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APVG-CG 11 December 2020

MEMORANDUM FOR RECORD

SUBJECT: United States Army Hawaii (USARHAW) Policy Letter #12 – Ready and Resilient, Risk Reduction, and Value of Life (Suicide Prevention and Intervention)

1. References:

a. Headquarter Department of the Army OPORD - Enduring Personal Readiness and Resilience, 30 November 2016.

b. Army Regulation (AR) 600-63, Army Health Promotion, 14 April 2015.

c. AR 350-53, Comprehensive Soldier and Family Fitness (CSF2), 19 June 2014.

d. AR 15-6, Procedures for Administrative Investigations and Boards of Officers, 01 April 2016.

e. Department of the Army Pamphlet (DA PAM) 600-24, Health Promotion, Risk Reduction, and Suicide Prevention, 14 April 2015.

f. Army Directive (AR DIR) 2018-07 (Prioritizing Efforts-Readiness and Lethality), 13 April 2018.

g. AR DIR 2018-23 (Improving the Effectiveness of Essential and Important Army Programs: Sexual Harassment/Assault Response and Prevention, Equal Opportunity, Suicide Prevention, Alcohol and Drug Abuse Prevention, and Resilience), 08 November 2018.

h. Memorandum, Secretary of the Army, Prioritizing Efforts-Readiness and Lethality (Update 7), 25 May 2018.

i. Memorandum, Director of the Army Staff, Commander's Risk Reduction Dashboard Increment II Training and Implementation, 08 September 2019.

j. United States Army Pacific (USARPAC) Value of Life (Suicide Prevention) Policy Memorandum SUS38, 11 April 2019.

k. USARPAC OPORD 16-08-039, Integrated Suicide Prevention Battlefield, 24 August 2016.

l. I Corps OPORD 118-17, Health Promotion and Suicide Prevention Campaign, 22 November 2016.

m. Policy Memorandum USAG-HI-40, Garrison Commander's Critical Information Requirement (CCIR) and Serious Incident Report (SIR) Requirements, 23 June 2020.

n. Policy Memorandum OTSG/MEDCOM 16-087, Release of protected Health Information to Unit Command Officials, 18 October 2016.

o. The Deputy Chief of Staff, Army G-1, "Commander's Toolkit for Suicide Prevention" available at http://www.armyg1.army.mil/hr/suicide/commandertoolkit.asp.

2. Policy. The readiness of our Army is paramount in our ability to fight and win on the battlefield; people are the number one priority. Promoting healthy lifestyles, reducing high-risk behaviors, encouraging a culture of intervention, and preventing suicide are priorities in this Command. Sustaining the health and well-being of our Soldiers, Family members, and Civilians is the principal responsibility of leaders and personnel at all levels as is providing the appropriate response to suicidal behavior incidents.

3. Terms of Reference.

a. Prevention. A continuum of awareness, intervention, and postvention. All efforts that surround building resilience, reducing stigma, building awareness and strategic communication.

b. Intervention. Actions undertaken to prevent an individual experiencing an acute crisis or a behavioral health disorder from attempting or committing suicide.

c. Postvention. Those actions taken after an incident of suicidal behavior that serve to moderate the effects of the event on the individual or survivor(s) of an individual who has contemplated, attempted, or completed suicide.

d. Suicidal Ideation (SI). Any self-reported thought of engaging in suicide-related behaviors (without an attempt).

e. Suicide Attempt (SA). A self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury. Therefore, this category includes behaviors where there is evidence the individual intended to die, but the event resulted in no injuries.

f. Completed Suicide (CS). Suicidal behavior that results in a fatality.

4. Prevention Actions. All commanders, leaders, supervisors, Soldiers, and Civilians are responsible for creating an environment that reduces the stigma of seeking help. It is incumbent on all of us to be aware of and recognize when someone may be at risk, and to be empowered to take appropriate action to save lives. Each of us is responsible for eliminating policies, procedures, and actions that inadvertently discriminate, punish, or discourage Soldiers or employees from seeking professional assistance. All USARHAW units will:

a. Focus on risk assessment, prevention, and build strength.

