Department of the Army
Headquarters, United States Army
Training and Doctrine Command
Fort Eustis, Virginia 23604-5750

***TRADOC Pamphlet 600-22**

15 June 2012

Personnel – General

LEADER'S GUIDE FOR RISK REDUCTION AND SUICIDE PREVENTION

FOR THE COMMANDER:

OFFICIAL:

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

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

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

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

***This regulation supersedes TRADOC Pamphlet 600-22, dated 16 February 2005.**

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

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

Distribution. This publication is available only on the TRADOC Homepage at http://www.tradoc.army.mil/tpubs/.

Summary of Change

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

This rapid action revision, dated 15 June 2012-

o Changes the pamphlet title from Leaders Guide for Suicide Prevention Planning to Leader's Guide for Risk Reduction and Suicide Prevention.

o Updates demographic data on Army suicides (para 1-4).

o Introduces the Composite Life Cycle Model as a tool for assessing the impact of multiple stressors on Soldiers and Families.

o Emphasizes the importance of effective leadership while deployed or at home location (para 2-1).

o Provides information on the current Army training products for risk factor identification and intervention (Ask, Care, Escort Card) (para 2-6).

o Updates administrative information throughout the publication.

o Unless otherwise stated, when the masculine gender is used, both male and female are included.

Contents

Table List

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Chapter 1
Introduction

1-1. Purpose
The purpose of this pamphlet is to provide a guide to U.S. Army Training and Doctrine Command (TRADOC) commanders and leaders that will build on their ability to manage behavioral risk in personnel and to promote health and wellness while reducing risk to the force during a period of strategic reset.

1-2. References
Required and related publications and required and referenced forms are listed in appendix A.

1-3. Explanation of abbreviations and terms
Abbreviations and terms used in this regulation are explained in the glossary.

1-4. Composite Life Cycle
As a leader, you have the responsibility to effectively manage high-risk behavior, to include suicidal behavior among those you lead. Each Soldier suicide is tragic to the country and to the Army Family. The Army suicide rate has usually been much lower than the United States (U.S.) civilian rate; however, in 2004 that trend shifted, and in 2008 the Army surpassed its equivalent civilian population rate (20.2 per 100,000 vs. 19.2). Across the total Army in 2009, 239 Soldiers took their lives. In addition, 146 Soldiers died because of high-risk behavior such as drug overdose, alcohol poisoning, criminal activity, and accidents. In 2011, 278 Soldiers committed suicide, and the data trend demands continued urgent attention to the health and discipline in the force. Army senior leadership recognizes the significant number of Soldiers who kill and harm themselves each year, and they are well acquainted with the trauma these events have on those left behind. Senior leadership has increased its focus on preventing suicide and reducing unnecessary high-risk behavior.

a. Complexity. Suicide is complex. Despite the progress made to better understand behavioral health issues and suicide over the past decades, research on suicide prevention lacks definitive answers as to why a certain Soldier would decide to take his life. What we do know is there is no single cause, but rather numerous known factors that increase a Soldier's risk for suicide. While one Soldier is strongly challenged by a group of factors, another Soldier finds these same factors insurmountable. Differences in the way people respond to similar stressful events raise the likelihood that there are protective buffers that provide resilience or the ability to bounce back from life's difficulties. On the other hand, there are also risk factors that can combine with challenging life events (relationship issues, financial issues, life transition points etc.) that lead to overwhelming stress and to suicide.

b. Composite Life Cycle. Life transitions with their accompanying life events (e.g., graduating school and then entering the Army; permanent change of station (PCS) plus a promotion; deployment with a change in mission) represent the military way of life. Many Soldiers experience a lifetime of transitions in their first few years in the military. These times of transition can lead to instability and periods of accumulated stress. On the positive end, transitions may be experienced and seen as learning or maturing events depending on where

someone is in his or her life. However, multiple transitions can collect to produce deterioration in well-being if the Soldier is unable to recover before the next transition.

