DEFENSE SUICIDE PREVENTION OFFICE

Under Secretary of Defense for Personnel and Readiness

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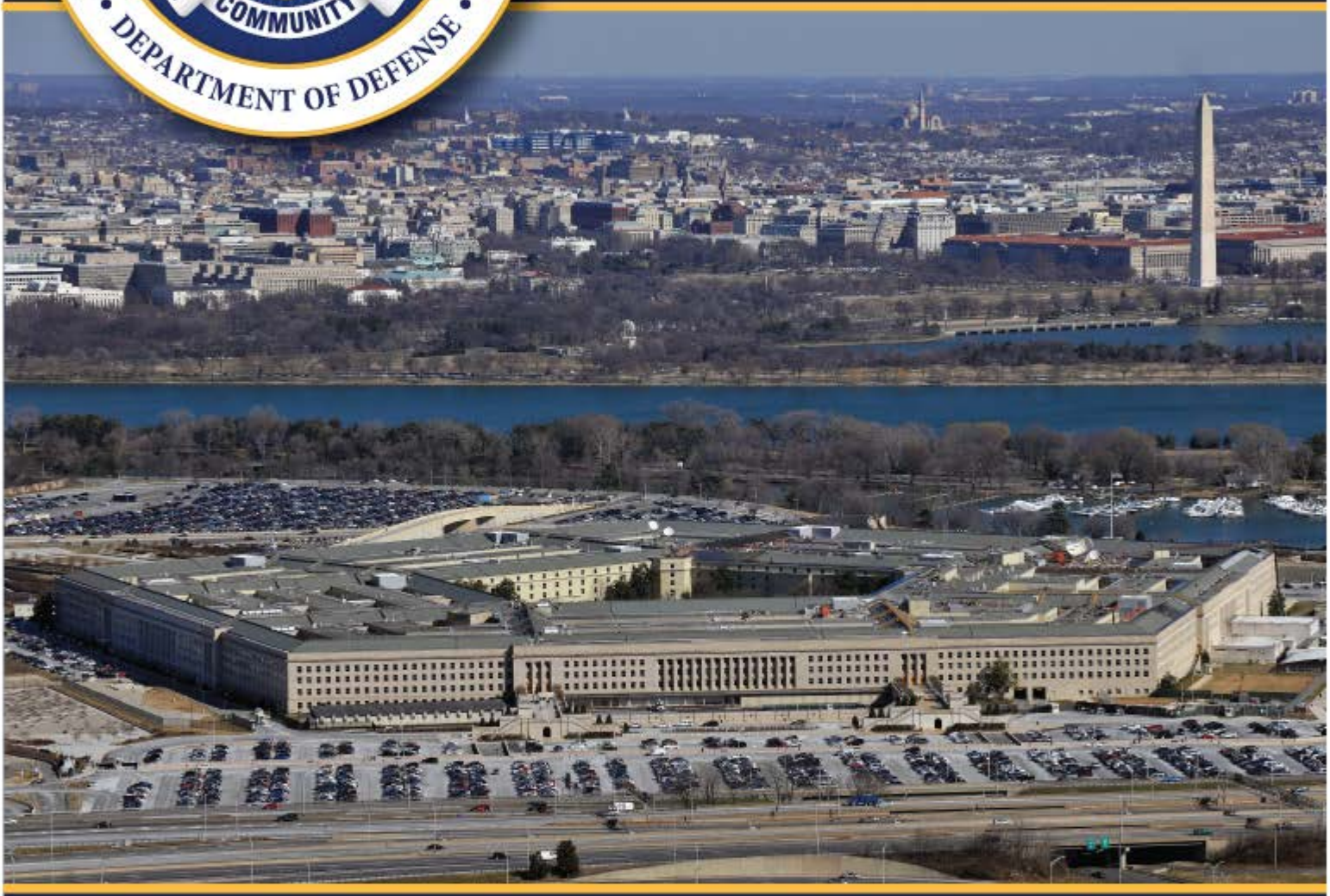

Leader Guide and Postvention Checklist

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Leaders Guide and Suicide Postvention Checklist

Purpose: This checklist is designed to assist leaders in guiding their response to suicides and suicide attempts.

