

Personnel--General

ARMY NATIONAL GUARD HEALTH PROMOTION PROGRAM

By Order of the Secretary for the Army:

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**Summary.** This regulation prescribes basic policies, responsibilities, and procedures for the Army National Guard Health Promotion Program.

**Applicability.** This regulation applies to members of the Army National Guard. The provisions of Chapter 4 apply to all agencies or businesses that operate within or visit Army National Guard work places.

**Impact on new manning system.** This regulation does not contain information that affects the New Manning System.

**Internal control systems.** This regulation is not subject to the requirements of AR 11-2 and does not contain internal control provisions or checklists for conducting internal control reviews.

**Supplementation.** Supplementation to this regulation is encouraged to tailor health promotion to each state, but is not required. If supplements are issued, states and territories are requested to furnish one copy

of each supplement to: Chief Surgeon, Health Services Division, Personnel Directorate, **ATTN:** NGB-ARP-H, ARMY National Guard Readiness Center, 111 South George Mason Drive, Arlington, Virginia 22204-1382. Policies established in this regulation may not be changed without prior approval of NGB-ARP-H.

**Interim changes.** Interim changes to this regulation are not official unless they are authenticated by the Chief, Administrative Services (NGB-AD). Users will destroy all interim changes on their expiration dates unless sooner superseded or rescinded.

**Suggested improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Chief, National Guard Bureau, **ATTN:** NGB-ARP-H, ARNGRC, 111 South George Mason Drive, Arlington, VA 22204-1382.

**Distribution:** A

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**Chapter 1  
Introduction**

**Section 1  
General**

**1-1. Purpose**

This regulation prescribes policies and responsibilities for the Army National Guard (ARNG) Health Promotion Program.

**1-2. References**

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

**1-3. Explanation of abbreviations and terms**

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

**1-4. Objective and scope of the ARNG Health Promotion Program**

**a.** The goal of the ARNG Health Promotion Program is to maximize readiness, combat efficiency, and work performance. Objectives include enhancing the quality of life for the total ARNG family and encouraging lifestyles to improve and protect physical, emotional, and spiritual health.

**b.** The ARNG Health Promotion Program encompasses a variety of activities designed to facilitate behavioral and environmental alterations to maintain optimum health. This includes a combination of health education and related organizational, social, emotional, spiritual, and health care activities and initiatives. These are integrated to produce a single, comprehensive program.

**c.** Functionally, the components of health promotion consist of all activities for members of the Total ARNG Family in the following areas:

- (1) Antitobacco.
- (2) Physical conditioning.
- (3) Weight control.
- (4) Nutrition.
- (5) Stress management.
- (6) Alcohol and drug abuse prevention.
- (7) Early identification of hypertension.
- (8) Suicide prevention.
- (9) Spiritual fitness.
- (10) Oral health.
- (11) Injury prevention.

**d.** In addition to the components listed above, health promotion necessarily includes other related activities. These include such things as physical and dental examinations, health risk appraisals, physical fitness centers, recreational activities, educational activities, as well as initiatives to promote social and emotional well-being. These activities are coordinated and integrated into a comprehensive ARNG Health Promotion Program.

**e.** Operationally, health promotion is implemented and enhanced at the unit level through a commander's health promotion program as provided in this regulation.

## **Section II Responsibilities**

### **1-5. Chief, National Guard Bureau (CNGB)**

The CNGB prescribes policy and programs for health promotion and preventive medicine within the ARNG, and supports/encourages the fifty-four state adjutants general to develop an inclusive health promotion program within their respective State/Territory.

### **1-6. The Director, Army National Guard (DARNG)**

The DARNG represents the CNGB in all matters pertaining to health promotion and preventive medicine within the ARNG.

### **1-7. Deputy Director, Personnel and Manpower, NGB-ARP**

Is responsible for providing program policy guidance on development and implementation of the following state run programs: antitobacco, nutrition, early identification of hypertension, oral health, physical conditioning, stress management, suicide prevention, weight control, and injury. The Director will monitor data, and provide guidance to the states on program development and implementation to achieve health promotion.

### **1-8. Chief, Office of the Chaplain, NGB-ARZ-CH**

Is responsible for providing program policy and guidance on development and implementation of spiritual fitness, suicide prevention and battle fatigue ministry. The Chaplain provides appropriate assistance to the Chief Surgeon, ARNG, in development and promulgation of medical technical policy and guidance for the following programs: Suicide Prevention and Stress Management.

### **1-9. Director, Counterdrug Directorate, NGB-CD**

Is responsible for providing program policy guidance on development and implementation of the state Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).

### **1-10. Deputy Director, Operations, Training and Readiness, NGB-ARO**

Is responsible for developing and implementing the ARNG physical conditioning and weight control programs and providing oversight to the states.

### **1-11. Commander, State Area Command (STARC)**

STARC will--

**a.** Establish and chair a state Health Promotion Council (HPC).

**b.** Designate a State Health Promotion Coordinator to coordinate state health promotion activities with outside agencies.

**c.** Coordinate with the State Surgeon to integrate health promotion activities and monitor program progress in the state.

**d.** Monitor aggregate data and implement a health promotion program for the state in accordance with this regulation and guidance from National Guard Bureau.

**e.** Appoint a task force chaired by the STARC Chaplain, with the State Surgeon in assist, to manage a state Army Suicide Prevention Program.

### **1-12. State Deputy Chief of Staff for Personnel (DCSPER), i.e., State Military Personnel Officer (MILPO)**

The DCSPER is the state proponent for--

**a.** Health Promotion Program.

**b.** Alcohol and Drug Abuse Prevention and Control Program.

**c.** Antitobacco Program.

**d.** Army Weight Control Program.

**e.** Oversight responsibility for morale, welfare and recreational physical fitness and recreation facilities.

**f.** Suicide Prevention Program.

**g.** Defines the role of and educates Family Support Program (FSP) personnel in support of suicide risk identification efforts using professional assistance from the Chaplain and State Surgeon.

**h.** Provides for suicide prevention education and community awareness programs for family members and civilian employees.

### **1-13. State Deputy Chief of Staff for Operations and Plans (DCSOPS), i.e., State Plans, Operations and Training Officer (POTO)**

**a.** The DCSOPS has staff responsibility for the Army Physical Fitness Program (APFP).

**b.** Coordinates training support packages for suicide risk identification for unit leaders.

**c.** Provides suicide risk identification integration training for state run leadership courses.

**d.** Implements DOD policy to control use of tobacco products for all state run training programs.

**e.** Provides injury risk early identification training for state run leadership courses.

### **1-14. State Deputy Chief of Staff for Logistics (DCSLOG)**

The DCSLOG is the proponent for development and implementation of policies and programs concerning nutrition in troop dining facilities with assistance from the State Surgeon.

### **1-15. State Surgeon**

**a.** Develops policy for all medical, dental, psychological, physiological, and health areas to include: weight and body fat standards, cardiovascular risk factor reduction, nutrition, suicide prevention and stress management. Assists in policy development in other areas including ARNG health promotion, physical fitness and exercise, weight control, control of substance abuse, and antitobacco use.

**b.** Is the staff proponent for implementation of health education and treatment programs for individuals affected by stress.

**c.** Acts as state executive agent for nutrition policy, standards, and education programs.

**d.** Is the staff proponent for early identification of hypertension.

- e. Is the staff proponent for oral health promotion.
- f. Plans, implements, and evaluates an automated health risk appraisal with procedures for administration, processing, compiling and utilizing the data for health promotion purposes at state level.
- g. Advises the State Adjutant General with respect to all medical and psychiatric aspects of health promotion to include the epidemiological aspects of suicide.
- h. Oversees the medical and health aspects of ARNG suicide prevention training programs.
- i. Assures the state provides:
  - (1) Health care providers and equipment to administer and interpret the health risk appraisal, teach classes, and compile statistics to support the health promotion program.
  - (2) Training for health care providers in suicide risk identification and treatment for individuals who may be at increased risk of suicide.
- j. Develops protocols for the identification and management of suicidal individuals in all patient care units and provide inservice suicide prevention training for health care providers.
- k. Appoints an appropriate AMEDD officer to conduct a psychological autopsy, as required, to clarify the nature of death focusing on the psychological aspects of the dead person. Primary purpose is to reconstruct and understand the circumstances, lifestyle, state of mind, etc, at the time of death.
- l. Provide advice and assistance to unit commanders in order to facilitate and implement health promotion policies.

