



RESERVE AFFAIRS

Reserve Component Suicide Postvention Plan: A Toolkit for Commanders



Command Suicide Response Quick Reference Checklist

- ✓ Contact military or local law enforcement/Security Forces, and 911 (situation dependent).
- ✓ Notify Chain of Command. Initiate Operational Reporting (OPREP) messages.
- ✓ Notify on-call Response Team to prepare for possible postvention.
- ✓ Validate with legal and criminal investigator who has jurisdiction over the scene and medical investigation. Normally, local medical examiners/coroners have medical incident authority in these cases, but some locations may vary.
- ✓ Contact Casualty Affairs to notify/assist Next of Kin (NOK) and receive their briefing.
- ✓ Consult with on-call Response Team to prepare announcement to unit.
- ✓ Make initial announcement to unit at next drill with a balance of “need to know” and rumor control. Involve Behavioral Health provider or Chaplain to support potentially distraught personnel. Avoid announcing specific details of the suicide. Do not mention the method used. Do not announce specific location, who found the body, whether or not a note was left, or why the member may have killed himself.
- ✓ Avoid memorializing/idolizing the deceased’s death or conveying the suicide is different from any other death to protect from “copycat” suicides.
- ✓ Consult with Public Affairs regarding public statements about the suicide and refer to the Public Affairs Guidance (PAG) for Suicide Prevention. When engaging in public discussions of the suicide:
 - Express sadness at the military’s loss and acknowledge the grief of the survivors;
 - Emphasize the unnecessary nature of suicide since assistance is available;
 - Express concern that the member did not recognize that help was available;
 - Ensure the audience knows you and the unit want personnel to seek assistance when distressed, including those who are currently affected;
 - Encourage fellow unit members to be attuned to those who may be grieving or having a difficult time following the suicide, especially those close to the deceased; and
 - Provide a brief reminder of the warning signs of suicide and gatekeeper protocols.
- ✓ Follow up with an e-mail to the community affected. Restate the themes noted above.
- ✓ Consider increasing the senior leadership presence during drill immediately following the announcement of death. Engage informally with personnel, communicate a message of support and provide information.
- ✓ Consult with the Chaplain regarding the Memorial service. This is an important opportunity to foster resilience by helping survivors understand and heal. A Memorial service has the potential to either increase or decrease the suicide risk for others. It is important to have an appropriate balance between recognizing the member’s military service and expressing disappointment about the way they died. Focus on survivors. Express disappointment in the deceased’s decision and promote help-seeking and the concept of looking out for each other.

Message from Reserve Affairs

When suicide happens everyone is affected. It touches other members of our units, our families, and us. Therefore, we must not only proactively conduct effective communication and intercept programs, but be prepared to appropriately respond to each tragedy as they occur. Suicide often leaves many questions in its wake, and as leaders, we are responsible for comforting survivors, assisting families, maintaining unit readiness and setting the response tone.



Additionally, myths and facts abound. The purpose of this tool kit is to help unit leadership respond. It provides insight and guidance for supporting your unit, dealing with families, and connecting with the community at large. Risk factors as well as potential survivor reactions are clearly outlined. Government benefits are discussed, so you can answer family questions that may arise. There is information on organizing a response team and a memorial service. A resource guide gives you extra options for assistance.

It is my hope that this Tool Kit will make you feel more prepared and confident to deal with those members of your unit who may die by suicide and with their families. The postvention plan also includes information on prevention, so that we can drive down the number of our troops we lose to suicide in the future.

I strongly urge you to review this document and keep it ready in the event you should be called upon to respond to a suicide. Remember that postvention is prevention.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. McGinnis', with a large, sweeping flourish underneath.

David L. McGinnis
Acting Assistant Secretary of Defense, Reserve Affairs

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Introduction

The purpose of this document is to give Reserve Component Commanders and other leaders a toolkit to develop a postvention plan after a unit member's suicide. Postvention refers to response activities that should be undertaken in the immediate aftermath of a suicide that has impacted the unit. Postvention has two purposes: to help survivors cope with their grief and to prevent additional suicides. It also may be an opportunity to disseminate accurate information about suicide, encourage help-seeking behavior and provide messages of resilience, hope and healing. There are also unit advantages in that postvention is geared towards facilitating unit cohesion, maintaining mission readiness and restoring unit effectiveness in the wake of a tragic event. Postvention activities may last a few days to several months, depending upon the needs of the unit or the span of a criminal investigation into the death. The toolkit also outlines particular roles and responsibilities.

Background

According to the World Health Organization (WHO), suicide is one of the leading causes of death worldwide and is a significant public health problem. Among those aged 15 to 44 years, self-inflicted injuries are the fourth leading cause of death and the sixth leading cause of ill-health and disability throughout the world (WHO, 2002). Each year, suicide results in more than 1.6 million deaths internationally, with more than 90 percent occurring in low and middle income countries (CDC, 2010). In the United States, suicide has been the 11th leading cause of death overall. It is the third cause of death among Americans 15 to 24 years of age, fourth among persons 25 to 44 and eighth among those persons 45 to 64 years of age. The suicide rate among the military has historically been lower than in the civilian population. According to RAND, the "suicide rate in the synthetic civilian population is both fairly constant and substantially higher than that in DoD. Of concern, however, is that the gap between DoD and the general population is closing. The most pronounced increases in the DoD suicide rate occurred between 2007 and 2008, so assuming that the national rate remains relatively stable in these years, the gap between the rate in DoD and the general population may be even narrower" (Ramchand, 2011). This has triggered major concern across the Services and the Department of Defense (DoD) to prevent and respond to suicide.

Since there are geographic trends for suicide, unit commanders should be aware of the civilian population trends in their area and how that might impact unit members. Over the last few years for which data are available, the top five states with the highest average suicide rates within the general population have been Montana, Nevada, Alaska, New Mexico, and Wyoming. The four states/territories with the lowest suicide rates have been Washington DC, New Jersey, New York, and Massachusetts, with Rhode Island, Connecticut, and Illinois sharing fifth place on the list. However, when comparing those numbers to those of the Army National Guard, the highest

suicide rates were from Minnesota, Oregon, Indiana, Ohio, and California. The lowest were Puerto Rico, New Hampshire, Wyoming, Rhode Island, and New Mexico. No suicides were reported in DC, Delaware, New Jersey, Nevada, and the Virgin Islands (CDC, 2010).

Since 2001 and the advent of the Global War on Terror, the United States Armed Forces have experienced an ever-changing operational tempo that has surpassed that seen in the previous generation. An all-volunteer force has carried out an extremely intense, dangerous, and consuming mission. This mission has greatly increased military reliance on the Reserve Components (RC) who have deployed and engaged in assignments alongside the active duty. A decade later, the National Guard and Reserve service has been re-defined, but the understanding and ability to support these Service members and their families in their communities has varied widely from state to state and by component. DoD has not always had visibility on the issues faced by Guardsmen and Reservists as they join, deploy, re-deploy or transition from the military. The problems that many Americans face are felt throughout the RC and can be intensified by the demands of military service. So, conditions such as divorce, substance abuse, family violence, financial crisis, criminal/legal problems, unemployment, or illness are complicated by deployments, isolation, combat stress, and readjustment. In the worst case scenario, the confluence of these circumstances leads to suicide. Between 2007 and 2011, there was an increase in the number of suicides among members of the Army National Guard – including an almost doubling in suicides from 2009 to 2010. Although there was a decline for the National Guard in 2011, DoD still finished the year higher than the previous. Regardless of the rates or trends regarding suicide, DoD has learned that commands need the ability to activate a postvention response plan when a member of their unit has died by suicide.

In July 2010, Reserve Affairs (RA) conducted a gap analysis among the Services and found a need for more informed suicide postvention planning that took into consideration the unique needs and circumstances of the RC that differ from the active duty (Yellow Ribbon Suicide Prevention Task Force, 2010). Additionally in 2010, the Suicide Prevention and Risk Reduction Committee (SPARRC) established a Postvention Subcommittee to examine the need for consistent postvention policy. After it completed its review, the working group developed recommendations for standardize suicide postvention guidelines for all Services (SPARRC Postvention Subcommittee, 2011). The SPARRC subcommittee identified those who respond to a completed suicide and work with suicide survivors across DoD as including chaplains, law enforcement, first responders and casualty officers. However, commanders are expected to lead this response. Within National Guard and Reserve units, there are those too who must respond to a suicide, often without the same resources and support as those assigned to active duty

installations or fleets. Months may go by before a unit¹ is notified of a death, and commands are much more reliant on civilian authorities or dispersed families for information and support.

Furthermore, the Services have looked beyond the SPARRC recommendations and have embraced their own approaches to postvention to include the use of peer support, trauma response teams, and agreements with the Tragedy Assistance Program for Survivors (TAPS). Additionally, the Substance Abuse Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services (HHS) has funded several projects, including the Suicide Prevention Resource Center (SPRC), which produces information and toolkits. The Department of Veterans Affairs (VA) offers support through the Military Crisis Line (1-800-273-TALK, press 1 for military) and produces suicide prevention awareness materials. In the private sector, information is available from the American Foundation for Suicide Prevention and the American Association of Suicidology. The purpose of the following guidance is to adapt the SPARRC recommendation and other literature to encompass the needs of the RC, their families, and other survivors.

This guidance is divided into three functional levels—unit, family, and community—in order to outline the requirements and tasks to be considered in crafting a response plan. Since each suicide, as any death, is unique, the guidance should be seen as a toolkit to assist commanders in pre-planning for a crisis, organizing options for a suicide response, maintaining organizational stability and effectiveness, and having readily available referral resources to ensure that postvention is accomplished in a timely manner, demonstrates sensitivity to those affected, facilitates cohesion, and disseminates appropriate information about the particular suicide and about suicide in general.



