

Army Regulation 600–63

Personnel—General

Army Health Promotion

Rapid Action Revision (RAR) Issue Date: 7 September 2010

**Headquarters
Department of the Army
Washington, DC
7 May 2007**

UNCLASSIFIED

SUMMARY of CHANGE

AR 600-63
Army Health Promotion

This rapid action revision, dated 7 September 2010--

- o Defines responsibilities for the Deputy Chief of Staff, G-1 as related to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention strategy through a multiple-staff/agency compliance arm (para 1-7a(1)).
- o Elaborates on Deputy Chief of Staff, G-1 responsibilities to collect feedback from multiple-staff/agency compliance assessments conducted at installations, states, territories, and Reserve support commands to adjust health promotion programs and initiatives (para 1-7a(2)).
- o Includes additional responsibilities for senior commanders related to establishing and executing an Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention compliance arm, using internal staffing assets (para 1-21c).
- o Requires State Adjutants General and commanders of Army Reserve Direct Reporting Units and major subordinate commands to ensure the execution of the plan's compliance arm at all states and territories, using internal staffing assets (para 1-23e).
- o Requires senior commanders, in coordination with the Community Health Promotion Council, to establish and execute a compliance arm of the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention (para 2-1i).
- o Requires senior commanders to measure and assess the effects of the Army Campaign Plan for Health Promotion, using the Army Campaign Plan for Health Promotion compliance checklist (para 2-1i).
- o Incorporates an Internal Control Evaluation Checklist (app B).
- o Makes additional rapid action revision changes (throughout).

Effective 4 June 2007

Personnel—General

Army Health Promotion

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:


JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision (RAR). This RAR is effective 7 October 2010. The portions affected by this RAR are listed in the summary of change.

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

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

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

Deputy Chief of Staff, G–1. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include a formal review by the activity’s senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army management control process. This regulation contains internal controls and provides an Internal Control Evaluation for use in evaluating key internal controls (see appendix B).

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

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of

Staff, G–1 (DAPE–HRI), 300 Army Pentagon, Washington, DC 20310–0300.

Committee Continuance Approval.

The Department of the Army committee management official concurs in the establishment and/or continuance of the committee(s) outlined herein. AR 15–1 requires the proponent to justify establishing/continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the U.S. Army Resources and Programs Agency, Department of the Army Committee Management Office (AARP–ZA), 2511 Jefferson Davis Highway, 13th Floor, Taylor Building, Arlington, VA 22202–3926. Further, if it is determined that an established “group” identified within this regulation, later takes on the characteristics of a committee, as found in the AR 15–1, then the proponent will follow all AR 15–1 requirements for establishing and continuing the group as a committee.

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

*This regulation supersedes AR 600–63, 28 April 1996; DA Pam 600–63–1, 1 July 1987; DA Pam 600–63–2, 1 September 1987; DA Pam 600–63–3, 1 September 1987; DA Pam 600–63–4, 1 September 1987; DA Pam 600–63–5, 1 September 1987; DA Pam 600–63–6, 1 September 1987; DA Pam 600–63–7, 1 September 1987; DA Pam 600–63–8, 1 September 1987; DA Pam 600–63–9, 1 September 1987; DA Pam 600–63–10, 1 September 1987; DA Pam 600–63–11, 1 September 1987; DA Pam 600–63–12, 1 September 1987; DA Pam 600–63–13, 1 September 1987; and DA Pam 600–63–14, 1 September 1987. This edition publishes a rapid action revision of AR 600–63.

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Chapter 1 Introduction

Section I General

1–1. Purpose

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

1–2. References

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

1–3. Explanation of abbreviations and terms

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

1–4. Responsibilities

See responsibilities in Section II of this chapter.

1–5. Army health promotion

a. Army health promotion is defined as any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental changes conducive to the health and well-being of the Army community. It focuses on the integration of primary prevention and public health practice into community and organizational structure to ensure that health and well-being are part of the way the Army does business. Health is the product of many personal, environmental, and behavioral factors. Health promotion programs must consider a broad range of health-related factors and should address the following functional areas:

- (1) Health education and the health promotion process.
- (2) Behavioral health interventions.
- (3) Physical programs.
- (4) Spiritual programs.

(5) Environmental and social programs. Figure 1–1 illustrates the relationship between the functional areas of Army health promotion and individual health and well-being.

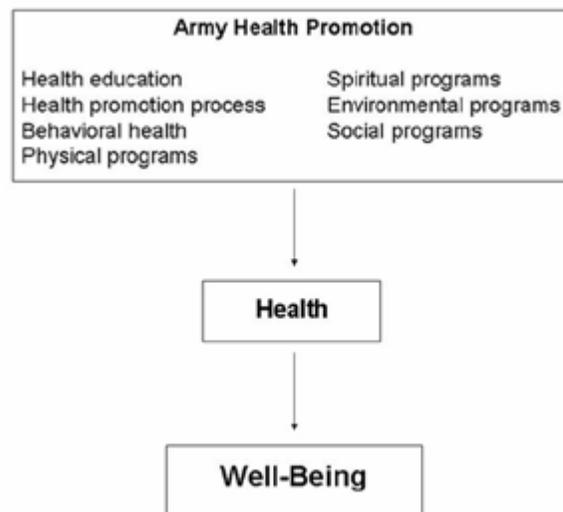


Figure 1–1. Health-related factors

b. Army health promotion involves—

- (1) Identifying community health needs and setting priorities.
- (2) Developing and implementing health promotion programs to meet identified needs.
- (3) Evaluating the effectiveness of these programs.
- (4) Resiliency.
- (5) Quality of life.
- (6) Wellness along with well-being.

c. The health promotion process is similar to the composite risk management (CRM) process described in FM 5–19 (see fig 1–2, below). Risk management is defined as the process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk costs with mission benefits.

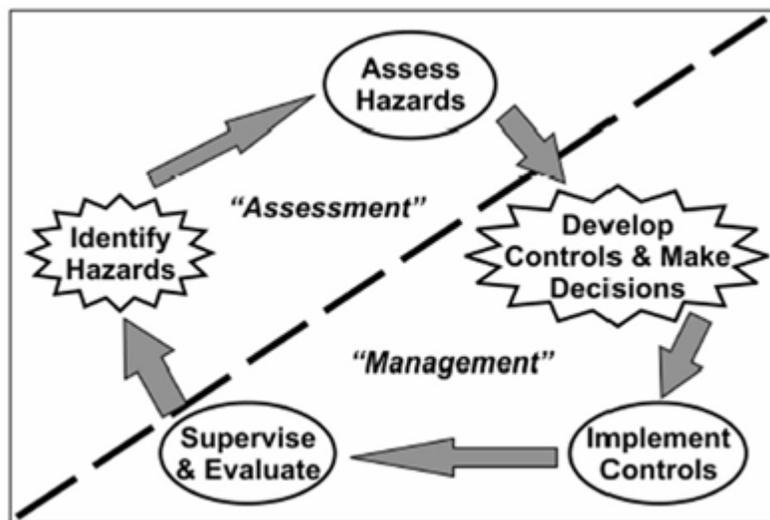


Figure 1–2. CRM Process

d. One may apply the principles used in the CRM process to reduce health risks and improve medical readiness in much the same way as managing risk in unit operations. Identification and prioritization of hazards to health are followed by the development and implementation of programs and policies that will make a difference. Command supervision and enforcement of interventions is critical. Reassessment enables determination of success or adjustments as needed.

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

1–6. Objective and scope of the Army Health Promotion Program

a. The goal of the Army Health Promotion Program is to maximize readiness, warfighting ability, and work performance. Objectives include enhancing the well-being of all Soldiers, Army civilians, Family members, and retirees; and encouraging lifestyles that improve and protect physical, behavioral, and spiritual health.

b. The Army Health Promotion Program encompasses a variety of activities designed to facilitate behavioral and environmental alterations to improve or protect health and well-being. This includes a combination of health education and related policies, organizational, social, behavioral, spiritual, and health care activities and initiatives. These are integrated to produce a single comprehensive program evaluating population needs, assessing existing programs, and coordinating targeted interventions. The health promotion process encompasses actions that will—

- (1) Gather data.
- (2) Store data electronically.
- (3) Measure data against Army standards.
- (4) Educate and provide intervention for individuals within the community.
- (5) Reevaluate the program.

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

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

Section II Responsibilities

1–7. Deputy Chief of Staff, G–1

The DCS, G–1 will serve as the Army Staff proponent for the following:

- a. Army Health Promotion Program policy and implementation of DODD 1010.10.
 - (1) Ensure compliance with the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention (ACPHP) strategy through a multiple-staff/agency compliance arm.
 - (2) Collect feedback from multiple-staff/agency compliance assessments conducted at installations, states, territories, and Reserve Support Commands (RSCs) to adjust health promotion programs and initiatives.
- b. The Army Substance Abuse Program (ASAP).
- c. The Tobacco Control Program.
- d. The Army Weight Control Program.
- e. Suicide prevention, to include coordination and monitoring of the Army Suicide Prevention Program (ASPP). To this end, the DCS, G–1 will—
 - (1) Ensure that the ASPP is coordinated with, and nested within, the DOD Issuance responsible for Department of Defense-wide suicide-prevention efforts.
 - (2) Ensure that the ASPP is represented on the Defense Centers of Excellence (DCoE) Suicide Prevention and Risk Reduction Council (SPRRC).
 - (3) Establish policy to provide health promotion, risk reduction, and suicide-prevention program policy for non-installation based commands and geographically dispersed Soldiers, to include ARNG and USAR components.
 - (4) Collect data to regulate, validate, and approve suicide-related event databases.
 - (5) Collect data and analyze suicide-related data for risk factors surrounding suicidal behavior to assist in the development and/or sustainment of effective strategies to reduce suicides and suicide attempts.
 - (6) Review and evaluate suicide-prevention programs and their implementation.
 - (7) Primary source for reporting of official Army suicide rates.
- f. Identification, surveillance, and administration of personnel infected with human immunodeficiency virus (HIV).

1–8. Deputy Chief of Staff, G–3/5/7

The DCS, G–3/5/7 will serve as the Army proponent and has Army Staff responsibility for the Army Physical Fitness Program (APFP).

1–9. Deputy Chief of Staff, G–4

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

1–10. The Surgeon General

TSG will—

- a. Provide guidance in accordance with AR 350–1 in medical, physiological, and health areas including behavioral health, nutrition, cardiovascular risk-factor reduction, and stress management. TSG establishes and reviews policy development in other areas, to include Army health promotion, control of substance abuse, suicide prevention, tobacco use, weight management, body fat standards, and injuries related to physical fitness and exercise.
- b. Implement policy, standards, and education for medical and dental programs (for example nutrition, early identification of hypertension, psychological and behavioral health, and oral health promotion).
- c. Appoint a representative with an appropriate health care background to serve along with the representative from DCS, G–1 as a member of the Department of Defense (DOD) Prevention Safety and Health Promotion Council.
- d. Advise the DCS, G–1 with respect to all medical and psychiatric aspects of health promotion, to include the epidemiological aspects of suicide.
- e. Oversee the medical aspects of Army training programs in suicide prevention.
- f. Assist the Army Medical Department (AMEDD) in providing—
 - (1) Training for health care providers in suicide-risk identification and treatment for patients who may be at increased risk of suicide.
 - (2) Responsible sexual behavior education materials for use in Army populations.
- g. Appoint a representative with an appropriate health promotion background to serve on a working group, as

warranted, to address issues related to the integration of health and fitness within the Army along with representatives from U.S. Army Family Morale, Welfare, and Recreation Command (FMWRC); United States Army Center for Health Promotion and Preventive Medicine (USACHPPM); DCS, G-1; DCS, G-3/5/7; U.S. Army Combat Readiness Center (CRC); Assistant Chief of Staff for Installation Management (ACSIM); and the Army Physical Fitness School (APFS).

