DEPARTMENT OF THE ARMY
UNITED STATES ARMY EUROPE
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26 October 2018

MEMORANDUM FOR

HQ USAREUR Staff Principals
All Army in Europe Commanders
Director, IMCOM-Europe

SUBJECT: USAREUR Suicide-Prevention Action Plan (AE Cmd Memo 2018-029)

This memorandum expires in 3 years.

1. Purpose. This memorandum—

a. Outlines general and specific command policy, guidance, and reporting procedures to be used by Army in Europe command teams in planning, prioritizing, and executing the USAREUR Suicide-Prevention Action Plan (SPAP).

b. Reemphasizes the requirement for unit leaders at the brigade level and above to prepare and publish a command suicide-prevention and -intervention action plan no later than 1 December 2018. The action plan must include verbiage that specifically promotes help-seeking behavior, destigmatizes obtaining behavioral-health (BH) support, and expresses intolerance for those who are critical of individuals who seek help by pursuing BH options.

c. Establishes the requirement for the expanded use of the "Global Assessment Tool (GAT)" (glossary) and Unit Risk Inventory (URI). Family members are highly encouraged to take part in community suicide-awareness and -prevention training on a voluntary basis.

d. Clarifies suicide-prevention training requirements and the associated target audiences.

e. Reemphasizes the requirement for first-line supervisors to engage subordinates (at least annually) to ensure they are aware of and have access to services and programs that promote healthy behavior.

f. Eliminates the terms "gesture" and "suicidal gesture" from all suicidal-behavior-incident reporting requirements and data collection. This will better align USAREUR suicidal-behavior-incident identification and description verbiage with DOD and the generally accepted clinical terminology (that is, "suicide," "suicide attempt," and "suicidal ideation" (glossary)).

g. Modifies suicidal-behavior reporting requirements. The USAREUR Consolidated Staff Inspection team will ensure that units comply with these requirements.

2. References. Appendix A (encl 1) lists references.

3. Abbreviations and Terms. The glossary in appendix B (encl 2) defines abbreviations and terms used in this memorandum.

4. Applicability. The USAREUR SPAP applies to all Army in Europe Soldiers and Department of the Army (DA) civilian employees.

5. Command Policy.

a. General.

(1) The USAREUR Senior Commander's (SC) philosophy on suicidal behavior within the ranks is that command teams and leaders at all levels must take reasonable, timely, and prudent steps to continuously reduce incidents of suicidal behavior within their area of responsibility (AOR). Our collective goal is to reduce incidents of suicide by 10 percent by 1 January 2020. Steps to reduce suicidal behavior include—

(a) Ensuring unit compliance with the policy, guidance, and requirements outlined in this memorandum.

(b) Ensuring subordinate-unit leaders are actively and effectively engaging Soldiers, Army Civilians, and Family members in promoting the USAREUR SPAP.

(c) Visibly demonstrating support and encouragement to those who seek BH support; concern for the well-being of all those who the unit encompasses; and intolerance for those who seek to undermine, stigmatize, or denounce help-seeking behavior.

(2) Leaders at all levels must develop and maintain a working knowledge of current "proximal risk factors" (glossary) consistently identified during the review and analysis of suicidal-behavior incidents. According to the DOD Suicide Risk Management and Surveillance Office, current Soldier proximal risk factors include relationship issues, substance abuse, financial issues, and legal or administrative proceedings associated with incidents of indiscipline.

(3) "First-line supervisors and junior leaders" (glossary) are pivotal components of the USAREUR SPAP because of their daily interaction with subordinates, situational

awareness, and ability to routinely assess the well-being of our team members. It is therefore incumbent on our junior leaders and first-line supervisors to engage subordinates (at least quarterly) to ensure they are aware of and able to access services and programs that promote healthy behavior.

(4) The "Commander's Risk Reduction Dashboard (CRRD)" (glossary) is designed to help battalion- and company-level commanders recognize trends in Soldiers and units who may be at an elevated risk of suicide or have a documented history of high-risk behavior. All Army battalion- and company-level commanders will establish and maintain a CRRD account and review unit personnel CRRD data at least monthly.