(1) The Risk Reduction Program offers the Unit Risk Inventory (URI), an anonymous questionnaire designed to screen for high-risk behaviors and attitudes that compromise unit readiness. The results of the URI are used to adjust training and prevention efforts within the unit. The URI is a great tool for incoming leadership teams to assess the climate within the unit.

(2) The Commander's Risk Reduction Toolkit (CRRT) enables Command Teams – Commanders at all levels, Command Sergeants Major, and Company First Sergeants, to compile a better composite picture of high-risk across their formation and helps facilitate development of applicable prevention and intervention strategies. Command Teams register for the CRRT through Army Vantage platform. Cyber Awareness Training and Safeguarding Personally Identifiable Information (PII) certification of completion are required for access; PDFs are uploaded to Army Vantage at the time of registration. Privacy Overview Act (https://www.lms.army.mil/) or Health Information Portability and Accountability Act (HIPAA) training can be substituted for Safeguarding PII, but cannot be used if it is within 30 days of expiration.

(3) In an effort to promote Soldier readiness and well-being programs, units will conduct quarterly brigade-level Health of the Force (HoF) meetings which identify, measure, track, analyze, and discuss issues and trends within their formations. Units should also develop mitigation strategies and identify best or promising practices for building protective factors with a focus on prevention.

(4) Battalions will conduct monthly Health of the Force (HoF) meetings aimed at improving Soldier and Family resilience and identifying and focusing resources on Soldiers deemed to be at-risk in any of the five dimensions of strength: emotional, physical, social, family, and spiritual.

(5) Company/Battery/Troop (C/B/T) Commands will appoint a Master Resilience Trainer (MRT) with Additional Skill Identifier (ASI) 8R, 8J, 8K, or 8L for unit level resilience.

(a) Brigades and Battalions will appoint, on additional duty orders, a MRT to serve as the BDE/BN Commander's MRT Manager. This individual is the principal advisor to the Command on MRT, coordinates resiliency skills training requirements, and prepares for Organizational Inspections. Each brigade will maintain, at a minimum, one MRT Level 2 in order to support the USARHAW MRT-C. Additionally, refresher training for MRTs will be coordinated by the Brigade MRT Manager and facilitated quarterly by the Ready and Resilient Performance Center (R2PC) personnel.

(b) C/B/T Leaders will ensure the 12 resiliency skills are annotated on the training schedule and executed annually by an MRT. Leaders are encouraged to conduct this training on a monthly basis to promote inculcation of MRT skills into the unit's culture.

(6) Each brigade will appoint a Suicide Prevention Program Manager (SPPM), the SPPM is required to attend their BDE's HoF and required to have representation at the 25th ID and USARHAW monthly Suicide Prevention Working Group (SPWG).

(a) Commanders will incorporate suicide prevention training into the overall training plan for the unit with annual suicide prevention training being conducted face to face. Unit leaders will lead the training and may use assets such as chaplains, legal representatives, MRTs, or other subject matter experts. Commanders will determine the duration, location, and means for conducting training but are highly encouraged to execute the following face-to-face suicide prevention training:

Ask, Care, Escort (ACE) and ACE-Suicide Intervention (ACE-SI)

ACE – Family member and DA Civilian

Ready and Resilient Performance Center Engage

Department of Defense Resources Exist, Asking Can Help (REACH)

Applied Suicide Intervention Skills (ASIST)

(7) Commanders will retain records of Soldiers' training and utilized Digital Training Management System (DTMS) to record Soldier and unit records and proficiencies.

b. Promote resources: Command teams and supervisors will ensure Soldiers and Civilians are aware of contact information for available helping agencies.