Research suggests the response by a unit's leadership can play a role in the prevention of additional suicides/suicide events or, in worst cases, inadvertently contribute to increased suicides/suicide attempts (suicide contagion).

This checklist is intended to augment any local policies. It incorporates "lessons learned" from leaders who have experienced suicide deaths in their unit. It is a guide intended to support a leader's judgment and experience. The checklist does not outline every potential contingency which may come from a suicide or suicide attempt.

**** Suicide Deaths impact approximately 115 individuals - Exposure heightens the risk for Suicide in others**
It's important to provide a "safety net" around those exposed and impacted.

Guidance for Actions Following a Death by Suicide	
1	Contact 911 (if law enforcement is not already involved), local law enforcement/service specific security office, and service specific investigative divisions. Note how the service specific investigative division's Duty Agent can be contacted, after hours.
2	Notify Chain of Command. Commander will initiate notification messages as per (list service specific references). Notify the service specific Casualty Assistance Office (CAO) or Casualty Assistance Calls Officer (CACO).
3	Notification of Chaplains Office and, depending on the service, the installation's non-medical counseling department, Behavioral Health Office, or Mental Health Clinic to prepare a team to respond to the suicide. Note how the Commander can contact the appropriate office, after hours, if needed.
4	Validate with the service specific investigative divisions or, for some services, the installation Staff Judge Advocate, who has jurisdiction of the scene and medical investigation. Normally, local medical examiners/coroners have medical incident authority in these cases, but some locations may vary.
5	Contact the service specific CAO or CACO to notify Next of Kin (NOK) IAW DODI 36-3002, (list service specific references). If necessary, receive briefing on managing casualty affairs. Ensure service specific CAO or CACO procedures are followed, when making notification to the immediate family members.
6	Consult with the installation's non-medical counseling department, Behavioral Health Office, or Mental Health Clinic to prepare an announcement to unit and co-workers.
7	Make initial announcement to work site/unit. Make initial announcement to service member's unit with a balance of "need to know" and rumor control. Consider having the Chaplain and the installation's non-medical counseling department, Behavioral Health Office, or Mental Health Clinic staff present, for support to potentially distraught personnel, but avoid using a Critical Incident Stress Management "psychological debriefing" model.
8	Consult with the local installation Public Affairs Office, regarding public statements about the suicide and refer to the service specific Public affairs Guidance (PAG) for Suicide Prevention.

9	When speaking to the service member's unit, avoid announcing specific details of the suicide. Merely state it was a suicide or reported suicide. Do not mention the method used. Location is announced as either on-installation or off-installation. Do not announce specific location, who found the body, whether or not a note was left, or why the member may have killed himself/herself.
10	Avoid idealizing deceased or conveying the suicide is different from any other death. Consult with the installation's non-medical counseling department, Behavioral Health Office, Mental Health Clinic, the Chaplain, as well as your Chain of Command for any actions being considered for memorial response.
11	When engaging in public discussions of the suicide: 1) Express sadness at the loss and acknowledge the grief of the survivors; 2) Emphasize the unnecessary nature of suicide as alternatives are readily available; 3) Express disappointment that the Service member did not recognize that help was available; 4) Reiterate to the audience to seek assistance when distressed, including those who are presently affected; 5) Encourage Service Member to be attuned to those who may be grieving or having a difficult time following the suicide, especially those close to the deceased; and 6) Provide brief reminder of warning signs for suicide.
12	After death announcement is made to the work center, follow-up your comments in an e-mail provided to the community affected. Restate the themes noted above.
13	Unless you discern there is a risk of being perceived as disingenuous, consider increasing senior leadership presence in the work area immediately following announcement of death. Engage informally with personnel and communicate message of support and information. Presence initially should be fairly intensive and then decrease over the next 30 days to a tempo you find appropriate.
14	Consult with the Chaplain Office, regarding Unit Sponsored Memorial Services. Memorial services are important opportunities to foster resilience by helping survivors understand, heal, and move forward in as healthy a manner as possible. However, any public communication after a suicide, including a memorial service, has the potential to either increase or decrease the suicide risk of those receiving the communication. It is important to have an appropriate balance between recognizing the member's military service and expressing disappointment about the way they died. If not conducted properly, a memorial service may lead to adulation of the suicide event and thus potentially trigger "copy-cat" events among unidentified/unstable personnel. Therefore, memorial services should avoid idealizing deceased. Commanders should avoid commenting on personal characteristics of the deceased. Focus instead on personal feelings and feelings of survivors. Express disappointment in deceased's passing and concern for survivors. Promote help-seeking. The goals are to: 1) Comfort the grieving; 2) Survivors experience a range of emotions including guilt, anger, relief, resentment, sadness, fear, rejection, help the deal with these emotions (survivors do not follow what we traditionally talk about as stages but can experience a range of emotions that can fluctuate); 3) Encourage Service members/family members to seek help (note- survivors are in a vulnerable state and may be suffering from trauma, spiritual crisis, increased suicide risk and communication challenges which my need to be addressed immediately. Connecting them to resources as soon as possible can decrease risk and help set them on a positive grief journey); 4) Prevent "imitation" suicides.