Part 1: Unit Level

Having a unit level coordinated response plan is paramount to ensuring that the organization remains stable, individual members are able to voice their concerns without fear of stigma, and any suicide contagion² is controlled. A suicide should be treated as any other death in the unit.

¹ For the purposes of this document, the term “unit” is meant to be nondescript and can apply to any military component.

² As described by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, contagion is the process by which one suicide death may contribute to another.

However, sensitivity should also include awareness to not overly simplify or sensationalize the death. Unit leaders should avoid glamorizing the death or giving the event undue prominence. Avoid providing specific details about the suicide, such as the location and means used. Messaging to unit members should include identifying the emotional struggles or behavioral health challenges associated with suicide and the “snowball effect” of co-existing physical, emotional, psychological, spiritual and social conditions (components of Total Force Fitness) and complex circumstances, while protecting the privacy of the members and the family involved. All Service members should know how to access available support systems and professional referrals when dealing with the suicide of a fellow Service member. Commands should be familiar with and able to use their Service-specific suicide prevention materials or those made available from DoD. Military OneSource is the DoD failsafe, so rely on the 1-800-342-9647 line for assistance and referrals.

Remember that suicide is preventable and postvention is prevention. Talking appropriately about what happened and giving facts about suicide is critical to preventing it. Research shows that it is a myth that once someone has made up their minds to die by suicide, there is nothing you can do about it. Since ambivalence about life and death is a factor, giving someone with suicidal ideation the support they need to live is essential (NAMI, 2009). (See Resource Guide in Appendix A for additional sources of assistance.)

Risk and Protective Factors

DoD internal and external studies and reports have identified individual risk and protective factors that relate to suicidal behavior. A DoD Task Force noted that protective factors stem from physical, psychological, spiritual, family, social, financial, vocational, and emotional well-



being.³ The Institute of Medicine (IOM) specifically identified risk factors for PTSD that cause a schism in wellness to be associated with combat exposure, military sexual assault, homecoming environment, gender, and ethnicity.⁴ Since PTSD is highly associated with suicidal thoughts and/or behaviors, individuals who have potential for both conditions should be identified.

The tables beginning on page 5 identify negative and positive factors that can affect an individual’s and organization’s ability to foster resistance, build resilience, and maintain readiness. These factors should assist with awareness and help commands develop programs and tailor their response plans for the unit and individuals that

³ DoD. *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives*. August 2010.

⁴ Institute of Medicine. *Posttraumatic Stress Disorder: Diagnosis and Assessment*. National Academies Press, Washington, DC, 2006. p. 59.

might be at risk. Commands should remember to incorporate the Total Force Fitness Model into their postvention response in order to encourage resilience and recovery.

INDIVIDUAL FACTORS

Risk Factors

“Dear John” letter/call, divorce, other relationship problems with family or at work
Criminal charges (civilian or military) or other legal problems
Depression, PTSD, TBI, grief
Anger, rage, violence or impulsivity
Guilt, shame, or stigma associated with behavioral health problems, won’t seek help
Physical injury/illness; chronic pain
Deployment & trauma exposure (combat, killing, sexual assault, disaster, etc)
Cumulative stressors or competing stresses between unit & family
History of substance abuse, workaholic, gambling
Drunk driving or driving too fast
Disillusionment with career or leadership, sudden change in work performance, loss of pleasure in things previously loved, irritability, isolation
Unsuccessful transition or deactivation: Civilian unemployment/under-employed, education barriers, homeless
Genetics, family history of suicide/previous attempts or ideations
Financial stresses & history of poverty
Childhood history of abuse or molestation
Inattentiveness to health & hygiene
Male, Caucasian, lower rank, younger age
Hopeless/foreshortened sense of future
Previous behavioral health treatment & prescription medication usage
Weapon availability or access to lethal means
Self-harm/mutilation, cutting history (i.e., noticeable razor marks or burns on skin)

Protective Factors/Resilience/Readiness

Supportive command and leadership
Unit cohesion
Family and friends – peer support
Member of a veterans or civic organization
Spirituality, faith, forgiveness, positive sense of values, beliefs and ethics,
Sense of purpose & meaning in life
Participation in relaxation, hobbies, recreation, yoga or sports
Anonymous 12-step program participation
Taking leave or vacation time
Problem-solving & goal-oriented skills
Resilience program education and training
Psycho-education (i.e., smoking cessation classes) or behavioral health treatment
Transition plan completed prior to leaving the military (i.e., Yellow Ribbon, TAP)

Clear procedures for self/peer/family suicidal intervention
Exercise regularly
Proper nutrition and meals
Sleeping regularly and soundly
Rank attainment & longer period of military service
Adaptability, flexibility, hopeful for future
Self-esteem, positive personality, intelligence, sense of humor
Work-life balance
Total Force Fitness awareness

In addition to the risk and protective factors that occur on an individual level, there are also those institutional elements that can be seen across organizations and contribute to the unit environment. These factors are outlined in the two tables below.

ORGANIZATIONAL FACTORS

Risk Factors

Decline in leadership
Lack of disciplinary or corrective actions for infractions or criminal activity
Frequency of rotations leads to inability to know troops and identify individual risks
Media connectivity to home while deployed can have +/- depending upon home front situation
Lack of accountability
Ineffective recruiting practices and waivers
Ground combat & increased operational tempo
Poor unit morale
Lack of centralized data/no investigatory repository
Not uniformly drug testing
Institutional racism/sexism and not investigating hate crimes
Tolerating high-risk behavior in the ranks
Unit isolation from a support community
Lack of resources or awareness of how to access them
Insufficient access to behavioral health support from DoD, VA or community
Reduced dwell time and ability to reset
Tolerating hazing and bullying; not sufficiently enforcing or training on policies
Leadership who talks about attempts, suicides, or behavioral health in a derogatory way

Protective Factors/Resilience/Readiness

Standard regulations & uniformity with Uniform Code of Military Justice (UCMJ)
Experienced & trained Commanders & Senior NCOs
Employer Support of the Guard and Reserve (ESGR) program
Yellow Ribbon Reintegration Program (YRRP) or Navy Returning Warrior Workshop support and encouraged participation with command presence.
Use of surveillance tools (drug testing)
Ensure families or friends are supported and have a crisis number to call

Community support programs & financial support, grants, loans, etc.
Veteran Treatment Court awareness and participation in advisory councils
Sufficient military support program staff and resources
Appropriate dwell time between deployments or use of shift work
Research availability to program managers
Shared best practices among providers and leaders
Communication between the ranks
Composite view of troops & situation
Unit cohesion, good morale & readiness
Adherence to military values & ethos
Sense of fairness across the force
Good order & discipline
Holistic view of warrior & family and support for Total Force Fitness compliance
Synchronized unit and individual readiness (including family)
Embedded behavioral health providers and Directors of Psychological Health
Return Service members back to original duty following behavioral health help; have a plan for removing and returning weapons

Potential Survivor Reactions to Suicide (Baugher & Jordan, 2009)

Most unit members will not experience complicated grief and will be fine in the long term. However, in dealing with survivors, whether fellow unit members, family, or community colleagues, it is important to understand the spectrum of reactions that might be demonstrated or underlying behavior, which may be related to the nature of the relationship between surviving unit members and the deceased (for example, unit members also may be related, neighbors, co-workers, or part of the same church, lodge or other community group) or other life circumstances survivors were also dealing with at the time of the suicide. Depending upon these factors there are some identifiable reactions to suicide that may include:

- Shock, disbelief and feeling overwhelmed by the circumstances
- Stigma associated with suicide, which can lead to embarrassment and shame. This may alienate family, friends, and fellow unit members from their traditional support systems, such as their civic or faith-based community
- Difficulty concentrating or remembering, which can lead to impaired judgment
- Denial about the true nature of the circumstances; blame others. May even refuse to believe it was a suicide
- Grief, depression and loss
- Fear and mistrust
- Helplessness, hopeless, challenges to faith
- Anger at the person over the suicide
- Guilt or a sense of responsibility, the “if-only” questions, guilt that comes with a sense of relief after a long struggle

- Rejection or abandonment issues
- Driven by a need for more information on the events leading to the suicide and the criminal investigation afterwards
- Physical reactions – loss of appetite, difficulty falling or staying asleep (nightmares), fatigue, restlessness, stomach problems, headaches, chest pains, loss of interest in previously pleasurable activities
- Unit members and families may exhibit anger, blame and resentment toward one another
- Suicidal thoughts of their own (Note: If you become aware of someone in your family or another unit member expressing thoughts of suicide, you must provide immediate care.)

Survivor Stages of Grief after a Suicide (Jackson, 2004)

Survivor reactions may be seen in stages and will change as a funeral and/or memorial are completed, a criminal investigation closes, anniversary dates come and go, and the unit composition changes. However, there are no set boundaries for these responses and a survivor may move back and forth between stages or may not experience the full range of reactions.

Suicide is a tragic and shocking event, no matter the circumstances leading up to it. Family members, friends, and peers of those who die by suicide will react differently depending on various factors. Many survivors have an initial response of shock and may seem “out of it” or



detached from the situation. Some will immediately ask questions about the circumstances of the death, in an attempt to integrate this information. In the coming days, weeks, and months, survivors may struggle with a complex set of emotions that may change moment to moment. The survivor’s stages of grief may occur all at once, separately, or sequentially.

Survivors should be reassured that whatever they are feeling is ok, there is no right or wrong way to grieve, and that what they are experiencing is normal for someone who has been exposed to such a trauma. The command should then reassure the survivors that they are not alone, that there is help available for them, and that the command will make sure that survivors are connected with the appropriate resources, such as TAPS.

