2020 ARMY STRATEGY FOR SUICIDE PREVENTION

"A Healthy Force is a Ready Force"
2020 Army Strategy for Suicide Prevention

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Introduction

In March 2009, in response to a growing number of Army suicides, the Vice Chief of Staff of the Army released the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP), and chartered the Army Suicide Prevention Task Force (ASPTF) and the Army Suicide Prevention Council (ASPC). Since that time, the Army has invested tremendous effort in investigating the causes of suicide within its ranks and in implementing policies and programs whose sole purpose is to promote resilience, prevent suicides, and enhance the readiness of the Force. The challenge of suicide remains a deep concern of the Nation and Department of the Army. Suicide is a multi-faceted problem that requires an equally sophisticated response. Life stressors including behavioral health issues, relationship difficulties, physical illness, and financial and legal problems can all weigh heavily on an individual, engendering feelings of burdensomeness and hopelessness. As these difficulties and feelings, real and/or perceived multiply within an individual, suicide can become an increasingly viable solution – a permanent solution for a temporary problem. To address this tragic problem, the Army has instituted a multi-disciplinary, holistic approach to health promotion, risk reduction, and suicide prevention that addresses the many challenges our Soldiers, Families and Army Civilians face. It is difficult to measure the behavioral impact of these efforts since no methodology has yet been developed to identify suicides that were avoided due to the establishment of new programs and policies. However, with the implementation of this 2020 Suicide Prevention Strategy, the Army will attempt to shift its culture by increasing the emphasis on leader involvement to protect and promote life.

Leaders become better prepared when they are educated and equipped with the policies, programs, and training to promote a healthy climate and reduce risky behavior in the Force. The key elements of the Army’s approach are:

- Leaders at all levels, from Senior Mission Commander to squad leader, sustain a visible and active focus on Soldier, Army Civilian, and Family issues impacting resilience and Health of the Force
- Increased emphasis on health promotion, resilience building and risk reduction to promote suicide prevention.
- Improved education, awareness and intervention.
- Enhanced access to quality behavioral health care.
• Increased screening and documentation of risk indicators that may lead to suicide including all traumatic brain injuries.

• Improved leader awareness of high risk behavior.

“Leaders across our Army recognize that the health of our Soldiers, Army civilians and family members is a top priority. We remain committed to doing what is needed to care for our most precious asset -- our people, thereby ensuring a healthy and resilient force for the future. We must maintain our shared focus and continue these most important efforts in the days ahead.” – GEN Lloyd J. Austin III, VCSA, 17 March 2012

This holistic approach has included publication of the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP), monthly Senior Suicide Review Group (SSRG) meetings, renewed emphasis on training, chartering the Army Suicide Prevention Task Force (ASPTF) and the Army Suicide Prevention Council (ASPC) (that subsequently were renamed as the Army Health Promotion Risk Reduction Task Force and Health Promotion Risk Reduction Council), and establishment of a Health Promotion Risk Reduction (HPRR) Division within the Army G-1. It has also included funding the Army Study to Assess Risk and Resiliency in Service Members (Army STARRS) in partnership with the National Institute of Mental Health (NIMH)–representing landmark new research in the field of risk reduction and suicide prevention, and publication of two major internal studies: the Army Health Promotion, Risk Reduction and Suicide Prevention (HP/RR/SP) Report 2010 (Red Book) and Army 2020: Generating Health & Discipline in the Force Ahead of the Strategic Reset Report 2012 (Gold Book), published in 2012. The DoD released The Challenge and the Promise: Strengthening the Force, Preventing Suicides and Saving Lives in August 2010. Established in 2008, the Comprehensive Soldier Fitness Program (CSF), now, the Comprehensive Soldier and Family Fitness Program (CSF2) has since become a valuable asset in building resilience skills. Additionally, the Army has been collaborating on initiatives with the Department of Defense (DoD), the Veterans Affairs and the other Services.

In May 2012, GEN Austin established the Health of the Force (HoF) initiative. The goals of this initiative are to establish a collaborative and coherent approach to maintaining Army readiness (Soldiers, Families, and Civilian workforce) tailoring prevention and response measures to promote physical fitness, emotional stability, personal growth, and dignity and respect. GEN Austin identified suicide prevention as one of his most pressing HoF issues.

The 2012 National Strategy for Suicide Prevention notes that suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. Many people may be surprised to learn that suicide was one of the top 10 causes of death in the United States in 2009. These deaths are only the tip of the iceberg. For every person who dies by suicide, about 25 others attempt suicide, and even more have ideations about taking their own lives. Every suicide attempt and death affects countless other individuals. Family members, friends, coworkers, and others in the community all suffer the long-lasting consequences of suicidal behaviors. The National Strategy for Suicide Prevention includes 13 goals and 60 objectives that have been updated to reflect advances in suicide prevention knowledge, research, and practice, as well as broader changes in society and health care delivery that have created new opportunities for suicide prevention.

**The 2012 National Strategy is organized into four interconnected strategic directions (see figure 1):**

1. Healthy and Empowered Individuals, Families, and Communities
2. Clinical and Community Preventive Services
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation
The four strategic directions are interrelated and interactive rather than standalone items. Several broad themes are at the core of the National Strategy and are addressed across all four strategic directions.

The goals and objectives in the revised National Strategy are broad in scope and encompass a wide range of activities. The goals and objectives have been organized around three prevention elements: universal, selective and indicated. This public health framework focuses attention on defined populations. Universal strategies target the entire population. Selective strategies are appropriate for subgroups that may be at increased risk for suicidal behaviors. Indicated strategies are designed for individuals identified as having a high risk for suicidal behaviors, including someone who has made a suicide attempt. Suicide mitigation and prevention requires a combination of these three strategies.
Preventing Suicide Attempts by Addressing Access to Lethal Means

<table>
<thead>
<tr>
<th>Approach</th>
<th>Target</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>Everyone in a defined population</td>
<td>Promote safe storage of firearms and ammunition.</td>
</tr>
<tr>
<td>Selective</td>
<td>Subgroups that may be at increased risk for suicidal behaviors</td>
<td>Reduce access to arms room weapons draw.</td>
</tr>
<tr>
<td>Indicated</td>
<td>Individuals identified as having a high risk for suicidal behaviors</td>
<td>Teach caregivers the importance of removing firearms and old medicines from the home before a patient who has been hospitalized for suicide risk is discharged.</td>
</tr>
</tbody>
</table>

Table 1- Sample Implementation of the Three Prevention Elements

The 2020 Army Strategy for Suicide Prevention is the capstone document that sets the context and direction to achieve the Army’s strategic suicide prevention goals and objectives.

The Army Strategy is linked to the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, the Department of Defense Directive for Suicide Prevention, 2012, the Army Campaign Plan 2011, the Army Health Promotion, Risk Reduction and Suicide Prevention Report 2010 (Red Book), and the Army 2020: Generating Health and discipline in the Force, Ahead of the Strategic Reset Report 2012 (Gold Book). The first three documents provide overarching direction and assure critical unity of effort. The Red Book and Gold Book provide powerful links to many years of research, effort and on-going achievements in health promotion, risk reduction and suicide prevention. These last two documents ground the Army on a solid conceptual and programmatic foundation for orderly transition into the future.

The 2020 Army Strategy for Suicide Prevention closely follows the National Strategy for Suicide Prevention. It is organized according to the four Strategic Directions of the National Strategy and incorporates the three Prevention Elements discussed above. Also, its goals and objectives are modeled after those of the National Strategy, thereby contributing to the implementation of the National Strategy. However, it slightly modifies the first three strategic directions to align with extensive work already done and to maintain synchronization with the Red Book and Gold Book. The Red Book in particular presents a model for continuity of care that is applicable to all
members of the Army Family throughout the entire duration of their careers or association with the Army. This model is the Care Continuum (Fig. 2) and recognizes that all individuals are always in one of three phases:

1) **Prevention.** Individuals in this area are perceived as unaffected by stressors and demonstrate no indicators of increased risk. The Army’s objective is to provide training and support to keep all members of the Army Family in this phase as much as possible. This phase aligns with the National Strategy’s “Universal” prevention element.

2) **Intervention.** Individuals in this phase have signaled that they are at increased risk and require institutional intervention. The duration of this phase is dependent on the individual’s response to intervention. This phase aligns best with the National Strategy’s “Selective” prevention element.

3) **Postvention.** The post-event stage coincides with the outcome of probable high risk behavior requiring institutional intervention. Individuals in this phase have attempted suicide or are the survivors — spouses, children, parents, significant others -- of the individual who completed suicide. Actions in this phase seek to return the failed suicide attempt to Intervention and then Prevention, and to assist family members and others associated with the attempted or completed suicidal act. This phase aligns with the “Indicated” prevention element.

![Figure 2-The Event Cycle and Care Continuum](image)

The 2020 Army Strategy for Suicide Prevention recognizes these four interconnected strategic directions and aligns them with the constructs of prevention, intervention and postvention:

1. Healthy and Empowered Individuals, Families, and Communities - **Prevention**
2. Clinical and Community Support Services – **Intervention**
3. Treatment and Recovery Services – **Postvention**
4. Surveillance, Research, and Evaluation
These strategic directions highlight what the Army must do to support the National Strategy and reach its own goals and objectives. These goals and objectives are adapted to their military context while retaining clear linkages back to the National Strategy. To maintain that linkage, National Suicide Prevention Strategy language has been incorporated and adapted as necessary as the explanatory language for the Army’s Goals and Objectives. These goals and objectives are grouped into one of the four Strategic Directions where they become the focus or their respective proponent organizations while retaining the critical and unifying health promotion, risk reduction and suicide prevention collaborative, enterprise approach. The 2020 Army Strategy for Suicide Prevention document serves as a guide for Army suicide prevention strategic planners, leaders, and subject matter experts.

<table>
<thead>
<tr>
<th>National Strategy Direction</th>
<th>Army Strategy Direction</th>
<th>3 Strategic Approaches</th>
<th>Care Continuum Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy and Empowered Individuals, Families, and Communities</td>
<td>Healthy and Empowered Individuals, Families, and Communities</td>
<td>Universal</td>
<td>Prevention</td>
</tr>
<tr>
<td>Clinical and Community Preventive Services</td>
<td>Clinical and Community Support Services</td>
<td>Selective</td>
<td>Intervention</td>
</tr>
<tr>
<td>Treatment and Support Services</td>
<td>Treatment and Recovery Services</td>
<td>Indicated</td>
<td>Postvention</td>
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<tr>
<td>Surveillance, Research, and Evaluation</td>
<td>Surveillance, Research, and Evaluation</td>
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</tbody>
</table>

Table 2-Army Strategy alignment with National Strategy
As stated previously, the Army Suicide Prevention Council (ASPC) was established in 2009 to implement the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention. It was rechartered as the Health Promotion and Risk Reduction Council (HP&RRC) in November 2011. Since 2009, this standing Council has reviewed 579 Task Action Plans and approved the completion of 353. This established, enterprise-wide Council will serve as the vehicle for tracking and validating the completion of the many tasks set forth in this Strategy.

The HP&RRC conducts bi-weekly meetings chaired by the Principle Deputy to the Assistant Secretary of Manpower and Affairs (PDASA), the Provost Marshal General of the Army, and the Deputy Surgeon General of the Army. The Council is comprised of representatives from across the Secretariat, ARSTAF and other Army agencies engaged in HP&RR activities. The HP&RRC implements immediate and enduring Policy- Doctrine-Organizations-Training-Materiel-Leadership-Personnel-Facilities-Resources-Research (Po-DOTMLPF-R2) solutions that improve health promotion and risk reduction policies, programs and processes.

When signed, the Council will adopt the Strategy and assume the task of tracking, coordinating and verifying the completion of the many short and long term tasks outlined in it. Through this vehicle that Army can assure that a collaborative, enterprise approach is taken to the planning, development and implementation of each of these tasks. Under the oversight of this Council, individual tasks can be responsibly modified if and when changing conditions dictate an adjustment to a task’s original concept or design, thus maintaining the Strategy’s relevance over time.

