



REPLY TO
ATTENTION OF:

DEPARTMENT OF THE ARMY
OFFICE OF THE VICE CHIEF OF STAFF
201 ARMY PENTAGON
WASHINGTON, DC 20310-0201

APR 16 2009

DACS

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP)

1. **Situation:** In calendar year 2008, the Army's confirmed suicide rate reached an all-time high of 20.2 per 100,000, a measure of tragedy and loss to our Army and Nation that we will simply not allow to continue. The intent of this Campaign Plan is to take a strategic approach to mitigating suicides and high-risk behavior across the Army. The Army will employ every available resource, and every member of the Army team, towards promoting overall Soldier and Family health. This campaign plan will emphasize the physical, mental, and spiritual aspects of health to achieve an immediate and lasting impact. This comprehensive approach is the optimal means of reversing the increasing occurrence of suicide among our Soldiers. Simply put, this campaign plan will operationalize my intent to do everything in our power to reduce the occurrence of suicides in our Army.

2. **Mission:** The Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP) is the means by which HQDA and leaders will direct actions necessary to implement immediate and enduring Policy - DOTMLPF- Resource solutions necessary to improve and, where necessary, immediately affect Army health promotion, risk reduction, and suicide prevention-related programs.

3. **Execution:**

a. VCSA Intent. My intent is to meet the guidance of the Secretary of the Army and the Chief of Staff to reduce the Army suicide rate. We will conduct a thorough, comprehensive analysis of existing health promotion systems and processes to take immediate action to adapt and improve enduring health promotion, risk reduction, and suicide prevention-related programs and operations.

b. Methods.

(1) ARSTAF Plan. The Army Suicide Prevention Task Force (ASPTF) and the Army Suicide Prevention Council (ASPC) are interim HQDA-level organizations chartered under my authority. These organizations will analyze existing programs and lessons learned; correct deficiencies; develop and implement immediate Policy - DOTMLPF - Resource solutions for Soldier and Family health promotion, risk reduction, and suicide prevention-related programs across the Army. The ASPTF and ASPC will transition a holistic and integrated Army health promotion, risk reduction, and suicide prevention-related program to the DCS, G1 and coordinating agencies. The process utilized by the ASPTF and the ASPC,

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as described in paragraph 4.a. below, is a modified version of the ARSTAF process, abbreviated to reflect the urgency and immediacy of this mission.

(2) Commanders' Plan. The second component of this campaign plan is to promulgate guidance for immediate implementation by Installation, Garrison, and Medical Treatment Facility (MTF) Commanders. Commanders, please direct your attention to paragraph 4.b. and Annex D, *Installation, Garrison, and MTF Commander Critical Actions / Tasks*.

c. End State. The suicide rate is reduced through improvements in Army Soldier and Family health promotion, risk reduction and suicide prevention that result in enhanced Soldier, Civilian, and Family resiliency and positive life coping skills. The Army has implemented campaign plan tasks, continues to assess effects, and incorporates lessons learned into future policy, programs, and initiatives.

4. Concept of Operation:

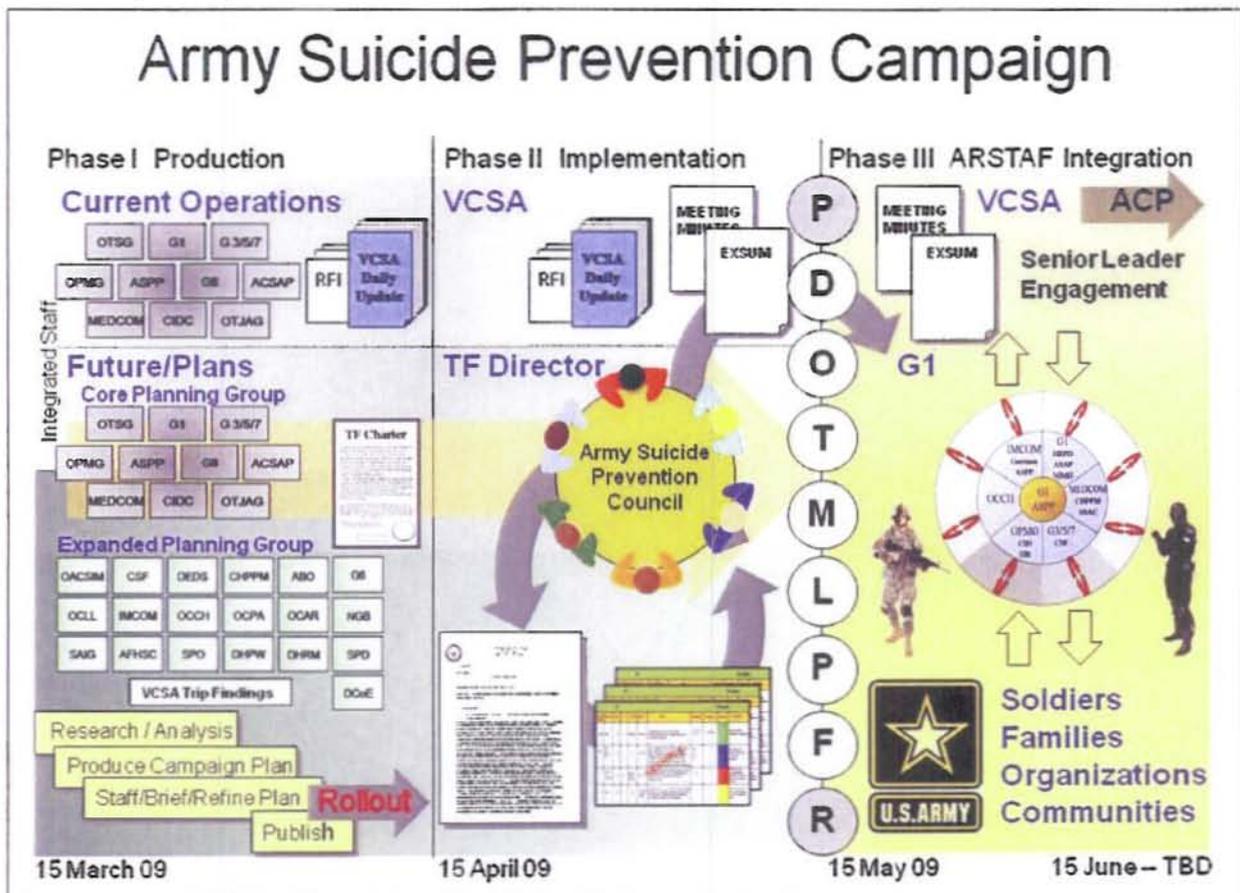


Figure 1. Army Suicide Prevention Campaign

"The Army's charter is more about holistically improving the physical, mental, and spiritual health of our Soldiers and their families than solely focusing on suicide prevention. If we do the first, we are convinced that the second will happen."
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a. ARSTAF Plan. The ACPHP formalizes the Army's commitment to improving Soldier and Family health promotion, risk reduction, and suicide prevention-related programs. The ACPHP will document, synchronize, and integrate the efforts of the Army Staff and coordinating staff, agencies and external partners to implement Policy - DOTMLPF - Resource solutions and to assess the effects and incorporate lessons learned into future policy, programs, and initiatives.

(1) Phasing (Figure 1). ASPTF actions initiated and completed prior to publication of this Plan are identified as Phase I. Phase II operations are designed to implement the ACPHP via the ASPC to rapidly develop, obtain VCSA approval, and field out-of-cycle and programmatic solutions to promote the health of our Army Soldiers and Families. Phase III focuses on transitioning and reseating ASPTF roles and responsibilities and integral processes into the HQDA proponent (DCS, G-1), coordinating staffs (e.g., OTSG, OCCH, ACSIM, OPMG) and external partners (e.g., Defense Centers of Excellence, Department of Veterans Affairs (VA), National Institute of Mental Health, Centers for Disease Control).

(a) Phase I – Production. This phase was initiated with the creation of the ASPTF on 6 March 2009 and ended with the publication of this Campaign Plan. Operations during Phase I included approval of the ASPTF charter; VCSA's installation visits and assessment; Congressional and public engagements; multi-disciplinary analysis and translation of tasks from findings and lessons learned into a synchronization matrix (Figure 4 and Annex B); and production of the campaign plan and other "informing" documents.

