

# Chapter 26

## SUICIDE AND HOMICIDE RISK MANAGEMENT: RATIONALE AND SUGGESTIONS FOR THE USE OF UNIT WATCH IN GARRISON AND DEPLOYED SETTINGS

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## INTRODUCTION

Unit watch procedures are routinely used in both garrison and operational settings as a tool to enhance the safety of unit personnel when a soldier presents with suicidal or homicidal thoughts. To date, no specific body of literature or US Army publication offers either a rationale or a set of guidelines for their use.

This chapter provides both a rationale and a set of suggestions for the use of unit watch based on fundamental military psychiatric principles, review of the relevant literature, and anecdotal experience. Finally, the chapter includes a discussion of the medicolegal issues specific to the use of unit watch.

## RATIONALE FOR UNIT WATCH

The management of suicidal and homicidal patients in the military environment is somewhat different from the management of such patients in the civilian sector for several reasons. One reason is that the military community provides additional resources, such as the chain of command and fellow soldiers, to assist the military clinician in addressing suicide and homicide risk. Another important reason is the necessity of managing suicide and homicide risk in a deployed or geographically isolated setting. Finally, management of suicide and homicide risk in the military requires addressing the challenge of heightened access to firearms in many settings. Unit watch has evolved within these circumstances as a practical and effective means to enhance the safety of the soldier and others and has gained some legitimacy in the psychiatric community.<sup>1-3</sup> Unit watches have been used in many environments from the battlefield to the garrison, primarily in cases involving a level of risk that is concerning but does not necessarily warrant hospitalization.

Psychiatric hospitalization, although often necessary for patients at high risk for attempting suicide or homicide, is not always the best option for managing suicide or homicide risk in a military setting for several reasons.<sup>1</sup> Hospitalization necessitates removal of the soldier from the unit and in some cases (notably those involving low to moderate risk of suicide) may delay recovery, especially when the symptoms are precipitated by battle fatigue.<sup>4-6</sup> Anecdotally, the authors have observed cases in which hospitalization seemed to exacerbate the symptoms by placing the soldier in the role of a psychiatric patient. Psychiatric hospitalization carries significant stigma in the military as in the general population and may permanently impede the soldier's reintegration into the unit. Fellow soldiers often make comments about hospitalized soldiers being "psycho" or needing to be "locked in a rubber room." Some soldiers lose their sense of self-worth and belonging when they are separated from their units and cannot maintain occupational functioning.

The unit watch (also known as the "command interest profile") is a term describing the use of the military system to limit the suicidal or homicidal soldier's access to people, places, or objects that might increase

that soldier's chances of harming self or others. Based on recommendations from the clinician, a variety of interventions are carried out by the command team, which may include searching the soldier's belongings and living quarters for dangerous items, removing such items from the soldier's possession, prohibiting access to alcohol and drugs, minimizing contact with people who may negatively influence the soldier's mental health, continuously observing the soldier, and ensuring that the soldier returns for mental health follow-up.

A unit watch is an excellent example of the military clinician working with the command team to address a soldier's mental health needs in the least restrictive setting possible through application of the time-honored military psychiatric principles of "PIES" (proximity, immediacy, expectancy, and simplicity), or "BICEPS" (brevity, immediacy, centrality, expectancy, proximity, and simplicity).<sup>7,8</sup> Many soldiers with suicidal or homicidal thoughts have been experiencing stressful life circumstances. Sometimes these circumstances are the direct result of the wartime environment and may represent battle fatigue. Suicidal or homicidal thoughts may occur in the absence of a diagnosable mental illness and may respond to simple interventions such as rest, expectation of recovery, command attention, and support from other members of the soldier's unit. Utilization of the PIES doctrine has demonstrated that suicidal or homicidal soldiers often benefit from brief, immediate care and support near their units. The unit watch is one mechanism for enhancing safety while providing this care and support.

A unit watch can reduce the chances of misperception about the soldier's condition because unit members see and interact with the soldier on a daily basis. Soldiers often report that just talking to other unit members proved helpful. Commanding officers and senior noncommissioned officers often provide invaluable support for soldiers on unit watch by listening to the soldier's concerns, sometimes modifying their style of interaction with the soldier based on a heightened sensitivity to the soldier's personal problems, and by providing social support and advice as they perform their roles in "watching" the soldier.

Though often useful, unit watch may not always be the best approach. The treating mental health professional uses clinical judgment to determine the best course of action. One factor to consider is that a unit watch carries some risk of stigmatization by peers. Fellow soldiers may become frustrated with the soldier because of increased workload and potentially increased hazards as they attempt to cover the soldier's battlefield responsibilities or provide personnel to monitor the soldier. This frustration may be exacerbated if the soldiers experiencing suicidal and homicidal thoughts, who often have a limited ability to give and receive social support, have already marginalized themselves. Many soldiers on unit watch have described to healthcare professionals episodes of ridicule and verbal harassment by both peers and leaders in their units. Regardless of the setting, stigma associated with receiving mental healthcare can be significant.<sup>9</sup> Adequate education of the unit leaders, who then train unit members to envision a unit watch as analogous to "helping a family member in distress," may help alleviate some of the stigma.

Leadership, unit cohesion, and group identification play decisive roles in a soldier's ability to cope with peacetime or wartime duties. A unit watch may focus the command team's attention on issues or stressors affecting their soldiers. In addressing these stressors, the command team may provide enhanced support to the soldier and may actually resolve some of the issues that are contributing to the heightened suicide or homicide risk. Ideally, the command team will consistently communicate the expectation that the unit watch is a team effort designed to help one of their own and to enhance both unit cohesion and the soldier's ability to contribute. Such support can reduce the agitation and hopelessness often present in soldiers with suicidal or homicidal thoughts.<sup>4,10</sup> Working with a command to ensure a unit watch environment that builds social support can be extremely helpful for the soldier. Strengthening such social support may play a key role in the soldier's recovery.<sup>11,12</sup>

Although some risk remains, the authors contend that unit watch significantly reduces the risk of a soldier accessing lethal means such as firearms, ropes, medication, or knives. Of these weapons, firearms deserve special mention. In 2004 and 2005, firearms were the most common method of suicide completion within the US Army (62% and 69%, respectively, per year).<sup>13,14</sup> By limiting access to firearms, a unit watch is likely to reduce the soldier's risk of suicide completion early in the course of treatment, thus allowing time for the treatment and supportive interventions by the command to take effect.