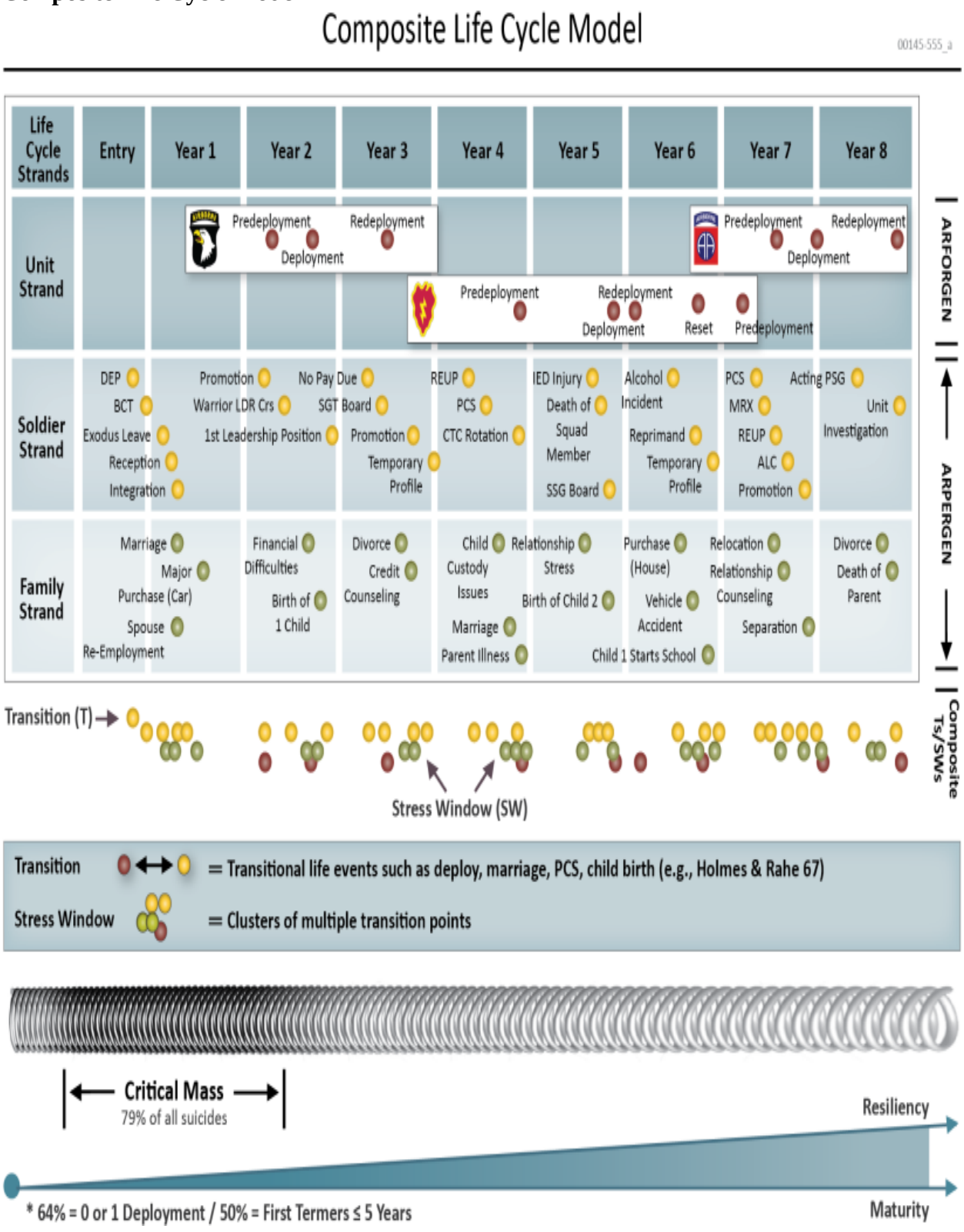
(1) The Composite Life Cycle Model (CLCM) is a useful framework that helps leaders and Soldiers better understand and appreciate the effects of stress during transitions, especially simultaneous transitions. It is a holistic model that looks beyond the unit and takes a composite view of the whole person across three separate strands or planes. Each Soldier simultaneously lives in three life cycles (Unit Life Cycle, Soldier Life Cycle, and Family Life Cycle).