(5) Effective immediately, all unit personnel will use Ask, Care, Escort–Suicide Intervention (ACE-SI) skills when needed.

(6) Some scientific research suggests a direct and statistically significant relationship between suicide or attempted suicide and a three-component suicidal-behavior model (developed by Dr. Thomas Joiner). The three components are as follows:

(a) Thwarted belongingness (that is, the thought that one is involuntarily or voluntarily socially isolated).

(b) Perceived burden (that is, the thought that one is a burden on others in some way).

(c) Desensitization to violence and a decreased fear of pain.

(7) To save individuals from the perceptions in (6)(a) through (c) above, leaders at all levels must sustain a robust and effective sponsorship program, take reasonable and recurring measures to promote unit cohesiveness and esprit de corps (including Family members), and sustain a supportive and compassionate command climate.

b. Specific.

(1) No later than 1 December 2018, each command team at the brigade level and above will prepare and publish an SPAP that addresses at least the following:

(a) A commitment to support the Army and USAREUR goal of reducing the incidents of suicidal behavior through awareness, education, promotion of help-seeking behavior, and bystander intervention.

(b) The requirement for unit leaders (with emphasis on junior leaders) to assemble at least annually and discuss suicidal behavior, associated proximal risk factors and warning signs, and the availability of preventive and educational services and programs. Group assemblies will not exceed 12 personnel, and discussions will be facilitated by first-line supervisors.

(c) Promotion of recurring and coordinated command-team engagements with respective local service and program agencies and personnel (for example, garrison suicide-prevention-program managers (SPPMs), Army Substance Abuse Program managers (ASAPMs), unit and garrison chaplaincy).

(d) A clear and concise Unit Watch policy by which subordinate unit leaders ensure that protective measures are in place for high-risk Soldiers. The Unit Watch policy will address at least weapons profiles, access to Government-issued and privately owned weapons, and battle-buddy designations for Soldiers identified by BH professionals as being at risk of suicide.

(e) The requirement for commanders to complete an investigation on all suspected Soldier suicides in accordance with AR 15-6 and AR 600-63, paragraph 1-31s.

(f) The requirement for commanders to complete DA Form 7747 and comply with the reporting procedures outlined in AR 600-63, paragraph 1-31w.

(g) The URI as the mandated tool for command teams and first-line supervisors to review, assess, and develop appropriate responses to individuals who are at risk of suicide. The installation risk-reduction coordinator or the staff member responsible for the Army Substance Abuse Program will coordinate and conduct this inventory at least annually. Reference material and resources on suicide prevention are available at *http://www.armyg1.army.mil/hr/suicide/commandertoolkit.asp*.

(h) The commitment to support the installation-based Family member suicide-prevention program (FMSPP).

(i) The requirement for unit suicide-prevention training, ACE-SI training, Applied Suicide Intervention Skills Training (ASIST), battalion and company assemblies ((b) above), health-promotion service and program terrain walks, and Comprehensive Soldier and Family Fitness events.

(j) The requirement to ensure maximum commander participation in commanders ready and resilient councils (CR2Cs).

(2) Command teams will ensure that all battalion- and company-level commanders establish a CRRD account on taking command and assess unit personnel with a documented history of high-risk behavior at least monthly.

6. Command Training Guidance.

a. ACE-SI. ACE-SI is a 4-hour training module for all company-level junior leaders and first-line supervisors including squad and section leaders, platoon sergeants, platoon leaders, first sergeants, executive officers, company commanders, and Army Civilians assigned at the company level. The key objectives are to provide training in the skills required to perform a suicide-risk assessment and to intervene in a suicide situation. ACE-SI is a one-time training requirement.

b. ACE-SI Train-the-Trainer (T4T) Module. ACE-SI T4T is a 6-hour training module separated into two tiers. Tier I is for trainers who train and certify other trainers after they have completed at least three ACE-SI 4-hour workshops and have been certified by the garrison SPPM. Tier II is for trainers who will provide or ACE-SI training only to the target audience (for example, Soldiers, Army Civilians, junior leaders, first-line supervisors).

