The Use of Unit Watch or Command Interest Profile in the Management of Suicide and Homicide Risk: Rationale and Guidelines for the Military Mental Health Professional

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ABSTRACT
Military mental health care professionals have, for decades, recommended that commanders implement a unit watch (now called a “command interest profile” at most Army posts) as a tool for enhancing the safety of personnel in the unit when a soldier presents with suicidal or homicidal ideation. Although these procedures are used extensively in garrison and in operational settings, there exists no specific body of literature or Army publication to offer either a rationale or a set of guidelines for their use. We have successfully used unit watch protocols for years both in the deployment setting and in garrison. This article provides both a rationale and a set of guidelines for their use based on fundamental military psychiatric principles, review of the relevant literature, and anecdotal experience with this intervention. Although further research is indicated, this article provides support for the use of unit watch in military settings.

INTRODUCTION
The management of suicide and homicide risk by mental health professionals in a military setting differs somewhat from the management of similar issues in the civilian community. One key difference is the necessity for clinicians to engage with the unit’s command team in a collaborative effort to enhance the safety of soldiers. Another key difference is the necessity of managing and treating psychiatric symptoms with the constrained resources found in deployed or geographically isolated settings. Based on these two key differences, the unit watch has become a primary tool of the military mental health professional for enhancing safety when a soldier presents with a level of suicide or homicide risk that is not high enough to necessitate hospitalization but is high enough to warrant an enhanced level of supervision as an adjunct to outpatient treatment. The unit watch is thus a common practice in a military setting and is even included as an option in the American Psychiatric Association (APA) Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors.

RATIONALE FOR THE USE OF UNIT WATCH
The procedure known as a “unit watch” has been recommended by military mental health professionals for decades. For the past several years, the term “command interest profile” has often been substituted for the term “unit watch” based on a recommendation from the Office of the Surgeon General Psychiatric Consultant. We will use the term “unit watch” throughout the article, but deem the two terms to be interchangeable. A unit watch encompasses a variety of interventions initiated by a soldier’s command team based on a recommendation from a clinician. These interventions typically 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 that may negatively influence the soldier’s mental health, continuously observing the soldier, and ensuring that the soldier returns for further evaluation and treatment.

The command team in a U.S. Army company typically consists of a commander (captain), a first sergeant (1SG), and subordinate officers and noncommissioned officers (NCO) in the unit. A command team is often an invaluable partner in managing a soldier’s suicide or homicidal risk. In some situations, a unit watch may be the best means that a command team in a deployed unit has to ensure the safety of unit members.

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the soldier’s mental health needs in the least restrictive setting through application of the time-honored military psychiatric principles of proximity, immediacy, expectancy, and simplicity (PIES). (Alternately the acronym BICEPS has been used, in which B is for brevity, I: immediacy, C: centrality, E: expectancy, P: proximity, S: simplicity.)

The unit watch may reduce the risk of a soldier acting on suicidal or homicidal impulses through several mechanisms. Unit watch protocols first and foremost limit access to lethal means for suicide or homicide. Although soldiers on a unit watch may surreptitiously gain access to items such as medications, ropes, or knives, it is highly unlikely that they could obtain access to firearms. This alone may substantially reduce the risk of suicide completion, since there is significant data indicating that firearms were the method of injury in a majority of completed suicides in the U.S. Army in 2004 (62%) and 2005 (69%).

Homicidal ideation presents an opportunity for utilization of a unit watch. In our experience, homicidal ideation usually occurs in the context of service members with personality or adjustment disorders or those who abuse alcohol and is only infrequently associated with major psychiatric illness. Hospitalization to protect the intended victim may not be the most clinically appropriate course of action. As an alternative measure the unit watch takes an added step to protect the victim by limiting access to lethal means and providing an observer to notify the chain of command or authorities if the behavior escalates. Additionally, a soldier or potential victim may be moved to another section and ordered to avoid all contact with each other. We contend that these interventions may be more effective at minimizing risk than simply notifying the local police and the potential victim.