The postvention plan initiated by commanders can assist survivors’ transition from stage to stage in a healthy manner and can reduce the complications of grief that can lead to blaming, acting-out behavior, unit cohesion disintegration, and suicide contagion. While most unit members will not experience complicated grief after a suicide and will adjust appropriately, a select few may need to be monitored in the short term, which can be seen in the following stages immediately after a suicide and can last a few months. Unit members who are identified as having severe grief or acute stress reactions may need to be referred to behavioral health experts. Commands may

also want to be mindful of anniversary dates that may stir up memories and reactions a year or so after a tragic event.

The stages to monitor for are as follows:

1. Shock – It is common to feel dazed in the wake of any tragedy. Suicide usually comes as unanticipated news to survivors. Emotional numbness allows survivors to “wrap their minds around” the death. Unit members most touched by the tragedy may appear disengaged or distracted for a few weeks. Shock can be accompanied by a physical state of physiological collapse, marked by a weak pulse, coldness, sweating, and irregular breathing. Medical care may be needed depending upon the intensity of this state.
2. Denial – Hand in hand with shock is the inability to fully grasp the situation and how it could have happened. Rationalizations and alternate explanations to the suicide prevail. “Government cover up” conspiracy theories may surface, so transparency and facts are key response elements.
3. Guilt/Blame – Survivors blame themselves or try to assign responsibility to military leaders who they believe were neglectful for things that they should have known, but did not or could not have foreseen. Regret predominates this stage, which can turn into anger. Guilt is sometimes generated by a sense of relief if the person had been suffering or acting out, or was creating problems and hardships for others.

Figure 1: Stages of Grief Some May Face Following Another's Suicide



Regardless of the source of

the guilt, attempts should be made to assuage it. No one can predict a suicide and there is no “if only” crystal ball for what could have been done differently.

4. Sadness – As acceptance takes hold, so does the basic sense of loss that accompanies a death. Sadness unresolved can turn into clinical depression. Special occasions and anniversary dates may trigger memories that generate sadness. Recognize those times and encourage life-affirming events/activities.
5. Anger - Feeling abandoned or betrayed by the person who took their own life is a common reaction among survivors. Furthermore, it is common to see anger between family members or unit friends for “not seeing it,” “not doing anything about it” or “causing it.” There may be anger directed towards the military in general, the unit, or the command by family or fellow Service members who need a scapegoat.
6. Acceptance – Although a suicide is tragic, survivors enter a stage where they can move on with their lives and find joy and fulfillment in relationships, work, and other activities again. Acceptance is derived from the realization that no one is to blame, there is nothing

that could have been done differently, events are beyond control, and the person lost made a regrettable choice based on their own pain, but it was ultimately their choice. Life is changed, but it does go on. This does not mean a family or unit members have “gotten over it,” but they have figured out how to “live with it.” Commands should use their Reserve Component Suicide Response Team (RCSRT) members (as described on page 12) to assist in venting and validating unit members’ emotional reactions and responses to the death.

Total Force Fitness

Postvention and prevention go hand in hand. The Total Force Fitness framework developed by the Office of the Joint Chiefs of Staff is a “methodology for understanding, assessing and maintaining Service members’ well-being and sustaining their ability to carry out missions.” (CJCSI 3405.01, 2011)

Total Force Fitness comprises eight domains, as illustrated at right. The domains—Physical, Environmental, Medical/Dental, Nutritional, Spiritual, Psychological, Behavioral and Social—are meant to instill resilience, hardiness, and wellness in our troops in an environment of repetitive deployments and combat operations. Although research has not been conducted on this framework and suicide



postvention, these domains are a means for instilling and monitoring the general well-being of the unit and identifying anyone who might be susceptible to suicide contagion.

A unit that has conducted on-going Total Force Fitness training and maintained such an environment well in advance of a crisis will help mitigate the negative impacts and enhance individual, family and organizational coping and recovery. This perspective should help commands be mindful of factors to monitor after a unit experiences a tragic loss.

The Total Force Fitness chart should help leaders know when to intervene, seek creative ideas and possibilities, and create an environment that supports behaviors needed to achieve individual healthy lifestyles, optimize safety, and create positive working conditions that support and maintain unit readiness. Total Force Fitness can be viewed along with the protective factors outlined previously. Resilience is the overall long-term goal for every unit member who may have been impacted by a tragedy, such as the suicide by a buddy. Most unit members will bounce back after the initial shock and sadness of a fellow unit member's death because their protective factors are strong and their unit environment encourages it.

“Resilience is the overall long-term goal for every unit member who may have been impacted by a tragedy, such as the suicide by a buddy.”

Command Consideration

Since members of the National Guard and Reserves are not usually in daily contact with their commands, the death of a member may not come to the attention of the unit until well after the fact. Therefore, commanders may not immediately have information about a member's death, but should make attempts to confirm as much about the death as possible to avoid speculation and rumors among the troops. In many cases involving suicide, a law enforcement investigation will be on-going. Commanders can obtain information from next of kin, investigators or medical examiners. A communication plan should be developed in consultation with the family to be sure what information can or cannot be disclosed to the unit. If there is an investigation underway, law enforcement should also be involved in deciding what to discuss with other unit members. However, commanders will need to provide as much information and remain as transparent as possible to keep unit members who were close to the deceased feeling informed and involved. Otherwise, anger, mistrust and frustration complicate the natural grieving process that co-workers and peers will experience. It is a tough balance between transparency and not disclosing where and by what means the individual died. Commanders may want to consider prefacing comments by acknowledging that there are a lot of questions and for various reasons, including those concerning privacy, some information that fellow unit members might see as key will not be released.

Five Steps to Suicide Assessment, Evaluation, and Triage Postvention

1. Identify Risk Factors - Use the risk factor list provided earlier to identify unit members who might be at risk for self-directed violence.
2. Identify Protective Factors – Use the community resources available to the unit and match them to the member's needs. See the Resource Guide in Appendix A.
3. Conduct Suicide Inquiry - Do not be afraid to ask *any* fellow unit member questions about suicidal thoughts or plans.

People Who Care, Ask:

- ✓ *Do you feel as if you could harm yourself?*
 - ✓ *How often are you having those kinds of thoughts?*
 - ✓ *Do you have a plan to harm yourself?*
 - ✓ *Do you have access to lethal means? If so, how can we secure those items?*
 - ✓ *Have you made any preparations to carry out your plan?*
 - ✓ *Have you made any previous attempts to harm yourself?*
 - ✓ *What can you do to protect yourself? How can I help?*
4. Determine Risk Level - If imminent risk is identified, call 911. If risk is contemplative, refer to the Military Crisis Line at 1-800-273-TALK (press 1 for military). If risk is identified in person, escort to medical care. Involve RCSRT members or chaplains to assist in getting the Service member to medical care.
5. Document – Keep track of all conversations with a member who expresses any indication that they could harm themselves or are experiencing unique or intense stressors. Know their safety plan and discuss the removal of weapons or other harmful means as a precaution. Follow up on referrals.

Reserve Component Suicide Response Team (RCSRT)

The role of the RCSRT is to support and advise the commander. The RCSRT can be a member of the Traumatic Event Management (TEM)⁵ who is specifically trained to respond to any tragedy. This model follows the response teams that the Services have that are installation-based for the active duty, which are described by RAND (Ramchand, 2011). Incidents include combat, disasters, or the sudden death of a unit member, as would be the case with a suicide. Response teams are usually comprised of about 5 to 10 members (a social worker, psychologist, chaplain, senior NCO, etc.) who implement the response effort following a completed suicide, depending upon the branch of service and command structure. The team lead is responsible for coordinating the response during the crisis under the leadership of the commander (AFSP & SPRC, 2011). The team should be trained in Psychological First Aid (PFA) basic core competencies (Everly, 2011) that include:

⁵ TEM is the term utilized by the U.S. Army referencing interventions and support activities in response to potentially traumatizing events (PTE) that occur individually or organizationally. It is a flexible set of interventions specifically focused on stress management for units and individual Soldiers. TEM is one of the nine functional areas of Combat and Operational Stress Control. The goal of TEM is to enhance Posttraumatic Growth (PTG), which describes an adaptive process resulting from exposure to PTEs that include improved relationships, renewed hope for life, an improved appreciation of life, an enhanced sense of personal strength, and spiritual development. <http://www.behavioralhealth.army.mil/provider/traumatic.html>

- Stabilization – Capable of using an intervention technique that de-escalates reactions, discourages unit member impulsivity and instills calm.
- Assessment – Able to determine the psychological and behavioral health status of unit members and the need for intervention.
- Empathic Communications – Possesses skills that entail respect, compassion, and concern for all people regardless of military affiliation, gender, race, creed, or color.
- Acute Interventions – Designed to mitigate acute distress and foster hope.
- Triage – Understand criteria for determining the need for referral to on-going care.
- Facilitation – Network with a care continuum for referral and advocacy purposes to military, TRICARE, VA, or community-based supportive services.
- Self Care – Ensure RCSRT responders are practicing their own stress management and have a forum to process the event.

PFA is a generic template that requires teams to be trained and prepared to respond to a crisis, such as in the case of a unit member’s death. PFA management constitutes a framework that incorporates elements of a traumatic event – in this case a suicide – and its psychological aspects and analyzes and coordinates “an integrated multi-component continuum of ... intervention services.” (Everly, 2011) This team should also be able to assess the risks for suicide contagion among individual unit members and make recommendation or referrals for additional professional interventions or experts. Activities could include offering response guidance to unit commanders, networking with Casualty Assistance Calls Officers (CACO) on behalf of the family, defusing or de-briefings, providing emotional support, and offering referrals to community resources for unit members.