Among US Army soldiers attempting or completing suicide in 2005, 57% of attempts and 17% of comple-

tions involved alcohol or drug use.<sup>14</sup> Such substance use may impair judgment and lower inhibitions against acting on suicidal or homicidal impulses. A properly executed unit watch ensures that soldiers at risk are not given access to alcohol or drugs, thereby reducing risk. Also, by limiting contact with people who might exacerbate the soldier's condition or become a victim of the soldier's homicidal intent, a unit watch may further reduce risk and prevent adverse outcomes.

Finally, the utilization of a unit watch for a soldier who presents with "military-specific" suicidal or homicidal ideation may be highly effective in reducing secondary gain, a term that describes the tangible advantages and benefits that result from being sick.<sup>15</sup> The terms "military-specific suicidal ideation" and "military-specific homicidal ideation" refer to the verbal expression of suicidal or homicidal thoughts with the implicit (as determined by the clinician) or explicit goal of avoiding a military duty such as a field training exercise or deployment, of receiving a transfer to another unit or occupational specialty, or of obtaining a separation from active duty. In such cases, soldiers essentially imply or state that they may or will kill themselves or a leader in their unit unless they are allowed to achieve the stated goal. Such statements are often accompanied by allegations of harassment against the unit chain of command that may or may not be well founded. In many cases of military-specific suicidal or homicidal ideation, the soldier's threats are directly linked to a desire to get out of the military. Such soldiers may believe that reporting suicidal or homicidal thoughts is an easy way to "get chaptered" (seek honorable administrative discharge) without negative consequences. In the absence of risk factors requiring hospitalization, military-specific suicidal or homicidal ideation is an indication for a unit watch, thus conserving inpatient treatment services for other service members who are more likely to benefit from these services. Additionally, soldiers in the unit rapidly develop an awareness that the mental health system is not there primarily to provide an escape from duties and responsibilities, but to provide supportive treatment, helping them function more effectively in a military environment.

While useful in the management of military-specific suicidal or homicidal ideation in garrison, unit watches in a theater of operations are even more valuable. Military-specific suicidal and homicidal ideation are arguably two of the most common presenting behavioral health symptoms on today's battlefield and could easily develop into an evacuation syndrome if not managed appropriately.<sup>11</sup> A force that is well-versed in unit watches from its garrison experience is much more likely to successfully employ the intervention

in wartime or other operations and thus benefit significantly in conserving its fighting, or peacekeeping, strength. However, the system as utilized in garrison requires modification in a deployed setting (discussed later in the chapter).

Two caveats warrant discussion when considering the rationale for the use of unit watch as a tool for enhancing the safety of soldiers at risk for suicide and homicide. The first is that although the unit watch may be beneficial for the soldier, it is only one component of a multifaceted treatment plan. Military mental health clinicians must provide psychological and pharmacologic treatment, as appropriate, to soldiers who present for care, whether or not a unit watch is used to enhance safety. For example, treating symptoms such as anxiety and insomnia is often essential in reducing suicide risk.<sup>1</sup> Treatment of these symptoms should be a priority in soldiers presenting with suicidal thoughts, and treatment should occur independently of the decision to utilize a unit watch.

The second caveat is that essentially no research exists that directly addresses the safety and efficacy of a unit watch as an intervention. The Army Suicide Event Report (ASER) does provide some data that obliquely address the safety of “under command observation” (defined further on the ASER form as “eg, CIP,” a reference to command interest profile). In calendar year 2004, ASER data were received for 54 of 70 suicide com-

pletions and 259 other suicide events (including both suicide attempts and other events that did not involve a suicide attempt, eg, hospitalization and evacuation for suicidal thoughts). In that year, one soldier who completed suicide (1%) and one (.4%) who attempted suicide were under command observation.<sup>13</sup> In calendar year 2005, 2 of the 723 reported suicide events (.2%) in the active duty Army population occurred while the soldier was under command observation (of the five ASER reports identified as “under command observation,” two cases involved ideation only with no attempt, and one was from another branch of service). During the same year, none (0%) of the 71 completed suicides reported to the Suicide Risk Management and Surveillance Office occurred under command observation.<sup>14</sup> (ASERS were not submitted for 12 of the 83 completed suicides that year; therefore, 71 reports were available.) Considering the widespread use of unit watch procedures in the US Army, these data offer some support to the hypothesis that unit watches are safe and may be effective in reducing suicidal behaviors in the short-term while treatment is initiated. Although a controlled study evaluating the safety and efficacy of unit watch procedures may be difficult to design, research about this common practice is certainly warranted. In the meantime, the decision to use unit watch must be based on clinical judgment and experience with consideration of the potential risks and benefits.

## SUICIDE RISK ASSESSMENT

Essential to the appropriate use of unit watches is the ability to assess and document the soldier’s risk for suicide in a format that clearly explains the clinician’s decision-making process. Much has been written about the factors most often associated with completed suicide in both the civilian population and the US military population.<sup>14-17</sup> These factors can be incorporated into a risk assessment that guides the clinician in appropriately choosing a unit watch or hospitalization. Although discussion of a comprehensive suicide risk assessment is beyond the scope of this chapter, a few risk factors are particularly relevant in a military setting.

One of the risk factors most highly correlative with completed suicide is diagnosis. Almost 95% of patients who attempt or commit suicide have a diagnosis of a mood disorder, a psychotic disorder, a substance-abuse disorder, dementia, or delirium. In populations under 30 years of age, the most common diagnoses among suicide completers in one study were antisocial personality disorder and substance-abuse disorders.<sup>18</sup> Based on anecdotal experience, a significant proportion of soldiers presenting with military-specific suicidal thoughts do not meet criteria for these diagnoses.

However, the absence of a psychiatric diagnosis must be interpreted with caution in the active duty Army population, because the ASER data from 2005 indicate that only 26% of suicide completers were given a psychiatric diagnosis.

An “unambiguous wish to die” over a “primary wish for change” as well as “communication internalized” (self-blame) versus “communication externalized” have been cited as important factors associated with high suicide risk.<sup>19</sup> The majority of soldiers with military-specific suicidal thoughts are primarily interested in a change (leaving the military, the theater of operations, or their units) and are angry at an external entity (the military or their chains of command), rather than blaming themselves for their dissatisfaction. Additionally, the association of suicide completion with a conflicted romantic relationship or recent divorce has been particularly well described in the military population.<sup>16</sup>

When many or all of the above-described risk factors for suicide completion are absent, this is often an indication that a unit watch is more appropriate than hospitalization. It is important that the clinician clearly document these and other factors in a formal

suicide-risk assessment that provides a rationale for the decision to utilize a unit watch. In a military setting, collateral history from the unit commander or from others in the unit is an important source of information in the suicide-risk assessment. Current practice in the field of suicide-risk assessment also emphasizes the ongoing nature of the evaluation. Individuals on unit watch should undergo frequent

reassessments by the mental health professional to determine whether the suicide risk has increased to the point that inpatient hospitalization is now indicated. Homicide risk assessment and management is similar to that described for suicide-risk assessment and management, with examination of risk factors and frequent reassessment playing crucial roles in the decision process.

