

Annex D (Army Reserve (AR) MSC Commander Critical Actions / Tasks) to the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention

The Army Reserve (AR) G1 will implement the following checklist to optimize efforts in support of health promotion, risk reduction, and suicide prevention-related programs, and set conditions for follow-on Army programmatic change:

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

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

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inform / standardize Soldier medico-legal actions and reduce risks associated with policy, program, and process gaps / seams?

- Do your MSC staffs / agencies integrate specific Soldier information to share among “need-to-know” commanders and “help providers” (e.g., law enforcement; behavioral health; to integrate Soldier medico-legal processes (administrative separations; MMRB, MEB, PEB, disciplinary actions; WTU referrals; etc.)?)
- Is there a “commander’s forum” to share observations / TTPs / lessons learned from suicide events (from successful intervention to events that led to Soldier’s death) that occurred in their commands?
- Do you have a comprehensive process to maximize use of information regarding health promotion, risk reduction, and suicide prevention (i.e., medico-legal trends across the installation, specific Soldier information, etc.) during recurring commander reports / briefs such as staff calls, QTBs, USR briefs, etc.?
- Do your MSCs have regularly scheduled health promotion, risk reduction, suicide prevention awareness observance activities (annually, quarterly, and monthly)? Are they formally scheduled on the JFHQs / MSC calendars and attended by appropriate senior leaders?
- Do you have a formal system or process to compare and bench your policies, programs, and services with other like units to identify and incorporate “best business practices”? Is there a “No Tolerance” policy for belittling Soldiers/civilians for seeking help/identifying behavioral health issues and are Soldiers/civilians informed of the policy?
- Do USARC/MSCs have a streamlined process in place for unit Commanders to request behavioral health support?

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

- Is there a designated individual in charge of MSC level Health Promotion Programs and affiliated services?
- Is there a unit-based behavioral health and comprehensive fitness program with appropriate designated supervision?
- Are behavioral health initiatives coordinated with Regional Directors of Psychological Health, unit chaplains, unit medical personnel, and family readiness groups (FRG), and other DoD assets to deliver health programs, risk reduction, and suicide prevention-related information and services at the Soldier / unit / Family level?
- Do you have a comprehensive MSC strategy [plan] to combat the stigma associated with Soldiers seeking behavioral health care (e.g., guidance added to leader and Soldier counseling, leaders attend mass screenings with their Soldiers, incorporate importance of behavioral health in training guidance and forums, mandatory in-person PDHRA completion, etc.)?

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- Are chaplains integrated in units with behavioral health specialists and FRGs to provide multi-disciplinary support, naturalize referrals, and reduce stigma associated with help seeking behavior?
- Do unit commanders know how to request Military Family Life Consultant (MFLC) and Joint Family Support Assistance Program (JFSAP) support in order to incorporate assets into commander/unit programs and fully integrate with other help providers to ensure coverage between contact and referral? Has your MSC appointed a Suicide Prevention Program Manager (SPPM) on orders to coordinate training, promote best practices, report and track suicides and suicide training results, and provide policy at the MSC level?
- Has your MSC appointed a Suicide Intervention Officers at every company and provided training in Peer Intervention Training skills?
- Does your MSC have a system in place to ensure that every death, to include non-duty deaths, are reported via SIR up to the AR Emergency Operation Center (EOC)?
- Has your MSC placed a requirement in the Yearly Training Guidance for all units to provide annually required Suicide Prevention Training for Soldiers/Leaders? Is there a system in place to verify that training is taking place and that results are reported up the chain of command?
- Has your MSC designated September as Suicide Prevention Month for 2009 on the Yearly Training Guidance and established protocols to support units in their activities and to track/promote participation.
- Do Commanders have knowledge of unique state level suicide prevention policies, programs, and resources?
- Has your MSC implemented the Yellow Ribbon Reintegration Program (YRRP) for all phases of the Deployment Cycle?
- Has your MSC develop Memorandums of Agreement with state and local agencies to leverage services and resources for Soldiers and their Families.
- Has the SPPM made listings of available services that support Soldier well being and health and publicized them to Reserve Centers (e.g., VA hospitals and local clinics, Crisis hotlines/clinics, Community Health Clinics, local hospitals and emergency rooms, Army OneSource, and National internet sites and resources).

3. Primary and Behavioral Health Care:

- Do your MSCs have an SRP screening process that uses a face-to-face interview with either a behavioral health specialist or primary care specialist with behavioral health specialists as back-up?
- Has the MSC implemented a coordinated program of periodic screening, and triage, to support Soldiers and their Families?
- Do you have systems / processes to leverage medical screening information (e.g., PHA, PDHA, PDRHA, screenings for TBI and PTSD, etc.) to notify commanders of Soldier compliance and risk

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factors revealed by that information; and for appropriate referrals and subsequent treatment plans?

- Is there a holistic and comprehensive case management system to synchronize individual / family case file management to integrate and coordinate a treatment plan that is all inclusive (e.g. primary health care, behavioral health care, substance abuse, family advocacy) to ensure the effort is simultaneously coordinated among all care providers?
- Have your MSCs developed information papers to clarify with leaders and Soldiers regarding available medical and behavioral health services, qualifying conditions, limitations and options for both active duty and non-active duty Soldiers? Have your MSCs provided unit Commanders with policies, practices, and resources to ensure Soldiers and Family members have access to medical and behavioral health services to the broadest possible extent?