(b) Phase II – Implementation. This phase was initiated with the publication of this plan. Phase II operations focus on implementation and integration of Policy – DOTMLPF - Resource solutions by the ASPC (Figure 3). The ASPC synchronizes and integrates all staff, agency, external partners, and field command efforts. Its primary purpose is to initiate, implement and approve multi-disciplinary health promotion, risk reduction, and suicide prevention-related solutions. Its mandate is to expedite solutions from HQDA through appropriate commands / support lines to the front lines and post, camp, and station, and to every theater of operation. The ASPC has a secondary role to assist commanders in implementing Annex D, *Installation, Garrison, and MTF Commanders Critical Actions / Tasks* via policy, program guidance, and resourcing.

(c) Phase III – ARSTAF Integration. This phase begins the dissolution of the ASPTF, upon VCSA order, and the transition of the functions of the ASPTF to the DCS, G1 and coordinating staffs. The DCS, G1 retains the Army Staff lead for all suicide prevention-related issues to include co-chairing the ASPC to implement and approve multi-disciplinary health promotion, risk reduction, and suicide prevention-related solutions. All related staff actions are processed through normal DCS, G1 staffing actions / functions and operational procedures.

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(2) Measure of Effectiveness. The VCSA determines that adjustments in health promotion, risk reduction and suicide prevention-related programs are being implemented throughout the Army as measured by Synchronization Matrix status and follow-up actions documented in Task Action Plans (see paragraph 4.a.(3)(d) below). Indicators of efficacy include retirement of critical tasks from the Synchronization Matrix, feedback from the field Army, and substantial subsuming of Synchronization Matrix management by proponent staff / agencies. Upon the VCSA determination that these indicators have been satisfied, transition to Phase III (ARSTAF Integration) will occur. In Phase III the DCS, G1 and coordinating proponents will monitor completion of all remaining tasks on the Synchronization Matrix as a routine staff function.

(3) Framework. The oversight, integration and synchronization of tasks required to implement solutions will utilize the Army functional structure of Policy – DOTMLPF - Resources. The Synchronization Matrix (Annex B) will be continually updated to monitor implementation, ensure synchronization across the Army, and to integrate new findings and recommendations under the guidance of the ASPC (Figure 3).

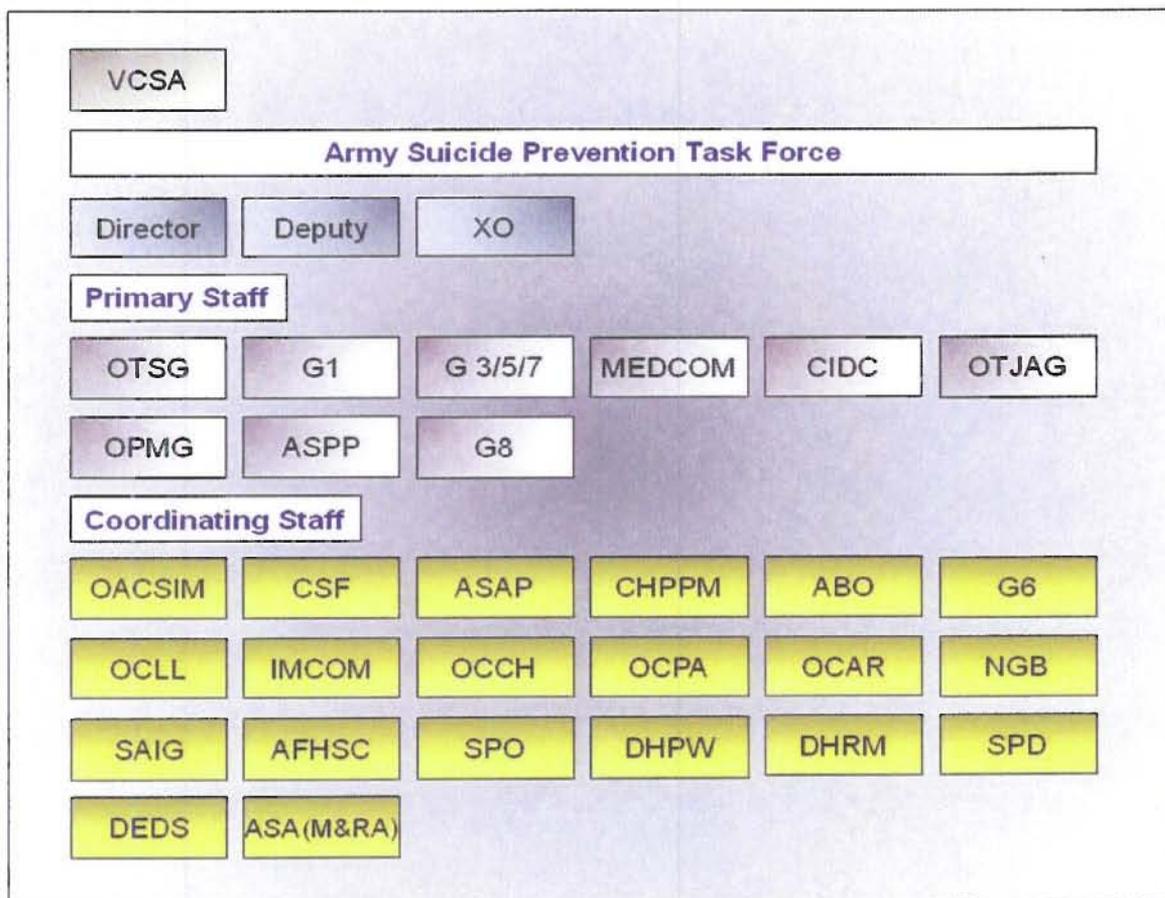


Figure 2. Army Suicide Prevention Task Force

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(a) Army Suicide Prevention Task Force (ASPTF). The ASPTF (Figure 2) is a HQDA-level interim organization designed to provide immediate, coordinated reporting and programmatic solutions for my engagement / approval and establish integrated, sustainable ARSTAF and external agency program participation.

1) Mission: The ASPTF will develop, synchronize, and implement this Plan to inculcate an enterprise approach to managing the Army's health promotion, risk reduction and suicide prevention-related policies and programs to reduce suicides and promote more resilient, trained, and ready forces in support of an era of "persistent engagement." The ASPTF is intended to encapsulate but expedite the Army staff Policy and DOTMLPF-Resource process for an immediate impact on suicide reduction.

2) Organization: The ASPTF staff is comprised of two elements, primary staff and coordinating staff members, representing a comprehensive multi-disciplinary representation from across the ARSTAF and partner agencies.

a) Primary staff: Primary staff is assigned full-time to the ASPTF, with duties as specified by Director, ASPTF. The primary staff must have unencumbered access to their respective staff / agency principals for immediate decision authority to execute ACPHP actions. Primary staff is responsible for staffing all ACPHP products through their respective staff / agency for Director, ASPTF or Chairpersons, Army Suicide Prevention Council (ASPC) approval.

b) Coordinating Staff: Coordinating staff will work from their designated offices but will provide immediate and dedicated support to the ASPTF. The coordinating staff will attend all meetings and provide all staff functions as required. Coordinating staff must have unencumbered access to their respective staff / agency principals for immediate decision authority to execute ACPHP actions. Coordinating staff is responsible for staffing all ACPHP products through their respective staff / agency for Director, ASPTF or Chairpersons, ASPC for approval.

(b) Army Suicide Prevention Council (ASPC). During Phase II, the Director, ASPTF will co-chair a recurring council with the DCS, G-1 that will monitor the execution of all health promotion, risk reduction, and suicide prevention-related program tasks, using the Synchronization Matrix as the primary tool.

1) ASPC Roles and Responsibilities.

a) Vice Chief of Staff. Approves (based upon the recommendations of the ASPC Chairpersons) all task status changes and introduction of new tasks. Adjudicates any unresolved issues with regard to ASPC operations.

