEADERSHIP ACTIONS IN IMPLEMENTING A SUICIDE PREVENTION PROGRAM

The Army provides capabilities for leaders to achieve readiness and lethality effectively and efficiently. This section describes the components that leaders must apply to complete an effective suicide prevention program.

Identify Risk Factors

A risk factor is a behavior or condition that, based on scientific evidence, is thought to increase vulnerability to a specific situation. The assignment of risk factors is not meant to blame the individual. Men are at higher risk for prostate cancer, but they are not blamed for having more prostate issues than women. Risk factors include:

- Excessive alcohol use or illegal drug use;
- Relationship problems, such as strain, a break-up, violence, or loss;
- Legal or disciplinary problems;
- The death of a close family member, friend, or battle buddy;
- Major illness, injury, or medical problems, such as chronic pain or disability;
- Work responsibility changes or setbacks (curtailment, restriction);

- Significant financial loss or hardship;
- Significant career transition (i.e., separation, permanent change of station [PCS], retirement);
- Spiritual despair (i.e., lacks meaning in their life);
- Social and emotional isolation; and
- Access to lethal means.

Address and Mitigate Risk Factors

The following are a few tactics that leaders should employ to identify and mitigate risk factors. They should establish a climate that is conducive to early detection. Engaged leaders establish trusting relationships with Soldiers, which allow them to know their Soldiers and their unique environment. Leaders should also establish a climate that encourages and normalizes growth, help-seeking, and visibility tools. Lethal means, including medications, firearms, etc., should be safely stored at all times, and there should be safety practices in place. Leaders should make sure to train Soldiers and families on risk factors, warning signs, and the Ask, Care, and Escort (ACE) suicide prevention model.

Develop and Enhance Protective Factors

Protective factors are the skills, strengths, or resources that help people effectively deal with stressful events. Protective factors enhance resilience, and help counterbalance risk factors (adverse life events such as relationships, work, or academic reverses). Protective factors may be personal, external, or environmental, and help make it less likely that a Soldier will engage in risky behaviors. A few protective factors are:

- Connections to friends, family, unit, and broader community;
- Problem-solving skills (i.e., stress reduction techniques or self-regulation);
- Emotional regulation and mental agility;
- Healthy practices such as sleep, fitness, and nutrition;
- Peer support for care-seeking and bystander intervention;
- Availability of physical and behavioral health care; and
- Cultural and spiritual beliefs that discourage suicidal behavior or create a strong sense of self-awareness.

Foster Command Climates of Dignity and Respect

Leaders should take deliberate steps to build cohesive teams, resolve conflict, and establish a positive climate through principles and guidelines from ADPs (i.e., ADP 6-22) and the Center for Army Lessons Learned (CALL) handbook, *Building Cohesive Teams*, 6 April 2021. Group norms are a factor that affects team performance, and can be either productive or counterproductive for team cohesion and resilience. Leaders will set a command climate of dignity and respect that normalizes and builds protective factors and resilience practices. Examples include:

- Promoting connectedness by programming time to be with friends, family, and community support.
- Establishing a routine means to communicate with unit members and their families.
- Advocating for the use of nonclinical (i.e., chaplain) counseling and help-seeking resources, and ensuring leaders allow Soldiers the time to access these in a timely manner.
- Enforcing a zero tolerance policy for bullying, hazing, racial slurs, and other indiscipline behaviors.

Model Army Values through Behavior

The Be-Know-Do model, "…aligns the desired outcome of leadership development activities and personnel practices to a common set of characteristics valued throughout the Army… Attributes are the desired internal characteristics of a leader — what the Army wants leaders need to be and know. Competencies are skills and learnable behaviors that the Army expects leaders to acquire, demonstrate, and continue to enhance — what the Army wants leaders to do."[1] To create a climate of trust and cohesion, officer and noncommissioned officer (NCO) leaders should:

- Be a source of stability, command presence, and calm; be honest with Soldiers in all areas; and be vigilant in adhering to Army values, thereby building trust in their integrity among unit members.
- Know the strengths and needs of team members; know the risk factors and warning signs of suicide; and know the available unit and community resources to build resilience and mitigate suicide risk.
- Do recognize and resolve conflict quickly; do display high ethical standards and foster a moral climate, and hold leaders and Soldiers accountable to the same; and do provide opportunities for growth and encourage professional help for others and seek help for self when needed.

Encourage Help-Seeking and Problem Solving

Seeking help for behavioral/emotional/psychological, financial, legal, or relationship issues can appear to run contrary to the Soldier's creed, which reads in part, "I am disciplined, physically and mentally tough…" However, when a "physically tough" Soldier is seriously injured or ill, no one believes that this physical toughness should keep him or her from seeking medical help to heal and resume the mission.

It is equally valid that "mentally tough" Soldiers can receive hidden wounds that need care and potentially professional treatment. Being mentally tough includes knowing when to seek help when the need is identified, and having the courage to make that decision, before a crisis occurs.

Stigma can erode the commitment between peers and leaders, which reduces trust within the unit. One key to reducing stigma is to pledge that when a Soldier does seek help, the impact to the mission is viewed as secondary. If help-seeking is normalized, there should be little notice by unit members. To reduce stigma and normalize these healthy behaviors, officer and NCO leaders should:

- Emphasize that taking care of mental health is just as much a part of being a good teammate as being physically fit.
- Talk positively about resources such as Chaplains, behavioral health, financial counseling, etc., and recommend those resources when necessary.
- Increase the visibility of helping agencies in the unit area, such as Military Family Life Consultants.
- Support (and not attempt to violate) confidentiality between the Soldier and mental health provider.
- Identify and remove organizational (i.e., training commitments) barriers to help-seeking behaviors.

Teach Soldiers to Communicate and Take Action

Surveys indicate that Soldiers who seek help are more likely to do so from either family, friends, or mental health providers outside of the military system. Soldiers identified the following as the top reasons for not seeking help: the perception of being "broken," confidentiality concerns, and fear of jeopardizing their career.

Leaders can create a climate of early help-seeking that strengthens and builds team knowledge, skills, and abilities to navigate stressful and uncertain situations in the following ways:

- Teaching and mentoring Soldiers on communication skills, and managing personal and interpersonal conflict.
- Bringing in experts, such as Resilience Centers or the Engage for Suicide Prevention training, which teach Soldiers to develop the skills to improve one-on-one communication through professional engagements, especially on complex topics.

Sponsorship and Integration

During PCS transitions, deliberate sponsorship and integration is vital to welcome new team members. This helps reduce stress and mitigate risk, particularly for first term Soldiers and those with families. When a leader rapidly learns and empathizes with a new Soldier's personal and professional background, the Soldier will feel protected in their new environment. This will also set the stage for the Soldier to engage in positive social relationships and activities at their new location. Leaders should optimize this transition in the following ways:

- Incoming Soldiers should be assigned to the company level, no later than 120-days before arrival, at a minimum, to allow for the assignment of a sponsor who can serve with the Soldier on arrival. Sponsors should be exclusively chosen and have more than 6 months on station.
- Leaders should utilize the Commander's Risk Reduction Toolkit (CRRT) and initial counseling to learn a Soldier's individual background, from before and during their service and including their family members. This shows empathy, and the leader learns individual risk history and risk factors.
- Look after quality of life considerations, such as housing, schooling, food security, and employment assistance.
- Familiarize Soldiers with local infrastructure and resources, with special emphasis on unique capabilities (i.e., medical/behavioral health) and opportunities (i.e., fitness, morale, welfare, and recreation), and those required by family circumstances (i.e., the Exceptional Family Member Program [EFMP]).
- Meet or call family members and ensure warm hand off to unit Soldier and Family Readiness Group (SFRG) representatives.

THE BRIGADE PREVENTION SYSTEM

Brigades and battalions have only a few dedicated resources for suicide prevention. However, there are various organic resources that can support the unit and its leaders in the effort to increase personnel readiness, and augment the official suicide prevention program. When these organic resources are given synchronized direction by the commander and staff, they can build protective factors and mitigate risk factors.

Chaplains. Chaplains collaborate with unit and installation behavioral health professionals to provide multidisciplinary support, normalize referrals, reduce stigma associated with help-seeking behavior, and deliver and support unit suicide prevention training. Chaplains provide comprehensive religious and spiritual support services to Soldiers.

Behavioral Health Providers. Behavioral health providers help treat mental health and substance abuse needs of unit members, and can be utilized in community-based prevention programs. They consist of multidisciplinary providers. In the embedded behavioral health model, they can help normalize referrals and reduce the stigma associated with help-seeking behavior

Unit Surgeon. Unit surgeons provide expert counsel to the commander regarding the holistic treatment and assistance plans for high-risk Soldiers and victims of interpersonal and intrapersonal violence. They provide expert counsel regarding the Health Insurance Portability and Accountability Act (HIPAA) and polypharmacy. Unit surgeons also monitor mental and physical health trends, and provide advice and counsel to the command regarding the overall fitness and wellness of unit members. They also help develop command initiatives to improve readiness.

Physician Assistants. Physician assistants provide local medical treatment for unit members and refer those who need more advanced care. Similar to unit surgeons, they monitor mental and physical health trends, provide advice and counsel to the command regarding the overall fitness and wellness of unit members, and help develop command initiatives to improve readiness.

Equal Opportunity Advisor. Equal opportunity advisors assist the commander in their effort to maximize human potential and ensure all Soldiers are treated with dignity and respect, and are able to be effective members of cohesive, ready teams. They will help commanders and organizational leaders to foster and maintain a positive command climate free from the personal, social, or institutional barriers that prevent Soldiers from reaching their full potential.

Sexual Assault and Harassment Program Personnel. Sexual assault personnel assist the commander in executing the Sexual Harassment/Assault Response and Prevention (SHARP) responsibilities to prevent and respond to sexual harassment, sexual assault, and associated retaliatory behaviors.

Sexual assault response coordinators, SHARP victim advocates, victim representatives, and SHARP training instructors support the commander with training and tracking requirements, program management, sexual assault, sexual harassment, and associated retaliatory behavior response, and case coordination.

Legal Personnel. Legal personnel provide legal counsel and assist the commander in fulfilling their statutory and regulatory requirements. They establish, oversee, and enforce effective processes that enable timely accountability and help contribute to an overall climate of good order and discipline.

Performance Experts and Master Resilience Trainers. Performance experts and master resilience trainers provide commanders with a resource and conduit to operationalize resilience, performance, organizational psychology, prosocial behavior, and other emotional intelligence skills within the unit and organizational training regimen to enhance personal readiness.

ACE-Suicide Intervention (ACE-SI) Trainers. ACE-SI trainers provide Soldiers with the necessary awareness, knowledge, and skills to intervene and take steps to confidently prevent suicides. ACE-SI leads training, but they also provide advice and counsel to the commander regarding any supplementary suicide prevention the unit may require. They are a resource to assist commanders during postvention after a suicide ideation, attempt, or death.

Soldier and Family Readiness Group Coordinator. Soldier and family readiness group coordinators assist the commander in developing and maintaining a relationship with the unit's families. They do this by ensuring timely and relevant communication of command information, training schedules, and unit or community events. They also organize activities that include unit family members, and provide information regarding installation resources and activities available to assist families. All of these things help improve cohesion and the sense of family members belonging to the unit and greater community.