#### 1-16. State Public Affairs Office (PAO)

The PAO is responsible for the development and implementation of a public affairs plan in support of the ARNG Health Promotion Program. This includes articles in internal print and broadcast media, and release of information about the ARNG Health Promotion Program to the public through the media and through community relations.

#### 1-17. Chaplain, State Area Command

The Chaplain:

- a. Is responsible for conducting the moral leadership program. The program objectives include:
  - (1) Establishing a command program or moral leadership training.
  - (2) Enhancing soldierly virtues and values within the members of the state.
  - (3) Instilling the values of responsible citizenship and service to country.
  - (4) Developing common moral and ethical standards for section and unit cohesion.
  - (5) Providing moral leadership material for the state.
- b. Encourages and promotes concepts of spiritual well-being and good health among soldiers and family members.
- c. Advises the State Adjutant General with respect to the spiritual aspects of health promotion (to include measures for suicide awareness and prevention training programs) and family support.
- d. The State Chaplain is responsible for the conduct and management of the state Army Suicide Pre-

vention Program and Family Member Suicide Prevention Program to include the three components of each; prevention, intervention and post-intervention.

- e. Coordinates with the State Surgeon concerning the technical medical and health aspects of training suicide awareness and prevention, and stress management as included in state programs.

#### 1-18. State Staff Judge Advocate (SJA)

- a. Provides staff assistance and advice on the application of appropriate laws and regulations concerning the Health Promotion Program.
- b. Reviews the liability implications of non health care personnel providing health promotion programs.

#### 1-19. State Deputy Chief of Staff for Engineers (DCSENG)

The DCSENG has special staff responsibility for the construction of physical fitness and recreation facilities supported by appropriated funds.

#### 1-20. Commanders of ARNG major commands (MACOM)

These commanders will--

- a. Monitor data, develop, and implement programs to achieve ARNG health promotion in accordance with guidance from the DCSPER.
- b. Appoint a MACOM Health Promotion Coordinator to provide staff supervision for the implementation of actions and procedures of this regulation and its relationship to all members of the total ARNG family.
- c. Appoint a MACOM Suicide Prevention Coordinator (Field Grade Officer) to provide assistance to commanders and staff supervision of the Army Suicide Prevention Program.
- d. Develop and implement a MACOM Suicide Prevention Plan.

#### 1-21. Commanders of ARNG units down to detachment level

These commanders will--

- a. Establish and chair a unit Health Promotion Council (HPC).
- b. Appoint a unit Health Promotion Coordinator to integrate health promotion activities and monitor program progress in their units.
- c. Monitor aggregate data and implement a health promotion program in their units in accordance with this regulation and instructions from their chain of command.
- d. Appoint a task force or committee and designate a presiding officer to plan, implement, and manage the Army Suicide Prevention Program for the unit.
- e. Remain sensitive and responsive to needs of the total ARNG membership.
- f. Encourage the total ARNG family to follow a lifestyle that improves and protects physical, emotional, and spiritual well-being.
- g. Enhance unit readiness by implementing the Health Promotion Program within their units using the Commander's Health Fitness Kit. The Kit can be ordered through: U.S. Army Publications, Distribution Center, 2800 Eastern Blvd., Baltimore, MD 21220-2896.

*h.* Initiate proactive measures to prevent loss of life within their unit due to suicide and to reduce the impact on survivors if a suicide takes place.

*i.* Demonstrate positive efforts to deglamorize use of all forms of tobacco and alcohol products.

*j.* Enhance ARNG unit readiness by identifying early deploying soldiers in Dental Fitness Classes 3 and 4 by way of annual dental screen for examination and treatment to attain at least Dental Fitness Class 2 (minor dental caries). (See para 2-12.)

## Chapter 2 Health Promotion Policies

### 2-1 General

*a.* Health promotion policies apply to all ARNG agencies and operational activities. Active participation in all aspects of health promotion will be encouraged.

*b.* Health promotion increases unit combat readiness and organizational efficiency by maximizing human resources. These activities encompass physical, emotional, spiritual, and social dimensions.

### 2-2. Antitobacco

*a.* Antitobacco is defined as the reduction, elimination, and deglamorization of tobacco product usage to improve the health and readiness of the ARNG member.

*b.* The use of all forms of tobacco products during initial entry training is controlled for soldiers. (See chap 4.)

*c.* Commanders and supervisors will encourage ARNG family members to engage in appropriate anti-tobacco activities. Commanders and supervisors will ensure ARNG soldiers understand the health dangers of second hand or ambient tobacco smoke.

*d.* As part of routine physical/dental examinations and at other appropriate times, health care providers will inquire about the individual's tobacco use, including use of smokeless tobacco products, and advise them of risks associated with its use, the health benefits of abstinence, and where to obtain help to quit.

*e.* Army policy on smoking in the work place is in Chapter 4.

### 2-3. Physical Fitness

Unit readiness begins with the physical fitness of soldiers and the NCOs and Officers who lead them! Physical fitness includes factors which allow people to function effectively in physical or mental work and in training or recreation, and still have energy to handle emergencies. It is the ability to cope within the physical demands of one's job, including the use of adequate reserves to cope with emergency situations. This includes cardiorespiratory fitness; endurance, muscular strength, muscular endurance, flexibility, and body composition. (See AR 215-1, AR 350-41, AR 350-41, DA Pam 350-21 for specific information.)

*a.* Soldiers.

(1) Commanders and supervisors will establish and conduct physical fitness programs for soldiers consistent with AR 350-41, FM 21-20, NGR 40-501,

and the unit mission. Exercise periods are to be conducted with sufficient intensity, frequency, and duration to maintain adequate cardiorespiratory endurance, muscular strength, muscular endurance, and flexibility.

(2) All soldiers are expected to conduct physical fitness training year-round to maintain standards of personal fitness.

(3) Soldiers, age 40 and over are required to complete the cardiovascular screening program (CVSP) and Health Risk Appraisal (HRA) as prescribed in AR 40-501 and NGR 40-501 during the periodic physical examination done after their 40th birthday.

*b.* Civilians employed by the ARNG.

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

(2) For employees engaged in an occupation that requires an above average level of physical strength, muscular endurance, cardiorespiratory endurance and/or flexibility and stamina for satisfactory performance, a physical exercise program may be a part of their jobs and may be conducted during duty hours.

(3) For other civilian employees, commanders are encouraged to emphasize changes in behavior which will cause a positive improvement in the employees' wellness.

*c.* Additional guidance and support for physical fitness aspects of health promotion may be obtained through Commandant, U.S. Army Physical Fitness School, **ATTN: ATSH-PF**, Building 468, Fort Benning, GA 31905-5000, and Director, Army Physical Fitness Research Institute, U.S. Army War College, Carlisle Barracks, PA 17013-5050.

### 2-4. Nutrition

*a.* Dietary allowances prescribed in AR 40-25 provide guidelines and standards for feeding healthy soldiers. They are intended for use by personnel involved in menu planning, dietary evaluation, nutrition, and education.

*b.* Nutrient standards for operational rations establish the criteria for evaluating the nutritional adequacy of these rations. Operational rations are composed of nonperishable foods. They are designed to provide complete nutrition for the soldier in simulated or actual combat conditions.

*c.* Basic guidelines for nutrition education are used to promote optimal fitness in the military population. They guide modification in food procurement policy, food preparation, recipe formulation, and menu development.

*d.* Unit commanders, dietitians, food advisers, and food service noncommissioned officers (NCO) will comply with the basic nutritional standards for garrison dining facilities in AR 30-1, appendix J. This appendix provides implementing guidance for meeting nutrition standards in garrison dining facilities and ensuring compliance with AR 40-25.

### 2-5. Weight control

*a.* Commanders and supervisors will monitor all soldiers in their commands in accordance with AR

600-9 to ensure they maintain proper body weight, body composition, and personal appearance standards. Traditional (M-day) soldiers will be weighed semi-annually. Active Guard (AGR) soldiers will be weighed semi-annually, usually in conjunction with the semi-annual APFT.

**b.** Commanders and supervisors will provide educational and other motivational programs in accordance with AR 600-9 in order to encourage individuals to attain and maintain proper body fat standards. ARNG civilians and family members should be encouraged to participate in these programs on a voluntary basis as determined appropriate by the chain of command.

**c.** Soldiers exceeding body fat (not pounds of weight) standards are subject to the restrictions established in AR 600-9.