In addition to an organized RCSRT response, there are other resources and tools available from the Services that foster resilience in the wake of a tragedy and assist in preventing additional suicidal behavior.

Reliance on the Total Force Fitness framework and ensuring those goals are being met by unit members is a way to foster healthy habits and reduces risky behavior and suicide contagion.

Each of the Services, which incorporate the RC, has a different response path:

Army - For Army-specific guidance on suicide prevention and its materials, the Shoulder-to-Shoulder program; Home Front; Ask, Care, Escort (ACE); and other videos and information, see resources at www.preventsuicide.army.mil.

Navy - Navy Reserve Psychological Health Outreach Program (PHOP) and Returning Warrior Workshops (RWW) provide postvention support and resources for suicide prevention. Materials

for sailors include Combat and Operational Stress Control First Aid (COSCFCA) and Ask, Care, Treat (ACT), which can be found at www.suicide.navy.mil.

Air Force - The Wingman Project is the suicide prevention program designed to assist Airmen through outreach, media and training opportunities. Materials are available at www.afrc.wingmantoolkit.org.

The Airman's Guide for Assisting Personnel in Distress Guide is also available at: <http://bit.ly/ISWHSO>

Air National Guard – The Wingman Project is also a tool used for the Air Guard population www.wingmanproject.org.

Marine Corps - Never Leave a Marine Behind focuses on changing behavior related to suicide. Materials can be found at www.usmc-mccs.org/suicideprevent/index.cfm?sid=ml. The Marine Corps DSTRESS Line provides 24/7, anonymous phone and chat counseling with a “By Marine-For-Marine” approach. The call center is staffed with veteran Marines, former Fleet Marine Force (FMF) Corpsmen and licensed clinicians with specific training in Marine Corps culture. The target audience is Marines, attached sailors, and families. The DSTRESS Line expanded Corps-wide on 23 March 2012. For assistance call 1-877-476-7734.

Coast Guard – The Office of Work-Life programs handles suicide prevention. Information, instructions, and resources are available at www.uscg.mil/hr/cg111/suicide_prevention.asp.

DoD/VA – Additional information on suicide prevention and resources for military and veterans can be accessed at www.suicideoutreach.org. It also has the links for all of the Service-specific programs plus VA information.

DoD Suicide Event Report (DoDSER)

Since 2008, the DoDSER (National Center for Telehealth and Technology (T2), 2011) has been a collaborative effort within the Defense Department. It standardizes suicide surveillance across the Services with the ultimate goal of suicide prevention. The DoDSER includes activated National Guard and Reserve members. In addition, the Armed Forces Medical Examiner System (AFMES) compiles suicide data from rosters provided by the Services' Suicide Prevention Program Managers on inactive Guard and Reserve members. The Services first began collecting data on inactive RC suicides in 2009.

When a death is ruled a suicide by the AFMES a designated professional, usually a Behavioral Health Officer from the Service, conducts a psychological autopsy by reviewing the records, conducts interviews with commanders, unit members, families, and other community contacts as appropriate, and responds to questions via a secured web-based application (<https://dodser.t2.health.mil>).

On January 1, 2010, the Services began to collect additional information on suicide attempts, with some of the Services collecting information on non-fatal self-harm (risk-taking behaviors) and suicidal ideation. DoD requires DoDSERs be completed within 15 working days of an incident for all deaths for which suicide has not been ruled out as the cause.

Part 2: Family Level

Incorporating the family and demonstrating respect for their wishes (within reason) is vital to the health of the unit since many Guardsmen and Reservists are in units with other family members, neighbors and friends, or co-workers from their civilian employment, which the active duty might not experience since they are more removed from their families of origin or hometowns. Therefore, the impressions and perspectives of the family will influence how members of the unit feel about the response and postvention performed by their commands.

Criminal Investigation

A primary concern for family and possibly fellow unit members immediately after the death will be the investigation that will take place. An investigation will be conducted by civilian or military law enforcement authorities, including medical examiners or coroners, depending upon the circumstances and location of a death (on or off a military installation). Unnatural deaths are investigated to ensure that they are not homicides, which can be staged to look like suicides. Investigations will include searching for evidence of additional criminal activity, such as illegal drug trade, robbery, or rape. The police may want to speak with family or unit members during the investigation, so they will need to be prepared for this interview. Investigations can last days or weeks. Police may hold personal property as evidence, but family members and friends have a right to know where those possessions are being stored and how to retrieve them once the investigation has concluded (Baugher & Jordan, 2009). Sensitivity toward the family or other unit members who may be questioned can reduce emotional distress and facilitate the investigation. If there are military-related issues or a military weapon involved, commanders should ensure proper cooperation and seek Uniform Code of Military Justice (UCMJ) advice.

“Maintaining a connection with the family throughout the investigation and offering to look at the investigation materials with them can provide comfort to the family and the other unit members involved.”

Family members can wait up to a year to receive the contents of the investigation. Families can become anxious while waiting for the results. They may look to the unit for information and support during this time. Regular communication regarding the status of the investigation will decrease anxiety among the survivors. Families may also receive the results of the investigation and/or personal belongings without notice. Maintaining a connection with the family throughout the investigation and offering to look at the investigation materials with them can provide

comfort to the family and the other unit members involved. It allows the family to know that the unit continues to care for the family and allows Service members to do something for the family of the deceased. This can offer healing and closure for both.

Casualty Affairs Officers (CAOs)

Each branch of the Service has its own representatives who handle casualty and memorial affairs for families of those who have died during active military service. Titles may vary, but the functions remain about the same. The CAO should be trained to professionally deal with families experiencing deep grief, recognize vulnerabilities, and set boundaries between assisting families and maintaining military decorum and avoiding personal relationships. Although a traditional CAO might not be assigned to inactive Guard or Reserve NOK, there is still a SGLI (as described below) beneficiary so someone must work with the family on this and also collect government property, stop any pay, and provide any veteran burial benefits if due. They will assist in ascertaining and obtaining the appropriate survivor benefits from DoD, VA, and/or Social Security and ensuring that each family's unique needs are met. They can handle such issues as changes to the Defense Enrollment Eligibility Reporting System (DEERS), Survivor Benefit Plan (SBP) payments and other services. CAOs can disseminate available resources to families and should have copies of the DoD Guide for Financial Decision-making, which can assist the RC-identified next of kin with preparation and submission of claims for benefits.

As described in this section, the CAO can answer questions related to programs offering: DoD Survivor Benefits; Veteran Death and Survivor Benefits; and Other Federal Benefits and Services.

DoD Survivor Benefits

Service Members Group Life Insurance (SGLI)

SGLI is a program of low-cost group life insurance for Service members on active duty, ready reservists, members of the National Guard, members of the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service, cadets and midshipmen of the four service academies, and members of the Reserve Officer Training Corps. SGLI coverage is available in \$50,000 increments up to the maximum of \$400,000.



Reserve Component Survivor Benefit Plan (RC-SBP)

SBP is the DoD insurance program, which provides an annuity to the survivor upon the member's death. RC-SBP is designed to give retirement eligible RC members an opportunity to insure their families. RC members who have 20 years of creditable service for retired pay at age 60, or earlier if eligible, may elect RC-SBP coverage for their survivors if they die prior to receiving retired pay. Survivor annuities can be as much as 55 percent of the retired pay. Cost

and coverage varies. SBP payments are offset by Dependents Indemnity Compensation (DIC) paid by VA.

Death Gratuity

The Services provide a \$100,000 tax-exempt payment to the survivors or other individuals identified by the Service member prior to his or her death while on active duty, active duty for training, and inactive duty for training.

A Service member may designate one or more persons to receive all or a portion of the death gratuity payment. Any amount not designated by the member will be paid to the living survivors of the member in accordance with existing law and regulation.

Burial Benefits

DoD will care for, transport and inter the remains of the deceased Service member who died while serving on active duty. The surviving spouse, children and siblings of the decedent, and the parents of both the Service member and surviving spouse are authorized to receive travel entitlements. If the spouse, children or parents choose not to travel to the funeral, the Person Authorized to Direct Disposition of Human Remains and two close relatives may use this benefit.

Travel entitlements include round-trip transportation and two days per diem upon arrival at the interment site. It is advisable to delay making any travel plans until after speaking with your casualty assistance officer or mortuary officer. This will ensure that transportation and arrival times are coordinated for maximum support and that no unauthorized expenses are incurred with the expectation of reimbursement.

TRICARE Reserve Select (TRS)

Qualified RC members (and their families) who are in the Selected Reserve can enroll and receive comprehensive healthcare services under TRICARE Standard and Extra programs. There is a fee-based option that requires the member to pay monthly premiums. If a member is covered on the day of his/her death, eligible surviving family members may purchase or continue TRS coverage for an additional six months from the date of the member's death. DEERS will automatically convert covered TRS members to Survivor Coverage. If only the member is covered by TRS at the time of death, the family has 60 days to purchase Survivor Coverage and pay monthly premiums.

Survivor Outreach Services (SOS)

The Army operates several centers that connect families of all fallen Service members, Reservists and Guardsmen with support and services. Support coordinators, financial counselors and benefits coordinators who can provide expertise on local, state, and federal benefits are available. SOS Offices can be found at several posts. The SOS office works with CAOs to

maximize family support and enhance coping. Additional information can be found at www.Armyonesource.com.

