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

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

   - Do you have a comprehensive, all-encompassing health promotion, risk reduction and suicide prevention-related strategy that links installation / garrison / MTF staffs and activities and is readily recognized and acknowledged by the unit commanders, Soldiers, Civilians, and Family members?

   - Is your health promotion, risk reduction and suicide prevention-related strategy formally organized via a published blueprint (wire diagram, etc.) that outlines the interdependent and dependent relationships of the multiple staffs / agencies and programs supporting that strategy?

   - Do you have an aggressive marketing, advertising and outreach plan to heighten Soldier, Civilian, and Family Member awareness of your health promotion, risk reduction and suicide prevention-related strategy that clearly depicts staff / agency charters, programs, services, and other activities?

   - Do you have a formal process / system to assess, report, and measure the effectiveness of your strategy and your marketing / advertisement? Does this process measure strategic goals, program / service objectives, and customer feedback, with mechanisms to adjust your strategy based on lessons learned?

   - Is there an Installation / Garrison Community Health Promotion Council (CHPC), or similar body, that meets regularly to integrate all staffs and agencies associated with providing health promotion, risk reduction and suicide prevention-related programs (e.g., CHPC coordinator, suicide prevention coordinator, risk reduction coordinator, clinical / non-clinical ASAP, clinical / non-clinical FAP, ACS [MFLC, FRC, AER, etc.], chaplains, DES, CID, CAO, DPTMS, primary care coordinator, behavioral health coordinator, SJA, safety, and MSC CDRs [as appropriate], etc.)?

   - Do you have formal charters signed by Installation / Garrison / MTF Commanders for all health promotion, risk reduction, and suicide prevention-related programs, councils, committees, task forces, etc.? Do charters clearly outline (at a minimum): (1) organizational structure; (2) mission; (3) scope and objectives (integration with other councils / committees) (4) authorities; (5) membership and roles / responsibilities; (6) meeting schedules; (7) standard products / services; (8) protocols for assessments, measuring, reporting, and incorporating lessons learned; and (9) marketing / outreach plan?

   - Do you require appropriate senior leadership attendance at meetings of installation / garrison / MTF health promotion, risk reduction, and suicide prevention programs / councils / committees / task forces, etc. to ensure those groups are empowered to make decisions and allocate resources appropriately?
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- Do your Installation / Garrison staffs / agencies provide you with a comprehensive, composite report of all Soldier medico-legal actions and trends across the installation / command (e.g., admin separations; MMRB, MEB, PEB, disciplinary actions; WTU referrals; ASAP referrals, etc.) to inform / standardize Soldier medico-legal actions and to reduce risks associated with policy, program, and process gaps / seams?

- Do your Installation / Garrison staffs / agencies integrate specific Soldier information to share among “need-to-know” commanders and “help providers” (e.g., law enforcement; behavioral health; clinical and non-clinical ASAP and FAP) to integrate Soldier medico-legal processes (administrative separations; MMRB, MEB, PEB, disciplinary actions; WTU referrals; etc.)?

- Do your Installation / Garrison staffs / agencies integrate and reconcile common medico-legal databases (e.g. ACI2, COPS, DAMIS, ACR, etc.) to ensure accurate, timely information regarding Soldier medico-legal actions?

- Is there a “commander’s forum” to share observations / TTPs / lessons learned from suicide events (from successful intervention to events that led to Soldier’s death) that occurred in their commands?

- Do you have a comprehensive process to maximize use of information regarding health promotion, risk reduction, and suicide prevention (i.e., medico-legal trends across the installation, specific Soldier information, etc.) during recurring commander reports / briefs such as staff calls, QTBs, USR briefs, etc.?

- Do you have an MOA in place to allow all primary and behavioral health care providers (MEDCOM and Corps / DIV / BDE) to be integrated under a central authority (Installation Commander and MTF Commander) to provide comprehensive, seamless primary / behavioral health care in MTFs, reduce provider-patient workload; and enhance provider professional development? Does your MOA have a provision to “surge” medical capabilities and capacity upon unit redeployment?

- Are redeploying BDE and BN commanders retained for 90-120 days during the reset phase to ensure leadership continuity and cognizant-mitigation of unit and Soldier stressors (e.g., complete PDHRA, insulate Soldier teams / networks, complete disciplinary / separation actions, integrate Soldiers and Families, naturalize health promotion, etc.)? Are you coordinating directly with HRC / SLD on a case by case basis to provide balance between late changes of command (25-36 months) and the reset mitigation of high-risk Soldiers and Families?