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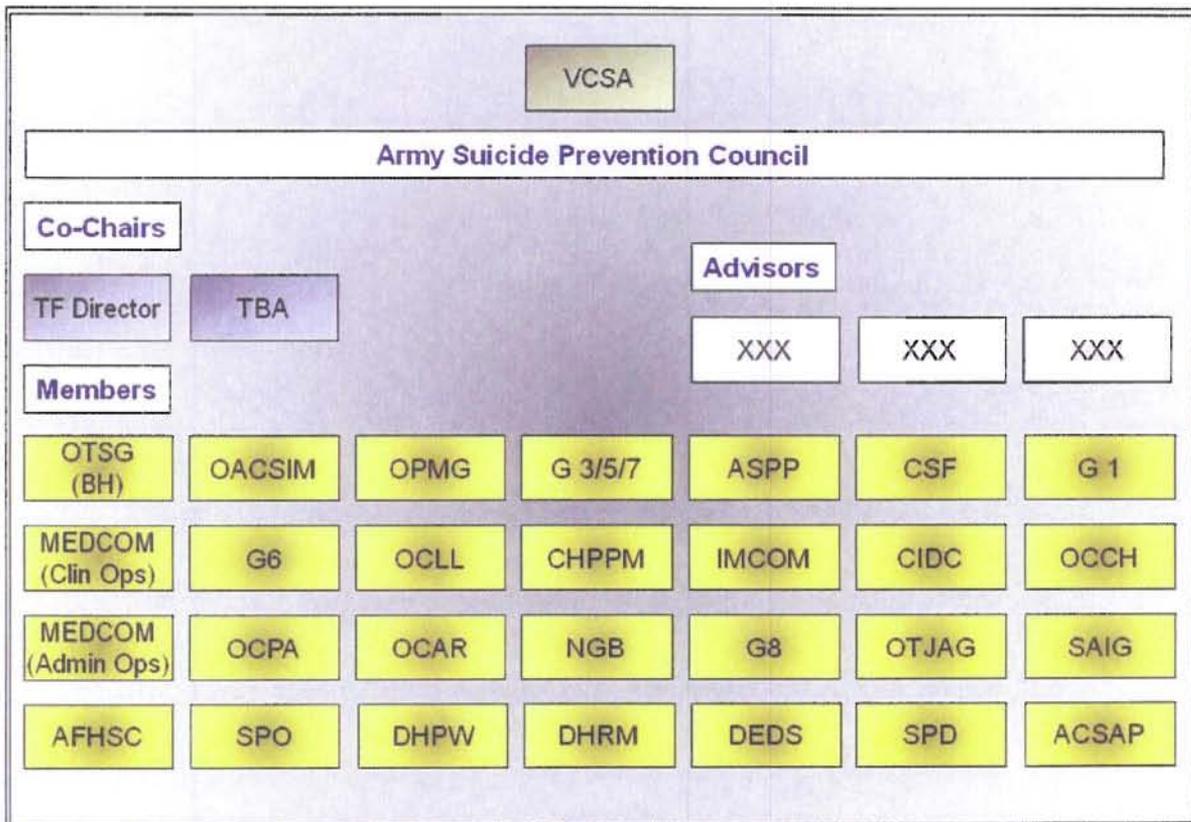


Figure 3. Army Suicide Prevention Council

b) Chairpersons. The ASPC Chairpersons will:

- i. Nominate out-of-cycle Policy - DOTMLPF - Resource solutions.
- ii. Provide oversight, synchronize efforts and resolve issues.
- iii. Identify priorities and establish the ASPC agenda.
- iv. Approve the agenda and minutes for each meeting.
- v. Recommend status changes, including final disposition of ASPC tasks.
- vi. Establish subgroups and assign work to Members to achieve ASPC objectives.
- vii. Have tasking authority to assign work to other Army organizations to achieve ASPC objectives.

c) Council Members. The Council Members of the ASPC are senior representatives (O-6 or civilian equivalent) from the key staff elements and proponents identified in Figure 3. Each Council Member may represent multiple accounts or multiple Council Members may represent a single account, with approval of the Director, ASPTF. Council Members may provide advice and recommendations on ASPC business; however, only the Chairpersons have decision authority. Council Members are generally responsible to ensure that tasks

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and other coordination assigned to their staffs / agencies by the ASPC Chairs are expedited, completed, and integrated. In addition, Council Members will:

- i. Attend scheduled ASPC meetings.
- ii. Report on the status of tasks assigned to their area of responsibility.
- iii. Propose changes in task status and OPR / OCR assignment.
- iv. Propose introduction of new tasks and retirement of completed tasks.

d) Advisory Members. Advisory Members are ARSTAF elements that are invited by the Chairpersons to provide recommendations and advice regarding ASPC business. Advisory Members will attend ASPC meetings by invite only.

2) ASPC linkage to ASPTF. Each member of the ASPC is supported by either a primary or coordinating staff member (account holder) on the ASPTF (see Figure 2). Primary and coordinating staff members are not the staff action officers for execution of the task; their function is to support the ASPTF and prepare the Council Member for ASPC meetings. The account holder is responsible for tracking all Synchronization Matrix tasks assigned to his/her office on the ASPTF Task Action Form (Figure 5) when necessary and providing the ASPC member regular status updates. Preparation of the ASPTF Task Action Form is discussed in paragraph 4.a.below.

3) ASPC Meetings.

a) Orientation Meeting. The initial meeting of the ASPC will be conducted NET 15 April 2009. The purpose of the initial meeting is to introduce the ASPC process and protocols and familiarize ASPC members with the Synchronization Matrix and their roles and responsibilities. I will attend the ASPC Orientation Meeting.

b) Regular Business Meetings. Regular business meetings of the ASPC will be conducted at the discretion of the Director, ASPTF. It is anticipated that the first regular meeting will occur shortly after the Orientation Meeting, with twice-monthly meetings (normally held on the first and third Wednesdays of each month) thereafter. Regular meetings will be conducted by a facilitator designated by the Director, ASPTF.

c) Regular business meeting agenda.

- i. Roll call of ASPC members present.
- ii. Review of prior ASPC meeting minutes.
- iii. Discussion of ASPC due-outs.
- iv. Review of open tasks and status change requests.
- v. Summary of ASPC co-chair recommendations.
- vi. Other items as determined by the Director, ASPTF.

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d) Meeting Deliverables. Following each ASPC regular business meeting, the ASPTF will prepare the following products within three business days:

- i. VCSA approval briefing, approved by the ASPC co-chairs.
- ii. Council meeting minutes for all ASPC members.
- iii. Updated Synchronization Matrix, reflecting the proposed status of all tasks, for all ASPC members.

(c) Policy - DOTMLPF - Resource Overview. A brief synopsis by functional area of planned or executed adjustments to Army health promotion, risk reduction and suicide prevention-related programs are provided below.

1) Policy. The ASPC will conduct an analysis of relevant policy, to include both the Army Regulation 600 series and 40 series, to analyze, integrate and revise program guidance.

2) Doctrine. The ASPC is engaged in the on-going analysis of programs and recommendations. Doctrine is being refined by drawing from recent field observations and lessons learned in order to educate Army Soldiers and leaders on problems and solutions from current operations. Currently, actions are underway to develop and publish revised Army health promotion, risk reduction and suicide prevention doctrine. Under ASPC guidance, the proponents of related doctrinal products will also ensure appropriate Army doctrine is revised.

3) Organization. Organization refers to the administrative and functional structures of the force as well as a culture that contributes to accomplishing the force's mission. Health promotion, risk reduction and suicide prevention program organizational recommendations focus on ensuring that behavioral health care providers and suicide prevention enablers are optimally positioned to implement programs.

4) Training. The Army is actively incorporating health promotion, risk reduction and suicide prevention training at unit and installation levels. Training programs will be based upon policy revisions and lessons learned.

5) Materiel. Material solutions that support health promotion, risk reduction and suicide prevention are focused upon the development of integrated information systems to provide Commanders, clinicians and preventive personnel a comprehensive overview of our Soldiers' and Families' wellness.

6) Leaders. Leader development in the area of health promotion, risk reduction and suicide prevention is crucial in de-stigmatizing the use of behavioral health care services by our Soldiers and Families and ensuring access to those services.

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7) Personnel. Personnel solutions that support health promotion, risk reduction and suicide prevention are focused upon appropriately staffing the programs and agencies that support our Families and Soldiers, with focus on behavioral health care providers.

8) Facilities. Facilities solutions that support health promotion, risk reduction and suicide prevention are focused upon providing sufficient physical infrastructure to ensure delivery of services (especially confidential counseling services) to our Soldiers and Families in a convenient and timely manner.

9) Resources. Resource solutions will enable the immediate implementation of changes to Army health promotion, risk reduction and suicide prevention programs, activities and initiatives. Such solutions may include expedited funding for personnel or interim contract solutions.

