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APVG-CG

25 MAY 2017

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: 25th Infantry Division Policy Letter #17 – Suicidal Incident Response Procedures

1. References.

a. AR 600-63, Army Health Promotion, 14 April 2015.

b. DA PAM 600-24, Health Promotion, Risk Reduction, and Suicide Prevention, 14 April 2015.

c. AR 600-8-4, Line of Duty, Procedures, and Investigations, 08 September 2008.

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

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

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

g. Army 2020: Generating Health and Discipline in the Force ahead of the Strategic Reset (Rev. 2), 2012.

h. Policy Memorandum USAG-HI-40, Garrison Commander's Critical Information Requirement (CCIR) and Serious Incident Report (SIR) Requirements, 26 August 2016.

i. OPORD 559-16, 25ID CCIR Reporting Guidance, Annex A: 25ID CCIR, 08 August 2016.

2. Policy. This serves as the recommended action guidance for all suicidal behavior incidents occurring within units assigned or attached to the 25th Infantry Division.

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 that the individual intended to die, but the event resulted in no injuries.

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

4. Prevention Actions

a. Unit leadership will ensure that supervisors at all levels are aware of direct contact numbers for the following personnel, at a minimum, to consult and refer Soldiers for behavioral health needs: Unit Behavioral Health Officer (BHO), unit Chaplain, respective Embedded Behavioral Health (EBH) Provider, and respective Embedded Behavioral Health Clinic (EBHC) front desk.

5. Intervention Actions

a. Suicidal Ideation (SI):

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

(2) For an immediate behavioral health assessment, the Soldier will be escorted to their respective EBHC during clinic office hours. 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 Tripler Army Medical Center Emergency Room (TAMC ER), or to a civilian hospital ER in emergency situations. The Soldier will be escorted to the clinic, TAMC ER, or civilian hospital ER by a Soldier of higher rank; the escort will stay with the Soldier until released by their chain of command.

i. Assessment at TAMC ER that results in non-hospital admission: If Soldier is evaluated at TAMC ER, assessing provider is expected to call the unit Commander and/or First Sergeant for collateral information and to discuss the pending assessment in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy protections. Prior to discharge, final assessment and recommendations will be communicated to unit Commanders and/or First Sergeants through direct communication with the assessing BH provider and through additional guidance issued through e-profile subject to HIPAA.

ii. Assessment that resulted in a hospital admission at TAMC ER: Within 48 hours of admission, TAMC Inpatient Service (4B2) provider will contact Company Commander and/or First Sergeant to discuss assessment, treatment plan and to set up a command meeting prior to discharge subject to HIPAA. In the command meeting discuss the following: duty limitations, type of profile, recommendations for possible administrative separation/MEB/etc...discharge plan, discharge date and to contact command unit if any of the above has changed prior to discharge. Upon discharge, Soldier's unit is expected to send an escort of a higher rank to pick up Soldier from the hospital.

iii. Assessment at a civilian hospital that resulted in non-hospital admission: Prior to discharge, unit commanders must speak to the treatment provider to discuss assessment and recommendations subject to HIPAA. Contact BDE Behavioral Health Officer or BDE Surgeon to coordinate follow-up appointment for a safety check the following duty day. Have SM bring discharge summary to their appointment. BHO/BDE Surgeon notify respective EBH Clinic staff of appointment.

iv. Assessment that resulted in a civilian hospital admission: Most civilian hospitals will call the TAMC Psychiatrist on Duty (PSOD) to transfer to TAMC inpatient ward (4B2) if bed is available. If they do not, the commander will request that the PSOD contact the provider to coordinate transfer. If there is no bed available and the Soldier must stay at the civilian hospital, contact the BDE Surgeon the following day and provide him/her with the following information: Full name and rank of Soldier, DOD ID or last 4 of the SSN, name of the hospital and treating provider, contact number for hospital and treating provider, that TAMC PSOD has been contacted and no beds are available, and a brief explanation that led to admission. The BDE Surgeon will coordinate with their respective EBH Clinic Nurse Case Manager (NCM) for tracking purposes and to coordinate discharge plan with the civilian hospital prior to discharge. The BDE Surgeon should also notify their BHO and respective EBH Service Line Chief.

(3) Within 48 hours after being discharge from EBH Clinic, ER, or inpatient hospitalization, the Company Commander or their representative provides a 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).

(4) Generate a Serious Incident Report (SIR) within 12 hours of the event.

b. Suicide Attempt (SA):

(1) Use intervention procedures from SI plan above, 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/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, the Soldier can be escorted to the Acute Care Clinic (ACC) during clinic hours, taken directly to TAMC ER, or by calling 911 for EMT support.

(4) Generate a Serious Incident Report (SIR) within 6 hours of the event.

c. Completed Suicide (CS): N/A

6. Postvention Actions

a. Suicidal Ideation (SI):

(1) Company Commander will place Soldier on the unit high-risk list for discussion and monitoring purposes during the monthly Battalion Health of the Force / High-Risk Review.

(2) Company Commander will notify unit BHO and/or unit Surgeon. In turn, BHO and/or unit Surgeon will go to their respective EBH Clinic's weekly Multi-Disciplinary Treatment Plan (MDTP) 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 postvention procedures from SI plan above with the following additions.

(2) At the discretion of the unit Commander, the Brigade's Suicide Response Team (SRT) will convene within 48 hours following all SA, to assist Commanders in assessing the situation, determine appropriate courses of action, directing interagency and inter-staff actions and advising the Company Commander (CC) (IAW AR 600-63 and DA Pam 600-24).

(3) Non-Fatality Suicide Review Boards (NFSRB) will be held quarterly in conjunction with BDE Health Promotion Council Meeting / High-Risk Review for all SA.

c. Completed Suicide (CS):

(1) Follow guidance IAW reference (i) and (b).

(2) Generate a Serious Incident Report (SIR) within 6 hours of the event.

(3) The Brigade Suicide Response Team (SRT) convenes within 48 hours following all CS to assist Commanders in assessing the situation, determine appropriate courses of action, directing interagency and inter-staff actions and advising the Company Commander (CC) (IAW AR 600-63 and DA Pam 600-24).

(4) Within 30 days of receiving the SIR for the CS, Division will initiate a Suicide Fatality Review Board (SFRB).

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 this policy will help prevent and mitigate the overwhelmingly negative effects of suicide from causing further harm to an individual, the unit, and our Army.

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

9. The point of contact for this policy letter is MAJ Josephine Horita, 25ID Division Psychiatrist, at 808-655-4738 or josephine.p.horita.mil@mail.mil.

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Annex 1: Prevention: Contact Numbers
Annex 2: Suicide Intervention Flowchart

Annex 3: Suicide Attempt Intervention Flowchart
Annex 4: Postvention Flowchart