The potential for access to alcohol and drugs can also be substantially reduced through a unit watch. Among U.S. Army soldiers attempting or completing suicide in 2005, the use of alcohol and drugs was present during suicide attempts (57%) and completions (17%) at significant rates. Since the use of alcohol and drugs in a suicidal individual may impair judgment and lower inhibitions against acting on suicidal or homicidal impulses, limiting access to these substances may reduce risk.

Limiting contact with individuals who may exacerbate the soldier’s suicidal or homicidal thoughts also may be of value in reducing the risk of acting on suicidal or homicidal impulses. The reduction in potential for homicide is based on the separation from the intended victim that a unit watch can provide. In soldiers experiencing suicidal thoughts related to conflict in their romantic relationship, suicide risk may be reduced by limiting contact with a significant other when the situation is volatile. This is often a complicated decision, since the hope of maintaining a relationship with the significant other may be seen by a suicidal soldier as the only reason to live. However, anecdotal experience indicates that unrestricted contact when the relationship is deteriorating often seems to worsen the situation.

A unit watch may also focus the command team’s attention on unit and other situational stressors that are playing a role in the soldier’s condition and thereby enhance the support for the soldier in addressing his or her concerns. This attention and support may play a significant role in risk reduction by diminishing the agitation and hopelessness that are often present in soldiers with suicidal or homicidal thoughts. Much has been written about the importance of leadership, unit cohesion, and group identification as essential elements of a soldier’s ability to cope in both wartime and peacetime. If the commander fully supports the unit watch and communicates to his command team that it is a way of helping a team member in distress, the unit watch can function to enhance group cohesion and has the potential to improve the soldier’s ability to cope.

The theoretical value of a unit watch as a management tool derives partially through extrapolation from the large body of literature on the military psychiatric principles of PIES. In a strict military formulation of suicidal and homicidal thoughts, these symptoms can be conceptualized as analogous to combat/operational stress reactions in war or as “stress fatigue” in a training environment. In the absence of a diagnosable mental illness, these stress reactions often respond to simple interventions such as rest, communication of an expectation of recovery, command attention to the soldier’s problems, and support from personnel in the soldier’s unit. The early literature on use of the PIES principles suggests that psychiatric hospitalization, which requires removal of the soldier from his unit, is likely to delay recovery from the symptoms of stress or battle fatigue. The anecdotal experience of military psychiatrists also suggests that hospitalization may even exacerbate symptoms by placing the soldier in the role of a psychiatric patient. Extrapolating from this formulation of suicidal and homicidal thoughts as somewhat analogous to combat stress or stress fatigue, we propose that, for a variety of reasons, psychiatric hospitalization for suicidal or homicidal thoughts can be counterproductive in the treatment of these symptoms. Although the unit watch should not take the place of hospitalization when suicide or homicide risk is high, it is often an excellent adjunct in the outpatient treatment of suicidal or homicidal soldiers who are at low to moderate risk for suicide or homicide.

One reason to avoid hospitalization is that the soldier maintains occupational functioning at some level, which may help the soldier preserve a sense of self-worth and belonging. An additional reason is that the soldier avoids the stigma that may accompany psychiatric hospitalization. Based on our anecdotal experience, this stigma sometimes has a profound effect on the reintegration of soldiers into their unit after hospitalization. Soldiers often report that their peers make comments about them being “psycho” or having been “locked in a rubber room.”

Although there may be some stigma associated with a unit watch, there is less room for misperception about the sol-
A third reason to avoid hospitalization when possible is that the soldier may gain more of an opportunity to address his concerns with his chain of command, especially if the clinician provides appropriate command consultation to ensure that the commander is aware of issues that may be responsive to command intervention. In addition to the commander, NCOs often provide invaluable support for soldiers on a unit watch by listening to the soldier’s concerns, by sometimes modifying their style of interaction with the soldier based on a heightened sensitivity to the soldier’s personal problems, and by providing advice as they perform their role of “watching” the soldier.

