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Personnel – General

Leader's Guide for Risk Reduction and Suicide Prevention

FOR THE COMMANDER:

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History. This publication is a rapid action revision. The portions affected are listed in the summary of change.

Summary. This pamphlet serves as a guide to commanders and leaders in United States Army Training and Doctrine Command (TRADOC) to assist with implementing the principles consistent with the Army Campaign Plan for Health Promotion and Risk Reduction. TRADOC Pamphlet 600-22 reflects the latest state of our understanding on the most effective ways to manage high risk and suicidal behavior based on valuable lessons learned, best practices, and current behavioral science research.

Applicability. This pamphlet applies to all elements of TRADOC, to include Headquarters, TRADOC, major subordinate organizations, centers of excellence, special activities and field operating activities, and schools and centers.

Proponent and exception authority. The proponent for this pamphlet is the Office of the TRADOC Surgeon. The proponent has the authority to approve exceptions or waivers to this pamphlet that are consistent with controlling law and regulations. The proponent may delegate this authority in writing to a division chief with the proponent agency or its direct reporting unit or field-operating agency in the grade of colonel or the civilian equivalent. Activities may request a waiver to this pamphlet by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All

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waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through higher headquarters to the policy proponent.

Suggested improvements. The proponent of this pamphlet is the Office of the TRADOC Surgeon. Send comments and suggested improvements on Department of the Army Form 2028 (Recommended Changes to Publications and Blank Forms) through channels to Commander, TRADOC (ATBO-M), 950 Jefferson Ave, Fort Eustis, VA 23604-5750.

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Summary of Change

TRADOC Pamphlet 600-22
Leader's Guide for Risk Reduction and Suicide Prevention

This rapid action revision, dated 8 October 2019-

- o Integrates the U.S. Army Training and Doctrine Command suicide prevention policy, making the policy letter obsolete (throughout).
- o Updates demographic data on Army suicides (para 1-5).
- o Moves information to para 2-2e on the current Army training products for risk factor identification and intervention (Ask, Care, Escort & ENGAGE).
- o Aligns U.S. Army Training and Doctrine Command guidance with Army Personal Readiness and Resilience policy.

This rapid action revision, dated 15 June 2012-

- o Changes the pamphlet title from Leaders Guide for Suicide Prevention Planning to Leader's Guide for Risk Reduction and Suicide Prevention.
- o This pamphlet integrates the TRADOC suicide prevention policy, therefore making the policy letter obsolete.
- o Updates demographic data on Army suicides (para 1-4).
- o Emphasizes the importance of effective leadership while deployed or at home location (para 2-1).
- o Provides information on the current Army training products for risk factor identification and intervention (Ask, Care, Escort Card & ENGAGE) (para 2-6).

- o Updates administrative information throughout the publication.
- o Unless otherwise stated, when the masculine gender is used, both male and female are included.

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Chapter 1

Introduction

1-1. Purpose

The purpose of this pamphlet is to provide a guide to U.S. Army Training and Doctrine Command (TRADOC) commanders and leaders to reduce the risk of suicidal behaviors within TRADOC

1-2. References

Required and related publications and required and referenced forms are listed in [appendix A](#).

1-3. Explanation of abbreviations and terms

Abbreviations and terms used in this regulation are explained in the [glossary](#).

1-4. Introduction

Reducing the risk of suicide across TRADOC consists of reasonable steps taken to lower the probability that an individual will engage in acts of self-destructive behavior. Primary prevention strengthens the factors that mitigate those risks (e.g. promote life initiatives, awareness, helping services, and reintegration), and implements control measures to address and minimize risk factors for suicide. Suicide risk reduction is dependent upon the existence of an environment that fosters trust among proactive, caring, and engaged individuals. The suicide risk reduction strategy establishes a community approach to suicide prevention. This involves commander visibility, Soldier-to-Soldier connection, and an individual's responsibility to live the Army Values. It focuses on preventing normal life stressors from turning into life crises. Programmed risk reduction measures (see para 2-1 below) focus on equipping the Soldiers, Army Civilians, and Family members with coping skills to handle life circumstances that might otherwise become overwhelming. Risk reduction includes early screening to establish baseline behavioral health (BH) and to offer specific remedial programs before problematic behavior occurs.