Better Opportunities for Single Soldiers (BOSS) Representatives. BOSS representatives assist the command by organizing and communicating information about events to help improve single Soldiers' well-being, safety, education, recreation, and overall resilience. Indirectly, the BOSS program promotes connectedness and positive behavior, while deterring undesirable activities within the single Soldier population.

Provost Marshal. The provost marshal assists the commander as liaison with military and civilian law enforcement, and provides trend analysis concerning criminal activity in the overall environment, on and off post.

Public Affairs Officer. Public affairs officers provide advice and counsel in effective communication planning. In conjunction with subject matter experts (SMEs), they develop campaigns that inform unit and family members of components of the integrated suicide prevention program, and incorporate safe messaging practices when reporting on suicide, to include safe language, safe storage, and links to crisis lines. The tools and resources for implementing safe language and messaging practices are located in the Leaders Suicide Prevention Safe Messaging Guide, which can be found at https://www.armyresilience.army.mil/suicide-prevention/pages/LeaderResources.html.

Leadership Responsibilities in the Prevention System

Brigade Commander. Brigade commanders should leverage organizational assessments, resources, and expertise to develop and oversee a process that will enable the visualization of risk and protective factors. This should be followed by the monitoring of initiatives that improve the overall health and wellness of the unit. They should monitor the operational tempo and predictability of training calendars at echelon, and hold subordinate leaders accountable to place people first and generate positive actions.

Battalion Commander. Battalion commanders should establish a command climate of dignity and respect, and ensure timely accountability when the standard is not met. They should educate leaders to take a holistic approach to overall Soldier wellness and the prevention of high-risk behaviors. They must maintain oversight of high risk Soldiers, and ensure leader focus and synchronize resources and subject matter expertise.

Command Sergeant Major (CSM). CSMs support and provide counsel to the commander. They develop officers and NCOs who are able to demonstrate empathy and take concrete actions on a daily basis to build trusting relationships and communicate with their Soldiers. CSMs ensure primary and collateral duty staff are sufficiently vetted, trained, and engaged to accomplish their duties. They should actively monitor all aspects of Soldier quality of life, and establish systems to ensure an engaged leadership presence in the unit environment. CSMs should not allow anyone to lose sight of the importance of people first and taking care of Soldiers.

Company Commander/First Sergeant. These leaders should provide experienced oversight, mentorship, and support to platoon-level leadership teams. They should develop detailed training schedules and frequently communicate with Soldiers and their families, while closely monitoring medical and legal actions as known risk factors. They should develop training plans that equip Soldiers with life and resilience skills to help them thrive, and maintain readiness during periods of personal and professional adversity.

Platoon Leader/Platoon Sergeant. These leaders should foster a culture of connectedness, caring, and accountability among all team members and their families, regardless of rank. They should educate and mentor subordinate leaders on a daily basis, and follow through on required Soldier actions, including intervening where needed to garner timely assistance.

Section/Squad Leader. These leaders must know individual Soldiers — where they came from and how they grew up, their family and state of their personal relationships, their hobbies and personal values, where and how they live, and their professional and personal goals. They should engender trust and confidence, be able to identify when something is wrong, and know where to go for help, resources, and leaders in the chain of command.

Endnote

1. Field Manual (FM) 6-22, *Leader Development,* 30 June 2015.

CHAPTER 3

Preparing: Seeing Ourselves through Visibility Tools and Identifying Risk

Commanders must continue to encourage their Soldiers to establish connections and develop the familiarity necessary to perceive behaviors that are out of character or a deviation from Army standards. To supplement the first-hand knowledge Army leaders should have regarding their individual Soldiers, the Army equips command teams with leader visibility tools and other resources. These help leaders better "see" the risk history and risk propensity for their Soldiers and units, and develop the appropriate prevention programs and targeted interventions. These visibility tools can provide insight to the operational environment, and help analyze and understand how to frame both the current and desired end state.

Objectives

- Identify and compare command visibility tools.
- Understand the utility of visibility tools and reporting systems on increased awareness of suicidal indicators.
- Construct a command climate informed by visibility tools.

COMMAND VISIBILITY TOOLS

Command visibility tools provide insight into risk and protective factor indicators across multiple domains (substance abuse, criminal offenses, and suicide attempts). This allows leaders to gain a holistic picture of personal readiness from entry to the end of service. These tools aid in identifying root causes.

These visibility and analysis tools should support the identification of priority areas and lead to data-informed prevention actions. Specific actions are a subjective call, but should use the data available, personal interactions from clinical and nonclinical personnel/leaders, and an understanding of the other environmental factors involved.

Engaged Leadership (Conducting Counseling, Quarters Visitation, Knowing Family, etc.)

Engaged leadership should result in strengthened connections in the unit, and a climate of trust and cohesion, with a performance-focused mission. The relationships between team members and leaders can help change the trajectory of someone's life so that their stressors do not culminate in crisis.

The following individual responsibilities must be met to be part of a team:

- **Building Relationships.** Build rapport by showing interest, communicating effectively, sharing experiences and hardships, visiting quarters, and knowing family and friends.
- **Demonstrating Flexibility and Adaptability.** Consider different points of view, and compromise when needed to strengthen the team for the larger mission.
- **Be Willing To Help Others.** Conduct regular and positive counseling, perform on-the-spot corrections, and identify specific actions to teach, train, and mentor.

Defense Organizational Climate Survey

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

The Commander's Risk Reduction Toolkit

The Commander's Risk Reduction Toolkit (CRRT) is a module within the Army Vantage cloud based platform (https://vantage.army.mil) that consolidates Soldier-level information from multiple authoritative databases to provide company and battalion command teamswith individual Soldier and aggregated unit data to assess the Soldiers' risk behaviors, unit trends, and deployment readiness. The CRRT is a critical part of the Army Risk Reduction Program (RRP), and one of many toolkits embedded in the Army Vantage platform. It provides visibility and assessment of individual Soldier and unit risk and deployment readiness. The CRRT provides company and battalion command teams visibility of the risk factor history of every newly assigned Soldier. It does not determine the level of risk for each Soldier or track accordingly, but it does enable a more seamless transition of the visibility of a Soldier's risk history as they move from unit to unit. Commanders can gain access to the CRRT by contacting their installation risk reduction coordinator.

The Behavioral Health Pulse

The Behavioral Health (BH) Pulse survey is a voluntary and anonymous survey tool that behavioral health officers (BHOs) can use in coordination with commanders to assess Soldiers' behavioral health. It requires at least 70 percent participation from each company. BHOs should provide and discuss the results of the analysis with the commander. BHOs can make recommendations to guide the commander in making appropriate choices for the best way forward to address concerns conveyed by the unit's data.

The BH Pulse survey contains aspects of a command visibility tool, whereby commanders can assess how a unit functions in terms of resilience compared to the rest of the Army. Metrics allow for trends analysis of how a unit changes over time in response to training, deployments, or significant events. The core survey is 15 minutes, and covers four main areas to indicate resilience: behavioral health, such as anxiety, suicidality, alcohol use, or stigma about seeking help; work environment issues, such as morale, role overload, unit cohesion, or garrison stressors; social relationships such as loneliness, social integration, or marriage issues; and interpersonal violence, such as sexual assault.

The Unit Risk Inventory

The unit risk inventory (URI) is an anonymous survey that provides a unit-level snapshot of 14 self-reported risk factors. These risk factors are accidents, injuries, sexual behaviors, suicide gestures or attempts, unexcused absences, drug or alcohol offenses, traffic violations, crimes against persons, crimes against property, spouse abuse, child abuse, and finance difficulties. URI summary results provide the unit risk profile with comparison data for unit, installation, and component. The re-integration URI (R-URI) screens for high-risk behaviors and attitudes affecting unit readiness and personnel well-being that may have occurred during deployment or since redeployment. A unit's URI and R-URI scores will be loaded into the CRRT.

The Army Readiness Assessment Program

The Army Readiness Assessment Program (ARAP) is a battalion commander's tool for addressing root causes of accidental loss by focusing on organizational safety and climate. ARAP provides battalion-level commanders with data on their formations' readiness posture through seven categories. ARAP is comprised of a web-based survey that can be completed anonymously by Soldiers and employees. The survey captures the unit posture on safety climate and culture, organizational processes, organizational climate, resources, supervision, and the safety program. Commands can request a survey here: https://earap.safety.army.mil/.

The Azimuth Check

The Azimuth Check is a confidential self-assessment tool comprised of a 10-minute survey that assesses a Soldier's overall fitness level across five ready and resilient (R2) dimensions: physical, emotional, social, spiritual, and family. Soldiers receive individualized feedback, including a graph comparing a Soldier's overall and dimension scores relative to their job function and the Army as a whole. Soldiers also receive articles and multimedia offerings via Armyfit (https://armyfit.army.mil/) about their dimension scores. The Commander's View enables commanders to see their unit's overall assessment based on the aggregated feedback of Soldiers in their formation who have taken the Azimuth Check.

Soldier Risk Assessment

Leaders may refer to the scientifically based, field-tested tools that provide tactics, techniques, and procedures to identify, manage, resource, and support Soldiers at risk for suicide and/or adverse behavioral health outcomes. These tools and associated processes begin with leader-led engagement at team, squad, and platoon level, and support a synchronized, multidisciplinary review process through each echelon of the chain of command.

COMMAND VISIBILITY

"Good leaders balance the needs of the mission and the welfare of their members by knowing their team, and regularly assessing their mental, physical, and emotional well-being and providing appropriate relief when needed."[1] A leader cannot detect and assess changes in their team members unless they know them. Meeting the families (calling them if they are not local), knowing who their friends are, and understanding each Soldier's challenges are integral to building mutual trust. Leaders should use a combination of formal and informal means to maintain visibility and awareness, which will allow them to focus on establishing connections and developing the personal familiarity required to help prevent undesirable behaviors and suicides. Command visibility tools do not replace personal relationships and knowledge; they enable it.

Analysis Tools and Summarizing the Data

Continuous assessments help measure the unit's health, ensure unit personal readiness, and support overall unit readiness and deployability. Trend analysis helps understand unit status, identify and understand indicators, and assess the outcome of prevention activities. When leaders at all levels assess and take steps to mitigate the impact of individual Soldier risk, it assists the commander and unit's focus on the mission. Assessments can:

- Mitigate risk and provide feedback and tools to Soldiers to help them become more self-aware and initiate steps to improve their personal readiness;

- Manage Soldiers' personal readiness trends;
- Inform actions that lead to a positive and sustained command climate, and promote a culture of trust; and
- Help leaders identify potentially harmful and damaging trends in the unit quickly, before they result in a crisis.

These visibility and analysis tools should support the identification of priority areas and lead to data-informed prevention actions. For example, commanders may:

- Identify areas of increased risk, and target actions to mitigate and deter;
- Use visibility tools to track outcomes and the overall effectiveness of targeted actions; and
- Signal the need for additional unit and/or community resources and capabilities.

Commander's Assets: Linking Visibility Tools with Unit and Community Prevention Resources

Table 3-1 identifies resources and subject matter experts that deliver, analyze, and make recommendations on Command Visibility Tools results.