Department of Veterans Affairs (VA) Veteran Death and Survivor Benefits

VA administers a variety of veterans' benefits and services that may also be applicable to those who die while activated and their survivors. Additionally, many National Guard or Reservists may also be veterans based on previous periods of activation and deployment. Survivors may be entitled to a variety of VA supportive services and benefits. Entitlements and eligibility will vary depending upon the service history of the member and the status of the family member(s). Survivors should be encouraged to contact VA at www.va.gov for additional information and to locate the nearest VA facilities. Military Casualty Affairs Officers should be able to assist in making this connection for the Next of Kin (NOK). VA benefits are not paid automatically upon the death of the Service member and a claim must be adjudicated by a VA representative, so all VA benefits require application.



VA has special considerations it must apply when a death has occurred by suicide. It does consider factors for service connection⁶ for mental unsoundness in suicide. In order for suicide to constitute willful misconduct, the act of self-destruction must be intentional. A person of unsound mind is incapable of forming intent, which is an essential element of crime or willful misconduct. VA requires that in order for benefits to be awarded the precipitating mental unsoundness must be service connected.

Whether a person at the time of suicide was so unsound mentally that he or she did not realize the consequence of such an act, or was unable to resist such impulse, is a question to be

“Where no reasonable adequate motive for suicide is shown by evidence, the act will be considered to have resulted from behavioral unsoundness.”

determined in each individual case, based on all available lay and medical evidence pertaining to his or her mental condition at the time of the suicide. The act of suicide or a bona fide attempt is considered to be evidence of mental unsoundness. Therefore, where no reasonable adequate motive for suicide is shown by the evidence, the act will be considered to have resulted from behavioral unsoundness. A reasonable adequate motive for suicide may be established by affirmative evidence showing circumstances that could lead a rational person to self-destruction. Affirmative evidence is necessary to justify reversal of military findings of mental unsoundness where VA criteria do not otherwise warrant contrary findings. In all instances any reasonable doubt should be resolved favorably to support a finding of service connection.

⁶ VA adjudicates a condition to be “service connected” if there is a documented nexus between the condition and a period of active military service.

Veterans' Benefits

Burial and Memorial Benefits

VA operates the National Cemetery Administration (NCA), with additional information located at www.cem.va.gov. Burial benefits available through NCA for eligible individuals who performed active military duty and who qualified as veterans include: a gravesite in any of 131 national cemeteries with available space, opening and closing of the grave, perpetual care, a government headstone, medallions or marker, a burial flag, and a Presidential Memorial Certificate at no cost to the family. Some Service members may also be eligible for burial allowances. Cremated remains are buried or inurned in national cemeteries in the same manner and with the same honors as casketed remains. Burial benefits available for spouses and dependents buried in a national cemetery include burial with the veteran, perpetual care, and the spouse or dependent's name and date of birth and death inscribed on the veteran's headstone, at no cost to the family. Eligible spouses and dependents may be buried, even if they predecease the veteran.

Burial benefits available for Service members buried in a private cemetery include a government headstone or marker, a burial flag, and a Presidential Memorial Certificate, at no cost to the family. Some Service members may also be eligible for burial allowances. There are no benefits available for spouses or other dependents buried in private cemeteries.

VA does not make funeral arrangements or perform cremations. Families should make these arrangements with a funeral provider or cremation office directly. Any items or services obtained from a funeral home or cremation office will be at the families' expense.

Survivors' Benefits

Office of Survivors Assistance

This office is the primary advisor to VA on all matters related to policy, legislation, and other initiatives affecting survivors. The office can help survivors navigate the VA system, understand eligibility criteria, and find necessary resources.

Civilian Health and Medical Program of the VA (CHAMPVA)

Under CHAMPVA certain survivors can receive reimbursement for most medical expenses, such as outpatient care, hospitalization and pharmacy. Surviving spouses and children of those who died while on active duty or were in the line of duty at the time of their death are not eligible for CHAMPVA if they are already eligible for TRICARE. However, the National Guard and Reserve may have periods of inactive service or be part of the Individual Ready Reserve (IRR). For additional eligibility information, the CHAMPVA office can be contacted at 1-800-733-8387.

Vet Centers

VA Vet Centers offer bereavement counseling to all eligible spouses, children, parents and siblings of those who have died on active duty. This includes families of federally-activated members of the National Guard and Reserve. There are 300 Vet Centers nationwide, and an online locator at www.vetcenter.va.gov can assist with identifying a nearby location. Vet Center bereavement services for surviving family members of service members may be accessed by calling (202) 461-6530.

Dependents Indemnity Compensation (DIC)

Survivors are eligible if the Service member died from a disease or injury incurred or aggravated while on active duty, in the line of duty, or on inactive duty for training or a service-connected disability or condition directly related to a service-connected disability. There is a basic rate for DIC, which is augmented if there are dependent children. There is also an income-based DIC paid to parents of Service members who died on active duty. Benefit rates and allowable income levels will change annually. Survivors must apply for DIC so that VA can adjudicate these claims in order for benefits to be awarded. DIC is not automatically paid.

Death Pension

VA provides pensions to low-income surviving spouses and unmarried children of deceased veterans with wartime service. Families of Reserve Component members who had a previous period of active military service during wartime might be eligible.

Survivors' and Dependents' Educational Assistance Program

This program provides education and training opportunities to eligible spouses or children of Service members who have died on active duty or died of a service-connected disability or died while such a disability existed. The program offers up to 45 months of education benefits. These benefits may be used for degree and certificate programs, apprenticeships, and on-the-job training. The period of eligibility for spouses of Service members who died on active duty expires 20 years from the date of death.

Marine Gunnery Sergeant John David Fry Scholarship

Children of those who have died in the line of duty since September 11, 2001, are potentially eligible to use Post 9/11 GI Bill benefits and a work-study program. VA may also provide vocational counseling to help participants reach their employment objectives.

Montgomery GI Bill (MGIB) Death Benefits

VA will pay a special MGIB death benefit to a designated survivor in the event of the Service member's service-connected death while on active duty or within one year after discharge. The member must either have been entitled to MGIB educational assistance or have been a participant in the program but for the high school diploma or length of service requirement. The

amount paid will be equal to the member's actual military pay reduction, less any education benefits already paid.

VA Home Loan Guaranty

An un-remarried surviving spouse of a Service member who died as a result of a service-connected disability may be eligible for a VA Loan Guaranty to buy a home.

Other Federal Benefits and Services

In addition to the aforementioned DoD and VA benefits and services, there are other federal and state benefits that can help survivors cope with the death of their loved one.

Military Personnel Records Center

In some cases, family members may want to seek additional information about their loved one's military service as they try to come to grips with the death. The National Personnel Records Center, Military Personnel Records (NPRC-MPR), is the repository of millions of military personnel, health, and medical records of discharged and deceased veterans. Record information is made available upon written request (with signature and date) to the extent allowed by law. Most military and medical records are on file at NPRC (MPR), including the DD 214 or a Report of Separation (or equivalent). The NOK of a deceased veteran has the same rights to full access to the record. NOK is defined as the un-remarried widow or widower, son or daughter, father or mother, brother or sister of the deceased veteran. NOK must provide proof of death for the Service member, such as a copy of the death certificate, funeral home letter, or published obituary.

Social Security Benefits

The Social Security Administration (SSA) pays a death benefit to survivors. Social Security helps by providing income for the families of workers who have died, including military members. SSA notes that 98 of every 100 children could get benefits if a working parent dies. Social Security pays more benefits to children than any other federal program. However, this benefit will vary by the income previously made by the deceased and the number of quarters worked. SSA can be contact at 1-800-772-1213 or online at www.ssa.gov.

Service Branch-Specific Survivor Benefits and Information

For Service-specific information, see the links that follow:

Air Force: www.afpc.af.mil/

Army: www.hrc.army.mil/site/Active/TAGD/CMAOC/cmaoc.htm

Army Emergency Relief Survivor Assistance <http://www.aerhq.org/dnn563/>

AER is available to help surviving spouses get through the initial period of adjustment following

the death of a spouse while waiting for their benefits such as SBP, DIC and social security to start.

Navy: www.public.navy.mil/bupers-npc/support/casualty/Pages/default2.aspx

Marine Corps:

www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MR_OLD/PERSONNEL/Casualty

Coast Guard: http://www.uscg.mil/isc/isc_new.asp

State Benefits Information

An information packet provided to the NOK by the CAO should include RC-specific information not only on federal, but also on state benefits and support services available from the state. Each state has its own Office of Veterans Affairs or a Veterans Commission, which provide an array of benefits and services to surviving family members. These offices can be contacted directly for assistance. A directory of state veterans' offices is located at: <http://www.va.gov/statedva.htm>.

Casualty Affairs Follow-up

RC CAOs or a command designee should follow up monthly and then quarterly with the NOK until the first anniversary of the death. Further follow-up should be performed annually or as the family requests. Commanders may also want to check in with surviving families to ensure their well-being since families may stay in contact with other unit members and command communication can mitigate further risk and assist in managing unit morale. It might also be advisable to invite surviving family members to certain unit events and commemorations.

Tragedy Assistance Program for Survivors (TAPS) Referral

TAPS is a peer support program that was established to assist survivors of military deaths in dealing with their grief and the complicated issues surrounding a military death. Additionally, TAPS has incorporated a specific focus area and designated staff to support survivors of suicide. TAPS offers telephonic and online peer support 24/7. TAPS provides a yearly Survivor of Suicide Seminar that offers comfort and healing for adults, as well as a "Good Grief Camp" for children. It also hosts regional Survivor Seminars across the country and an annual meeting in Washington, DC, over Memorial Day weekend with special sessions for suicide survivors.

The World Health Organization (WHO) recognizes the benefits of self-help support and encourages the establishment and utilization of such groups for suicide survivors. These groups can provide a sense of community, empathy and normality under difficult circumstances, anniversary commemoration, coping mechanisms, and education surrounding fears, grief and hopelessness (WHO, 2008). TAPS is strongly aligned with the WHO description of a survivor's support group, and use of TAPS was recommended (DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010).