(1) The USARHAW Suicide Prevention Program Manager can be reached during normal business hours, Monday-Friday at, 1-808-787-1465 and supports unit compliance for all suicide prevention program requirements and provides suicide prevention training on an ad hoc basis.

(2) The USAG-HI Suicide Prevention Program Manager can be reached during normal business hours, Monday-Friday, at 1-808-655-9105 and provides training and resources to all USARHAW personnel – military and civilian.

(3) The National Suicide Prevention Lifeline is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. Immediate assistance can be obtained by dialing 1-800-273-TALK (8255).

(4) Military and Family Life Consultants and unit Chaplains are also a significant source of support.

(5) Military OneSource, reachable at 1-800-342-9647, is a 24-hour, toll-free service offering a wide range of individualized consultations, coaching, and non-medical counseling for many aspects of military life.

(6) Clinical Behavioral Health support is available through either the unit's Embedded Behavioral Health Officers or the Installation Directors of Psychological Health at Desmond T. Doss Health Clinic: 1-808-221-3995 and TAMC: 1-808-433-6406.

5. Intervention Actions.

a. Suicidal Ideation (SI).

(1) Appropriately respond using ACE-SI trained leaders within the organization.

(2) For an immediate behavioral health assessment, during clinic hours, the Soldier will be escorted to their respective Behavioral Health (BH) Clinic, TAMC Emergency Department (ED), or the Desmond T. Doss Acute Care Clinic (ACC). Time permitting, the unit should call the clinic ahead of time and provide information and background on the Soldier prior to their arrival. During non-clinic hours, the Soldier can be escorted to TAMC ER, or to a civilian hospital ED in emergency situations. At all times, Soldiers Private – Specialist will be escorted by the rank of Corporal or above, all Sergeants and above will be escorted by a leader at least one higher rank, and the escort will stay with the Soldier until released by their chain of command.

(a) Assessments that result in non-hospital admission at TAMC: If the Soldier is evaluated, the assessing provider is expected to call the unit Commander or Senior Enlisted Officer for collateral information and to discuss the pending assessment in

accordance with published MEDCOM guidance on the release of protected health information (PHI) to command officials. Prior to discharge, the final assessment and recommendations will be communicated to unit Commanders or Senior Enlisted Officer through direct communication with the assessing Behavioral Health (BH) provider and through additional guidance issued through e-profile. Commanders will ensure that the Soldier is released to a unit escort in the event of discharge from the ED.

(b) Assessment that results in a hospital admission at TAMC ED: Within 48 hours of admission, the TAMC Inpatient Service (4B2) provider will contact the unit Commander or Senior Enlisted Officer to discuss assessment, the treatment plan and to set up a command meeting prior to discharge, subject to HIPAA. Upon discharge, the Soldier's unit is expected to send an escort of a higher rank to pick up the Soldier from the hospital.

(c) Assessment at a civilian hospital that results in non-hospital admission: Commanders will ensure that released Soldiers follow-up the next day in their appropriate supporting BH clinic for a safety check and further BH support. The unit will contact the Unit Behavioral Health Officer (BHO), Brigade (BDE) Surgeon, or respective BH Nurse Case Manager to coordinate a follow-up appointment for a safety check NLT the following duty day. The Soldier will bring the discharge summary to their appointment. The BHO/BDE Surgeon will either conduct the safety assessment or notify the respective BH Clinic staff of the appointment.

(d) Assessment that results in a civilian hospital admission: Most civilian hospitals will call the TAMC Psychiatrist on Duty (PSOD) to transfer the Soldier to the TAMC inpatient ward. If there is no bed available at TAMC or the Soldier is inappropriate for transfer due to medical instability and must remain at the civilian hospital, the Commander will contact the unit BHO or BH Nurse Case Manager to task them with coordinating the discharge plan and follow-on care. If the Command has been notified of the Soldier's admittance they will track the Soldier's discharge and ensure next day follow-up care is planned. As with ED discharges, the Soldier will be released to a unit escort of higher rank upon discharge, if circumstances permit.