1-11. The Chief of Public Affairs

The CPA will develop and implement a public affairs plan in support of the Army Health Promotion Program. This includes articles in internal print and broadcast media, and release of information about the Army Health Promotion Program to the public through the media and through community relations.

1-12. Chief of Chaplains

The CCH will—

- a. Provide Army special staff responsibility for the installation Chaplain Family Life Center program, spiritual fitness, and deployment-related stress ministry.
- b. Encourage and promote concepts of spiritual well-being and good health among Soldiers and Family members.
- c. Coordinate suicide-prevention activities and training with the DCS, G-1 and TSG.

1-13. The Judge Advocate General

TJAG will—

- a. Provide staff assistance and advice for the interpretation of laws and regulations for the Army Health Promotion Program.
- b. Review the liability implications of nonhealth professionals providing health promotion programs.

1-14. Chief of Engineers

The COE will provide Army special staff responsibility for the construction of installation physical fitness and recreation facilities, supported by appropriated funds.

1-15. Chief, National Guard Bureau

The CNGB will—

- a. Prescribe policy and programs for health promotion and suicide prevention within the Army National Guard/Army National Guard of the United States (ARNG/ARNGUS) as established by the DCS, G-1 within the ARNG/ARNGUS.
- b. Encourage state adjutants general to develop health promotion programs, including suicide prevention and oral health.
- c. Identify the requirements for the distribution of training kits to support suicide-intervention skills training for gatekeepers.
- d. Identify the requirements for carrying out train-the-trainer workshops to support suicide-intervention training for gatekeepers. See DA Pam 600-24.

1-16. U.S. Army Reserve

- a. The Chief, Army Reserve (CAR) in coordination with the DCS, G-1 will prescribe policy and monitor health promotion for the U.S. Army Reserve (USAR), and execute health promotion policy and procedures for USAR troop program units (TPUs) in the continental United States.
- b. The Commanding General, U.S. Army Pacific (CG, USARPAC) will execute health promotion policy and procedures for all assigned USAR TPU and activities in Hawaii and in possessions, trusts, and territories administered by the United States in the Pacific Command Area.
- c. The Commanding General, U.S. Army Europe and Seventh Army will execute health promotion policy and procedures for all assigned USAR TPU in Europe.
- d. The Commanding General, U.S. Army Human Resources Command (USAHRC), will administer health promotion policy and procedures for the Individual Ready Reserve (IRR).
- e. The Commanding General, U.S. Army Southern Command (USARSOUTH), will administer health promotion policy and procedures for all assigned USAR TPU in the Southern Command area.
- f. The Commanding General for South Eastern Task Force (CGSETAF) will administer health promotion policy and procedures for all assigned USAR TPU in the Southern Eastern Task Force area.
- g. The Commanding General for Special Operations Command (USSOCOM) will administer health promotion policy and procedures for all assigned USAR TPU in the Special Operations Command.
- h. The Commanding General for Army Central Command (ARCENT) will administer health promotion policy and procedures for all assigned USAR TPU in the ARCENT.
- i. Identify the requirements for distributing training kits to support suicide-intervention skills training for gatekeepers.

j. Identify the requirements for carrying out train-the-trainer workshops to support suicide-intervention training for gatekeepers (see DA Pam 600–24).

1–17. Commanding General, U.S. Army Center for Health Promotion and Preventive Medicine

The Commanding General, USACHPPM will—

- a. Recommend Army Health Promotion Program policy implementation and change.
- b. Define the role and identify training requirements and training opportunities for health promotion coordinators in support of CHPCs.
- c. Develop and disseminate standardized, evidence-based programs and tools.
- d. Identify and develop population-based, comprehensive, and integrated military health information systems.
- e. Develop science-based metrics for program evaluation and health promotion outcomes.
- f. Provide subject matter expert (SME) consultation, education, and training for Army Health Promotion Program efforts and CHPCs.
- g. Serve as an information source for current issues and best practices for health promotion initiatives.
- h. Provide recommendations for population- and community-based research.

1–18. Assistant Chief of Staff for Installation Management

The Assistant Chief of Staff for Installation Management (ACSIM) provides Army staff oversight and policy development responsibility for installation morale, welfare, recreation, lodging, and Family programs and is responsible for the U.S. Army FMWRC and the Installation Management Command (IMCOM).

- a. The Commanding General, U.S. Army FMWRC will—
 - (1) Appoint a representative to serve as an adviser to the Community Health Promotion Council.
 - (2) Define the role of, and train Army Community Service (ACS) personnel, using USACHPPM-developed and DCS, G–1 approved training materials, per paragraph 1–17, above, in support of suicide-risk-identification efforts, using technical assistance from mental health officers.
 - (3) Ensure that suicide-prevention information is integrated into all Family Advocacy Program briefings given to Family members.
 - (4) Provide Survivor Outreach Services (SOS) to Families who experience loss due to suicide.
 - (5) Provide referral services to unit members and coworkers who experience loss due to suicide.
 - (6) Promote instructional opportunities for Soldiers, Families, and civilians to develop and sustain personal relationships, team dynamics, conflict management, and problem solving.
- b. The Commanding General, IMCOM will—
 - (1) Be responsible for installation management services and programs on Army installations.
 - (2) Appoint a suicide-prevention coordinator to provide installation assistance for execution of the ASPP and to serve as a liaison to the Assistant Chief of Staff for Personnel, Army Command (ACOM), Army Service Component Command (ASCC), and Direct Reporting Unit (DRU) Suicide Prevention Program coordinators.
 - (3) Develop and implement an IMCOM suicide-prevention program execution plan.
 - (4) Ensure ACS integrates suicide-prevention information into all Family Advocacy Program briefings given to Family members.
 - (5) Develop and implement an integrated Family member suicide-prevention program in coordination with FMWRC.
 - (6) Identify the requirements for the distribution of training kits to support suicide-intervention skills training for gatekeepers.
 - (7) Identify the requirements for carry out train-the-trainer workshops to support suicide-intervention training for gatekeepers. Refer to DA Pam 600–24.

1–19. Commanding General, U.S. Army Training and Doctrine Command

The Commanding General, U.S. Army Training and Doctrine Command (CG, TRADOC) will serve as the functional proponent for the Army Physical Fitness Program. The Commander, U.S. Army Training Center and Fort Jackson will serve as the specified proponent for physical fitness and will—

- a. Coordinate the inclusion of all components of Army health promotion into Army school curricula.
- b. Exercise responsibility for Army physical fitness doctrine.
- c. Develop training support packages for suicide-risk identification for unit leaders.
- d. Provide suicide-risk identification training for leadership courses.
- e. Implement Army policy to control use of tobacco products during initial entry training (IET).

1–20. Army Commands, Army Service Component Commands, and Direct Reporting Unit commanders

These commanders will—

- a. Monitor data, develop, and implement programs designed to achieve Army health promotion.
- b. Appoint a community health promotion (CHP) coordinator to provide staff oversight of actions and procedures implemented in accordance with this regulation and its relationship to all members of their command.
- c. Appoint a suicide-prevention coordinator to provide assistance for, and staff supervision of the ASPP.
- d. Develop and implement a suicide-prevention plan appropriate for their command.

1–21. Senior commanders

These commanders will—

- a. Have the overall responsibility for health promotion, risk reduction, and suicide-prevention efforts.
- b. Designate, as appropriate, garrison commanders to serve as representatives of the Community Health Promotion Council (CHPC).
- c. Establish and execute an ACPHP compliance arm and execute the requirements of the ACPHP compliance arm using internal staffing assets, under the CHPCs, with each CHPC member and the installation staff having responsibility for a particular health promotion function.

1–22. Garrison commanders

These commanders will—

- a. Establish and chair a CHPC.
- b. Partner with the Medical Command (MEDCOM) in implementing health promotion programs, to include providing facilities support and staff assistance for unit health promotion events.
- c. Monitor aggregate data and implement a health promotion program at their installations in accordance with this regulation and instructions from their ACOM, ASCC, or DRU commanders.
- d. Appoint a task force or committee and designate a presiding officer to plan, implement, and manage the ASPP.
- e. Coordinate with union organizations representing Army civilians, as applicable.
- f. Encourage all members of the CHPC to attend the Army Health Promotion Course sponsored by USACHPPM.

1–23. State adjutants general and Army Reserve Direct Reporting Unit/major subordinate command commanders

These commanders will—

- a. Carry out all aspects of the health promotion, risk reduction, and suicide-prevention program for their command.
- b. Establish and chair a CHPC and appoint a CHPC coordinator when practical for their organization. When a CHPC is not practical, develop and implement strategies to accomplish similar goals to that of the CHPC.
- c. Appoint a Suicide Prevention Program manager (SPPM).
- d. Appoint a task force with the SPPM as the presiding officer to plan, implement, and manage the ASPP.
- e. Ensure the execution of the ACPHP compliance arm at all states/territories using internal staffing assets, under the CHPCs, with each CHPC member and related staff having responsibility for a particular health promotion function.

1–24. Medical Command/medical center commanders

Medical Command/medical center (MEDCOM/MEDCEN) commanders will—

- a. Serve as principal advisers to the installation/community commander with respect to the Army Health Promotion Program.
- b. Provide equipment and health care personnel to administer and interpret the self-reported health information tool, teach classes, and compile statistics to support the health promotion program and review/assess Post Deployment Health Assessment (PDHA)/Post Deployment Health Reassessment (PDHRA) updates as required.
- c. Use process action teams (PATs) to address specific issues involving health promotion at the medical treatment facilities (MTFs).
- d. Partner with installation and garrison staff in their areas of operation to prioritize health promotion services from the installation and community perspective.
- e. Develop and implement health promotion programs for the installation and community in partnership with the installation and garrison staff through the CHPC.
- f. Develop and implement protocols for the identification and management of suicidal patients in each patient care unit of the MTF, and provide in-service suicide-prevention training for health care providers.
- g. Provide a credentialed mental health officer to conduct a psychological autopsy when required by regulation.
- h. Provide advice and assistance to Reserve Component commanders to facilitate and implement health promotion policies.
- i. Appoint a designated DOD suicide-event report (DODSER) program manager to collect a DODSER on every active duty suicide. The DODSER program manager will assist in the completion of an annual DODSER report.