Personnel							
Bin / #	OPR	OCR	Task	Suspense	Status	Linkage	Comments
Pe 6.4.4	ASPTF MEDCOM	MTF Cdr FC	Centralize management of primary care and behavioral health care providers under a central authority (SR MTF CDR / Senior Medical Officer) at installations to optimize patient care; provider to patient workload; and provider professional development.	1 Nov 09		D2.2.8 O3.1.2 L5.1.3 Po1.26.2 Po1.27.9 Po1.28.1	Installation-level MOAs required
Organizations							
Bin / #	OPR	OCR	Task	Suspense	Status	Linkage	Comments
O 3.4.3	OTSG MEDCOM	G3 FM	Immediately assess and adjust the medical templates in the Automated Staffing Assessment Model (ASAM) to grow primary / behavioral health care provider populations to increase medical capabilities / capacity at all levels on the Installation; review TO&E design to increase behavioral health providers in tactical formations (DIV to BN level). Grow the Army medical community to compensate for both appropriate rules of allocation under a protracted conflict and to compensate for the "Grow the Army Initiative" from ~482K to ~548K to increase capabilities / capacity and to reduce "compassion fatigue" as outlined above.	1 Sep 09		R3.4.3 L5.1.3 Pe6.4.5 Po1.2.10 Po1.24.1 Po1.26.2 Po1.27.12 Po1.27.17 Po1.27.2 Po1.27.5 PO1.28.1 Po1.7.3 Po1.7.5	Address increased workload requirements based on GTA and BRAC

Figure 4. Synchronization Matrix Exemplar

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(d) Synchronization Matrix (Annex B). All ongoing Policy – DOTMLPF – Resource solutions developed to improve health promotion and related suicide prevention programs will populate the Synchronization Matrix. The purpose of this matrix is to facilitate synchronization and monitor implementation by tracking each task's Office of Primary Responsibility (OPR), Office of Coordinating Responsibility (OCR), suspense date and status, and to provide the synchronization or linkage to other tasks within the matrix. An exemplar of synchronization matrix entries is shown in Figure 4.

1) The primary fields of the synchronization matrix are:

a) Bin / # - Policy – DOTMLPF – Resource domain + series number.

b) OPR – Office of Primary Responsibility – the staff office(s) primarily responsible for preparing and executing the task action plan.

c) OCR – Office of Coordinating Responsibility – the staff office(s) responsible for providing input / support to the OPR as required.

d) Task / Suspense – Self-explanatory.

e) Status – The status of each task is color-coded. The initial status of tasks on the Synchronization Matrix is Green and the objective is to move each task to Black status. Task status changes are discussed below. The status codes are:

-  • Green – Task is on track to achieve deadlines for completion as defined in Task Action Plan (TAP).
-  • Amber – Task is in progress but may not meet deadlines for completion as defined in TAP.
-  • Red – Task is impeded from further progress and will not meet deadlines for completion as defined in TAP.
-  • Blue – New task to be added to the Synchronization Matrix.
-  • Black – Task is completed and can be retired from the Synchronization Matrix.

f) Linkage – Task may be either independently (completion of listed task will result in completion of other task) or dependently (accomplishment of other task required to complete listed task) linked to other tasks on the Synchronization Matrix.

2) Monitoring of Task Implementation. The mechanism for monitoring task implementation is the ASPTF Task Action Form (Figure 5). The Task Action Form provides a clear path to task completion by specifying specific sub-tasks with suspense dates and

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identifying constraints and required follow-up actions. Council Members will utilize the Task Action Form to brief the ASPC when requesting a task status change or proposing a new task for addition to the matrix. The Task Action Form is normally not required for tasks that are on track for completion by the scheduled date (green status); however, the Task Action Form is required when the Council Member proposes that the task is completed and can be retired (black status).

Bin	#	OPR	OCR	Topic	Suspense	Status	Comments
Pe	09-1	ASPTF MEDCOM	MTF CDR FC	Centralized medical care (primary and behavioral) at installations	15 May 09 thru 1 Sep 09		Staffed with: > OTSG > DCS, G1
Finding: Installations are not providing centralized management and professional / technical development of medical health / behavioral health care providers when BCTs return to the installations (e.g., 40-5 doctors at the MTF, 56 doctors at tactical units not providing care).							
Task / Outcome: (T) Centralize management of primary care and behavioral health care providers under a central authority (Senior MTF CDR / Senior Medical Officer) at installations to optimize patient care, provider to patient workload, and provider professional development (O) All health care providers at installations are integrally managed in providing patient care to Soldiers							
OPR	Suspense	Sub-Tasks					
ASPTF	15 May 09	Develop draft "VCSA Sends"; VCSA approves / distributes to ARSTAF, ASCC, ACOMs, DRUs, and Corps, DIV, Installation Senior CDRs as a bridging mechanism for each subsequent task as follows					
ASPTF OTSG	25 May 09	Draft Memo for VCSA to provide implementing instructions and clarify installation and unit command relationships IAW AR 10-87 and "constraints" below					
MTF CDR SR MO	1 Jul 09	Develop and staff a MOA with Senior CDR (approve) at local installation to implement optimal patient care within the intent of this task					
OTSG	1 Sep 09	Revise Medical Policy to incorporate DA Memo guidance					
Constraints: - CDRs must retain flexibility to integrate medical providers into their team during predeployment training such as NTC, JRTC, etc - CDRs must retain flexibility to align their care providers to their command population before providing general support - Although medical care is the primary function of Corps DIV BCT care providers, they also must support general staff functions							
Follow-up: - This Task is incorporated into the ASPCP Sync Matrix for follow-up assessment by the Army Suicide Prevention Council - Senior CDRs (or MEDCOM CDR) back brief implementation of guidance and MOA status during the VCSA Suicide Prevention Update - OTSG will continue to track implementation, best practices and lessons learned							

Army Suicide Prevention Task Force Task Action Form

Figure 5. ASPTF Task Action Form.

3) Criteria for Task Status Changes. Council Members will propose task color status changes (see paragraph (4.a.(3)(d))) based on the following criteria:

a) Amber task status will be proposed when a task remains on track for completion, but will not be completed by the specified deadline. The ASPTF Task Action Form will be completed by the OPR with a detailed explanation of the issue and a proposed alternative deadline for task completion.

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b) Red task status will be proposed when a task will not be completed. The ASPTF Task Action Form will be completed by the OPR with a detailed explanation of the impediment and proposed alternatives.

c) Blue task status will be proposed for new tasks to be introduced to the synchronization matrix. The ASTPF Task Action Form will be completed by the proposed OPR specifically addressing the requirement for the new task.

d) Black task status will be proposed when all sub-tasks associated with a task have been completed and the OPR believes the task can be removed (retired) from the synchronization matrix. The ASPTF Task Action Form will be completed by the OPR detailing the completion status of the task and all associated subtasks.

b. Commander's Plan.

(1) Commanders, the Army and each of you have an extensive support structure of health promotion, risk reduction, and suicide prevention-related policies, programs and resources. We as an Army are working hard to support Soldiers, Civilians, and Families. As you fully appreciate, our Army is tired and under immense stress as the result of a protracted conflict and associated OPTEMPO, DEPTMPO and PERSTEMPO factors. Under these strains, current efforts are not enough. Many of our Soldiers, Civilians, and Families need our immediate help to cope, build resilience and overcome cumulative stressors, complex medical and behavioral health issues, and subsequent compassion fatigue among our "help" providers.

(2) We recognize that this Army Campaign Plan must encompass much more than suicide prevention - it is really about the physical, mental, and spiritual health of our Soldiers, Civilians, and Families. This Plan takes a comprehensive, multi-disciplinary approach that focuses on all aspects of health and factors in promoting total health across the Force. It prioritizes, synchronizes, and implements a series of critical tasks that I firmly believe will emphasize health as the most critical component in re-energizing Force readiness and endurance.

(3) This Campaign Plan recognizes about 250 tasks across the Army that must be executed to achieve this goal; of this total, I have identified actions / tasks at Annex D that must be implemented immediately by you at every camp, post, and station and in every MTF to:

- Maximize the effects of your Health Promotion, Risk Reduction and Suicide Prevention-related Programs;
- Optimize your policy, programs, and resources; and

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- Set conditions for new and supplemental Army programmatic solutions and resources.

