

Installation, Garrison, MTF, and Unit Commander Critical Actions/Tasks

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1. Recognizing and Planning for Transitions

- Are commanders educating leaders/front line supervisors on the relationship between transitions (e.g., deployments, PCS, disciplinary actions, marriage, child birth, etc.) and associated stress?
- Are commanders incorporating unit, Soldier and Family transitions into their planning, operations and administrative battle rhythm? Is this guidance routinely delegated down the chain of command to squad/section/team leaders?

a. Unit Integration/Reintegration

- Do garrison-level integration and reintegration programs for Soldiers and Families exist that mitigate the impacts of stress during critical periods of transition? Do these programs interface/synchronize with unit-level integration and reintegration programs?
- Are leaders conducting initial counseling during integration/reintegration to increase Soldier awareness of unit and community policies, programs and services? This is particularly important but often overlooked during reintegration as an important measure to reset Soldiers in the garrison environment (it may be helpful to view reintegration as "initial integration" to the unit/community).
- Do commanders have active unit integration programs that ensure immediate accountability for incoming Soldiers, assign sponsors and provide necessary support for stabilization?
- Do integration programs focus on specific Soldier categories including leaders, career Soldiers, first-term Soldiers and single Soldiers?
- Do integration programs focus on professional development (promotion status, training records, education, etc.), Soldier readiness (family care plans, MEDPROS, SGLI, etc.) and quality of life (housing, commute, family assistance, etc.)?
- Are integration programs aligned with barracks utilization plans that promote unit/team cohesion and enable chain of command supervision?
- Are leaders (battalion and below) inspecting implementation of integration programs?
- Do units develop reintegration programs in coordination with their rear detachment that focus on activities appropriate for the first 90 days and 90-180 days to ensure continuous surveillance, detection and intervention?

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- Do reintegration programs recognize the effects of leader turnover (e.g., changes of command, PCS, PME, TDY, and internal moves) and include appropriate plans to ensure continuity and seamless transition?
- Do reintegration programs leverage integration program protocols to focus on Soldier professional development, readiness and quality of life? For example, reintegrating Soldiers may need to attend PME, transfer to another unit/platoon/squad, locate new housing, or purchase/repair transportation.
- Are commanders identifying returning Soldiers who may be at risk based on behavior/stress indicators and directing them to appropriate services (ensure confidentiality when identifying Soldiers to avoid stigma that may dampen intervention measures or help-seeking behavior)?
- Do reintegration programs emphasize appropriate community program referrals to mitigate deployment related stress/re-socialization including behavioral health/medical conditions, family reintegration, heightened adrenaline (compensation via motorcycle, sport cars, etc.), grief/guilt, team separation/transitions, alcohol binge drinking/tobacco cessation, financial counseling (bonus/combat pay), etc.?
- Do reintegration programs provide requisite transition support for demobilizing Reserve Component/WIAS Soldiers? Ensure a tactical pause to complete reverse SRP, medical screening/treatment, employment legal support... all requisite reintegration programs associated with active duty Service Members as emphasized above.

b. Sponsorship

- Do commanders enforce the mandatory sponsorship requirements in AR 600-8-8, especially those for first-term Soldiers and Family members?
- Do commanders ensure that a trained sponsorship pool exists at the unit or installation level to respond to programmed and un-programmed arrivals?
- Are commanders tracking their sponsorship programs based on their 90 day gains roster as part of their command and staff meetings?
- Are sponsors provided the requisite time, leader emphasis and resources to ensure that unit sponsorship is their primary duty?
- Do commanders ensure that rear detachment sponsorship is provided to Family members during the deployment of the Soldier or civilian employee sponsor?

c. Transition Accountability

- Do commanders maintain accountability of Soldiers while absent from the unit for PME, TDY, WIAS, emergency leave, etc.?
- Are leaders appropriately documenting/verifying all contact information on Soldier leave/pass requests and ensuring appropriate risk assessment/travel preparation?
- Are leaders conducting daily accountability formations to ensure appropriate unit/Soldier status?

d. Deployment Transition Planning (This is not intended as a deployment checklist but emphasizes some programs and measures associated with promoting health and reducing risk identified during the Army Campaign that need additional leader emphasis.)