## **2-6. Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)**

ADAPCP includes all activities to eliminate substance abuse (alcohol and other drugs), including prevention, identification, education, and rehabilitation services. It includes residential and nonresidential treatment for Active Guard (AGR) soldiers. Traditional (M-day) soldiers are required to pay their own referral and rehabilitation costs using certified drug and alcohol counselors of their choice or their health plan's choice. The State Alcohol and Drug Control Officer will assist traditional soldiers in finding low cost providers for these services.

**a.** Substance abuse is incompatible with military service. ARNG soldiers who are identified as drug abusers and/or alcohol abusers will be referred for evaluation and processed for discharge. Those who are retained will be required to enroll in and complete a state certified rehabilitation program at his/her own cost. Consideration and processing for separation of soldiers identified as substance abusers will be in accordance with AR 600-85 and applicable administrative regulations.

**b.** If substance abuse is suspected, all levels of the chain of command must take prompt action, regardless of the abusing soldier's rank or grade,

**c.** Implementation of an ADAPCP capability is required for ARNG activities in accordance with AR 600-85.

**d.** Unit commanders will ensure that an active and aggressive drug testing program is maintained.

**e.** Substance abuse policy will be given adequate publicity to ensure that ARNG civilians, and family members are aware of:

- (1) Command support.
- (2) Available information.
- (3) Referral procedures.
- (4) Rehabilitation services of ADAPCP.

**f.** Commanders, supervisors, ADAPCP personnel, and health care providers will provide education for all members of the total ARNG family on the detrimental effects of substance abuse on combat readiness and a healthy lifestyle. All education on substance abuse will conform to the guidelines of AR 600-85.

## **2-7. Stress management**

Stress management includes all assistance provided to cope with the demands, real or perceived, from the environment and from within the individual.

**a.** Stress, its effects, and its management, is a concern for leaders at every level. Techniques and considerations for the management of stress in Army operations are in FM 26-2.

**b.** Health care providers, trained in stress management, and the state Unit Ministry Team (UMT) assist commanders in the development and implementation of a comprehensive stress prevention effort to increase the ability of individual soldiers to positively deal with stress.

**c.** Health care providers implement health education and treatment programs for individuals affected by stress. Protocols for referring members of the total ARNG family to other agencies will agree with established procedures.

**d.** Health care providers conduct training programs designed to alert other health care providers, commanders, and supervisors regarding evidence of stress affecting an individual.

## **2-8. Suicide prevention**

**a.** Suicide prevention is the concern of every member of the Total ARNG Family.

**b.** A coordinated program for suicide prevention will be established at every ARNG activity in accordance with the policies set forth in chapter 5.

## **2-9. Spiritual fitness**

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

**a.** Commanders at all levels will encourage and provide for human self-development activities leading to increased spiritual fitness in accordance with this regulation, AR 600-20, AR 165-20 AR 165-1, and other applicable directives.

**b.** Army leaders should develop an awareness of the lifestyles, cultural backgrounds, stages of development, possible relationships to religious beliefs, and needs of soldiers, ARNG civilians, and family members. The State Health Promotion Council will recommend, coordinate, and ensure the integration of spiritual fitness programs for units, soldiers, family members, and ARNG civilians in their area of responsibility.

**c.** Commanders at the unit level will develop soldier and family support activities to strengthen, reinforce, and implement the enhancement of spiritual fitness. They will ensure the scheduling of time for activities, programs, and training to accomplish the goals of spiritual fitness, as well as recommending and conducting spiritual fitness programs.

d. In providing for self-development activities, commanders and other leaders must ensure advocacy of a religion does not occur. The practice of religion, to the extent it relates to spiritual fitness, must be left to the sole discretion of each person. Each person must be free to worship or not as he or she may choose without fear of being disciplined or stigmatized by his or her choice. (See AR 165-20 AR 165-1, AR 600-20 and DA Pam 600-75.)

e. All soldiers are expected to live by the tenets of the professional Army ethic and those individual values that support and sustain the ARNG way of life (See FM 100-1). Commanders and supervisors have available the State UMT, whose objective is to establish a command program of moral leadership training.

#### 2-10. Physical examination

a. Health care providers will conduct physical examinations and a health risk appraisal in accordance with the procedures of AR 40-501, NGR 40-501, and separate directives.

b. All soldiers age 40 and over will be screened for cardiovascular risk as well as other limiting factors as part of their periodic physical examination and in accordance with AR 40-501 and NGR 40-501. Physicians or other health care providers will counsel soldiers regarding their individual risk factors.

#### 2-11. Hypertension Identification

a. The early identification of hypertension includes all initiatives to identify those with a positive family history, and to identify the following health risk factors:

- (1) High blood pressure.
- (2) Tobacco use.
- (3) Elevated cholesterol level.
- (4) Obesity.
- (5) Poor nutrition.
- (6) Inactivity.
- (7) Stress.
- (8) Alcohol and drug abuse.

b. These initiatives include early identification, information regarding control and lifestyle factors, and treatment referral. Health care providers will--

(1) Inform soldiers during the periodic physical examination about the effects on hypertension of cholesterol, weight, blood pressure, family history, and lifestyle habits.

(2) Maintain protocols for referring individuals identified with significant health risk factors to appropriate health specialists for further care.

(3) Conduct a cardiovascular screening program for soldiers age 40 and over as prescribed in AR 40-501, NGR 40-501, and separate directives.

(4) Provide basic information materials on hypertension suitable for use by commanders, supervisors, or counselors outside the health care setting.

(5) Develop and implement procedures to provide annual blood pressure measurement for soldiers and selected family members. As a minimum, hypertension screening is provided as part of all medical examinations, and the health risk appraisal. Individuals with abnormal screening results will receive appropriate medical referrals.

#### 2-12. Oral health

a. Oral health promotion includes initiatives to increase the overall fitness and dental readiness of early deploying soldiers, reduce the incidence of dental disease in the ARNG, identify ARNG members in need of dental treatment, and direct them to sources of appropriate care. It expands the traditional dental program by--

(1) Requiring a minimum level of dental health for early deploying soldiers.

(2) Using the HRA questionnaire dental data as a tool to help evaluate unit/community oral health.

(3) Integrating hypertension screening and tobacco use counseling into the dental examinations and treatment plans of early deploying soldiers.

b. Oral Health Fitness Program. The Oral Health Fitness Program is designed to ensure that early deploying soldiers maintain optimum oral health and do not lose valuable personal or unit time due to preventable dental disease. Early deployers are required to receive an annual dental screening. Results of the examination are used to establish a Dental Fitness Classification which is monitored by the soldier's unit through the installation automated personnel data base. Commanders will ensure that early deploying soldiers receive dental screenings and encourage clinical treatment from the soldier's private dentist to maintain at least a Dental Fitness Class 2 (minor dental caries). A brief description of the classifications follows. The complete description is found in AR 40-35.

(1) Dental Fitness Class 1: Requires no dental treatment.

(2) Dental Fitness Class 2: Unlikely to have a dental emergency within 12 months.

(3) Dental Fitness Class 3: Likely to have a dental emergency within 12 months.

(4) Dental Fitness Class 4: Needs a dental examination, or status is unknown.

c. Clinical Preventive Dentistry Program. Clinical preventive measures for early deploying soldiers are included in this program and include training on plaque control technique instruction and evaluation, oral prophylaxis, and nutritional counseling as appropriate.

d. Community Preventive Dentistry Program. Community education programs are prescribed under this program.

#### 2-13. Health risk appraisal

a. Individuals will be aware of their health risk profile and of ways to improve their lifestyles to reduce health risks.

b. Health care providers will use the approved health risk appraisal instrument in accordance with applicable regulations and directives to screen ARNG soldiers, civilians and family members for health risk factors. The results of this appraisal will be given to the individual as a health risk appraisal profile.

c. All soldiers will receive a health risk appraisal as part of the periodic physical examination (for example, 5-year, annual, General Officer, over-40 screen, flight physical, assessment in the ARNG, unit initiated, and referral as indicated). The health appraisal profile is

the responsibility of the administering treatment facility officer-in-charge.

**d.** ARNG Commanders will ensure:

(1) During unit inprocessing that soldiers receive a health risk appraisal unless their current health risk appraisal occurred within the last 12 months.

(2) During regular records screening that soldiers have a health risk appraisal in accordance with regularly scheduled physical.

(3) A program of education and consultation is available to meet identified needs.

(4) Soldiers understand their health risk appraisal profile and the command actions that can be taken to manage health risks. They are counseled about their health risk appraisal profile results and the health consequences of failing to modifying their health behavior.

### 2-14. Army Fit to Win program

**a.** The Active Army Fit to Win program provides the means to begin integrated and coordinated implementation of the State Health Promotion Program. When fully implemented, such an activity will allow commanders to--

(1) Actively market all aspects of the state program.