(4) Your caring and compassionate leadership ensures that our Soldiers, Civilians and Families receive the required front-line prevention and intervention services to reduce, identify, treat and heal their physical and "unseen" wounds. On behalf of the SA and CSA, our senior leaders and the Army Staff are working hard to assist you in your efforts to promote health and reduce risks across our Force. It will take all of us working together to fully implement this campaign plan; the ASPTF and I stand ready to assist you in accomplishing this critically important mission.

5. Shaping Operations: The strategy for communicating the Army Health Promotion, Risk Reduction and Suicide Prevention Campaign Plan is focused on informing, educating and persuading three critical major audiences: Soldiers and their Families, critical policy and resource decision makers (Congress) and key media agenda setters (who will shape public perception). Our purpose is to be effective, persuasive, compelling and consistent in communicating the circumstance and the content of the plan to our key audiences and stakeholders. Our communication priorities in order of importance are: 1) inform and educate Soldiers and Families as to what has happened and action that is being taken; and 2) as appropriate, provide factual, transparent information to key agenda setting media to make sure that the American public understands that the Army takes the mission of reducing Soldier suicides seriously and solutions are actively being incorporated into policy, procedures and training.

a. Execution. We will accomplish this strategy with an active Congressional Engagement Plan, Command Information Plan and Media / Public Engagement Strategy. See Annex C (Strategic Communications).

b. End State. Our desired end-state is a common understanding and appreciation that the Army is taking an active and effective approach to reducing the number of Soldier suicides.

6. Specified Tasks:

a. Director, Army Suicide Prevention Task Force. During Phase II (as described in paragraph 4.a. above), the Director, ASPTF will:

(1) Lead the Army effort to monitor and synchronize all Army actions to implement Policy-DOTMLPF-Resource improvements to Army health promotion, risk reduction and suicide prevention-related programs.

(2) Coordinate and execute all necessary actions to complete tasks assigned in the Synchronization Matrix (Annex B), as described in paragraph 4a above.

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b. Deputy Chief of Staff, G-1.

(1) During Phase II (as described in paragraph 4.a. above), the DCS, G-1 assists the Director, ASPTF in monitoring and synchronizing Army actions to implement Policy - DOTMLPF - Resource improvements to Army health promotion, risk reduction and suicide prevention-related programs.

(2) During Phase III (as described in paragraph 4.a. above), assume proponent responsibility and integrated community leadership for the Army health promotion, risk reduction and suicide prevention-related programs. DCS, G1 will continue to monitor and synchronize Army actions to implement Policy - DOTMLPF - Resource improvements to Army health promotion, risk reduction and suicide prevention-related programs.

c. Deputy Chief of Staff, G-3/5/7.

(1) Assist the Director, ASPTF in monitoring and synchronizing all Army actions to implement Policy – DOTMLPF - Resource decisions to improve health promotion, risk reduction and suicide prevention-related programs.

(2) Ensure the ACPHP is synched with the Army Campaign Plan.

(3) Coordinate and formally task the Field Army (ACOM, ASCC, DRU, etc.) with all appropriate tasks in support of the ACPHP.

(4) Ensure growth validation incorporates new rules of allocation or other organizational templates.

d. Office of the Chief of Public Affairs. ICW OCLL, assist the ASPTF in establishing a communication planning group to produce a long term strategic communication plan that nests into the long term ACPHP. Establish over-arching messaging for the effort and provide support to highlight current programs, new initiatives and new policies and procedures launched as part of the campaign. The communication planning group, chaired by the subject matter expert lead with appropriate staff in support, will meet on a bi-weekly basis to maintain Strategic Communication efforts and plan support to operational and tactical product launches and event support required by the task force.

7. Commander's Critical Information Requirements (CCIR): CCIR will be provided immediately to the Director, ASPTF (Phase II) or the DCS, G-1 (Phase III):

a. Any incidents of attempted or suspected suicidal acts by Soldiers.

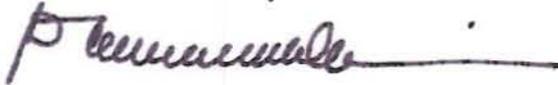
"The Army's charter is more about holistically improving the physical, mental, and spiritual health of our Soldiers and their families than solely focusing on suicide prevention. If we do the first, we are convinced that the second will happen."
- Gen Peter W. Chiarelli, VCSA, 29 March 2009

DACS

SUBJECT: Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP)

b. Initiation or guidance to initiate any new suicide prevention-related inspection, assessment, review or investigation of any Army organization.

c. Any suicide prevention-related Congressional or media engagement.



PETER W. CHIARELLI
GEN, USA
Vice Chief of Staff, Army

ANNEXES:

A – ASPC/ASPTF Membership

B – Synchronization Matrix

C – Strategic Communications Plan

D – Installation, Garrison and MTF Commanders Critical Actions/Tasks

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Ann (ASPC/ASPTF Membership) to Army Campaign
 Plan for Health Promotion, Risk Reduction and Suicide
 Prevention (ACPHP)

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Ann (ASPC/ASPTF Membership) to Army Campaign
 Plan for Health Promotion, Risk Reduction, and Suicide
 Prevention (ACPHP)

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Annex C (Strategic Communication) to the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention

1. General: Implementation of the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP) will be supported by a strategic communication effort to inform and educate key audiences of the Army's ongoing, comprehensive approach to health promotion, risk reduction and suicide prevention. Building on and making connections between existing Army programs related to preventive medicine, health promotion and resiliency initiatives, the ACPHP strategic communication effort will focus on highlighting existing programs, and communicating specific improvements, enduring solutions across the full spectrum of health promotion, risk reduction and suicide prevention-related programs.

2. Background: In response to increased suicide rates, the Army has established the Army Suicide Prevention Task Force (ASPTF), an interim organization focused on promoting Soldier, Civilian and Family wellness and launched a Health Promotion, Risk Reduction and Suicide Prevention Campaign plan to better synchronize efforts between multiple programs focused on care, support, services and Army policy. This annex will focus strategic communication efforts to increase awareness among Soldiers, Civilians and Family members of programs / initiatives designed to promote wellness and to improve the resiliency of our Army community.

3. Purpose: To inform and educate key audiences of the campaign plan's mission, end state and comprehensive actions designed to promote wellness within our Army community.

4. ACPHP Staff Lead / Primary Audiences:

a. **Staff Lead:** The ASPTF, an interim HQDA-level organization chartered under the Vice Chief of Staff of the Army. All other ARSTAF elements are in support.

b. **Primary Audiences:**

(1) **Installation, Garrison and MTF Commanders.** Initial effort will focus on Commander's actions to implement the recommendations and tasks listed in Annex D to the ACPHP. We will support Commanders by providing outlets to the community regarding new and modified programs and initiatives at the installation level.

(2) **Soldiers, Civilians and Families.** Effort will focus on informing and educating Soldiers, Families, DA Civilians, and the contracted work force using a multi-faceted communication approach incorporating the use of operational channels (OPORDs, EXORDs, FRAGOs, ALARACTS) and command information, community relations and social media across the institutional and operational Army (IMCOM, FORSCOM, MEDCOM, TRADOC, FMWRC, etc.) Tools include VCSA Sends, STAND-TO, Senior Army Leader's Paper (SALP), AKO, the Army home page and Command Information (CI) outlets, including Soldier's Magazine, Army News Service (ARNEWS) and Soldier Radio and TV (SRTV). Additionally, we will publicize through these CI outlets approved updates and revisions to both individual and collective programs and

Annex C (Strategic Communication) to the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention

services at installations and institutional training in TRADOC schools. PAOs at garrisons/installations and commands affected by these changes / updates / revisions will submit CI products (broadcast and print) that inform our internal publics on these changes to ARNEWS and SRTV. Clearance for these will be at the source.

c. Congress: OCLL will work with the Staff Lead and SMEs to inform and educate Congress on the comprehensive changes the Army is making across multiple functional areas in health promotion, risk reduction and suicide prevention. OCLL will inform by electronic IMCs (Information to Members of Congress), Office Calls, and briefings. OCLL will educate Congress through Congressional participation in Army-level events and unit activities at Posts, Camps, and Stations. They will assist in witness preparation for any hearings, Oversight committee briefing (SASC, HASC, SAC-D and HAC-D), and member inquiries. OCLL will work with OCPA to ensure strategic communications, themes and messages are synchronized.

d. External Media: OCPA will work with the Staff Lead and SMEs to schedule events and products highlighting the comprehensive changes the Army is making across the Policy – DOTMLPF – Resource domains to address this issue. Reinforcing key health promotion, risk reduction and suicide prevention themes and messages, OCPA will engage external media in an effort to increase accurate, balanced and comprehensive coverage of ASPCP activities.