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

(3) An example of applying the CLCM is illustrated in the following scenario: A unit's pending deployment (Unit Life Cycle Strand) can be stressful to a new Soldier, but this is the Soldier's first deployment (Soldier Life Cycle Strand) and coincides with the Soldier's recent PCS (Soldier Life Cycle Strand). This means the Soldier is transitioning into the Army and into a new unit while transitioning into combat. If these transitions were combined with an additional stressor like a disciplinary action, a promotion to a new job requiring new skills or a major Family issue (Family Life Cycle Strand), this scenario could become very complex and, for some Soldiers, overwhelming. See table 1-1, for a diagram of the CLCM.

Table 1-1

Composite Life Cycle Model



(4) A leader's familiarity with the CLCM is valuable because it helps identify a critical '*Stress Window'* where transitions have accumulated for a Soldier. This is especially important for young Soldiers on their first enlistment. Multiple transitions within the first 2 years can cause major stress across Life Cycle strands. New Soldiers may not have the resiliency or life experience necessary to successfully navigate significant and multiple transitions.

(5) Soldiers within the first 2 years of their initial enlistment account for the majority of Army suicides.

Chapter 2
Leadership While Deployed or at Home Station

2-1. Managing high-risk behavior

a. Managing high-risk behavior and preventing suicide is a leadership responsibility across all levels from the most senior leader to the most junior. Distressed Soldiers must be led to the best available support resources through a positive and supportive command climate that fosters early identification and intervention opportunities. Soldiers who ended their lives often engaged in high-risk behavior long before they decided to take their lives.

b. Military cultural norms, while beneficial for survival and mission accomplishment on a battlefield, can sometimes interfere with responsible support seeking behavior; the effect is a less ready force.

(1) Leadership must foster a climate that reinforces and supports Soldiers who responsibly seek professional services for matters pertaining to their psychological, ethical, and spiritual readiness.

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

c. As a result of protracted overseas contingency operations, many commanders and subordinate leaders are now experienced Warriors; however, some have grown unaccustomed to leading Soldiers in a garrison environment. As a result of important lessons learned and thoughtful planning, several critical tasks for leaders have been identified for managing high-risk behavior and suicide prevention. These critical tasks are summarized over the next few pages and will serve as useful initial guidance.

2-2. Plan for transitions

a. Leaders and first-line supervisors understand the relationship between significant stress and significant transitions (e.g., deployments, PCS, disciplinary actions, marriage, divorce, child-birth, etc.).

b. Leaders include the Unit Life Cycle, Soldier Life Cycle, and Family Life Cycle strands into their planning and battle rhythm down the chain of command to squad/section/team leaders.

c. Leaders support active unit integration programs that ensure immediate accountability for incoming Soldiers, assign sponsors, and provide necessary support for stabilization.

2-3. Know your Soldiers

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

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

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

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

2-4. Train

a. Leaders ensure all Soldiers receive required training IAW Army Regulation (AR) 350-1 (Army Substance Abuse Program, Army Suicide Prevention Program, Army Traffic Safety Training Program, and Sexual Assault Prevention and Response Prevention).

b. Skills-based training in resilience and comprehensive fitness is essential to suicide prevention. Soldiers trained in maintaining psychological well-being and suicide prevention are significantly more likely to seek counseling and to assist fellow Soldiers in getting professional support.

c. When individuals exhibit signs of distress, peers, leaders, and Family members must have the skills and confidence to recognize the warning signs and respond with the right level of support. Family members generally do not receive adequate education and training in suicide

prevention and they, above all, are the best “detectors” of subtle behavioral changes associated with suicidal risk.