(2) Within 48 hours after being discharged, or during the next available workday, the unit Commander or organization's leadership will provide counseling, not as a punitive act, but to show support, identify stressors, provide resources, and if applicable, set up a one-on-one training session with the Master Resilience Trainer (MRT).

(3) Generate a Serious Incident Report (SIR) within 12 hours IAW reference (m).

(4) Provide the Enhanced Suicidal Incident Report within 5 business days to usarmy.hawaii.r2@mail.mil.

b. Suicide Attempt (SA).

(1) Use SI intervention procedures listed with the following additions.

(2) During and immediately after an attempt, the safety of the Soldier, individuals within the vicinity, and responders is priority. This may or may not entail contacting other agencies, such as the Military Police or local law enforcement to establish a safe environment for intervention.

(3) Before a behavioral health evaluation can occur, the Soldier must first be medically cleared. Depending on the severity of the attempt, escort the Soldier to the Desmond T. Doss ACC during clinic hours, take the Soldier directly to TAMC ED, or call 911 for emergency medical support.

(4) Generate a SIR within 12 hours of the event IAW reference (m).

(5) Provide the Enhance Suicidal Incident Report within 5 business days to usarmy.hawaii.r2@mail.mil.

c. Completed Suicide (CS). N/A

6. Postvention Actions.

a. Suicidal Ideation (SI).

(1) The Command will place the Soldier on the unit high-risk list for discussion and monitoring purposes during monthly reviews.

(2) The Command will notify the unit BHO. In turn, BHO personnel will go to their respective EBH Clinic's weekly Multi-Disciplinary Treatment Plan meeting for discussion and monitoring purposes.

(3) Within 30 days of the initial counseling for the SI, a follow-up counseling session with the Soldier and leadership should occur, not as a punitive action, but to show support and track progress.

b. Suicide Attempt (SA).

(1) Use SI postvention procedures listed above with the following additions.

(2) At the discretion of the unit Command, the unit's Suicide Response Team (SRT) will convene within 48 hours following a SA.

(3) Brigades will conduct Non-Fatality Suicide Review Boards which will be held quarterly in conjunction with unit Health of the Force/High-Risk Review for all SA.

c. Completed Suicide (CS).

(1) Follow guidance IAW reference (b).

(2) Generate a SIR within 8 hours IAW reference (m).

(3) In the event of an attempted, suspected, or known suicide, Commanders may request a Suicide Response Team (SRT), through the Command Surgeon, which convenes to bring a variety of agencies to the table to problem solve and offer support to the Soldier and Command team.

(4) Submit a DA Form 7747 (Commander's Suspected Suicide Event Report) for every suicide or equivocal death which is being investigated as a possible suicide to usarmy.pentagon.hqda-dcs-g-1.mbx.csser@mail.mil and usarmy.hawaii.r2@mail.mil IAW with established timelines; Section I – Serious Incident Report: within 24 hours of the incident, Section II – Commander's Initial Report, within 5 days of the incident, and Section III – Commander's Final Report, within 60 days of the incident.

(5) Within 90 days of a suspected or known suicide, the Command will convene a Suicide Fatality Review Board, comprised of subject matter experts and suicide intervention/response stakeholders, to assess the effectiveness of current policies and procedures and make recommendations to address identified concerns.

7. The guidance above serves as a reference tool for leaders at all levels to ensure suicidal behavior incidents are responded to and addressed appropriately. Adherence to these measures will help prevent and mitigate the overwhelmingly negative effects of suicide from causing further harm to an individual, the unit, and the Army.

8. In an effort to evaluate Suicide Prevention Program needs and coordinate prevention activities, the Commander's Ready and Resilient Council will establish a Suicide Prevention Working Group (SPWG) IAW DA Pam 600-24. The SPWG is a consortium of suicide prevention stakeholders that meet monthly to review mandatory training, identify potential prevention areas, conduct analyses, and make recommendations to the 25th ID and USARHAW leadership regarding prevention efforts and policy guidance.