In order to work with TAPS and share information, it is recommended that there be a Memorandum of Agreement (MOA) between TAPS and the branch of service, as well as a release of information form to be signed by the family. The Marine Corps, Navy, and Air Force have MOAs in place with TAPS already. The MOA and a signed release form allow the unit to immediately connect the family with peer-based care, as well as extensive, individualized bereavement resources and referrals. It is recommended that the CACO introduce this benefit to the family and obtain a signature as soon as possible. TAPS will then be in contact with the surviving family members beginning two weeks from the date of death. TAPS will provide the command with follow-up information on the status of the family, including services and resources provided, and address ongoing needs of the family. For additional information on MOA development, contact the TAPS office at 202-588-TAPS. However, an MOA is not required for survivors to be assisted by TAPS. Anyone can call 800-959-TAPS to reach a peer support counselor. A sample MOA for TAPS is provided in Appendix D for unit commands not already covered by the Services.

Funeral and Memorial Services

Regardless of school, workplace, or community organization, which includes the military, those who knew the deceased may want to pay respects - especially if attending a formal funeral or if burial is not an option based on the costs and geographic dispersion from the unit and the location of the funeral/burial. Therefore, makeshift memorials, candlelight vigils or commemorations can be planned, so that spontaneous tributes (though well-intended) are not disruptive to the components' primary mission. Care should be taken to avoid glorifying or romanticizing the manner of death. Planning for memorializations allows for a balance between mission and individual coping. RC guidance for planning memorial services should involve the unit, commemorate the service of the member (not the death) and involve the identified next of kin. Commands should have a consistent policy that treats all deaths equally regardless of cause.

Public Memorials/Displays

Best practices (AFSP & SPRC, 2011) dictate not to glorify how a person died, but rather to focus on how they lived and served. There does not need to be an exceptional or distinguishing memorial for that person, but he or she should not be excluded from any public memorials, such as plaques, flagpoles and benches, in honor of all unit members who have died. Excluding them would only enhance focus on the manner of death. However, most of the concern over memorializations is regarding youth and "suicide contagion" (SPRC, 2004). Given that the National Guard or Reserve member is usually older and more established, there is less likelihood of "copycat" suicides, but the age of the unit members could be a consideration. According to the DoDSER, 47 percent of all decedents were primarily under age 25, and 25 percent were between 25 and 29 years old (T2, 2011). There appears to be cause for concern since Service members primarily fall into this age range and contagion has been noted in the general population.

Therefore, careful planning and discussion should take place prior to these events, and they should be seen as an opportunity to transmit and disseminate a prevention message to those in vulnerable age groups.



Commemorations can be used to honor the life of the unit member in the same way as other deaths. Factors to be considered should be the timing after the death, the type of memorial or display, and the wishes of the family. Some families have been very distraught over their loved ones not being included in a unit level memorial while others would prefer donations be made to a favorite

charity. So to ensure stability and harmony between the unit and its neighbors, work with the family to develop an appropriate commemoration that meets and fits with the unit's traditions. Discontented families can impact perceptions of other unit members and their families and lead to degradation of unit morale beyond the grief already being felt.

Unit members may want to do something special for the family and should be allowed to do so regardless of the circumstances surrounding the death. They may want to take up a collection for a widow, start a scholarship fund for children, or send flowers to parents. Different from the active duty, RCs, especially among the Guard, will remain neighbors with the deceased's families since this is the community in which they all permanently live. Other family members—e.g., siblings, parents and cousins—might be unit members as well or may also serve in the Guard or Reserve. Coordinating with employers may also be useful since families may be stretched to accommodate two sets of commemorations and would appreciate having to just coordinate one event. Commemorations should be allowed to take place as long as they remain appropriate to the unit, do not interfere with the mission, and respect the family.

Stateside Memorial Service

Generally, the memorial service structure will remain the same, no matter the cause of death. However, in the event of a particularly tragic death, such as suicide, involving your Director of Psychological Health, Crisis Response Team leader or TAPS Mentor for on-hand support during the memorial service along with the Chaplain can help facilitate grieving and can convey messages of recovery and hope.

There is guidance from the Suicide Prevention Resource Center (SPRC) regarding religious services and public memorials. The goals of the memorial service should be to:

- Comfort the mourners who may be experiencing extreme emotional pain and shock

- Assist in dealing with any sense of guilt or responsibility for the death and ruminations for what might have been done differently
- Be prepared to deal with anger at the military, the commander, other unit members, and the deceased for his/her actions
- Reduce stigma by discussing factual risk factors (physical and emotional pain, relationship problems, financial/legal troubles, hopelessness, substance abuse, etc.) in general and do not attribute weakness, selfish, cowardice, poor character or bad parenting to the death
- Speak with sensitivity by not associating suicide with a crime or a sin. Say, “died by suicide” rather than “committed suicide.”
- Monitor for suicide contagion (see below) by avoiding phrases like “at peace” so as not to give the appearance to others that life’s problems can be overcome by a peaceful afterlife. Balance this notion with theology or religious doctrine. Seek the advice of the chaplain.
- If not conducted properly, a memorial service may lead to adulation of the suicide event and thus potentially trigger “copycat” events among unidentified/unstable personnel. Therefore, memorial services should avoid idolizing/eulogizing the manner of death. Commanders should avoid commenting on circumstances surrounding the suicide and focus on the unit and express concern for survivors.
- If there are younger, more vulnerable unit members or families in attendance, ensure that they get the support they need from the unit or community groups (SPRC, 2004).
- Continue to reinforce the goals of Total Force Fitness among the unit.

Memorial Service (Interfaith) Template

The following is a guideline that has been adapted from the SPRC (SPRC, 2004) and the Armed Forces Chaplains Board (The Armed Forces Chaplains Board, 1998) for use by any unit or community chaplain:

- Welcome (chaplain)
 - Posting of Colors (Honor Guard)
 - National Anthem
 - Invocation - Opening Prayer (chaplain)
 - Hymn (optional depending on desires and involvement of the family)
 - Sacred Readings, Special Poems, or Music (unit members)
- Utilize sacred texts of the faith represented by the departed, if applicable
- Brief remarks of remembrance by unit members (optional) or civilian friends/co-workers
 - Brief remarks of remembrance by the commander and/or employer
 - Brief remarks by a state representative (optional)

- Message (chaplain)
- Focus on hope/healing rather than theological or personal beliefs about suicide
 - Prayer of Commemoration for the Departed (optional) (chaplain)
- If utilized, use prayers representing the faith of the deceased
 - Closing Hymn (suggest Service-appropriate Hymn)
 - Postlude - Closing Remarks
- Include a reminder that “we need to take care of ourselves and each other. If you are struggling with feelings of suicide, or you know someone who is, seek help immediately. There is help, help works and you don’t have to suffer.” Give crisis #1-800-273-TALK or any other relevant local number.
 - Retiring of Colors (Honor Guard)
 - Taps (Honor Guard)
 - Benediction (chaplain)

In-theater Memorial Services

When a National Guardsman or Reservist is in theater or on a deployment, any unit recognition of those who have died there should also include members who have died by suicide. This gives other unit members time to grieve, cope with emotions or numbness, express any sense of guilt or responsibility over the death, and be identified for further follow up, especially if they witnessed the death or knew of the suicide plan. Commands should provide the opportunity and forum for peers to discuss reactions to the death. Involve the chaplain, psychological health support, or a RCSRT approach to monitor for suicide contagion or recklessness among unit survivors.

Part 3: Community Level

Since members of the National Guard and the Reserve live, work, worship, volunteer and do business within the communities in which they live, those community organizations become crucial support points when loss occurs. The Total Force Fitness model recognizes the importance of the social support network. These support systems may be involved when a suicide occurs since media, civilian employers, neighbors and friends will all be touched. Commands should be prepared to respond to media inquiries and feel comfortable involving other community members in handling postvention.

Media Recommendations

Since military deaths and suicides are sometimes seen as newsworthy, the media may contact commands, unit members, or families looking for an interview. However, keep in mind that survivors are not experts and should not be put upon to comment. Survivors are often in shock and overwhelmed with emotions immediately following a death by suicide. Therefore, individual statements at this time should be discouraged in order to prevent regrets in the future.

“Survivors are often in shock and overwhelmed with emotions immediately following a death by suicide. Therefore, individual statements at this time should be discouraged in order to prevent regrets in the future.”

RC public information officers or unit leaders who respond to the media should be trained on the media guidelines developed and endorsed by the WHO, CDC, and the Annenberg Public Policy Center (as identified by the SPARRC) to reduce the potential for contagion and encourage responsible reporting of suicides. Messages also should foster help-seeking behavior and reduce stigma. The media can assist in honoring a member’s service, but not the manner in which they died. Care should be taken not to glamorize or romanticize suicide. (See Appendix C for Media Messaging.)

Give fact sheets to the media that help foster an understanding of suicidal ideation, suicidal behavior and how to cope with a suicide. The official responder to the media should also prepare unit members and families who might be contacted by the media on what to expect and be given resources for messages, such as information from DoD’s website www.suicideoutreach.org or www.realwarriors.net.

Suicide Nomenclature

In communicating with the community, RC leadership should use the suicide nomenclature, including definitions of suicide, suicide attempt, suicide survivor, and postvention developed by the SPARRC. The DoD/VA working group has recommended the adoption of the CDC’s Self-Directed Violence Classification nomenclature for suicides (National Center for Injury Prevention and Control, Division of Violence Prevention, 2011). On October 11, 2011, the Office of the Under Secretary of Defense, Personnel and Readiness, issued a memorandum directing the use of the CDC classifications. Definitions and nomenclature from CDC are provided in Appendix E.