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

(1) Ask, Care, Escort (ACE) training is the Army-approved suicide prevention and awareness training model that meets the annual Army training requirement for all Soldiers, leaders, and Department of Army (DA) civilians. The key learning objectives are awareness training on risk factors, warning signs, and support resources. Training should be conducted at the lowest level possible to enhance squad, crew, team, and section level participation and strengthen the buddy care system. See appendix B for the ACE Card.

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

(3) The U.S. Army Public Health Command (USAPHC) and Army G-1 have developed Suicide Prevention Resource websites with several educational resources.

(a) USAPHC: See Suicide Prevention Training at: http://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePreventionEducation.aspx.

(b) Army G-1: www.preventsuicide.army.mil

2-5. Communicate high-risk behavior

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

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

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

d. Leaders inform Soldiers and Families of the availability of non-MTF behavioral health support programs (e.g., Tri-service Medical Care (TRICARE) Assistance Program (TRIAP), Military OneSource, TRICARE Tele-Behavioral Health).

2-6. Reduce stigma

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

a. When people believe they have some type of stigma (physical, psychological, or social), they will likely be concerned about social disapproval or that their social status will drop amongst peers, leading to isolation. As long as healthy support-seeking behavior is unfairly stigmatized due to stereotypes and limited understanding, it will be feared and avoided. For Soldiers and leaders there is often the perception that support-seeking behavior will be detrimental to their careers, or they will be viewed negatively by their peers or those they lead. Mental toughness is seen as a sign of strength in military culture, while seeking assistance may be seen as a sign of weakness or source of shame or embarrassment.

b. The perceived stigma associated with seeking behavioral health support represents a very real barrier to Soldiers who would benefit most from professional support. Bear in mind that keeping behavioral health issues a secret tends to increase stress, degrade one's ability to think clearly, lead to poor decisionmaking, contribute to depression and anxiety, and worsen suicidal thinking.

c. Leaders at all levels encourage support seeking behavior and convey no-stigma messages as a routine matter of unit operations. See table 2-1 for tactics to reduce stigma.

Table 2-1
Reduce Stigma - Tactics

Support confidentiality between Soldiers and their Behavioral Health providers
Reinforce the power of the buddy system as a support system in times of crisis
Normalize healthy, responsible support-seeking behavior and avoid actions that discourage individuals from self referring for professional care. Send a clear message that behavioral healthcare is part of a normal, routine maintenance cycle.
Encourage help from Behavioral Health providers that does not involve treatment such as educational briefings on healthy sleep, stress management, and optimal performance
Provide educational opportunities for Soldiers, Family members, and civilians on topics such as anxiety, depression, stress, and Post-Traumatic Stress Disorder (PTSD)
Convey "no-stigma" messages as a routine matter of unit operations

2-7. Build resilience

a. Resilience plays an important role in preventing suicide and reducing high-risk behavior. Resilience also plays a critical role in how you respond to intense stress such as trauma, illness, major loss, and misfortunes. Resilience essentially means "to spring back or rebound" from difficult situations and it is NOT a matter of being spared difficult situations or maintaining an image of strength or a "tough façade."

b. Building resilience results from a combination of factors such as having a sense of belonging to a valued group, connecting with friends, maintaining a network of caring and supportive relationships, having confidence in one's strengths, accepting change as a part of life, and managing strong feelings and impulses. See table 2-2 for several resilient behaviors that can mitigate the negative effects of trauma and adversity.