9. The success of our Army's readiness and resilience, risk reduction, and suicide prevention program depends on the concentrated focus of leaders on activities that encompass the physical, behavioral, spiritual, social, and cultural dimensions in our commands. The total effect of a solid program will be an overall improvement in unit and organizational performance and readiness through enhanced individual well-being.

10. This policy will be permanently posted on unit bulletin boards. Commands, to Company level, will ensure all Soldiers, Families, and DA Civilians are informed of this policy.

11. This policy letter remains in effect until superseded or rescinded in writing.

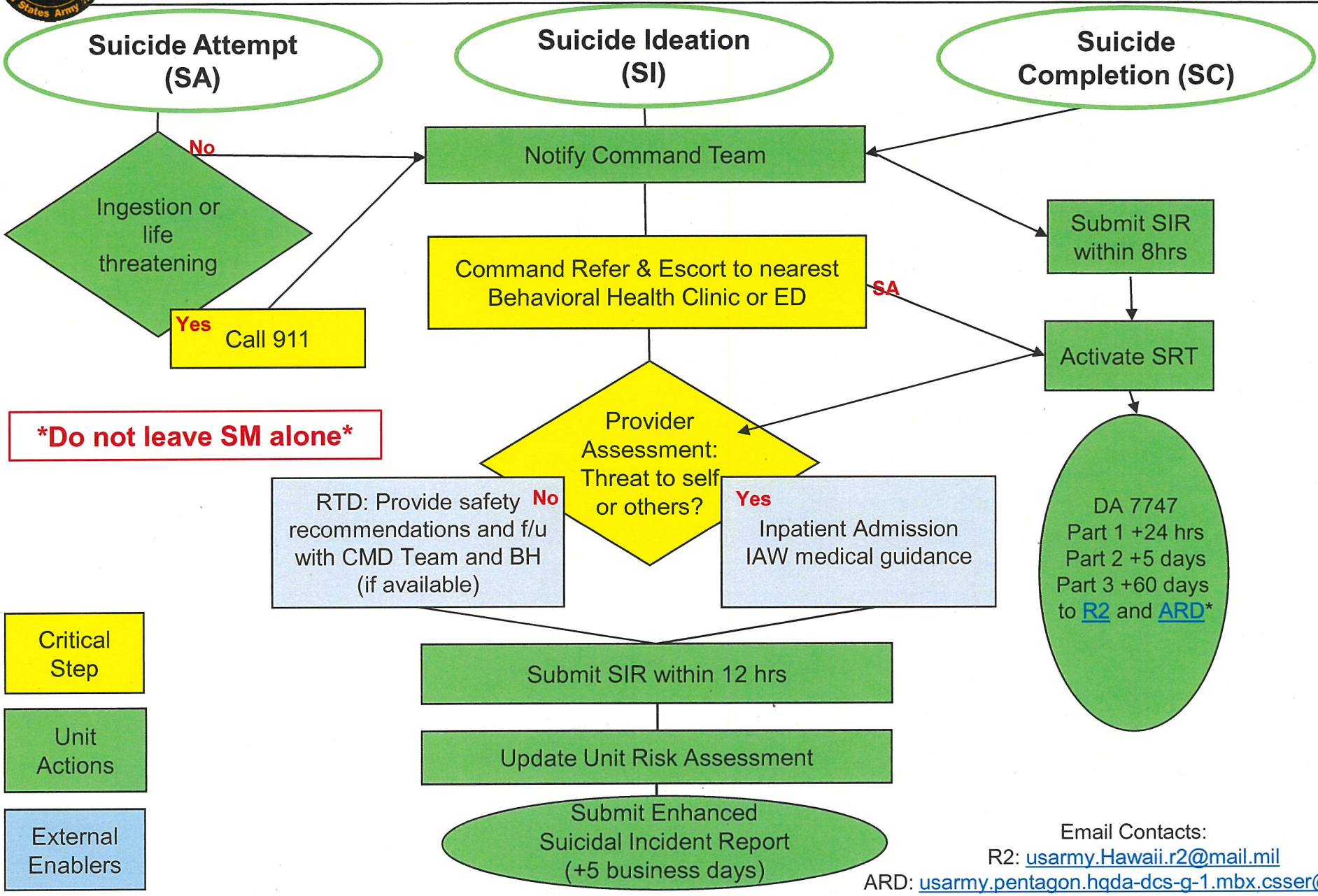
12. The point of contact of this policy letter is the USARHAW Ready and Resilient Program Specialist at 808-787-1464 or usarmy.hawaii.r2@mail.mil.