(2) Conduct community needs assessments in health promotion areas.

(3) Sustain program participation.

(4) Support ARNG-wide data collection for program evaluation.

**b.** DA Pam 600-63 (1-13) details operations and education.

## Chapter 3

### State Health Promotion Program

#### 3-1. Implementation guidance

**a.** The success of the ARNG Health Promotion Program is determined by the commanders. Commanders lead the way. Commanders who embrace health promotion for themselves and their soldiers will enhance and improve unit readiness. An effective, focused, comprehensive program at the state and unit level is the key to achieving the overall goals.

**b.** State health promotion programs must focus on initiatives and activities to enhance individual health in each of the major areas of the program.

**c.** The operational pamphlets for implementing the program are contained in the Army's Fit to Win program. (See DA Pam 600-63.)

**d.** State health promotion programs should contain the following key elements.

(1) Unit and community needs assessment to determine specific population needs and resources already available to meet needs.

(2) Programs designed to target specific health risks identified in individual assessment.

(3) Programs aimed at behavioral change.

(4) Effective marketing.

(5) Proactive programs to foster suicide prevention and increase spiritual fitness.

(6) A program designed to influence the total ARNG population (soldiers, family members, and civilians).

(7) Continuous quality improvement.

**e.** Additional guidance and support for health promotion issues are available through: Commander, USACHPPM, ATTN: MCHB-DC-HHR, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010-5422.

#### 3-2. State Health Promotion Council

**a.** The Commander, State Area Command (STARC), administers and monitors the state health promotion program through the Health Promotion Council (Council members are the Commander's primary advisers). The presiding officer of the Health Promotion Council is the Commander, STARC.

**b.** The Health Promotion Council will provide an effective tool for program operation and administration by providing a system of clear communication lines. It will enable planning coordinated efforts in the state to maximize resources and determine the best organization to provide the service.

**c.** The membership encompasses the full scale of health and fitness interests in the state. The council may meet as a separate group or as part of other established councils (i.e., Human Resources Council). However, the membership encompasses the full scale of health and fitness interests in the state:

(1) Commander, State Area Command.

(2) State Command Sergeant Major.

(3) Chief of Staff for Personnel (DCSPER).

(4) State Surgeon/State Chief Nurse.

(5) Chief of Staff for Operations (DCSOPS).

(6) Chaplain, State Area Command.

(7) Human Resource Officer (HRO).

(8) State Occupational Health Nurse.

(9) State Safety Officer.

(10) Family Support Coordinator.

(11) State Alcohol and Drug Control Officer.

(12) ARNG Major Command Health Promotion Coordinators.

**c.** Principal tasks of each state Health Promotion Council are to--

(1) Assess community needs.

(2) Identify existing health promotion programs in the state/territory.

(3) Customize program designs to address significant health risks specific to local communities within the state/territory.

(4) Assure qualified personnel are providing the programs or interventions.

(5) Ensure Health Risk Assessment (HRA) is used to identify high risk individuals.

(6) Ensure there's a system to refer high risk individuals into educational or intervention programs aimed at risk reduction.

(7) Use effective marketing to achieve and maintain high participation rates.

(8) Provide continuous quality improvement by periodic participant and management evaluation of satisfaction.

### 3-3. Development of the state health promotion program

*a.* The Commander, STARC in concert with the State Health Promotion Council develops and implements the health promotion program. See figure 3-1.

*b.* Once state needs are identified, specific program elements to address each of the major health promotion areas must be initiated. These include classes, seminars, workshops, health care interventions, and activities in each of the Fit to Win program areas based on identified needs. Existing programs may be used to meet these needs.

*c.* Commanders will ensure the goals, objectives, and purpose of the health promotion program are well-publicized throughout their commands. Such efforts should keep soldiers, ARNG civilians, and family members aware of program benefits. This includes the relationship and interaction among members of the overall program and its component parts.

*d.* These initiatives, facilitated by the Fit to Win Coordinators in the field using all the resources of the Health Promotion Council, will ensure the effectiveness of the overall program and should ensure participation by all state ARNG elements.

*e.* Screening and assessment of individuals are primarily accomplished by using a health risk appraisal to assess the current state of health and fitness. This is an automated, personalized instrument, asking the participant about family health history, lifestyle, and attitudes. Other data, such as height, weight, blood pressure, and cholesterol level are also used.

*f.* Assessment begins during IET and OBC. It is continued during periodic physical examinations, annual medical/dental screening, unit inprocessing, by referral, or is unit initiated. Self-referral is the principal means of accessing family members and ARNG civilians.

*g.* The data is entered into the MILPO data base, is compiled and used by the Fit to Win Coordinator, the State Health Promotion Council, and unit commanders to allocate resources, revise programs, and monitor progress of the unit readiness posture.

*h.* Individual data from the health risk appraisal are compared, where possible, against predetermined standards. If standards are met, positive behavior is reinforced. Interim referrals may be initiated by the commander or health care providers prior to the next scheduled health risk appraisal.

*i.* A health risk appraisal profile, compiled and printed using an automated process, is given to the individual.

*j.* If follow-up is required based on identified individual or unit needs, the intervention and education stage begins and strategies are targeted. Purely medical interventions are referred to private physicians for traditional (M-day) soldiers, family members, and ARNG civilians at personal expense. Medical interventions for Active Guard/Reserve (AGR) soldiers are referred to federal facilities at government expense.

*k.* Reevaluation occurs with the next scheduled health risk appraisal.

*l.* Figure 3-2 portrays the health risk appraisal process in all its stages.

### 3-4. Health promotion process

*a.* The health promotion process described in paragraph 3-3 encompasses actions that will--

(1) Bring people into the program.

(2) Gather the necessary data.

(3) Enter data into a computer program and data base.

(4) Measure data against Total Army standards.

(5) Educate and intervene for individual and unit well-being.

(6) Reevaluate the program.

*b.* Army Health promotion emphasizes positive action to increase physical, emotional, and spiritual well-being.

### 3-5. Health risk appraisal administration and command requirements

*a.* Administering the health risk appraisal at the unit level involves the individual, the commander, health care providers, and other resources available within the state. Their interaction is monitored by the State Health Promotion Council.

*b.* The laboratory analysis of the health risk appraisal is done by drawing blood.

*c.* Blood pressure, height, weight, and heart rate are measured and entered on the health risk appraisal instrument.

*d.* After completion of the health risk appraisal questionnaire, all data are entered into the computer. An individual health risk appraisal profile is printed. A copy is given to each individual. Unit commanders will ensure all personnel in their command are evaluated.

*e.* Health care providers will monitor unit soldiers recommended for or enrolled in health education programs and referred for medical intervention. They will advise the commander on the state of unit wellness.

*f.* Aggregate data are also compiled by health care providers using the individual data. Quarterly reports allow commanders and the State Health Promotion Council to:

(1) Monitor program status, progress of fitness initiatives, and overall community, and unit wellness.

(2) Ensure appropriate health promotion programs are initiated.

(3) Manage resources necessary to support the program.

### 3-6. Unit climate profile (UCP)

*a.* Unit "Climate" factors such as cohesiveness, morale, and attitude have a profound impact on the effectiveness and efficiency of a unit. DA Pam 600-69 provides a way for company-level commanders to identify unit strengths and weaknesses associated with unit climate factors. An easy-to-use UCP questionnaire and its resulting profile include information on:

(1) Officer leadership.

(2) NCO leadership.

(3) Immediate leaders.

(4) Leader accessibility.

(5) Promotion policy.

(6) Rewards and corrective actions.

(7) Quality of training.

(8) Tools, equipment, and supplies.

- (9) Job satisfaction.
  - (10) Freedom from harassment.
  - (11) Military courtesy and discipline.
  - (12) Human relations.
  - (13) Unit cohesiveness.
  - (14) Athletic and nonathletic recreational activities.
  - (15) Social activities.
  - (16) Freedom from substance abuse.
  - (17) Food service and soldier eating habits.
  - (18) Soldier attitude toward unit.
  - (19) Morale.
  - (20) Reenlistment potential.
- b. The UCP requires no specific training to administer or analyze. Soldiers are requested to give their honest responses to an anonymous questionnaire. Information obtained will be used to help, where needed, to review and improve unit-level operations.