**RECOMMENDATIONS FOR UNIT WATCH PROCEDURES**

**In Garrison**

There are many different approaches to the implementation of unit watch in the military system. A model for conceptualizing the role of unit watches in a garrison setting is presented in Table 26-1. Whatever approach is taken by the clinician, the unit watch should be regarded as a “temporary profile,” a recommendation to a commander regarding the soldier’s temporary

duty restrictions that is likely to be helpful in ensuring the soldier’s health and welfare. Most Army commanders are familiar with the concept of unit watch and will support such recommendations, especially when notified via a memorandum signed by the mental health professional. The memorandum format ensures that instructions are written and easily understood.

The memorandum is given to the soldier’s escort, usually a noncommissioned officer, who signs for its

**TABLE 26-1**  
**MANAGING SUICIDE AND HOMICIDE RISK IN GARRISON**

	Full Duty	Buddy Watch	24-Hour Watch	Admit to Psychiatric Ward
	Least restrictive ←————→ Most restrictive			
Actions	Return to duty	1. Secure weapons and medication 2. Soldier is under direct observation from first formation until lights out	1. Secure weapons and medications 2. Soldier is under direct observation 24 h/day	Admit to psychiatric ward
Examples	1. SI/HI without plan/intent, few risk factors, contracts for safety	1. Primary indication is “military-specific” SI/HI, no intent, few risk factors 2. SI/HI due to psychiatric disorder but risk level does not warrant 24 h watch or hospitalization 3. Step down from unit watch	1. Primary indication is “military-specific” SI/HI with plan and/or intent but few risk factors 2. SI/HI due to psychiatric disorder but risk level does not warrant hospitalization	1. High suicide or homicide risk requiring psychiatric hospitalization 2. Suicide/homicide risk not diminishing after (no more than) 5 days despite treatment while on 24 h or buddy watch
Advantages	1. RTD 2. No stigma	1. Less stigma than 24 h watch 2. Some safety precautions 3. Lower personnel demands than 24 h watch 4. Reasonable likelihood of RTD	1. High level of safety precautions 2. Reasonable likelihood of RTD	Highest level of safely precautions
Disadvantages	No safety precautions	Fewer safety precautions vs 24 h watch	Stigma, high personnel demands for unit	Low likelihood of RTD, stigma, loss of social and occupational roles that sometimes support recovery

HI: homicidal ideation; RTD: return to duty; SI: suicidal ideation

receipt and is instructed to deliver it to the commander or first sergeant. This allows the clinician to release the service member with a recommendation for a unit watch at times when the clinician may not be able to contact the commander immediately. As with all medical profiles, the commander may choose to ignore the clinician's recommendation, but then assume significant responsibility for the outcome of the case.

The garrison system proposed in this chapter con-

sists of two types of unit watches. The first is called a "buddy watch"; it recommends that the soldier be under direct observation only from first formation until lights out, rather than 24 hours a day, for up to 5 days from the initiation of the watch until a reevaluation occurs. This watch is generally for lower-risk individuals, provides more flexibility for use (eg, over a weekend), and is generally better received by the chain of command and the soldier. It is valuable in a

**EXHIBIT 26-1**

**BUDDY WATCH MEMORANDUM**

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DATE:

MEMORANDUM FOR (COMMANDER, UNIT)

SUBJECT: Buddy Watch for \_\_\_\_\_ (Soldier's name and last 4)

1. The soldier was evaluated at the \_\_\_\_\_ Behavioral Health Clinic. The results of the evaluation indicate that this Soldier is at some risk for self-harm or harm to others. The risk level at this time does not warrant hospitalization, but a Buddy Watch for both support and safety is recommended.
2. Buddy Watch procedures are as follows:
  - a. Command should assign someone to constantly monitor the soldier from first formation until lights out. The Soldier may be allowed to go to the latrine alone if the latrine doorway is monitored by the buddy or NCO assigned to watch the Soldier. During the night, constant monitoring is not required, but the soldier must not sleep in a room alone. Actions that specifically identify a Soldier on a Buddy Watch to large numbers of unit personnel (e.g. having the Soldier wear a road guard vest throughout the day) are not authorized.
  - b. Health and welfare inspection of the soldier's room to remove hazardous material (e.g. pills, knives, etc.).
  - c. No access to alcohol or dangerous objects such as:
    - 1) Personal weapons, knives, cigarette lighters, jewelry with sharp edges, blow dryers (silverware other than sharp knives is acceptable).
    - 2) Pills (medication should be dispensed one dose at the time by medic, PA, NCO, etc).
    - 3) The Soldier may carry a military-issued firearm if the firing pin or bolt has been removed from the weapon.
  - d. It is recommended that the Soldier perform his/her regular (noncombat) duty and PT. Physical exercise often improves behavioral health symptoms.
3. This plan will be in effect from today until it is terminated by the Behavioral Health clinician in agreement with the commander. Continuing a buddy watch after a Behavioral Health clinician has recommended termination is not authorized and may be perceived as harassment.
4. If this Soldier's condition worsens, the Soldier's supervisor should call the Behavioral Health clinic at xxx-xxxx during duty hours or bring the Soldier to the \_\_\_\_\_ Emergency Room after hours. If phone contact cannot be established with a Behavioral Health clinician during the duty day, escort the Soldier immediately to the Behavioral Health clinic for evaluation.

This Soldier's next appointment at the \_\_\_\_\_ Behavioral Health clinic is on \_\_\_\_\_ (date) at \_\_\_\_\_ (time).

\_\_\_\_\_  
Representative from Command

\_\_\_\_\_  
Clinician

Adapted from a form developed at the 2nd Infantry Division, initially by Captain Sally Chessani (now Colonel Sally Harvey), licensed clinical psychologist.

NCO: noncommissioned officer; PA: physician's assistant; PT: physical training

variety of situations, including the typical presentation with military-specific suicidal ideation and very few risk factors for suicide completion.