1–25. Commanders

Commanders at all levels will—

- a.* Publish a health promotion policy that includes suicide-prevention efforts. This policy includes a full scope of prevention activities as listed in this regulation to promote a community of healthy behaviors.
- b.* Remain sensitive and responsive to the needs of Soldiers, Army civilians, Family members, and retirees.
- c.* Encourage all Soldiers, civilians, and Family members to practice a lifestyle that improves and protects physical, behavioral, and spiritual well-being.
- d.* Enhance unit readiness and maximize human resources by implementing the health promotion program within their units.
- e.* Ensure that Soldiers identified with suicide-risk symptoms/behaviors are not belittled, humiliated, or ostracized by other Soldiers and are not identified through special markings or clothing (that is, Soldiers wear reflective training vests with signs identifying them as high-risk individuals).
- f.* Promote the battle buddy system throughout the deployment cycle for all Soldiers regardless of rank, position, and organizational affiliation.
- g.* Ensure that Soldiers are treated with dignity and respect and are encouraged to seek assistance if they are experiencing challenges or have been identified with suicide-risk symptoms.
- h.* Ensure that policies are in place for unit watch, weapons profiles, and other unit-related procedures that relate to suicide-risk symptoms or suicide-related events.
- i.* Refer Soldiers who are undergoing disciplinary action and have multiple risk factors present to appropriate support services to mitigate risk.
- j.* Ensure that Families, unit members and coworkers who experience loss due to suicide are provided/offered long-term assistance. See appendix D of DA Pam 600-24 for a specific list of available prevention, intervention, and postvention resources.
- k.* Demonstrate positive efforts to deglamorize the use of all forms of tobacco products.
- l.* Initiate proactive measures to prevent loss of life within their units due to suicide and to reduce the impact on survivors if a suicide takes place.
- m.* Enhance unit readiness and maximize human resources by encouraging Soldiers to attain and maintain dental wellness (Dental Fitness Class 1) and referring Soldiers in Dental Fitness Classes 3 and 4 for examination and treatment with a goal of attaining at least Dental Fitness Class 2.
- n.* Ensure that all Soldiers and Family members are aware of the availability of dental care at post facilities and understand the use of the dental insurance plan for treatment at civilian facilities.
- o.* Conduct an AR 15–6 investigation on every suicide and equivocal death which is being investigated as a possible suicide.
- p.* Ensure that commanders of active army units share information including but not limited to behavioral problems (for example, belligerence, depressive symptoms, hygiene, obsessive behavior), family/relationship problems, financial problems, and any other information relating to the Soldier's (or the Soldier's Family's) physical or behavioral health, well-being, or readiness on Title 10 Reserve Component Soldier suicides with parent ARNG/ARNGUS and USAR component units.
- q.* Establish task forces, committees, and risk reduction teams to facilitate local health promotion initiatives to reduce high-risk behaviors and build resiliency.
- r.* Share a Soldier's information only with those who have a need to know. If a commander or healthcare professional has any questions regarding who has a need to know, they should contact the servicing judge advocate before sharing any information.
- s.* Maintain records of Soldiers' annual suicide-prevention awareness training.

1–26. The garrison Installation Management Command chaplain

- a.* Serves as a member of the Community Health Promotion Council and provides input regarding spiritual health into installation health promotion programs.
- b.* Ensures that all chaplains on the installation are trained as gatekeepers.
- c.* Ensures that all chaplains on the installation are able to train the Army-approved Ask, Care, Escort (ACE) suicide-prevention and intervention-training programs developed by the USACHPPM.
- d.* Administers the suicide-prevention program for both military and civilian members with a goal to reduce suicides.
- e.* Serves as the presiding officer of the Suicide Prevention Task Force and coordinates the efforts of task force members.
- f.* Serves as a member of the CHPC representing suicide-prevention issues and providing input into related programs.
- g.* Tracks the training of all Applied Suicide Intervention Skills Training (ASIST) and ACE-certified personnel and ASIST/ACE training for the installation, state, and RSC.

- h.* Serves as the point of contact for program information and advice to the commander and to major subordinate commands.
- i.* Integrates suicide-prevention into community, Family, and Soldier support programs as appropriate.
- j.* Coordinates with internal and external organizations to share information, trends, best practices, lessons learned, and training developments.

1–27. Suicide Prevention Program manager

- a.* Administers the suicide-prevention program for both military and civilian members with a goal to reduce suicides.
- b.* Serves as the presiding officer of the Suicide Prevention Task Force and coordinates the efforts of task force members.
- c.* Serves as a member of the CHPC representing suicide-prevention issues and providing input into related programs.
- d.* Tracks the training of all ACE-certified personnel and ACE training for the installation, state, and RSC.
- e.* Serves as the point of contact for program information and advice to the commander and to major subordinate commands.
- f.* Integrates suicide prevention into community, Family, and Soldier support programs as appropriate.
- g.* Coordinates with internal and external organizations to share information, trends, best practices, lessons learned, and training developments.

**Chapter 2
Community Health Promotion Program**

2–1. Implementation guidance

- a.* The success of the Army Health Promotion Program is determined by the combined efforts of community, garrison, state Joint Forces Headquarters and Army Reserve DRUs, and major subordinate command (MSC) leaders. An effective, comprehensive, and integrated program at the installation, community, and garrison leader levels is the key to achieving overall goals.
- b.* The USACHPPM will serve as health promotion advisor and consultant for the Army Health Promotion Program.
- c.* Health promotion programs increase unit readiness, combat and organizational efficiency, and productivity by maximizing human resources. Health promotion activities encompass physical, behavioral, spiritual, and social dimensions and are positive actions. The total effect of health promotion activities and health education improve unit and organizational performance by enhancing individual well-being. Suicide prevention is one aspect in enhancing one’s well-being. The major health promotion functional areas are outlined in paragraph 2–1*d*(5) below.
- d.* The garrison commanders will establish a Community Health Promotion Council (CHPC). Noninstallation based commands will establish a CHPC where practical. When supporting elements and resources are too geographically dispersed to support a CHPC, noninstallation based commands will develop and implement strategies to accomplish similar goals. The CHPC may be combined with other similar established programs on the installation.
 - (1) The CHPC will be organized to provide a comprehensive approach to health promotion, and be concerned with the environment and its relationship to people at the individual, organizational, and community levels.
 - (2) All tenant organizations fall under the CHPC for health promotion policy and programs. As the designated representative of the senior commander, the garrison commander, through the CHPC, will provide comprehensive health promotion policy and programs that are applicable to all garrison residents.
 - (3) A formal charter will be established and signed for all health promotion, risk reduction, and suicide-prevention councils, teams, and committees in accordance with AR 15–1. The primary signature authority will be the garrison commander, The Adjutant General (TAG), or the USAR DRU/MSC commander. These charters must clearly outline—
 - (a)* Organization and membership.
 - (b)* Mission.
 - (c)* Scope and objective (integration with other councils/committees).
 - (d)* Meeting schedule.
 - (e)* Standard products/services.
 - (f)* Metrics, assessment, and reporting protocols.
 - (g)* A marketing/outreach plan.
 - (4) The CHPC will identify and eliminate redundancies and voids in programs and services by evaluating population needs, assessing existing programs, and coordinating targeted interventions.
 - (5) The CHPC will ensure health promotion programs comprise the following functional areas:
 - (a)* Health education/health promotion processes to raise individual and community awareness.
 - (b)* Behavioral health interventions to improve psychological health and reduce self-destructive behaviors.

- (c) Physical programs directed towards achieving optimal physical wellness.
- (d) Spiritual programs to foster spiritual awareness and enrichment.
- (e) Environmental and social programs that promote and sustain healthy lifestyles, strengthen community action, and encourage proactive public health policies.
 - e. Health promotion initiatives to address community needs may include media awareness campaigns, classes, seminars, workshops, activities and health interventions, policy changes, resource coordination/reorganization, and other initiatives to accomplish required goals. Existing programs may be used to meet these needs.
 - f. The CHPC will initiate preventive interventions that directly impact the total population (Active, Reserve, and ARNG/ARNGUS Soldiers, Family members, retirees, and Army civilians).
 - g. The CHPC will assist, develop, and implement means to allow commanders to monitor program goals and objectives.
 - h. The CHPC will ensure necessary health promotion knowledge, skills, and training will be available for the community.
 - i. Senior commanders of Active Army, ARNG/ARNGUS, and Army Reserve, will establish and execute an ACPHP compliance arm, managed in coordination with the CHPC members, to measure and assess the effects of the ACPHP by the senior commander. Compliance arm assessments will—
 - (1) Ensure compliance with the ACPHP strategy at the command level.
 - (2) Use the ACPHP checklist to measure performance and compliance (see DA Pam 600–24 for checklist).
 - (3) Identify problems and craft effective and meaningful corrective actions to resolve any problems.
 - (4) Gather and report feedback through higher level commands to the DCS, G–1 to help improve health promotion programs and initiatives.

2–2. Community Health Promotion Council membership

- a. The garrison commander, community leader, TAG or USAR DRU/MSC commander administers and controls the health promotion program through the CHPC and the community health promotion coordinator; these are the commander’s primary advisers. The presiding officer of the CHPC is the commander or designee from the command group.
- b. The commander will ensure the goals, objectives, and purposes of the Health Promotion Program are well-publicized throughout the command to keep Soldiers, Army civilians, Family members, and retirees aware of program benefits. This includes the relationship and interaction with CHPC members and overall program components.
- c. The CHPC will be a multidisciplinary team appointed on orders by the installation commander or community leader. The CHPC members act as advisors to the installation commander or community leader on health promotion programs, to include program procedures, community health education, health risk assessments, and program evaluation efforts.
- d. Principal CHPC tasks are to—
 - (1) Assess community needs.
 - (2) Analyze data resulting from program assessments or evaluations.
 - (3) Keep an inventory of resources.
 - (4) Develop, implement, and evaluate courses of action to address identified community needs.
 - (5) Integrate existing health promotion programs with other similar installation and community programs.
 - (6) Develop a comprehensive marketing plan based on existing resources and demographics.
 - (7) Report progress, challenges, and successes to the Well-Being Council, as defined by IMCOM.
- e. The community health promotion coordinator will provide logistical and advisory support to the commander and the CHPC.
- f. The CHPC members normally serve for a minimum of 1 year, subject to reappointment at the end of the year. Members should have authority and responsibility to provide resources to assist with achievement of CHPC goals. The CHPC membership will include the following:
 - (1) Garrison commander, community leader, TAG or USAR DRU/MSC commander, CHPC chair.
 - (2) Suicide Prevention Program manager.
 - (3) Health promotion coordinator.
 - (4) Garrison command sergeant major.
 - (5) Director, Human Resources Directorate (civilian Personnel Advisory Center, Military Personnel Services, Education).
 - (6) Family Advocacy Program manager (FAPM).
 - (7) Commander, MTF.
 - (8) Director of Logistics.
 - (9) Director for Plans, Training, and Mobilization.
 - (10) Commander, Dental Activity/Director of Dental Services.
 - (11) Staff chaplain.

- (12) Public Affairs officer.
- (13) Major tenant commanders.
- (14) Health promotion coordinator (HPC), if available to command.
- (15) Alcohol Drug Control officer.

g. Consultants, as needed. For example, this category could include representatives from the installation safety, public affairs, and civilian personnel offices; ASAP, medical/dental/ veterinarian, environmental science, American Red Cross, and DOD Dependents Schools organizations; fitness, food service, or Reserve Component advisors; the Inspector General; or other selected community members.

h. The CHPC members are encouraged to attend the Army Health Promotion Course. See <http://chppm-www.apgea.army.mil/trng.asp> for Army Health Promotion Course description, dates and locations.

2-3. Community Health Promotion Council administration

- a.* The garrison commander, community leader, or designee serves as the CHPC chairperson.
- b.* The CHPC will convene at least quarterly. The chairperson will identify a recorder to assist the CHP coordinator during council sessions. See DA Pam 600-24 for details regarding the CHPC responsibilities.
- c.* At a minimum, the health promotion coordinator provides overall administrative assistance to the installation commander or community leader and the CHPC by—
 - (1) Serving as liaison between the installation commander/community leader, CHPC members, and other military and civilian representatives.
 - (2) Assisting with integrating all CHPC resources to meet identified goals and objectives.
- d.* The CHPC will implement a health promotion improvement program and complete a quality assurance review once a year, or as otherwise directed by the installation commander/community leader. Although the CHPC chairperson is primarily responsible for the quality assurance review, each CHPC member and the installation staff having responsibility for a particular health promotion function will monitor compliance of that function. The purpose of the review is to evaluate the installation program objectively, identify areas that need improvement, develop an improvement plan, and request needed resources. The USACHPPM Directorate of Health Promotion Wellness (USACHPPM-DHPW) will provide program evaluation consultation to assist with the CHPC yearly quality assurance review.
- e.* The USACHPPM-DHPW will provide SMEs to the Community Health Promotion Council, as needed.