- Are redeploying maneuver unit (DIV / BDE / BN) primary care and behavioral health care personnel retained for 90-120 days during the reset phase (as feasible) to ensure continuity of care, cognizant-mitigation of unit and Soldier stressors, and sufficient treatment “handoff” to incoming medical personnel? Are you coordinating directly with HRC and local MTF commanders to retain or align PROFIS primary care providers with unit reset plans?

- Are redeploying unit level Soldiers retained for 90-120 days during the reset phase to ensure team / network continuity and cognizant-mitigation of unit and Soldier stressors.
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(e.g., team-based re-integration, team-supported family re-integration, refocus high-adrenaline behavior, etc.)? Are you coordinating with AG / G1 to centrally manage retention of the full-spectrum of MOSs?

- Does your installation / garrison have regularly scheduled health promotion, risk reduction, suicide prevention awareness observance activities (annually, quarterly, and monthly)? Are they formally scheduled on the installation / garrison calendars and attended by appropriate senior leaders?

- Do you have a formal system or process to compare and benchmark your policies, programs, and services with other like installations to identify and incorporate “best business practices” (e.g., CHPC or other formal council establishes a relationship with other installation CHPCs)?

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

- Is there a designated leader (e.g. MTF Commander) in charge of installation Health Promotion Programs and affiliated services?

- Is there a unit-based behavioral health and comprehensive fitness program with appropriate designated counselors and clinical supervision?

- Are behavioral health initiatives coordinated with unit chaplains, unit medical personnel, CSCTs, and MFLCs to deliver health programs, risk reduction, and suicide prevention-related information and services at the Soldier / unit level?

- Do you have a comprehensive Installation / Garrison strategy [plan] to combat the stigma associated with Soldiers seeking behavioral health care (e.g., guidance added to leader and Soldier counseling, leaders attend mass screenings with their Soldiers, incorporate importance of behavioral health in training guidance and forums, etc.)?

- Are chaplains integrated with behavioral health specialists in units, and with CSCTs and MFLCs to provide multi-disciplinary support, naturalize referrals, and reduce stigma associated with help seeking behavior?

- Do you have adequate number of ASAP and FAP staff (clinical and non-clinical) to provide timely support to Soldiers and Family members? Is there a back-log or waiting list for services? Are your education and training forums small enough to encourage dialogue / group participation?

- Is your ASAP staff (clinical and non-clinical) co-located and interact regularly to share information on substance abuse cases / trends to better inform health promotion, risk reduction and suicide prevention-related programs on the installation?

- Do you periodically and systematically track, monitor and report ASAP / FAP / AFAP and other program personnel strength / hiring / retention / qualification / certification issues to ensure adequate support to commanders?
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- Are commanders directly involved in formulating ASAP treatment plans / contracts with counselors and referred Soldiers to ensure leadership commitment to recovery programs?

- Do you have established procedures for the ADCO to receive information (abstracts) derived from Centralized Operations Police Suite (COPS) on a recurring basis to maximize information sharing related to high risk behaviors?

- Are Military Health System personnel providing direct oversight of network inpatient detoxification and recovery programs to maintain situational awareness of Soldier recovery?

- Do you have systems to ensure timely communication among Military Health System personnel, ASAP, and civilian inpatient / detoxification facilities?

- Are civilian inpatient / detoxification facilities located physically close enough to your installation – with enough bed space – to ensure timely transfer of care to those off-post facilities?

- Are Military and Family Life Consultants (MFLC) readily available to Soldiers and Families, incorporated into commander / unit programs, and fully integrated with other help providers to ensure seamless coverage between contact and referral?

3. Primary and Behavioral Health Care:

- Are your primary health care and behavioral health care providers consolidated (co-located) to provide comprehensive medical treatment, share treatment plan information, and reduce stigma associated with behavioral health?

- Are your Corps / DIV / BDE primary / behavioral health providers treating patients in modern MTFs to ensure that Soldiers receive comprehensive, state-of-the-art medical health care commensurate with Family medical care (e.g., facility, equipment, and specialty consultation and services, etc.)?

- Are MTF coordinators linked to Corps / DIV / BCT surgeons to coordinate / schedule facility access for patient care IAW the MTF commander's comprehensive medical care plan?

- Are medical / clinic operating hours convenient for Soldier / Family care access and maximum facility usage? Is there sufficient clinical and support staff to operate expanded hours, and have you considered hiring part time employees and RC providers to expand operating hours?

- Does your MTF have a quality assurance process by which “at risk medication” prescriptions are tracked and peer reviewed? "At risk medication" prescribing would include (label or off label use) drug combinations comprised of three or more of the following: Opioid Narcotics, Anxiolytics, Antipsychotics, Sedative-hypnotics, mood stabilizers, and anti-convulsants.
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- Does the Behavioral Health Department provide psychotherapy for Soldiers being prescribed multiple psychotropic medications as deemed appropriate?