Another scenario in which this watch may be useful is in managing soldiers who are urgently command-

referred for verbal expression of suicidal thoughts or self-injurious behavior the previous night when they were intoxicated. On presentation, the service member may have no current suicidal ideation, may claim to have no memory of the statements or self-injurious

**EXHIBIT 26-2**

**24-HOUR WATCH MEMORANDUM**

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DATE:

MEMORANDUM FOR (COMMANDER, UNIT)

SUBJECT: 24 Hour Watch for \_\_\_\_\_ (Soldier's name and last 4)

1. The Soldier was evaluated at the \_\_\_\_\_ Behavioral Health clinic on \_\_\_\_\_. The results of the evaluation indicate that this Soldier is at some risk for self-harm or harm to others. The risk level at this time does not warrant hospitalization, but a 24 Hour Watch for both support and safety is recommended.
2. 24-Hour Watch procedures are as follows:
  - a. Continuous monitoring should occur at all times, including accompanying the soldier to the latrine and during meals.
  - b. The soldier should sleep in a room with a unit member who is awake at all times or in a dayroom (cleared of dangerous items) near the Staff Duty/CQ area so that the Soldier is constantly monitored throughout the night. Other actions that specifically identify the Soldier on a 24 Hour Watch to large numbers of unit personnel (e.g. having the Soldier wear a road guard vest throughout the day) are not authorized and may be perceived as harassment.
  - c. Health and welfare inspection of the soldier's room to remove hazardous materials (e.g., pills, knives, weapons, etc.). Instead of removing the Soldier's weapon, the weapon may be inactivated (e.g., removing the bolt or firing pin from an M-16).
  - d. Other than family members, visitors from outside the unit must be cleared by the commander.
  - e. No access to alcohol or dangerous objects such as:
    - 1) Personal weapons, knives, cigarette lighters, jewelry with sharp edges, blow dryers (silverware other than sharp knives is acceptable).
    - 2) Pills (medication should be dispensed one dose at a time by medic, PA, NCO, etc.).
    - 3) The Soldier may carry a military-issued firearm if the firing pin or bolt has been removed from the weapon.
3. Soldier should perform his/her regular (noncombat) duty and PT. Physical exercise often improves behavioral health symptoms.
4. This plan will be in effect from today until it is terminated by the Behavioral Health clinician in agreement with the command. Continuing a 24 hour watch after a Behavioral Health clinician has recommended termination is not authorized and may be perceived as harassment.
5. If this Soldier's condition worsens, the Soldier's supervisor should call the Behavioral Health clinic at xxx-xxxx during duty hours or escort the Soldier to the Emergency Room (or TMC in theater) after duty hours. If phone contact cannot be established with a Behavioral Health clinician during the day, bring the Soldier to the Behavioral Health clinic during duty hours for evaluation.
6. This soldier's next appointment at the \_\_\_\_\_ Behavioral Health clinic is on \_\_\_\_\_ at \_\_\_\_\_.

\_\_\_\_\_  
Representative from Command

\_\_\_\_\_  
Clinician

CQ: charge of quarters; NCO: noncommissioned officer; PA: physician's assistant; TMC: troop medical clinic

**EXHIBIT 26-3**

**INFORMATION PAPER FOR COMMANDERS**

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MCXC-BH

INFORMATION PAPER

SUBJECT: Management of Soldiers with Suicidal or Homicidal Ideation

1. References: FM 4-02.55 COMBAT AND OPERATIONAL STRESS CONTROL, FM 22-51 Leader's Manual for Combat Stress Control
2. Purpose. To provide information to commanders regarding the use of unit watches in the management of Soldiers who express suicidal and homicidal ideation.
3. Overview:

When it is brought to the commander's attention that a Soldier has expressed suicidal ideation, the commander should immediately contact his supporting behavioral health activity to insure that an evaluation of risk is performed. Procedures for this are not within the scope of this information paper. Once the Soldier is evaluated, the behavioral health professional will have examined the risk factors (e.g. the psychiatric diagnosis, any history of previous attempts, family history of attempts, the presence and lethality of a plan for suicide) and will make recommendations to the commander. These recommendations will include one of the following: return to full duty with close monitoring and support for low risk soldiers, Buddy Watch (or Basic Precautions in Operational environments) for low to moderate risk Soldiers, 24 Hour Watch for moderate risk Soldiers, and hospitalization for soldiers at high risk. The value to the soldier and commander of Basic Precautions, Buddy Watch, and 24 Hour Watch as opposed to hospitalization are as follows:

The soldier is able to maintain occupational functioning at some level and maintains social connection in the unit. This helps to prevent feelings of worthlessness and a sense of isolation that sometimes result from psychiatric hospitalization.

The soldier avoids the stigma that is unfortunately commonly associated with psychiatric hospitalization. While there may be some stigma associated with a unit watch, at least the soldiers in the unit see the soldier on a daily basis and are much less likely to develop misperceptions about the Soldier's problem, e.g. that the Soldier is "psycho" and is "locked in a rubber room". These misperceptions are prevalent in our culture and are sometimes very damaging in the Soldier's reintegration to the unit after a psychiatric hospitalization.

The Soldier has the opportunity to address his or her concerns with the chain of command. NCOs often provide significant relief from depressed feelings when they listen to and support a Soldier who has expressed suicidal ideation. In this way, the unit implements the Army's concept of the unit as the Soldier's "family" and provides extra care and support to a unit member in distress.

Soldiers with "military specific" suicidal ideation (e.g. "I will kill myself if you don't let me out of the Army") become aware more rapidly that the behavioral health system does not provide an escape route from their duties and responsibilities, though it does react to help the Soldier adjust to their situation. This message is transmitted to the entire unit and is likely to lessen the number of Soldiers who develop "military specific" suicidal ideation. This MAY ENHANCE RETENTION AND COMBAT READINESS by reducing the number of soldiers that seek out the mental health system as an escape route from the Army.

The unit chain of command gains significant experience in managing Soldiers who express suicidal ideation. This experience and familiarity with unit watches MAY ENHANCE COMBAT READINESS because the unit will most likely need to employ similar procedures in an operational environment. The proficient use of unit watches in a combat setting may prevent an "evacuation syndrome" in which significant numbers of Soldiers who express suicidal thoughts are evacuated from theater because units have not been trained in the management of this problem.

4. Types of Unit Watches:

- a. Buddy Watch: A unit member is assigned to constantly monitor the soldier from first formation until lights out. The soldier should not sleep in a room alone but constant monitoring is not required at night. The Soldier will follow up with Behavioral health within 5 days (usually sooner) of the initiation of the watch so that the risk level can

(Exhibit 26-3 continues)

**Exhibit 26-3** *continued*

be reassessed. If significant risk remains at that point, the Soldier is often hospitalized so that the unit's combat readiness is not unduly affected by an extended period of observation of the soldier.