5. Key Theme / Messages:

Army enduring theme: *“Holistically improving the physical, mental, and spiritual health of our Soldiers and their families”*

a. ACPHP messages:

The Army Campaign Plan for Health Promotion will identify and implement immediate solutions—across the Army—to improve health promotion, risk reduction and suicide prevention-related programs.

An Army Suicide Prevention Task Force and Army Suicide Prevention Council have been established to rapidly analyze existing programs and develop solutions to reduce the rate of Army suicide.

The Army Suicide Prevention Task Force and Army Suicide Prevention Council will focus on improving Army health promotion, risk reduction and suicide prevention programs to improve resiliency and positive life coping skills throughout our Army community.

b. Army enduring suicide prevention messages:

Suicide Prevention is critical in the Army.

Annex C (Strategic Communication) to the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention

Suicide prevention is about Soldiers taking care of Soldiers. In the Army, we always take care of our battle buddies.

Everyone in the Army Family needs to be involved in suicide prevention.

Taking care of our own is part of our culture and ethos.

We are committed to decreasing stigma associated with seeking help, to improving access to care, and to incorporating suicide prevention training into all training programs

World class training and resources are available to assist Soldiers, Families, and Army Civilians in suicide prevention.

The loss of an American Soldier's life is a tragedy regardless of the reason.

Our goal is to provide men and women wearing the Army uniform and their Families the best available support to help them overcome the stresses that society in general, as well as military service entails.

6. Strategic Communication Event Matrix/Desired Effects:

Date	Event	Actions	Desired Effect
April XX	Strategic Communications Plan/Public Affairs Guidance	Distributed in coordination with Campaign Plan	Ensure Army leaders/staff/commands execute Task Force/Campaign guidance.
April XX	ARNews/STAND-TO/SALP		Increase internal audience awareness of Task Force/Campaign Plan mission, end state and ongoing actions.
April XX	Host MHM Media Roundtable	Engage Senior Army leaders and Task Force	Increase public awareness of Army Suicide Campaign Plan mission, end-state, and objectives via targeted local and national media.
April XX	Social Media— Bloggers Roundtable	Outreach to Soldiers/Army Families/Veterans/ Military bloggers and TSG Blog	Use social media to increase awareness of Army Suicide Campaign Plan programs; enhance public understanding of Army Suicide prevention efforts.

Annex C (Strategic Communication) to the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention

April XX	Command Information product(s)	Conduct Interviews with senior Army and Suicide prevention, risk reduction SMEs	Educate Soldiers, Family members on Army Campaign Plan initiatives and resources.
April XX	External media release(s)	Release updated Task Force accomplishments to targeted external media	Educate internal/external audiences on Army Campaign Plan initiatives.
May 7	Monthly Suicide Data Release	Release GreenTop/IMC with updated Army suicide data/facts	Inform key audiences of current Army suicide data/status of Army suicide prevention efforts.
June 11	Monthly Suicide Data Release	Release GreenTop/IMC with updated Army suicide data/facts	Inform key audiences of current Army suicide data/status of Army suicide prevention efforts.
July 9	Monthly Suicide Data Release	Release GreenTop/IMC with updated Army suicide data/facts	Inform key audiences of current Army suicide data/status of Army suicide prevention efforts.
Aug 13	Monthly Suicide Data Release	Release GreenTop/IMC with updated Army suicide data/facts	Inform key audiences of current Army suicide data/status of Army suicide prevention efforts.
Sep1	National Suicide Prevention Month	Implement Army-wide communication effort to increase effectiveness of suicide prevention programs	Decrease Army suicide rate; Inform/educate key audiences of ongoing Army suicide prevention efforts.

Annex C (Strategic Communication) to the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention

Sep 10	Monthly Suicide Data Release	Release GreenTop/IMC with updated Army suicide data/facts	Inform key audiences of current Army suicide data/status of Army suicide prevention efforts.
Oct 8	Monthly Suicide Data Release	Release GreenTop/IMC with updated Army suicide data/facts	Inform key audiences of current Army suicide data/status of Army suicide prevention efforts.

OFFICIAL:

**CHIARELLI
GEN**

Annex D (Installation, Garrison, and MTF Commander Critical Action / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

Installation, Garrison, and Medical Treatment Facility (MTF) Commanders will implement the following checklist to optimize efforts in support of health promotion, risk reduction, and suicide prevention-related programs, and set conditions for follow-on Army programmatic change:

1. Program / Service Integration (Community Integration of Health Promotion, Risk Reduction, and Suicide Prevention-related Programs):

- Do you have a comprehensive, all encompassing health promotion, risk reduction and suicide prevention-related strategy that links installation / garrison / MTF staffs and activities and is readily recognized and acknowledged by the unit commanders, Soldiers, Civilians, and Family members?
- Is your health promotion, risk reduction and suicide prevention-related strategy formally organized via a published blueprint (wire diagram, etc.) that outlines the interdependent and dependent relationships of the multiple staffs / agencies and programs supporting that strategy?
- Do you have an aggressive marketing, advertising and outreach plan to heighten Soldier, Civilian, and Family Member awareness of your health promotion, risk reduction and suicide prevention-related strategy that clearly depicts staff / agency charters, programs, services, and other activities?
- Do you have a formal process / system to assess, report, and measure the effectiveness of your strategy and your marketing / advertisement? Does this process measure strategic goals, program / service objectives, and customer feedback, with mechanisms to adjust your strategy based on lessons learned?
- Is there an Installation / Garrison Community Health Promotion Council (CHPC), or similar body, that meets regularly to integrate all staffs and agencies associated with providing health promotion, risk reduction and suicide prevention-related programs (e.g., CHPC coordinator, suicide prevention coordinator, risk reduction coordinator, clinical / non-clinical ASAP, clinical / non-clinical FAP, ACS [MFLC, FRC, AER, etc.], chaplains, DES, CID, CAO, DPTMS, primary care coordinator, behavioral health coordinator, SJA, safety, and MSC CDRs [as appropriate], etc.)?
- Do you have formal charters signed by Installation / Garrison / MTF Commanders for all health promotion, risk reduction, and suicide prevention-related programs, councils, committees, task forces, etc.? Do charters clearly outline (at a minimum): (1) organizational structure; (2) mission; (3) scope and objectives (integration with other councils / committees) (4) authorities; (5) membership and roles / responsibilities; (6) meeting schedules; (7) standard products / services; (8) protocols for assessments, measuring, reporting, and incorporating lessons learned; and (9) marketing / outreach plan?
- Do you require appropriate senior leadership attendance at meetings of installation / garrison / MTF health promotion, risk reduction, and suicide prevention programs / counsels / committees / task forces, etc. to ensure those groups are empowered to make decisions and allocate resources appropriately?