1-5. Background

a. As a leader, you have the primary responsibility to promote and safeguard the morale of persons under your command or charge, beginning with awareness of problems that affect morale. This leads to effective management of high-risk behavior, to include suicidal behavior, among those you lead.

b. Each Soldier suicide is tragic to the Army Family and to the country. Historically, the Army suicide rate has usually been much lower than the U.S. civilian rate. However, in 2004 that trend shifted, and in 2008 the Army surpassed its equivalent civilian population rate (20.2 per 100,000 vs. 19.2) and has remained higher since that time. In 2016, 144 Soldiers committed suicide at a rate of 26.7 per 100,000 compared to the U.S. population rate of 13.9 per 100,000. That trend demands a renewed focus with inventive solutions in order maintain the health and discipline in the force. Army senior leaders recognize the significant number of Soldiers who kill and harm themselves each year, and they are well acquainted with the trauma these events

have on those left behind. Senior leaders have increased their focus on reducing unnecessary high-risk behavior and preventing suicide.

c. Complexity. Suicide is complex. The Army recognizes suicidal intent is very difficult to identify or predict, even for BH professionals. Some suicides may still occur even in units with the best leadership climate, the most dedicated suicide risk reduction initiatives, and the most efficient crisis intervention. Research on suicide risk reduction lacks definitive answers as to why a certain Soldier would decide to take his or her life. Numerous factors increase a Soldier's risk for suicide. While one Soldier is strongly challenged by a group of factors, another Soldier finds these same factors overwhelming. Most people have protective buffers that provide resilience or the ability to bounce back from stressful events. On the other hand, there are risk factors that can combine with challenging life events (relationship issues, financial issues, work challenges, life transition points, etc.) that lead to overwhelming stress and to suicide. Leaders must exercise all means within their control to effect healthy work climates, dedicated suicide risk reduction initiatives, and efficient crisis interventions.

d. Suicide risk reduction. Suicide-risk reduction consists of reasonable steps taken to lower the probability that an individual will engage in acts of self-destructive behavior.

1-6. Understanding suicide risk

a. Psychological/emotional risk factors. Clinical research studies conducted by the Military Suicide Research Consortium have shown that individuals in the highest risk for suicide score high in tests that measure hopelessness and isolation, and perceive themselves to not belong, and to be burdensome to others. In addition, sleep deficits have been shown to be a significant contributing factor to suicide, as individuals don't think as clearly and have fewer mental resources to draw upon to manage emotions and effectively engage in the problem solving process.

b. Transitional periods. Life transitions, and events that accompany them (e.g., graduating school and then entering the Army; permanent change of station plus a promotion; deployment with a change in mission), represent the military way of life. Many Soldiers experience lifetimes of transitions in their first few years in the military. On the positive end, transitions may be experienced and seen as learning or maturing events depending on where someone is in his or her life. However, multiple transitions can accumulate to produce deterioration in well-being if the Soldier is unable to recover before the next transition.

(1) First, a Soldier lives as a unit member and is closely tied to cycles of training, deployment, redeployment, and reset. At the same time, a Soldier has a unique schedule of personal and professional transitions that are usually less predictable. Even a positive event such as a promotion or reenlistment can be linked to significant challenges (e.g., change in jobs with higher expectations, increased responsibility, or a change in work relationships). Finally, a Soldier is part of a family system. Families experience unique transitions and needs that Army programs and services cannot always address. Transitions within the family include marriage, birth of a child, relationship problems, aging parents, and school cycles.

(2) A leader's familiarity with the risks that transitions pose is valuable because it helps identify a critical window of risk where transitions have accumulated for a Soldier. This is especially important for young Soldiers on their first enlistments. Multiple transitions within the first 2 years can cause major stresses for Soldiers and their families. New Soldiers may not have the resiliency nor life experience necessary to successfully navigate significant and multiple transitions.

(3) Soldiers within the first 2 years of their initial enlistments account for a significant number of Army suicides.