c. Applied Suicide Intervention Skills Training (ASIST) 11. ASIST 11 is a 2-day Army-approved intervention training course for primary and secondary gatekeepers. (AR 600-63, table 4-1, provides a list of gatekeepers.) It is a one-time optional training course for which the DA G-1 determines and authorizes the curriculum. The primary purpose of ASIST is to provide gatekeepers with advanced suicide-intervention skills, including the ability to—

(1) Develop an understanding of how personal and societal attitudes affect views on suicide and intervention.

(2) Provide guidance and suicide first aid to a person at risk in a way that meets the individual’s safety needs.

(3) Identify the key elements of an effective suicide safety plan and the actions required to implement the plan.

(4) Appreciate the value of improving and integrating suicide-prevention resources in the community at large.

(5) Recognize and help individuals who show suicide-related warning signs or risk factors.

7. Responsibilities.

a. USAREUR SC. The USAREUR SC will—

(1) Appoint, in writing, a USAREUR SPPM to provide assistance for and staff oversight of the USAREUR SPAP.

(2) Through the USAREUR SPPM and during the USAREUR CR2C, review suicidal-behavior data and command trends and provide guidance on developing, implementing, and improving programs, processes, and procedures designed to achieve and sustain Army health-promotion goals and objectives.

(3) Through the USAREUR SPPM, ensure the USAREUR SPAP is reviewed and updated annually to reflect DOD and DA policy, guidance, and training requirements.

b. Senior Responsible Officers (SROs). SROs will convene a fatality review board (FRB) following all suicide completions in their AOR. The FRB serves to identify and incorporate lessons learned for improvements in programs and services and should comprise at least the following members:

(1) The SRO.

(2) The garrison director of human resources or casualty affairs officer or both.

(3) The unit chaplain.

(4) The unit commander; the brigade command sergeant major (CSM), the battalion CSM, or the company first sergeant, or all of them (depending on the level of assignment of the deceased within the unit); and the supervisor of the deceased.

(5) The commander of the respective medical treatment facility (MTF).

(6) The serving staff judge advocate.

(7) The commander of the local criminal-investigation activity.

(8) The installation suicide-prevention coordinator.

c. HQ USAREUR Staff Offices.

(1) Office of the Deputy Chief of Staff (ODCS), G1. The ODCS, G1, will—

(a) Serve as the staff proponent of the USAREUR SPAP.

(b) Staff the USAREUR SPPM as a full-time position, exempt the position from any planned or projected manpower resource reductions, and ensure that sufficient operational funding (for example, TDY funding) is available to execute mission-essential requirements.

(c) Develop, coordinate, and maintain oversight of the USAREUR SPAP.

(d) Obtain, compile, develop, and analyze suicidal-behavior data, statistics, and trends.

(e) Provide a suicide-prevention and -intervention briefing to all newly assigned commanders, rear-detachment commanders, CSMs, and Family support groups during USAREUR Precommand and Company Commanders/First Sergeants Courses.

(f) In coordination with the Office of the Public Affairs Officer (PAO) and the ODCS, G6, seek to develop automated search engines and notification software to be used in identifying suicidal-behavior verbiage within Army in Europe and unit social-media venues.

(g) Maintain an updated roster of all Army in Europe suicide-prevention POCs.

(2) Office of the PAO. The Office of the PAO will—

(a) On request, coordinate public awareness campaigns for suicide prevention.

(b) Coordinate proposed releases of Army in Europe suicidal-behavior data with the USAREUR SPPM before releasing the data to the media.

(3) Office of the Command Surgeon (OCSURG). The OCSURG will—

(a) Inform the USAREUR SPPM and USAREUR command teams about proximal risk factors and stress factors that may result in increased numbers of persons at risk for suicide based on data obtained from Department of Defense Suicide Event Reports (DODSERs), psychological autopsies, and other relevant sources.