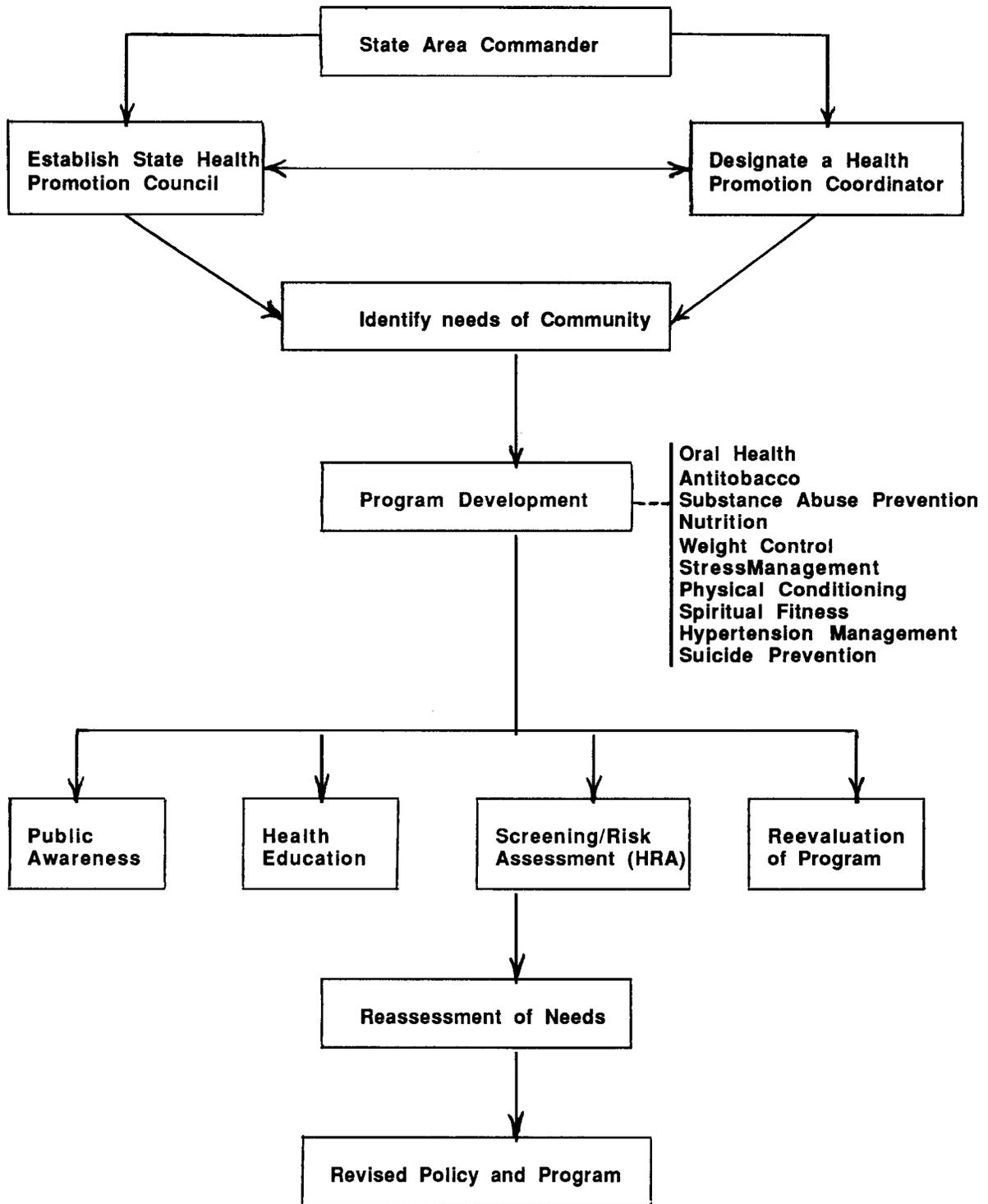


Figure 3-1. Development of a State Health Promotion Program

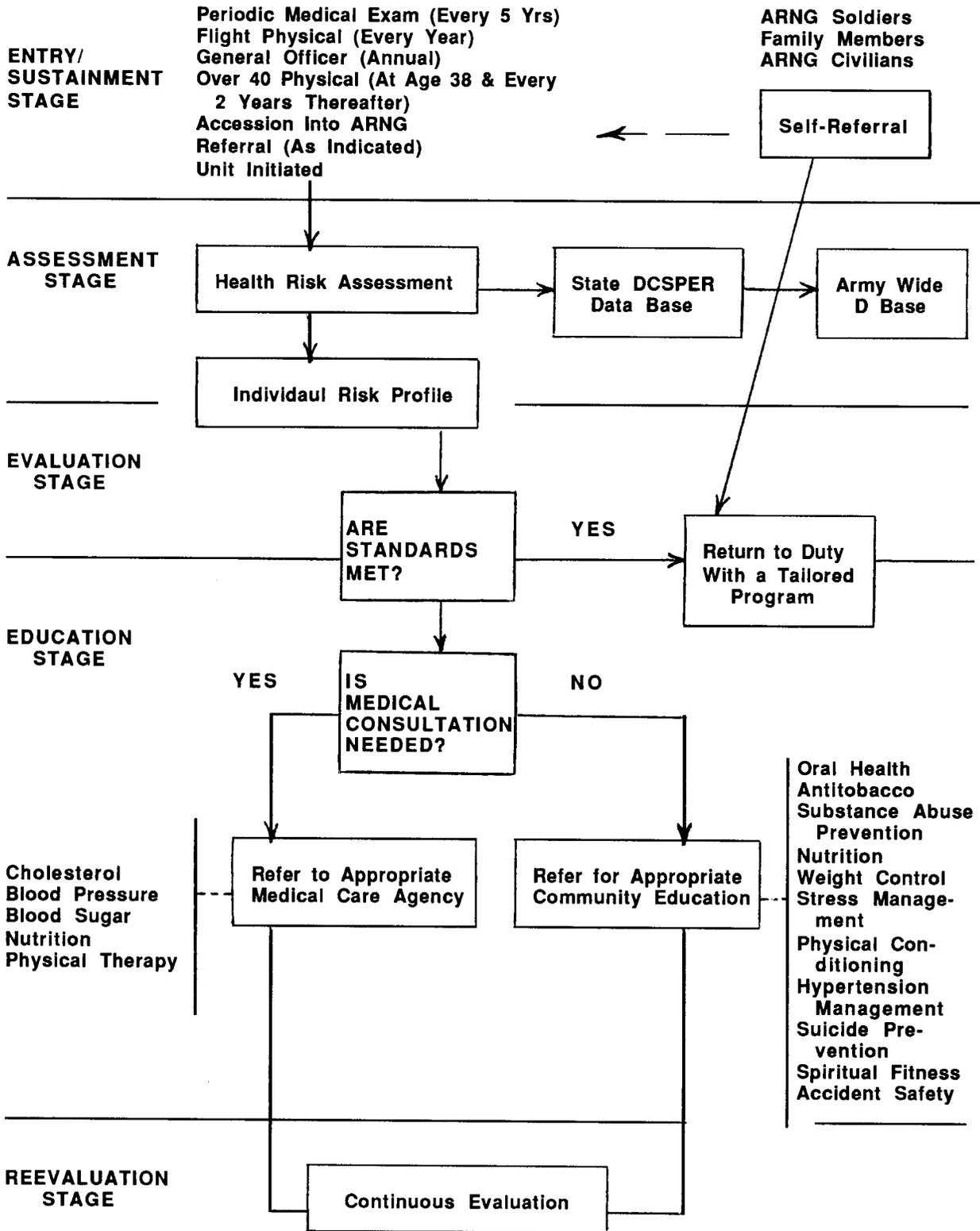


Figure 3-2. Health Promotion Process

## Chapter 4 Controlling smoking

### 4-1. Guidance for controlling smoking in ARNG controlled areas

**a.** The provisions of this chapter apply to the ARNG, civilians employed by the ARNG, and any individual who operates within or visits an ARNG work place.

**b.** Use of tobacco products harms individual and unit readiness by impairing physical fitness and by increasing illness, absenteeism, premature death, and health care costs. Readiness will be enhanced by establishing the standard of a smoke-free and tobacco free environment that supports abstinence from and discourages any use of tobacco.

**c.** Full cooperation of all commanders, supervisors, soldiers, and ARNG civilians is expected to ensure people are protected from the effects of second hand smoke.

**d.** All organizational elements that occupy space in or on conveyances, offices, buildings, or facilities over which the ARNG has custody and control will comply with ARNG policy guidance. This includes space assigned to the ARNG by General Services Administration (GSA) or space contracted from other sources.