2-4. The Suicide Prevention Task Force

- a.* Each installation, Army Reserve DRU/MS, and state Joint Force Headquarters (JFHQ) will establish a SPTF to plan, implement, and manage the local ASPP. The membership of this task force will be tailored to meet local needs.
- b.* Commanders may assign the suicide-prevention mission to the Suicide Prevention Program manager (SPPM—who serves as the chair of the Suicide Prevention Task Force (SPTF) and a member of the CHPC—or may elect to establish a separate SPTF to function as a subcommittee of the CHPC. When using the CHPC to manage the ASPP, care must be taken to ensure that suicide prevention remains a primary responsibility. Responsibilities of the task force members, with respect to suicide prevention, must be clearly established. Specific details regarding the SPTF are outlined in DA Pam 600-24.
- c.* The SPTF will—
 - (1) Coordinate program activities and the suicide-prevention activities of the command, interested agencies, and persons.
 - (2) Evaluate program needs and make appropriate recommendations to the commander.
 - (3) Review, refine, add, or delete items to the program based on an ongoing evaluation of needs.
 - (4) Develop awareness training for suicide-prevention activities and identify appropriate forums for training.
 - (5) Evaluate the impact of the pace of training and military operations on the quality of individual and Family life in the military community.
 - (6) Recommend command policy guidance for training and operations issues to assure that Soldiers and their leaders have sufficient opportunity for quality Family life.
 - (7) Be aware of publicity generated with respect to suicides in the community and develop public awareness articles for publication.
 - (8) Meet at the discretion of the task force presiding officer.
 - (9) In the event of a suicide, review the results of the psychological autopsy (as applicable) to look for the possible causes of the suicide and, if necessary, evaluate prevention efforts and make recommendations to the commander.
 - (10) Coordinate with civilian support agencies, as necessary.
 - (11) Implement an integrated Family member suicide-prevention program.

2-5. Collaboration and health promotion integration

- a.* Collaboration and integration among community agencies enhance knowledge, experience, and resources and

have the potential of minimizing duplication of efforts. Collaboration extends beyond services available on military installations to include potential community partners, such as local and state health departments, school systems, and organizations (American Red Cross, American Heart Association, and so forth).

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

- (1) The U.S. Army Center for Health Promotion and Preventive Medicine, <http://chppm-www.apgea.army.mil/>.
- (2) The Centers for Disease Control and Prevention, <http://www.cdc.gov>.
- (3) The Department of Health and Human Services, <http://www.hhs.gov>.
- (4) The Deployment Health Clinical Center, <http://www.deploymenthealth.mil>.
- (5) The Navy Environmental Health Center, <http://www-nehc.med.navy.mil/hp>.
- (6) The Air Force Institute of Operational Health, <http://www.brooks.af.mil/afioh/>.
- (7) The National Institutes of Health, <http://www.nih.gov/>.

c. See DA Pam 600–24, chapter 5 and chapter 7 for specific resources and outreach programs for geographically dispersed individuals and Family members.

Chapter 3

Health Promotion Process

3–1. General

Health education is a planned process that promotes, maintains, and improves individual, Family, and community health by raising awareness, enhancing knowledge, and inspiring readiness to change through healthy lifestyle choices.

3–2. Framework

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

a. Assessment is the appraisal of individual and community needs for health education in order to determine—

- (1) Health knowledge, perceptions, attitudes, motivation, and practices.
- (2) Priority areas, nature, and emphasis needed for health education based on results of collected data.
- (3) Appropriate health education activities for the designated target population.

(4) The assessment process includes the selection of valid sources of information about health needs utilizing existing computer resources, databases, or other appropriate data-gathering instruments. Members of the CHPC will provide necessary information for community assessment.

b. Planning is a comprehensive approach to preparing and developing an effective health education program, and begins by establishing specific behavioral goals and learning objectives that are realistic and measurable. Planning also requires recruitment and commitment of personnel and decision makers, selection of educational methods and strategies appropriate to the target population, procurement of resources, inclusion of program evaluations, and communication with the CHPC.

c. Implementation is the execution of the planned health education program. The program implementer will deliver a series of planned learning activities designed to achieve changes in health awareness, knowledge, attitude, skills, and behavior. These activities involve setting up, managing, and executing instructional sessions, methods, strategies, wellness activities, interventions, and promotion measures that address program objectives.

d. Evaluation is the review of the program to determine the effectiveness of health education and whether program objectives were met and requires the collection and examination of appropriate data. It documents the strengths and weaknesses of program planning and execution, and monitors participant performance, quality control, and fiscal accountability.

e. Communication is the sharing of health education needs, concerns, and resources with the target population and program stakeholders (persons or groups that are interested in the success of the program).

(1) Communication should include increasing awareness, illustrating skills, reinforcing knowledge, affecting attitude and behavior changes, supporting risk reduction and disease prevention health policies, and reporting program effectiveness to stakeholders.

(2) Communication services should incorporate the sharing of community resources, responding to requests for health information, referring requesters to valid health information sources, and assisting with marketing and public relations. The CHPC fosters networking among stakeholders and health care personnel, and should liaise between the target population and health care providers. The CHPC will coordinate with the Public Affairs Office to support health education efforts through media partnerships and mass media.

3–3. Resources

Health information can be obtained from a variety of sources, including professional organizations, journals, textbooks, government publications (local, state, federal), colleges/universities, medical centers, professional conferences, and the internet. In addition to the collaborative resources listed in paragraph 2–4 of this regulation, other health-related resources can be found through the following sites:

- a. Army Knowledge Online, <https://www.us.army.mil/suite/login/welcome.html>.
- b. National Commission for Health Education Credentialing, <http://www.nchec.org>.
- c. Institute of Medicine of the National Academies, <http://www.iom.edu>.
- d. American Alliance for Health, Physical Education, Recreation and Dance, <http://www.aahperd.org/index.cfm>.

Chapter 4 Behavioral Health

4–1. General

Behavioral health (BH) problems take a significant toll on the readiness of the U.S. Army. While treatment options are available and effective, prevention and BH promotion offer more efficient strategies for containing the cost of BH problems to the Army. Behavioral health is not simply the absence of psychiatric or psychological problems; BH promotion and mental health promotion influence overall well-being and promote a healthy and ready force.

a. Behavioral health promotion involves a complex network of factors from wide-ranging social and programmatic areas (for example, medical, housing, finance, social services, education, and so forth). For BH promotion efforts to be successful, efforts must take a multisectoral approach and address the challenge of promoting BH by targeting interventions at multiple BH-related areas. The three cornerstones of effective strategies to promote optimal BH include—

- (1) Strengthening individuals.
- (2) Strengthening communities.
- (3) Reducing structural barriers to health.

b. Community Health Promotion Councils will ensure initiatives are established that address each of the three cornerstones and ensure preventive activities are carried out to reduce the risk and impact of mental illness on the installation.

(1) Programs that strengthen individuals should focus on increasing the number and quality of resources available to Soldiers, Family members, retirees, and DA civilians. Examples of such programs include efforts to improve housing, stress inoculation interventions, installation newcomer briefings, relationships enhancement programs, and so forth.

(2) Programs that strengthen communities should strive to enhance connections between individuals and community organizations, as well as enhancing communication and cooperation between community organizations. Such programs could include community health fairs, partnerships between medical activities and units, partnerships between Child and Youth Services (CYS) and BH services and between medical activities (MEDDACs) and DOD schools.

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

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

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

- (1) Identifying high-risk individuals early.
- (2) Providing psychosocial programs to improve self-management skills and to develop appropriate behaviors.
- (3) De-stigmatizing BH care.
- (4) Increasing awareness of individual strengths and group capabilities.
- (5) Shifting the focus from tertiary care to primary prevention.
- (6) Using community resources (for example, Force Health Protection & Readiness, <http://www.ha.osd.mil/fhpr/healthyandfit.cfm>).

e. In addition to general BH promotion and prevention activities, the CHPC will ensure that specific programs are

implemented in each of the following areas—councils, teams, and committees related to specific programs listed here report information and status of trends to the CHPC on a quarterly basis:

- (1) Stress management (paragraph 4–2).
- (2) Combat operational stress control (paragraph 4–3).
- (3) Suicide prevention and surveillance (paragraph 4–4).
- (4) Responsible sexual behavior (paragraph 4–5).
- (5) Army Substance Abuse Program (paragraph 4–6).

4–2. Stress management

a. Behavioral health management includes assistance provided to Soldiers and Family members so they may cope with the demands - real or perceived - from stress related to work, home, and within themselves. Behavioral Health Services will do the following:

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

b. The CHPCs will ensure stress management activities are carried out in accordance with guidance provided in this chapter.

c. The garrison commander, Army Reserve DRU/MSA commander, Joint Force Headquarters commander, and/or CHPC may designate a process action team (PAT) to review and evaluate stress management activities for the community. If a PAT is designated, care must be taken to ensure that its membership reflects a cross-section of the CHPC membership as a whole and is not limited solely to BH and chaplaincy assets.

(1) The PAT approach will encompass the full range of methods available for identifying risk factors, and promoting protective elements that can help individuals become resilient in the face of adversity, thereby moderating the impact of stress and transient systems on their social and emotional well-being.

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

d. Stress management is a concern for leaders at every level. Techniques and considerations for the management of stress in Army operations can be found in FM 6–22.5.

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

4–3. Combat and operational stress control

The stress of active combat operations often leads to a combat and operational stress reaction (COSR). The prevention and treatment of COSR is often done by mental health teams that are deployed to provide combat and operational stress control (COSC) interventions. The purpose of COSC efforts is "to preserve the fighting strength" of the line; COSC efforts are preventive in nature. In order to reduce stigma, practice "expectancy," and return Soldiers to duty as quickly as possible, three levels of primary prevention service are provided:

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

b. COSC indicated prevention. Surveillance and mitigation activities involving contact by BH personnel with individual Soldiers identified as having possible warning signs or pre-diagnostic COSRs. Such cases can be aided by their unit, brief visits, or by restoration treatment for 1-3 days in Combat Stress Control (CSC) Team-type medical facilities. The COSC case information is recorded as a patient encounter but classified by one or more COSR codes rather than "diagnosed" with Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM–IV) codes.

c. Combat operational stress reaction treatment prevention. Mitigation/stabilization activities to reduce long-term morbidity and complications in Soldiers with one or more DSM–IV-diagnosable psychiatric/mental disorders. A Soldier with COSR whose condition persists and prevents return to effective duty within 4 days or requires more invasive clinical follow-up and/or a patient record of continuing BH treatment, should be tracked through normal medical channels using standard medical forms and databases.

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

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

(2) The CSC Teams—

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

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

(c) Record work activities during deployment using the USACHPPM Combat Operation Stress Control - Work Activity Recording System (COSC-WARS).

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

4-4. Suicide prevention and surveillance

This paragraph establishes policy and guidance for the Army Suicide Prevention Program (ASPP). The success of the ASPP is predicated on the existence of proactive, caring, and courageous Soldiers, Family members, and Army civilians who recognize imminent danger and take immediate action to save a life.

a. *ASPP purpose.* The ASPP—

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

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

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

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

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

(3) Preserve mission effectiveness and warfighting capability.

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

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

e. It is the Army's goal to prevent suicide for Soldiers, Family members, and civilian employees. However, it must be recognized that in some people, suicidal intent is very difficult to identify or predict, even for a behavioral health professional. Some suicides may be expected even in units with the best leadership climate and most efficient crisis intervention and suicide-prevention programs. Therefore, it is important to redefine the goal of suicide prevention as being suicide-risk reduction. Suicide risk reduction consists of reasonable steps taken to lower the probability that an individual will commit acts of self-destructive behavior.

f. The ASPP provides a systematic framework in which commanders may work to lower the risk of suicide for Soldiers, Family members, and civilian employees. This will lead to lower suicide rates in the Army and will impact significantly on the loss of life and productivity that can result from suicidal behavior. See DA Pam 600-24, paragraph 2-2 for specific information regarding the ASPP.

g. *ASPP responsibilities.* Suicide prevention is a commander's program and is the responsibility of every leader. Leaders care for their personnel and create an environment that encourages help-seeking behaviors. Garrison, Army Reserve DRU/MSO commanders, and TAGs are responsible for integrating and administering suicide-prevention programs for their organization.