Chapter 2

Leader Strategies

2-1. Managing suicide risk

a. Managing suicide risk focuses on preventing normal life stressors from turning into life crises. Leaders identify early indicators of potential stressors and prevent their adverse outcomes through gradual intervention before the stressors accumulate into crisis. Programmed risk reduction measures focus on equipping Soldiers, Army Civilians, and Family members with coping skills to handle life circumstances that might otherwise become overwhelming. Suicide risk management includes early screening to establish baseline psychological health and to offer specific remedial programs before dysfunctional behavior occurs. Suicide risk management is dependent upon caring and proactive small unit leaders who make the effort to know their subordinates, including estimating their ability to handle stress, and who offer a positive, cohesive environment which nurtures and develops positive coping skills. Managing high-risk behavior is a leadership responsibility across all levels from the most senior leader to the most junior. Supervisors must lead distressed Soldiers to the best available support resources through positive and supportive command climates that foster early identification and intervention opportunities. Soldiers who ended their lives often engaged in high-risk behavior long before they decided to take their lives. Leaders shall:

(1) Encourage healthy lifestyles with an emphasis on proper nutrition, fitness, and sleep, and maximize human resources by implementing health promotion within their units.

(2) Promote the battle buddy system. See TRADOC Regulation (TR) 350-6 for a description of the battle buddy system in initial entry training; the same principle can apply throughout TRADOC organizations.

(3) Ensure that Soldiers identified with suicidal risk symptoms/behaviors will not be subjected to stigma through overt or covert policies that belittle, humiliate, or ostracize them.

(4) Ensure that Soldiers will be treated with dignity and respect and are encouraged to seek assistance if they are experiencing challenges or demonstrate suicide risk.

(5) Ensure that policies will be in place for unit watch, weapons profiles, and other unit related procedures that relate to signs of suicidal behaviors (for initial entry training units, TR 350-6; for other TRADOC organizations, Department of the Army (DA) Pamphlet 600-24).

b. In order for suicide risk reduction to achieve maximum effects, commanders and leaders must set the best possible conditions. This includes utilizing all available tools from policy guidance to leadership responsibility and personal accountability. To reduce the risk of suicide, measures must integrate holistic capabilities across the Army to assist leaders in implementing local suicide risk reduction measures. Risk reduction includes alcohol and drug awareness training, sexual harassment/assault response and prevention, information and awareness on healthy behavior/healthy lifestyles, and military life programs. All of these programs should emphasize the importance of awareness and early identification of, and intervention in, problems that negatively impact personal, professional, and organizational health.

c. Military cultural norms, while beneficial for survival and mission accomplishment on a battlefield, can sometimes interfere with responsible support-seeking behavior; such interference can result in a less-ready force.

(1) Leaders must foster climates that reinforce and support Soldiers who responsibly seek professional services for matters pertaining to their emotional, physical, and spiritual readiness.

(2) Balancing Soldier accountability with Soldier-Family care and force readiness requires high levels of interpersonal leadership skill. Leaders should promote Soldier health, while ensuring good order and discipline. This requires considering all pertinent information when holding Soldiers accountable. Leaders do the right thing for both the Soldier and the Army through firm discipline. This will require compassionate and fair leaders who understand when to mentor and shape a Soldier's career and when to accept that the Army and Soldier are not a good fit. A leader may have to exercise separation authority in order to ensure the readiness, health, welfare, morale, and discipline of the unit.

d. As a result of protracted overseas contingency operations, many commanders and subordinate leaders are now experienced Warriors. However, some have grown unaccustomed to leading Soldiers in garrison environments. Leaders in training environments will be responsible for Soldiers who do not have the same reference point, thus contributing to disconnectedness between leaders and the led. As a result of important lessons learned and thoughtful planning, several critical tasks for leaders have been identified for managing high-risk behavior and suicide risk reduction, and closing the gap in shared experiences. These critical tasks are summarized below and will serve as useful initial guidance.

2-2. Mitigating strategies

a. Plan for Transitions

(1) Leaders and first-line supervisors should use military community-based education targeting Army values to enhance the culture of trust. Senior leaders should focus on developing the supervisory skills of junior leaders. Targeted education opportunities should address military

life issues, suicide risk reduction, substance use, sexual harassment/assault response and prevention, and unhealthy behaviors and the consequences of such in Soldiers' lives.