**e.** This policy does not cancel or supersede other instructions that control smoking because of fire, explosion, or other safety considerations.

### 4-2. Policy

Smoking of tobacco products is prohibited in all ARNG-occupied work places, with the exception of smoking area facilities discussed in subparagraph 4-2.b. below. The work place includes any area inside a building or facility over which the ARNG has custody and control where work is performed by military personnel, civilians, or persons under contract to the ARNG.

**a.** Notices will be displayed at entrances to buildings and facilities over which the ARNG has custody and control which state that smoking is not allowed except in designated outdoor smoking areas. Indoor designated smoking areas are prohibited.

**b.** If possible, designated outdoor smoking areas will provide a reasonable measure of protection from the elements. However, the designated areas will be at least 50 feet from common points of ingress/egress and will not be located in areas that are commonly used by nonsmokers. Military construction funds will not be used to support smoking by constructing special areas outside.

**c.** All tobacco products are prohibited in all military vehicles and aircraft and all official vans and buses.

**d.** Health care providers will not smoke in the presence of patients and soldiers.

**e.** Smoking by students is prohibited in state controlled ARNG schools such as state officer candidate schools and the Professional Education Center. Visiting adults, faculty, and staff may smoke out of the presence or view of students in smoking areas designated in accordance with this policy.

**f.** Smoking is prohibited where it presents a safety hazard. Example: firing ranges, ammunition storage

areas, fuel dumps, motor pools, and equipment maintenance shops.

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

**h.** Smokers will not be allowed additional time beyond routine breaks to be away from their jobs for smoke breaks. Supervisors will monitor their workers and initiate appropriate administrative action if workers are non-compliant with applicable regulations and negotiated agreements.

**i.** States will provide tobacco cessation programs for all requesting eligible health care beneficiaries. If not available through supporting federal medical treatment facilities, or through state organic medical personnel, commanders may coordinate programs through local community resources such as the American Cancer Society and American Lung Association. To the extent possible, state occupational health nurses will provide smoking cessation programs for civilian employees. If such programs are not feasible in a particular state, the occupational health nurse will refer civilian employees seeking such a program to local community resources.

**j.** To the extent possible, the State DCSPER will provide oversight to the provision of smoking cessation programs for ARNG soldiers and employed civilians.

### 4-3. Signs for controlling smoking

**a.** Commanders are authorized to continue to use locally manufactured signs already reproduced or posted.

**b.** If locally manufactured signs are not in use, DA Form 5560-R (No Smoking Except in Designated Smoking Areas) and DA Form 5560-1-R (Designated Smoking Area) will be used for restricting smoking. These will be locally reproduced on 8 1/2 by 11- inch paper. **A copy for local reproduction is at the back of this regulation.** The letters will be printed in red or black on white background.

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

### 4-4. Enforcement

Failure to comply with prescribed policy potentially subjects ARNG soldiers to a variety of penalties. The penalty depends on the nature and frequency of the violation, the status of the offender, and other relevant factors as determined by the chain of command. Violation of ARNG policies subjects military personnel to a variety of possible administrative or disciplinary actions (e.g. counseling, reprimand) and subjects civilian personnel to possible disciplinary actions. Repeated violations may also result in the request for removal/relocation of violators from the immediate work area: i.e., ARNG military personnel, civilian employees, and any individual who operates within or visits an ARNG work place or activity.

## Chapter 5 Suicide prevention and psychological autopsy

### 5-1. General

This chapter sets guidelines for establishing the Army Suicide Prevention Program (ASPP). This program:

- a. Supports the Army's goal to reduce the suicide risk for the Total ARNG Family.
- b. Establishes requirements for suicide risk identification training.
- c. Outlines responsibilities for the ASPP.
- d. Requires a psychological autopsy for specified deaths (see para 5-8); e.g., suicide while in duty status (EAD, AT, IDT, ADSW, RMA, ATA, etc).

### 5-2. Army Suicide Prevention Program

A coordinated suicide prevention program will be established in every state. Army Suicide Prevention Programs will provide:

- a. A suicide prevention and awareness education program for both military and civilian leaders, managers, supervisors, and where possible, ARNG family members. This program will train personnel in suicide risk identification and in procedures for crisis intervention and referral. Unit Ministerial Teams are well equipped to provide suicide prevention education awareness.
- b. For the concentration of medical and Unit Ministerial Teams referral resources to provide assistance as required to organizations and their members following the suicide of any member of the Total ARNG Family.
- c. Assistance for families who have experienced the loss of a family member to suicide to the extent permitted by applicable laws and regulations.

### 5-3. Suicide Prevention Task Force

a. Each state will establish, plan, implement, and manage an ARNG Suicide Prevention Program Task Force. The Task Force will consist of the following personnel:

- (1) Chaplain, STARC.
- (2) Deputy Chief of Staff, Personnel (DCSPER).
- (3) Family Support Officer/Director.
- (4) State Surgeon.
- (5) Director, HRO.
- (6) Provost Marshall.
- (7) Staff Judge Advocate.
- (8) State Command Sergeant Major.

b. The suicide prevention mission: that is, initiatives and activities taken to reduce the incidence of suicide and improve the identity ratio of at-risk people, may be assigned to the state Health Promotion Council or may elect to establish a separate Suicide Prevention Task Force to function as a subcommittee of the Health Promotion Council. When using the Health Promotion Council to manage the Army Suicide Prevention Program, care must be taken so that suicide prevention does not take a second place to other responsibilities of the Council. Responsibilities of Health Promotion Council members, with respect to suicide prevention, must be clearly established. Where a separate Suicide Prevention Task Force has not been established,

the Health Promotion Council will perform all the duties given to the Suicide Prevention Task Force.

### 5-4. Coordination of helping services

a. The State Army Suicide Prevention Program will make provision for the coordination of services provided by military and civilian helping agencies such as the Community Mental Health Service (CMHS), Unit Ministry Teams, Family Support Coordinators, Substance Abuse Prevention and Rehabilitative Program, American Red Cross, Youth Activities (YA), local public schools, and other agencies as appropriate.

b. This coordination will include information about and planning for programs and services as well as information pertaining to specific clients, if it is in the best interests of the clients and if released, whether intra-Army or outside the Army, is in accordance with the Privacy Act (5 U.S.C. section 552a) done with regard for the requirements of client confidentiality. Only individuals limited to a need-to-know are permitted at meetings where information about individual cases are discussed without the permission of the individual concerned.

### 5-5. Training

a. Sequential and progressive suicide risk identification training will be integrated, without increasing the length of the program of instruction, into every Army leadership development course conducted by the ARNG school system. Specifically, this information will be provided at all levels of the Noncommissioned Officer Education System (NCOES) and officer leadership courses, courses taught at the ARNG Professional Education Center, and state ARNG Officer Candidate Schools. As a minimum, students will receive a copy of DA Pam 600-70, or a locally produced information pamphlet containing essentially the same information. Students will also be given the opportunity to view the Army videotape "Suicide Prevention" (SAVPIN 701299 DA (TVT8-93)).

b. Formal training in suicide prevention and suicide risk identification will be presented as part of the unit level officer and NCO professional development courses.

c. Regularly scheduled courses for all civilian supervisors and designated HRO personnel will include training in suicide prevention.

d. Helping professionals (physicians, nurses, psychologists, social workers, chaplains, and counselors) and military police will receive regular inservice training in suicide prevention and crisis intervention.

e. Army/ARNG mental health officers who are credentialed or licensed as a psychiatrist, clinical or counseling psychologist, social worker, or psychiatric nurse specialist will provide the professional expertise for all suicide prevention education programs.

f. Unit Ministry Teams (chaplains and chaplain assistants) will be trained in suicide prevention and suicide risk identification. Chaplains will assist health care providers by providing suicide prevention education awareness training. This is a staff function at all levels for the chaplain.

g. Family Support Program personnel will be trained by health care providers or chaplains, and will

conduct a suicide prevention education program for family members. Inservice training in suicide prevention for the staffs of family support services will be coordinated by the Family Support Coordinator and may be conducted by health care providers or chaplains. Family Support Program personnel will not be used to conduct suicide prevention training for military units or soldiers.

#### **5-6. Family Member Suicide Prevention Program (FMSPP)**

**a.** The STARC chaplain is responsible for the conduct and management of the three components of the Family Member Suicide Prevention Program listed below. In carrying out this responsibility, the STARC chaplain works through the STARC Suicide Prevention Task Force and coordinates with the various community helping agencies which may provide service or assistance in any of the three components. The STARC chaplain may delegate responsibility to unit chaplains for the conduct of the three components of the Family Member Suicide Prevention Program as it relates to their units. The Family Member Suicide Prevention Program components are:

(1) Prevention is the first component and is intended to provide information through briefings, classes, workshops, seminars, and similar settings. Its purpose is to educate family members in suicide risk identification and procedures for intervention and referral to community helping agencies.