(1) Program administration on installations is vested with the garrison commander, who requires the director of human resources to manage the program and community initiatives, in conjunction with the CHPC. The CHPC will ensure a proactive, coordinated, and synchronized local program. It is the responsibility of each CHPC to ensure that suicide-prevention activities are carried out in accordance with guidance provided in this chapter. The CHPC chairperson may designate a subcommittee of CHPC members to manage suicide-prevention activities, or the CHPC may elect to have the Installation Suicide Prevention Task Force manage suicide-prevention activities.

(2) Program administration for noninstallation based organizations without a CHPC is managed by the Suicide Prevention Task Force under the supervision of the Suicide Prevention Program Manager. The SPTF will develop a

proactive, coordinated, and synchronized program that spans all geographically dispersed Soldiers and builds relationships to leverage local agencies to meet needs normally met by installation-based services.

h. Suicide prevention strategies. Army suicide-prevention focuses on maintaining individual readiness through five overarching strategies.

(1) Developing positive life coping skills.

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

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

(2) Encouraging help-seeking behavior.

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

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

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

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

(e) The CHPC SPTF will monitor use of such helping agencies to ensure prompt and easy access and identify any usage trends. This should include ensuring that these agencies are properly resourced and identifying possible obstacles for use.

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

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

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

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

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

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

(e) Leaders will ensure all UMT members and Family Life chaplains within their command receive suicide-prevention training which includes recognizing potential danger and warning signs, suicidal risk estimation, confidentiality requirements, how to conduct unit suicide-prevention training, and intervention techniques to employ when it is known that a person they are counseling is at risk for suicide.

(f) The CHPC SPTF will ensure all installation gatekeepers are properly trained on recognizing behavioral patterns that place individuals at risk for suicide. Gatekeepers will be trained on suicide-intervention techniques to effectively reduce the immediate risk (see table 4-1 for primary and secondary gatekeepers).

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

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

(a) The CHPC SPTF will implement suicide-prevention strategies and objectives for all assigned or attached installation tenant units, regardless of service or ACOM.

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

1. Army divisions and other large activities with adequate support should consider establishing a risk management team (RMT) in accordance with AR 600-63. This is an optional element of the ASPP. The RMT will actively monitor the progress of Soldiers identified as at risk. The team is charged with the responsibility of addressing the medical and administrative needs presented by high risk cases.

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

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

(5) Conduct suicide surveillance, analysis, and reporting that keeps senior leaders aware of the problem of suicidal behavior, track demographic trends that could be helpful in developing or refining ASPP objectives, and immediately identify events that could potentially raise the level of risk for a segment of the Army.

i. *Suicide prevention phases.* The ASPP comprises three principle phases or categories of activities to mitigate the risk and impact of suicidal behaviors: prevention, intervention, and "postvention."

(1) Prevention focuses on preventing normal life "stressors" from turning into life crises. "Prevention Programming" focuses on equipping the Soldier, Family member, and Army civilian with coping skills to handle overwhelming life circumstances. Prevention includes early screening to establish baseline mental health and to offer specific remedial programs before dysfunctional behavior occurs. Prevention is dependent upon caring and proactive small unit leaders who make the effort to know their subordinates, including estimating their ability to handle stress, and who offer a positive, cohesive environment which nurtures and develops positive life-coping skills.

(2) Intervention attempts to prevent a life crisis or mental disorder from leading to thoughts of suicide to help someone manage suicidal thoughts and take action to intervene when a suicide appears imminent. It encourages and/or mandates professional assistance to handle a particular crisis or treat a mental illness. Early involvement is a crucial factor in suicide-risk reduction. Intervention includes alteration of the conditions that produced the current crisis, treatment of underlying psychiatric disorder(s) that contributed to suicidal thoughts, and follow-up care to assure problem resolution. This also could include controlling a person's environment such as removing the means and enacting watchful care from a buddy. Commanders play an integral part during this phase, as it is their responsibility to ensure a particular problem or crisis has been resolved before assuming the threat has passed.

(3) "Postvention" is required when an individual has attempted or completed a suicide. After an attempt, commanders, NCOs, and installation gatekeepers must take steps to secure and protect such individuals before they can harm themselves and/or others. "Postvention" activities also include unit-level interventions following completed suicidal acts, to minimize psychological reactions to the event, prevent or minimize potential for suicide contagion, strengthen unit cohesion, and promote continued mission readiness.

j. *Training.* Suicide prevention training will be specialized and multitiered, and geared towards five specific groups, each with different responsibilities within the ASPP. The ASPP Program Manager will issue annual guidance on content and method. See AR 350-1 for frequency of training, and refer to DA Pam 600-24.

(1) *Approved Army Training Packages.* The ACE training developed by USACHPPM is the Army-approved prevention training for Soldiers, leaders, Families, and civilians. The Army ACE Peer Intervention Training is the approved intervention training for junior leaders and front line supervisors. Trainers must be certified by attending a train-the-trainer session approved through USACHPPM.

(2) *Soldiers and Army civilian employees.*

(a) *Soldiers.* All Army Soldiers will receive yearly basic suicide awareness and prevention training focusing on the identification of suicide warning and danger signs, and what lifesaving actions they should take. Wherever practical, training shall be conducted in person and in small groups, rather than using large groups, video teleconference, or web-based training. Specific training modules are to be developed for military medics and medical personnel focusing on the review of clinical protocols for responding to crisis situations involving Servicemembers who may be at high risk for suicide, and clinical tracking requirements and protocols for those known to be at increased risk of suicide. The following topics will be included in training: the importance of mental health, stress reduction, and life-coping skills, such as alcohol/drug abuse avoidance; financial, stress, and conflict management; and marriage and Family-life skills. The Army-approved training for Soldiers is the ACE Suicide Prevention Training for Soldiers developed by USACHPPM. This is required annual training for all Soldiers. Commanders should seek assistance from the SPTF, UMTs, brigade or division mental health sections, combat stress control units, or local community mental health organizations for trainers. For qualified instructors, Army units should seek assistance from UMTs, brigade or division mental health sections, installation combat stress control units, or local community mental health organizations. Unit commanders also should encourage spouses to take suicide-prevention training, such as those that are available through Family Readiness Groups.

(b) *Army civilian employees.* Army civilian employees will also receive yearly suicide training. Army civilian employees may be excused from the Army Suicide Prevention Training if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse DA civilians from the scheduled training will offer those employees alternatives to the training, such as written materials on suicide prevention. Commanders and supervisors are reminded to meet all applicable labor relations obligations in implementing the Suicide Prevention Training. Commanders/supervisors should coordinate with their local civilian personnel

advisory center prior to scheduling training. The Army-approved training for civilians is the ACE Suicide Prevention Training for DA civilians. Civilian supervisors should arrange training directly through the installation chaplain office or local mental health department. Wherever practical, training shall be conducted in person and in small groups, rather than using large groups, video teleconference, or web-based training. The following topics will be included in training: the importance of mental health, stress reduction, and life-coping skills, such alcohol/drug abuse avoidance; financial, stress, and conflict management; and marriage and Family-life skills.

(3) *Leadership training.* All Army leaders will receive training on the current Army policy toward suicide prevention, suicide-risk identification, and early intervention with at-risk personnel. This includes how to refer subordinates to the appropriate helping agency, and how to create an atmosphere within their commands that reduces stigma and encourages help-seeking behavior. All leaders will receive the ACE Suicide Prevention Training for Leaders on an annual basis. All junior and first-line leaders will receive the 4-hour Army ACE Peer Intervention Training for additional training in suicide intervention. These are the Army-approved training programs for leaders. Both of these were developed by USACHPPM. Civilian supervisors also will receive training that focuses on referral techniques/protocols for their employees. Sequential and progressive suicide-prevention and crisis-intervention training will be integrated into every Army leadership-development course.

(4) *Gatekeepers.* Gatekeepers are individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and civilians in need. Gatekeepers will receive training in recognizing and helping individuals with suicide-related symptoms or issues. Gatekeepers can be identified either as "primary gatekeepers" (whose primary duties involve assisting those in need who are more susceptible to suicide ideation) or "secondary gatekeepers" (who may have a secondary opportunity to come in contact with a person at risk). Table 4-1 provides examples of primary and secondary gatekeepers.

Table 4-1
Gatekeepers

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

(5) *Deployment cycle support.* The DCS, G-1 will define suicide-prevention training requirements for the different phases of the deployment cycle. The checklist for these requirements is found in DA Pam 600-24, Chapter 6-2.

(6) *Unit ministry teams.* Chaplains and their assistants in UMTs will assist commanders to provide suicide-prevention and awareness training for Soldiers, Army civilians, and Family members in their respective units and communities. All chaplains and assistants will receive basic and advanced suicide prevention/awareness training as determined by the Chief of Chaplains. Chaplains and UMTs will consult with local BH assets to ensure that information provided to units is scientifically and medically accurate.

(7) *Behavioral health professionals.*

(a) Behavioral health professionals provide health promotion, prevention, and clinical services to address suicidal and self-injurious behaviors. Behavioral health professionals also provide UMTs and other installation/community organizations with medically and scientifically supported information on suicide and suicide prevention. As such, BH professionals will receive training on state-of-the-art techniques and information sources pertaining to suicide prevention. The MEDCOM will ensure that uniformed BH professionals receive initial training as part of residency and fellowship programs sponsored by MEDCOM and/or as part of the advanced training portion of the Basic Officer Leadership Course. Refresher and update training will be provided to uniformed BH professionals through the biannual Behavioral Science Short Course. Army civilian and contract BH providers will ensure they remain current on suicide-prevention information.

(b) Army mental health officers will provide the technical expertise for all suicide-prevention education/awareness training. It is the role of mental health officers to "train the trainers" in all suicide-prevention programs.

(8) *Family members.* Garrison commanders will provide suicide-prevention training to Family members using chaplains as primary trainers. ACS personnel may assist as required. In-service training in suicide prevention for the staffs of ACS, CYS, and youth activities will be coordinated by the ACS officer/director and may be conducted by mental health officers or chaplains. ACS personnel will not be used to conduct suicide-prevention training for Army units.

k. *Family Member Suicide Prevention Program (FMSPP).*

(1) Installation-based FMSPP.

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

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

(2) The noninstallation based FMSPP is unique in that it must address the needs of units, Soldiers, and Families that are geographically dispersed and not normally in close proximity to Army-based services and support.

(a) The noninstallation based FMSPP will be coordinated at the local unit level between the commander and the unit Family Program Coordinator. The SPTF in conjunction with the state or Army Reserve DRU/MSF Family Program will provide support as requested. The SPTF, with the support of local unit commanders, will develop memorandum of agreements (MOAs) to leverage community services for crisis intervention and referral and ensure that commands are publicizing these resources to their Soldiers and Families.

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

l. Suicide prevention programs for deployments.

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

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

(3) Unit commanders will provide suicide-prevention training to Soldiers before and after authorized absences while deployed (e.g. mid-tour leave, rest and recuperation)

(4) Deployed commanders will convene quarterly Suicide Prevention Review boards in theaters at the corps/division TF/JTF level HQ, and report findings to DCS, G-1.