The HP&RRC process involves the development and tracking of specified tasks, heretofore called task action plans (TAPs). Tasks from this Strategy will become TAPs and will be adopted en masse upon the final approval of this Strategy. They will then become the purview of the entire Council. If multiple offices are named as tasks leads, one of the them will be designated as the Office of Primary Responsibility (OPR) and all other supporting agencies will be designated as Offices of Coordinating Responsibility (OCRs). The OPR of the proposed task develops the initial TAP details and specifications and presents the completed TAP to the HP&RRC for approval. Once approved by the HP&RRC, the
task is entered into the HP&RR Synchronization Matrix and is grouped with similar themed tasks for presentation at future HP&RRC meetings. While the proponent works to complete the task, regular status updates are provided to the HP&RRC in conjunction with other similarly themed tasks (typically, on a quarterly basis). When the OPR has completed work on the task, supporting documents are submitted and reviewed by G-1(HPRR) to ensure that the intent of the task was met. After this review is completed, the final deliverable of the task is forwarded to the Office of the Judge Advocate General (OTJAG) for a legal review of the content. After completing the legal review, the TAP is included in the next HP&RRC agenda and is reviewed by the Co-Chairs and HP&RRC members for final approval. Completed tasks are displayed along with ongoing tasks of similar themes to allow the responsible HP&RRC members to provide future updates on the implementation of the effort.
2020 Army Suicide Prevention Goals and Objectives

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities – Prevention

The National Suicide Prevention Strategy, mirrored by the Army Strategy, states that the goals and objectives in this strategic direction seek to create supportive environments that will promote the general health of the Army Family and reduce the risk for suicidal behaviors and related problems. Suicide shares risk and protective factors with behavioral and substance abuse disorders, trauma, and other types of violence, such as bullying and domestic violence. As a result, a wide range of partners can contribute to suicide prevention, including organizations and programs that promote the health of Soldiers, Army Civilians, and Families, particularly children and youth. Eliminating the biases and prejudices associated with suicidal behaviors, behavioral and substance abuse disorders, and exposure to violence is a key area of concern within this strategic direction. In particular, there is a need to increase the understanding that behavioral and substance abuse disorders respond to specific treatments and that recovery is possible. Communication efforts, such as campaigns and social marketing interventions, can play an important role in changing knowledge, attitudes, and behaviors to promote suicide prevention. Safe and positive messages addressing mental illness, substance abuse, and suicide can help reduce prejudice and promote help seeking. These types of messages can help create a supportive environment in which someone who is experiencing problems feels comfortable seeking help, and where commands, families and communities feel empowered to link a person in crisis with sources of care and assist the person in attaining or regaining a meaningful life.

GOAL 1. Integrate and coordinate suicide prevention activities across Army Activities and all Army COMPOs – Prevention

Suicide prevention should be infused into programs carried out in diverse settings and systems, such as workplaces, schools, law enforcement and criminal justice settings, health care provider offices, community-based agencies, and faith-based organizations. Greater coordination of efforts among different stakeholders and settings can increase the reach and impact of suicide prevention activities, while preventing duplication and promoting greater cost-effectiveness of efforts. In particular, it is important to take advantage of existing programs and efforts that address risk and protective factors for suicidal behaviors, including programs that may not yet include suicide as an area of focus. For example, many school-based programs seek to prevent drug use and violence among youth by building problem-solving skills and increasing connectedness to teachers, mentors, and other caring adults in the community. These types of strategies can also be useful for suicide prevention.
**Objective 1.1: Integrate Suicide Prevention into Army values, culture, leadership, and work of all commands, agencies, organizations and programs with a role to support Army suicide prevention activities** - Prevention

Suicide prevention should be integrated into the work of all commands, agencies, organizations and programs that provide services and support in the community or that interact with members of the Army Family under stress. These entities include, but are not limited to: Commanders and first-line supervisors; chaplains and chaplain assistants; Family Advocacy Program Workers; Army Emergency Relief Counselors; Hotlines, crisis lines, and call centers; emergency room workers and all behavioral health providers; DOD school counselors; provost marshal personnel; and other institutions in the community. Commanders and first line supervisors, health care providers, behavioral health workers, and other local resources can play an important role in suicide prevention. Integrating suicide prevention into the work of these agencies will promote greater understanding of suicide and help counter the stigma, silence, and denial that can prevent individuals from seeking help as well as enhancing direct intervention care.

**Lead Agency:** G-1

**Supporting Agencies:** Comprehensive Soldier and Family Fitness (CSF2), OTSG (USAPHC), ACSIM

**Short Term Tasks:**

1. 1 Sep 2012 – Publish via Office of the Chief Public Affairs (OCPA) Portal and Army Suicide Prevention Program (ASPP) website Senior Leader Messaging: Written and Video

2. 1 Sep 2012 – Submit Company Commander/1SG Suicide Prevention Course Training Support Packages (TSP) to TRADOC

3. 1 Sep 2012 Update Suicide Prevention Training Strategy with CSF2 language

4. 12 Sep 2012 – Obtain VCSA approval on 2020 Suicide Prevention Goals and Objectives based on the 2012 Draft National Strategy for Suicide Prevention

5. 12 - 13 Sep 2012 – Conduct Pentagon Health Fair 12-13 Sep 2012

6. 15 Sep 2012 – Develop and implement the 2020 Army Strategy for Suicide Prevention

7. 15 Sep 2012 - Release new Leaders’ Guide accessible via mobile phone “app”.
8. 15 Sep 2012 - In conjunction with (ICW) HoF Campaign Plan (EXORD) Recommend that all unit leaders read and become familiar with concepts and topics in the 2020 Army Strategy for Suicide Prevention, “Red Book” and “Gold Book”; conduct periodic refreshers.

9. On-going - Issue guidance for senior commanders to ensure that Community Health Promotion Councils (CHPCs) are established IAW AR 600-63 - Army Health Promotion with installation-wide participation mission, medical and garrison assets. (VCSA HoF Notes) Where implemented with adequate and visible Command support, Community Health Promotion Councils (CHPC) are a best practice.

10. 27 Sep 2012 – Conduct SUICIDE STAND DOWN – PHASE ONE – Immediate Action Training- Disseminate training materials to Commanders; prescribe requirements; Local units will sponsor life and awareness enhancing activities that will assist the Army family in esteeming life and caring for self, peers and others in the Army family and will include a terrain walk. The day could begin with a fun run to include families and then include events sponsored by the Community Health Promotion Council, Master Resilience Trainers (MRTs), family advocacy, behavioral health, the chaplain’s office, Army Substance Abuse Program and others as appropriate. These will be initiated at each camp, post and station under the direction of the senior commanders. There will be differing mixes of HPRRSP facilities on each camp, post, or station for the HPRRSP terrain walk. Local commands must determine the duty positions and numbers of leaders that will visit each facility to assure that each has space to accommodate the visitors and that the primary mission is not interrupted.

11. 1-30 Sep 2012 - Impact military culture and change attitudes through education and outreach programs and events (i.e. Army Suicide Prevention Month, Health Fair, leader discussions, assessments, etc.)

12. 15 Oct 2012 - Synchronize Community Health Promotion Councils (CHPC) and similar forums (i.e., ARNG SP and R3) on posts, camps, and stations efforts utilizing social media and PAO. This should be incorporated into the Strategic Communications (STRATCOM) plan for the CHPC as a whole, facilitated by the Health Promotion Officer.

13.

14. 1 Nov 2012 - Release Targeted Institutional Training Messages based on feedback from the field

15. TBD - Health Promotion Officers at FORSCOM installations synchronized installation efforts utilizing social media and PAO in order to reinforce all suicide prevention messaging and to reach a wider audience.
2020 Army Strategy for Suicide Prevention

Long Term Tasks:

1. On-going - Conduct “continuous process improvement” of training in accordance with established strategies and training paradigms, ensuring training is reviewed and updated annually as circumstances, feedback from the field and emerging research warrant.

2. On-going - United States Army Public Health Command provides oversight to oversee HPOs facilitating synchronized efforts across the Army.

3. 15 Jan 2013 - Complete Online training support package and curriculum for all Suicide Prevention Program Managers.

4. 2nd Qtr CY2013 - Integrate Suicide Prevention content into junior leader courses (change the Army culture by emphasizing leaders’ current authority and responsibilities for subordinate personnel well-being).

Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at all posts, camps and stations – Prevention

Suicide prevention is sometimes organized differently at the different camps posts and stations, which can make it difficult for the many agencies and programs involved in suicide prevention to work collaboratively. Increased coordination of suicide prevention activities among these various partners could help improve services and outcomes, while promoting the greater sustainability of suicide prevention efforts over the long term.

Lead Agency: G-1
Supporting Agencies: CSF2

Short Term Tasks:

1. 27 Sep 2012 - Per EXORD 282-12, Qualified Master Resilience Trainers support Commanders’ training events for unit leadership.

2. 2 Oct 2012 (T)- Resilience Reporting Requirements added to Unit Status Reports. Sustain

3. 15 Oct 2012 - Publish CSF2 EXORD to provide direction to Commanders and Soldiers on the elements and execution of resilience training.

4. 25 Oct 2012 - Assess Army policy and programs and identify program gaps and redundancies via the HPRR Portfolio Management process.
**2020 Army Strategy for Suicide Prevention**

**Long Term Tasks:** Develop and implement identified program changes

1. On-going - CHPCs coordinate with ACS and unit leaders on conduct of at least one community-wide and/or unit-wide awareness event per quarter designed to educate Soldiers, Families, and Civilians on support programs and resources.

2. On-going - Integrate resilience and risk mitigation programs to Suicide Prevention efforts


4. 1 Oct 2015 - Reach unit objective of one Master Resilience Trainer per company-sized element.

5. 1 Nov 2012 - Incorporate resilience training during Soldier in-processing at posts, camps and stations.

**Objective 1.3: Sustain and strengthen collaborations across public and private agencies to advance suicide prevention – Prevention**

Because suicide affects many different groups and is related to substance abuse, combat trauma, domestic violence, relationship and legal issues, many Army and civilian agencies have a role to play in suicide prevention. The HPRR Council, Health of the Force, Comprehensive Soldier and Family Fitness and numerous public and private sector programs provide important forums for collaboration and sharing of best practices. A proactive collaborative approach could have a greater impact in preventing suicide in the Army.

**Lead Agency:** G-1

**Supporting Agencies:** OTSG, ACSIM, PHC, OCPA

**Short Term Tasks:**

1. 1 Oct 2012 - Inventory existing private sector academic and research partnerships to leverage on-going research and best practices.

**Long Term Tasks:**
1. On-going - Sustain/Continue collaborating with Penn State’s clearinghouse which is focused on evaluating, vetting programs and practices for military families to assess their effectiveness.

2. Sustain - Maintain close relationship with Joining Forces, Joining Community Forces, DCoE, DoD/OSD, VA, National Action Alliance, National Institute of Mental Health, Community Covenant and other federal and not for profit organizations to identify emerging programs/initiatives and promising practices for possible application Army wide.

3. 1 Nov 2012 - Evaluate and expand partnerships as appropriate in coordination with OSD.

GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors – Prevention

A wide range of communication efforts, such as communication campaigns and social marketing interventions, can play an important role in suicide prevention. These efforts can help change knowledge, attitudes, and behaviors among specific segments of the Army Family. This can promote changes in the environment that will support suicide prevention. For example, the dissemination of positive messages that focus on recovery and hope can help reduce the biases and prejudices associated with mental and substance use disorders and with suicide. Using these interventions can increase understanding of the stigma often associated with help seeking and provide information that will empower individuals to take action. Communication efforts addressing suicide prevention should be research-based and reflect safe messaging recommendations specific to suicide. The channels and messages that are most appropriate will vary depending on the targeted segment of the Army Family. Prevention

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the Total Army Family – Prevention

Research findings from behavioral health science, communications, social marketing, and other relevant disciplines should inform the development of all communication efforts addressing resilience and suicide prevention. Communication efforts should target defined audiences, or segments of the population, such as groups with higher suicide risk. Demographic factors, such as age, combat exposure, or gender, may be used to identify different audience segments, along with factors related
to the action being promoted. Efforts promoting behavior change should convey a clear call to action and provide specific information the audience needs to act.