(2) The second component of the Family Member Suicide Prevention Program is intervention. Intervention provides immediate assistance by the unit chaplain (or other designated chaplain resource), timely referral to mental health or hospital emergency personnel, and close coordination with the medical health care team in order to provide greatest assistance to soldiers and their family members and unit commanders.

(3) Post-intervention is the third component. Post-intervention facilitates reentry of the soldier and surviving family members into the unit and community, provides pastoral care to surviving family members and unit personnel, conducts memorial services and ceremonies as requested, and provides input into the psychological autopsy.

**b.** Where appropriate, soldier and family member suicide education and awareness may be conducted concurrently. Though the content will be clearly prescribed, the context of the education and awareness activities is at the discretion of the STARC Chaplain. Available operational and training funds may be used to support both the Unit Ministerial Team training mission and the conduct of suicide prevention education and awareness activities. Chaplains are encouraged to be innovative and creative when determining possible education and awareness delivery systems. All existing religious and spiritual fitness programs, stress management programs, and community/family programs as well as all other available military and civilian resources and programs should be viewed as contributory to and/or significant components in the overall family member suicide prevention education and awareness training.

**c.** In his capacity for oversight of the medical aspects of Army training programs in suicide prevention, the State Surgeon in collaboration with the STARC Chaplain will establish the basic medical and mental health content for family member suicide prevention and awareness training.

**d.** The STARC Chaplain, in close coordination with the State Surgeon, will establish minimum chaplain training standards and ensure that all chaplains and chaplains assistants conducting family member suicide prevention education and awareness activities are adequately trained by appropriate health care personnel in basic family member suicide prevention and education skills.

**e.** The primary mission of the chaplain Unit Ministry Team in the Family Member Suicide Prevention Program is education and awareness. Unit personnel will refer any suicidal individual to health care providers for counseling. Chaplains will not provide clinical services. If any Unit Ministry Team personnel are involved with a crisis intervention involving a suicidal individual, they will notify/seek medical treatment personnel as soon as the situation permits.

#### **5-7. Reporting and data analysis**

**a.** Suicides and suspected suicides of soldiers, family members, and ARNG civilians will be reported immediately to local civilian law enforcement. Those cases involving Active Army jurisdiction will be referred by the military police to the local United States Army Criminal Investigation Command (USACIDC) field element for appropriate investigation in accordance with AR 195-2.

**b.** The State Suicide Prevention Task Force will collect and analyze state data on suicide attempts. This analysis will include the numbers of high, medium, and low lethality attempts by category of personnel and by unit. Data reflecting the reasons for suicide attempts will be collected.

**c.** Notification of the death of a member of the ARNG must be provided to NGB-ARO-OC in accordance with the provisions of NGR 500-1/ANGI 10-8101, Military Support To Civil Authorities.

#### **5-8. Psychological autopsy**

**a.** As provided in AR 195-2, a psychological autopsy will be conducted by a medical officer and provided to United States Army Criminal Investigation Division Command for deaths that meet the criteria established below. Subjects for investigation include AC soldiers and ARNG soldiers who are Active Guard/Reserve (AGR), on Inactive Duty for Training (IDT), Active Duty for Training (ADT), or Annual Training (AT):

(1) Confirmed or suspected suicides.

(2) Single car motor vehicle accidents with no survivors, when requested by the commander of the local USACIDC office.

(3) Accidents involving unusual or suspicious circumstances: for example, deaths due to substance abuse, or resulting from self-inflicted gunshot wounds.

(4) All cases in which the mode (manner) of death is equivocal, that is, death cannot be readily es-

tablished as natural, accidental, a suicide, or a homicide.

(5) Other cases when requested by the commander or special agent in charge of the local USACIDC office.

b. The report of the psychological autopsy (RCS exempt: AR 335-15, para 5-2b(8)) will be included in the CID Report of Investigation as prescribed in AR 195-2.

c. States are required to submit casualty notifications (DA Form 1300) to Casualty Affairs Office, Total Army Personnel Center (TAPC-PED) in all cases described above. Upon review of DA Form 1300, Casualty Affairs Office may request the states to submit completed reports of psychological autopsies within 90 days, forwarded by the preparing officer through the deceased soldier's state to each of the following:

(1) HQDA (SGPS-CP-F), 5111 Leesburg Pike, Falls Church, VA 22041-32458.

(2) HQDA (DAPE-MPH DAPE-HR-PR), WASH DC 20310-0300.

(3) Commander, Walter Reed Army Medical Institute of Research, ATTN: SGRD-UWI-A, WASH DC 20307-5100.

(4) SAMR (HP), OASA (M & RA), 111 Army Pentagon, Washington, D.C. 20310-0111.

## Appendix A References

### Section 1 Required Publications

**AR 30-1**  
The Army Food Service Program

**AR 40-501**  
Standards of Medical Fitness

**AR 165-20**  
Duties of Chaplains and Responsibilities of Commanders

**AR 190-40**  
Serious Incident Report

**AR 195-2**  
Criminal Investigation Activities

**AR 215-2**  
The Management of Army Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentalities

**AR 350-15**  
Army Physical Fitness Program

**AR 600-9**  
The Army Weight Control Program

**AR 600-20**  
Army Command Policy and Procedures

**AR 600-63**  
Army Health Promotion

**AR 600-85**  
Alcohol and Drug Abuse Prevention and Control Program

**AR 690-400**  
Employee Performance and Utilization

**DA Pam 350-18**  
The Individual's Handbook on Physical Fitness

**DA Pam 350-21**  
Family Fitness Handbook

**DA Pam 600-63**  
(1-13) Fit To Win

**DA Pam 600-69**  
Unit Climate Profile Commander's Handbook

**DA Pam 600-70**  
U.S. Army Guide to the Prevention of Suicide and Self-destruction Behavior

**FM 21-20**  
Physical Fitness Training

**FM 26-2**  
Management of Stress in Army Operations

**FM 100-1**  
The Army

**NGR 10-2**  
State Area Command, Army National Guard

**NGR 25-30**  
National Guard Bureau Publications

**NGR 40-1**  
Mission and Function of the ARNG Special Medical Brigades

**NGR 40-3**  
Medical Care for Army National Guard Members

**NGR 40-501**  
Standards of Medical Fitness-Army National Guard

**NGR 350-1**  
Army National Guard Training

**NGR 351-1**  
Individual Military Education and Training

**NGR 351-3**  
NonCommissioned Officer Evaluation System

**NGR 385-5**  
Army National Guard Regional Accident Prevention

**NGR 385-10**  
Army National Guard Safety and Occupational Health Program

**NGR 500-1**  
Military Support to Civil Authorities

**NGR 600-2**  
Screening of the Army National Guard

**NGR 600-12**  
National Guard Family Program

**NGR 600-85**  
Drug Abuse Prevention and Control

**Section II**  
**Related Publications**

*A related publication is merely a source of additional information. The user does not have to read it to understand the regulation.*

**AR 5-3**  
Installation Management and Operation

**AR 40-25**  
Nutrition Allowances, Standards, and Education

**AR 40-35**  
Preventive Dentistry

**AR 40-216**  
Neuropsychiatry and Mental Health

**AR 215-1**  
The Administration of Army Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentalities

**AR 360-5**  
Public Information

**AR 360-61**  
Community Relations

**AR 385-10**  
Army Safety Program

**AR 600-21**  
Equal Opportunity in the Army

**AR 608-1**  
Army Community Service Program

**AR 608-10**  
Child Development Services

**AR 672-1**  
Award of Trophies and Similar Devices in Recognition of Accomplishments

**AR 690-990-2**  
Hours of Duty, Pay, and Leave

**AR 930-5**  
American National Red Cross Service Program and Army Utilization

**DA Pam 28-9**  
Unit Level Recreational Sports

**DA Pam 350-15**  
Commander's Handbook on Physical Fitness

**DOD Directive 1010.10**  
Health Promotion

**NGR 25-5**  
Army National Guard Training Areas

**NGR 37-106**  
Official Participation of National Guard Personnel at Meetings of Private Organizations and Government Agencies Outside of the Department of Defense