Suicide Contagion

A primary concern with the messaging surrounding suicide is the potential for one suicide to lead to another. Individuals who were related to or were close to someone who died by suicide are at a greater risk for suicide themselves. Suicide-related data does show that there is a low

suggestibility – about 1 to 5 percent annually (AFSP & SPRC, 2011) – of suicide contagion. However, it is important to note that younger individuals are more likely to be influenced by the actions of their peers. This is a concern raised mostly in school-based response plans, but commanders should note that those who are younger enlisted, are closest to the deceased, witnessed the death, attempted suicide themselves or are experiencing their own life stressors might be more susceptible and influenced by their peers (AFSP & SPRC, 2011) than more mature and established unit members. Thus, commanders should be more mindful of how a suicide might affect this more susceptible group and monitor their risk behaviors more closely.

To manage potential suicide contagion, inform Directors of Psychological Health or the response team leader of any unit members who might be of concern because they:

- Are grieving another death, or are experiencing post-deployment stress, PTSD or TBI
- Are dealing with other stressors, such as civilian unemployment, divorce, parenting issues, foreclosure, or illness
- Were a witness to the death or were in recent communication with the deceased
- Were close friends or related to the unit member who died
- Are expressing extreme guilt, remorse, depression, or anger over the death
- Are younger, single members with limited support and are isolated from family or community
- Are acting out, are impulsive or are exhibiting risky behavior – e.g., recent car accidents, traffic violations, fights and increased use of substances or gambling

Role for Employers

When a unit member has died by suicide, keep in mind that as a Reservist or Guardsman, they were also an employee of another entity, which might want to participate in ceremonies or memorials. Employers also offer survivor benefits, insurance, medical coverage, and other assistance that would be helpful to have paired up with any military or VA benefits the next of kin will receive. A courtesy phone call to a deceased Service member's employer may also yield

“A courtesy phone call to a deceased Service member's employer may yield added support to the family and better coordination for all mourners.”

added support to the family and better coordination for all mourners involved. For example, a large business or factory in a small town might also employ other unit or

family members who knew the deceased, so consulting with those executives could improve support and services for everyone involved.

The Employer Support of the Guard and Reserve (ESGR) is designed to facilitate the relationship between the RC member and his/her employer. There are almost 5,000 ESGR

volunteers nationwide who can assist in communicating with civilian supervisors (2010 Reserve Forces Almanac, 2011). ESGR can be reached at 1-800-336-4590 or online at www.ESGR.mil.



Role for Funeral Home Directors

The funeral home director is another asset in dealing with the immediate aftermath of a death. They will be able to assist the family in making decisions that reflect how their loved one lived



as opposed to how they died. A family member may seek the assistance and support of other unit members and their families to select a funeral home or chaplain, or involve them in the selection of a cemetery and a casket. The CAO should be able to work with the family and the funeral home director to answer questions about a flag-draped casket, burial in uniform and military protocols. Seek out and encourage the funeral home director's counsel on these and other

related issues prior to a burial. You may also be able to help inform on any unit-specific traditions, customs or history that might be pertinent to the unit member's remembrance.

Appendix A: Resource Guide

Military Services' Suicide Prevention

- **Air Force** – www.af.mil/suicideprevention.asp
- **Army** – www.armyg1.army.mil/hr/suicide/default.asp
- **Coast Guard** – www.uscg.mil/worklife/suicide_prevention.asp
- **Marine Corps** – www.usmc-mccs.org/suicideprevent/index.cfm
- **Navy** – http://www.public.navy.mil/bupers-npc/support/suicide_prevention/Pages/default.aspx
- **National Guard** – <http://www.ng.mil/features/resiliency/default.aspx>

Community Suicide Prevention

DoD Websites

- **After Deployment** – www.afterdeployment.org
- **Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury** www.dcoe.health.mil/SuicidePreventionWarriors.aspx 866-966-1020
- **Military OneSource** – www.militaryonesource.com 800-342-9647
- **Real Warriors** – www.realwarriors.net 866-966-1020
- **Suicide Prevention and Risk Reduction Committee (SPARRC)** – www.suicideoutreach.org
- **TRICARE Behavioral Health Resource Center** – <http://www.tricare.mil/mybenefit/home/MentalHealthAndBehavior/GettingHelp>

VA Websites

- **Department of Veterans Affairs (VA)** – www.mentalhealth.va.gov/suicide_prevention/
- **Military Crisis Line** – <http://www.veteranscrisisline.net/ActiveDuty.aspx>, 1-800-273-TALK, press 1 for military/veterans,
 - [online chat](http://www.veteranscrisisline.net/ChatTermsOfService.aspx?account=Veterans%20Chat) at <http://www.veteranscrisisline.net/ChatTermsOfService.aspx?account=Veterans%20Chat> and text at 838255
 - In Europe call 00800 1273 8255 or DSN 118

Other Federal Websites

- **Centers for Disease Control and Prevention (CDC)** – www.cdc.gov/ViolencePrevention/suicide/index.html 800-CDC-INFO (800-232-4636)

Non-Federal Websites

- **American Association of Suicidology** – www.suicidology.org 202-237-2280
- **American Foundation for Suicide Prevention/SPAN USA** – www.afsp.org 888-333-AFSP (2377)
- **Blue Star Families** – www.bluestarfam.org
- **Compassionate Friends** – www.compassionatefriends.org 877-969-0010
- **Military Pathways** – www.mentalhealthscreening.org/programs/military/
- **National Alliance on Mental Illness (NAMI): The Connect Program** – www.theconnectprogram.org 603-225-5359
- **Suicide Prevention Resource Center (SPRC)** – www.sprc.org
- **The Link's National Resource Center for Suicide Prevention and Aftercare** – www.thelink.org 404-256-2919
- **Tragedy Assistance Program for Survivors (TAPS)** – www.taps.org 800-959-TAPS
- **Vets4Warriors** – <http://www.vets4warriors.com/> 1-855-838-8255 or 1-855-VET-TALK
- **World Health Organization (WHO)** – <http://www.who.int/topics/suicide/en/>

Appendix B: Acronyms

AAS – American Association of Suicidology
ACE – Ask, Care, Escort
ACT – Ask, Care, Treat
AER – Army Emergency Relief
AFMES – Armed Forces Medical Examiner System
AFSP – American Foundation for Suicide Prevention
CACO – Casualty Assistance Calls Officer
CAO – Casualty Assistance Officer
CDC – Centers for Disease Control and Prevention
CHAMPVA – Civilian Health and Medical Program of VA
CISD – Critical Incident Stress Debriefing
CISM – Critical Incident Stress Management
COSCF A - Combat and Operational Stress Control First Aid
DCoE – Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DEERS – Defense Enrollment Eligibility Reporting System
DIC – Dependents’ Indemnity Compensation
DoDI – Department of Defense Instruction
DoDSER – Department of Defense Suicide Event Report
ESGR – Employer Support of the Guard and Reserve
HHS – Department of Health and Human Services
IOM – Institute of Medicine
MGIB – Montgomery GI Bill
MOA – Memorandum of Agreement
NAMI – National Alliance on Mental Illness
NCA – National Cemetery Administration
NGB – National Guard Bureau
NIMH – National Institute of Mental Health
NPRC-MPR – National Personnel Records Center, Military Personnel Records
OSG – Office of the Surgeon General
PFA – Psychological First Aid
PTE – Potentially Traumatizing Events

PTSD – Posttraumatic Stress Disorder
RA – Reserve Affairs
RC – Reserve Component
RCSRT – Reserve Component Suicide Response Team
SAMHSA – Substance Abuse and Mental Health Services Administration
SDV – Self-Directed Violence
SBP – Survivor Benefit Plan
SOS – Survivor Outreach Services
SPARRC – Suicide Prevention and Risk Reduction Committee
SPRC – Suicide Prevention Resource Center
SSA – Social Security Administration
TAP – Transition Assistance Program
TAPS – Tragedy Assistance Program for Survivors
TBI – Traumatic Brain Injury
TEM – Traumatic Event Management
TRS – TRICARE Reserve Select
UCMJ – Uniform Code of Military Justice
VA – Department of Veterans Affairs
VTC – Veterans Treatment Court
VSO – Veterans Service Organization
WHO – World Health Organization
YRRP – Yellow Ribbon Reintegration Program

Appendix C: Suicide Facts and Appropriate Messaging

The following recommendations for the media on reporting suicide are those endorsed by the SPARRC. (CDC, NIMH, OSG, SAMHSA, AFSP, AAS, Annenberg Public Policy Center)

General suicide information:

“Since we are talking about suicide, this is an opportunity to give you accurate information about suicide prevention and ways to get help for yourself or someone you may know who is feeling depressed, stressed, or suicidal.”

In regard to families:

“The family has requested that information about the cause of death not be shared at this time.”

Suicide facts:

- More than 90 percent of suicide victims have a significant psychiatric illness at the time of their death. These are often undiagnosed, untreated, or both. Mood disorders and substance abuse are the two most common.
- When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.
- Research has shown that when open aggression, anxiety or agitation is present in individuals who are depressed, the risk for suicide increases significantly.
- The cause of an individual suicide is invariably more complicated than a recent painful event such as the break-up of a relationship or the loss of a job. An individual suicide cannot be adequately explained as the response to an individual’s stressful occupation, or an individual’s membership in a group encountering discrimination. Social conditions alone do not explain a suicide.