- Are commanders in coordination with HRC effectively managing transitions of deploying key leaders by slating leadership into deploying units at least 90 days prior to deployment?
- Are commanders in coordination with HRC effectively managing transitions of leaders by retaining them at least 90 days after redeployment?
- Are commanders effectively managing transitions of mobilized Reserve Component, IRR and WIAS Soldiers to actively integrate into the unit and reintegrate back to home station/unit?
- Have Rear Detachment leaders been selected and appropriately task organized to optimize rear detachment cohesion and effectiveness?
- Have Rear Detachment leaders been selected and integrated 90 days prior to deployment and retained 90 days following redeployment (to the extent possible)?
- Are systems in place to transfer responsibility for and ensure continuity of pending disciplinary/administrative actions between deploying and rear detachment commanders?
- Is the Family Readiness Groups (FRG) active and organized to provide optimal support to the Families of Soldiers (in coordination with the Family Readiness Support Assistant [as available], Family Assistance Centers and rear detachment leaders)?
- Are commanders effectively managing transitions of mobilized Reserve Component, IRR and WIAS Soldiers to integrate Families into the unit FRG/plan?
- Does the FRG plan support Families departing the community, geographically isolated Families and Families of single Soldiers?

- Are leaders comprehensively screening Soldiers to ensure deployment readiness? Leaders should not place an over-reliance on SRP readiness but holistically view readiness across composite life cycle events (Soldier and Family transitions/stress such as compassionate reassignment/ill Family member, BH program enrollment, ongoing disciplinary/administrative actions, spouse pregnancy, other risk indicators).
- Are commanders collaborating with medical and behavioral health providers in determining the impact of medical conditions (BH, mTBI, PTSD), the effects of treatment (e.g., medication side effects and multiple medication interactions) and continuity of care on Soldier deployability/employability?

2. Leader-Subordinate Interaction

a. Surveillance

- Are leaders identifying Soldiers who may be at risk based on behavior/stress indicators and directing them to appropriate services (ensure confidentiality when identifying Soldiers to avoid stigma that may dampen intervention measures or help-seeking behavior)?
- Are leaders employing all available active and passive surveillance measures to detect Soldiers engaging in high risk behavior (urinalysis screening, unit surveys, unit commander's financial report, blotter reports, etc.)?
- Do commanders ensure that leaders to the squad/section/team level know their Soldiers (e.g., family circumstances, living arrangements, interests, financial situation, education, career goals)?
- IAW AR 600-20, do commanders conduct climate surveys within 90 days of assuming command and at least annually thereafter to increase leader awareness of potential unit and individual stress/risk factors?
- Do commanders at the brigade level and higher ensure that the Unit Risk Inventory (URI) is administered to all Soldiers at least 90 days before an operational deployment and returned to ASAP NLT 30 days prior?
- Do commanders ensure that the Reintegration Unit Risk Inventory (R-URI) is administered to all Soldiers between 90 and 180 days after returning from an operational deployment?
- Do senior commanders encourage subordinate commanders (battalion and below) to administer the URI after changes of command to identify trends in high risk behaviors?
- Are commanders conducting 100% urinalysis of all Soldiers assigned rather than 100% of their unit end strength?

- Are leaders at squad/section/team inspecting POVs/motorcycles for appropriate licensing, vehicle operating condition, training and safety/emergency equipment?
- Are commanders designating leader/team oversight for Soldiers under investigation or pending disciplinary/administrative actions?

b. Counseling

- Do commanders ensure that first-line supervisors conduct initial counseling with all Soldiers within the first 30 days of arrival to the unit/assumption of a new duty position?
- Do first-line supervisors provide junior enlisted Soldiers with monthly performance counseling? Are the counseling sessions formally documented on DA Forms 4856?
- Are NCOs and company-grade Officers receiving formal performance counseling within 30 days of the beginning of the rating period and at least quarterly thereafter from raters?
- Are leaders using informal/formal developmental counseling techniques (e.g., crisis/referral counseling) to help Soldiers manage composite life cycle events as appropriate?
- Do leaders monitor the unit/organization counseling program to ensure Soldiers are receiving effective, documented and timely counseling?
- Are leaders counseling officers and NCOs on personal finances, including military programs and benefits (e.g., no pay due, TSP, educational benefits, survivor benefits, etc.)?

c. HP&RR Training

- Do commanders ensure all Soldiers receive required training on HP/RR/SP topics IAW AR 350-1, including:
 - Substance Abuse (in-processing, annually and redeployment)?
 - Suicide Prevention (annually, predeployment and redeployment)?
 - Resilience (predeployment and redeployment)?
 - Sexual Assault Prevention and Response (annually, predeployment and redeployment)?
 - Prevention of Sexual Harassment (semi-annually)?
 - Traffic Safety (in-processing)?