Table 2-2
Build Resilience - Tactics

Leverage Comprehensive Soldier Fitness (CSF) resources starting with the confidential online Global Assessment Tool http://csf.army.mil/ to track overall resilience and well-being. Work the Comprehensive Resilience Modules (CRM) to improve wellness and readiness.
Recognize that no one has all the resources to manage all personal problems alone. Practice support seeking as a sign of strength.
Recognize and accept that everyone has fears and learn to face fears in a healthy way.
Avoid isolation when faced with intense stress.
Attend life skills or related training through installation Soldier Support Centers.
Create and promote good relationships with Family and close friends.
Take care of your physical, mental, and spiritual fitness.
Learn to manage and regulate your emotions; avoid impulsive behavior.
Maintain realistic optimism and believe in your ability to survive and function as a good Soldier.
Actively and regularly participate in unit activities.
Seek out a mentor or confidante to confide in during times of stress.
Join social support groups, faith-based organizations, or self-help groups.
Take a break from problems to relax.
Take a step back to solve a problem before reacting to the problem. Break up big tasks into smaller ones and address smaller, more notable tasks.
Leaders strive to teach their Soldiers to become more resilient by modeling resilience and working to develop resilience in themselves.

2-7. Know the warning signs

a. High risk and suicidal behavior can be prevented. Although some suicides occur with minimal warning, most individuals who are suicidal give warning signs. The latest large scale research from the Army Study to Assess Risk and Resilience in service members highlights the careful attention and care that leaders must give to Soldiers during times of transition. Leaders should be familiar with the major transition points that can arise in a Soldier's Composite Life Cycle, see table 2-3.

Table 2-3
Composite Life Cycle Critical Transition Points

180 days after redeployment or prior to deployment
Recent divorce, loss of significant other, break-up of relationship
Medical illness or chronic physical pain
UCMJ, administrative, or legal action in the last 6 months
Drug or alcohol offense
New arrival to current duty station (within last 6 months)
Recent promotion or increase of duty responsibilities
Change in finances (foreclosure, divorce, child support, over spending)
Social or occupational embarrassment (not promoted, reduction in rank, public humiliation/teasing by peers)
Failure of APFT or significant decrease in APFT score or failure to maintain appropriate height/weight standards

b. Risk factors for suicide are different from warning signs in subtle ways, yet they have many common features. Leaders should understand the important differences because it will help them decide the best course of action to take when supporting a struggling Soldier. Risk factors for suicide are circumstances that place an individual at an increased overall risk for suicide and is less about the risk for immediate suicide. Warning signs, however, are more related to the risk of suicide at the present time, and this means intervening in a timely manner using good judgment. The most effective suicide prevention is often the least dramatic and usually involves a meaningful private conversation and getting to the right level of support. See table 2-4 for the suicide risk factors and warning signs.

Table 2-4
Suicide Risk Factors and Warning Signs

Risk Factors (Increases the Overall Risk of Suicide)	Warning Signs (Requires Timely Action)
Seeing oneself as a burden to Family, friends, or society	Statements that convey, "I am of more value to Family/friends being dead."
View of oneself as not belonging and feeling strongly alienated from the group	Isolation and withdrawal from social situations
Failed intimate relationship or strained relationship	Problems with girlfriend/boyfriend or spouse
Drug or alcohol abuse	Increased alcohol and/or drug use or abuse
Current/pending legal actions (Art 15, UCMJ)	Soldier experiencing financial problems or in trouble for misconduct (Art 15, UCMJ)
Personal history of depression, PTSD, or Behavioral Health Condition	Change in mood (depression, irritability, rage, anger)
Significant loss (death of a loved one, job loss, status loss, etc.)	Feeling sad, hopeless, anxious, psychological pain
Previous suicide attempt	Talking/hinting about suicide, expressing a strong wish to die or a desire to kill someone else
Family history of suicide attempt or depression	Obsession with death (in music or poetry or artwork)
Serious or chronic medical condition	Noticeable changes in eating/sleeping habits and personal hygiene
Work-related problems	Disregard for personal well-being or giving away possessions
Domestic violence or violent social environment	Themes of death in letters or notes
Excessive debt	Finalizing personal affairs
Access to lethal means of suicide	Sudden or impulsive purchase of a firearm or other means of killing oneself such as poisons or medications
Severe, chronic, unmanageable stress (real or perceived)	Suddenly making changes to a will or SGLI

2-8. Support resources

a. For Individuals Seeking Support. There are several hotline services for crisis intervention and for general information that have become available to Soldiers and Family members. As a result of these numerous service options, there has been confusion as to which ones to use in what circumstances.

b. Hotline services are basically divided into two categories of support:

(1) Crisis services. This type of service is for urgent, life-threatening support. Personnel are encouraged to call the National Suicide Prevention Lifeline: 1-800-273-8255, press "1" for military.