Key message point:

- Effective treatments for most of these behavioral health conditions are available (but underutilized) and may encourage those with such problems to seek help. Acknowledging the deceased person’s problems and struggles, as well as the positive aspects of his/her life or character, contributes to a more balanced picture.
- Research shows that, during the period immediately after a death by suicide, grieving family members or friends have difficulty understanding what happened. Responses may be extreme, problems may be minimized, and motives may be complicated.
- Studies of suicide based on in-depth interviews with those close to the victim indicate that, in their first, shocked reaction, friends and family members may find a loved one’s death by suicide inexplicable or they may deny that there were warning signs.
- Thorough investigation generally reveals underlying problems unrecognized even by close friends and family members. Most victims do, however, give some warning signs of their risk for suicide. These investigations almost always find multiple causes for suicide and fail to corroborate a simple attribution of responsibility.

- Referring to a “rise” in suicide rates is usually more accurate than calling such a rise an “epidemic,” which implies a more dramatic and sudden increase than what we generally find in suicide rates.
- Research has shown that the use in headlines of the word “suicide” or referring to the cause of death as “self-inflicted” increases the likelihood of contagion.
- Whenever possible, it is preferable to avoid referring to suicide in the headline. Unless the suicide death took place in public, the cause of death should be reported in the body of the story and not in the headline. Consideration of how the individual died could be reported in the body of the article, and one should describe the deceased as “having died by suicide,” rather than as “a suicide,” or having “committed suicide.” The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
- Avoid detailed descriptions regarding the circumstances or information about the location and means used to complete a suicide.
- Contrasting “suicide deaths” with “non-fatal attempts” is preferable to using terms such as “successful,” “unsuccessful” or “failed.”
- In covering murder-suicides be aware that the tragedy of the homicide can mask the suicidal aspect of the act. Feelings of depression and hopelessness present before a homicide or suicide are often the impetus for both.
- Suicide pacts are mutual arrangements between two people who kill themselves at the same time, and are rare. They do not simply constitute the act of loving individuals who do not wish to be separated. Research shows that most pacts involve an individual who is coercive and another who is extremely dependent.

Topics to include in a media release:

- Identify adjusted trends in suicide rates—both military and civilian
- Note recent treatment advances and peer support successes
- Offer individual stories of how treatment or other intervention was life-saving
- Tell the stories of Service members and other people who overcame despair without attempting suicide
- Engage in myth-busting about suicide; include the facts
- List ways to enhance protective factors from stress, depression and suicide
- List warning signs of suicide and self-harming behavior
- Recommend actions that can be taken to prevent suicide by both you and others

Appendix D: Sample MOA with TAPS

MEMORANDUM OF AGREEMENT

BETWEEN

[Insert : Military Unit]

AND

TRADEGY ASSISTANCE PROGRAM FOR SURVIVORS

1. Purpose. This Memorandum of Agreement (MOA) is between the Tragedy Assistance Program for Survivors (hereinafter referred to as "TAPS") and the [unit] (hereafter military unit) Its purpose is to set forth the terms of an agreement by which TAPS will enter into a Cooperative Agreement to provide peer facilitated suicide bereavement services/counseling to surviving family members of deceased service members.

2. Background.

a. Providing emotional peer support, and grief education and trauma resources, which promotes resilience and hope for the surviving unit and family members of suicide. Research shows that peer support after a tragedy offers survivors a sense of community, empathy and normality under difficult circumstances and fosters resilience and hope.

b. TAPS is a 24/7 tragedy assistance resource for anyone who has suffered the loss of a military loved one, regardless of the relationship to the deceased or the circumstances of the death. TAPS was founded in 1994 and has established itself as the front line resource to the families and friends of our military men and women. The services provided by TAPS are free. TAPS connects survivors with like circumstances of loss; a very key point for survivors. It also offers educational opportunities and healing events. All the Service branches advertize for and promote the use of TAPS by surviving family members or friends; however, it is up to these individuals to establish contact with TAPS. Furthermore, TAPS has developed a specialization in suicide education and outreach and can provide practical experience and insights into postvention activities.

c. DoD is responsible for the development and implementation of casualty policy, postvention plans and procedures. These responsibilities include military branch personnel contact with the primary next of kin of all deceased Service member approximately 60 days from the date of loss. The focus of the DoD is to establish a continuing point of contact at headquarters for any follow-on questions or concerns and to identify those next of kin that may be in need of emotional/bereavement support. Survivors are asked if they utilized the services of TAPS and if not, the military representative offers to facilitate the connection. The efforts of TAPS and the Defense Department are well coordinated. The services provided by TAPS would be most beneficial if they were provided closer to the date of loss, and done proactively.

3. Scope. This MOA applies to family members and friends of deceased Active Duty, National Guard or Reserve who authorize the release of Personally Identifiable Information (PII) and as provided by unit personnel to TAPS.

4. Agreement and Responsibilities.

a. Pursuant to this agreement, the military unit agrees to:

(1) Provide TAPS with a completed Authorization for Disclosure of Information form that provides accurate next of kin contact information (address, telephone). This form will be provided electronically for all cases where the department desires TAPS intervention. The form must be initialed and signed by the family member or friend indicating their consent to the disclosure of their PII.

(2) Provide TAPS a copy of the Casualty Information Release Form that provides information pertinent to the military component and the casualty incident.

(3) Provide the funeral date or an optional date that TAPS will utilize as their date to initiate contact with the family or other survivors. The goal of DoD is to have the family contacted within a day or two following the burial/memorial service. When the funeral is delayed more than ten days from the date of loss, TAPS initial contact will begin on the date provided by DoD. To assist TAPS in

planning for the contact, DoD will provide this information as soon as it is obtained from the family.

(4) Ensure the Casualty Assistance Calls Officer (CACO) informs the family of the pending call from TAPS.

b. Pursuant to this agreement, TAPS agrees to:

(1) Initiate contact to the families as requested by the military department. Contact with the families will be initiated on or about the date requested by the department. The requested date will be provided on the bottom of the Authorization for Disclosure of Information form.

(2) Provide world-class emotional help, hope, and healing to family members who are grieving the loss of a military member.

(3) Provide DoD a synopsis of the contact with the family including the name and contact information of the TAPS representative, the name of the family member that was contacted, and a brief write-up of any concerns/plans for the family. TAPS agrees to provide the synopsis via email to: (insert address). The goal of the synopsis is to ensure DoD can contact the TAPS representative when/if needed, and to ensure future communications with the family are considered/viewed seamless by the family.

(4) TAPS will not release any family member PII to any third party. The family member PII is provided only for the use of TAPS.

5. Effective Date. Memorandum of Agreement (MOA) is effective upon signature by both organizations. Termination of this MOA is upon written request of either organization.

TAPS

Branch of Service

Appendix E: CDC Uniform Definitions

Self-directed violence (analogous to self-injurious behavior)

Self-directed violence is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. This does not include behaviors such as parachuting, gambling, substance abuse, tobacco use or other risk-taking activities, such as excessive speeding in motor vehicles. These are complex behaviors, some of which are risk factors for SDV but are defined as behavior that, while likely to be life-threatening, is not recognized by the individual as behavior intended to destroy or injure the self.⁷ These behaviors may have a high probability of injury or death as an outcome, but the injury or death is usually considered unintentional.⁸

Non-suicidal self-directed violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. *Suicidal self-directed violence:* Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

Undetermined self-directed violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based on the available evidence.

Suicide attempt: A non-fatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Interrupted self-directed violence – by other or by self: By other - A person takes steps to injure self, but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act, such as after the initial thought or after onset of behavior. By self (in other documents this may be termed “aborted” suicidal behavior) - A person takes steps to injure self but is stopped by self prior to fatal injury.

Other suicidal behavior including preparatory acts: Acts or preparation towards making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (i.e., buying a gun or rope, collecting pills, excessive drinking) or preparing for one’s death by suicide (e.g., writing a suicide note or giving things away).

⁷ Farberow, N. L. (Ed.) (1980). *The Many Faces of Suicide*. New York: McGraw-Hill Book Company

⁸ Hanzlick R, Hunsaker JC, Davis GJ. *Guide for Manner of Death Classification*. National Association of Medical Examiners. Available at: <http://www.charlydmiller.com/LIB03/2002NAMEmannerofdeath.pdf>. Accessed September 1, 2009.

Suicide: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Unacceptable Terms

The CDC panel felt the following terms are unacceptable for describing self-directed violence:

Completed suicide - This terminology implies achieving a desired outcome, whereas those involved in the mission of “reducing disease, premature death, and discomfort and disability”⁹ would view this event as undesirable. Alternate term: suicide.

Failed attempt - This terminology gives a negative impression of the person’s action, implying an unsuccessful effort aimed at achieving death. Alternate terms: suicide attempt or suicidal self-directed violence.

Nonfatal suicide – This terminology portrays a contradiction. “Suicide” indicates a death while “nonfatal” indicates that no death occurred. Alternate term: suicide attempt.

Parasuicide – Formally used to refer to a person’s self-directed violence whether or not the individual had intended to die. However, the WHO is now favoring the term suicide attempt. Alternate terms: non-suicidal self-directed violence or suicidal self-directed violence.

Successful suicide – This term implies achieving a desired outcome whereas those involved in the mission of “reducing disease, premature death, and discomfort and disability” would view this event as undesirable. Alternate term: suicide.

Suicidality - This terminology is often used to refer simultaneously to suicidal thoughts and suicidal behavior. These phenomena are vastly different in occurrence, associated factors, consequences and interventions so should be addressed separately. Alternate terms: suicidal thoughts and suicidal behavior.

Suicide gesture, Manipulative act, and Suicide threat – Each of these terms gives a value judgment with a pejorative or negative impression of the person’s intent. They are usually used to describe an episode of nonfatal, self-directed violence. A more objective description of the event is preferable such as non-suicidal, self-directed violence or suicidal, self-directed violence.

⁹ J. Last, Dictionary of Epidemiology, 1988

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