- Do you have a comprehensive alternative pain management approach for Soldiers coping with chronic pain to reduce the dependency on Opioid Narcotics (e.g., alternative treatment modalities for pain such as spinal cord stimulation, acupuncture services, and biofeedback, etc.)?

- Does your installation have an SRP screening process that uses a face-to-face interview with either a behavioral health specialist or primary care specialist with behavioral health specialists as back-up?

- Has the installation implemented a coordinated program of periodic screening, triage, and multidisciplinary treatment to support Soldiers and their Families? Have on-line programs been implemented to increase screening rates and improve efficiency (i.e., Automated Behavioral Health Clinic)?

- Do you have systems / processes to leverage medical screening information (e.g., PHA, PDHA, PDRHA, screenings for TBI and PTSD, etc.) to notify commanders of Soldier compliance and risk factors revealed by that information; and for appropriate referrals and subsequent treatment plans?

- Is there a “medical care provider forum” to increase collaboration or improve identification of at-risk Soldiers and Families to maximize their care and enhance general suicide prevention measures?

- Is there a holistic and comprehensive case management system to synchronize individual / family case file management to integrate and coordinate a treatment plan that is all inclusive (e.g., primary health care, behavioral health care, substance abuse, family advocacy) to ensure the effort is simultaneously coordinated among all care providers?

- Does your PTSD / mTBI program fully utilize opportunities for collateral contacts with spouses and other family members to assess and validate symptoms associated with PTSD / mTBI?

- Does your PTSD / mTBI program fully utilize opportunities for individual and family psychotherapy to assist with resolution of symptoms and improve coping and subsequent recovery?

- Does your PTSD / mTBI program utilize neuropsychological / psychological assessment to validate complaints and symptoms, quantify deficits prior to developing a plan of treatment and again after treatment to assist with determination of return to duty or referral to MEB?

- Do your Review of Care meetings include all providers involved in the care of an individual Soldier?

- Does your PTSD / mTBI program utilize Rehabilitation Psychologists as treatment providers?
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 reintegration training?
- Has the Senior Commander implemented a program to actively engage leaders and their spouses / fiancés / parents in support of a comprehensive, health promotion, risk reduction, overall fitness plan to strengthen relationships and support networks?
- Have you reviewed the OPTEMPO of the units assigned to the installation to sync / implement Soldier and Family resiliency-focused programs to improve total family wellness / quality of life?
- Are training and retreat programs, which are intended to improve resiliency (i.e., Strong Bonds, Battle Mind, ASIST, etc.), adequately funded to allow maximum participation? Is there a backlog or wait list? Are additional resources required? If so, do you have a plan to address those needs?

5. Warrior Transition Units:

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

6. Reducing High-risk Behavior:

- Do you encourage subordinate commanders at all levels to comply with regulatory guidance to initiate or process administratively separate Soldiers for misconduct to include serious drug / alcohol or multiple drug / alcohol incidents?
- Has the installation implemented policies and programs to identify and assist Soldiers who enlist with waivers or significant pre-existing conditions?
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- Do your commanders refer Soldiers to ASAP who have either a positive urinalysis or a drug / alcohol related incident IAW AR 600-85?

- Do Soldiers receive an individual comprehensive evaluation within 12 working days of being referred to ASAP counselors IAW AR600-85?

- Are ASAP timelines (referrals and ASAP intervention) reported to the Senior Commander?

- Do you offer installation MWR adventure-type activity programs to Soldiers to divert / reduce Soldier combat-related adrenaline-rush that leads to inappropriate high risk / adrenaline seeking activities?

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

- Does the Installation have a program for redeploying battalion and company commanders to provide refresher training on Soldier-specific administrative and medico-legal requirements to reduce high-risk populations (e.g., administrative separations; commander's disciplinary reports; UCMJ, MMRB, MEB, and PEB processes)?

- Do you have a program to provide refresher training for incoming commanders and rear-DET commanders on policies and processes associated with disciplinary actions, disciplinary action reporting, administrative separation, and medical board processes / options? (Many commanders have only known multiple deployments and have little / no experience on "institutional roles and responsibilities" such as administrative, disciplinary, and accountability policies / processes.)

- Have local Company Commander and First Sergeant's Course Programs of Instruction regarding suicide prevention been updated to include the importance of developing positive life coping skills in their Soldiers?

- Does the Installation Chaplain have opportunities for (a) in-service training on counseling skills or (b) external training / certification (e.g., professional courses, fellowships, internships, exchanges, etc.) that focus on comprehensive wellness, behavioral health referral consultations, and integration within the behavioral health community including behavioral health providers, CSCTs, ASAP / AFAP, MFLCs, etc.?