Annex D (Installation, Garrison, and MTF Commander Critical Action / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

- Do your Installation / Garrison staffs / agencies provide you with a comprehensive, composite report of all Soldier medico-legal actions and trends across the installation / command (e.g., admin separations; MMRB, MEB, PEB, disciplinary actions; WTU referrals; ASAP referrals, etc.) to inform / standardize Soldier medico-legal actions and to reduce risks associated with policy, program, and process gaps / seams?
- Do your Installation / Garrison staffs / agencies integrate specific Soldier information to share among “need-to-know” commanders and “help providers” (e.g., law enforcement; behavioral health; clinical and non-clinical ASAP and FAP) to integrate Soldier medico-legal processes (administrative separations; MMRB, MEB, PEB, disciplinary actions; WTU referrals; etc.)?
- Do your Installation / Garrison staffs / agencies integrate and reconcile common medico-legal databases (e.g. ACI2, COPS, DAMIS, ACR, etc.) to ensure accurate, timely information regarding Soldier medico-legal actions?
- Is there a “commander’s forum” to share observations / TTPs / lessons learned from suicide events (from successful intervention to events that led to Soldier’s death) that occurred in their commands?
- Do you have a comprehensive process to maximize use of information regarding health promotion, risk reduction, and suicide prevention (i.e., medico-legal trends across the installation, specific Soldier information, etc.) during recurring commander reports / briefs such as staff calls, QTBs, USR briefs, etc.?
- Do you have an MOA in place to allow all primary and behavioral health care providers (MEDCOM and Corps / DIV / BDE) to be integrated under a central authority (Installation Commander and MTF Commander) to provide comprehensive, seamless primary / behavioral health care in MTFs, reduce provider-patient workload; and enhance provider professional development? Does your MOA have a provision to “surge” medical capabilities and capacity upon unit redeployment?
- Are redeploying BDE and BN commanders retained for 90-120 days during the reset phase to ensure leadership continuity and cognizant-mitigation of unit and Soldier stressors (e.g., complete PDHRA, insulate Soldier teams / networks, complete disciplinary / separation actions, integrate Soldiers and Families, naturalize health promotion, etc.)? Are you coordinating directly with HRC / SLD on a case by case basis to provide balance between late changes of command (25-36 months) and the reset mitigation of high-risk Soldiers and Families?
- Are redeploying maneuver unit (DIV / BDE / BN) primary care and behavioral health care personnel retained for 90-120 days during the reset phase (as feasible) to ensure continuity of care, cognizant-mitigation of unit and Soldier stressors, and sufficient treatment “handoff” to incoming medical personnel? Are you coordinating directly with HRC and local MTF commanders to retain or align PROFIS primary care providers with unit reset plans?
- Are redeploying unit level Soldiers retained for 90-120 days during the reset phase to ensure team / network continuity and cognizant-mitigation of unit and Soldier stressors

Annex D (Installation, Garrison, and MTF Commander Critical Action / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

(e.g., team-based re-integration, team-supported family re-integration, refocus high-adrenaline behavior, etc.)? Are you coordinating with AG / G1 to centrally manage retention of the full-spectrum of MOSs?

- Does your installation / garrison have regularly scheduled health promotion, risk reduction, suicide prevention awareness observance activities (annually, quarterly, and monthly)? Are they formally scheduled on the installation / garrison calendars and attended by appropriate senior leaders?
- Do you have a formal system or process to compare and bench your policies, programs, and services with other like installations to identify and incorporate "best business practices" (e.g., CHPC or other formal council establishes a relationship with other installation CHPCs)?

2. Specific Programs / Staffs (Health Promotion, Risk Reduction and Suicide Prevention-related Programs):

- Is there a designated leader (e.g. MTF Commander) in charge of installation Health Promotion Programs and affiliated services?
- Is there a unit-based behavioral health and comprehensive fitness program with appropriate designated counselors and clinical supervision?
- Are behavioral health initiatives coordinated with unit chaplains, unit medical personnel, CSCTs, and MFLCs to deliver health programs, risk reduction, and suicide prevention-related information and services at the Soldier / unit level?
- Do you have a comprehensive Installation / Garrison strategy [plan] to combat the stigma associated with Soldiers seeking behavioral health care (e.g., guidance added to leader and Soldier counseling, leaders attend mass screenings with their Soldiers, incorporate importance of behavioral health in training guidance and forums, etc.)?
- Are chaplains integrated with behavioral health specialists in units, and with CSCTs and MFLCs to provide multi-disciplinary support, naturalize referrals, and reduce stigma associated with help seeking behavior?
- Do you have adequate number of ASAP and FAP staff (clinical and non-clinical) to provide timely support to Soldiers and Family members? Is there a back-log or waiting list for services? Are your education and training forums small enough to encourage dialogue / group participation?
- Is your ASAP staff (clinical and non-clinical) co-located and interact regularly to share information on substance abuse cases / trends to better inform health promotion, risk reduction and suicide prevention-related programs on the installation?
- Do you periodically and systemically track, monitor and report ASAP / FAP / AFAP and other program personnel strength / hiring / retention / qualification / certification issues to ensure adequate support to commanders?

Annex D (Installation, Garrison, and MTF Commander Critical Action / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

- Are commanders directly involved in formulating ASAP treatment plans / contracts with counselors and referred Soldiers to ensure leadership commitment to recovery programs?
- Do you have established procedures for the ADCO to receive information (abstracts) derived from Centralized Operations Police Suite (COPS) on a recurring basis to maximize information sharing related to high risk behaviors?
- Are Military Health System personnel providing direct oversight of network inpatient detoxification and recovery programs to maintain situational awareness of Soldier recovery?
- Do you have systems to ensure timely communication among Military Health System personnel, ASAP, and civilian inpatient / detoxification facilities?
- Are civilian inpatient / detoxification facilities located physically close enough to your installation – with enough bed space – to ensure timely transfer of care to those off-post facilities?
- Are Military and Family Life Consultants (MFLC) readily available to Soldiers and Families, incorporated into commander / unit programs, and fully integrated with other help providers to ensure seamless coverage between contact and referral?

3. Primary and Behavioral Health Care:

- Are your primary health care and behavioral health care providers consolidated (co-located) to provide comprehensive medical treatment, share treatment plan information, and reduce stigma associated with behavioral health?
- Are your Corps / DIV / BDE primary / behavioral health providers treating patients in modern MTFs to ensure that Soldiers receive comprehensive, state-of-the-art medical health care commensurate with Family medical care (e.g., facility, equipment, and specialty consultation and services, etc.)?
- Are MTF coordinators linked to Corps / DIV / BCT surgeons to coordinate / schedule facility access for patient care IAW the MTF commander's comprehensive medical care plan?
- Are medical / clinic operating hours convenient for Soldier / Family care access and maximum facility usage? Is there sufficient clinical and support staff to operate expanded hours; and have you considered hiring part time employees and RC providers to expand operating hours?
- Does your MTF have a quality assurance process by which "at risk medication" prescriptions are tracked and peer reviewed? "At risk medication" prescribing would include (label or off label use) drug combinations comprised of three or more of the following: Opioid Narcotics, Anxiolytics, Antipsychotics, Sedative-hypnotics, mood stabilizers, and anti-convulsants.

Annex D (Installation, Garrison, and MTF Commander Critical Action / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

- Does the Behavioral Health Department provide psychotherapy for Soldiers being prescribed multiple psychotropic medications as deemed appropriate?
- Do you have a comprehensive alternative pain management approach for Soldiers coping with chronic pain to reduce the dependency on Opioid Narcotics (e.g., alternative treatment modalities for pain such as spinal cord stimulation, acupuncture services, and biofeedback, etc)?
- Does your installation have an SRP screening process that uses a face-to-face interview with either a behavioral health specialist or primary care specialist with behavioral health specialists as back-up?
- Has the installation implemented a coordinated program of periodic screening, triage, and multidisciplinary treatment to support Soldiers and their Families? Have on-line programs been implemented to increase screening rates and improve efficiency (i.e., Automated Behavioral Health Clinic)?
- Do you have systems / processes to leverage medical screening information (e.g., PHA, PDHA, PDRHA, screenings for TBI and PTSD, etc.) to notify commanders of Soldier compliance and risk factors revealed by that information; and for appropriate referrals and subsequent treatment plans?
- Is there a "medical care provider forum" to increase collaboration or improve identification of at-risk Soldiers and Families to maximize their care and enhance general suicide prevention measures?
- Is there a holistic and comprehensive case management system to synchronize individual / family case file management to integrate and coordinate a treatment plan that is all inclusive (e.g. primary health care, behavioral health care, substance abuse, family advocacy) to ensure the effort is simultaneously coordinated among all care providers?
- Does your PTSD / mTBI program fully utilize opportunities for collateral contacts with spouses and other family members to assess and validate symptoms associated with PTSD / mTBI?
- Does your PTSD / mTBI program fully utilize opportunities for individual and family psychotherapy to assist with resolution of symptoms and improve coping and subsequent recovery?
- Does your PTSD / mTBI program utilize neuropsychological / psychological assessment to validate complaints and symptoms, quantify deficits prior to developing a plan of treatment and again after treatment to assist with determination of return to duty or referral to MEB?
- Do your Review of Care meetings include all providers involved in the care of an individual Soldier?
- Does your PTSD / mTBI program utilize Rehabilitation Psychologists as treatment providers?