(2) Educational/Counseling services. This second category is for general information and for free confidential counseling. Personnel are encouraged to contact Military OneSource, 1-800-342-9647.

c. Commanders and leaders. Subject matter expertise and consultation is available on each installation for leaders to get ideas and suggestions for managing complex matters and obtaining additional information. Each installation's suicide prevention program manager coordinates community efforts and serves as a valuable central support hub. See AR 600-63, paragraph 4-4 for additional information.

2-9. Family readiness

For Soldiers and Families seeking information or additional support, help is available through several services. Below is a non-comprehensive list of available support services.

a. Army Community Service.

b. Army Emergency Relief.

c. Army Substance Abuse Program.

d. Behavioral Health Services.

e. Better Opportunities for Single Soldiers.

f. Chaplain Services.

g. Child Development Center.

h. Comprehensive Soldier Fitness (CSF).

i. Exceptional Family Member Program.

j. Family Advocacy Program.

k. Family Assistance Programs.

l. Financial assistance.

m. Legal Assistance.

n. Medical Treatment Facility.

o. Suicide Prevention Program Manager.

2-10. Postvention

As a leader you may need to lead your unit through the loss of a Soldier to a completed suicide or through the effects of an attempted suicide. The major objectives, whether a completed or attempted suicide, are to support those affected, minimize psychological reactions, strengthen unit cohesion, and maintain mission readiness.

Table 2-5.
Postvention Guidelines, see DA Pam 600-24, paragraph 4-1, for more information.

Completed Suicide	Attempted
Provide support to Soldiers and Family members impacted by a suicide. Ensure Soldiers and Family members stay connected to a support system.	Provide care for the Soldier who has attempted Suicide. Assist Soldier with navigating the health care system to receive appropriate care.
Welcome unit members to discuss and process intense emotions and express concerns.	Provide support to Soldiers and Family members impacted by a suicide attempt.
Have the facts of the event and balance honest information sharing with the victim's privacy. Be sure not to condemn or glorify their actions.	Emphasize and train Soldiers on the vital role that the 'Buddy System' plays in unit cohesion and readiness.
Invite an outside facilitator (i.e., chaplain or behavioral health provider) to support with the debriefing.	Improve unit intervention skills, build knowledge, and build confidence to respond to a suicidal risk factors and warning signs.
Promote the idea that the outcome of a crisis need not be suicide; there are other alternatives.	Foster a culture that reinforces responsible help-seeking behavior as an accepted part of being a responsible Soldier.
Honor the Soldier and support the disposition of remains. Funeral honors are an important part of the healing process for fellow Soldiers and Family members.	
Conduct a memorial service to promote an atmosphere that helps unit members, friends and Family members heal and move forward in a healthy manner.	

Appendix A
References

Section I
Required Publications
ARs, DA pamphlets, and DA forms are available at http://www.usapa.army.mil/. TRADOC publications and forms are available at http://www.tradoc.army.mil/publications.htm.

This section contains no entries.

Section II
Related Publications

AR 350-1
Army Training and Leader Development

AR 600-63
Army Health Promotion

AR 600-85
Army Substance Abuse Program (ASAP),

DA Pam 600-24
Health Promotion, Risk Reduction, and Suicide Prevention, 30 September 2010

FM 6-22
Army Leadership: Competent, Confident, and Agile

Army 2020 Generating Health and Discipline in the Force Report 2020 (Gold Book); accessible at http://www.armyg1.army.mil/hr/suicide/references.asp, click on “Gold Book” icon.