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

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

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

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

(b) AR 15-6: Commands from all components will conduct an AR 15-6 investigation on every suicide or equivocal death which is being investigated as a possible suicide. (See chap 1, para 1-25 of this document for commanders' responsibilities.)

(c) The criminal investigation division (CID) conducts investigations on active duty equivocal deaths to determine if criminal activity was involved. For nonactive duty deaths, CID has limited legal authority to conduct investigations, but can leverage professional relationships to liaise with local authorities where appropriate under the guidelines of AR 195-2 to support local commanders in obtaining police reports, coroner's reports, and death certificates.

(d) Line of duty (LOD) investigations are conducted on all deaths of Soldiers who at the time of death were on active duty, in an inactive duty training (IDT) status, or where the death is suspected to be connected to a previous duty incident. The LOD investigations are conducted in accordance with AR 600-8-4. Commands from all components will provide initial serious incident reports per AR 190-45 and subsequent reports on every suicide or equivocal death, which is being investigated as a possible suicide no later than 30 days from the date of the incident. See DA Pam 600-24 for procedural guidance for subsequent reports.

(e) Psychological autopsies will ascertain the manner of death for active duty deaths only in cases where there is an equivocal cause of death (such as, death cannot be readily established as natural, accidental, suicide, or homicide.) Psychological autopsies will be initiated only at the request of the involved medical examiner or U.S. Army Criminal Investigation Command (USACIDC) investigator. Additionally, the senior commander may request a psychological autopsy through CID. Psychological autopsies are completed by a fellowship-trained forensic psychiatrist or psychologist. The psychological autopsy will be provided to USACIDC. Psychological autopsy results will be made available for review to the DCS, G-1 ASPP, the local SPTF and the USACHPPM. (See DA Pam 600-24, annex A for an example of psychological autopsy questions/categories.)

(3) The Department of Defense Suicide Event Report (DODSER) is the DOD solution for monitoring suicides for all branches of the military. The DODSER (Army version formerly called the Army Suicide Event Report [ASER]) was developed to examine the causes and circumstances of suicide behaviors among military personnel. The DODSER standardizes the data collected on all suicide events. It is an integral part of the Army's Suicide Prevention Program. The DODSER should be completed for all fatalities, hospitalizations, and evacuations where the injury or injurious intent is self-directed. It is not intended to replace the psychological autopsy, which is limited to fatalities in which the manner of death is uncertain. Formal requests to complete the DODSER are sent to DODSER POCs (Medical Treatment Facility [MTF] commanders) for each Armed Forces Medical Examiner (AFME) confirmed event; follow-up messages are sent for all events for which a DODSER is not received in the required time frame. Additionally, compliance reports that highlight delinquent DODSERS are issued monthly to MTF command POCs. Each MTF commander will designate a behavioral health professional to complete and submit the DODSER to a secure website: <https://abhto.amedd.army.mil/dodser>. In collaboration with the MTF commander, the Chief, Behavioral Health Services, and the CHPC will monitor the completion of the DODSER.

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

(5) Each CHPC or SPTF will establish policies and procedures for the implementation of a Suicide Response Team (SRT) for their respective installation or organization. The SRT will consist of chaplains, BH professionals, and other counselors and helping agencies, as appropriate. The SRT will coordinate with any organic BH and chaplaincy assets to respond to any known or suspected suicide occurring in subordinate or tenant organizations by offering additional support to unit commanders, ensuring that proper guidelines are followed for local media coverage, and monitoring completion and submission of appropriate reports as outlined in para 4-4m of this regulation. The SRT will never assume tactical control of suicide-response activities for a unit with organic BH or chaplaincy assets.

(a) At the discretion of the commander, the SRT will convene within 48 hours of an attempted or completed suicide to support the command and installation effected. As an adjunct to the CHPC, its function is to assist the commander in assessing the situation, determining appropriate courses of action, directing immediate interagency and interstaff actions, and advising the commander. See AR 600-63 for specific information regarding team intervention and composition. Team intervention will include taking actions necessary to provide for the immediate welfare of Families who have suffered a suicide or suicide attempt.

(b) At a minimum, the SRT should be composed of the following:

1. The division surgeon.
2. The division psychiatrist.
3. The battalion or separate company commander.
4. A representative of the battalion/headquarters chaplain.
5. A representative of the Assistant Chief of Staff G1 (personnel) (G1/AG).
6. A representative of the staff judge advocate.
7. A representative of the provost marshal.
8. A representative of the Alcohol and Drug Control Office (ADCO).
9. A representative of the Army Community Services (ACS) office.

(c) Battalion and separate company commanders:

1. Convene the SRT, through the division surgeon, when Soldiers within the command are identified as a suicide risk.

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

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

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

n. *Army psychological autopsy.* Psychological autopsy results will be used by the DCS, G-1 ASPP, the local SPTF,

and the USACHPPM. (See DA Pam 600–24, annex A for an example of psychological autopsy questions/categories.) When results of the psychological autopsy are available, offices responsible for examining investigative findings, (for example, CID, USACHPPM, ASPP, SPTF) determining trends, pulling data points, and capturing/distributing lessons learned will use the results of the psychological autopsy to the fullest extent possible. When available, include information from the DD Form 1300 (Report of Casualty), LOD investigation, and AR 15–6. See DA Pam 600–24, annex A for details regarding psychological autopsies.

4–5. Responsible sexual behavior

- a.* Responsible sexual behavior includes—
 - (1) The ability to understand and weigh the risks.
 - (2) Responsibilities.
 - (3) Outcomes and impact of sexual actions, to include sexual assault.
 - (4) Practicing abstinence when appropriate.
- b.* Unprotected sexual intercourse places persons at risk for HIV infection, other sexually transmitted infections (STIs), and unintended pregnancy. Unintended pregnancies can be disruptive to unit readiness as well as to the physical, social, mental, and behavioral health of the Soldiers involved. Unintended pregnancy has been identified as a risk factor for child abuse, neglect, low-birth weight, cigarette smoking, alcohol use, and spouse abuse.
- c.* The CHPC will monitor the rates of unintended pregnancies, STIs, and sexual assaults in the community. Using a multidisciplinary approach, the CHPC will ensure individuals and groups receive appropriate education and interventions regarding responsible sexual behavior.
- d.* Commanders and leaders at all levels in all components will—
 - (1) Promote and maintain a culture in which responsible sexual behavior is encouraged, supported, and expected.
 - (2) Coordinate with the servicing MEDDAC or MEDCEN to accomplish education on responsible sexual behavior for personnel under their command.
 - (3) Assist the servicing MEDDAC or MEDCEN in developing and implementing responsible sexual behavior education programs for Soldiers, Family members, and other health care beneficiaries in the community.
- e.* All Soldiers are expected to attend any required training pertaining to responsible sexual behavior.

4–6. Army Substance Abuse Program

The ASAP is a comprehensive program conducted to prevent and control substance abuse through a wide variety of activities, including prevention, identification, education, and rehabilitation services comprised of inpatient and outpatient treatment. (See AR 600–85.)

- a.* Alcohol and drug abuse are incompatible with readiness. Soldiers identified as alcohol abusers who, in the opinion of their commanders, warrant retention will be afforded the opportunity for rehabilitation in accordance with AR 600–85. Soldiers identified as alcohol abusers who, in the opinion of their commanders, do not warrant retention will be considered for separation. Soldiers who are involved in two serious incidents of alcohol-related misconduct in 1 year will be processed for separation, in accordance with AR 600–85 and applicable administrative regulations.
- b.* The Risk Reduction Program (RRP) is a component of the ASAP. Within the RRP is a forum in which representatives from the installation human services agencies such as the ASAP, Family Advocacy Program (FAP), ACS, preventive medicine, chaplain and Judge Advocate General (JAG) meet to discuss high-risk behaviors and recommended intervention. This forum is the Installation Prevention Team (IPT). The focus of the IPT is to review and analyze the installation’s risk reduction unit data and, in collaboration with commanders, develop prevention strategies and interventions to address high risk factors affecting units. IPT members will also collaborate to develop and implement Installation Prevention Plan’s (IPP). See AR 600–85 for specific details regarding the IPT.
- c.* All levels of the chain of command must take prompt action, regardless of rank or grade of the individual involved, if alcohol or illicit drug use is suspected.
- d.* Implementation of an ASAP is required for installations, communities, and activities in accordance with AR 600–85.
- e.* Commanders at every level will ensure that an active and aggressive drug testing program is maintained.
- f.* Substance abuse policy will be given adequate publicity to ensure that eligible civilians, Family members, and retirees are aware of—
 - (1) Command support.
 - (2) Available information.
 - (3) Referral procedures.
 - (4) ASAP rehabilitation services.
- g.* Enrollment of Army civilians, Family members, and retirees is voluntary. The commander of the servicing installation or activity is responsible for developing procedures by which Army civilians may use ASAP facilities and services, namely the Employee Assistance Program.
- h.* The CHPC will assist commanders, supervisors, and health care providers, in coordination with the local ASAP

program, to provide prevention education for all members of the Total Army Family on the detrimental effects of alcohol and drug abuse on combat readiness and a healthy lifestyle.

- i. The CHPCs will ensure that ASAP activities are carried out in accordance with guidance provided in this chapter.
- j. The garrison commander and/or CHPC may designate a PAT to review and evaluate ASAP activities for the community. If a PAT is designated, care must be taken to ensure its membership reflects a cross-section of the CHPC membership as a whole, and is not limited solely to BH assets.

4-7. Tobacco Control Program

- a. See chapter 7 for the Army policy on smoking in the workplace.
- b. The use of all forms of tobacco products during initial entry training is controlled for Soldiers (see chapter 7).
- c. Commanders and supervisors will encourage Family members and retirees to engage in appropriate anti-tobacco activities.
- d. As a part of routine physical and dental examinations and at other appropriate times, such as at prenatal and well baby clinics, health care providers will inquire about the patient's tobacco use, including use of smokeless tobacco products, and advise the patient of risks associated with use, the health benefits of abstinence, and where to obtain help to quit, such as the MEDCOM Web site concerning management of tobacco use (<https://www.qmo.amedd.army.mil/smoke/smoke.htm>).
- e. Installations will provide tobacco cessation programs for all health care beneficiaries and as resources permit, for civilian employees. If not available through military medical treatment facilities, commanders will coordinate programs through local community resources, such as the American Cancer Society and the American Lung Association. To the extent possible, occupational health clinics will provide tobacco cessation programs for civilian employees. If such programs are not feasible at a particular installation, the occupational health clinic will refer civilian employees seeking such a program to local community resources.

Chapter 5 Physical Health

5-1. General

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

5-2. Fitness and Health Program

a. *Physical fitness.* Physical fitness is defined as a set of attributes that one must have or achieve that relates to the ability to perform physical activity. Guidance on Soldier physical fitness is provided in AR 350-1 and in FM 21-20. The Physical Fitness Training Program includes the Army Reconditioning Program and guidance for the Army Pregnancy/Postpartum Physical Training Program.

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

c. *Army civilians.*

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

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

(3) The command may establish a total fitness program by subsidizing all or part of the cost of providing physical fitness facilities, or by other approved means.

(a) Commanders/supervisors may approve up to 3 hours administrative leave per week to allow employees to participate in command sponsored physical exercise training, monitoring, and/or education, provided these activities are an integral part of a total fitness program and are time-limited to 6 months in duration.

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

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

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

e. Use of physical fitness and recreation facilities.

(1) Fitness Extension Services. Commanders may use appropriated fund contracts for organizational memberships in local commercial or municipal fitness facilities only as prescribed in AR 215–1, paragraph 8–10.

(2) Army civilians who are not subject to mandatory physical fitness standards may use physical fitness and other recreational facilities to the maximum extent possible consistent with AR 215–1, chapter 7, on a space-available basis at no cost to the Government.