Table 3-1. Point of Contact for Visibility Tools

Unit and Community Resources	Subject Matter Expert Target Areas
BHO	BH Pulse tool
Unit master resilience trainer	Azimuth Check
Equal opportunity advisor (Defense Equal Opportunity Management Institution [DEOMI] certified)	DEOCS survey
Risk reduction coordinator	CRRT access, URI, and R-URI tool
R2 performance centers/performance experts	Azimuth Check

Leadership Actions

- Utilize visibility tools to detect risk and protective factors in Soldiers.
- Incorporate assessments to construct a positive command climate.
- Harness community resources to build a visibility system.

Endnote

1. Center for the Army Profession and Leadership (CAPL), *Building and Maintaining a Positive Climate Handbook*, July 2020.

CHAPTER 4

Executing: Target Specific Risk Areas/ Personnel; Build Positive Factors; Remove Negative/Harmful Factors

The commitment to a prevention approach relies on the time and study dedicated to team-building fundamentals. "A team that has commitment creates clarity around directives and priorities which align the entire team around common objectives."[1] The leader's actions and commitment to prevention will directly and indirectly influence team members' behaviors and perceptions. This leads to norms that promote a climate of trust and personal readiness.

Depending on the situation, prevention activities are some of the most important actions that leaders can take. There are four tiers of prevention activities (see Figure 4-1):

- Actions that create environments of emotional/psychological and physical safety for all. These activities are foundational and universal and are intended to be applied to the entire unit on a recurring and systematic basis.
- Actions to identify and support people that may be at risk of suicide.
- Actions to support people known to be at risk of suicide.
- Actions to sustain suicide prevention and improve quality of life.

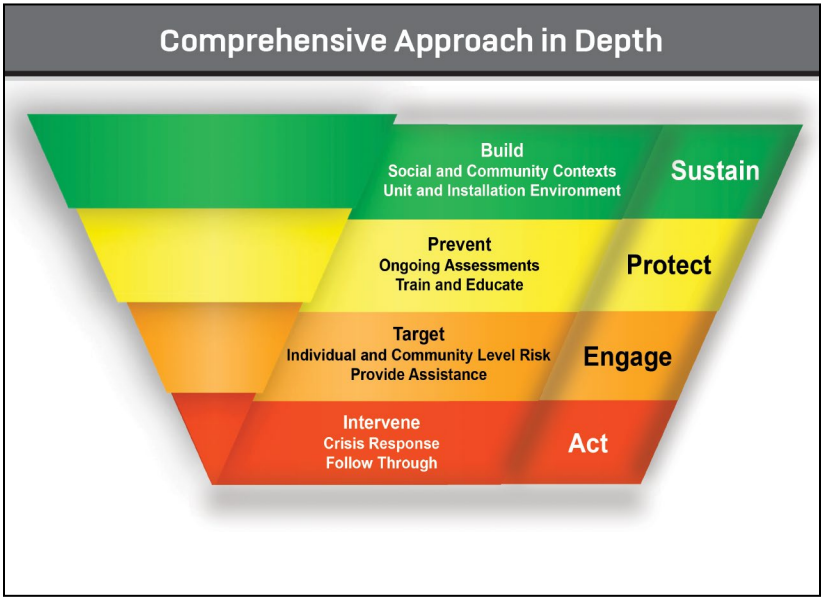


Figure 4-1. Tiers of Prevention Activity

Objectives

- Describe the prevention tiers.
- Identify leader actions and prevention efforts for each prevention tier.
- Understand the suicide prevention training requirements and documentation standards.
- Understand the exception to policy process for suicide prevention training.
- Recognize strategies for safe firearms practices as part of the suicide prevention program.
- Identify higher-risk individuals/units for self-harm/suicide via visibility tools, and complete crisis response plans with a counselor/chaplain/trained prevention specialist, which includes lethal means safety behaviors.

TIER ONE: SUSTAIN UPSTREAM PREVENTION

This represents the overall social and environmental factors that sustain and improve quality of life and general well-being. These include the social and community contexts that have bearing on Soldiers and family members. Includes quality of life initiatives that improve on-post neighborhoods, barracks and housing; the food environment for available healthy choices; and social connectedness from a community standpoint.

TIER TWO: PROTECT—FOUNDATION OF UNIVERSAL PREVENTION

These actions create an environment of psychological and physical safety for all. These serve as the foundation for a proactive suicide prevention program. Command teams will generate the most activity for unit members in this tier.

Normalize Help-Seeking and Reduce Stigma

Stigma has been shown to act as a barrier to early help-seeking and behavioral health service utilization. There are a few reasons why individuals may not seek help. They may want to deal with the problem by themselves, or they might think the problem will resolve on its own over time. Individuals may also believe their problems or behavioral health issues should remain a secret. This can be because of shame or embarrassment; the fear that their career may be affected; the concern that their personal problems could be exposed; and the belief that seeking help is a sign of weakness.

The following are a few ways in which leaders should dedicate time and resources to reducing stigma:

- Identify and remove organizational barriers to help-seeking behaviors.
  - Utilize the Defense Organizational Climate Survey (DEOCS), the Behavioral Health (BH) Pulse survey, and/or the unit risk inventory (URI) to identify unit perceptions regarding stigma and help-seeking.
  - Based on these unit surveys, leaders should identify actions that reduce stigma and increase proactive, positive prevention and help-seeking behaviors.
- Know resources and make the appropriate referrals when necessary, including chaplains and clinical providers.
  - Support and increase the awareness of confidentiality between Soldiers, their chaplain, and their behavioral health provider/medical provider.
  - Increase the presence of chaplains, BH providers, and Military Family

Life Consultants to normalize help-seeking and life-skills building.

- Increase the presence of performance experts to normalize life-skills building. Conduct leader development to increase knowledge about risk and protective factors, and address the attitudes and beliefs of all Soldiers, Army civilians, and family members about anxiety, stress, depression, post-traumatic stress disorder (PTSD), substance misuse, and treatment.

- Establish and enforce zero-tolerance policies toward bullying, hazing, belittling, discrimination, and other behaviors that fail to respect each person's dignity and worth and erode cohesion, good order, and discipline.

Integrated Prevention across the Physical, Spiritual, Social, Psychological, and Family Domains

A whole-of-person approach to prevention includes the physical, spiritual, family, and social and psychological/emotional dimensions. Building protective factors across the dimensions can positively impact a person's ability to manage stress and gain life skills. Examples include:

- Promoting healthy behaviors and encouraging sleep, physical activity, and access to healthy nutrition options.

- Integrating family and friends into unit activities, and promoting positive social activities (i.e., Warrior Adventure Quest, Better Opportunities for Single Soldiers, and Strong Bonds).

See Appendix A for a matrix of installation services by risk and protective factor (Figures A-1 and A-2). The installation and command staff should tailor this matrix to reflect local resources and contact information.

TIER THREE: ENGAGE—ACTIONS TO IDENTIFY AND SUPPORT PEOPLE AT RISK

There are many reasons why Soldiers in distress do not seek help or support on their own (i.e., wanting to take care of problems themselves, a misidentification of root causes, a lack of problem-solving skills, etc.). Identifying Soldiers at risk can help leaders reach those in greatest need, and connect them to care and support. Examples of activities in this tier include gatekeeper training (Ask, Care, and Escort-Suicide Intervention [ACE-SI]) and teaching about warning signs.

The ACE Gatekeeper Model — Annual and Advanced Suicide Prevention Training Requirements

Annual suicide prevention training develops knowledge on suicide-related help-seeking and stigma, risk and protective factors, stressors and warning signs, early and crisis intervention, and postvention principles. Suicide prevention training is for Soldiers, leaders, civilians, and family members. There are two recognized annual suicide prevention-training choices: ACE and Engage for Suicide Prevention.

The ACE 60-minute training is modular, with one mandatory 30-minute module covering suicide impact, risk reduction, protective factors, warning signs, and ACE principles. Three additional 30-minute modules, which cover stigma, active listening, and practicing ACE, will be available for selection by commanders. ACE is designed to be taught by Soldiers under the guidance and mentorship of chaplains, master resilience trainers, and suicide prevention program managers.

The Engage for Suicide Prevention training targets junior enlisted Soldiers. This training is designed to increase awareness of risk indicators for suicide, substance misuse, and sexual harassment; the individual sense of responsibility for intervening; and indirect and direct plans for effective intervention. The performance experts at the ready and resilient (R2) training centers teach this training.

Advanced suicide prevention is found in the ACE-SI training. The foremost goals of the Tier One ACE-SI course is to enable Soldiers, and Department of the Army (DA) civilians with the skills for early identification of suicide warning signs, and help them know when and how to take action. Additional goals include helping them understand ways to combat the stigma related to help-seeking, the use of emergency and non-emergency resources, how risk factors and protective factors impact suicide risk, and how to support reintegration and postvention.

The ACE-SI Tier Two training is the Army's 16-hour suicide intervention train-the-trainer course for Army leaders and prevention professionals who plan to deliver the system. The training consists of the ACE-SI course and a module on small-group facilitation, and includes practice teaching. Attendees who complete the 16-hour course can train the ACE-SI course, but ACE-SI is not a prerequisite for ACE-SI Tier Two training. Those attending the Tier Two training are selected by commanders from among the population of E-6 and above, junior leaders, and first-line supervisors with at least a year left on station. Installation Army Substance Abuse Program offices are the point of contact (POC) for scheduling training.

Commanders will maintain a record of completion for all suicide prevention training using a memorandum for record. Commanders can continue to use Digital Training Management System (DTMS) to record training completion if practical, and/or efficient.

Suicide ideation battle drill cards for leaders, Soldiers, and family members (see Appendix B) provide a decision-making and action template for steps on how to intervene upon seeing a problem.

Reduce Access to Lethal Means of Suicide

Although they can be important during a crisis, firearms and ammunition should always be stored safely to protect one's self, family members, and friends. Examples of safe storage include using a gun safe, lockbox, and gunlocks. Research has shown that owning a handgun and storing a loaded firearm are associated with increased risk of suicide — two-fold and four-fold respectively. This increased risk is because suicide attempts are frequently impulsive. The decision is made during a short-term crisis and involves little planning.

Research also shows that the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes, and people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. Therefore, making it more challenging or time-consuming to access lethal means, such as firearms and controlled medications, increase the time interval between deciding to act impulsively and the act itself. This can be lifesaving.

Individual and Soldier Actions. Even though there are many ways to practice safe storage, many Soldiers do not correctly secure firearms in their homes. Commanders should educate their Soldiers about the importance of safe firearm and controlled medication storage, and provide specific common sense safety methods and resources that can help protect themselves, their family members, and friends. To put it simply: always use gunlocks, store unloaded firearms in a safe and store ammunition in a separate locked storage container, and keep controlled medications in a safe.

Family Member Actions. In periods of crisis or heightened emotions, unsafe firearm storage can increase risk. Family members can learn more about safe storage practices from BH and suicide prevention personnel so they can help ensure the safety of loved ones who may be at risk of suicide.