(2) Leaders actively mobilize resources during periods of transition to help Soldiers and their families stabilize more quickly and effectively. These include utilizing the Army Sponsorship program, Military and Family Life Counselors, Chaplains, the Army Performance Centers, and BH services where appropriate.

b. Know your Soldiers

(1) Leaders within all levels of the chain of command should know their Soldiers and demonstrate genuine care for them (e.g., Family circumstances, living arrangements, interests, financial situation, education, career goals).

(2) Leaders use available active and passive measures (e.g., urinalysis screening, unit surveys, blotter reports, health and welfare inspections, etc.) to identify Soldiers who may be engaging in high-risk behavior and confidentially direct them to appropriate services.

(3) Leaders monitor the unit's counseling program to ensure Soldiers are receiving effective, documented and timely developmental counseling. Leaders strengthen supervisor-subordinate interactions and mentoring skills through training and by building interpersonal relationships with subordinates.

(4) Leaders have primary responsibility for maintaining good order and discipline and have an accurate composite view of their Soldiers. Leaders emphasize good order and discipline in barracks and garrison by periodically conducting health and welfare inspections, random drug testing, recognition ceremonies, safety briefs, and accountability formations.

c. Commander and leader tasks

(1) Command team visibility requires commanders and other leaders to be aware of issues affecting the training environment.

(2) Continually assess behaviors that impact health and readiness. This includes protecting sleep schedules to the greatest extent possible, and monitoring the unit culture around drug and alcohol use.

(3) Foster a climate and train and develop skills to enhance health and readiness.

(4) Ensure dissemination of information and communication tools that focus on risk reduction (e.g. wellness newsletter, contact information for helping agencies, morale, welfare, and recreation events that enhance unit cohesion and belonging, etc.).

(5) Utilize online social media information platforms. The platforms could offer quick assessments, educational information about risk identification and helping resources.

(6) Encourage innovation. Risk reduction initiatives could include motivational speakers or simulations that focus on social norming, wellness, and social support.

(7) Ensure all Soldiers are current in their annual periodic health assessments (PHAs). The PHA contains a mental health assessment.

(8) Ensure all Soldiers are current in their post-deployment health reassessments (PDHRA). The PDHRA is administered 90 to 180 days after redeployment addresses physical and behavioral issues that evolve after the post-deployment health assessment (PDHA). Some BH issues are significantly more prevalent in the PDHRA than in the PDHA.

(9) Utilize Master Resilience Trainers in Resilience and Performance Enhancement Training.

d. Training

(1) Leaders ensure all Soldiers receive appropriate and targeted training in Personal Readiness (previously titled substance abuse and suicide prevention), Army Traffic Safety Training Program (see Army Regulation (AR) 385-10), risk management training (see AR 350-1 and TRADOC OPOD 16-014, Risk Management Integration Plan (2016), and Sexual Harassment/ Assault Response and Prevention) (see AR 350-1, table F-1). This includes annual in-person, small group suicide prevention training (see AR 600-63).

(2) Skills-based training in resilience, Soldier to Soldier communication, leader to Soldier communication, and holistic health and fitness are essential to suicide risk reduction. Soldiers trained in maintaining psychological and physical well-being that includes an emphasis on proper sleep and suicide risk factor recognition are significantly more likely to seek counseling and to assist fellow Soldiers in getting professional support.

(3) When individuals exhibit signs of distress, peers, leaders, and Family members must have the skills and confidence to recognize the warning signs and respond with the right level of support. Family members generally do not receive adequate education and training in suicide risk reduction. Direct leaders and family members, above all, are the best “detectors” of subtle behavioral changes associated with suicidal risk.

(4) Each unit’s suicide risk reduction training and awareness education effort is vital for commanders and leaders to ensure their personnel have the knowledge, skills, and confidence to maintain readiness and a robust “buddy care” system.

e. Risk reduction tools

(1) Ask, Care, Escort (ACE) Suicide Intervention training remains an Army-approved suicide awareness and risk reduction training model that meets training requirement for all Soldiers, leaders, and DA civilians. The key learning objectives are awareness training on risk factors, warning signs, and support resources. Training should be conducted at the lowest level

possible to enhance squad, crew, team, and section level participation and strengthen the buddy care system.