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

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

5–3. Injury prevention

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

a. Unit commanders will—

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

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

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

(4) Ensure Soldiers receive physical training appropriate to their levels of physical conditioning, and follow a gradual progression of physical training as outlined in FM 21–20 and in the Standardized Physical Training (SPT) Program (for initial entry training (IET)) in order to avoid unnecessary injury. Although the SPT program is specific to IET, the principles are applicable to operational units conducting physical training.

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

(6) Focus on achieving greater unit physical readiness by emphasizing improvements in the unit Army Physical Fitness Test (APFT) pass rate rather than the average unit APFT.

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

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

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

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

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

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

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

(5) Provide direct medical oversight and consultation to unit officers responsible for physical training in accordance with FM 21–20 and SPT.

5–4. Ergonomics

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

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

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

- (1) Interface with existing programs.
- (2) Include a written plan with goals and objectives.
- (3) Address the five critical program elements—workplace analysis, hazard prevention and control, health care management, education and training, and program evaluation. The degree of emphasis on each critical program element will vary according to the hazards and concerns at each installation.
- (4) Assist in procurement initiatives to ensure ergonomic design criteria are considered.

5–5. Oral health

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

- (1) Requiring a minimum level of dental health for active duty Soldiers.
- (2) Providing information to the community concerning the dental insurance program for Family members, and Reserve Component dental care.
- (3) Using the dental data from periodic health assessments as a tool to help evaluate community oral health.
- (4) Integrating hypertension screening and tobacco use counseling into the dental examinations and treatment plans.

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

(1) *Dental Readiness Program.* This program includes all traditional preventive dentistry activities described in AR 40–35. The Dental Readiness Program is designed to ensure that Soldiers maintain optimum oral health and do not lose valuable personal or unit time due to preventable dental disease or orofacial injuries.

(a) Each active duty Soldier is required to receive an annual dental examination. Results of the examination are used to establish a Dental Fitness Classification, which is monitored by the Soldier’s unit through the installation automated personnel database. Commanders will encourage Soldiers to attain and maintain Dental Fitness Class 1 (dental wellness) and ensure that Soldiers receive examinations and required treatment to maintain at least a Dental Fitness Class 2.

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

1. *Dental Fitness Class 1.* Patients with a current dental examination who do not require dental treatment or reevaluation.

2. *Dental Fitness Class 2.* Patients with a current dental examination who have an oral condition that requires treatment or reevaluation, but is unlikely to cause a dental emergency within 12 months.

3. *Dental Fitness Class 3.* Patients who are likely to have a dental emergency within 12 months.

4. *Dental Fitness Class 4.* Needs a dental examination, or dental status is unknown.

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

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

(a) Hypertension screening, referral, and follow-up.

- (b) Tooth decay, tobacco, periodontal, and oral cancer risk assessment.
- (c) Skin and lip cancer assessment.
- (d) Orofacial injury risk assessment and mouthguard fabrication.
- (e) Detection of signs of Family abuse and neglect.
- (3) *Community Oral Health Promotion and Disease Prevention Program*. Contents of the program include—
 - (a) Support the fluoridation of community water supplies.
 - (b) Alternative fluoride administration (supplement or fluoride varnish) to Family members by health care providers, such as physicians and nurses.
 - (c) Community education programs coordinated through partnerships with the local medical and installation communities to promote oral health to a broad audience.
 - (d) School-based programs established through a cooperative arrangement with on- or off-post schools that have a significant proportion of military dependent children in the area of responsibility. Dental Clinic Command dental activities will provide, on a separate space available basis, an oral screening examination (with parental consent), instructions on oral hygiene procedures, and topical application of anti-carcinogenic agents. Sports mouthguards and pit and fissure sealants may be provided as appropriate.
 - (e) Establishment of a system for reporting child neglect or abuse to the local Family Advocacy Program reporting point of contact, per AR 608–10.
- c. The proponent for oral health will ensure that community oral health promotion activities are carried out in accordance with guidance provided in this chapter.
- d. The senior mission commander and/or CHPC may designate a PAT to review oral health promotion activities for the community. If a PAT is designated, care must be taken to ensure that its membership reflects a cross-section of the CHPC membership as a whole and is not limited solely to dental assets.

5–6. Nutrition

- a. *Good nutrition*. Good nutrition and healthful eating are crucial elements for ensuring Soldier readiness and peak performance. Good nutrition is also important for promoting health and reducing chronic disease. Good health involves balancing proper eating habits with physical fitness and activity from an early age to ensure healthy lifestyle habits are inherently prioritized. The CHPC will recommend, coordinate, and ensure the integration of nutrition education programs for units, Soldiers, Family members, and Army civilians in their area of responsibility.
- b. *Registered dietician*. The RD is the consultant and nutrition expert for the MTF commander and the installation commander, and the RD is the food and nutrition expert for healthy lifestyle habits throughout the life cycle.
- c. *Nutrition care specialists*. The nutrition care specialist assists in the supervision of medical nutrition care operations to include preparing, cooking, and serving food for regular and modified diets in field and fixed hospitals. Nutrition care specialists work under the supervision of the RD.
- d. *Standards of practice*.
 - (1) Military Dietary Reference Intakes (MDRIs) prescribed in AR 40–25 provide guidelines and standards for feeding healthy Soldiers. They are intended for use by personnel involved in menu planning, dietary evaluation, nutrition education and research, and food research and development.
 - (2) The primary care provider will refer Soldiers to a RD for nutrition counseling when appropriate.
 - (3) The CHPC will assess the nutritional needs of Soldiers, their Families, and Army civilians. The council will ensure educational programs are offered to meet communities’ assessed nutritional health needs, while promoting necessary lifelong behavioral changes to maintain optimal health and wellness.
 - (4) Food advisors and food service managers will comply with the basic nutritional standards for installation dining facilities, in accordance with AR 30–22, which provides guidance for meeting nutrition standards in dining facilities and ensuring compliance with AR 40–25.
 - (5) Commanders will ensure that a RD is an active member of the CHPC.

5–7. Weight management

- a. *Underweight status*. Extremely underweight Soldiers are at risk for compromised health, performance, and readiness. Excessive weight loss could result from a stressful life situation that interferes with one’s typical eating habits, or it could result from eating disorders such as bulimia or anorexia nervosa. In either case, a registered dietitian can provide guidance on energy balance and nutritional requirements to achieve an ideal body weight.
- b. *Overweight status*. There is an alarming increase in the number of people who are overweight and obese. An overweight status results when a person consumes more calories from food and beverages than are burned through physical activity. Soldiers who are overweight or obese increase their risk for type 2 diabetes, coronary heart disease, high blood pressure, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and some types of cancer. Weight loss is helpful in improving the health outcomes of these diseases.
- c. *Standards*. Soldiers are responsible for complying with weight control standards as specified in AR 600–9.
- d. *Guidelines*.

- (1) Commanders and supervisors will ensure Soldiers are provided educational support programs in accordance with AR 600–9 and AR 40–25 in order to attain and maintain proper body fat standards. Negative motivational programs should not be used, as they result in Soldiers using unsafe fad diets and dietary supplements in an attempt to lose weight quickly, as opposed to smart nutrition and training practices that result in long term, safe weight loss.
- (2) Soldiers who exceed body fat standards may be subject to separation procedures, as established in AR 600–9.

Chapter 6

Spiritual Fitness

6–1. General

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

6–2. Spiritual fitness

- a.* Commanders at all levels shall encourage and provide for human self-development activities leading to increased spiritual fitness in accordance with this regulation, AR 600–20, AR 165–1, and other applicable directives.
- b.* Army leaders should develop an awareness of the lifestyles, cultural backgrounds, stages of development, possible relationships to religious beliefs, and the needs of their Soldiers, Army civilians, and Family members. The CHPC will recommend, coordinate, and ensure the integration of spiritual fitness programs for units, Soldiers, Family members, and Army civilians in their area of responsibility.
- c.* Commanders at the installation state JFHQ, DRU/MSC, and community level shall develop Soldiers and Family support activities to undergird, reinforce, and implement the enhancement of spiritual fitness. They will ensure time is scheduled for activities, programs, and training to accomplish the goals of spiritual fitness programs.
- d.* In providing for self-development activities, commanders and other leaders must ensure they do not favor one form of religion over another. The practice of religion, to the extent that it relates to spiritual fitness, must be left to the sole discretion of the Soldier, Family member, or Army civilian. They must be free to worship or not worship as they choose without fear of being disciplined or stigmatized for their choice. (See AR 165–1 and AR 600–20).
- e.* All Soldiers and Army civilians are expected to live by the tenets of the professional Army ethic and those individual values that support and sustain the Army way of life. (See FM 1.)

Chapter 7

Environmental Health

7–1. General

- a.* The overall mission of environmental health programs is to create and maintain a supportive, safe, and healthy environment. This is accomplished through two primary mechanisms. First, environmental health programs strive to achieve and sustain health-enhancing human environments that are protected from biological, chemical, and physical hazards, and are secure from the adverse effects of environmental threats. Programs in this category include but are not limited to air quality, water quality (including fluoridation), toxic management and pesticide use, and a wide range of workplace health and safety issues. Second, environmental health is promoted through proactive public health policies that reduce risk from environmental exposures and encourage healthy lifestyles. Programs in this category include but are not limited to tobacco control practices, and policies governing MWR facilities, such as hours of operation.
- b.* The CHPC will recommend, coordinate, and ensure the development and integration of appropriate environmental health programs and policies for units, Soldiers, Family members, and Army civilians in their communities.

7–2. Guidance for controlling tobacco use in DA controlled areas

- a.* Using tobacco products (to include cigarettes, cigars, cigarillos, smokeless tobacco, inhaled tobacco, and all other tobacco products designed for human consumption) harms readiness by impairing physical fitness and by increasing illness, absenteeism, premature death, and health care costs. Readiness will be enhanced by promoting the standard of a tobacco-free environment that supports abstinence from, and discourages the use of any tobacco product.
- b.* Full cooperation of all commanders, supervisors, Soldiers, and Army civilians is expected to ensure people are protected from the harmful effects of tobacco products.
- c.* All organizational elements (Active Army and Reserve Components; appropriated and nonappropriated fund

civilian personnel) that occupy space in or on conveyances, offices, buildings, or facilities over which DA has custody and control will comply with Army policy and guidance. This includes space assigned to the Army by the General Services Administration or space contracted from other sources.

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

7-3. Policy for controlling tobacco use

a. Tobacco use is prohibited in all DA-occupied workplaces except for designated smoking areas, as authorized by DODI 1010.15, Smoke-Free DOD Facilities. The workplace includes any area inside a building or facility over which DA has custody and control, and where work is performed by military personnel, civilians, or persons under contract to the Army.

(1) Notices will be displayed at entrances to buildings and facilities over which DA has custody and control that state that smoking is not allowed except in designated smoking areas. Designated smoking areas must comply with the provisions of DODI 1010.15.

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

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

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

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

d. Health care providers will not use any tobacco products in the presence of patients. Military treatment facility commanders will ensure that the latest Veterans Affairs/DOD Clinical Practice Guidelines concerning Management of Tobacco Use are in use and enforced in all primary care facilities on the installation (see <http://www.oqp.med.va.gov/cpg/cpg.htm>).

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

f. Use of tobacco products is prohibited in and at all CYS facilities and sports fields, except in designated areas out of the presence or view of children/youth.