Commander Actions. Commanders should communicate and normalize safe storage practices, provide examples of reducing access to lethal means for persons at risk of suicide, and focus on safe storage of lethal means. Commanders should always emphasize the importance of safe storage as a common sense practice for the safety of anyone who may be in a Soldier's

home (i.e., young child or a friend in hidden crisis). When necessary, commanders should take authorized actions to remove any access to lethal means for high risk Soldiers. Always know the policies surrounding privately owned firearms (POFs). Army Regulation (AR) 600-63, *Army Health Promotion*, 14 April 2015, and the All Army Activities Message (ALARACT) 057/2020, *Privately Owned Firearms and Behavioral Health*, 18 June 2020, provide instructions on the commander's authority and responsibility for their Soldiers behavioral health risk and POFs. Commanders should consult with supporting healthcare assets to help identify potential risks, coordinate care requirements, and determine how to mitigate the identified risk. Commanders should also coordinate with chaplains and suicide prevention, safety, and behavioral health personnel to provide education on the safe storage of lethal means. Such practices may include storing unloaded firearms locked in a secure place (i.e., in a gun safe, lockbox, self-storage facility, or reputable pawn shop), and separating them from the ammunition. Finally, commanders should inform Soldiers on safe practices for alcohol, educate Soldiers on the impact of alcohol as an impediment to impulse control, and understand alcohol and/or substance abuse can indicate risk for suicide.

TIER FOUR: ACTIONS TO SUPPORT PEOPLE KNOWN TO BE AT RISK

Commanders play an integral role in ensuring the safety of at risk personnel, and making sure they have access to appropriate health care. Tier Four is often referred to as intervention, and focuses on preventing a life crisis from stressors (i.e., relationship, domestic, or legal) leading to suicidal behavior for those identified with risk.

Leaders play an essential role in ensuring the crisis has been mitigated and that conditions that produced the current situation have been addressed. First-line supervisors are best positioned to work with the Soldier to resolve situational issues and develop strategies to prevent them from escalating to crisis level again. Leaders should be careful to not presume a threat has passed because there are no immediate concerns.

Manage At-Risk Soldiers

The identification of at-risk Soldiers should be made in collaboration with the highly specialized professionals assigned and/or designated to support commands. These nonclinical (chaplains, Military Family Life Consultants) and clinical (behavioral health) providers should also support leaders with the management of at-risk Soldiers.

Chaplains support the commander with spiritual resources for Soldiers who identify as religiously affiliated and have attempted suicide, have experienced suicidal ideation, or are at risk of suicide.

Health Insurance Portability and Accountability Act

In the process of "engaging with questions," medical issues may surface which are an underlying cause for risk behavior. The following lists provide examples of information requirements that leaders can know and can ask for without their Soldiers' approval (time and date of appointments), what leaders cannot know (what is discussed at medical appointments and diagnosis), and examples of other readiness-related data elements that are not part of the Health Insurance Portability and Accountability Act (HIPAA).

Leaders Health Insurance Portability and Accountability Act Guidance

How HIPAA impacts a leader:

- HIPAA strikes a balance that permits the important uses of information while protecting the privacy of people who seek healthcare.
- Commanders need to know health information about Soldiers (and certain specific issues with families) that could impact the unit's readiness and the individual Soldier's ability to perform their duties.
- A primary goal of HIPAA is to make sure that an individuals' health information is adequately protected, while allowing the flow of health information that is needed to provide and promote high-quality health care.

The following list comprises what commanders can know or ask for without a Soldiers' approval:

- Medical evaluation board-related data
- Requirements for deployability
- Performance limiting medications (i.e., narcotics or sleep medication)
- Performance limiting conditions (i.e., epilepsy, heart disease, or hallucinations)
- Duty related to the Personnel Reliability Program (nuclear/biological/chemical)
- Flight status
- Command-directed mental health evaluation results (i.e., whether they were successful or not)
- Medical line of duty determinations or accident investigations

- Eligibility for Soldier recovery units
- Hospitalization, serious injury, or very serious injury status
- The status of appointments made and missed
- Army body composition program documentation
- Army Family Advocacy Program initial and follow-up reports
- An immediate threat to life or health (suicide/homicide)

The following are some examples of questions relating to these topics:

- What is the status of the medical on Sergeant Smith?
- Has Private (PVT) Smith had all of his required vaccinations to deploy?
- Specialist (SPC) Smith just had surgery. What medications were prescribed that would limit his duties as a mechanic?
- Is Chief Warrant Officer 2 cleared for flight duty? Chemical surety mission?
- What is the status of the family advocacy case involving Captain (CPT) Rogers?
- Sergeant First Class (SFC) Jones is seeing multiple doctors (specialists) for various conditions. Is SFC Jones on any medications or treatment plan that would interfere with deployment?
- Is CPT Mission a candidate for a Soldier Recovery Unit?

The following list is what commanders have no official right to know:

- Medical information that does not impact readiness or ability to do the job
- Soldier family information (unless and only as it applies to family advocacy in accordance with AR 608-18, *The Army Family Advocacy Program*, 30 October 2007)

The following are some examples of questions related to this topic:

- Is PVT Smith's wife in for a medical appointment?
- What medication is CPT Mission on?
- Is SFC Jones on birth control pills?
- I heard Colonel (COL) Rogers is having surgery on his gallbladder – is that correct?
- Did SPC Smith refer himself to behavioral health?

Endnote

1. Center for Army Lessons Learned (CALL), *Building Cohesive Teams*, 6 April 2021.

CHAPTER 5

Assessing: Monitoring Progress through Ready and Resilient and Suicide Prevention Processes

The ready and resilient (R2) and suicide prevention processes establish a framework to make sure commanders and stakeholders are sustaining personal readiness, and fostering a culture of trust throughout their respective organizations. Because of the complexity of suicide and other self-harm and prohibited abuse (i.e., sexual harassment, sexual assault, domestic violence, spouse abuse, or child abuse), leaders should establish a system to effectively manage the multiple and overlapping risk protective factors and accompanying targeted prevention actions.

Objectives

- Understand the elements of executing a unit R2 process for suicide prevention.
- Recognize the differences between the unit R2 process, the commander's R2 council (CR2C), and other installation suicide prevention committees/ working groups.
- Apply the principles of postvention.

READY AND RESILIENT PROCESSES

R2 forums (which may also be named brigade health promotion teams, unit resiliency teams, unit resiliency councils, etc.) are designed to provide brigade or unit leadership with a forum to synchronize and monitor the standards for a safe, healthy environment for Soldiers, family members, and civilians. These forums are designed to provide multiple levels of leadership with a routine assessment, and develop and assess targeted actions in their formation.

Establishing a Unit Ready and Resilient Process

Brigade and battalion commanders should establish a unit R2 process to provide early detection of risk behavior through systematic investigation. It should also help commanders implement timely, local, and targeted responses, and enhance overall readiness. It will represent the interests of Soldiers and families in the unit. These processes should incorporate an integrated and holistic approach consistent with the five domains (physical, spiritual, psychological/emotional, social, and family). The R2 process will

guide leaders and first-line supervisors and help identify those at increased risk to themselves or others, and direct Soldiers to the appropriate resources in support of early prevention.

Unit R2 processes utilize command visibility tools to conduct assessments, determine actions driven by data and trends, prioritize strengthening protective factors, reduce the risk of multiple problems leading to crisis, and foster resilience and a climate and culture of trust. Commanders can use this forum to manage high-risk Soldiers. The collection and assessment of metrics (risk and protective factors) assists with identifying gaps, concerns, and any opportunities to build resilience. This also measures the performance of resources, the effectiveness of interventions, and the ability to reassess the overall well-being of the unit.

Membership

The brigade commander and command sergeant major (CSM) co-chair and oversee the unit R2 process. They are responsible for educating leaders about the mission and purpose, and for developing the process for presenting Soldier and unit issues. Subordinate commanders and CSMs make up the briefers. Associate members include the following:

- Brigade and battalion representatives from the S1,
- Surgeons,
- Chaplains,
- The staff judge advocate,
- Behavioral health and safety representatives,
- Master resilience trainers,
- A sexual assault response coordinator and victim advocate,
- The Provost Marshal,
- Equal opportunity representatives,
- Alcohol and substance abuse representatives,
- Family advocacy representatives,
- Embedded military and family life consultants,
- The Soldier and family readiness group lead, and
- Others as identified by the command.

Auxiliary members from higher command may include, but are not limited to, the community ready and resilient integrator, the suicide prevention program manager, the risk reduction coordinator, a family life chaplain, and Army Community Services (ACS).

A specialized team of unit and community clinical and nonclinical counselors will be established to identify and monitor at-risk Soldiers, and facilitate appropriate referrals and training to increase resilience and readiness. Members will be able to discuss pertinent information, and by definition of their duty position, are legally and ethically obligated to protect specific personal information relayed in confidence. Auxiliary members will be present during the discussion of individuals only when the issue is managed by the particular organization (i.e., if the Soldier has a financial hardship, ACS will be present during the Soldier discussion only).

Inputs

- Key individuals from within the unit that have been identified as subject matter experts from the community (garrison and medical).
- Assessments and trend analysis of individuals and teams from Command Visibility Tools and other reporting systems.
- Inventory of programs, training, initiatives, and practices.
- Community resources (programs, practices, training, initiatives).
- Coordination of recurring meetings, at least monthly.
- Unit priorities and recommendations from subordinate command R2 processes, installation CR2C, and supporting working groups.

Outputs

- Identification of priority areas (risk and protective factors) and emerging issues (i.e., increased discipline problems).
- Monitoring of performance metrics (measures of performance and measures of effectiveness).
- Recommendations for targeted individual and unit prevention and risk mitigation activities (policies, training, practices, initiatives, etc.).
- Leader awareness and responsiveness to individual and unit issues.
- Attendance and reporting at the CR2C.
- Brigade R2 policy that operationalizes suicide prevention policy and program.

Templates for battalion and brigade-level unit R2 forums and supporting working groups are located in Appendix C. These represent the ideal process in a relatively unconstrained environment. When constraints exist, the integrity of key staff, agenda items, and meeting inputs should be represented in a combination of alternative battle rhythm events that can achieve the same outputs.

Synchronizing with the Community Ready and Resilient Council

Suicide prevention is a complex public health problem, and should be addressed by multiple functional sectors. Therefore, the installation senior commander's CR2C aims to create synergy and opportunities for collaboration to address crosscutting problems across many sectors.

The Community Readiness and Resiliency Integrator (CR2I) serves as a consultant to brigade and battalion commanders to establish unit R2 processes and synchronize unit processes with the installation CR2C. Brigade and separate battalion installation tenant unit commanders will participate in the CR2C.

SUICIDE PREVENTION AND POSTVENTION PROCESSES

To move upstream and prevent suicide behaviors, commands can benefit from analyzing the decedent's behaviors to understand the factors (Soldier, environment, leadership, etc.) which were known, and to discover what was not known. This effort is to create information and lessons learned. These lessons learned may be used to prevent future suicides.

Three milestone meetings anchor the postvention process:

- Installation-wide battalion commander after action review (AAR)
- Suicide response team
- Suspected Suicide Fatality Review and Analysis Board (S2FRAB)

It is highly recommended that commands establish procedures that align the reporting, postvention, and lessons learned from these events. This will increase visibility at all levels to determine factors that may have prevented the death, and to identify the factors that enabled the Soldier to decide to die by suicide.

The results of the S2FRAB should transition into the Suicide Prevention Working Group (SPWG), unit R2 forums, and CR2C to implement and monitor identified gaps and lessons learned.

Suspected Suicide Reporting and Investigations

In the rare event of a suicide, there are several critical actions required of the command team. This section discusses the numerous legal and administrative requirements that a commander must fulfill. Satisfying the legal and administrative requirements should not downplay the command response to the human tragedy at the forefront of all actions. Upon notification of a suspected suicide, the most critical goal is to provide calm and focused leadership.