- b. **24-Hour Watch:** A unit member is assigned to constantly monitor the Soldier throughout an entire 24 hour period. Unit commanders often use a Staff Duty NCO or CQ personnel for this purpose. This type of watch is generally only used in "military specific" suicidal ideation where the Soldier is making specific threats related to a wish for release from the Army or a deployment but does not have other risk factors (eg, a depressive disorder, a history of suicide attempts) that would warrant hospitalization. The Soldier will generally be seen back within 24 hours due to the time-intensive nature of this procedure for the unit. At that point, the clinician will again assess the risk and make a determination regarding the appropriate recommendation.
- c. **Recommendation for Basic Precautions:** While a recommendation for Basic Precautions is not technically a unit watch, it is a set of safety precautions used only in an operational environment. The essential elements of Basic Precautions are that the Soldier does not participate in combat (or "off-FOB") duties and that the firing pin or bolt is removed from the Soldier's weapon.

5. **The Homicidal Soldier:**

Soldiers who express homicidal thoughts should also be referred to Behavioral Health for an evaluation so that the mental health professional can rule out a mental disorder as a cause of the homicidal thoughts, assess the risk, and initiate treatment if there is evidence of a behavioral health disorder. In the absence of a serious behavioral health disorder contributing to the homicidal thoughts, the presence of homicidal thoughts is often not an indication for psychiatric hospitalization. The mental health professional will generally take steps to insure that the commander warns the personnel who are threatened, and may recommend a Buddy Watch or 24 Hour Watch as a method of protecting the threatened individual. If the risk level is very high, the commander has the option of consulting SJA regarding the possibility of placing the Soldier in pretrial confinement if hospitalization is not indicated.

6. **Summary:**

The use of unit watches is a valuable tool for the commander in supporting Soldiers and enhancing combat readiness. Behavioral Health clinicians will work with you to determine the appropriate management tool and will hospitalize the Soldier if the risk level warrants this intervention. Behavioral Health clinicians can not predict suicide or homicide but are trained to follow clear guidelines about the level of risk that warrants hospitalization. Your supporting Behavioral Health clinicians will insure that your Soldier receives the most appropriate intervention for their level of risk.

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Representative from Command

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Clinician

CQ: charge of quarters; FOB: forward operating base; FM: field manual; NCO: noncommissioned officer; SJA: Staff Judge Advocate

act, and may demonstrate minimal risk factors for a suicidal act. However, there is clearly some risk, especially if alcohol use is resumed. The buddy watch significantly minimizes the opportunity for continued alcohol use, and thus may reduce the suicide risk while outpatient treatment, including referral to the Army Substance Abuse Program, is initiated. Other situations in which a buddy watch may be valuable are situations in which "stepping down" from hospitalization or 24-hour watch is prudent. Exhibit 26-1 is an example of specific procedures for buddy watch.

The second type of unit watch is called a "24-hour watch," avoiding another commonly used term, "CQ (charge-of-quarters) watch," for two reasons. Some

units do not have a CQ duty and the commander may infer from the term that the unit is being asked to perform a task for which it is not equipped. The commander may also infer from "CQ watch" that the clinician is recommending that the soldier be moved to a central area (eg, dayroom) in the unit where observation is possible by soldiers performing CQ duty. Moving the soldier to a central area is sometimes necessary but should be avoided whenever possible because such a move may enhance the sense of humiliation or stigma. The primary characteristic of a 24-hour watch is that the soldier is under constant observation during a 24-hour period, after which an evaluation by a mental health officer must take place. Specific procedures for

## EXHIBIT 26-4

### STANDARD OPERATING PROCEDURES FOR BUDDY WATCH AND 24-HOUR WATCH

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#### STANDARD OPERATING PROCEDURES

##### Buddy and 24-Hour Unit Watch

1. **PURPOSE:** To establish procedures for the use of Buddy and 24 Hour Unit Watches in the management of Soldiers undergoing evaluation and treatment for suicidal statements or behaviors.
2. **SCOPE:** All personnel assigned to or working in the Department of Behavioral Health.
3. **GENERAL:**
  - a. All patients seen in the clinic who describe a history of current or recent (i.e. within the past two weeks) suicidal ideation, suicide attempt, or homicidal ideation must be seen by a Behavioral Health clinician prior to release of the soldier. (Risk assessments after clinic hours will be performed by Emergency Department staff, in consultation with the on-call Behavioral Health clinician.)
  - b. The evaluation of potential for harm will include a thorough psychiatric history and examination of risk factors. The suicide risk factors assessed will include at a minimum the following: history of previous attempts, frequency and duration of suicidal ideation/plan/intent, access to lethal means, presence or absence of substance abuse, signs and symptoms of mood and anxiety disorders, current significant stresses, social supports, reality testing, and any family history of completed suicide. The homicide risk factors assessed will include at a minimum the following: history of previous violence, frequency and duration of homicidal ideation/plan/intent, and determination of access to lethal means.
  - c. The disposition should be appropriate based on the assessment and must address the safety of all involved.
  - d. Documentation of the assessment will be completed on the day of the evaluation.
4. **PROCEDURES:**
  - a. A Buddy Watch may be recommended to the commander if there is some risk for harm to self or others, but the mental health officer clearly documents a risk assessment explaining that the Soldier's risk is not high enough to warrant hospitalization. The Buddy Watch allows for monitoring the Soldier while treatment is initiated, and may have advantages over hospitalization. These are described in Attachment C.
  - b. A 24-Hour Watch may be recommended for Soldiers who require more constant supervision than provided by a Buddy Watch and is typically implemented for Soldiers who make specific threats to harm themselves or others in order to avoid duty or to force a discharge from service (eg, "I will kill myself if you don't let me out of the Army"). The risk assessment explaining the clinician's conclusion that the Soldier's risk is not high enough to warrant hospitalization must be clearly documented.
  - c. The procedures for Buddy Watch and 24-Hour Watch are explained in detail in Attachments A and B. The essential difference in these two procedures is that a Soldier on Buddy Watch requires observation only from first formation until lights out, whereas a Soldier on 24 Hour Watch must be observed at all times.