(2) ENGAGE is a strategic shift from programmatic Intervention focus to a proactive risk reduction model that emphasizes Soldier-to-Soldier connection and provides commanders increased visibility of individual/unit readiness with variety of tools. The ENGAGE skill is the enabler to achieving bystander intervention. ENGAGE training is implemented through Ready and Resilient Performance Centers. This training allows commanders to target areas of concern within a unit and dose the intervention to the appropriate levels.

(3) Leader Actions. Leaders minimize barriers and obstacles that prevent friends and Family members from receiving suicide risk reduction training. ACE training is not mandatory for Family members. However, commanders and leaders should encourage Family members to participate during appropriate venues (e.g., Family readiness group meetings, spouse meetings, pre- and post- deployment briefings, etc.).

f. Communicate high-risk behavior

(1) Leaders recognize indicators of high-risk behavior and refer Soldiers to appropriate programs and services. They facilitate Soldier attendance and participation.

(2) Leaders immediately report all drug-related offenses using DA Form 4833, Commander's Report of Disciplinary or Administrative Action (e.g., illegal possession, use, sale, or trafficking in drugs) to installation law enforcement for investigation. Leaders also report all positive urinalysis results to installation law enforcement within 72 hours of notification from the proper notifying authority. There is a 90 percent chance that a Soldier who tests positive a second time will go on to test positive three or more times. Leaders intuitively question the fitness and professionalism of any Soldier who commits multiple or serial drug offenses. Illicit drug use or excessive alcohol use is associated with higher levels of suicide attempts and ideations.

(3) Leaders consult on suspected spouse and child abuse with the Family Advocacy Program point of contact.

(4) Leaders inform Soldiers and Families of the availability of non-military treatment facility BH support programs [e.g., Tri-service Medical Care (TRICARE) Assistance Program, Military OneSource, TRICARE Tele-Behavioral Health, Military Family Life Counseling, National Suicide Prevention Lifeline, 800-273-TALK (8255)].

g. Reduce stigma

General George Casey, Chief of Staff, Army, was quoted by the American Forces Press Service on 10 November 2009, as stating, "The stigma attached to seeking mental health treatment is not just an Army problem ... this is a societal problem that we all have to wrestle with..."

(1) When people believe they have some type of stigma (physical, psychological, or social), they will likely be concerned about social disapproval or that their social status will drop

amongst peers, leading to isolation. As long as healthy support-seeking behavior is unfairly stigmatized due to stereotypes and limited understanding, it will be feared and avoided. For Soldiers and leaders there is often the perception that support-seeking behavior will be detrimental to their careers, or they will be viewed negatively by their peers or those they lead. Mental toughness is seen as a sign of strength in military culture, while seeking assistance may be seen as a sign of weakness or source of shame or embarrassment.

(2) The perceived stigma associated with seeking BH support represents a very real barrier to Soldiers who would benefit most from professional support. Bear in mind that keeping BH issues a secret tends to increase stress, degrade decision-making abilities, contribute to depression and anxiety, and worsen extreme thought patterns that contribute to suicidal behaviors.

(3) Leaders at all levels encourage support seeking behavior and convey no-stigma messages as a routine matter of unit operations.

h. Reduce stigma - tactics

(1) Support confidentiality between Soldiers and their BH providers.

(2) Reinforce the power of the buddy system as a support system in times of crisis

(3) Normalize healthy, responsible support-seeking behavior and avoid actions that discourage individuals from independently seeking care. Send a clear message that behavioral healthcare are part of normal mental and emotional performance enhancement activities.

(4) Encourage help from BH providers that focuses on preventive care and maintenance such as informational briefings on healthy sleep, stress management, benefits of physical fitness, balanced nutrition, and leisure activities. Also, prevention can focus on methods to monitor and record behaviors and their effects.

(5) Provide educational opportunities for Soldiers, Family members, and civilians on topics such as anxiety, depression, stress, traumatic brain injury, and Post-Traumatic Stress Disorder.

(6) Convey “no-stigma” messages as a routine matter of unit operations.

2-3. Assessing compliance

[Table C-1](#) provides the “Evaluation Checklist” that should be used to assess compliance with the strategies presented in chapter 2.