2 Encls
1. Suicidal Incident Procedure Flowchart
2. Enhance Suicidal Incident Report

JAMES B. JARRARD
Major General, USA
Commanding

Enclosure 1 (Suicidal Incident Response Flowchart) to USARHAW Policy Letter #12 – R2 Suicide Prevention

Suicidal Incident Response Flowchart



Email Contacts:
R2: usarmy.Hawaii.r2@mail.mil
ARD: usarmy.pentagon.hqda-dcs-g-1.mbx.csser@mail.mil

Suicide SIR background information

Date of incident _____ Time of incident _____ Type of Incident [Select]

Personal Data

Last Name _____ First Name _____ Rank _____ MOS _____

Age _____ Race _____ Gender _____ Marital Status _____

Command _____ BDE _____ BN/SDRN _____ CO/TRP/BA _____

Type of Housing _____ If Barracks, Barracks BLDG Number not the room number _____

Length of time in Unit - Months _____ Was the Soldier in transition? (Within 6 months) _____

Did SM live alone? (Did SM have a roommate or spouse living with him? _____

The following questions concern actions during the incident

Incident Location _____ Primary Method Used _____

Were Illicit Drugs Used? _____ Was alcohol involved? _____

Prior to the incident, did the SM communicate potential self-harm? _____

Was the SM hospitalized or returned from deployment as a result? _____ Were there self-inflicted Injuries? _____

Describe self-inflicted injuries _____

Was there evidence that SM intended to die? _____ (Note: The intent to die is an attempt not ideation)

Describe the evidence that SM intended to die

The following questions concern actions prior to the incident:

Was the service member subject to?:

Court Martial? _____ Admin Separation? _____ UCMJ actions? _____ Investigation for misconduct? _____

Prior to the event was the SM experiencing?:

Personal relationship issues? _____ Supervisor or coworker conflicts? _____ Financial Difficulties? _____

A history of substance abuse? _____ Receiving Behavioral Health care? _____

Was the SM experiencing sleep issues or being treated for sleep disorder by a medical provider? _____
(For example: was SM complaining he couldn't sleep? Was he not sleeping enough because of extra duty?)

Was the SM experiencing chronic pain or being treated for it by a medical provider? _____
(For Example: Was SM self medicating for pain everyday? Was he on long term physical profile?)

Was the SM receiving additional or corrective training? _____ Was the SM on extra duty or restrictions? _____

Did the SM indicate he/she felt left out or was disconnected from the unit? _____

Did the SM indicate he/she felt like a burden on the unit or others? _____

How many previous deployments did the Soldier have? _____

Description of the event

What was the SM's primary motive? _____

Describe the sequence of events. This could come from the narrative of the SIR:

If known, provide a brief explanation as to why the SM engaged in suicidal behavior. Where there any factors identified from the READI-CAB, SLRRT,or R4 that may have led to the incident? If the READI-CAB, SLRRT,or R4 was not used prior to the incident; what was occurring in the SMs life that might have led to thoughts of suicide?