



DEPARTMENT OF THE ARMY
HEADQUARTERS, JOINT READINESS TRAINING CENTER AND FORT POLK
6661 WARRIOR TRAIL, BUILDING 350
FORT POLK, LOUISIANA 71459-5339

REPLY TO
ATTENTION OF:

AFZX-CG

JUN 12 2012

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Command Policy Memorandum G1-11 – Brigade/Battalion Resiliency Teams (BRT)

1. References:

- a. Army Regulation 600-85, The Army Substance Abuse Program, 2 Feb 09; Rapid Action Revision, 2 Dec 09.
- b. Department of the Army Pamphlet 600-24, Health Promotion, Risk Reduction, and Suicide Prevention, 17 Dec 09.
- c. United States Army Vice Chief of Staff, Army Health Promotion, Risk Reduction and Suicide Prevention Report, 9 Aug 10.
- d. Army Regulation 600-63, Army Health Promotion, 7 May 2007; Rapid Action Revision 7 Sep 10.
- e. FORSCOM Memorandum: United States Army Forces Command Soldier Risk Policy and Tool (FSRPT), 19 Nov 10.
- f. United States Army Vice Chief of Staff, 2020 Generating Health and Discipline in the Force, 17 Jan 12.

2. In support of the Army Comprehensive Soldier Fitness (CSF) program, the Joint Readiness Training Center (JRTC) and Fort Polk has implemented Brigade/Battalion Resiliency Teams (BRT) and Brigade/Battalion Health Promotion Teams (BHPTs). The Army CSF program is designed to increase Soldier and Family fitness by developing strengths in the five domains of emotional, social, spiritual, physical, and Family resiliency. Issues identified in any of the domains directly impact comprehensive fitness and readiness. Each brigade or battalion (as applicable) will standardize its practices and reporting methods based on guidance within this policy letter. The BRTs will provide CSF related data and information to the Community Health Promotion Council (CHPC) in order to facilitate CSF policy direction and resource allocation by the Commanding General.

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3. Mission of the BRT:

a. All Major Subordinate Commands (MSCs) will execute a BRT meeting on a monthly basis. The BRT will assist brigade, battalion, and company level commanders with efforts to improve readiness by facilitating increased resiliency in Soldiers, their Families, and collectively, the unit. BRTs will incorporate an integrated, holistic approach consistent with CSF, which encompasses physical, spiritual, mental, relational, emotional, and organizational resiliency; it will guide leaders and first line supervisors in their efforts to truly know their Soldiers, help identify those at increased risk to themselves or others, and direct Soldiers to appropriate resources in support of early intervention. These prevention efforts will emphasize wellness and increase readiness by reducing the risk of multiple problems leading to a crisis or tragic incident. The BRT will educate and empower leaders at all levels to proactively apply all available resources to mitigate, rather than merely react to stressors which might overwhelm Soldiers and their Families. In concert with the CHPC, the BRT will focus on effective, well-integrated use of installation resources and coordinated efforts between commanders, unit resources, and installation agencies to implement effective policy, training, and interventions.

b. The BRT will assist the command with early identification and surveillance of Soldiers considered at risk to themselves or others. This team will facilitate appropriate referrals and training in order to increase resiliency and readiness. The BRT core team members will meet monthly to discuss identified high risk and extremely high risk cases which may cross into various agencies' area of responsibility (e.g. medical, financial, marriage, and alcohol challenges) and to relay input from contributing and auxiliary BRT members, Soldiers, and Families. Meetings held for the purpose of discussing specific Soldier situations will be limited to core members only in order to protect the private information of individual Soldiers and Families. Auxiliary BRT members will be present during discussion of individuals only when the issue is managed/represented by the specific organization (e.g. if the Soldier has financial hardship, Army Community Service/Army Emergency Relief representative will be present during that Soldier discussion only).

c. The BRT will implement the Hero Assessment and Mitigation Plan (HAMP). The HAMP will allow commanders to have better visibility of their assigned personnel. The HAMP point of contact will provide each MSC commander with a weekly visibility report. This report will systematically provide personnel information to commanders on a newly assigned Soldier that may be at risk to themselves or others. The HAMP is a three

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phased system designed to capture any conditions or behaviors that may place a Soldier in a high or extremely high risk category. Commanders will provide the Commanding General and Health Promotion Officer (HPO) with a quarterly BRT update on high or extremely high risk Soldiers at each quarterly CHPC.

4. BRTs will consist of the following members:

a. Core Members at brigade or battalion level as appropriate:

- (1) MSC Commander and CSM
- (2) MSC Medical Officer (MEDO)
- (3) MSC Surgeon
- (4) MSC Behavioral Health Officer (BHO) or Behavioral Health Representative
- (5) MSC Staff Judge Advocate Representative
- (6) MSC Chaplain
- (7) Battalion/Company Commanders/CSMs/1SGs as indicated for specific issues/cases
- (8) Unit Master Resiliency Trainers (MRT)
- (9) MSC S1/S2/S3
- (10) MSC Safety Officer
- (11) Embedded Military Family Life Consultants (MFLC), as applicable
- (12) Family Readiness Support Assistants (FRSA)
- (13) MSC BOSS or EO Representative

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b. Auxiliary Members as required:

- (1) Family Life Chaplains
- (2) Army Community Services (ACS) Unit Service Coordinators (USCs)
- (3) Behavioral Health Department, USA MEDDAC SMEs
- (4) Army Substance Abuse Program (ASAP)
- (5) Risk Reduction Coordinator
- (6) Suicide Prevention Program Manager
- (7) Health Promotion Officer
- (8) Other members as identified

c. Team Member Responsibilities:

(1) The MSC Commander will chair the monthly BRT and will ensure the meeting is attended and supported by all relevant personnel.