(b) In coordination with the Regional Health Command Europe (RHCE), take reasonable efforts within available resources to ensure "BH healthcare providers" (glossary) support training events and are available to facilitate the clinical assessment, intervention, and evaluation of high-risk personnel.

(c) In coordination with the USAREUR SPPM, coordinate and periodically monitor in-service training for human-service professionals (for example, chaplains, BH healthcare providers, and "healthcare providers" (glossary).

(4) Office of the Chaplain. The Office of the Chaplain will—

(a) On request, designate a chaplain to serve on the USAREUR-led "suicide-prevention task force (SPTF)" (glossary).

(b) Ensure "unit ministry teams (UMTs)" (glossary) use the training sources identified in this memorandum (for example, ACE-SI, ASIST) as the principal tools for conducting suicide-prevention training.

(c) Ensure all UMTs can recognize and help individuals with suicide-related warning signs or risk factors.

(5) Office of the Provost Marshal (OPM). The OPM will establish policy for USAREUR reporting in accordance with AE Regulation 190-45.

d. Unit Commanders. Unit commanders will—

(1) Demonstrate sensitivity and responsiveness to the needs of Soldiers, Army Civilians, and Family members.

(2) Become familiar with the community agencies that provide suicide-prevention support.

(3) Use AR 600-63 and this memorandum to—

(a) Publish a health-promotion policy that supports healthy behavior and includes suicide-prevention and -intervention measures.

(b) Ensure that Soldiers showing suicide-risk symptoms or behavior are consistently cared for and not degraded, humiliated, or ostracized.

(c) Promote the "battle-buddy system" (glossary) for all Soldiers.

(d) Ensure that Soldiers are treated with dignity and respect and are encouraged to seek assistance when experiencing personal challenges or after they have been identified as showing suicide-risk symptoms.

(e) Ensure compliance with paragraph 5b(1)(d).

(f) Refer Soldiers who are undergoing disciplinary actions or who are identified as having additional proximal risk factors to appropriate support services to mitigate the potential for suicide.

(g) Ensure that Families, unit members, and coworkers who experience loss due to suicide are offered assistance.

(h) Initiate proactive measures to prevent “contagion suicides” (glossary).

(i) Conduct an investigation of every suicide in accordance with AR 15-6.

(j) Establish task forces, committees, and risk-reduction teams to facilitate local health-promotion initiatives to reduce high-risk behavior and build individual resiliency.

(k) Maintain awareness of suicide-prevention training resources and related items of interest available at *http://www.armyg1.army.mil/hr/suicide/default.asp* and *https://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePreventionEducation.aspx*.

(l) Ensure that each unit at the company level and above has at least two suicide-intervention-skills trainers capable of conducting ACE-SI training.

(m) Ensure that a resource professional such as a chaplain or BH specialist is present or on call when conducting ACE-SI or ASIST training.

(n) Maintain a list of community agencies that provide crisis-prevention and -intervention services and post the list in public areas (for example, barracks, dining facilities). Commanders should consult these agencies and become familiar with their services before a crisis occurs. They should also maintain contact with their respective garrison SPPMs and ASAPMs.

(o) Develop a suicide “postvention” (glossary) plan and implement it as necessary.

e. IMCOM-Europe.

(1) Garrison Leaders and Staff Members. Through garrison leaders and staff members, IMCOM-Europe will execute community oversight responsibilities and ensure community suicide-prevention and -intervention programs emphasize the following:

(a) Education. Garrisons will ensure suicide-prevention and -intervention educational resources are available to support unit- and community-based educational activities.

(b) Crisis Intervention. Garrison SPPMs and ASAPMs will maintain and distribute a list of community agencies that provide crisis-intervention services.

(c) Treatment. Garrisons will maintain and distribute a list of MTF departments, services, and community and unit counseling agencies that provide treatment.

(d) "Postvention." Garrisons will develop plans to manage the adverse effects of suspected and attempted suicides. The goal is to support those affected by promoting a healthy recovery, mitigating the possibility of suicide contagion, strengthening unit cohesion, and promoting continued individual and mission readiness.