**Lead Agency:** G-1

**Supporting Agencies:** OCPA, CSF2, ACSIM, ACSAP

**Short Term Tasks:**

1. **On-going - ICW Strategic Communication Plan –** provide Army-wide distribution/awareness of primary resources:
   - (a) National Suicide Prevention Lifeline (800-273-TALK/8255)
   - (b) Veterans Crisis Line (800-273-TALK/8255, Press 1)
   - (c) Veterans Online Chat
     (http://www.veteranscrisisline.net/ChatTermsOfService.aspx)

2. **On-going - ICW Strategic Communication Plan --** Promote to Families the Suicide Prevention Tip Cards, vignettes, video clips and slides that have already been developed on AKO by USAPHC to address Family members.

3. **15 Sep 2012 -** Develop and issue “Apps,” Quick Series Leaders’ Guide

4. **15 Nov 2012 -** Revise CSF2 Strategic Communications plan for reaching teenagers, ARNG, USAR personnel via social media/networking mediums.

5. **TBD - ICW Strategic Communication Plan -** promote availability of medical community ombudsman for Soldier, Family medical questions/issues.

**Long Term Tasks:**

1. **On-going -** Participate with the White House in the Joining Forces initiative to support Soldiers who are leaving the Service with employment, behavioral health, and veterans’ support.

2. **On-going -** Provide dynamic, current messaging on resilience skills (CSF2) to COMPOs 1, 2, & 3 as well as Family members and DA Civilians.

3. **On-going -** Identify Stigma Campaign strategic messages.


5. **Jan/Feb 2013 -** Deliver Stigma Campaign messaging products to camps, posts, and stations upon completion of Communications Campaign Plan data gathering

6. **Feb 2013 (T) -** Launch Senior Leader Messaging-PSAs
7. Feb-Mar 2013 - Commanders include anti-stigma guidance and discussions in quarterly HoF meetings with Unit Leaders

8. Mar-April 2013 - Target anti-stigma messaging to Unit Leaders


10. 2\textsuperscript{nd} Qtr 2013 - ICW Strategic Communication Plan -- Improve communication outreach to Families through available media to increase Family awareness of Health of the Force issues, of installation resources available to assist them, and empower them to feel free to engage Leaders of all levels on Health of the Force issues impacting Soldiers, Families, or units. (goal is to reduce/eliminate Soldier bottleneck on not relaying information)

11. 2\textsuperscript{nd} Qtr 2013 - ICW HPRRSP Training Strategy -- Relook multiple mandatory training sessions for Soldiers and determine if they can be merged/transitioned into an integrated and holistic training package focused on management of high risk behavior (instead of stove-piped around specific topics, i.e., suicide prevention, sexual assault, sexual harassment, drug and alcohol, etc).

12. 3\textsuperscript{rd} Qtr CY 2013 - Integrate suicide prevention information (goals, risk and protective factors, community resources, etc.) into all Army Community Service briefings that ACS is required by regulation to provide, i.e., community, unit, Family members, Soldiers, gatekeepers, etc. Educate and reinforce with leaders the importance of being available when Family members contact them.

**Objective 2.2: Increase communication efforts that promote positive messages and support safe crisis intervention strategies – Prevention**

Technology is changing the way we communicate, and the pace at which new communications tools are introduced continues to accelerate. These media and applications include interactive educational and social networking Web sites, email outreach, blogs, mobile apps, and programs using mobile devices and texting. Mobile health apps have become increasingly popular, particularly among young adults. Innovative applications currently being developed and applied to suicide prevention include virtual worlds, gaming, and text analysis. Emerging media and applications provide new opportunities for suicide prevention, particularly for persons who may be socially isolated or otherwise difficult to reach.

**Lead Agency:** G-1

**Supporting Agencies:** OCPA, IMCOM

**Short Term Tasks:**
2020 Army Strategy for Suicide Prevention

1. On-going - Update Army Suicide Prevention Website by ensuring that all products are available for viewing/downloading/ordering.

2. On-going - Publish resources such as VA Make the Connection, Military One-Source, Suicide Hot Line:
   (a) Military Crisis Line - 1-800-273-TALK (8255) - Press 1
   (b) National Suicide Prevention Lifeline - 1-800-273-TALK (8255)
   (c) Military One Source - 1-800-342-9647
   (d) The Defense Center of Excellence (DCoE) - 1-866-966-1020
   (e) CSF2 website and branding
   (f) CSF2 e-Newsletter

3. 15 Sep 2012 - Disseminate new CSF2 website and branding

4. 15 Oct 2012 - Explore optimal methodology of pushing information to Soldiers and Families through e-mail/web presence. Note: ACS has the technology to push Suicide Prevention information to units, families, high risk and geographically-dispersed populations through the Army OneSource (AOS) website.

5. 1 Dec 2012 - Consolidate and simplify access to online resources by promoting a single or more limited array of online websites.

6. 4TH Qtr CY12 – Deploy Master Resilience Trainer Resource Center on the Soldier Fitness Tracker (SFT) to provide training materials and aids, and current messaging to master resilience trainers. CSF2 will continue to update and add functionality to the site.

Long Term Tasks:

1. 3rd Qtr CY 2013 - Launch GTSY-SHARP online social networking tool

2. 3rd Qtr CY 2013 - Develop, deploy CSF2 Resilience Skills mobile application

3. 3rd Qtr CY 2013 - Create opportunities for families to be active participants in supporting their service members:
   (a) Create connections between family, Service, and service member through communications that are local, personal, and positive
   (b) Collect Family contact information so that local chain of command, chaplains, ombudsmen can reach out on an individual basis
   (c) Craft and send positive themed letters to Family specifically requesting their assistance and emphasizing the key role they play in supporting the service member
(d) If a relationship already exists between a local recruiter and family, reinforce the connection and make sure that the family recognizes the recruiter as a resource

(e) Encourage communication (when possible) between service member and family/friends

**Objective 2.3: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care – Prevention**

Commanders, first line supervisors, Family members, friends, coaches, coworkers, and others can play an important role in recognizing when someone is in crisis and connecting the person with sources of help. However, many of these persons may not know the warning signs of suicidal behavior or where a distressed person can go for help. It is crucial to widely disseminate information on warning signs, skills for interacting with individuals in crisis, and available resources. In doing so, it is important to use communication strategies that are research-based, thoughtfully planned, and designed to meet the needs of specific groups. Incorporating stories of individuals who received help and benefited may motivate others to take action.

**Lead Agency:** IMCOM (G-9)

**Supporting Agencies:** USAPHC, OTSG

**Short Term Tasks:**
1. On-going - Update Army Suicide Prevention Program webpage with resources, policies, trends, best practices, etc.

**Long Term Tasks:**
1. 15 Sep 2012 - Launch Leaders Guide “App” for smart phones for immediate access to resources.
2. 1 Oct 2012 - Resources for families: evaluate effectiveness of current programs.
3. 2nd Qtr CY 2013 ICW Strategic Communication Plan -- Provide Families with the information they need to act:
(a) Identify definitive sources of information – the starting hubs for information
   (Risk Factors – What to look for; Website; Telephone; Handout – refrigerator magnet)

(b) Have all resources highlight these definitive sources of information

(c) Create a “Need to Know” template for family to have (unit, CO, base, etc…)

(d) Handouts contain information that is relevant to the service member and their family (local recruiter’s office, nearby local religious services, etc.)

(e) Contact information for service member’s chain of command, or installation chaplain in the event of suicidal ideations or actions.

(f) Create a “What to do” template for family to have in the event of suicidal ideations or actions.

**Objective 2.4: Develop, implement, monitor, and update guidelines regarding how to address consistent and safe messaging on suicide and related behaviors – Prevention**

OCPA serves as the primary communications medium for disseminating relevant, real-time HPRR information throughout the Army and to public media platforms. Additionally, OCPA provides guidance and assistance in the development of communication vehicles on campaigns an initiatives for enhancing senior leaders' awareness. For example, Public Affairs Guidance, Communications Plans, STAND-TOs, Public Service Announcements, and Media Releases.

**Lead Agency:** OCPA

**Supporting Agencies:** G-1(HRDP PAO)

**Short Term Tasks:**
1. On-going - Continue HPRR/SP collaboration with OCPA

**Long Term Tasks:**
1. On-going - Continuously assess communication strategies, identified issues and address as appropriate.
2. 1 Oct 2012 - DOD Risk Communications Agency
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote resilience, wellness and recovery – Prevention

Although knowledge of effective treatment for mental and substance use disorders has increased over the years, there remains a need to increase awareness of the factors that can help offer protection from suicide risk. Connectedness to others, including family members, fellow Soldiers, gate keepers, community organizations, and social institutions has been identified as an important protective factor. These positive relationships can help increase a person’s sense of belonging, foster a sense of personal worth, and provide access to sources of support. It is also important to increase the understanding that mental and substance abuse disorders are treatable, and that recovery is possible. All in Army Family should understand the important role they can play in promoting resilience and wellness, and in promoting the full recovery of those who may be experiencing problems.

Objective 3.1: Promote programs and practices that highlight protective factors and build resilience – Prevention

Many factors can help prevent suicide by promoting physical, mental, emotional, and spiritual wellness. These protective factors include problem-solving skills and social support that can help individuals cope with emotional distress. The use of these tools should be the norm rather than the exception. They should be taught at early ages to strengthen the resilience of individuals and communities to overcome challenges and crises. Policies and programs that foster social connectedness can help promote mental and physical health, and recovery.

Lead Agency: G-1

Supporting Agencies: OTSG/MEDCOM, USAPHC, CSF2

Short Term Tasks:
1. On-going - Continue to collect promising/best practices from SSRG and post on webpage, share with commanders via ASPP website under “What’s New” and S-1 Net.

2. 25 Sep 2012 - Increase engagement/involvement of company grade leaders in Health of the Force issues:
   (a) SMCs/GCs lead quarterly meetings/discussions with subordinate unit leaders to discuss Ready and Resilient Force issues (e.g., awareness of risk and
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protective factors, unit Risk Reduction Program statistics/indicators, leader counseling and intervention skills, installation support resources, etc.)

(b) (EXORD 282-12, ALARACT 221/2012) Unit Commanders lead quarterly meetings/discussions with subordinate unit leaders to discuss Ready and Resilient Force issues (e.g., awareness of risk and protective factors, unit Risk Reduction Program statistics/indicators, leader counseling and intervention skills, installation support resources, etc.)

(c) (EXORD 282-12, ALARACT 221/2012) Commanders ensure that unit leaders receive recurring training in the conduct of face to face interaction and communication with Soldiers. Commanders lead quarterly peer-to-peer unit-level leader training on counseling goals and skills IAW Appendix B of FM 6-22 Army Leadership

3. 27 Sep 2012 - Phase I Army Suicide Prevention Stand Down Day (See EXORD 282-12, ALARACT 221/2012)

4. 1 Oct 2012(T) - Launch Company Commander/First Sergeant Course

5. Oct 2012 - Complete and link Comprehensive Resilience Modules (CRMs) to Global Assessment Tool (GAT) results.

6. Oct 2012 - Develop questions assessing the physical Dimension of the GAT

Long Term Tasks:

1. On-going - Educate, inform and equip leaders to comply with and support policies and programs that provide services and promote help-seeking, mitigation of harassment and secure reporting behaviors

2. On-going - Resilience skills inculcated throughout the Army via synchronized organizational, institutional and self-development training.

3. On-going - Highlight promising practices, positive interventions via such media as ASPP website, SSRG, S-1 Net

4. 1-30 Sep 2012 - Impact military culture and attitudes through education and outreach programs and events (i.e. Army Suicide Prevention Month, Health Fair), both short and long term.

5. 28 Sep 2012 – Start Phase II Army Suicide Prevention Stand Down.

6. Nov 2012 - Develop a means for the Community Resource Guide (CRG) at all Army installations. The CRG is a comprehensive inventory of installation programs that cover every stage in the continuum of care. This one-stop shop for services and programs increases the ability of members of the Army family to discover services based on need versus agency. (TAP R-008) The CRG is facilitated through the
CHPC process, and in addition to marketing programs and services to end-users, it is also used to identify gaps and overlap in programming, and is an excellent referral tool for leaders and service providers. USAPHC is the SME for the CRG.

7. 1 Apr 2013 - Assess Leaders’ Skills to address At-Risk Soldiers: Review Safe Vet program for applicability; incorporate into training

8. 1 Apr 2013 Interdisciplinary Pain Management Centers (IPMC) currently functioning at several locations following the Pain Management Campaign and Task Force recommendations. Implement a comprehensive pain management strategy that is holistic, multidisciplinary, and multimodal in its approach, utilizes state of the art/science modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain.