- Do commanders at all levels educate their Soldiers using a standardized program of instruction on the consequences of a domestic violence conviction (*Lautenberg Amendment*) as stated in AR 600-20?
- Do commanders ensure all newly assigned Soldiers are briefed on ASAP policies and services within 30 days of arrival to the unit?

d. Good Order and Discipline

- Do commanders emphasize Soldier good order and discipline in the barracks/garrison by periodically conducting unannounced urinalysis tests; military working dog (MWD) sweeps; health, welfare and morale inspections; recognition ceremonies; safety briefings and accountability formations?
- Do commanders have plans/procedures in place for unit charge of quarters for detecting, intervening and reporting high risk indicators/incidents?
- Do commanders ensure that all Soldiers are treated with dignity and respect if they are experiencing challenges or have been identified with stress/risk indicators?
- Do commanders and behavioral health providers formally collaborate and share information concerning Soldiers at-risk of violence when confiscating/re-issuing weapons?
- Do commanders ensure that Soldiers living in the barracks register their privately owned weapons with the PMO and store their privately owned weapons in the unit arms room?
- Do commanders ensure that Soldiers residing on the installation register their privately owned weapons with the PMO and store them IAW AR 190-11 and local installation policy?
- When notified that a Soldier has a qualifying domestic violence conviction (as defined in AR 600-20) under the *Lautenberg Amendment*, does the commander take immediate action as required by Federal Law?
- Do commanders at all levels appropriately address inappropriate behavior/substandard performance using counseling, extra training, and, if appropriate, flags, bars from reenlistment and other adverse personnel actions?
- **Are company commanders reviewing monthly Unit Commander's Finance Reports (UCFR) in order to identify and assist Soldiers with financial issues?**
- Do commanders facilitate Soldier attendance/participation at medical appointments? Do commanders take appropriate action when a Soldier misses medical appointments?

e. Accountability

- Do commanders ensure Personnel Asset Inventories (PAI) are conducted at changes of command, before units change duty locations and whenever deemed necessary?
- Are commanders ensuring that Soldier's personal/government property is inventoried and appropriately stored when the Soldier is determined to be AWOL?

f. Administrative Separations

- Do commanders initiate administrative separation of all Soldiers who are involved in two serious incidents of alcohol-related misconduct within 12 months?
- Does the separation authority process the administrative separation of Soldiers who have tested positive for illicit drugs a second time during their career?
- Does the separation authority process the administrative separation of Soldiers who are convicted of driving while intoxicated/driving under the influence a second time during their career?
- Do commanders at all levels initiate administrative separation of Soldiers as appropriate, based upon a pattern of criminal behavior (e.g., multiple felonies)?

3. Reporting of High-Risk Behavior and Referral to Programs/Services

a. Command Reporting

- Do commanders immediately report all drug related offenses (e.g., illegal possession, use, sale, or trafficking in drugs) to installation law enforcement for investigation?
- Do commanders report all positive urinalysis results to installation law enforcement within 72 hours of notification by the ADCO?
- Do commanders report suspected illicit pharmaceutical drug use to installation law enforcement?
- Do commanders immediately report all incidents of sexual assault to CID?
- Do battalion commanders complete DA Forms 4833 (*Commander's Report of Disciplinary and Administrative Action*) with supporting documentation (e.g., copies of Article 15s, court martial orders, reprimands) for all CID investigations and return the completed report within the required 45 days?

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- Do company, troop, and battery level commanders complete DA Forms 4833 with supporting documentation (e.g., copies of Article 15s, court martial orders, reprimands) in all cases investigated by military police (MP) investigations, civilian detectives employed by the DA, and the PM/DES and return the completed report within the required 45 days?
- Have commanders submitted all delinquent DA Forms 4833 to the appropriate law enforcement office? Do senior commanders ensure all DA Forms 4833 are returned within the required timeframe?
- Do unit commanders report AWOL Soldiers to the installation personnel office, Provost Marshal Office and the military pay office within 48 hours of the AWOL determination?
- Do commanders change the status of Soldiers to "dropped from rolls" (DFR) after a Soldier has been AWOL for 30 days and submit the DFR separation packet within 30 days of the DFR date?
- Do commanders report suspected spouse and child abuse to installation law enforcement and to the Family Advocacy Program (FAP) point of contact?

b. Program Referrals

- Do leaders evaluate and manage individual Soldier readiness across composite life cycle events by referring Soldiers to appropriate programs and services?
- Do leaders ensure Families are aware of available HP/RR/SP programs and services?
- When commanders recognize indicators of high risk behavior:
 - Do they refer Soldiers to appropriate program/service providers (e.g., ACS for financial issues, Social Work Services for Family issues)?
 - Do they facilitate Soldier attendance/participation at these programs?
 - Do they take appropriate action when a Soldier does not participate in a command referred program?
- When a commander identifies a Soldier as a potential substance abuser, is the Soldier referred to ASAP for evaluation within 5 working days using DA Form 8003, *ASAP Enrollment*?
- Do commanders ensure that Soldiers who have demonstrated non-fatal suicide behaviors (attempts, ideations, self-harm, etc.) receive appropriate medical intervention (e.g., emergency medical services or behavioral health)?