Unit Postvention

Postvention consists of the structured activities following a suicide attempt or death by suicide that promote recovery and healing among those affected. Postvention includes support to the bereaved, and assistance to anyone whose risk of suicide might be increased in the aftermath of suicide behaviors. Proactive postvention can help confront and stabilize any suicide-specific issues among Soldiers.

Commanders should examine their own beliefs and assumptions about suicidal behaviors, as their thoughts and feelings toward suicide can, unintentionally or intentionally, influence communication about the death and the nature of interaction with survivors.

Leaders need to actively engage Soldiers early (within 48-hours of the death) and throughout the postvention. Leaders should make sure that Soldiers know the process to receive the support they need. Soldiers benefit from an active postvention approach where support and resources (for example, grief counseling, support groups, and peer mentoring) are offered directly and as soon as possible following a death or a suicide attempt, within hours if possible and appropriate.

Commanders should consult their chaplain and installation director of psychological health, the unit assigned behavioral health officer (BHO), or a trusted embedded behavioral health team for specific support and approaches after a suicide attempt.

Leader skills and actions:

- Increase leadership engagement, formally and informally. Formal actions should include increasing senior leadership presence in the work area immediately following the announcement of death, unless there is a risk of being perceived as disingenuous. Informal actions include engaging with personnel, and communicating messages of support and information. Initially, leadership presence should be intensive and gradually decrease over the next 30-days to an appropriate tempo.

- Command teams should be familiar with the following information about people bereaved by suicide that may be helpful:
  - Common reactions to suicide loss include intense grief, trauma symptoms, guilt, and preoccupation with why the suicide behavior occurred.
  - There are also physiological responses, such as sleep disruption, appetite loss, and difficulty concentrating or making decisions.
  - The severe or long-term reactions of loss can include depression, increased anxiety or hypervigilance, a changed view of the world, strain in interpersonal relationships, and the possibility of post-traumatic growth.
- Make it a priority to assist affected unit members in identifying and connecting with bereavement resources. Commanders should provide the space and time for bereavement and grief to help their unit members.
- Balance the need to grieve and access necessary grief resources with returning to the mission and operational readiness. Allow sufficient time to grieve and facilitate access to behavioral health resources. Leaders should use their best judgment in determining what and when this return to routine is appropriate and healthy.

Commands should simultaneously execute postvention processes and initiate the required 15-6 investigation and reporting. There are two required reports: Department of the Army (DA) Form 7747, *Commanders Suspected Suicide Event Report (CSSER)*, 1 June 2020, and Department of Defense (DD) 2996, *Department of Defense Suicide Event Report (DODSER)*, 1 March 2015.

DA Form 7747. Commanders from all components must complete and submit a DA Form 7747 on every suspected Soldier's death by suicide. The commander responsible for the unit where the incident occurred prepares the DA Form 7747 with assistance from the 15-6 investigating officer. The DA Form 7747 has three distinct supporting sections (the Serious Incident Report, the Commander's Initial Report, and the Commander's Final Report). Encrypt and submit completed DA Form 7747s by email to usarmy.pentagon.hqda-dcs-g-1.mbx.csser@army.mil.

DD Form 2996. The DODSER is used to report all suicides and suicide attempts regardless of hospitalization for all active duty and Reserve Component Soldiers, including the selected reserve (see Department of Defense Instruction [DODI] 6490.16, *Defense Suicide Prevention Program*, 11 September 2020). The DODSER program manager functions within the Defense Health Agency, is responsible for administering the program for the Army, and provides technical support for DODSER completion. Installation medical treatment facilities identify a point of contact (POC) to complete the DODSER for suspected suicides.

Installation-wide Battalion Commander After Action Review

When there is a suspected suicide, senior commanders must convene all battalion commanders on the installation within 96-hours. The intent is to deliver timely and relevant information that may serve to assist. Commanders can recognize warning signs through the sharing of key observations.

Reporting. A Serious Incident Report (SIR) (Section 1) consists of the minimally required information to inform Army senior leaders of an occurrence. Units are required to submit a SIR (initial report) within 24-hours following a death. Encrypt and submit by email to: usarmy.pentagon.hqda-dcs-g-1.mbx.csser@army.mil

The Suicide Response Team

The Suicide Response Team (SRT) assists and advises the commander with assessing the situation, determining appropriate courses of action, and immediately directing interagency and inter-staff actions. SRT supports the suicide prevention objective to increase the timeliness and usefulness of suicide behavior surveillance and associated risk and protective factors in the reporting system to improve preventive actions. The garrison commander should convene the SRT and assemble the community resources within 48-hours of a death by suicide or suspected suicide.

Reporting. DA Form 7747 Section 2 builds upon SIR information with additional questions that commands can readily attain without extensive interviews and investigation. Section 2 is due within five days, and should be sent via encrypted email to usarmy.pentagon.hqda-dcs-g-1.mbx.csser@mail.mil. The information should be obtained during the SRT process.

Suspected Suicide Fatality Review and Analysis Board

Senior commanders will convene the S2FRAB no later than 60-days after a suspected suicide. S2FRABs provide a comprehensive, objective, standardized, and big-picture analysis of individual, systemic, and environmental factors. The S2FRAB facilitates gathering more information than what is obtained from the Army Regulation (AR) 15-6, Procedures for Administrative Investigations and Boards of Officers, 1 April 2016, investigation, to determine if additional lessons are learned about how units care for Soldiers. S2FRABs bring together units with suspected suicides and subject matter experts to identify and improve prevention, intervention, and postvention activities.

Reporting. DA Form 7747 Section 3 consists of questions that will provide all echelons of leadership the information for analysis and study trends and patterns. This section also meets the requirements outlined in AR 15-6 regarding the conduct of in-depth interviews and investigations. This section is due within 60-days and will be sent via encrypted email to usarmy.pentagon.hqda-dcs-g-1.mbx.csser@mail.mil. Complete the DD Form 2996 (DODSER) within 60-days of notification of the Armed Forces Medical Examiner (AFME) confirmation of suicide, or within 30-days of an identified suicide attempt.

APPENDIX A

Matrix of Installation Resources by Risk and Protective Factor

Figures A-1 and A-2 are a matrix of installation services by risk and protective factor. Installation and command staff should tailor this matrix to reflect local resources and contact information.

Installation Assets by Risk and Protective Factor								
Military Crisis Line 1 (800) 273-8255 / OCONUS 00800-1273-8255 (DSN118) / Korea 0808-555-118 (DSN 111)								
Helping Resource	Commander/ Supervisor	ASAP and Employee Assistance Program	Army Community Service	Behavioral Health Provider/ IDPH	Chaplain	Employ-ment Readiness Program	Emergency Room	EO/EEO
	Soldiers	Soldiers, Families, Civilians	Soldiers and Families	All	Soldiers and Families	Families	All	Soldiers and Civilians
Resilience	X	X	X	X				
Finances/ Budget	X	X	X	X		X		
Community Programs			X		X			
Spiritual Growth	X			X	X			
Relationship Problems	X	X	X	X	X			
Loneliness/ Isolation	X	X		X	X			
Workplace Stress or Problems	X	X		X	X			X
Alchohol/Drugs	X	X		X				
Fatigue/Sleep	X	X		X				
Deployment	X	X	X	X	X			
Retirement/ Separation	X	X	X	X	X			
Anxiety/Panic/ Depression	X	X		X	X		X	
Chronic Pain	X	X		X	X			
Grief and Loss	X	X		X	X			
Suicidal Thoughts	X	X		X	X		X	

Figure A-1. Matrix of Installation Resources Part One

Installation Assets by Risk and Protective Factor									
Military Crisis Line 1 (800) 273-8255 / OCONUS 00800-1273-8255 (DSN118) / Korea 0808-555-118 (DSN 111)									
Helping Resource	Exceptional Family Member Program	Family Advocacy Program	Financial Readiness Program	MWR	Performance Expert/R2 Training Center	Relocation Assistance Program/ Sodlier and Family Assistance Center	Survivor Outreach Services	SARC/ Victim Advocates	OSD-Military and Family Life Consultants
	Soldiers and Families	Soldiers and Families	Soldiers and Families	All	All	Soldiers and Families	Soldiers and Families	Soldiers and Civilians	Soldiers and Families
Resilience		X			X		X		X
Finances/ Budget	X		X			X	X		
Community Programs				X					
Spiritual Growth									
Relationship Problems		X							X
Loneliness/ Isolation	X	X					X	X	X
Workplace Stress or Problems								X	X
Alchohol/Drugs									
Fatigue/Sleep									X
Deployment	X		X		X				X
Retirement/ Separation			X		X		X		X
Anxiety/Panic/ Depression		X			X	X			X
Chronic Pain								X	
Grief and Loss		X			X		X		X
Suicidal Thoughts		X			X	X		X	

Figure A-2. Matrix of Installation Resources Part Two

APPENDIX B

Suicide Ideation Battle Drill Cards

Figures B-1 through B-4 are the Suicide Ideation Battle Drill cards for leaders, Soldiers, and family members. These cards provide a decision-making and action template for steps to intervene upon seeing a problem.