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

h. The use of any tobacco products during initial entry training is governed by TRADOC Regulation 350-6, Enlisted Initial Entry Training (IET) Policies and Administration, 30 Dec 05. Cadre and faculty of any military school will not use tobacco products in the presence or view of students while on duty. All personnel attending training provided by the Army, regardless of service, will adhere to Army policy regarding the use of tobacco products. Commandants will evaluate their policies and practices to eliminate conflicting messages on use of tobacco products.

i. Health education classes regarding the use of tobacco products and its related health problems will be provided throughout professional military training. Classes will be offered during basic and advanced courses for enlisted and officer (warrant and commissioned) Soldiers.

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

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

l. Installations will provide tobacco use cessation programs for all health care beneficiaries. If not available through MTFs, commanders will coordinate programs through local community resources, such as the American Cancer

Society and American Lung Association. To the extent possible, occupational health clinics will provide tobacco use cessation programs for Army civilian employees. If such programs are not feasible at a particular installation, the occupational health clinic will refer civilian employees seeking such a program to local community resources.

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

7-4. Signs for controlling tobacco use

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

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

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

7-5. Enforcement for controlling tobacco use

Failure to comply with the prescribed policy subjects Active Army and Reserve Component Soldiers, Family members, retirees, and appropriated and nonappropriated fund civilian personnel to a variety of penalties. The penalty depends on the nature of the violation, the status of the offender, and other relevant factors. Violation of Army policies subjects military personnel to a variety of possible administrative or disciplinary actions (such as counseling or reprimand) and it subjects civilian personnel to possible disciplinary actions. Repeat violations also can result in the removal of personnel from activities or barring them from activities (MWR facilities, youth activity center, and so forth) or installations.

Appendix A References

Section I Required Publications

AR 30–22

The Army Food Program (Cited in para 5–6.)

AR 40–5

Preventive Medicine (Cited in para 5–4.)

AR 40–25

Nutrition Standards and Education (Cited in paras 5–6, 5–7.)

AR 40–35

Dental Readiness and Community Oral Health Protection (Cited in para 5–5.)

AR 165–1

Chaplain Activities in the United States Army (Cited in para 6–2.)

AR 215–1

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

AR 350–1

Army Training and Leader Development (Cited in para 5–2.)

AR 600–9

The Army Weight Control Program (Cited in para 5–7.)

AR 600–20

Army Command Policy (Cited in para 6–2.)

AR 600–85

The Army Substance Abuse Program (Cited in para 4–6.)

AR 608–10

Child Development Services (Cited in para 5–5.)

FM 1

The Army (Cited in para 6–2.)

FM 5–19

Composite Risk Management (Cited in paras 1–5, 5–3.)

FM 6–22.5

Combat and Operational Stress Control Manual for Leaders (Cited in para 4–2.)

FM 21–20

Physical Fitness Training (Cited in paras 5–2, 5–3.)

Section II Related Publications

A related publication is a source of additional information. The user does not have to read it to understand this publication.

AR 15–6

Procedures for Investigating Officers and Boards of Officers

AR 190-45
Law Enforcement Reporting

AR 195-2
Criminal Investigation Activities

AR 385-10
The Army Safety Program

AR 600-8-4
Line of Duty Policy, Procedures, and Investigations

AR 608-1
Army Community Service Center

DA Pam 40-21
Ergonomics Program

DA Pam 600-24
Health Promotion, Risk Reduction, and Suicide Prevention

TRADOC Reg 350-6
Enlisted Initial Entry Training (IET) Policies and Administration (Cited in para 7-3.) (Available at <http://www.tradoc.army.mil/tpubs/regndx.htm>.)

DODD 1010.10
Health Promotion and Disease/Injury Prevention (Available at <http://www.dtic.mil/whs/directives/>.)

DODI 6055.1
DOD Safety and Occupational Health (SOH) Program (Available at <http://www.dtic.mil/whs/directives/>.)

DSM-IV
Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (This manual may be ordered at <http://www.appi.org>.)

Section III **Prescribed Forms**

Unless otherwise indicated, DA Forms are available on the APD Web site (<http://www.apd.army.mil>).

DA Form 5560
No Smoking (Prescribed in para 7-4.)

DA Form 5560-1
Designated Smoking Area (Prescribed in para 7-4.)

Section IV **Referenced Forms**

DA Form 2028
Recommended Changes to Publications and Blank Forms

DD Form 1300
Report of Casualty

Appendix B

Internal Control Evaluation Checklist

B-1. Function

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

B-2. Purpose

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

B-3. Instruction

Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key internal controls must be formally evaluated prior to each milestone decision review. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2 (Internal Control Evaluation Certification).

B-4. Test questions

a. Has the Chief of Public Affairs developed and implemented a public affairs plan in support of the Army Health Promotion Program?

b. Has a suicide prevention program manager (SPPM) been appointed at the U.S. Army Installation Management Command-, ARNG- and USAR-level, to provide assistance for the execution of the Army Suicide Prevention Program, and to serve as a liaison to the DCS, G-1, and supported ACOM, ASCC, and DRU SPPMs?

c. Has a SPPM been appointed by the ACOM, ASCC, and DRU commanders to provide assistance for, and staff supervision of the ASPP?

d. Has a suicide prevention plan been developed and implemented by ACOM, ASCC, and DRU commanders?

e. Has each garrison commander established a Community Health Promotion Council?

f. Have commanders at all levels developed a health promotion policy that includes suicide prevention?

g. Have provisions been implemented by commanders to ensure that Soldiers identified with suicide risk symptoms and behaviors are not belittled, humiliated, or ostracized by other Soldiers?

h. Does the SPPM administer suicide prevention for both military and DA civilians, serve as the presiding officer of the Suicide Prevention Task Force, and track suicide prevention training?

i. Is the appropriate ACE suicide prevention training administered annually to all Soldiers and DA civilians and made available to Family members?

j. Is the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention (ACPHP) Compliance Checklist utilized by commanders to measure compliance with ACPHP initiatives?

B-5. Supersession

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

B-6. Comments

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

Glossary

Section I Abbreviations

ACE

ask, care, escort

ACOM

Army Command

ACPHP

Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

ACS

Army Community Service

ACSIM

Assistant Chief of Staff for Installation Management

AFME

Armed Forces Medical Examiner

AMEDD

Army Medical Department

APFP

Army Physical Fitness Program

APFS

Army Physical Fitness School

APFT

Army physical fitness test

ARNG

Army National Guard

ARNGUS

Army National Guard of the United States

ASAP

Army Substance Abuse Program

ASCC

Army Service Component Command

ASER

Army Suicide Events Report

ASPP

Army Suicide Prevention Program

ATTN

Attention

BH

behavioral health

BOLC

Basic Officer Leader Course

CAR

Chief, Army Reserve

CCH

Chief of Chaplains

CG

Commanding general

CGSETAF

Commanding General for South Eastern Task Force

CHEP

Community Health Education Program

CHP

Community health promotion

CHPC

Community Health Promotion Council

CMHS

Community Mental Health Service

COD

Community operation division

COE

Chief of Engineers

COSC

Combat and operational stress control

COSC-WARS

Combat and Operational Stress Control-Work Activity Recording System

COSR

Combat and operational stress reaction

CPA

Chief of Public Affairs

CPO

Civilian personnel officer

CRC

Combat Readiness Center

CRM

Composite risk management

CSC

Combat stress control

CYS

Child and Youth Services

DA

Department of the Army

DCoE

Defense Centers of Excellence

DCS

Deputy Chief of Staff

DCS, G-1

Deputy Chief of Staff, G-1

DCS, G-4

Deputy Chief of Staff, G-4

DENTAC

Dental activity

DOD

Department of Defense

DODD

Department of Defense directive

DODEA

Department of Defense Educational Activity

DODI

Department of Defense instruction

DODSER

Department of Defense Suicide Event Report

DRU

Direct reporting unit

DSM-IV

Diagnostic and Statistical Manual of Mental Disorders, 4th edition

FAPM

Family Advocacy Program Manager

FMSPP

Family Member Suicide Prevention Program

FMWRC

Family, Morale, Welfare and Recreation Command

HIV

human immunodeficiency virus

HQDA

Headquarters, Department of the Army

HVAC

Heating/ventilation/air conditioning

IET

Initial entry training

IMCOM

Installation Management Command

IPP

Installation Prevention Plan

IPT

Installation Prevention Team

IRR

Individual Ready Reserve

ISRT

Installation Suicide Response Team

JFHQ

Joint Force Headquarters

MDRI

Military dietary reference intakes

MEDDAC

Medical Department Activity

MEDCEN

Medical center

MEDCOM

Medical command

MOA

Memorandum of Agreement

MSC

Major Subordinate Command

MTF

Medical treatment facility

MWR

Moral, welfare, and recreation

NCO

Noncommissioned officer

PAO

Public affairs officer

PAT

Process Action Team

PDHA

Post deployment health assessment

PDHRA

Post deployment health reassessment

RD

Registered dietician

RMT

Risk management team

RRP

Risk Reduction Program

RSC

Regional Support Command

SIR

Serious Incident Report

SME

Subject matter expert

SOS

Survivor Outreach Services

SPPM

Suicide Prevention Program Manager

SPT

Standardized physical training

SPTF

Suicide Prevention Task Force

SRT

Suicide Response Team

STI

Sexually transmitted infection

TJAG

The Judge Advocate General

TPU

Troop program unit

TRADOC

Training and Doctrine Command

TSG

The Surgeon General

UMT

Unit ministry team

UPH

Unaccompanied personal housing

USACHPPM

United States Army Center for Health Promotion and Preventive Medicine

USACHPPM–DHPW

United States Army Center for Health Promotion and Preventive Medicine-Directorate of Health Promotion Wellness

USACIDC

U.S. Army Criminal Investigation Command

USAHRC

U.S. Army Human Resources Command

USAR

U.S. Army Reserve

USARCEN

U.S. Army Central Command

USARPAC

U.S. Army Pacific Command

USARSOUTH

U.S. Army Southern Command

USSOCOM

U.S. Special Operations Command

TRADOC

Training and Doctrine Command

Section II**Terms****Army Substance Abuse Program**

A comprehensive program designed to eliminate substance abuse, including prevention, identification, education, and rehabilitation services. It includes nonresidential and residential treatment.

Battle buddy system

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

Behavioral health provider

Trained mental health person who is credentialed or licensed as a psychiatrist, clinical or counseling psychologist, social worker, or psychiatric nurse practitioner/psychiatric nurse specialist.

Body composition

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

Equivocal death

Cases where the available facts and circumstances do not immediately distinguish the mode of death are called "equivocal." Ambiguity or uncertainty existing among any of the four identified modes of death makes it equivocal.

Fitness Coordinator

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

Flexibility

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

Geographically dispersed

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

Health

Term used to describe the general condition of the body. Good health is normally characterized by functioning optimally and freedom from disease and abnormality.

Health care providers

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

Health promotion

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

Hypertension identification

Actions to identify early those health risk factors such as high blood pressure, including smoking, cholesterol level, weight, Family history, nutrition, and inactivity. These actions include early identification, provision of information regarding control and lifestyle factors, and treatment referral.

Mode (manner) of death

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

Muscular endurance

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

Muscular strength

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

Nutrition

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

Physical fitness

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

Psychological autopsy

A procedure designed to clarify the nature of an individual's death by focusing on the psychological aspects of the person. The primary purpose of the autopsy is to reconstruct and understand the circumstances, lifestyle, and state of mind of the individual at the time of death.

Self-harm

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

Spiritual fitness

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

Stress management

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

Suicide

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

Suicide attempt

A self-inflicted potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury. Therefore, this category includes behaviors where there is evidence that the individual intended to die, but the event resulted in no injuries.

Suicidal ideation

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

Suicide prevention

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

Suicide prevention task force

A committee responsible for planning, implementing, and managing the local Army Suicide Prevention Program.

Unit ministry team

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

Section III**Special Abbreviations and Terms**

This section contains no entries.

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