When a Soldier is placed on a watch, the Behavioral Health clinician will make an attempt to contact the commander to discuss the reasons for the watch and other pertinent concerns. The appropriate form will be forwarded to the commander through the Soldier's escort. If the commander requests additional information about unit watch or expresses uncertainty about unit watch, the information paper titled Management of Soldiers With Suicidal or Homicidal Ideation will be forwarded to the commander through the Soldier's escort. A Soldier on a Buddy Watch will be seen for a follow up appointment at least every five working days until the watch is discontinued. A Soldier on a 24-Hour Watch will be seen for re-evaluation within 24 hours. A Behavioral Health clinician will evaluate the Soldier at each return appointment until the watch is discontinued. The decision to recommend discontinuation of a unit watch will be made only by a Behavioral Health clinician. A memorandum recommending discontinuation of the watch will be signed by the Behavioral Health clinician and forwarded to the commander.

Unit watches are recommendations to commanders. Behavioral Health clinicians must discuss their recommendations with the commander and be sensitive to specific command and unit circumstances. In all cases, the safety of the Soldier and others that might be at risk will be the primary concern.

The Buddy Watch or 24-Hour Unit Watch will only be used for soldiers who have been assessed for their level of risk by a clinician at this institution. Unit watches may be utilized by Emergency Department clinician if the on-call mental health care clinician has been consulted by the Emergency Department clinician and they are in agreement regarding the disposition.

**EXHIBIT 26-5****UNIT WATCH DISCONTINUATION MEMORANDUM**

Date: \_\_\_\_\_

MEMORANDUM FOR (Commander, Unit) \_\_\_\_\_

SUBJECT: Release from Twenty Four Hour Watch/Buddy Watch for \_\_\_\_\_

SSN: \_\_\_\_\_

1. The above named service member was recommended for Twenty Four hour Watch/Buddy Watch on \_\_\_\_\_ .
2. The above named service member was evaluated at \_\_\_\_\_ Behavioral Health clinic again on \_\_\_\_\_. I currently do not believe that the service member is an imminent risk to self or others and recommend the service member be removed from Twenty-Four Hour Watch/Buddy Watch.
3. Although this service member is not currently at significant risk for dangerousness to self or others, please understand that the service member's risk level may change.
4. If the service member experiences a recurrence of suicidal or homicidal thoughts or demonstrates other behaviors indicating there is risk for harm to self or others, the service member should be escorted to the clinic (duty hours) or to the Emergency Department (after hours) for evaluation.
5. The service member's next scheduled appointment at Outpatient Behavioral Health Services is on \_\_\_\_\_ at \_\_\_\_\_.
6. Point of contact for this memorandum is the undersigned at xxx-xxxx.

\_\_\_\_\_  
Clinician

this watch are outlined in Exhibit 26-2.

The procedures outlined for both types of unit watch are designed to give the commander specific guidance regarding measures to ensure the soldier's safety. This written guidance helps to reduce confusion, which often results if a more vague verbal recommendation for a unit watch is used to communicate with the chain of command. The 24-hour watch is at times useful in the management of a soldier with military-specific suicidal or homicidal ideation who has very few risk factors except for a verbalized threat, such as "I will kill myself (or my squad leader) if I have to go back to my unit." It is often, though not necessarily, used in conjunction with an environmental change, for instance, an agreement with the commander that the service member will be moved to a different platoon, if the threats of suicide or homicide are specific to alleged harassment by a noncommissioned officer in the service member's section, squad, or platoon.

In addition to the memoranda outlining specific recommendations, the authors suggest that a unit watch information paper (Exhibit 26-3) be forwarded to the commander, especially if the commander expresses confusion or skepticism about the recommendation for

a unit watch. This document provides education for the command team and may alleviate concerns about the safety and value of a unit watch. Command support of the unit watch is crucial. If not fully informed and educated about the unit watch, unit leaders may feel compelled to intervene further and attempt to force the mental health system to psychiatrically hospitalize the service member.

Exhibit 26-4 is an example of a standard operating procedure for the behavioral health team, providing a general guide for the use of unit watch in a garrison setting. Clinicians' beliefs about the need for psychiatric hospitalization in various situations differ significantly, so no absolute guidelines about which clinical factors require hospitalization over unit watch are included in this chapter. This variation in decisions regarding hospitalization reinforces the critical role of documenting the clinical assessment and decision-making process in each case. Finally, when the clinician decides to recommend discontinuation of the unit watch, it is helpful to forward to the command team a standard document with this recommendation. Commanders may wait for such written notification before discontinuing a watch. Exhibit 26-5 is a sample memorandum.

### Deployed Settings

The garrison system for unit watch must be modified to function in a deployed setting for two reasons. The first is a recognition that access to lethal weapons is heightened immeasurably in a deployed setting; thus, the buddy watch must be removed from the range of options. The 24-hour watch is used instead for soldiers at heightened risk who do not require hospitalization. Another option for lower risk soldiers used during the deployment has been dubbed “basic precautions.” The essential elements of the basic precautions profile are removal of the firing pin (or bolt) from the soldier’s weapon and suspending combat duties until further notice. Exhibit 26-6 shows the basic precautions memorandum that was used to successfully communicate to the commander the necessary precautions by one of the authors (SP) during a 2006–2007 deployment. During this deployment, basic precautions were applied extensively in a variety of situations, including those involving vague suicidal or homicidal thoughts but few other risk factors in soldiers requiring a period of treatment before return to full duty.

The second reason is that, depending on the unit, the clinician may have ready access to a “patient hold” area such as that operated by the medical company in a brigade support battalion. Although traditional combat stress control doctrine has emphasized separation of soldiers presenting with psychiatric issues from those presenting with medical and surgical illness, utilization of the patient hold area for brief management of suicide risk has been effective in deployed settings. Based on these two modifications, a model for conceptualizing the role of unit watches in a deployed setting is presented in Table 26-2. This model was used by one author (SP) to train primary care clinicians and mental health professionals in the management of suicide and homicide risk during the 2006–2007 deployment. The following is an example of a unit watch used in a deployed setting.

**Case Study 26-1:** A 31-year-old married African-American man deployed to a combat zone came to the mental health clinic after learning that his wife planned to leave him. He stated that if only he was given the chance to go home, he could save his marriage. He reported that he was

**EXHIBIT 26-6**

**BASIC PRECAUTIONS**

---

\_\_\_\_\_ TMC  
 FOB \_\_\_\_\_, Iraq

Date \_\_\_\_\_

MEMORANDUM FOR Commander,

SUBJECT:       Basic Precaution for \_\_\_\_\_ SSN: \_\_\_\_\_

This service member was evaluated at the FOB \_\_\_\_\_ TMC. Based on this evaluation of the service member’s recent behaviors and current mental status, the following precautions are recommended to the commander for the service member’s support and safety. The evaluation did not indicate a high enough risk of dangerousness to warrant hospitalization or a unit watch at this time.