9. 1 Jun 2013 – (TAP T-037) Develop a comprehensive nutrition campaign that includes specific messaging for important nutrients for Soldiers in both garrison and theater environments.

Objective 3.2: Reduce stigma associated with seeking help for suicidal ideations and behaviors, behavioral health and substance use disorders – Prevention

Bias, prejudice, stigma, and discrimination discourage many people from seeking help, or even from sharing the psychological distress that could lead to suicidal behaviors. In some cases, cultural or religious beliefs that oppose suicide may help protect some individuals from suicidal behaviors. In others, they may present barriers to help seeking, and can increase the distress of those who have been bereaved by suicide. Broad communication, public education, and public policy efforts are needed to promote mental health, increase understanding of mental and substance abuse disorders, and eliminate barriers to help seeking. These efforts should increase awareness that no one is immune from experiencing these difficulties. Seeking treatment should be seen not as a sign of weakness, but as a step toward recovery.

Lead Agency: G-1

Supporting Agencies: OTSG/MEDCOM, USAPHC, ACSIM/IMCOM

Short Term Tasks:
1. On-going - Visit select installations to obtain information to develop stigma campaign messaging
2. 1 Nov 2012 - Develop draft strategic messaging to promote resilience, recovery and help-seeking as a sign of strength that not only benefits the individual, but his/her
family, unit and the Army. 1 Nov 12 ICW Stigma Reduction Campaign Plan -- Target stigma reduction messaging to Unit Leaders (still lack unit leader support of Soldiers making BH appointments).

3. 1 Nov 2012 - ICW Stigma Reduction Campaign Plan – Provide guidance to Commanders to include stigma reduction guidance and discussions in quarterly HoF meetings with Unit Leaders.

4. 1 Feb 2013 - Inventory and evaluate on-going Stigma Reduction Efforts (specifically HPRR, ASPP and BH) through the HPRR Portfolio Capabilities Assessment

**Long Term Tasks:**

1. 1 Dec 2012 - Develop products and procedures to publicize stigma campaign messaging

2. Jan/Feb 2013 - Develop Stigma Campaign messaging to promote resilience, recovery and help-seeking as a sign of strength that not only benefits the individual but his/her Family, unit and the Army, to camps, posts, and stations.

3. Feb 2013 - Launch Senior Leader Messaging – PSAs.

4. Feb-Mar 2013 - Commanders include anti-stigma guidance and discussions in quarterly HoF meetings with unit leaders.

5. Mar-Apr 2013 - Target anti-stigma messaging to unit leaders.

6. TBD - Identify gaps and actions (to fill those gaps), or redefine Army approach to training and/or stigma reduction messaging.

**Objective 3.3: Promote the understanding that recovery from behavioral and substance use disorders is possible – Prevention**

Social attitudes, bias, and stigma often present barriers to treatment and undermine the recovery of persons with mental or substance use disorders. Friends and family, health professionals, and others may at times be overly protective or pessimistic about what someone with a mental or substance use disorder will be able to achieve. These attitudes can undermine the person’s hope for the future and ability to recover. A better understanding of crisis, trauma, and recovery can help individuals and groups within the Army Family promote resilience and wellness among all. It is important to increase awareness that, in most cases, individuals who have a behavioral or substance use disorder can recover and regain or attain meaningful lives and service.

**Lead Agency:** OTSG/MEDCOM, DCOMM

**Supporting Agencies:** G-1 (ACSAP)
Short Term Tasks:
1. On-going - Continue support for behavioral health strategic messaging (Depression Awareness Month and Mental Health Awareness Month in May).
2. TBD - Assess current messaging available to Soldiers, Leaders, Army Civilians and Family members.

Long Term Tasks:
1. 1 Feb 2013 - Determine appropriate messaging to reinforce Objective 3.3
2. TBD - Craft STRATCOM to communicate that improving/seeking behavioral health has value.
Strategic Direction 2: Clinical and Community Support Services – Prevention

Suicide affects all members of the Army Family, regardless of rank, gender, marital status or combat exposure. The factors that contribute to these preventable deaths are multiple and complex. Some of the factors that can increase the risk for suicidal behaviors may be longstanding, such as having a substance abuse disorder. Others, such as the loss of a loved one or career failure, may be recent events that could increase the immediate risk for suicidal behaviors. Or the effects of the horrible realities of war can push others into a downward spiral. Suicide prevention requires that support systems, services, and resources be in place to promote wellness and help individuals successfully navigate these challenges. Clinical and community-based programs and services play a key role in promoting wellness, building resilience, and preventing suicidal behaviors among various groups. Clinical preventive services, including suicide assessment and preventive screening by primary care and other health care providers, are crucial to assessing suicide risk and connecting individuals at risk for suicide to available clinical services and other sources of care.

GOAL 4. Develop, implement, and monitor programs that promote wellness and prevent suicide and high risk behaviors – Prevention

Suicide prevention requires that a variety of preventive clinical supports and community-based programs be available at each post, camp and station, for all three Army components, Army Civilians and Family members. These mitigate suicide risk. These programs should support the active participation of a diverse range of Gate keepers, first responder and community members in suicide prevention programs, including professionally trained helpers and other care providers. Clinical and community-based services should seek to promote wellness, reduce risk factors, increase resilience and protective factors, link individuals in crisis with appropriate services and supports, and address the environmental and social conditions that can contribute to suicidal behaviors.

Objective 4.1: Strengthen the coordination, implementation, and evaluation of comprehensive Department of Army HP&RR (including suicide prevention) programming - Prevention

The goal of saving lives can often be achieved only by a combination of efforts by a variety of responders that can meet the needs of diverse groups within the Army Family.
Suicide prevention efforts should engage multiple partners and sectors, focus on the entire career or lifespan of the individual, and provide services that are culturally and demographically appropriate.

**Lead Agency:** G-1, G-3/5/7, OCCH, OTSG

**Supporting Agencies:** USAPHC, ACSIM/IMCOM, ARNG, USAR,

**Short Term Tasks:**
1. 25 Oct 2012 - Conduct HP&RR Capabilities Assessment to identify programs that meet HP&RR goals and their evaluation standards to insure programs do what they purport to do.

**Long Term Tasks:**
1. On-going - Annually conduct Recurring Capabilities Assessment. Identify portfolio gaps, redundancies and programs that are not validated.
2. On-going - Develop an Army Health Promotion & Risk Reduction Portfolio fully supported by evidence based programs providing effectiveness, quality, accountability, and efficiency established through a program evaluation process.
   (a) Provide senior Army leadership with actionable information to advocate for / make decisions regarding maximum effective health promotion and risk reduction programs.
   (b) Develop a process for program evaluation and promote evidence-based practices Identify requirements for future program evaluation efforts and Increase collaboration among programs in the portfolio.

**Objective 4.2: Encourage post, camp, station and community-based settings to implement programs and provide education that promote wellness and prevent suicide and related behaviors – Prevention**

Many institutions, agencies, and organizations on post and in the community have a role to play in promoting health, reducing risk factors, increasing protective factors, training personnel who are in contact with individuals with suicide risk, and providing support to individuals in crisis. A few examples include: health care organizations, veterans service organizations, faith-based organizations, law enforcement institutions, schools, youth-serving organizations, and of course, the workplace. Engaging these and other on-post and community groups can greatly expand the reach of suicide prevention efforts, making it possible to provide assistance and support to individuals who may be most vulnerable and/or underserved.
Lead Agency: ACSIM/IMCOM

Supporting Agencies: USAPHC, ARNG, USAR, CSF2, ACSAP

Short Term Tasks:

1. On-going - Community Covenant is an Army program designed to foster and sustain effective state and local efforts that enhance Soldier and Family strength, readiness and resilience.

2. On-going - Promote and support physical resilience through weekly unit intramural sports (e.g., Commander’s Cup), robust PT programs, combatives, foot marching, and marksmanship, etc. IAW AR 350-1, Table G-1.

3. November 2012 - Establish CHPC standards for the synchronization of an installation HPRRS system for implementing and evaluating programs. US Army Public Health Command (USAPHC) is the subject matter expert for Community Health Promotion Council (CHPC) implementation and oversees the standardized CHPC process, facilitated by centrally-managed Health Promotion Officers (HPO). USAPHC provides consultation to installations without a centrally-managed HPO. The CHPC process includes standardized deliverables that include the development of a strategic plan, linked to the Senior Commander’s objectives, that helps unify and oversee program implementation and impact.

4.

5. 1 Jan 2013 - Task for OCPA and OACSIM/G-1/OTSG: Develop a communication strategy for inspired communities to illustrate and guide them in local implementation of best practices (e.g., putting up suicide prevention posters in local establishments, urging local faith-based groups to include messages of hope and help-seeking behavior in their regular discussions, running help-seeking stories in local media, etc.)

6. 1st Qtr CY 2013 - Implement the Total Army Sponsorship Program uniformly at all levels (from reception through integration). Commanders review and validate that effective sponsorship programs are in place IAW AR 600-8-8, Total Army Sponsorship Program. Reports shall be submitted to IMCOM IAW HQDA EXORD 018-12 Total Army Sponsorship Program and IMCOM report to OACSIM program proponent.

7. TBD - (CSF2) Establish pilot program to incorporate resilience training into Soldier in-processing

Long Term Tasks:
1. On-going - Sustain and ensure wide and frequent promotion of Soldier, Family, and DAC participation in community events, recreation programs, and social gatherings. Goal is to increase connections to unit, friends, Family, and community.
   
   (a) TBD - Fully resource installation support services to assist Commanders with critical needs (e.g., SP coordinators, fill ASAP coordinators, drug-testing coordinators, ASAP civilian/Family treatment assets, and adequate BH psychiatrist
   
   (b) TBD - (VCSA visit notes) Installation and unit leaders will ensure that MRTs and assistants that depart units are backfilled within 90 days.

2. June 2013 - Complete full implementation of the Commanders/1SG Course.

3. TBD - Ensure BDE Commanders have access to all required support services.

**Objective 4.3: Intervene to reduce suicidal thoughts and behaviors among all personnel within the Army Family – Prevention**

Several groups within the Army family may be at an increased risk for suicidal behaviors. Risk and protective factors can vary across commands and communities and change over time. Different interventions are needed to meet the distinctive needs of different groups within the Army family. Suicide prevention programs must continuously identify emerging at-risk groups, and develop and implement programs tailored to their unique needs. Each planned initiative should also rigorously assess outcomes, both desired and unanticipated.

**Lead Agency:** G-1

**Supporting Agencies:** USAPHC, ARNG, USAR, ACSIM/IMCOM

**Short Term Tasks:**

1. On-going/Sustain - Leaders monitor URI/R-URI data and respond accordingly to Soldier self-reported needs for additional information on risk management (e.g., 4% of Soldiers Army-wide have requested information/briefing materials on suicide; 7% have requested information on depression; 10% on anger management; etc.)

2. 27 Sep 2012/Sustain - Increase engagement/involvement of company grade leaders in Health of the Force issues: (per EXORD) Unit leaders complete risk assessments for all Soldiers to shape leader-led discussions and subsequent training using the DA Soldier and Leader Risk Counseling Tool.
Long Term Tasks:

1. 1 Feb 2013 - Develop and implement installation Suicide Prevention Program Manager (SPPM) training module.
2. 31 Dec 2012 – (TAP M-021) Develop Commanders’ Dashboard to provide current Soldier specific data on high risk behavior history to provide opportunities for preventive programming and appropriate interventions.
3. 2nd Qtr 2013 - Develop training to support unit level suicide prevention personnel.
4. 4th Qtr 2014(T) - (NSPS Obj. 5.3) Identify appropriate screening tools for discrete venues (e.g., MEPS, PHA, PDHRA, ACS, MTF, etc.) and standardize if possible to make training of personnel who conduct screens and make referrals more effective.
   (a) Ensure commanders Army wide are aware of these tools.
   (b) Continue conducting screenings for behavioral health needs, including suicidal thoughts and behaviors, depression, and substance abuse, and make referrals to treatment and community resources, as needed. (note: screens should be in one objective, while referrals are in another)

Objective 4.4: Strengthen efforts to increase access to and delivery of programs and services for behavioral health and substance use disorders – Prevention

Having a serious behavioral disorder such as major depression or PTSD is a recognized risk factor for suicidal behaviors. This is particularly true if the person also has a substance abuse disorder. Health care systems should be encouraged to recognize and respond to behavioral and substance use problems in the same way they respond to physical health problems. Greater coordination among the different programs that provide services addressing mental health, substance use, and physical health care will also increase access to care. This coordination can range from information sharing among different service providers to the delivery of these various services in the same setting. These linkages will help provide multiple access points for behavioral health care (many “right doors” to treatment), thereby helping to ensure that individuals who may be at risk for suicidal behaviors are connected to appropriate sources of care.