- Following incidents of blast/concussive/overpressure exposure, are Soldiers at risk for mTBI evaluated, treated and tracked as close to the time of injury as possible IAW the Army Campaign Plan for Warrior mTBI?
- Are commanders informing Soldiers and Families of the availability of non-MTF behavioral health programs (e.g., TRIAP, TRICARE Tele-BH, Military OneSource) and encouraging participation as appropriate?

c. Information Sharing

- Are commanders communicating/benchmarking HP & RR policies and processes with other commanders to identify and implement best business practices?
- During a pending investigation of a suspected suicide or equivocal death, do commanders ensure their official interactions with the next of kin (NOK) are coordinated with law enforcement and the casualty assistance officer?
- Do commanders and service providers understand that when safety, readiness, or welfare may be **adversely impacted by a medical condition or treatment, Soldiers' f** protected health information (PHI) can be accessed, without Soldier consent, pursuant to HIPAA and the Privacy Act?
- Have installation commanders established a forum for commanders to share lessons learned from fatal and non-fatal suicidal behavior and successful interventions?
- Do installation/garrison commanders have a mutual support plan requiring the PM to provide extracts from DA Forms 3997, *Military Police Desk Blotter*, on all incidents involving alcohol and/or drugs on a daily basis to the ADCO?
- Are commanders coordinating with health care providers regarding medical profiles to ensure appropriate compliance, rehabilitation and reintegration (e.g., medical, behavioral health, substance abuse, family advocacy counseling)?

4. Providing Community/Installation Support

a. Installation Law Enforcement (Provost Marshal/Director of Emergency Services / Criminal Investigation Division)

- Does installation law enforcement provide DA Forms 4833 to unit commanders in a timely manner?
- Does installation law enforcement have a formalized system in place to follow up on delinquent DA Forms 4833 from unit commanders?
- Does installation law enforcement provide data to the installation commander regarding unit compliance on the timely return of completed DA Forms 4833?

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- Does installation law enforcement provide periodic analysis of information reported on DA Form 4833 (such as trends in offenses and types/levels of adjudication) to the installation commander?
- Do DES and CID routinely coordinate to appropriately staff and resource Drug Suppression Teams (DST) in support of installation drug surveillance, detection and intervention?
- Are Military Working Dog (MWD) teams readily available to support command health and welfare inspections?
- Does installation law enforcement ensure use of appropriate offense/information codes in ACI2 and COPS?
 - Do law enforcement officials correctly classify Family member abuse, alcohol/drug involvement, and other offenses by assigning the appropriate code in their data systems (COPS, ACI2)?
 - Are criminal investigators using appropriate codes when modifying criminal offenses to ensure accurate data entry/query (type-overs will not modify the offense code)?
 - Are military police appropriately referring offenses in COPS, cell 6 "MP action referred to" (ensure referrals are complete to preserve case status and case data)?
- Does the installation DES/PM share information from non-blotter service calls/encounters with other installation stakeholders to ensure situation awareness among community programs? Use of the MP Journal may mask important incidents/trends from other program providers (e.g., CID, FAP, ASAP, ACS, etc.).
- Does law enforcement provide information to Defense Incident Based Reporting System (DIBRS) for input into National Incident Based Reporting System (NIBRS) as required by the Uniform Federal Crime Act?
- Does installation law enforcement routinely work policy, programs and processes with other Services (i.e., DoD base clustering, Joint Basing)?
- Does installation law enforcement have formal memoranda of understanding (MOU) with its civilian counterparts in compliance with AR 190-45 regarding information flow, jurisdiction and investigations of criminal activity?
- Has installation law enforcement established formal forums with local professional civilian counterparts to share emerging threats/risks and law enforcement trends within the surrounding community (e.g., synthetic drug use)?