(2) The MEDO will assist the MSC commander with BRT and CHPC preparation in regard to collecting metrics for reports and preparing slides.

(3) The MSC Surgeon or MEDO will be the primary proponent for physical resiliency to the BRT and will present the number of Soldiers currently not deployable because of a medical concern and ensure that other measures of physical resiliency (overall PT scores for example) are available as appropriate or requested.

(4) The MSC BHO or BH representative will be the primary proponent for emotional resiliency to the BRT. The BHO will collect input from the MFLC, the chaplain, behavioral health no shows, and blotter trends when evaluating the emotional resiliency of the MSC. The BHO will advise commanders and certify that appropriate measures are taken in order to ensure Soldiers receive the care they need in a supportive Command environment.

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(5) The MSC SJA representative will monitor blotter reports and use legal process data to assist in identifying high risk areas. The SJA will advise commanders to ensure that appropriate measures are taken in order to maintain good order and discipline within the MSC.

(6) The MSC Chaplain will be the primary proponent for spiritual resiliency to the BRT. He/she will report on marriage and relationship enhancement and aid the Suicide Prevention Program Manager with the facilitation ACE/ASIST training.

(7) The Master Resiliency Trainer (MRT) will maintain primary responsibility for the coordination and execution of CSF training.

(8) The MSC S1 will provide unit population information including demographics and be ready to report the status of any administrative actions.

(9) The MSC S2 will provide data on security trends, security clearance holds/denials, and seasonal information.

(10) The MSC S3 will provide unit training requirements data, compliance percentages with assigned training from higher, due outs, and utilized in order to execute any OPORDs or FRAGOs approved by the command.

(11) The MSC Safety OIC/NCOIC will provide reports on traffic accidents, Army Ground Accident Report (AGAR), duty-related injuries and any other aspects of physical safety.

(12) The MSC MFLC provides input on both emotional and Family resiliency to the BRTs. MFLCs contribute an independent perspective and can be utilized to develop and implement new programs for Soldiers and their Family members.

(13) The MSC FRSA will be the primary proponent of Family resiliency to the BRT and will provide feedback to the command regarding this dimension of Soldier fitness.

(14) The MSC BOSS and/or EO representative will be a proponent of social resiliency to the BRT and will provide feedback to the command regarding this dimension of Soldier fitness. Additional metrics that can be reported include reenlistment rates and command climate surveys.

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(15) The MSC Unit Prevention Leader (UPL) will provide the BRT with trends of alcohol and substance use. He/she will also report on unit training requirements to ensure all military personnel are provided prevention education training. The unit level UPLs can design, develop, and administer target group-oriented alcohol and other drug prevention education and training programs.

(16) The Suicide Prevention Program Manager will serve as a subject matter expert in suicide awareness and prevention programming. She/he will also be the POC for the installation Suicide Prevention Action Plan.

(17) The HPO will serve as a process consultant of the BRT. The HPO will facilitate synchronization of programs and initiatives between garrison and medical agencies.

5. The MSC Commander (BRT Chairman) will ensure that brigade/battalion leaders are educated about the mission and purpose of the BRT. Performance metrics collected and assessed by the BRTs will help identify health concerns, detect opportunities to build resilience and measure the performance of resources. These metrics include but are not limited to Army Physical Fitness Test results, Serious Incident Reports, drug offenses, behavioral health follow ups, domestic violence incidents, master resilience training, and alcohol and substance abuse program referral and completion rates.

6. Per FORSCOM policy, all Soldiers must be assessed using the FORSCOM Soldier Risk Policy and Tool (FSPRT) within 30 days of arriving on installation.

a. Soldiers who are identified by leadership, co-workers, or Family members as high or extremely high risk must be referred to the BRT for review and assistance as appropriate.

b. Commanders must take a holistic view of their Soldiers in determining the level of individual risk. Historical behaviors as well as current financial, relationship, disciplinary, family, physical, or professional behavior should be evaluated to identify Soldiers that may be in the high or extremely high risk category.

c. High and extremely high risk behaviors are defined as behaviors resulting in a serious outcome that can lead to an intervention by leadership, law enforcement, and/or

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d. It is a battalion or higher level commander's responsibility to assess the Soldier based on his/her knowledge of actions and activities to determine if the Soldier should be placed into a higher risk category. Soldiers will be reassessed using the FSRPT every six months. Unscheduled reassessment is warranted if there has been an incident or a behavior that may result in a change in individual risk status.

7. The point of contact for this policy is Ms. Lisa M. Martinez, Fort Polk Health Promotion Officer, at 337-718-2254 or lisa.m.martinez2@us.army.mil.



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