Lead Agency: OTSG/ IMCOM

Supporting Agencies: G-1(ACSAP), ACSIM/, ARNG, USAR, USAPHC

Short Term Tasks:
1. On-going - Increase staffing for behavioral health and substance abuse counselors
2. On-going – Develop Army wide implementation for Confidential Alcohol Treatment Program
3. 1-OCT-2012 & On-going - Establish Child and Family Assistance Centers (CAFAC) at select installations
4. 12-NOV-2012 - Establish Embedded Behavioral Health (EBH) in support of select units
5. TBD - Publish a Comprehensive Behavioral Health Service Line Operations Order (OPORD)

**Long Term Tasks:**
1. On-going - Increase number of Suicide Prevention Program Managers for ARNG/USAR and IMCOM
2. TBD - Evaluate advisability of possible permanent Confidential Alcohol Treatment Program
3. TBD - Establish fully functioning behavioral health service line
4. TBD - Increase Army Substance Abuse Program counselors to 562 to meet industry standard of 1 counselor to 30 Soldiers/patients

**Objective 4.5: Encourage health care providers to provide appropriate commander's guidance/actions in the management of high risk suicidal individuals who have access to firearms and other lethal means – Prevention**

Health care providers play a pivotal role in assessing high risk individuals and providing guidance to commanders to provide effective support to Soldiers. A primary focus is in insuring the safety and well-being of Soldiers and the Army community. Effective guidance to commanders is essential in accomplishing this.

**Lead Agency:** G-1

**Supporting Agencies:** OPMG, CRC, OTSG

**Short Term Tasks:**
1. 1 Dec 2012 - Obtain legal review to determine feasibility of establishing a service wide lethal means policy.
2. 1 Jan 2013 - Assess existing policies to address ways to reduce means to lethality that can be enhanced through policy changes.
Long Term Tasks:
1. 1 Feb 2013 - Publish a lethal means restriction policy.

Objective 4.6: Incorporate suicide awareness into firearm safety and responsible firearm ownership – Prevention

In 2009, about half of suicides in the United States resulted from the use of firearms. Incorporating suicide awareness into firearm safety and responsible firearm ownership is an opportunity to address this issue.

Lead Agency: CRC
Supporting Agencies: OPMG

Short Term Tasks:
1. TBD - Assess appropriateness for integration of suicide prevention in weapons training

Long Term Tasks:
1. TBD - Complete assessment and develop COAs.
2. TBD - Complete assessment and focus on preventing deaths that occur in the form of Russian roulette, accidental discharges during cleaning, etc.

GOAL 5. Provide training to community and clinical service providers on the prevention of suicide and other high risk behaviors – Prevention

All community-based and clinical prevention professionals whose work brings them into contact with persons with suicide risk should be trained on how to address suicidal thoughts and behaviors, and on how to respond to those who have been affected by suicide. Training programs should be tailored to the specific needs and roles of the providers, and be regularly updated and refreshed to reflect new knowledge in the field and over time.

Objective 5.1: Provide training on suicide prevention to Family members, gatekeepers, unit leaders and community groups that have a role in the prevention of suicide and high risk behaviors – Prevention
Thousands of Commanders, first line supervisors and responders, crisis line volunteers, law enforcement professionals, clergy, individuals working in law enforcement, and others who are on the frontlines of suicide prevention should be trained on suicide prevention. A number of training curricula exist to address the distinct needs of these various groups. These training programs should continue to be implemented, evaluated, and updated, and new programs should be developed to meet the needs of different at-risk populations and types of community service providers. In addition, there is a need to make education programs available to family members and others who are in close relationships with persons at risk for suicide or who have been affected by suicidal behaviors. Prevention

**Lead Agency:** IMCOM, USAR/ARNG/OCCH

**Supporting Agencies:** G-1, CSF2, USAPHC

**Short Term Tasks:**

1. On-going Continue ASIST Training for Gatekeepers
2. On-going --Tailor ACE awareness-module to Family members and gatekeepers
3. TBD - ICW HPRRSP Training Strategy -- ACS staff and installation behavioral health staff member co-facilitate unit leader training on a quarterly basis to address suicide prevention, high risk behaviors, and local military installation and civilian community resources available across the entire spectrum of problem areas (financial, counseling, domestic abuse, child abuse, deployment, employment, transition, etc.).

   Note: immediate goal is to facilitate and strengthen the implementation of the DA Soldier and Leader Risk Counseling Tool; this should be done at least semi-annually to keep up with unit leader rotations.

**Long Term Tasks:**

1. TBD - Update of HPRRSP training to address input from research and feedback from the field.

**Objective 5.2: Provide training to Commanders, Leaders, behavioral health and substance abuse providers on the recognition, screening, assessment, and management of at-risk behavior – Prevention**

   Behavioral health and substance abuse providers should have the essential foundation of attitudes, knowledge, and clinical prevention skills to address and reduce suicide risk and increase protective factors among patients. Caring for individuals with suicide risk requires being able to work collaboratively with the patient. Skill
development, practice using those skills, and a culture of shared responsibility can help build comfort, confidence, and competency to engage and care for these individuals.

**Lead Agency:** OTSG/MEDCOM/IMCOM

**Supporting Agencies:** G-1 (ACSAP), USAPHC

**Short Term Tasks:**

1. TBD - Draft and disseminate MEDCOM guidance to garrison program and care providers to maximize use of existing information, tools and channels in support of the campaign related to prescription abuse.

2. TBD - Review MEDCOM provider training related to risk assessment, risk mitigation and subsequent care.

3. TBD - Task: ACS staff conduct quarterly training in counseling skills/procedures (e.g., FM 6-22, Appendix B, Counseling) in order to better serve as the Army’s “front door” for access to community services – especially prevention programs (increase staff ability assess need, refer to community service, and follow-up to ensure right service was provided). Linked to OBJ 2-1 task to have OCPA develop/distribute PSAs to promote ACS as the “front door” for access to any/all wellbeing programs and services.

**Long Term Tasks:**

1. TBD - USAPHC developed the OTSG Polypharmacy and Overdose Medical Education (POME) training program into a robust educational training program for patients requiring polypharmacy and for those who take care of Soldiers requiring polypharmacy. POME will be a core program that will bundle all of the current initiatives with appropriate documentation and metrics for measuring effectiveness in accordance with OTSG policy memorandums 10-076 and 09-022. Expected completion date: 31 Mar 2013.

2. TBD - Incorporate provider training for risk assessment, risk mitigation and subsequent care.

**Objective 5.3: Implement core training requirements on the prevention of suicide and related behaviors by primary health care providers – Prevention**

All education and training programs for health professionals, should adopt core education and training guidelines addressing the prevention of suicide and related behaviors. All certification programs in relevant disciplines should include these guidelines as a part of their curricula. Programs should also ensure that graduates
achieve the relevant core competencies in suicide prevention appropriate for their respective discipline.

**Lead Agency:** OTSG/MEDCOM/IMCOM

**Supporting Agencies:** TRADOC

**Short Term Tasks:**
1. TBD - Assess current training modules related to risk assessment and referral of high risk soldiers currently provided to the healthcare professionals during initial entry.

**Long Term Tasks:**
1. TBD - Integrate a block of instruction on identifying and managing high risk patients on initial entry.

**Objective 5.4:** Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk – **Prevention**

Communication and collaboration across multiple levels of care is a key to the successful management of suicide risk. Clinical preventive and communication protocols for clinicians and clinical supervisors, emergency workers, crisis staff, and other professionals can help improve diffusion of best practices and collaborative management of suicide risk. Care for individuals with suicide risk must be comprehensive and continuous until the risk is reduced. Each setting and service provider has an important role in verifying that the subsequent supportive services have the information and resources they need in order to help keep the individual safe. Protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others should address the implementation of effective strategies for improving communication and collaboratively managing suicide risk.

**Lead Agency:** ACSIM, OTSG/MEDCOM, IMCOM

**Supporting Agencies:** ARNG/USAR/IMCOM G-1, USAPHC

**Short Term Tasks:**
1. TBD - To be determined in consultation with MEDCOM/OTSG
2. TBD - Publish behavioral health service line OPORD
**Long Term Tasks:**

1. 30 Apr 2013 - Establish Fully functioning behavioral health service line

2. 30 Jul 2013 - Develop a web portal for best practices. ASPP will link to this portal.
Strategic Direction 3: Treatment and Recovery Services – Intervention, Postvention

Individuals at high risk for suicide require clinical evaluation and care to identify and treat behavioral health and medical conditions, and to specifically address suicide risk. In the past, it was believed that appropriately treating underlying conditions (e.g., mood disorders, substance abuse) would remove the risk for suicide. However, this is not always the case. A growing body of evidence suggests that suicide prevention is enhanced when specific treatments for underlying conditions are combined with strategies that directly address suicide risk. Evidence-based and promising approaches for caring for high-risk patients include safety planning (i.e., working collaboratively with patient to develop an action plan for times of crises) and specific forms of therapy that can be used to support treatment for underlying behavioral health conditions. Addressing suicide risk may be particularly important when treating individuals who have survived a suicide attempt.

GOAL 6. Promote suicide prevention as a core component of behavioral health and substance abuse services using systems-level strategies that provide coordination and continuity of care - Intervention, Postvention

There is substantial evidence that discontinuities in treatment and fragmentation of care can increase the risk for suicide. Death by suicide in the period after discharge from inpatient psychiatric units is more frequent than at any other time during treatment. Proactive follow up and active engagement strategies following discharge have been found to help reduce death by suicide and suicide attempt. While providers of mental health and substance abuse services have a special responsibility for addressing suicide risk, suicide prevention should not be viewed as an area of specialization that applies only to these professionals or to a single setting. Suicide prevention requires the active engagement of health and social services, as well as the coordination of care across multiple settings, thereby ensuring continuity of care and promoting patient safety. Increasing collaboration among providers is also a promising, viable, and efficient way to increase access to suicide prevention and treatment services. This approach can help minimize stigma and discrimination, while increasing opportunities to improve overall health outcomes.
Objective 6.1: Promote the adoption of “Plan for Life” as a planning goal by health care and community support systems that provide services and support to defined patient populations – Intervention

Plan for life is a therapeutic paradigm that adapts to the values, level of understanding and life experiences of each individual. It simply involves formulation of daily plans for living that deliberately incorporates positive, self-esteem and relationship building activities and includes strategies for eliminating self-defeating thoughts and activities. The plan is developed through the collaboration of the behavioral health professional and the individual, which fosters professional oversight with personal “buy-in”. The Plan for Life concept remains under development.

Lead Agency: OTSG/MEDCOM
Supporting Agencies: G1 ASPP

Short Term Tasks:

1. TBD – Conduct assessment for adoption of Plan for Life by OTSG and ASAP as a treatment/intervention goal for health care and community support systems that provide services and support to defined patient populations. This was a suggestion; needs to be coordinated with OTSG

Long Term Tasks:

Objective 6.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings – Intervention

Trusting therapeutic relationships are fundamental to reducing suicide risk and promoting recovery and wellness. These relationships are most productive when the patient is actively engaged in making choices that will keep him or her safe. There is a need to promote appropriate strategies that will foster therapeutic alliances between patients and providers. The personal needs, wishes, and resources of the patient should be the foundation for developing a plan for continuing care and safety. This plan should be developed through direct and open communication, with the patient being engaged and empowered. Where appropriate and practical, families should be engaged and empowered as well.