4. Family / Friends Participation:

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

5. Warriors in Transition:

- Do MSCs have policies and programs in place to monitor and optimize Soldier return to duty?
- Do MSCs have a system / criteria to ensure Soldiers needing care can be processed for Active Duty for Medical Extension (ADME) and Medical Retention Processing 2 (MRP2)?
- Do MSCs have processes / procedures in place to ensure Warriors in Transition either at the WTUs or Community Based Warrior Transition Units are kept in contact with their unit leadership?
- Does the AR have clear policy and criteria for nominating and vetting WTU cadre to ensure that only Officers and NCOs who have demonstrated success in prior equivalent-level leadership roles be assigned to WTU leader positions?

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6. Reducing High-risk Behavior:

- Do the MSCs have a process/procedure in place to encourage subordinate commanders at all levels to comply with regulatory guidance to initiate or process administratively separate Soldiers for misconduct to include serious drug / alcohol or multiple drug / alcohol incidents?
- Has the MSC implemented policies and programs to identify and assist Soldiers who enlist with waivers or significant pre-existing conditions?
- Do you offer MWR adventure-type activity programs to Soldiers to divert / reduce Soldier combat-related adrenaline-rush that leads to inappropriate high risk / adrenaline seeking activities?
- Do Soldier selected for recruiting duty receive the mandated mental health evaluation prior to departing for school house training?
- Do the MSCs have a process in place by which Soldiers who have served in an imminent danger pay area and are within the first 24 months of active duty service and are being considered for separation for a personality disorder are evaluated to rule out other significant contributing factors such as PTSD, Traumatic Brain Injury (TBI), and/or other comorbid mental illness? And do the MSCs have a process in place by which Soldiers with PTSD, TBI, and/or other comorbid mental illness contributing to the diagnosis of personality disorder are evaluated under the physical disability system in accordance with AR 635-40?

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

- Does the MSC have a program for redeploying battalion and company commanders to provide refresher training on Soldier-specific administrative and medico-legal requirements to reduce high-risk populations (e.g., administrative separations; commander's disciplinary reports; UCMJ, MMRB, MEB and PEB processes)?
- Do MSCs have a program to provide refresher training for incoming commanders and rear-DET commanders on policies and processes associated with disciplinary actions, disciplinary action reporting, administrative separation, and medical board processes / options? (Many commanders have only known multiple deployments and have little / no experience on "institutional roles and responsibilities" such as administrative, disciplinary, and accountability policies / processes.)
- Have local Company Commander and First Sergeant's Course Programs of Instruction regarding suicide prevention been updated to include the importance of developing positive life coping skills in their Soldiers?
- Is the unit commander, senior NCO and unit administrator trained to a level of proficiency to respond to Soldier/Civilian/Family member crisis and/or suicidal behavior.
- Do MSC Chaplains have opportunities for (a) in-service training on counseling skills or (b) external training / certification (e.g., professional courses, fellowships, internships, exchanges, etc.) that focus on comprehensive wellness, behavioral health referral consultations, and integration within the behavioral health community including behavioral health providers, etc.?
- Is the MSC SPPM tracking the number of Applied Suicide Intervention Skills Training (ASIST) Trainers.

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- Do the MSCs have at least two (2) ASIST qualified trainers (in addition to the Chaplains) that can sponsor the 2-day ASIST workshop?
- Have MSCs incorporated the Army Suicide Stand-down and Prevention training (e.g., *Beyond the Front*, ACE, etc.) for retraining / refresher training this fiscal year? For instance, *Beyond the Front* could be utilized in smaller forums, under new group dynamics, with changed interactive options / outcomes, with Families, or aggregated with other products / forums.

8. Medico-legal and Command Systems:

- Is there a method for tracking at risk Soldiers due to cross-leveling?
- Are Commanders incorporating the importance of Soldier, Civilian, and Family physical and mental health in all initial and subsequent performance counseling to enhance program and service awareness and reduce stigma associated with help seeking behavior?

9. Postvention and Investigations:

- Are there procedures in place for commanders to participate with the Casualty Assistance Officer to meet and talk with the family (spouse parent, fiancé, etc.) in an incident related to suicide?
- Do MSCs have a Suicide Response Team (team of experts) to immediately assist commanders in coordinating and integrating “postvention” activities in the event of a completed / attempted suicide?
- Are commanders appointing an AR 15-6 investigation for suicide or suspected suicide to provide a comprehensive review of all possible causes: mental / physical illness, financial problems, failed relationships, other cumulative stress factors, trigger events, etc., to inform current and improve future programs and services?
- Are the MSCs tracking general trends for all equivocal deaths resulting from high-risk behavior to inform current and improve future programs and services?
- Are Line of Duty Determinations (LODs) being performed in all deaths and injuries arising from suicide-related events (equivocal deaths, attempts, and gestures, etc.)?