2. Precautions:

- a. Remove the firing pin (or bolt) from this service member’s weapon.
- b. No combat or “Off-FOB” duties until further notice.
- c. Service member should perform duties not involving combat operations and should participate in PT. PT may help improve the service member’s behavioral health symptoms.

3. If this service member’s condition worsens, the service member’s supervisor should call FOB \_\_\_\_\_ TMC Behavioral Health at xxx-xxxx or escort the service member to the TMC for evaluation.

This service member’s next appointment at FOB \_\_\_\_\_ TMC is on \_\_\_\_\_  
 at \_\_\_\_\_ with \_\_\_\_\_.

\_\_\_\_\_  
 Representative from Command

\_\_\_\_\_  
 Clinician

FOB: forward operating base; PT: physical therapy; SSN: social security number; TMC: troop medical clinic

**TABLE 26-2**  
**MANAGING SUICIDE AND HOMICIDE RISK DURING DEPLOYMENT**

	Full Combat Duty	Basic Precautions	24-Hour Watch (or admit patient to hold)	Evacuation to Combat Support Hospital
	Least restrictive ←—————→ Most restrictive			
Actions	Soldier verbally contracts for safety	1. Secure bolt from weapon until further notice 2. No off-FOB duties until further notice	1. Secure weapons and medications 2. Soldier is under direct observation 24 h/day	Enact evacuation procedures
Examples	Suicidal thoughts, few risk factors, able to contract for safety	1. Primary indication is military-specific SI/HI 2. Psychiatric disorder with SI/HI but risk not high enough to warrant unit watch 3. Step down from unit watch	1. Military-specific SI/HI but risk not high enough to warrant hospitalization 2. Psychiatric disorder with SI/HI but risk not high enough to warrant hospitalization	1. Suicide or homicide risk high enough to warrant hospitalization 2. Medically serious suicide attempt (overdose, lacerations requiring sutures) 3. Suicide/homicide risk not diminishing after (no more than) 5 days despite treatment while on unit watch
Advantages	1. RTD 2. No stigma	1. Much less stigma than unit watch 2. Some level of safety precautions	1. High level of safety precautions 2. High likelihood of RTD 3. Consistent with PIES	Highest level of safety precautions
Disadvantages	No safety precautions	Fewer safety precautions vs unit watch	1. Stigma 2. "Sick role" with patient hold	Low likelihood of RTD, stigma, violates PIES unless clearly indicated

FOB: forward operating base; HI: homicidal ideation; PIES: proximity, immediacy, expectancy, and simplicity; RTD: return to duty; SI: suicidal ideation

suicidal and would kill himself if he wasn't allowed to leave. During the initial evaluation, he didn't describe a defined plan for carrying out his suicide and reported never before experiencing suicidal thoughts. He denied any previous mental health history, had no medical illness, and was not using alcohol, street drugs, or medications. A 24-hour watch was recommended to the commander, along with frequent mental health treatment to help him cope with his emotional crisis. On meeting to discuss a safety plan for the soldier, the command team reported that he had recently been serving well in his role as a member of a logistics team. During the meeting the soldier's first sergeant reminded the soldier how proud the battalion commander was of the soldier's proficiency in a recent task. He then expressed how the command team valued the soldier, not just as a "number" but as a person and team member. The command team agreed to provide 24-hour supervision for the soldier in a nonstigmatizing manner by removing the bolt from his weapon and removing his ammunition and knives from his possession, as well as allowing him to remain on base where he would probably not need his weapons. He was allowed to choose the soldiers who would be assigned to monitor him, selecting those with whom he felt the closest connection. He was then returned to duty with mental health follow-up planned in 2 days. He reported that during the day while on

24-hour watch he spent time talking to his escorts about his problems. During this time period, he continued his usual work schedule and came to the clinic every other day for a brief assessment and supportive therapy. Within 2 weeks, he had come to terms with his pending divorce, realizing that his presence at home would probably not have affected his wife's plans. He also noted that his distress over the loss of his marriage wouldn't resolve by throwing away his life or military career. The 24-hour watch was discontinued at that point. His bolt, ammunition, and knives were returned to him and, though his wife did leave him, he was able to continue with the mission and complete the deployment. His emotional state had returned to near baseline approximately 1 month after his initial presentation. After several months of monthly follow-up, he required no further treatment for the remainder of the deployment.

The soldier in this case presented with suicidal ideation in acute emotional crisis after learning of his wife's plan to divorce him. His access to a weapon and his primary stressor of interpersonal loss placed him at significant risk for a suicide attempt. However, he did not have a formulated plan for suicide, a significant medical or mental health history, or a substance-use

problem. Thus, his treating clinician decided that the appropriate treatment setting would be to ensure the patient's safety via a 24-hour watch, long enough for his immediate emotional crisis to resolve. An adequate nonstigmatizing safety environment was created for the soldier, and the unit provided emotional support as well as safety. As expected, his emotional crisis resolved within 2 weeks and his symptoms resolved within 1 month as he gained understanding and acceptance of his changing life situation.

In a garrison or deployed setting, the clinician must clearly document the suicide or homicide risk assessment, giving a clear rationale that makes the case for the specific treatment setting (eg, buddy watch, 24-hour watch, basic precautions, patient hold) rather than hospitalization or evacuation. The military unit

is a unique and cohesive community that often allows these interventions to effectively reduce suicide or homicide risk. However, because these interventions are relatively unknown in the civilian sector, meticulous documentation of suicide risk factors and the reason that unit watch was considered a safe intervention for the soldier are essential in each case. Documentation of discussions with command, education given to the command, and assurance that the command is capable of carrying out a proper unit watch are also recommended. Finally, the widespread use of the unit watch by military mental health providers, and its inclusion in the American Psychiatric Association practice guidelines, may help establish this as an appropriate, if not yet evidence-based, intervention within the military.<sup>1</sup>

### MEDICOLEGAL ISSUES

The legal implications of using a unit watch are of concern to many clinicians. There is no exact equivalent to the unit watch in the civilian sector, although it is loosely analogous to sending a patient home with parents or family members who promise to watch the patient and confiscate weapons or excess pills. Suicide watches in a prison may use similar procedures, despite the obvious differences between a prison environment and an Army barracks. Although the need for collaboration with the legal community on these issues is obvious, no literature specifically addresses this aspect. The following brief summary lays out the basic medicolegal issues involved.