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.” We introduce the terms “military-specific suicidal ideation” and “military-specific homicidal ideation,” defined as 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. The soldiers essentially imply or state that they may or will kill themselves, or a leader in their unit, unless allowed to achieve the stated goal. Such statements are often accompanied by allegations of harassment against the chain of command in the unit that, in our experience, may or may not be well-founded. In the most extreme cases of truly “military-specific” suicidal or homicidal ideation, the soldier’s threats are directly linked through collateral information from the commander to a subculture of peers within the military environment, a subculture which is circulating information that builds social support can be extremely helpful for the soldier. Strengthening such unit social support may play a key role in the soldier’s recovery.13,14

Two caveats warrant discussion when considering the rationale for the use of unit watches as a tool for enhancing the safety of soldiers who are at risk for suicide and homicide. The first is that while the unit watch may be beneficial in several ways for the soldier, the unit watch should not be construed by the clinician, the command team, or the patient as THE treatment. It is more appropriately viewed as a

Military-specific suicidal or homicidal ideation is thus a strong indicator for the use of a unit watch in the absence of other factors that elevate the risk level enough to require hospitalization. Although valuable in the management of military-specific suicidal or homicidal ideation in garrison, the utilization of unit watches is even more valuable in a theater of operations. Military-specific suicidal or homicidal ideation is, in our opinion, one of the combat operational stress reactions that is most likely to present on today’s battlefield and could easily develop into an evacuation syndrome if not managed appropriately.14 For example, during a tour at the 25th Infantry Division, one of us received a call from the division social worker who was deployed as the primary mental health asset of a peacekeeping force. She reported that a soldier had presented with suicidal thoughts and had been hospitalized at a civilian facility after the suicidal thoughts continued, along with some neurovegetative symptoms, despite several days of treatment while on a unit watch. When the force surgeon reviewed the situation, he initially made a decision that all service members presenting with suicidal thoughts would immediately be evacuated to the nearest inpatient psychiatric treatment facility outside of the continental United States so that the civilian “standard of care” would be met in insuring evaluation by a psychiatrist. Fortunately, the division social worker was able to successfully argue that this course of action would quite possibly lead to an evacuation syndrome, and the force surgeon agreed to continue assessment of the need for evacuation on a case-by-case basis. This example indicates that while we have focused primarily on the benefit for the soldier in using unit watches, a force which is well-versed in unit watches from their garrison experience is much more likely to successfully employ this concept in wartime or other operations and thus benefit significantly in conserving the fighting, or peacekeeping, strength.

Two caveats warrant discussion when considering the rationale for the use of unit watches as a tool for enhancing the safety of soldiers who are at risk for suicide and homicide. The first is that while the unit watch may be beneficial in several ways for the soldier, the unit watch should not be construed by the clinician, the command team, or the patient as THE treatment. It is more appropriately viewed as a
component of the treatment setting rather than as the treatment itself. Military mental health clinicians will need to 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 are often essential in reducing suicide risk. Treatment of these symptoms should be a priority in soldiers presenting with suicidal thoughts and treatment should occur independent of the decision to utilize a unit watch.

The second caveat is that there exists essentially no research 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 “(e.g., CIP),” which is a reference to Command Interest Profile). In 2004, ASER data were received for 53 of 70 suicide completions and 259 other suicide events (including events that did not have a suicide attempt such as suicidal ideation without attempt, hospitalization, suicide attempt after the unit watch was discontinued, and evacuation). One soldier who completed suicide (1%) and one (0.4%) who attempted suicide were under unit watch. In calendar year 2005, 2 (0.2%) of the 723 reported attempts in the active duty Army population occurred while the soldier was under command observation (5 reported, 2 were only ideation with no attempt, 1 was from another service). During the same year, none (0%) of the 71 completed suicides, with ASER reports, occurred under command observation. (Of the 83 completed suicides that year, 12 did not have ASERs submitted therefore there were 71 available reports). Considering the widespread use of unit watch procedures in the U.S. Army, these data offer some support to the hypothesis that unit watches are safe and may be efficacious 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 highly used practice is certainly warranted. The decision to use a unit watch must be based on expert clinical opinion with consideration of the benefits and potential risks and with the understanding that suicide completion sometimes occurs while on unit watch.