(2) Garrison Community Ready and Resilient Integrators (CR2Is), SPPMs, and ASAPMs.

(a) Garrison SPPMs or ASAPMs will chair garrison SPTFs and coordinate the efforts of the task-force members.

(b) Garrison CR2Is, SPPMs, and ASAPMs will—

1. Serve as members on CR2Cs.

2. On request, provide advisory services to command-team personnel regarding the garrison suicide-prevention program.

3. Make every reasonable effort to integrate suicide prevention into Soldier, Army Civilian, community, and Family support programs.

4. Develop, coordinate, and implement an installation-based FMSPP in accordance with AR 600-63, paragraph 4-8.

(c) SPPMs will maintain a record of all certified ACE-SI trainers and provide this information to the responsible CR2I on a quarterly basis.

f. United States Army Criminal Investigation Command (USACIC). The USACIC will—

(1) Investigate suspected cases of suicide.

(2) Request a DODSER on suicide victims from appropriate healthcare professionals.

(3) Ensure a "psychological autopsy" (glossary) (para 8f) is performed only in cases where the manner of death is unclear.

(4) Establish liaison with local civilian law-enforcement agencies, coroners, and medical examiners to obtain information about off-post suicide-related events involving military personnel, Army civilian employees, or Family members.

g. RHCE.

(1) The CG, RHCE, will appoint, in writing, an RHCE DODSER program manager (PM) who will ensure that each MTF commander appoints a DODSER POC for the purpose of preparing and submitting DODSERs to the DODSER PM at the DOD.

(2) RHCE MTF commanders will—

(a) Serve as principal medical advisors to unit and garrison commanders with respect to the Army CR2C.

(b) Provide equipment and healthcare personnel to administer the self-reported health-information tool, interpret self-reported health information, teach classes, compile statistics to support the Army CR2C, and review and assess postdeployment health-assessment and -reassessment updates as required.

(c) Use process action teams to address specific issues involving "health promotion" (glossary) at the MTFs.

(d) Partner with unit and garrison staffs in their areas of operation to prioritize health-promotion services.

(e) Develop, coordinate, and implement health-promotion programs through garrison CR2Cs and the USAREUR CR2C.

(f) Develop and implement protocols to identify and manage suicidal patients in each patient-care unit of their MTFs and provide in-service suicide-prevention training for healthcare providers.

(g) Provide a credentialed mental-health officer to conduct a psychological autopsy (para 8f) when required by policy.

(h) Provide advice and assistance to Reserve-component commanders to facilitate and implement health-promotion policy.

8. Suicidal-Behavior Surveillance and Reporting. Suicidal-behavior surveillance is crucial to understanding the magnitude of various types of suicidal behavior and to identifying trends, factors, and reasons for such behavior. The knowledge gained from surveillance can then be applied to preventive measures. Surveillance will be accomplished through the following:

a. Command Interest Item (CII). A CII is the primary means for a unit to initially notify HQ USAREUR of all incidents of suicidal behavior (that is, suspected deaths by suicide, suicide attempts, and suicidal ideations). Units will submit CIIs to the USAREUR Watch Officer as follows:

(1) Suspected deaths by suicide must be reported within 12 hours after the alleged incident.

(2) Suspected suicide attempts must be reported within 24 hours after the alleged incident.

(3) Suicidal ideations must be reported within 48 hours after the alleged incident.

b. DA Form 7747, Commanders Suspected Suicide Event Report. Commanders (all Army components) must prepare and submit DA Form 7747 to the Law Enforcement Liaison Officer, OPM, HQ USAREUR, for every suspected suicide or "equivocal death" (glossary) that is being investigated as a possible suicide. Active Army units are required to submit an initial report within 5 calendar days after a death, and all units (including Army National Guard and United States Army Reserve units) are required to submit a completed report within 30 calendar days.

c. Line-of-Duty Investigation (LoDI). An LoDI will be conducted in accordance with AR 600-8-4 on all deaths of Soldiers who, at the time of death, were on active duty or in an inactive-duty training status, or for whom the death is suspected to be connected to a previous duty incident.