Lead Agency: OTSG/MEDCOM
Supporting Agencies: OCCH, G1 (ASPP), USAPHC

Short Term Tasks:
1. 01-Oct-2012 - Establish the EBH capability in support of all Brigade Combat Teams.
2. 01-Dec-2012 - Establish BH screening protocols into the Patient Centered Medical Home to identify at-risk and suicidal patients.
3. TBD - Develop the Behavioral Health Data Platform

Long Term Tasks:
1. 01-Apr-2013 - Incorporate DoD/VA clinical practice guidelines for the assessment and management of suicide and high-risk behaviors into routine care.
2. 01-Apr-2013 - Incorporate BH support into Patient Centered Medical Home team.
3. 01-Apr-2013 - Develop protocols on how to assess/refer/treat patients with co-morbid symptoms.

Objective 6.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide – Intervention

Timely access to care is critically important to individuals in crisis. Crisis hotlines, online crisis chat/intervention services, self-help tools, crisis outreach teams, and other services play an important role in providing timely care to patients with high suicide risk. Virtual or remote care, such as telephone calls to crisis hotlines, and counseling by telephone, texting, or the Internet allow individuals in crisis to access help 24 hours a day, 7 days a week. This type of care typically is available at low or no cost to individuals in crisis, and provides immediate access, convenience, and a higher level of anonymity than face-to-face therapy arrangements. Providing detailed instructions about how to access care 24 hours a day, 7 days a week is a critical part of safety planning for providers working with patients at high risk.

Lead Agency: OTSG/MEDCOM
Supporting Agencies: ACSIM/IMCOM, G-1(ACSAP), OCCH, ARNG, USAR

Short Term Tasks:
1. 01-Oct-2012 - Establish the Embedded Behavioral Health capability in support of all Brigade Combat Teams.
2. 01-Oct-2012 - Implement BH care in the Patient/Soldier Centered Medical Home
3. TBD - Established the BH Service Line throughout MEDCOM to standardize BH care, improve quality and ensure sufficient resources locally to ensure rapid access to care.
4. 01-Oct-2012 - Promote training for Primary Care and BH professionals on empirically-validated assessment and management of acute suicide risk.

5. 01-Oct-2012 - Decrease wait time to make/attend BH interventions/counseling sessions (the longer the wait, the more time for influence of stigma). TBD - Publish a Comprehensive Behavioral Health Service Line OPORD

6. 1 Dec 12 - Increase training of unit leaders to reinforce goals and benefits of BH services in order to reduce stigma associated with help seeking.

7. 

**Long Term Tasks:**

1. Nov 2012 – Initial deployment of ACSAP’s Risk Reduction Program will implement the Commander’s Dashboard to track Soldiers evidencing a history of high risk behavior to provide Commanders an opportunity to ensure Soldiers are provided timely and appropriate prevention, training and intervention services to mitigate the risk for continuing high risk behaviors, including suicide.

2. 1 Apr 13 - Incorporate DoD/VA clinical practice guidelines for the assessment and management of suicide and high-risk behavior into routine care.

3. TBD - Establish fully functioning behavioral health service line

**Objective 6.4: Establish linkages between providers of behavioral health and substance abuse program services and community-based programs, including peer support programs - Intervention**

To be effective in suicide prevention, providers of mental health and substance abuse services must coordinate services with each other and with other service providers in the community. It is generally recognized that behavioral health and substance abuse services can have a greater impact when community and Army gatekeepers refer at-risk patients to these specialized providers. The effects of behavioral and substance abuse services can also be enhanced when specialized providers refer patients to community programs that can augment care.

Timely and effective cooperation, collaboration, and communication between behavioral health and substance abuse providers and sources of support in the on post and in the community are critical to promote patient safety and recovery. Post, camp and station behavioral health and substance abuse providers should develop linkages with community-based supports.

**Lead Agency:** OTSG/MEDCOM/IMCOM
Supporting Agencies: ACSIM/IMCOM, G-1(ACSAP), ARNG, USAR, USAPHC

Short Term Tasks:

1. 01-Oct 2012 - Utilize installation Community Health Promotion Council to coordinate BH/ASAP and community based programs for acute suicide risk.
2. 01-Oct 2012 - Publish local resource guide for BH/ASAP and other community based program personnel.
3. 1 Apr 2012 - Establish Directors of Psychological Health Program
4. 01-Oct 2012 - Publish Behavioral Health System of Care (BHSOC) OPORD

Long Term Tasks:

1. 01-Oct-2013 - Implement Directors of Psychological Health Program
2. 01-Oct-2013 - Establish a fully functioning (BHSOC)

Objective 6.5: Promote continuity of care, collaboration and rapid follow-up addressing safety and well-being of all persons treated for suicide risk in emergency departments, hospital inpatient units, or outpatient and support programs (suicide prevention and intervention programs, health care systems, and accredited local crisis centers) – Postvention

Patients leaving the ER or hospital inpatient unit after a suicide attempt, or otherwise at a high risk for suicide, require rapid, proactive follow-up. Having survived a suicide attempt is one of the most significant risk factors for later death by suicide. The risk is particularly high in the weeks and months following the attempt, including the period after discharge from acute care settings such as ERs and inpatient psychiatric units. Among patients with high suicide risk, particularly those who have attempted suicide, immediate follow up and continuity of care are crucial to promoting positive outcomes. All patients who are admitted to an inpatient mental health unit require follow up mental health services after discharge, as well as connections to community-based supports. Health care systems should seek to dramatically shorten the time between inpatient discharge and follow up outpatient treatment. For example, EDs and others providing services to these patients could set a goal of ensuring that follow up occurs within 48 hours or, at most, within a week of discharge. Continuity of care following a suicide attempt should represent a collaborative approach between patient and provider that gives the patient a feeling of connectedness.

Lead Agency: OTSG/MEDCOM
Supporting Agencies: ACSIM/IMCOM, G-1(ACSAP), ARNG, USAR

Short Term Tasks:
1. 01-Nov-2012 - Evaluate current post-discharge continuity of care policies across MEDCOM MTFs to identify best practices that reduce re-admission and demonstrate successful treatment.
2. TBD - Publish a Behavioral Health Service Line OPORD

Long Term Tasks:
1. TBD - Establish a fully functioning and mature behavioral health service line

Objective 6.6: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts - Postvention

Health care delivery systems should evaluate performance rigorously, and incorporate suicide prevention and appropriate responses to suicide attempts in continuous quality improvement efforts, as a way to improve their capacity to save lives at risk. Such efforts could include formal root cause analyses of suicide attempts and deaths by suicide, supervisory reviews, reviews of aggregate data for trends, or focused quality assurance studies on issues related to suicide risk. Health care systems should consider whether the implementation of lessons learned can be part of a strategy aimed at eliminating suicides, as well as part of overall quality improvement. Such reviews should focus on identifying systemic issues where improvement holds promise for increasing the quality of care.

Lead Agency: OTSG/MEDCOM

Supporting Agencies: ACSIM/IMCOM, G-1(ACSAP), ARNG, USAR, PHC

Short Term Tasks:
1. 1 Nov 2012 – Submit requests to USAPHC for suicide attempts and completion trends to analyze locally.
2. TBD - Publish a Behavioral Health Service Line OPORD

Long Term Tasks:
1. TBD - Establish fully functioning behavioral health service line
GOAL 7. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors – Intervention

Primary care physicians play an important role in the assessment and management of suicide risk. Effective clinical and professional practices in the assessment and treatment of individuals with high suicide risk can help prevent these individuals from acting on their despair and distress in self-destructive ways. These practices should be grounded in evidence-based care or in best practices, in cases where promising approaches have been identified but more research is needed. Suicide risk assessment programs often target patients with known risk factors for suicide, including those who have previously expressed suicidal thoughts or made a suicide attempt, and persons with mood or substance use disorders. Treatment of patients with suicide risk often includes both medications (e.g., antidepressants) and psychosocial approaches, such as cognitive-behavioral therapy and supportive counseling.

Objective 7.1: Adopt, disseminate, and implement guidelines and treatment protocols for the assessment of suicide risk among persons receiving care in all settings, including MEDCOM facilities and all installation programs – Intervention

The assessment of suicide risk is critical to identifying high-risk individuals and providing needed services and supports. Assessment of suicide risk should be an integral part of primary care, hospital care (particularly ED care), care for mental and substance use disorders and crisis response (e.g., help lines, mobile teams, first responders, crisis chat services).

**Lead Agency:** OTSG/MEDCOM/IMCOM/ASAP

**Supporting Agencies:** ACSIM/IMCOM, G-1(ACSAP), ARNG, USAR

**Short Term Tasks:**

1. Dec 2012 - Establish A VA/DoD clinical practice guideline (CPG) for the assessment and management of suicidal behaviors is currently under development by the VA/DoD CPG committee’s panel of subject matter experts. This will provide guidance to providers on assessment and management of the suicidal patient. As of 28 Mar 12, the CPG is expected to be published in Dec 12.

2. TBD - Publish BHSOCC OPORD
Long Term Tasks:
1. TBD - Establish a fully functioning behavioral health service line

**Objective 7.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk – Intervention**

Disjointed service delivery, lack of effective communication among caregivers, and clinician concerns associated with the possible loss of a patient to suicide are barriers to effective clinical care for persons with suicide risk. These barriers can create an environment where a person with suicide risk may feel reluctant to disclose suicidal thoughts and feelings to a helping professional because he or she senses discomfort and is afraid of being automatically referred to inpatient care. Unprepared caregivers, acting in isolation, are more likely to experience heightened anxiety than trained caregivers empowered to share the responsibility for managing suicide risk. Guidelines on the treatment of specific behavioral health conditions are necessary, but they are not sufficient. There is a need for guidelines for clinical practice that address the care indicated for individuals identified as being at risk for suicide.

**Lead Agency:** OTSG/MEDCOM

**Supporting Agencies:** ACSIM/IMCOM, G-1(ACSAP), ARNG, USAR

Short Term Tasks:
1. Dec 2012 - Publish a VA/DoD clinical practice guideline (CPG) for the assessment and management of suicidal behaviors is currently under development by the VA/DoD CPG committee’s panel of subject matter experts. This will provide guidance to providers on assessment and management of the suicidal patient. As of 28 Mar 12, the CPG is expected to be published in Dec 12.

2. TBD - Publish a Comprehensive Behavioral Health Service Line OPORD

Long Term Tasks:
1. TBD - Establish a fully function behavioral health service line

**Objective 7.3: Ensure Health care providers and other caregivers have the skills required to promote safe disclosure – Intervention**

Settings that provide care to patients with suicide risk must be nonjudgmental and psychologically safe places in which to receive services. Patients who have thoughts of suicide may feel embarrassed, guilty, and fearful of disclosing their thoughts
and feelings to others. These patients may also fear losing autonomy or the ability to make their own treatment decisions. To address these barriers to treatment, collaborative and non-coercive approaches should be used whenever possible. Health care providers and other caregivers must have the skills required to promote disclosure.

**Lead Agency:** OTSG/MEDCOM  
**Supporting Agencies:** ACSIM/IMCOM, G-1, ARNG, USAR, OCCH

**Short Term Tasks:**
1. TBD - Publish behavioral health service line OPORD.
2. 01-Dec-2012 - Equip behavioral health providers with guidance on the use of the revised DA Form 8001 Limits of Confidentiality used by behavioral health providers prior to rendering services to briefly explain to a patient the meaning of confidentiality and conditions under which disclosure of patient information to third parties must occur. Write a chapter to be included in revised AR 40-66 Medical Record Administration and Healthcare Documentation that will provide guidance on the management and release of behavioral health records.

**Long Term Tasks:**
1. TBD - Establish a fully functioning behavioral health service line
2. 01-Dec-2012 - OTSG will publish an ALARACT informing behavioral health providers of the revised DA Form 8001 which now allows use with both behavioral health and substance abuse patients.
3. 01-Apr-2012 - Publish guidance in revised AR 40-66 Medical Record Administration and Healthcare Documentation.
4. 01-Apr-2012 - Create a Behavioral Health Transition Form that will be used by MEDCOM privileged screening providers (unit physician, physician assistant, or the Service member’s behavioral health provider) to summarize behavioral health care rendered, when a Service member is transitioning to another installation, or to a gaining provider that will not have access to his/her medical record in a timely manner.