RISK ASSESSMENT

Essential to the appropriate use of unit watches is the ability to assess and document the soldier's suicide or homicide risk in a format that clearly explains the clinician's decision-making process. Much has been written regarding the factors most often associated with completed suicide in both the civilian population and the American military population. 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 article, we would like to point out a few risk factors that are particularly relevant in a military setting.

One of the risk factors most highly correlated 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. Based on anecdotal experience, we have found that a significant number 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, since 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. We find these two risk factors particularly interesting in the setting of military-specific suicidal thoughts, in that the majority of soldiers with this presentation are primarily interested in a change (leaving the military) and are angry at an external entity (the military, or their chain of command), rather than focusing on “self-blame” for their dissatisfaction. Finally, the association of suicide completion with a conflicted romantic relationship or recent divorce has been particularly well-described in the military population.

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 a more appropriate disposition 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 data from the unit commander or others in the unit is an important source of information in a 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 such that inpatient hospitalization is now indicated.

GUIDELINES FOR UNIT WATCH PROCEDURES

There are many different approaches to the implementation of unit watches in the military system. Although there is room for variation in different settings, we propose a set of guidelines similar to those that guided the implementation of unit watches per standing operating procedures (SOP) at the 2nd Infantry Division, the 25th Infantry Division, and at Womack Army Medical Center in the mid-to-late 1990s when one of us formulated earlier versions of an SOP. We maintain that the unit watch, according to our proposed guidelines, should
be regarded as a "temporary profile," a recommendation to a commander regarding the soldier's temporary duty restrictions which are likely to be helpful in insuring his or her health and welfare. Most Army commanders are familiar with the concept of a unit watch and will support such recommendations especially when written and signed by the mental health professional and when instructions are written and easily understood.

Detailed written instructions that are specific for the individual patient are given: to the soldier's escort, usually a NCO, who signs for their receipt and is instructed to deliver them to the commander or 1SG. This allows the clinician to release the service member with a recommendation for unit watch, e.g., escorted by a NCO, with a recommendation for the unit watch at times when the clinician may not be able to contact the commander directly to await the commander's decision. As with all medical profiles, the commander may choose to ignore the clinician's recommendation, but he or she may then assume significant responsibility regarding the outcome.

The system we propose consists of two types of unit watches. The first is called a "Buddy Watch" (the term "Modified Command Interest Profile" is suggested for use as an alternative) and is distinguished primarily by the recommendation that the soldier be under direct observation only from first formation until lights out rather than 24 hours a day. The second distinguishing feature for the clinician is that the proposed system allows for a 3-day period from the initiation of this watch until a re-evaluation is required. The 3-day period is the maximum duration between evaluations for a soldier on unit watch, although the clinician may re-evaluate the soldier sooner if indicated. This watch is generally for lower risk individuals, provides more flexibility for use (e.g., over a weekend), and is generally better received by the chain of command and the soldier. It is valuable in a 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 the soldier who is urgently command-referred for verbal expression of suicidal thoughts or self-injurious behavior "the night before" when he or she was intoxicated. On presentation, the service member may have no current suicidal ideation, may claim to have no memory of the statements or self-injurious act, and demonstrate minimal risk factors for a suicidal act, but there is clearly some risk especially if he or she resumes alcohol use. The Buddy Watch significantly minimizes the opportunity for continued alcohol use over the 3-day period 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. Figure 1 is an example of specific procedures for Buddy Watch: (adapted from a form devel-