Mental health clinicians in the civilian community have serious concerns about liability when a patient completes a suicide or commits a homicide. Many malpractice lawsuits involve plaintiffs who complete suicide after a psychiatric assessment concluded that hospitalization was not indicated. Factors in finding the mental health clinician liable for damages often include inadequate risk assessment or inadequate response to that risk.<sup>20</sup> Inadequate documentation of the risk assessment is a frequent factor that leads to a verdict against the clinician. Failure to frequently reevaluate the suicide risk may also be a basis for a finding of malpractice. Prison staff and supervisors have been found liable in cases of completed suicides in civilian prisons because of their responsibility for the health and well-being of their wards. Insufficient training of personnel or inadequate adherence to standard operating procedures may result in findings of negligence.

Military commanders and clinicians have a unique protection from liability in the form of the *Feres* doctrine, which is an exception to the Federal Tort Claims

Act. The doctrine stems from *Feres v US*,<sup>21</sup> which consolidated three lawsuits concerning the injury or death of three service members due to possible negligence on the part of the military. Two of the cases involved physician malpractice. The US Supreme Court ruled that there was no cause of action under the Tort Claims Act for wrongful death or personal injury to a member of the armed forces if the injury or death was "in the course of activity incident to their service in the Armed Forces."<sup>21</sup> Many lawsuits alleging malpractice or seeking consortium for loss of finances have been barred because of the *Feres* doctrine, including suits in which unit commanders were accused of failure to take appropriate actions when there was direct evidence of a soldier's suicidal intent. Legal action by both active duty members suing through military courts and civilian dependents suing through federal courts have been barred.

The suicide of a soldier while that individual is under unit watch could potentially call into question whether the mental health clinician did not fully appreciate the suicide risk or did not ensure that an adequate intervention was used. The commander could also be questioned concerning the competence of the unit to perform a unit watch. Another issue is that soldiers performing the watch may have little or no experience with the procedures involved in a unit watch, and they may not fully appreciate that serious adverse outcomes might result if the procedures are not strictly followed. Although lawsuits are often barred through the *Feres* doctrine, the military may nonetheless take disciplinary action against physicians or commanders if an internal investigation uncovers fault or negligence. Monetary payments may be given out for compensable events. Department of

Defense Directive 6025.13 outlines the procedures for investigation of potential provider malpractice.<sup>22</sup> If the surgeon general for the specific military branch makes a determination that an adverse privileging action should be placed against a physician, then that finding will be entered into the National Practitioner Data Bank (NPDB).<sup>22,23(pA-3)</sup> The NPDB is a database that provides information concerning specific areas of a practitioner's licensure, including professional society memberships, medical malpractice payment history, record of clinical privileges, adverse licensure actions, withdrawal of clinical privileges, and other negative actions taken against an individual healthcare practitioner. Such information is provided through legally authorized queries to assist state licensing boards, hospitals, and other healthcare entities in establishing the qualifications of the healthcare practitioners they seek to license, hire, or privilege. These actions are representative of the military's ongoing efforts to ensure that military healthcare is comparable to civilian standards. A survey of all military malpractice cases from 1978 to 1987 revealed that of 14 cases involving attempted or completed suicide, six cases resulted in monetary settlements totaling \$754,000.<sup>24</sup>

The use of unit watch for management of homicide risk is perhaps the easier case to make. The landmark *Tarasoff* decision, although binding only within the state of California, gave clinicians the responsibility to take measures to protect the potential victim if the clinician believes there is a probability that the patient will commit murder.<sup>25,26</sup> In the *Tarasoff* case, a patient told his psychiatrist that he planned to kill a female love interest. The murder was carried out, and the psychiatrist was found liable for not taking action such as alerting the victim and committing the patient. Many states now require *Tarasoff*-like duties to protect potential victims, either through case or statutory law. However, there is no federal law regarding this issue (federal law applies to the military). Some states have ruled that psychiatrists are liable for violent acts by their patients even when no specific victim can be identified, when no specific threat was made, or when homicides occur

several months after a risk assessment.<sup>27-29</sup>

The military psychiatric community commonly assumes that a duty to protect exists, despite the lack of clear statutory guidance. The Feres doctrine would not exempt a military clinician from potential liability if an active duty patient hurt or killed an individual not on active duty; in such a case, relevant state law would be applicable. Unless one is familiar with the laws of each state, the best practice in the military is to adhere to a *Tarasoff*-like standard of care. The use of unit watch to prevent an individual from carrying out an act of homicide would be an added medicolegal (and ethical) safeguard when a clinician is assessing a soldier's threats.

In the authors' experience, a large proportion of soldiers presenting with homicidal ideation toward their chains of command have diagnoses of adjustment disorder, personality disorder, or, sometimes, alcohol-abuse disorder. In the absence of a severe mental disorder, these service members do not meet criteria for hospitalization, but are often hospitalized because the clinician believes that it is necessary to protect the potential victim. As an alternative measure, unit watch helps protect potential victims by limiting access to lethal means and providing an observer to notify the chain of command or authorities if the potential perpetrator takes any confrontational action. As an adjunct to the unit watch, additional clinical actions in the case of a potential homicide sometimes include a recommendation that the commander move the soldier to another section of the unit (in the case of homicidal ideation toward an immediate supervisor), that the commander warn the potential victim about the homicide threat, and that the commander give both parties a direct order to avoid all contact except as necessary in the performance of their daily duties. In many cases, these interventions may actually be more effective in minimizing risk than simply notifying the local police and the potential victim, in keeping with the civilian standard of care when the patient does not meet commitment criteria because of the lack of evidence of a severe mental disorder.

## SUMMARY

Although there are no simple answers in the assessment and management of suicide and homicide risk in any setting, military clinicians practice in a unique community that necessitates a uniquely military approach to the issue. The recommendations and information presented in this chapter may help validate and standardize a military approach, and will hopefully stimulate research in this area. For example, publication of a case series of soldiers successfully managed

with unit watch according to the guidelines discussed above would further validate this technique. A retrospective or prospective study comparing various outcome measures for soldiers at a post where unit watch is commonly used with outcomes for a control group of soldiers at a post where unit watch is not commonly used might also be possible. Optimization, validation, and eventually incorporation of this chapter's recommendations into the curricula in military behavioral

health training programs, combat operational stress control doctrine, and other military publications will contribute to a wealth of resources available to military

mental health professionals to support and guide the successful management of suicide and homicide risk in the active duty population.

#### Acknowledgment

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