**Objective 7.4: Adopt and implement guidelines to effectively engage Families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk – Intervention**

Family members and close friends can play an important role in enhancing the safety of patients with suicide risk. These individuals should be trained to understand, monitor, and intervene with loved ones who are at risk for suicide. Because the exact timing of
suicidal behaviors is very difficult to predict, it is important that key members of the family unit and social support network be knowledgeable about risk factors and about how to help protect an individual from suicide. While family member participation is voluntary, these individuals are well advised to know when to contact treatment providers or emergency services, and how to take reasonable precautions to reduce access to lethal means. Family members need to feel able to ask directly about suicidal thoughts, but should not be placed in the position of providing around-the-clock “suicide watches.” Involving the patient’s family and/or close friends is an important way to help ensure patients leaving the ED after a suicide attempt or those being discharged after inpatient care keep their follow up appointments.

**Lead Agency:** ACSIM/IMCOM

**Supporting Agencies:** OTSG/MECOM, ARNG, USAR, OCCH

**Short Term Tasks:**

1. TBD - Publish a Comprehensive Behavioral Health Service Line OPORD
2. TBD - Obtain legal guidance on communicating with family members and concerned others as this relates to HIPPA
3. TBD - ICW Strategic Communication Plan -- Provide Families with the information they need to act
   - (a) Identify definitive sources of information – the starting hubs for information
     - (1) Risk Factors – What to look for
     - (2) Websites/Telephone numbers
     - (3) Handouts – refrigerator magnet
   - (b) TBD - Create a “Need to Know” template for family to have (unit, CO, base, etc…), to include contact information for chain of command, chaplain, etc.
   - (c) TBD - Create a “What to do” template for family to have

**Long Term Tasks:**

1. TBD - Establish a VA/DoD clinical practice guideline (CPG) for the assessment and management of suicidal behaviors is currently under development by the VA/DoD CPG committee’s panel of subject matter experts. This will provide guidance to providers on assessment and management of the suicidal patient. As of 28 Mar 12, the CPG is expected to be published in Dec 12.
Objective 7.5: Develop standardized protocols for use by emergency first responders based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs – Postvention

ERs are key settings for providing services to persons with high suicide risk, particularly those who have attempted suicide. Standardized protocols should be developed for use within ERs that allow for differentiated responses based on risk profiles and assessed clinical needs (e.g., intoxicated and suicidal, chronically suicidal, suicidal with active psychosis). These protocols should emphasize patient-centered and stepped approaches that allow relative suicide risk to be assessed and matched with a continuum of services.

**Lead Agency:** OTSG/MEDCOM

**Supporting Agencies:**

**Short Term Tasks:**

1. Dec 2012 - Establish a VA/DoD clinical practice guideline (CPG) for the assessment and management of suicidal behaviors is currently under development by the VA/DoD CPG committee’s panel of subject matter experts. This will provide guidance to providers on assessment and management of the suicidal patient. As of 28 Mar 12, the CPG is expected to be published in Dec 12.

2. TBD - Publish a Comprehensive Behavioral Health Service Line OPORD

3. 1 Apr 12 - Provide 24-hour crisis teams (NSSP)

**Long Term Tasks:**

**GOAL 8. Provide care and support to individuals affected by suicide deaths and attempts to promote healing, and implement community strategies to help prevent further suicides – Postvention**

The mental health and medical communities often fail to provide needed services to individuals who have attempted suicide, and to those who have been affected by a suicide attempt or death. Individuals who have made a suicide attempt may receive insufficient care in the community. Those who have been bereaved by suicide may receive little or no guidance or support for the traumatic impact of this occurrence. While most individuals bereaved by suicide recover from the trauma, many people may suffer alone and experience harmful effects that can be devastating and sometimes long
lasting. For these reasons, it is crucial to pay attention to the needs of these potentially vulnerable but underserved groups. In addition, deaths by suicide can affect whole organizations and communities, leading to concerns regarding suicide contagion, particularly among youth.

Objective 8.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the installation and state/territorial, and community levels – Postvention

Guidelines for providing care and support to individuals bereaved by suicide are needed. Communities vary tremendously in the extent to which they provide these types of support services. Individuals bereaved by suicide often have difficulty finding the services they need when they are ready to access them. Developing comprehensive national guidelines for effective support will provide a “roadmap” for the kinds of services that communities can work to provide for these groups.

Lead Agency: G1, ACS, ACSIM, IMCOM

Supporting Agencies: ACSIM/IMCOM, ARNG, USAR, OCCH

Short Term Tasks:

1. 1st Qtr CY13 - Define Civilian Aid to the Secretary of the Army (CASA) role in engaging community support to geographically dispersed individuals bereaved by suicide.

2. 2nd Qtr CY13 - Review and update Survivor Outreach Services (SOS) Operation Manual to enhance state/territorial and community support to individuals bereaved by suicide.

3. 3rd Qtr CY13 - ACS SOS publish regulatory guidance.

Long Term Tasks:

1. 4th Qtr CY13 - Develop a process to engage multi-level community and support organizations to meet the needs of geographically dispersed individuals bereaved by suicide.
Objective 8.2: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups – Postvention

Making a suicide attempt is the strongest risk factor for later death by suicide. Promoting the positive engagement of those who have attempted suicide in their own care is likely crucial in successfully reducing risk for suicide. In addition, these individuals can be powerful agents for challenging stigma and activating hope for others.

Lead Agency: OTSG/MEDCOM
Supporting Agencies: G-1, OCCH, ACSIM/IMCOM

Short Term Tasks:
1. Dec 2012 - Publish a Comprehensive Behavioral Health Service Line OPORD
2. Dec 2012 - Establish a VA/DoD clinical practice guideline (CPG) for the assessment and management of suicidal behaviors is currently under development by the VA/DoD CPG committee’s panel of subject matter experts. This will provide guidance to providers on assessment and management of the suicidal patient. As of 28 Mar 12, the CPG is expected to be published in Dec 12.

Long Term Tasks:
1. TBD - Establish a fully function behavioral health service line

Objective 8.3: Adopt, disseminate, implement, and evaluate guidelines for commands to respond effectively to suicide clusters and contagion within their ranks, and support implementation with education, training, and consultation - Postvention

The 2001 National Strategy described the phenomena of “suicide contagion” and “suicide clusters.” Contagion has been described as the process by which exposure to suicidal behaviors from interpersonal contacts or the media can lead to an increase in suicidal behaviors, particularly among adolescents and young adults. A suicide cluster has been defined as a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community. CDC has estimated that cluster suicides may account for 1–5 percent of suicides among adolescents and young adults.
Lead Agency: OTSG/MEDCOM

Supporting Agencies: G-1/OCPA, USAPHC

Short Term Tasks:

1. On-going upon request - Continue Suicide Specialized Augmentation Response Team (SSART) and Public Health Command Army Epidemiological Consultations (EPICONs) that provide camps, posts and stations with an assessment of suicides and recommendation for intervention, prevention strategies.

Long Term Tasks:

1. 1 Apr 2012 - Identify and publish best practices and recommendations derived from SSART and EPICONs.

Objective 8.4: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide – Postvention

Clinicians, first responders, emergency personnel, and possibly commanders and first line supervisors who lose a patient to suicide should be provided with support to deal with the emotional aftermath of this traumatic event. Such support should address trauma and grief reactions and potential suicide risk among caregivers. Mechanisms for review of such deaths should avoid blaming the caregiver. Instead, the goal should be to respond to the caregiver’s need for support, and help the provider respond to patients who may be at risk for suicide in the future.

Lead Agency: OTSG/MEDCOM

Supporting Agencies: OCCH, OPMG, CRC, IMCOM, ASAP

Short Term Tasks:

1. TBD - Publish a Comprehensive Behavioral Health Service Line OPORD

Long Term Tasks:

1. TBD - Develop a care provider support program through the Comprehensive Behavioral Health Service Line

Strategic Direction 4: Surveillance, Research, and Evaluation

The Army Strategy’s fourth strategic direction addresses suicide prevention surveillance, research, and evaluation activities, which are closely linked to the goals
and objectives in the other three areas. Surveillance refers to the On-going, systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality. In contrast, research and evaluation are activities that assess the effectiveness of particular interventions, thereby adding to the knowledge base in the area of suicide prevention. The past decade has seen substantial improvements in suicide-related surveillance, research, and evaluation. However, additional efforts are needed to inform and guide suicide prevention efforts nationwide. Toward that end, the collection and integration of surveillance data should be expanded and improved.

GOAL 9. Increase the timeliness and usefulness of surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

The regular collection and rapid dissemination of suicide-related data are needed to guide appropriate public health action. The time between when an event takes place and when the data are ready for dissemination must be shortened. This is no simple task, as it involves collecting information on several behaviors (e.g., suicidal thoughts, attempts, deaths) that may be available at many levels (e.g., commanders, provost personnel, medical responders and gate keepers). The information may come from several different sources, including 15-6 investigations, CID reports, vital statistics, ERs, inpatient hospital records, and urgent care centers, and may not be linked. In addition, there are continuing concerns and constraints regarding the accumulation of potentially identifiable data.

Objective 9.1: Improve quality, use and timeliness of vital record and suicide related data

Timeliness of reporting of statistics on suicide mortality is a core issue. Although several efforts are underway to rapidly provide information about suicide-related deaths, often there are substantial delays in certifying and reporting these deaths. These delays make it difficult to know when suicide rates climb as a result of contextual factors, such as economic difficulties, as well as to plan interventions, or to know if suicide prevention efforts are having an effect in reducing deaths by suicide.

Lead Agency: OTSG/MEDCOM (USAPHC)
Supporting Agencies: G-1 MEDCOM (MRMC, RAIR), ARI
Short Term Tasks:
1. On-going - (NSSP OBJ 9-1) Revise/update the SSRG to encourage Command focus on development and sharing of best practices in efforts to prevent suicides and sustain the Health of the Force.

2. 01-Apr-2012 - (NSSP OBJ 9-1) Standardize the use of tools and methods to conduct assessments and detect risk; disseminate guidelines for risk assessments, along with appropriate tools and protocols, to all settings that provide care for individuals with suicide risk.

3. On-going - HPRR Task Action Plan (TAP) Po-166 Department of Defense Suicide Event Report

4. On-going - (DoDSER) QA Memo

5. On-going - DoDSER expansion to inactive RC Soldiers

6. On-going - HPRR TAP M-021 Commander’s Risk Reduction Dashboard (CRRD)

7. On-going - Brigade Health Promotion Team Dashboards

8. On-going - BHDP development and implementation

9. On-going - ABHIDE enhancements

10. On-going - Risk Reduction Program surveys and reports

11. On-going - CSF2 GAT survey

12. On-going - BH 360 development

13. On-going - Army STARRS concentration of risk model and assessment of data source quality

14. 3rd Qtr CY 2012– Expand the DoDSER to include inactive Reserve Component (RC) Soldiers

15. 4th Qtr CY 2012- Publish DoDSER Quality Assurance (QA) Memorandum

16. 4th Qtr CY 2012 – Publish After Action Report on USAPHC coordination with DSPO on standardizing suicide rate reporting
20. 4th Qtr CY 2012 - Develop TAP, [e.g. Health Promotion Risk Reduction (HPRR)]on Brigade Health Promotion Team Dashboard standards

21. 4th Qtr CY 2012 – Develop TAP (e.g. HPRR) on integration of suicide-related data sources.

22. 3rd Qtr CY 2013 - Assess existing data sources and reports to identify gaps or improvements required.

**Long Term Tasks:**

1. Ongoing – Support evaluation efforts of Comprehensive Soldier and Family Fitness (CSF2) as directed by senior leaders.

2. Ongoing - Make adjustments as identified to improve timeliness and quality of suicide-related data.

3. Ongoing – Support development and implementation of OTSG Behavioral Health Data Platform (BHDP) and BH 360.

4. Ongoing – Continue to enhance the ABHIDE to improve the quality of data.

5. Ongoing – Continue to support the Army STARRS.

6. 1st Qtr CY 2013 - Support DA development of CRRD.

7. 3rd Qtr CY 2013 - Identify integration opportunities, gaps, and redundancies of suicide-related data.

8. 4th Qtr CY 2013 - Make adjustments to policies, programs and training as indicated by the above actions to improve timeliness and quality.
Objective 9.2: Improve and expand HP&RR, PHC, state/territorial, capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

The surveillance of suicidal behaviors and related issues (e.g., behavioral and substance abuse disorders) has improved over the years, but additional advances are needed. There is a need to broaden the audience for the sharing of reports on suicides and suicide attempts. These reports describe the magnitude of the suicide problem and how suicide differentially affects particular groups. In addition, the reports should help to inform policies for the use of behavioral health, family advocacy, and substance abuse services.