Chapter 3

Leader actions

3-1. Intervention

a. Intervention attempts to prevent a life crisis or BH disorder from leading to suicidal behaviors by helping someone manage suicidal thoughts and by taking action to intervene when a suicide appears imminent.

b. It encourages and/or mandates professional assistance to handle a particular crisis or treat a BH illness.

c. Early involvement is a crucial factor in suicide-risk reduction. Intervention includes addressing the conditions that produced the current crisis, treating the underlying psychiatric disorder(s) that contributed to suicidal thoughts, and providing follow-up care to assure problem resolution.

d. Intervention may also include inspecting and modifying a person's environment, such as removing items that an individual may use to harm him or herself when residing on post, or requesting surrender of items when off post, and providing close monitoring and care from a buddy. Prior to the removal of any items from an individual or requesting that an individual surrender items, commanders will work in concert with their servicing legal office and local law enforcement to ensure that all laws and regulations are followed.

e. Commanders play an integral part during this phase, as it is their responsibility to ensure a particular problem or crisis has been resolved before assuming the threat has passed.

3-2. Postvention

a. Postvention occurs when an individual has attempted to complete a suicide. After an attempt, in conjunction with professional consultation, commanders, noncommissioned officers, and supervisors must take steps to secure and protect such individuals from causing additional harm to themselves or others.

b. Postvention activities (counseling, community awareness) also include unit-level interventions. In particular, following a completed suicide actions should be taken to minimize possible psychological reactions to the event, prevent or minimize the potential for suicide contagion, strengthen unit cohesion, and promote mission readiness. For more information on developing a good postvention response contact your local BH personnel and the Suicide Prevention Program Manager.

c. Each installation Command Surgeon's Office or Installation Director of Psychological Health will establish policies and procedures for the implementation of a Suicide Response Team (SRT) for their respective installation or organization following a suspected suicide. The SRT will consist of chaplains, BH professionals, and other agencies as commanders deem appropriate. The SRT will coordinate with BH and ministry assets to respond to any known or suspected

suicide occurring in subordinate or tenant organizations by offering additional support to unit commanders, ensure that proper guidelines are followed for local media coverage, and monitor completion and submission of appropriate reports as outlined in AR 600-63.

d. In the event of a completed suicide, commanders are encouraged to conduct a memorial event. The event should focus on providing comfort to the grieving, helping attendees deal with guilt or anger, encouraging Soldiers or family members to seek help, and reducing risk of contagion suicides.

Appendix A

References

Section I

Required Publications

This section contains no entries.

Section II

Related Publications

AR 600-63

Army Health Promotion

DOD Instruction 6200.06

Periodic Health Assessment (PHA) Program

Field Manual (FM) 6-22

Leader Development

HQDA EXORD 015-14

Deployment Health Assessment Program

TR 350-6

Enlisted Initial Entry Training Policies and Administration

Appendix B

Training Materials

U.S. Army Public Health Command (APHC)

<http://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePreventionEducation.aspx>

Army Deputy Chief of Staff, G-1

www.preventsuicide.army.mil

<http://www.armyg1.army.mil/hr/suicide/training.asp>

Appendix C

Evaluation Checklist

Table C-1 provides leaders with a quick reference guide for all tasks leaders are responsible to accomplish to ensure the highest level of risk management within their formations.

Table C-1
Evaluation checklist

Task	Reference
Encourage healthy lifestyles with an emphasis on proper nutrition, fitness, and sleep, and maximize human resources by implementing health promotion within their units (para 2-1a(1)).	AR 40-5 AR 600-63
Promote the battle buddy system (para 2-1a(2)).	TR 350-6; the same principle can apply throughout TRADOC organizations
Ensure that Soldiers identified with suicidal risk symptoms/behaviors will not be subjected to stigma through overt or covert policies that belittle, humiliate, or ostracize other Soldiers (para 2-1a(3)).	AR 600-63
Ensure that Soldiers will be treated with dignity and respect and are encouraged to seek assistance if they are experiencing challenges or demonstrate suicide risk (para 2-1a(4)).	AR 600-63
Ensure that policies will be in place for unit watch, weapons profiles, and other unit related procedures that relate to signs of suicidal behaviors (para 2-1a(5)).	TR 350-6; the same policies could apply in other TRADOC organizations, depending on risk
Alcohol and drug awareness training (para 2-1b)	AR 600-63 AR 600-85
Sexual harassment/assault response and prevention (para 2-1b)	AR 600-20
Information and awareness on healthy behavior/healthy lifestyles (para 2-1b)	AR 600-63
Information and awareness on military life programs (para 2-1b)	AR 600-63
Foster a climate that reinforces and supports Soldiers who responsibly seek professional services for matters pertaining to their emotional, physical, and spiritual readiness (para 2-1c(1))	AR 600-63
Use military community-based education targeting Army values to enhance the culture of trust (para 2-1a(1))	FM 6-22
Developing the supervisory skills of junior leaders (para 2-1a(1))	FM 6-22
Mobilize resources during periods of transition to help Soldiers and their families stabilize more quickly and effectively (para 2-1a(2))	DA Pamphlet 600-24