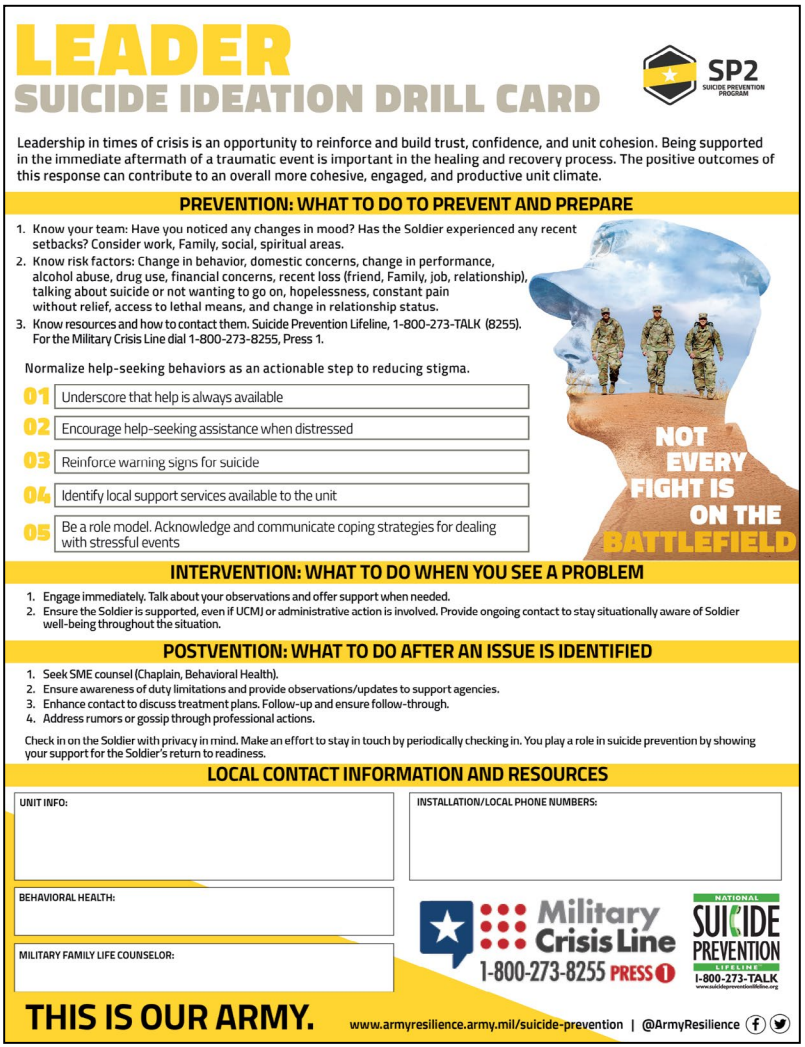


Figure B-1. Leader Suicide Ideation Drill Card

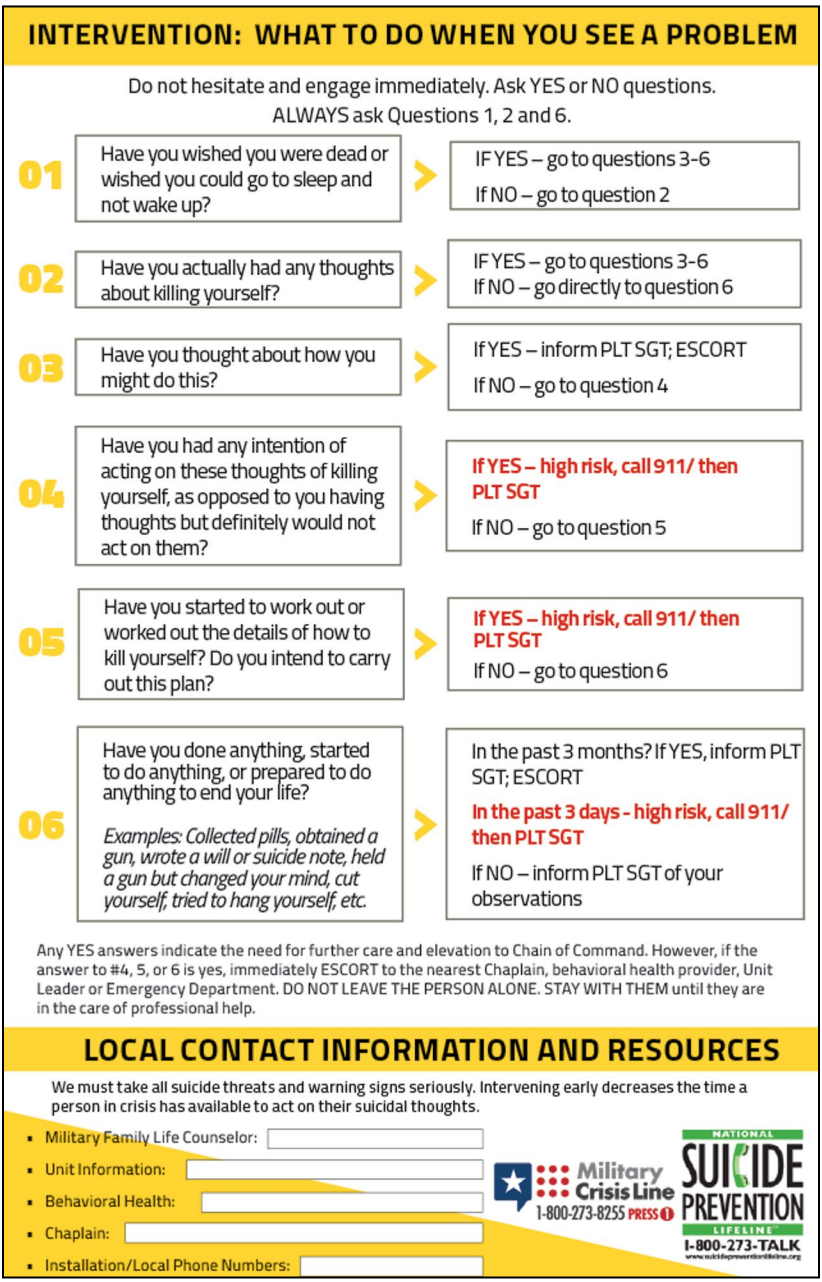


Figure B-2. Soldier Intervention Drill Card

FAMILY MEMBER
SUICIDE IDEATION DRILL CARD

SP2 SUICIDE PREVENTION PROGRAM

You can help prevent suicide or suicide attempts by actively intervening when your spouse or partner expresses suicidal ideation. Be alert and engaged before they are overwhelmed by life stressors and risk factors. Suicidal ideation, or suicidal thoughts, means thinking about planning suicide. Thoughts can range from a quick consideration to a detailed plan.

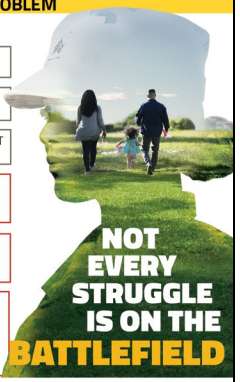
PREVENTION: WHAT TO DO TO PREVENT AND PREPARE

1. Be alert: Have you noticed any changes in mood? Has the Soldier experienced any recent setbacks? Consider work, Family, social, spiritual areas.
2. Know risk factors: Change in behavior, relationship problems, alcohol abuse, drug use, new or crushing debt, recent loss, talking about suicide, constant pain without relief, and access to lethal means.
3. Know resources and how to contact them. Suicide Prevention Lifeline, 1-800-273-TALK (8255). For the Military Crisis Line dial 1-800-273-8255, Press 1.

INTERVENTION: WHAT TO DO WHEN YOU SEE A PROBLEM

Do not hesitate and act immediately. Ask YES or NO questions. ALWAYS ask Questions 1, 2 and 6.

01	Have you wished you were dead or wished you could go to sleep and not wake up?	IF YES – go to questions 3-6 IF NO – go directly to question 2
02	Have you actually had any thoughts about killing yourself?	IF YES – go to questions 3-6 IF NO – go directly to question 6
03	Have you thought about how you might do this?	IF YES – notify Soldier's immediate supervisor; ESCORT IF NO – go to question 4
04	Have you had any intention of acting on these thoughts of killing yourself, as opposed to you having thoughts but definitely would not act on them?	**IF YES – high risk, call 911/ then notify Soldier's immediate supervisor** IF NO – go to question 5
05	Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	**IF YES – high risk, call 911/ then notify Soldier's immediate supervisor** IF NO – go to question 6
06	Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.*	In the past 3 months? If YES, then notify Soldier's immediate supervisor; ESCORT **In the past 3 days? High risk, call 911/ then notify Soldier's immediate supervisor** If NO, inform Soldier's supervisor of your observations



Any YES answers indicate the need for further care. However, if the answer to #4, 5, or 6 is yes, immediately ESCORT to the nearest Emergency Room, Mental Health Clinic, Chaplain, behavioral health provider, or Soldier's immediate supervisor. DO NOT LEAVE THE SOLDIER ALONE. STAY WITH THEM until they are in the care of professional help.

POSTVENTION: WHAT TO DO AFTER AN ISSUE IS IDENTIFIED

Stay connected and show concern. You play a role in suicide prevention by showing your support for recovery.

LOCAL CONTACT INFORMATION AND RESOURCES

STAY CONNECTED AND SHOW CONCERN. YOU PLAY A ROLE IN SUICIDE PREVENTION BY SHOWING YOUR SUPPORT FOR RECOVERY.

UNIT INFO:

INSTALLATION/LOCAL PHONE NUMBERS:

CHAPLAIN:

BEHAVIORAL HEALTH:

MILITARY FAMILY LIFE COUNSELOR:

Military Crisis Line
1-800-273-8255 PRESS 1

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK

THIS IS OUR ARMY.

www.armyresilience.army.mil/suicide-prevention | @ArmyResilience

Figure B-3. Family Member Suicide Ideation Drill Card

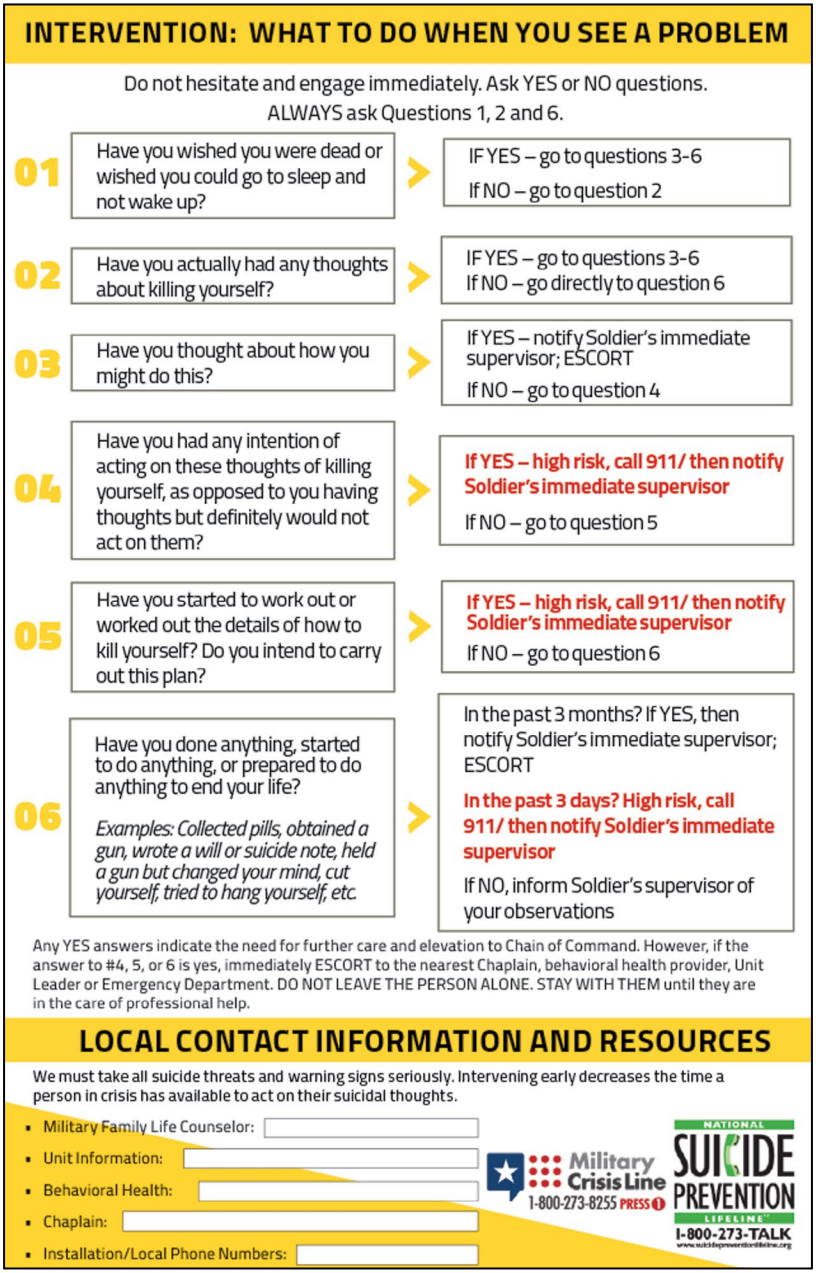


Figure B-4. Family Member Intervention Drill Card

APPENDIX C

Seven-Minute Drill Templates

Figures C-1 through C-11 are templates for battalion and brigade-level unit ready and resilient (R2) forums and supporting working groups. These represent the ideal process in a relatively unconstrained environment. When constraints exist, the integrity of key staff, agenda items, and meeting inputs should be represented in a combination of alternative battle rhythm events that can achieve the same outputs.