Annex D (Installation, Garrison, and MTF Commander Critical Action / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

4. Family / Friends Participation:

- Do you have a means to connect Soldier Families (e.g., spouse, children, parents) and, in particular, single-Soldier Families (e.g., parents, fiancé, and children) with commanders and their programs?
- Do you include Soldier Families (e.g., spouse, fiancé, children, and parents) in re-integration training?
- Has the Senior Commander implemented a program to actively engage leaders and their spouses / fiancés / parents in support of a comprehensive, health promotion, risk reduction, overall fitness plan to strengthen relationships and support networks?
- Have you reviewed the OPTEMPO of the units assigned to the installation to sync / implement Soldier and Family resiliency-focused programs to improve total family wellness / quality of life?
- Are training and retreat programs, which are intended to improve resiliency (i.e., Strong Bonds, Battle Mind, ASIST, etc.), adequately funded to allow maximum participation? Is there a backlog or wait list? Are additional resources required? If so, do you have a plan to address those needs?

5. Warrior Transition Units:

- Do you have policies and programs at your WTU to monitor and optimize Soldier return to duty?
- Do you have a system / criteria to vet each Soldier recommended for assignment to the WTU to ensure that Soldiers remain with their units / teams as appropriate, and that only Soldiers who clearly require WTU-level management are assigned to the WTU IAW or supplemental to FRAGO 3?
- Does the Installation / WTU have clear policy and criteria for nominating and vetting WTU cadre to ensure that only Officers and NCOs who have demonstrated success in prior equivalent-level leadership roles be assigned to WTU leader positions?
- Do your WTUs track and report pharmaceutical usage to Senior Command leadership?
- Are Opioid narcotic prescriptions in the WTU / WTB limited to 7 days (with commander's authority to exempt on an individual basis)?

6. Reducing High-risk Behavior:

- Do you encourage subordinate commanders at all levels to comply with regulatory guidance to initiate or process administratively separate Soldiers for misconduct to include serious drug / alcohol or multiple drug / alcohol incidents?
- Has the installation implemented policies and programs to identify and assist Soldiers who enlist with waivers or significant pre-existing conditions?

Annex D (Installation, Garrison, and MTF Commander Critical Action / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

- Do your commanders refer Soldiers to ASAP who have either a positive urinalysis or a drug / alcohol related incident IAW AR 600-85?
- Do Soldiers receive an individual comprehensive evaluation within 12 working days of being referred to ASAP counselors IAW AR600-85?
- Are ASAP timelines (referrals and ASAP intervention) reported to the Senior Commander?
- Do you offer installation MWR adventure-type activity programs to Soldiers to divert / reduce Soldier combat-related adrenaline-rush that leads to inappropriate high risk / adrenaline seeking activities?

7. Education / Training [Health Promotion, Risk Reduction and Suicide Prevention-related Programs]:

- Does the Installation have a program for redeploying battalion and company commanders to provide refresher training on Soldier-specific administrative and medico-legal requirements to reduce high-risk populations (e.g., administrative separations; commander's disciplinary reports; UCMJ, MMRB, MEB, and PEB processes)?
- Do you have a program to provide refresher training for incoming commanders and rear-DET commanders on policies and processes associated with disciplinary actions, disciplinary action reporting, administrative separation, and medical board processes / options? (Many commanders have only known multiple deployments and have little / no experience on "institutional roles and responsibilities" such as administrative, disciplinary, and accountability policies / processes.)
- Have local Company Commander and First Sergeant's Course Programs of Instruction regarding suicide prevention been updated to include the importance of developing positive life coping skills in their Soldiers?
- Does the Installation Chaplain have opportunities for (a) in-service training on counseling skills or (b) external training / certification (e.g., professional courses, fellowships, internships, exchanges, etc.) that focus on comprehensive wellness, behavioral health referral consultations, and integration within the behavioral health community including behavioral health providers, CSCTs, ASAP / AFAP, MFLCs, etc.?
- Is the Installation Suicide Prevention Program Manager tracking the number of Applied Suicide Intervention Skills Training (ASIST) Trainers and ASIST-level Crisis Intervention trained personnel on post?
- Does the Installation have at least two (2) ASIST qualified trainers that can sponsor the 2-day ASIST workshop?
- Does the Installation have at least one (1) ASIST-trained personnel at each community support agency (e.g., SJA, MP, ACS, etc.)?
- Have you incorporated the Army Suicide Stand-down and Prevention training (e.g., *Beyond the Front*, ACE, etc.) for retraining / refresher training this fiscal year? For

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instance, *Beyond the Front* could be utilized in smaller forums, under new group dynamics, with changed interactive options / outcomes, with Families, or aggregated with other products / forums.

8. Medico-legal and Command Systems:

- Do you have a reporting / tracking system to monitor compliance with regulatory guidance on administrative separations of Soldiers for misconduct, to include serious drug / alcohol or multiple drug / alcohol incidents and other serious criminal activity?
- Do unit commanders, medical health providers, ASAP / FAP clinicians and non-clinician personnel have a composite picture of high-risk Soldiers to sync medico-legal actions for Soldiers who commit multiple criminal / substance abuse events, prevent recidivism, and reduce high-risk Soldier populations?
- Do your medical board policies permit unit commanders to refer a Soldier to the MMRB after a MEB / PEB determination to retain an MOS-limited Soldier; extend the deadlines for MEB processing to complete the board with a single series of medical consults; authorize resumption of MEB processing for expired cases with only a file review as an option to expedite the case; and ensure adequate number of medical / legal personnel to expedite backlogs / surges for MEB / PEB services for pre- and post-deployment?
- Do unit commanders and Soldiers receive timely adjudication of disability status, fitness for MOS, and fitness for duty as a result of MMRB / MEB / PEB?
- Are procedures / policies in place for commanders to respond to Soldiers who refuse treatment "against medical advice (AMA)"?
- Is there a method for tracking at risk Soldiers due to intra-post transfers between activities, units and tenants?
- Are Commanders incorporating the importance of Soldier, Civilian, and Family physical and mental health in all initial and subsequent performance counseling to enhance program and service awareness and reduce stigma associated with help seeking behavior?

9. Postvention and Investigations:

- Is your Quality Improvement / Quality Assessment Program performing root cause analysis on all deaths that occur within 31 days of last scheduled appointment?
- Are there procedures in place for commanders to participate with the CAO to meet and talk with the family (spouse, parent, fiancé, etc.) in an incident related to suicide?
- Do you have a Suicide Response Team (team of experts) to immediately assist commanders in coordinating and integrating "postvention" activities in the event of a completed / attempted suicide?
- Are commanders appointing an AR 15-6 investigation for suicide or suspected suicide to

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provide a comprehensive review of all possible causes: mental / physical illness, financial problems, failed relationships, other cumulative stress factors, trigger events, etc., to inform current and improve future programs and services?

- Are AR 15-6 investigations deliberately scoped and appropriately timed to ensure effective coordination with CID and MTF personnel conducting official, ongoing postvention activities (e.g., investigation, coordination of autopsy, ongoing toxicology and forensic examinations, etc.)? Are your 15-6 investigative officers coordinating with the CID Special Agent in Charge and the MTF DODSER Coordinator to synchronize efforts and ensure an accurate, inclusive, and synergistic 15-6 investigation?
- Is CID coordinating with specific commanders regarding equivocal death investigations to ensure commanders take appropriate, timely actions (AR 15-6, LOD, etc.) in the event that the equivocal death is determined to be a suicide? Are you tracking general trends for all equivocal deaths resulting from high-risk behavior to inform current and improve future programs and services?
- Are Line of Duty Determinations (LODs) being performed in all deaths and injuries arising from suicide-related events (equivocal deaths, attempts, and gestures, etc.)?
- Are post-suicide LOD investigators coordinating and communicating with an appropriate MTF behavioral health officer to obtain an opinion from that officer regarding whether the Soldier who died of suicide was "mentally sound" at the time of the suicide incident?
- Are Soldiers receiving instruction that dependents of active duty Soldiers generally will not receive Dependency and Indemnity Compensation (DIC) benefits from VA in the event of suicide?
- Has your Medical Treatment Facility migrated from the Army Suicide Event Reporting (ASER) system to the DoD Suicide Event Reporting system (DoDSER) for reporting suicide-related event data? If not, have you taken all steps necessary to expedite that migration?
- Is your Medical Treatment Facility working with CID, Fatality Review Board, and AR 15-6 / LOD investigator to ensure timely and accurate reporting of suicide-related event data on DoDSER?