Lead Agency: OTSG/MEDCOM (USAPHC)

Supporting Agencies: G-1

Short Term Tasks:
1. Ongoing – Support development of TAP (e.g. HPRR) on including the Serious Incident Report (SIR) system into current Army surveillance systems.

2. 4th Qtr CY 2012 - Develop TAP (e.g. HPRR) on Brigade Health Promotion Team Dashboard standards

3. 4th Qtr CY 2012 - Publish DoDSER QA Memorandum

4. 4th Qtr CY 2012 - Publish quarterly DoDSER Installation Reports

5. 4th Qtr CY 2012 - Support DA development of Commanders Risk Reduction Dashboard.

6. 4th Qtr CY 2012 - Collaborate with ARNG to incorporate data from the Army Leader Unit Risk Reduction Tool (ALURRT).

Long Term Tasks:
1. CY 2014 - Identify the current number and competency of personnel to collect, analyze, and report suicide-related data.

2. CY 2014 – Inform Suicide Prevention and Policy efforts through the Polypharmacy and Overdose Medical Education (POME) Training Program based on OTSG Policy Memorandum 10-076/ TAP (e.g. HPRR) T-038
3. CY 2015 – Identify the need for additional personnel to collect, analyze, and report suicide-related data.

**Objective 9.3: Insure the quality of surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.**

Existing sources of data on suicidal behaviors do not provide a complete picture of suicide and suicidal ideations and antecedents within the Army Family. There is a need to increase the quality and breadth of surveys and other data collection instruments that include questions on suicidal behaviors and related risk factors.

**Lead Agency:** G-1

**Supporting Agencies:** OTSG/MEDCOM (i.e., WRAIR), ACSAP

**Short Term Tasks:**

1. 4th Qtr 2013 - Conduct an assessment of current Army surveys dealing with suicidal behavior and update as necessary.

**GOAL 10. Promote and support research on suicide prevention.**

Research on suicide prevention, and on the treatment of mental and substance use disorders, has increased considerably in recent years. Findings have contributed to the development of assessment tools, resiliency-building interventions, and treatment and symptom-monitoring techniques. Continued advancements will lead to the development of better assessment tools, treatments, and preventive interventions. It also will lead to more effective and efficient therapeutic interventions for individuals who engage in suicidal behaviors.

**Objective 10.1: Develop an Army suicide prevention research agenda with comprehensive input from multiple stakeholders.**

All members of the Army family have a stake in the development and implementation of a Department wide suicide research agenda that can ultimately be measured in terms of knowledge gained and measurable declines in suicide attempts and deaths. This agenda should build on existing knowledge of suicide prevention and surveillance findings to identify priority research areas. Topics could include: impact of
TBI and PTSD, demographics with increased suicide risk, gender and ethnic differences, social and economic factors, genetic contributions, protective factors, promising interventions for suicide prevention and treatment, and interventions for individuals who have been affected by suicide.

**Lead Agency:** OTSG/MEDCOM (MRMC)

**Supporting Agencies:** G-1, CSF2

**Short Term Tasks:**
1. 01-Dec2012 - Research areas that have been identified and the HP&RR Council reviews recommendations for research and completed on-going and completed. Collaborate with MMRC, CSF2/DUSA Research Facilitation Team, and others to assess gaps and share results.

**Long Term Tasks**
1. On-going - Assess on-going research needs.
2. On-going - Increase collaboration and ease of suicide-related information sharing among DOD and Army organizations/agencies.

**Objective 10.2: Disseminate the Army suicide prevention research agenda and findings.**

After the research agenda is developed, it should be disseminated to researchers and program planners at the Department level and to all three Army components so that it can inform the development of new suicide prevention interventions and programs. The research agenda will also be useful to the various agencies and planners that fund suicide prevention research in identifying knowledge gaps and areas of need.

**Lead Agency:** OTSG/MEDCOM (MRMC)

**Supporting Agencies:** G-1, OCPA

**Short Term Tasks:**
1. 1 Oct 2012 - Updated the Suicide Prevention website.

**Long Term Tasks:**
1. On-going 4th Qtr CY14 - Update information continuously.
2. On-going 4th Qtr CY14 - NSPS: Translate findings into recommendations and suggestions for practical applications in multiple settings. For example, best
practices for suicide prevention as identified in the National Strategy to reduce suicide rates among patients (page 27 Lessons from the UK), include:

(a) Providing 24-hour crisis teams;

(b) Removing ligature points -- materials that could be used for suicide;

(c) Conducting follow up with patients within 7 days of discharge;

(d) Conducting assertive community outreach, including providing intensive support for people with severe mental illness;

(e) Providing regular training to frontline clinical staff on the management of suicide risk;

(f) Managing patients with co-occurring disorders (mental and substance use disorder);

(g) Responding to patients who are not complying with treatment;

(h) Sharing information with criminal justice agencies

(i) Conducting multidisciplinary review and sharing information with families after a suicide.

Note: In 1998, few of the 91 mental health services in the study were carrying out any of these recommendations. By 2004, about half were implementing at least seven recommendations, and by 2006, about 71 percent were doing so. Over time, as more recommendations were implemented, suicide rates among patients declined. Each year, from 2004 to 2006, mental health services that implemented seven or more recommendations had a lower suicide rate than those implementing six or fewer. Among all recommendations, providing 24-hour crisis care was linked to the largest decrease in suicide rates.

**Objective 10.3: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.**

Conducting research on suicide prevention involves many challenges. Although the absolute number of suicides in a population may be cumulatively quite large, the risk
of suicide to any given individual, even those with multiple risk factors, is relatively small. Suicide is a relatively rare outcome, which makes it difficult to conduct randomized controlled trials (RCTs) that evaluate the impact of an intervention in preventing suicide. Researchers would benefit from information on the most appropriate research designs for rare events, and on appropriate outcomes that are suitable to answer well-defined research questions. A Department repository of research methods would be a useful resource for suicide prevention researchers. The repository could include a link to national databases that can be used as research tools. Other contents could include information on appropriate and rigorous study designs, common measures that should be used in research studies, successful implementation efforts and adaptations, and safety and ethical considerations.

**Lead Agency:** OTSG/MEDCOM (MRMC)

**Supporting Agencies:** G-1

**Short Term Tasks:**

1. On-going 1st Qtr CY13 - Research resources have been identified and we are accessing information on on-going research to share with staff.

**Long Term Tasks:**

1. On-going - Continue to identify new research partners.

**GOAL 11. Evaluate the impact and effectiveness of suicide prevention interventions and systems and the outcomes, and synthesize and disseminate findings.**

Program evaluation is a driving force for planning effective suicide prevention strategies, improving existing programs, informing and supporting policy, and demonstrating the results of resource investments. Suicide prevention interventions should be guided by specific testable hypotheses and implemented among groups of sufficient size to yield reliable results. Given the state of the field, program evaluations should emphasize measurable behavioral outcomes, in addition to other outcomes (e.g., changes in knowledge or attitudes) and process measures (e.g., number of people attending program sessions). Programs that share risk factors with suicide should be encouraged to incorporate suicide prevention components and related measures in their program design and evaluation plans.
Objective 11.1: Evaluate the effectiveness of suicide prevention interventions and assess outcomes.

Program evaluations and other studies must evaluate the effectiveness of broad range of intervention and can be used for suicide prevention and their impact on the prevention of suicide attempts and deaths.

Lead Agency: OTSG/ MEDCOM (USAPHC)

Supporting Agencies: G-1, OTSG/MEDCOM (MRMC)

Short Term Tasks:
1. On-going - DCOE evaluation of ACE-SI Training
2. On-going - HPRRC TAP D-005 Portfolio Program Capabilities Review (HPRR Portfolio)
3. On-going - DCOE Psych Health evaluation
4. On-going - MRMC effectiveness trials
5. On-going - EBH Evaluation
6. On-going - TRADOC EBH implementation and evaluation
7. On-going - DA Soldier and Leader Risk Reduction Tool implementation and evaluation
9. On-going - Q4 CY 2012 - Develop evaluation plan for SLRRT

Long Term Tasks:
1. CY 2014 – Support the DCOE Psychological Health Evaluation
2. Ongoing- Evaluate the effectiveness of best practices identified from SSRG, HotF tour, CHPC, SPTF, etc.
3. Ongoing- Continue to support the evaluation of the POME in conjunction to assess the effectiveness of POME on risk factors.
4. Ongoing – Evaluate the impact of Army STARRS’ risk algorithm.
5. Ongoing - Collaborate with MRMC to develop protocol for translating research findings into Army-wide practice.

6. Ongoing – Continue collaborative ACE-SI study between DOD Center of Excellence and USAPHC, "Resilience and Prevention Study ACE Suicide Intervention (ACE SI) Program Formative Data Analysis Report”.

**Objective 11.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention and interventions.**

Systematic reviews serve an important role in the assessment and synthesis of research findings. These reviews can help identify effective interventions and provide recommendations for future programs and research.

**Lead Agency:** OTSG/MEDCOM (USAPHC)

**Supporting Agencies:** OTSG/MEDCOM (MRMC)

**Short Term Tasks:**

1. 4th Qtr CY 2012 – Develop TAP (e.g. HPRR) to prioritize DA suicide intervention programs for review.

2. 4th Qtr CY 2012 - Support development of Behavioral Health System of Care (BHSOC) evaluation strategy.

3. 25 Oct 2012 - Publish the HPRR Council Program Capabilities Assessment.

**Long Term Tasks:**

1. Ongoing - Continue collaborating with Penn State’s clearinghouse to review suicide prevention and intervention programs and create a catalog of information on evidence-based suicide prevention /intervention programs.

2. FY 2014 - Continue to support DCOE Psych Health Evaluation Initiative.

**Objective 11.3: Examine how suicide prevention efforts are implemented in different installations, states/territories, and communities and to identify best practices.**

Suicide prevention efforts are implemented differently in commands and components and in states and territories. There is a need to evaluate the delivery structure of suicide prevention systems to identify these differences, and to assess the effectiveness of different system designs for the delivery of suicide prevention services.
Findings from these assessments are used to generate recommendations regarding the most efficient and effective suicide prevention programs and practices.

**Lead Agency:** OTSG/MEDCOM (USAPHC)

**Supporting Agencies:** ACSIM/IMCOM, G-1, ARNG, USAR

**Short Term Tasks:**
1. 4th Qtr CY 2012 - Coordinate with ARNG, USAR, and installation Suicide Program Managers to utilize SPTF and CHPC to identify efficient, effective methods and best practices.
2. 4th Qtr CY 2012 - Develop TAP (e.g. HPRR) to identify local and regional variances for suicide related programs and initiatives.

**Long Term Tasks:**
1. 4th Qtr CY 2013 – Assess the effectiveness of Fort Leonard Wood’s Embedded Behavioral Health model.
2. 1st Qtr CY 2014 - Assess methods identified and provide recommendations to revise policies, practices and guidance.

**Objective 11.4: Evaluate the impact and effectiveness of the 2020 Army Strategy for Suicide Prevention in reducing suicide morbidity and mortality.**

The 2020 Army Strategy represents a comprehensive, long-term approach to suicide prevention. The goals and objectives are broad in scope and encompass a wide range of activities. The 2020 Army Strategy represents a roadmap that, when followed, will lead to the vision of an Army Family largely freed from the tragic experience of suicide. In coming years the Army will evaluate the goals and objectives in the 2020 Army National Strategy and determine if the strategy itself has been useful in reducing suicide morbidity and mortality. Adjustments will be made in future Army suicide prevention strategies as warranted by these reviews.

**Lead Agency:** G-1

**Supporting Agencies: As required**

**Short Term Tasks**
1. 4th Qtr CY 2012 - Develop TAP (e.g. HPRR) for an evaluation strategy to measure the quality of the Army Strategy document.
2. Ongoing - Monitor rates, assess input from SSRG to identify effective practices that impact the suicide rates. Publish findings and best practices on ASPP website.

**Long Term Tasks:**

1. CY 2016 - Develop evaluation plan to assess the impact and effectiveness of the Army strategy for suicide prevention.

2. 2017-2020 - Conduct evaluation of the Suicide Prevention Strategy and its effectiveness.