**NGR 37-111**  
Administration of Training and Special Work Workdays

**NGR 135-381**  
Management of the Army National Guard Incapacitation System

**NGR 200-3**  
State and Federal Environmental Responsibilities

**NGR 230-65**  
Unit Funds

**NGR 350-6**  
Competitive Marksmanship

**NGR 350-10,**  
Competitive Biathlon

**NGR 600-21**  
Equal Opportunity Program in the Army National Guard

**NGR 614-1**  
Inactive Army National Guard

**NGR 635-101**  
Efficiency and Physical Fitness Boards

**NGR 635-102**  
Officers and Warrant Officer Selective Retention

**NGR 672-1**  
Trophies and Awards Program for Army National Guard

**NGR 672-5**  
Service Recognition

**NGR 870-5**  
Army National Guard Lineage and Honors

**Section III**  
**Prescribed Forms**

**DA Form 5560-R,**  
No Smoking Except in Designated Smoking Areas

**DA Form 5560-1-R**  
Designated Smoking Area

**Glossary**

**Section 1**  
**Abbreviations**

**AC**  
Active Component

**ACS**  
Army Community Service

**ADAPCP**  
Alcohol and Drug Abuse Prevention Control Program

**ADSW**  
Active Duty Special Work

**ADT**  
Active Duty for Training

**AGR**  
Active Guard and Reserve

**AMEDD**  
Army Medical Department

**APFP**  
Army Physical Fitness Program

**APFT**  
Army Physical Fitness Test

**APFRI**  
Army Physical Fitness Research Institute

**ARC**  
American Red Cross

**ARNG**  
Army National Guard

**ARPERCEN**  
Army Reserve Personnel Center

**ASPP**  
Army Suicide Prevention Program

**AT**  
Annual Training

**ATA**  
Additional Training Assembly

**CCH**  
Chief of Chaplains

**CDS**  
Child Development Services

**CFSC**  
Community and Family Support Center

**CG**  
Commanding General

**CHEP**  
Community Health Education Program

**CHPPM**  
Center for Health Promotion and Preventive Medicine

**CINC**  
Commander-in-Chief

**CNGB**  
Chief, National Guard Bureau

**COD**  
Community Operations Division

**COE**  
Chief of Engineers

**CONUS**  
Continental United States

**CMHS**  
Community Mental Health Service

**CPA**  
Chief of Public Affairs

**CPO**  
Civilian Personnel Office

**CRD**  
Community Recreation Division

**CVSP**  
CardioVascular Screening Program

**DA**  
Department of the Army

**DARNG**  
Director, Army National Guard

**DCSLOG**  
Deputy Chief of Staff for Logistics

**DCSPER**  
Deputy Chief of Staff for Personnel

**DENTAC**  
Dental Activity

**DFW**  
Drug free Federal Workplace

**DOD**  
Department of Defense

**DODDS**  
DOD Dependent Schools

**DOL**  
Director of Logistics

**DPCA**  
Director of Personnel and Community Affairs

**EAD**  
Extended Active Duty

**FORSCOM**  
U.S. Forces Command

**FMSP**  
Family Member Suicide Prevention Program

**FSD**  
Family Support Division

**GSA**  
General Services Administration

**HIFIT**  
Health Initiatives Fitness Team

**HPC**  
Health Promotion Council

**HQDA**  
Headquarters, Department of the Army

**HRA**  
Health Risk Appraisal/Assessment

**HRO**  
Human Resource Office

**IDT**  
Inactive Duty Training

**IET**  
Initial Entry Training

**IRR**  
Individual Ready Reserve

**MACOM**  
Major Army Command

**MEDDAC**  
Medical Department Activity

**MEDCEN**  
Medical Center

**MEDCOM**  
Medical Command, U.S. Army

**MILPO**  
Military Personnel Officer

**MTF**  
Medical Treatment Facility

**NAF**  
NonAppropriated Funds

**NCO**  
NonCommissioned Officer

**NCOES**  
NonCommissioned Officer Evaluation System

**NGB**  
National Guard Bureau

**OBC**  
Officer Basic Course

**OSUT**  
One Station Unit Training

**OTSG**  
Office of The Surgeon General

**PAO**  
Public Affairs Officer

**PSC**  
Personnel Service Center

**RC**  
Reserve Component (ARNG & USAR)

**RMA**  
Readiness Management Assembly

**SIR**  
Serious Incident Report

**SOUTHCOM**  
U.S. Southern Command

**SPTF**  
Suicide Prevention Task Force

**SRMT**  
Suicide Risk Management Team

**STARC**  
State Area Command, ARNG

**TAG**  
The Adjutant General

**TDY**  
Temporary Duty

**TJAG**

The Judge Advocate General

**TPU**

Troop Program Unit

**TRADOC**

Training and Doctrine Command, U.S. Army

**TSG**

The Surgeon General

**UCMJ**

Uniform Code of Military Justice

**UCP**

Unit Climate Profile

**UMT**

Unit Ministry Team

**USACFSC**

U.S. Army Community and Family Support Center

**USACHPPM**

U.S. Army Center for Health Promotion and Preventive Medicine

**USACIDC**

U.S. Army Criminal Investigation Command

**USAPHS**

U.S. Army Physical Fitness School

**USAR**

U.S. Army Reserve

**USAREUR**

U.S. Army Europe

**USARSO**

U.S. Army South

**USASSC**

U.S. Army Soldier Support Center

**UTA**

Unit Training Assembly

**WESTCOM**

U.S. Western Command

**YA**

Youth Activities

**Section II****Terms****Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)**

A comprehensive program to eliminate substance abuse, including prevention, identification, education,

and rehabilitation services. It includes nonresidential and residential treatment.

**Antitobacco**

The reduction, elimination, and deglamorization of tobacco product usage to improve the health and readiness of the Army National Guard.

**Body Composition**

Quantification of the major structural components, fat and lean body mass, of the human body.

**Cardiorespiratory Endurance**

Functional capability of the heart, lungs, and blood vessels to take in and deliver oxygen to the working muscles and remove waste products. Essentially, it is the body's ability to receive and utilize oxygen in the cells for energy production.

**Equivocal Death**

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

**Fitness Coordinator**

Civilian health and fitness individual under the supervision of the installation commander with the responsibility of managing and coordinating the installation's program of health fitness.

**Flexibility**

Functional capability of the joint to move through a normal range of motion. It is highly specific and dependent on the muscles and connecting tissue surrounding a joint. Good flexibility is characterized by a freedom of movement, which contributes to ease of movement and economy of muscular effort.

**Health**

Optimal functioning with freedom from disease and abnormality.

**Health Care Provider**

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

**Health Promotion**

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

**Hypertension Identification**

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

**Master Fitness Trainer**

Graduate of the Master Fitness Trainer Course developed by the Soldier Physical Fitness School, Fort Benning, to train selected officers and noncommissioned officers in all aspects of the Army Fitness Program. They perform as unit advisors to commanders/supervisors on fitness programs, and they establish and monitor both unit and individual fitness programs.

**Mental Health Officer**

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

**Mode (Manner) of Death**

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

**Muscular Endurance**

Capability of a muscle, or group of muscles, to perform repeated functions for an extended period of time.

**Muscle Strength**

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

**Nutrition**

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

**Physical Fitness**

Ability to cope within the physical demands of one's job, including the use of adequate reserves to cope with emergency situations. Components of physical fitness include cardiorespiratory endurance, muscular strength and endurance, flexibility, and body composition.

**Psychological Autopsy**

Clarification of the nature of death focusing on the psychological aspects of the dead person. Primary purpose is to reconstruct and understand the circumstances, lifestyles, and state of mind at the time of death.

**Spiritual Fitness**

The development of those personal qualities needed to sustain a person in times of stress, hardship, and

tragedy. These qualities come from religious, philosophical, or human values and form the basis for character, disposition, decision making, and integrity.

**Stress Management**

Assistance provided to cope with the demands, real or perceived, from the environment and from within the individual.

**Suicide Attempt**

Any overt act of self-destructive behavior not resulting in death.

**Suicide Prevention**

The initiatives and activities taken to reduce the incidence of suicide and improve the identity ratio of at-risk people.

**Unit Ministry Team**

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



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**NO SMOKING**



**Except in  
Designated  
Smoking Areas**

Sign should be posted **ONLY** at entrance(s) to Department of the Army owned or controlled buildings/facilities.  
**DA FORM 5560-R, AUG 86**



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# Designated Smoking Area

DA FORM 5560-1-R, AUG 86

\* U.S. GOVERNMENT PRINTING OFFICE: 1997-500-059/60003

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