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- Do installation commanders conduct disciplinary control review boards to determine which off-post activities should be placed off limits? Are civilian law enforcement and other local agencies represented as stakeholders on the disciplinary control review board?
- b. Army Substance Abuse Program (ASAP) Outreach, Education and Surveillance**
- Do Alcohol and Drug Coordination Officers (ADCOs) notify commanders of Soldiers with positive urinalysis results immediately upon verification?
 - Do installation/garrison ADCOs monitor and evaluate the ASAP evaluation completion rate? Do the ADCOs provide quarterly reports to the installation commander, battalion commanders and ASAP?
 - Do ASAP Coordinators match data collected on high-risk behavior incidents (quarterly risk reduction program report) with data available on the associated response (e.g., DA Forms 4833, 8003) to determine compliance with command referral requirements?
 - Do ASAP Coordinators proactively coordinate with unit commanders to schedule Unit Risk Inventories (URI) based on deployment timelines?
- c. Community Health Promotion Council (CHPC)**
- Does the installation have an active CHPC, appropriately represented by all community stakeholders, that monitors HP/RR/SP policy, structure, process and program execution?
 - Does the CHPC collect and analyze feedback from program customers to validate requirements for existing programs and identify/generate new requirements? Are mechanisms in place to report best business practices to HQDA?
 - Does the CHPC identify, synchronize and coordinate installation and community support to enhance access to HP/RR/SP services?
 - Does the CHPC maintain an inventory of resources available via local community services (e.g., VSO, American Red Cross, universities) to supplement existing HP/RR/SP services?
 - Does the CHPC utilize the Army Campaign Plan Health Promotion (ACPHP) checklist (DA Pam 600-24) to ensure compliance with the ACPHP strategy?

d. Installation Emergency Management (IEM)

- Does the installation have a family assistance emergency plan with procedures and protocols for mass casualty and crisis response situations?
- Are installation emergency management programs and plans synchronized and rehearsed to prevent gaps and duplication of effort among agencies?

5. Healthcare Wellness and Risk Reduction

- Have the recommendations of the *Pain Management Task Force Report (May 2010)* been implemented, as appropriate? The following tasks are highlights from the report:
 - Have programs been implemented to manage (e.g., sole provider and limited duration prescriptions) patients identified with substance abuse history or who are receiving chronic pain management?
 - Have complementary and integrative pain treatment approaches been adopted in primary care clinics? Are these options routinely communicated to patients?
 - Are providers allowed to conduct osteopathic manipulation in order to minimize the use of narcotic pain medication?
 - **Has the Veteran's Health Administration (VHA) Stepped Care Model** been adopted to reduce pain and suffering while improving quality of life for Soldiers and Families?
- Are all redeploying Soldiers (including Reserve Component) being administered the Post Deployment Health Reassessment (PDHRA) no later than 90-180 days after redeployment?
- Are appropriate clinical practice guidelines being used for treating patients with TBI or PTS(D) co morbid conditions (e.g. depression, substance abuse, adjustment disorder, anxiety, etc.)?
- Are medical personnel sharing a Soldier's relevant protected health information (PHI) with the unit commander when safety, readiness or welfare may be adversely impacted by a medical condition or treatment?
- Do MTF commanders have a quality assurance and peer review policy by which "at risk medication" prescriptions are tracked when more than two psychiatric/psychotropic medications are prescribed?
- Do MTF commanders have a system to ensure that DODSERs are submitted by a credentialed BH clinician for all suicide completions/fatalities within 60 days of the date the event was determined by AFME to be a suicide?

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- Do MTF commanders have a system to ensure that DODSERS are submitted by a credentialed BH clinician for all suicide behaviors that resulted in hospitalization or theater evacuation within 30 days of the date of hospitalization or evacuation?
- Are MTF commanders providing missed appointment reports to unit commanders in accordance with MEDCOM policies?
- Do MTFs conduct a "warm handoff" of patients who are in/out processing and require ongoing medical/behavioral health care?
- Are PROFIS personnel staying with their unit during "reintegration" periods IAW MEDCOM policy?
- Are unit medical personnel centrally managed in garrison to optimize installation/community medical capabilities?
- Are tele-behavioral capabilities being used to increase access or surge capability for behavioral health during unit deployment cycles and other critical windows (e.g., post deployment screening)?
- Are non-MTF behavioral health programs readily available/offered to Soldiers and Families (e.g., TRIAP, TRICARE Tele-BH, Military OneSource)?
- Are MTF commanders communicating/educating unit commanders on the full range of behavioral health programs offered to Soldiers and Families?
- Do healthcare providers report all allegations and suspected incidents of spouse and child abuse to installation law enforcement?