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**MEMORANDUM FOR (COMMANDER, UNIT)**

**DATE:**

**SUBJECT:** Buddy Watch for

1. The soldier was evaluated at the Army Medical Center Department of Behavioral Health. The results of this 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. During the night, constant monitoring is not required but the soldier must not sleep in a room alone. The soldier's roommate or other responsible peers in the unit may monitor the soldier after duty hours if approved by the commander.

   b. Health and welfare inspection of the soldier's room to remove hazardous material (e.g., pills, knives, weapons, etc.). Instead of removing weapons they may be inactivated such as removing the bolt from an M-16.

   c. No alcohol.

   d. No access to potential self-injurious objects such as:

      1) Weapons, knives, cigarette lighters.

      2) Pills (medication should be dispensed one dose at the time by medic, PA, NCO, etc).

   e. Soldier should perform his/her regular duty and PT. Physical exercise often improves depressed mood.

3. This plan will be in effect from today until it is terminated by the Department of Behavioral Health in agreement with the commander.

4. If this soldier shows signs of further deterioration, the soldier's supervisor should call the Department of Behavioral Health at xxx-xxxx during duty hours or the Emergency Room at xxx xxxx after hours.

5. This soldier's next appointment at Department of Behavioral Health is on at

Signed ________________________________
Representative from Command

Cl电信 ________________

**FIGURE 1.** Buddy watch memorandum.
opned at the 2nd Infantry Division, initially by CPT Sally Chessani, now COL Sally Harvey, Licensed Clinical Psychologist).

The other type of watch, alluded to in the previous paragraph, is called a “24-Hour Watch” (the term “Command Interest Profile” is suggested for use as an alternative). We avoid another commonly used term, “CQ Watch,” for two reasons. First, some units do not have a Charge of Quarters (CQ) duty. The commander may infer from the term “CQ Watch” that his unit is being asked to perform a task for which it is not equipped. Second, the commander may infer from the term “CQ Watch” that the clinician is recommending that the commander move the soldier to a central area (e.g., dayroom) in the unit where the soldier can be observed by the soldiers performing CQ duty. Moving the soldier to a central area may sometimes be necessary but should be avoided whenever possible, since such a move may enhance the sense of humiliation or stigma for the soldier. The primary characteristic of a 24-Hour Watch is that the soldier is observed constantly during a 24-hour period, after which an evaluation by a mental health officer must take place. Specific procedures for this watch are outlined in Figure 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 avoid 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, e.g., “I will kill myself (or my squad leader) if I have to go back to my unit.” It is often, although not necessarily, used in conjunction with an environmental change, e.g., in an Army setting, an agreement with the commander that the soldier will be moved to a different platoon, if his threats of suicide or homicide are specific to alleged harassment by a NCO in his section, squad, or platoon.

In addition to forwarding the memorandum that outlines the specific interventions necessary for the unit watch, we

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**MEMORANDUM FOR COMMANDER, UNIT**

**DATE:**

**SUBJECT:** 24 Hour Watch for

1. The soldier was evaluated at the __________ Army Medical Center Department of Behavioral Health on __________. The results of this 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. The soldier sleeps by the Staff Duty/CQ or in a room with a unit member awake at all times to monitor the soldier.
   b. Continuous monitoring should occur at all times, including when the soldier is in the latrine or eating meals.
   c. A health and welfare inspection of the soldier’s room to remove hazardous materials (e.g., pills, knives, weapons, etc.). Instead of removing weapons they may be inactivated such as removing the bolt from an M-16.
   d. No telephone calls or visitors except those cleared by the commander.
   e. No alcohol.
   f. No access to potential self-injurious objects such as:
      1. Weapons, knives, cigarette lighters.
      2. Pills (medication should be dispensed one dose at a time by medic, PA NCO, etc.).
      3. Jewelry with sharp edges.
      4. Silverware.
      5. Blow dryers.