d. DD Form 2996, Department of Defense Suicide Event Report. Designated MTF DODSER POCs will complete and submit DODSERs for all suicides and for suicide attempts and suicidal ideations that result in hospitalization to the DODSER PM at the DOD. This includes evacuations from the theater where the injury or injurious intent is self-directed ("self-harm" (glossary)). For each event confirmed by the Armed Forces Medical Examiner (AFME), the DODSER PM at the DOD will send formal requests to complete DD Form 2996 through MTF commanders to DODSER POCs. Followup messages will be sent for all events for which a DD Form 2996 is not received within the required 60 calendar days. For suicide attempts and suicidal ideations resulting in hospitalization, MTF commanders are responsible for ensuring a DD Form 2996 is submitted within the required 30 calendar days.

e. Suicide Response Team (SRT). According to AR 600-63, the SRT will convene within 48 hours after an attempted or completed suicide to support the command and installation affected by the incident. The SRT will also institute procedures within the affected unit to facilitate the identification, evaluation, and medical evacuation of Soldiers at an increased risk of suicide. SRTs should comprise at least the following:

(1) A surgeon or medical doctor.

(2) A psychiatrist or BH professional.

(3) The battalion or separate company commander.

(4) A chaplain.

(5) An SPPM.

(6) A representative of the garrison staff judge advocate.

(7) A representative of the garrison provost marshal.

(8) An Army Substance Abuse Program representative.

(9) An Army Community Service representative.

f. Psychological Autopsies. Psychological autopsies will ascertain the manner of death for active-duty deaths only in cases where the manner of death is equivocal (that is, when the cause of death cannot be readily established as natural, accidental, suicidal, or homicidal). Psychological autopsies will be initiated through the AFME only at the request of the involved medical examiner, USACIC investigator, or the USAREUR SC. DA Pamphlet 600-24 provides the format for psychological autopsies. Incidents

that meet the criteria for requesting a psychological autopsy must be received by the Commander, RHCE, within 30 calendar days after the death even if a physical autopsy is not performed. The local USACIC office will send toxicology reports regarding the suicide to the Commander, RHCE, on request.

9. POC. The POC for this memorandum is the Deputy Director, Personnel Readiness Directorate, ODCS, G1, HQ USAREUR, at military 537-1002.

Encls

CHRISTOPHER G. CAVOLI
Lieutenant General, USA
Commanding

APPENDIX A
REFERENCES

AR 15-6, Procedures for Administrative Investigations and Boards of Officers

AR 40-1, Composition, Mission, and Functions of the Army Medical Department

AR 40-66, Medical Record Administration and Healthcare Documentation

AR 190-45, Law Enforcement Reporting

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

AR 600-8-8, The Total Army Sponsorship Program

AR 600-20, Army Command Policy

AR 600-63, Army Health Promotion

AR 600-85, The Army Substance Abuse Program

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

AE Regulation 40-6, Referring Soldiers for Mental Health Evaluations

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

FRAGO 4 to HQDA Operation Order, Enduring Readiness and Resilience, date-time group 031810Z May 18

DD Form 2996, Department of Defense Suicide Event Report (DODSER)