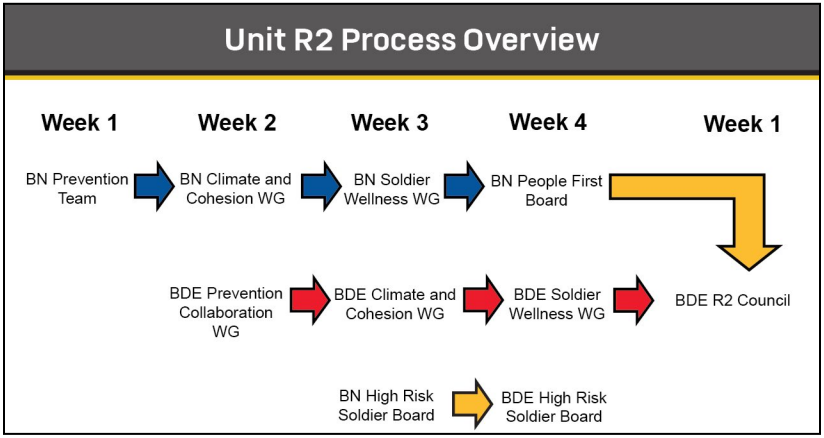


Figure C-1. Unit R2 Process Overview

BN Prevention Team

Purpose: BN staff conducts environmental assessments and implements problem solving strategies to generate initiative proposals to mitigate risk factors and prevent harmful behaviors in the BN's operational environment.

Frequency/Day/Time: 1st week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: S2

Slide Library Address: [Insert]

Chair: XO

Alternate Chair: Operations SG

Attendees:

- ❑ CO HQs PSG
- ❑ MEDO
- ❑ S1
- ❑ S2
- ❑ A/S3
- ❑ Targeting Officer
- ❑ BN SHARP Representative
- ❑ BN Retention
- ❑ BN Legal Clerk
- ❑ CRRT (BN CDR's Delegate)
- ❑ Chaplain

Command Group Attendees:

- ❑ XO
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ CRRT Analysis (BN CDR's Delegate)
- ❑ BH Pulse Assessment (MEDO)
- ❑ Financial Readiness Assessment (S1)
- ❑ AER Trends (S1)
- ❑ Legal Non-Deployable Status (S1)
- ❑ Flags (S1)
- ❑ Bars (Retention)
- ❑ Administrative Separations (Legal Clerk)
- ❑ UCMJ Actions (Legal Clerk)
- ❑ Blotter Report Metrics (S2)
- ❑ DA 4833 Compliance (S2)
- ❑ Prime for Life Status (S2)
- ❑ UA Compliance (S2)
- ❑ Personnel Security (S2)
- ❑ AR 350-1 Training (Suicide Prevention,
- ❑ Resilience, SHARP) (S3)
- ❑ Additional Duty Capacity (SHARP, ACE-SI, MRT, UPL)
- ❑ SHARP Assessment (BN SHARP Rep

Outputs:

- ❑ Updated Running Estimates
- ❑ Completed Assessments
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List

Feeds: Provides information to People First Board/BN command and staff

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Changes to CDR Guidance	
	Current Initiatives Update	
	Staff Assessments	
	Initiative Nominations	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-2. Battalion Prevention Team

BN Climate and Cohesion WG

Purpose: BN staff conducts environmental climate and quality of life assessments, and implements problem solving strategies to generate initiative proposals to build social protective factors in the BN's operational environment.

Frequency/Day/Time: 2nd week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: S1

Slide Library Address: [Insert]

Chair: XO

Co-Chair: CSM

Attendees:

- ❑ CO XOs
- ❑ CO 1SGs
- ❑ MEDO
- ❑ S1
- ❑ S4
- ❑ S3 NCOIC
- ❑ Targeting Officer
- ❑ BN BOSS Representative
- ❑ Chaplain
- ❑ BN SFRG Liaison
- ❑ CRRT (BN CDR's Delegate)
- ❑ Junior Soldiers/Leaders

Command Group Attendees:

- ❑ CSM
- ❑ XO
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ CRRT Analysis (BN CDR's Delegate)
- ❑ DEOCS Assessment (S1)
- ❑ BH Pulse Assessment (MEDO)
- ❑ Awards (S1)
- ❑ Evaluations (S1)
- ❑ Sponsorship Status (S1)
- ❑ SFRG Assessment (S1)
- ❑ Facilities Maintenance (Real Property, Motorpool) (S4)
- ❑ Barracks WO Status (S4)
- ❑ Training Schedule Status (S3)
- ❑ CQ/Courtesy Patrol Observations (S3 NCOIC)
- ❑ Leadership Development Programs (S3)
- ❑ BOSS (BN BOSS Representative)

Outputs:

- ❑ Updated Running Estimates
- ❑ Completed Assessments
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List

Feeds: Provides information to People First Board/BN command and staff

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Changes to CDR Guidance	
	Current Initiatives Update	
	Staff Assessments	
	Initiative Nominations	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-3. Battalion Climate and Cohesion Working Group

BN Soldier Wellness WG

Purpose: BN staff conducts environmental assessments, and implements problem solving strategies to generate initiative proposals to mitigate risk and build emotional and physical protective factors in the BN's operational environment.

Frequency/Day/Time: 3rd week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: MEDO

Slide Library Address: [Insert]

Chair: S3

Co-Chair: Operations SGM

Attendees:

- ❑ CO 1SGs
- ❑ Chaplain
- ❑ S1
- ❑ MEDO
- ❑ A/S3
- ❑ S3 NCOIC
- ❑ Targeting Officer
- ❑ MRT
- ❑ CRRT (BN CDR's Delegate)

Command Group Attendees:

- ❑ S3
- ❑ Operations SGM
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ CRRT Analysis (BN CDR's Delegate)
- ❑ BH Pulse Assessment (MEDO)
- ❑ Azimuth Check Assessment
- ❑ EBH Metrics (MEDO)
- ❑ MEDPROS (MEDO)
- ❑ IDES Status (MEDO)
- ❑ ABCP Status (S1/MEDO)
- ❑ Sick Call/Profiles/MSK Injury Metrics (MEDO)
- ❑ Medical ND Status (S1)
- ❑ Soldier Recovery Unit (S1)
- ❑ UMT Counseling Assessment (CH)
- ❑ ACFT Performance (S3)
- ❑ Resilience Assessment (S3)
- ❑ P3T/Special Population PT Assessment (S3/MEDO)

Outputs:

- ❑ Updated Running Estimates
- ❑ Completed Assessments
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List

Feeds: Provides information to People First Board/BN command and staff

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Changes to CDR Guidance	
	Current Initiatives Update	
	Staff Assessments	
	Initiative Nominations	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-4. Battalion Soldier Wellness Working Group

BN People First Board

Purpose: BN leadership teams assess the population and environment in the command, and identify problem solving initiatives to mitigate risk and build protective factors for the BN's Soldiers and families.

.

Frequency/Day/Time: 4th week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: Targeting Officer

Slide Library Address: [Insert]

Chair: BN CDR

Alternate Chair: XO

Attendees:

- ❑ CO CDRs
- ❑ 1SGs
- ❑ S3
- ❑ A/S3
- ❑ S3 NCOIC
- ❑ S1
- ❑ SFRG Liaison
- ❑ S2
- ❑ S4
- ❑ S6
- ❑ MEDO
- ❑ BN BOSS Representative
- ❑ Chaplain

Command Group Attendees:

- ❑ BN CDR
- ❑ CSM
- ❑ XO
- ❑ S3
- ❑ Operations SGM
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ Campaign Plan Assessment (MOP/MOE)
- ❑ CDR Guidance and Intent
- ❑ Current Initiatives Status
- ❑ Staff Running Estimates and Assessments
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List

Outputs:

- ❑ Updated Campaign Plan
- ❑ CDR Guidance
- ❑ Approved Collection Plan for Information Requirements
- ❑ Approved Initiatives Priorities List
- ❑ Requests for Assistance (BDE, Installation)

Feeds: BDE R2 Council

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Review CDR Guidance	
	Current Initiatives Update	
	Staff Assessments	
	Approved Prioritized Initiatives List	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-5. Battalion People First Board

BDE Prevention Collaboration WG

Purpose: BDE staff conducts environmental assessments and implements problem solving strategies to generate initiative proposals to mitigate risk factors, and prevent harmful behaviors in the BDE's operational environment.

Frequency/Day/Time: 1st week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: S1

Slide Library Address: [Insert]

Chair: S2

Co- Chair: Operations SGM

Alternate Chair: XO

Attendees:

- ❑ BN Operations SGMs
- ❑ S1
- ❑ S2
- ❑ A/S3
- ❑ BHO
- ❑ Provost Marshal
- ❑ Chaplain
- ❑ BDE SHARP Representative
- ❑ BDE Suicide Prevention Representative
- ❑ BDE Safety Representative
- ❑ BDE Legal
- ❑ BDE UPL
- ❑ CRRT (BDE CDR's Delegate)

Command Group Attendees:

- ❑ Operations SGM
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ CRRT Analysis (BDE CDR's Delegate)
- ❑ BH Pulse Assessment (BHO)
- ❑ Financial Readiness Assessment (S1)
- ❑ Legal Non-Deployable Metrics (S1)
- ❑ UCMJ Metrics (BDE Legal)
- ❑ Prime for Life Status (S2)
- ❑ UA Compliance (S2)
- ❑ Personnel Security (S2)
- ❑ AR 350-1 Training (Suicide Prevention, Resilience, SHARP) (S3)
- ❑ Additional Duty Capacity (SHARP, ACE-SI, MRT, UPL)
- ❑ SHARP Assessment (BDE SHARP Representative)
- ❑ Safety Trends (BDE Safety)
- ❑ Blotter Report Metrics (Provost Marshall)
- ❑ DA 4833 Compliance (Provost Marshall)
- ❑ Civilian Crime Trends (Provost Marshall)
- ❑ Domestic Violence Assessment (Provost Marshall)

Outputs:

- ❑ Updated Running Estimates
- ❑ Completed Assessments
- ❑ Refined MOP/MOE
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List
- ❑ Messaging Plan

Feeds: Provides information to BDE R2 Council

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Current Initiatives Update	
	Staff Assessments	
	Initiatives Nominations	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-6. Brigade Climate and Cohesion Working Group

BDE Climate and Cohesion WG

Purpose: BDE staff conducts environmental climate and quality of life assessments and implements problem solving strategies to generate initiative proposals to build social protective factors in the BDE's operational environment.