3. Soldier should perform his/her regular duty and PT. Physical exercise often improves a depressed mood.

4. This plan will be in effect from today until it is terminated by the Department of Behavioral Health in agreement with the commander.

5. If this soldier shows signs of further deterioration, the soldier’s supervisor should call the Department of Behavioral Health at xxx xxxx during duty hours at ___ Emergency Room at xxx xxxx

6. This soldier’s next appointment at Department of Behavioral Health is on __________ at __________.

Representative from Command ___________________________  Clinician ___________________________

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FIGURE 2. Twenty-four-hour watch memorandum.
recommend that, at each episode of implementation of a unit watch, the clinician forward to the commander an information paper (for example, Fig. 3) which outlines the rationale for the use of unit watches. Education through this information paper can be very helpful for the command team. For example, such education may alleviate the concerns of higher level commanders who, upon learning from the junior-level commander about the unit watch, may otherwise feel compelled to intervene and attempt to force the mental health system to psychiatrically hospitalize the service member. The final piece of education, which actually should precede the implementation of a unit watch system, should occur with the staff of the mental health facility or combat stress unit in order for the clinicians to develop a clear understanding of the role of unit watches as an intervention. We propose that this education occur through the implementation of a SOP. We have included a sample SOP (Fig. 4). This SOP provides a general guideline for the use of unit watches in a military setting. We prefer to avoid absolute guidelines about which clinical factors require hospitalization over unit watch, as there is significant room for variation among competent clinicians regarding the need for psychiatric hospitalization in various situations. This variation points out again the critical role of the suicide or homicide risk assessment in documenting the clinician's decision-making process, as exemplified by the following clinical vignettes.

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. In some cases, when the commander has been unavailable for phone contact and the recommendation to discontinue the unit watch was transmitted to the commander via the "buddy" or NCO, patients have reported that the commander chose to continue the unit watch in the absence of a written recommendation from the mental health professional. We have included a sample unit watch discontinuation memorandum (Fig. 5).

CLINICAL VIGNETTES

The following clinical vignettes will provide examples to familiarize the military clinician with common presentations in which a unit watch is a reasonable intervention.

Case 1

A junior-enlisted active duty soldier in his early 20s with 11 months time in service, who is assigned to a mechanized infantry battalion, presents as a self-referral with suicidal thoughts for the past 5 days with a plan of lacerating his wrist with his field knife. He states that he cannot continue in his current assignment because his squad leader is too tough on him and he misses his girlfriend and family back home in the continental United States. On review of symptoms, he reports depressed mood, poor sleep, and low energy "ever since I got here" but other neurovegetative symptoms are absent. He has been drinking approximately five to eight beers every Friday and Saturday night, but denies criteria for alcohol abuse or dependence. His unit is scheduled to spend a week in the field beginning tomorrow. The soldier's chain of command reports that he has shown deterioration in his performance over the past 2 weeks manifested by failing to maintain standards of appearance and being late to formation. The unit plans a summarized Article 15. He has no history of suicide attempts and no history of past psychiatric treatment. He is not willing to contract for safety. Mental status examination reveals no psychomotor retardation, a frustrated and constricted affect, and normal concentration and memory. The clinician makes a diagnosis of adjustment disorder with depressed mood.

The soldier's suicide risk is not high enough to warrant hospitalization based on the absence of a major psychiatric disorder (no mood disorder, psychotic disorder, or substance abuse disorder) or a history of previous suicide attempts. Other factors which argue for low to moderate suicide risk are the age of the patient, the absence of any difficulties in his romantic relationship, the expression of a primary wish for change rather than death, and the prominence of anger at the Army and chain of command over self-blame. Recommendations: A buddy watch is recommended to the commander. The NCO escort agrees to forward these recommendations to the commander and ensure that the soldier is returned from the field in 3 days for a follow-up assessment and further treatment.