Table C-1
Evaluation checklist, continued

Know your Soldiers and demonstrate genuine care for them (e.g., Family circumstances, living arrangements, interests, financial situation, education, career goals) (para 2-2b(1)).	FM 6-22
Use available active and passive measures (e.g., urinalysis screening, unit surveys, blotter reports, health and welfare inspections, etc.) to identify Soldiers who may be engaging in high-risk behavior and confidentially direct them to appropriate services (para 2-2b(2)).	AR 600-85 AR 600-20
Monitor the unit’s counseling program to ensure Soldiers are receiving effective, documented and timely developmental counseling. Strengthen supervisor-subordinate interactions and mentoring skills through training and by building interpersonal relationships with subordinates (para 2-2b(3)).	FM 6-22
Maintain good order and discipline and have an accurate composite view of their Soldiers. Leaders emphasize good order and discipline in barracks and garrison by periodically conducting health and welfare inspections, random drug testing, recognition ceremonies, safety briefs, and accountability formations (para 2-2b(4)).	AR 600-20
Be aware of issues affecting the training environment (para 2-2c(1)).	FM 6-22
Continually assess behaviors that impact health and readiness. This includes protecting sleep schedules to the greatest extent possible, and monitoring the unit culture around drug and alcohol use (para 2-2c(2)).	AR 600-63
Foster a climate and train and develop skills to enhance health and readiness (para 2-2c(3)).	AR 600-63
Ensure dissemination of information and communication tools that focus on risk reduction (e.g. wellness newsletter, contact information for helping agencies, morale, welfare, and recreation events that enhance unit cohesion and belonging, etc.) (para 2-2c(4)).	AR 600-63
Utilize online social media information platforms. The platforms could offer quick assessments, educational information about risk identification and helping resources (para 2-2c(5)).	https://www.army.mil/socialmedia/soldiers/

Table C-1
Evaluation checklist, continued

Encourage innovation. Risk reduction initiatives could include motivational speakers or simulations that focus on social norming, wellness, and social support (para 2-2c(6)).	AR 600-63
Ensure all Soldiers are current in their annual PHAs. The PHA contains a mental health assessment (para 2-2c(7)).	AR 40-501
Ensure all Soldiers are current in their PDHRAs. The PDHRA is administered 90 to 180 days after redeployment addresses physical and behavioral issues that evolve after the PDHA (para 2-2c(8)).	AR 600-8-101
Utilize Master Resilience Trainers in Resilience and Performance Enhancement Training (para 2-2c(9)).	AR 350-53

Glossary

Section I Abbreviations

ACE	Ask, Care, Escort
AR	Army regulation
BH	behavioral health
DA	Department of the Army
FM	field manual
PHA	periodic health assessment
PDHRA	post-deployment health reassessment
PDHA	post-deployment health assessment
SRT	Suicide Response Team
TR	TRADOC regulation
TRADOC	U.S. Army Training and Doctrine Command
TRICARE	Tri-service Medical Care

Section II Terms

battle buddy

A team of two or three Soldiers or employees in the same unit. Battle buddies promote team spirit and improve safety, motivation, and esprit de corps. [Source: TR 350-6]

suicidal behavior

Includes completed suicide; suicide attempt (non-fatal self-injury where the individual's intent was to die; suicidal gesture (risking of death without the intent to die); and suicidal ideation (having thoughts of, or fascination with death). [Source: "[Suicide Awareness Briefing for Leaders](http://www.armyg1.army.mil/hr/suicide/training.asp)," Suicide Awareness and Prevention Products, <http://www.armyg1.army.mil/hr/suicide/training.asp>]