Frequency/Day/Time: 2nd week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: S1

Slide Library Address: [Insert]

Chair: XO

Co- Chair: CSM

Alternate Chair: S3

Attendees:

- ❑ CO XOs
- ❑ CO 1SGs
- ❑ S1
- ❑ S2
- ❑ S4
- ❑ S8
- ❑ Chaplain
- ❑ BHO
- ❑ BDE BOSS Representative
- ❑ Provost Marshal
- ❑ BDE Steering Committee Liaison
- ❑ PAO

Command Group Attendees:

- ❑ CSM
- ❑ XO
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ CRRT Analysis (BDE CDR's Delegate)
- ❑ DEOCS Assessment (S1)
- ❑ BH Pulse Assessment (BHO)
- ❑ Sponsorship Program Assessment (S1)
- ❑ SFRG Assessment (S1)
- ❑ Facilities Maintenance (Real Property,
- ❑ DFAC, Motorpool, Gym) (S4)
- ❑ Barracks Assessment (S4)
- ❑ Training Predictability Assessment (S3)
- ❑ Leadership Development Program(s) (S3)
- ❑ MWR Assessment (BDE BOSS Representative)
- ❑ Off-Post Environmental Assessment (S2/Provost Marshall)
- ❑ Child and Youth Services Assessment (S2)
- ❑ Soldier and Family Programs Assessment (S2)
- ❑ Spouse Employment (S2)
- ❑ FAP Metrics (S1)

Outputs:

- ❑ Updated Running Estimates
- ❑ Completed Assessments
- ❑ Refined MOP/MOE
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List
- ❑ Messaging Plan

Feeds: Provides information to BDE R2 Council

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Changes to CDR Guidance	
	Current Initiatives Update	
	Staff Assessments	
	Initiatives Nominations	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-7. Brigade Soldier Wellness Working Group

BDE Soldier Wellness WG

Purpose: BDE staff conducts environmental assessments and implements problem solving strategies to generate initiative proposals to mitigate risk, and build emotional and physical protective factors in the BDE's operational environment.

Frequency/Day/Time: 3rd week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: MEDO

Slide Library Address: [Insert]

Chair: S3

Co- Chair: BDE Surgeon, Chaplain

Alternate Chair: XO

Attendees:

- ❑ BDE Operations SGM
- ❑ BN Operations SGMs
- ❑ A/S3
- ❑ S1
- ❑ Chaplain
- ❑ Surgeon
- ❑ BHO
- ❑ MEDO
- ❑ Dietician/BDE Food Service Advisor
- ❑ PAO

Command Group Attendees:

- ❑ S3
- ❑ Operations SGM
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ CRRT (BDE CDR's Delegate)
- ❑ BH Pulse Assessment (BHO/MEDO)
- ❑ EBH Metrics (BHO)
- ❑ UMT Counseling Assessment (CH)
- ❑ Spirituality Assessment (CH)
- ❑ MEDPROS (MEDO)
- ❑ Sick Call/Profiles/MSK Injury Metrics (Surgeon)
- ❑ Soldier Recovery Unit (S1)
- ❑ Nutrition Assessment (Dietician/BDE Food Service Advisor)
- ❑ Resilience Training Assessment (S3)
- ❑ Gym/PF Resource Assessment (S3)

Outputs:

- ❑ Updated Running Estimates
- ❑ Completed Assessments
- ❑ Refined MOP/MOE
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List
- ❑ Messaging Plan

Feeds: Provides information to BDE R2 Council

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Review to CDR Guidance	
	Current Initiatives Update	
	Staff Assessments	
	Initiatives Nominations	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-8. Brigade Prevention Collaboration Working Group

BDE R2 Council

Purpose: BDE leadership teams and multi-disciplinary SMEs monitor the unit People First campaign, assess the population and environment in the command, and synchronize command and installation resources to mitigate risk and build protective factors for the BDE's Soldiers and families.

Frequency/Day/Time: 4th week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: S3/Targeting Officer

Slide Library Address: [Insert]

Chair: BDE CDR

Alternate Chair: XO

Attendees:

- ❑ CSM
- ❑ BN CDRs
  BN CSMs
- ❑ S3
- ❑ S3 NCOIC
- ❑ S1
- ❑ S2
- ❑ S4
- ❑ S6
- ❑ S8
- ❑ Chaplain
- ❑ Surgeon
- ❑ BHO
- ❑ SJA
- ❑ PAO

Command Group Attendees:

- ❑ BN CDR
- ❑ CSM
- ❑ XO
- ❑ S3
- ❑ Operations SGM
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ Campaign Plan Assessment (MOP/MOE)
- ❑ CDR Guidance and Intent
- ❑ Current Initiatives Status
- ❑ Staff Running Estimates and Assessments
- ❑ Requests for CDR Guidance
- ❑ Information Requirements
- ❑ Recommended Initiative Priorities List

Outputs:

- ❑ Updated Running Estimates
- ❑ CDR Guidance
- ❑ Approved Collection Plan for Information Requirements
- ❑ Approved Initiatives Priorities List
- ❑ Requests for Assistance (BDE, Installation)

Feeds: CR2C

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Review of Campaign Plan/LOEs	
	Review to CDR Guidance	
	Current Initiatives Update	
	Staff Assessments	
	Approved Prioritized Initiatives List	
	Review Due-outs and Suspenses	
	Guidance/Closing Remarks	

Figure C-9. Brigade R2 Council

BDE High-Risk Soldier Board

Purpose: BN leadership teams and multi-disciplinary SMEs collaborate to identify at-risk and high-risk Soldiers, and develop and assess detailed action plans to address individual risk and protective factors.

Frequency/Day/Time: 1st week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: XO

Slide Library Address: [Insert]

Chair: BN CDR

Alternate Chair: XO

Attendees:
- ❑ CSM
- ❑ CO CDRs
- ❑ 1SGs
- ❑ Chaplain
- ❑ BDE Surgeon
- ❑ BDE BHO
- ❑ PAO
- ❑ MEDO
- ❑ BN Legal Clerk

Command Group Attendees:
- ❑ BN CDR
- ❑ CSM
- ❑ XO
- ❑ *Additional staff as needed*

Inputs: [Insert description]
- ❑ CDR Guidance and Intent
- ❑ CRRT (Individual Risk History)
- ❑ High Risk Soldiers (Counseling, R4 Tool)
- ❑ Administrative Separations (BDE SJA)
- ❑ Investigations (BDE SJA)
- ❑ IDES Status (MEDO)
- ❑ Polypharmacy (BDE Surgeon)
- ❑ SUDCC (BDE Surgeon)
- ❑ Soldier Recovery Unit (S1)
- ❑ Family Advocacy Program
- ❑ Requests for CDR Guidance/Resources

Outputs:
- ❑ CDR Guidance
- ❑ Resource Allocation
- ❑ Requests for Assistance (BDE, Installation)

Feeds: Feeds: BDE High-Risk Soldier Council

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Command Team Soldier Assessments	
	Review Due-outs and Suspenses	
	Guidance/ Closing Remarks	

Figure C-10. Battalion High Risk Soldier Board

BDE High-Risk Soldier Board

Purpose: BDE leadership teams and multi-disciplinary SMEs collaborate to assess high-risk Soldier action plans and synchronize interventions.

Frequency/Day/Time: 2nd week of the month

Location: [Insert]

MS Teams/Dial-in: [Insert group or dial-in information]

Staff Proponent: BDE Surgeon

Slide Library Address: [Insert]

Chair: BN CDR

Alternate Chair: XO

Attendees:

- ❑ CSM
- ❑ BN CDRs
- ❑ BN CSMs
- ❑ S1
- ❑ Chaplain
- ❑ Surgeon
- ❑ BHO
- ❑ SJA

Command Group Attendees:

- ❑ BN CDR
- ❑ CSM
- ❑ XO
- ❑ *Additional staff as needed*

Inputs: [Insert description]

- ❑ CDR Guidance and Intent
- ❑ BN High-Risk Soldier Assessments
- ❑ BN Requests for CDR Guidance
- ❑ BN Requests for BDE/Installation Assistance

Outputs:

- ❑ CDR Guidance
- ❑ Resource Allocation
- ❑ Requests for Assistance (Higher CMD, Installation)

Feeds: NA

Meeting Agenda:

Briefer	Content	Timeline
Duty Title	Opening Remarks	
	Status of Actions/ Due-outs	
	Command Team Soldier Assessments	
	Review Due-outs and Suspenses	
	Guidance/ Closing Remarks	

Figure C-11. Brigade High Risk Soldier Board

GLOSSARY

AAR	after action review
ABCP	Army Body Composition Program
ACE	Ask, Care, and Escort
ACE-SI	Ask, Care, and Escort-Suicide Intervention
ACFT	Army Combat Fitness Test
ACS	Army Community Service
ADP	Army doctrine publication
AER	Army Emergency Relief
AFME	Armed Forces Medical Examiner
AR	Army regulation
ARAP	Army Readiness Assessment Program
A/S3	assistant/operations officer
ASAP	Army Substance Abuse Program
ASIST	Applied Suicide Intervention Skills Training
BDE	brigade
BH	behavioral health
BHO	behavioral health officer
BN	battalion
BOSS	Better Opportunities for Single Soldiers
CALL	Center for Army Lessons Learned
CAPL	Center for the Army Profession and Leadership
CDR	commander
CH	chaplain
CO	company
COL	colonel
CPT	captain
CQ	charge of quarters
CR2C	Commander's Ready and Resilient Council
CR2I	Community Readiness and Resiliency Integrator

CRRT	Commander's Risk Reduction Toolkit
CSSER	Commanders Suspected Suicide Event Report
CSM	command sergeant major
DA	Department of the Army
DD	Department of Defense (form)
DEOCS	Defense Organizational Climate Survey
DEOMI	Defense Equal Opportunity Management Institution
DFAC	dining facility
DOD	Department of Defense
DODI	Department of Defense instruction
DODSER	DOD Suicide Event Report
DTMS	Digital Training Management System
EBH	embedded behavioral health
EEO	equal employment opportunity
EFMP	Exceptional Family Member Program
EO	equal opportunity
EXORD	execution order
FAP	family advocacy program
FM	field manual
HIPAA	Health Insurance Portability and Accountability Act
HQ	headquarters
HQDA	Headquarters, Department of the Army
IDES	integrated disability evaluation system
IDPH	Installation Director of Psychological Health
LOE	line of effort
MEDO	medical officer
MEDPROS	medical protection system
MOE	measure of effectiveness
MOP	measure of performance
MRT	master resilience training
MSK	musculoskeletal

MS-Teams	Microsoft Teams
MWR	morale, welfare, and recreation
NCO	noncommissioned officer
NCOIC	noncommissioned officer in charge
ND	non-deployable
OCONUS	outside the continental U.S.
OSD	Office of the Secretary of Defense
P3T	pregnancy postpartum physical training
PAM	pamphlet
PAO	public affairs officer
PCS	permanent change of station
PF	physical fitness
POC	point of contact
POF	privately owned firearm
PSG	platoon sergeant
PT	physical training
PTSD	post-traumatic stress disorder
PVT	private
R2	ready and resilient
RRP	Risk Reduction Program
R-URI	re-integration URI
S1	personnel staff officer
S2	intelligence officer
S2FRAB	Suspected Suicide Fatality Review and Analysis Board
SARC	Sexual Assault Response Coordinator
SFC	sergeant first class
SFRG	Soldier and Family Readiness Group
SG	sergeant
SGM	sergeant major
SHARP	Sexual Harassment/Assault Response and Prevention
SIR	Serious Incident Report

SJA	staff judge advocate
SME	subject matter expert
SPC	specialist
SPWG	Suicide Prevention Working Group
SRT	Suicide Response Team
SUDCC	substance use disorder clinical care
UA	urinalysis
UCMJ	Uniform Code of Military Justice
UMT	unit ministry team
UPL	unit prevention leader
URI	unit risk inventory
WG	working group
WO	warrant officer
XO	executive officer

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No. 22-663
NOV 2021

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