DA Form 7747, Commanders Suspected Suicide Event Report

APPENDIX B
GLOSSARY

SECTION I
ABBREVIATIONS

ACE-SI	Ask, Care, Escort–Suicide Intervention
AFME	Armed Forces Medical Examiner
AOR	area of responsibility
AR	Army regulation
ASAPM	Army Substance Abuse Program manager
ASIST	Applied Suicide Intervention Skills Training
BH	behavioral health
CG	commanding general
CII	command interest item
CR2C	commanders ready and resilient council
CR2I	community ready and resilient integrator
CRRD	Commander's Risk Reduction Dashboard
CSM	command sergeant major
DA	Department of the Army
DD	Department of Defense [form]
DOD	Department of Defense
DODSER	Department of Defense Suicide Event Report
FMSPP	Family member suicide-prevention program
FRB	fatality review board
GAT	Global Assessment Tool
HQDA	Headquarters, Department of the Army
HQ USAREUR	Headquarters, United States Army Europe
IMCOM-Europe	United States Army Installation Management Command Directorate Europe
LoDI	line-of-duty investigation
mil	military
MTF	medical treatment facility
OCSURG	Office of the Command Surgeon, Headquarters, United States Army Europe
ODCS	office of the deputy chief of staff
OPM	Office of the Provost Marshal, Headquarters, United States Army Europe
PAO	Public Affairs Officer, United States Army Europe
PM	program manager
RHCE	Regional Health Command Europe
SC	senior commander
SPAP	suicide-prevention action plan
SPPM	suicide-prevention-program manager

SPTF	suicide-prevention task force
SRT	suicide response team
T4T	train the trainer
UMT	unit ministry team
URI	Unit Risk Inventory
USACIC	United States Army Criminal Investigation Command
USAREUR	United States Army Europe

SECTION II
TERMS

Army Substance Abuse Program
A comprehensive program that is designed to eliminate substance abuse and includes prevention, identification, education, and rehabilitation services

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

behavioral-health healthcare provider
Trained behavioral-health clinician who is credentialed or licensed as a psychiatrist, clinical or counseling psychologist, social worker, psychiatric nurse practitioner, or psychiatric nurse specialist

Commander's Risk Reduction Dashboard (CRRD)
A dashboard that consolidates information from multiple Army databases and presents commanders with concise information about which Soldiers in their units (both currently assigned and inbound) have been involved in at-risk behavior, some of which may be associated with suicide, and when those instances occurred. Reports generated by the CRRD are used by commanders to make decisions on how best to help Soldiers through intervention.

contagion suicide
suicidal behavior prompted by suicidal behavior of other people (for example, battle buddy, significant other)

equivocal death
A case of death in which the available facts and circumstances do not immediately distinguish the mode of death. Ambiguity or uncertainty existing among any of the four identified modes of death makes the death equivocal. (See "mode (manner) of death" below).

first-line supervisors and junior leaders
For the purpose of suicide-prevention training, officers in the grade of captain (O3) and below, including company commanders, and noncommissioned officers in the grade of staff sergeant (E6) and below

gatekeeper
An individual who, in the performance of assigned duties and responsibilities, provides specific counseling to Soldiers and Army Civilians in need

Global Assessment Tool
A tool developed by the U.S. Army to monitor psychosocial fitness and well-being of Soldiers and provide a means to objectively gauge the success of newly implemented resilience training programs.

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

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

healthcare provider
A physician, nurse practitioner, physician assistant, registered nurse, mental-health specialist, occupational or physical therapist, or registered dietitian under the supervision of a unit surgeon or a commander of a medical treatment facility. For the purpose of this memorandum, this term includes comparable personnel of U.S. Armed Forces and host nations.

mode (manner) of death
Any of the following five categories: natural, accidental, suicidal, homicidal, unknown. These categories are distinguished from the cause of death (for example, gunshot wound, heart disease).

postvention
An intervention conducted after a suicide. The purpose of this intervention is to provide support to Family members and friends of suicide victims by facilitating the healing of individuals from grief and distress, mitigating other negative effects of exposure to suicide, and preventing suicide among individuals who are at a high risk after exposure to suicide.

proximal risk factor
A circumstance that represents an immediate vulnerability for a particular condition or event. Some examples of proximal risk factors include substance abuse, financial difficulties, personal relationship issues, difficulties because of physical impairment or injury, poor work or academic performance, and stressful life events.

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 or herself (that is, had no intent to die). Persons engage in self-harm behavior when they wish to use the appearance of intending to kill themselves to achieve some other end (for example, to seek help, to punish others, to receive attention, to regulate negative mood).

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.

suicidal ideation
Any self-reported thoughts of engaging in suicide-related behaviors (without a suicide attempt)

suicide prevention
Initiatives and activities designed to reduce the incidence of suicide and improve the identification 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