Section III
Referenced Forms

DA Form 4833
Commander's Report of Disciplinary or Administrative Action

Section IV
Prescribed Forms

This section contains no entries.

Appendix B
Ask, Care, Escort (ACE)

B-1. ACE Description

Ask, Care, Escort (ACE) is the Army approved model for peer intervention and provides an easy to remember acronym for a Soldier, Leader, Family member, or Department of the Army Civilian to use.

a. See Table B-1 for description and summary of ACE components.

Table B-1
ACE Components

A.C.E. Components
Ask: Stay calm and ask the following types of questions: "Are you thinking of hurting of killing yourself?" "Do you want to die?" "Do you wish you were dead?" "Have you thought of how you would kill yourself?" -Take threats seriously. Trust your impressions as some warning signs may be subtle. Do not ignore cries for help. -Look for any outward sign that shows a deviation from your Soldier's usual self. -Normalize the subject of suicide. Talk openly about suicide. Don't be afraid to discuss suicide with the person. Be willing to listen and allow your Soldier to express his or her feelings. Don't make moral judgments, act shocked, or make light of the situation. Don't try to minimize the problem. Trying to convince a person it's not that bad or they have everything to live for may only increase their feeling of guilt and hopelessness. -A Soldier needs to feel comfortable discussing suicide and asking those who are contemplating suicide the tough questions.
Care: Care for the person, they may be in pain. Persons who attempt suicide most often feel alone. Understand that your Soldier may be in pain and sees no more options for reducing his or her suffering. You can help by letting them know that they are not alone and assuring them that help is available. -Almost every person thinking about suicide is highly ambivalent about their intentions to die, and they are also pulled by a strong urge to live. Most people are open to genuine offer of support. -Active listening may produce relief. Calmly control the situation; do not use force. -Take action by removing any lethal means, such as weapons or pills. If the Soldier is armed, say, "Let me unload your weapon and keep it safe for you while we talk." Don't act shocked or alarmed! Encourage the Soldier to talk. -After the Soldier has talked as much as he or she wants, say, "We need to reach back for some support on this. There are people nearby who can help us."
Escort: Never leave the person alone. - Escort to the Chaplain, Emergency Department, Behavioral Health Professional or Medical

Professional in Primary Care
-Adopting an attitude that you are going to help your Soldier will save his or her life.
-Ensure someone stays with your Soldier until he or she receives appropriate help. Don't leave your Soldier alone.
-Get help immediately! A suicidal person needs immediate attention.
-Never try to force someone to get help. Law enforcement and medical personnel should be summoned to the scene if the individual declines assistance.

B-2. ACE Training and Cards
ACE cards are available as graphic training aid at
http://www.usaasc.info/alt_online/article.cfm?iID=0905&aid=13

Appendix C
Additional Suicide Links of Interest

See below additional suicide links of interest

U.S. Army Public Health Command (USAPHC).
http://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePreventionEducation.aspx

U.S. Army G1, http://www.armyg1.army.mil/hr/suicide/default.asp

http://www.suicidepreventionlifeline.org/

http://www.militaryonesource.mil/MOS/f?p=MOS:HOME:0

Glossary

ACE	Ask, Care, Escort
AR	Army regulation
ASIST	Applied Suicide Intervention Skills Training
CLCM	Composite Life Cycle Model
COE	centers of excellence
DA	Department of Army
DOD	Department of Defense
FAP	Family Advocacy Program
HPRRSP	Health Promotion, Risk Reduction, Suicide Prevention
MSO	major subordinate organizations
OIF	Operation Iraqi Freedom
PCS	permanent change of station
TRADOC	United States Army Training and Doctrine Command
TRIAP	TRICARE Assistance Program
TRICARE	tri-service medical care

UCMJ	Uniform Code of Military Justice
USAPHC	U.S. Army Public Health Command

Section II
Terms

This section contains no entries.

Section II
Special Abbreviations and Terms

This section contains no entries.