Case 2

A 31-year-old married African American male deployed to a combat zone came to the mental health clinic after learning his wife and child 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 suicidal and would kill himself if he was not allowed to leave. In the initial evaluation, he did not have a defined plan for carrying out his suicide and had never before had suicidal thoughts. He denied previous mental health history, had no medical illness, and was not using alcohol, street drugs, or medications. It was felt that his case was appropriate for a 24-hour watch with frequent mental health follow-up to help him cope with his emotional crisis. On meeting with the command team to discuss a safety plan for the soldier, the command team reported that he had previously been appropriately serving in his role as a member of a logistics team. During the meeting the soldier's ISG reminded the soldier how proud the "Old Man" (battalion commander) was at how proficiently the soldier had recently accomplished a skilled task. He then expressed how the command team valued the soldier not just as a number or worker, 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
FIGURE 3. Information paper for commanders.
soldiers intended to escort him from among those from whom he felt the most support. 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 it would not be worth throwing away his life or military career. The 24-hour watch was discontinued. His bolt and ammunition were returned to him, and, although 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 by 1 week.
Unit Watch Use in Management of Suicide and Homicide Risk

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 Outpatient Behavioral Health Services 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 an imminent risk to self or others, please understand that the service member’s risk level may change.

4. If the service member shows signs of further deterioration, the soldier should return for evaluation under emergency command referral procedures or non-emergency command procedures as deemed appropriate. If you have any questions about the command referral process, please contact Outpatient Behavioral Health Services.

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

FIGURE 5. Unit watch discontinuation memorandum.

month after his wife told him of her plans and after several months of monthly follow-up he needed no further care.

The soldier presented with suicidal ideation in acute emotional crisis after learning of his wife’s plans 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 felt appropriate treatment would be to ensure the patient’s safety 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 several months as he gained understanding and acceptance of his changing life situation.

The clinician must clearly document the suicide or homicide risk assessment, giving a clear rationale that makes the case for unit watch rather than hospitalization or evacuation from the zone of operations. We believe that the military unit is a unique and cohesive community that allows the unit watch to be a responsible way to minimize suicide or homicide risk. Because this is an intervention 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 is essential in each case. Documentation of discussions with command, education given to command, and assurance of the clinician that the command is capable of carrying out a proper unit watch is also recommended. Finally, the widespread use of the unit watch by military mental health providers, and its inclusion in the APA Practice Guidelines, may help establish that this is an appropriate intervention within the military.\textsuperscript{12}

DISCUSSION

Although there are no simple answers in the assessment and management of suicide and homicide risk, we believe that military psychiatrists practice in a unique community, which requires a unique military approach to this issue. There is no clinical literature or case law to support the recommendations for unit watch, so we must rely on clinical experience and extrapolations from available data. This article represents an effort to codify that experience. Clinical experience within the military community teaches that unit watch is a useful adjunct to outpatient care. It may have to be a substitute for hospitalization in deployed situations when conditions do not allow for safe evacuation to a higher level of care. APA Practice Guidelines indicate clearly that, “The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.”\textsuperscript{11} This notion can support the use of unit watch in military environments characterized by constrained resources—typically deployed environments—even for individuals for whom hospitalization might be indicated in civilian or garrison settings. The unit watch may often be better health care practice than arbitrarily removing a marginally adjusted soldier from his or her unit simply because the
presenting symptoms might qualify the individual for a higher level of care. Although military physicians are not individually subject to the sorts of lawsuits their civilian colleagues confront, they are—or ought to be—mindful that they are always subject to court martial proceedings if they practice negligently. The SOPs established in this article may prove beneficial and protective to clinicians using unit watches. Much research is still needed to validate these procedures. Case series, retrospective, or prospective studies, or outcomes comparisons, all represent opportunities for further research and validation of these techniques. We hope that this article will form a foundation for such further work in this topic.

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REFERENCES