- Is the Installation Suicide Prevention Program Manager tracking the number of Applied Suicide Intervention Skills Training (ASIST) Trainers and ASIST-level Crisis Intervention trained personnel on post?

- Does the Installation have at least two (2) ASIST qualified trainers that can sponsor the 2-day ASIST workshop?

- Does the Installation have at least one (1) ASIST-trained personnel at each community support agency (e.g., SJA, MP, ACS, etc.)?

- Have you incorporated the Army Suicide Stand-down and Prevention training (e.g., Beyond the Front, ACE, etc.) for retraining / refresher training this fiscal year? For
instance, Beyond the Front could be utilized in smaller forums, under new group dynamics, with changed interactive options / outcomes, with Families, or aggregated with other products / forums.

8. Medico-legal and Command Systems:

- Do you have a reporting / tracking system to monitor compliance with regulatory guidance on administrative separations of Soldiers for misconduct, to include serious drug / alcohol or multiple drug / alcohol incidents and other serious criminal activity?

- Do unit commanders, medical health providers, ASAP / FAP clinicians and non-clinician personnel have a composite picture of high-risk Soldiers to sync medico-legal actions for Soldiers who commit multiple criminal / substance abuse events, prevent recidivism, and reduce high-risk Soldier populations?

- Do your medical board policies permit unit commanders to refer a Soldier to the MMRB after a MEB / PEB determination to retain an MOS-limited Soldier; extend the deadlines for MEB processing to complete the board with a single series of medical consults; authorize resumption of MEB processing for expired cases with only a file review as an option to expedite the case; and ensure adequate number of medical / legal personnel to expedite backlogs / surges for MEB / PEB services for pre- and post-deployment?

- Do unit commanders and Soldiers receive timely adjudication of disability status, fitness for MOS, and fitness for duty as a result of MMRB / MEB / PEB?

- Are procedures / policies in place for commanders to respond to Soldiers who refuse treatment "against medical advice (AMA)?"

- Is there a method for tracking at risk Soldiers due to intra-post transfers between activities, units and tenants?

- Are Commanders incorporating the importance of Soldier, Civilian, and Family physical and mental health in all initial and subsequent performance counseling to enhance program and service awareness and reduce stigma associated with help seeking behavior?

9. Postvention and Investigations:

- Is your Quality Improvement / Quality Assessment Program performing root cause analysis on all deaths that occur within 31 days of last scheduled appointment?

- Are there procedures in place for commanders to participate with the CAO to meet and talk with the family (spouse, parent, fiancé, etc.) in an incident related to suicide?

- Do you have a Suicide Response Team (team of experts) to immediately assist commanders in coordinating and integrating "postvention" activities in the event of a completed / attempted suicide?

- Are commanders appointing an AR 15-6 investigation for suicide or suspected suicide to
provide a comprehensive review of all possible causes: mental/physical illness, financial problems, failed relationships, other cumulative stress factors, trigger events, etc., to inform current and improve future programs and services?

- Are AR 15-6 investigations deliberately scoped and appropriately timed to ensure effective coordination with CID and MTF personnel conducting official, ongoing postvention activities (e.g., investigation, coordination of autopsy, ongoing toxicology and forensic examinations, etc.)? Are your 15-6 investigative officers coordinating with the CID Special Agent in Charge and the MTF DODSER Coordinator to synchronize efforts and ensure an accurate, inclusive, and synergistic 15-6 investigation?

- Is CID coordinating with specific commanders regarding equivocal death investigations to ensure commanders take appropriate, timely actions (AR 15-6, LOD, etc.) in the event that the equivocal death is determined to be a suicide? Are you tracking general trends for all equivocal deaths resulting from high-risk behavior to inform current and improve future programs and services?

- Are Line of Duty Determinations (LODs) being performed in all deaths and injuries arising from suicide-related events (equivocal deaths, attempts, and gestures, etc.)?

- Are post-suicide LOD investigators coordinating and communicating with an appropriate MTF behavioral health officer to obtain an opinion from that officer regarding whether the Soldier who died of suicide was "mentally sound" at the time of the suicide incident?

- Are Soldiers receiving instruction that dependents of active duty Soldiers generally will not receive Dependency and Indemnity Compensation (DIC) benefits from VA in the event of suicide?

- Has your Medical Treatment Facility migrated from the Army Suicide Event Reporting (ASER) system to the DoD Suicide Event Reporting system (DoDSER) for reporting suicide-related event data? If not, have you taken all steps necessary to expedite that migration?

- Is your Medical Treatment Facility working with CID, Fatality Review Board, and AR 15-6 / LOD investigator to ensure timely and accurate reporting of suicide-related event data on DoDSER?