15	Public memorials such as plaques, trees, or flags at half-mast may, in rare situations, encourage other at-risk people to attempt suicide in a desperate bid to obtain respect or adulation for themselves. Therefore, these types of memorials are not recommended.
16	Utilize or refer grieving co-workers to installation resources, such as Chaplains, non-medical counseling department, Behavioral Health Office, or Mental Health Clinic staff, as well as Military One Source (1-800-342-9647). For civilians, consider Employee Assistance Programs (EAP available 24/7 at 1-800-222-0364) and follow-up services with the installation team that responded and provided assistance for the suicide at the unit/workplace (usually the team is made up of members from the previously mentioned resources). Discuss service options, with installation resources mentioned previously, if non-beneficiaries (i.e., extended family members, fiancé or boy/girlfriends) are struggling and asking for help. The Tragedy Assistance Program for Survivors (TAPS) is available for non-beneficiaries, as well: 800-959-TAPS (8277)
17	Participate, as requested, with any appointed independent reviewer process (suicide investigations or medical investigations). Avoid defensiveness. Acknowledge the processes are intended to determine if there are any "lessons learned" in regards to suicide prevention, not to affix blame.
18	Anniversaries of suicide (1 month, 6 month, 1 year, etc.) are periods of increased risk. Promote healthy behaviors during this time period and be attuned to those who may be grieving or having a difficult time.

Guidance Concerning Actions Following a Suicide Attempt	
Purpose: This checklist is designed to assist leaders in regards to addressing suicide attempts by those in their unit. There can be many factors considered in a person's decision to attempt suicide, and the proper response to the attempt can diminish the risk factors for another attempt, and greatly aid in restoring the individual to the work center with minimal disruption.	
1	Suicide is an act made by a person seeking relief from real or perceived pain. A person who makes a suicide attempt may have either (1) been prevented from making an action they intended to result in death; (2) not intended to die, but felt the need to demonstrate an attempt for others to know they are in pain; (3) been under the influence of drugs (including alcohol) which caused an impaired decision (often referred to as "impulsive"; (4) been suffering from mental illness and extremely impaired but did not die as a consequence of the suicide plan.
2	Contact 911 (if law enforcement is not already involved), local law enforcement/service specific security office, and service specific investigative divisions. Note how the service specific investigative division's Duty Agent can be contacted, after hours.
3	Notify Chain of Command. Commander will initiate notification messages as per (list service specific references). Ensure notifications are kept to short list of "need to know" and contain minimum amount of information to convey nature of critical event. Being appropriate with "need to know" helps avoid stigmatizing the member's return to a work center where many people are aware of what happened.
4	If attempt was by an Active Duty member: If not already involved, call primary care manager, on-call medical provider, or unit physician. The provider can complete, or assign a clinical provider to complete, a safety plan and coordinate a service specific command directed evaluation (sometimes referred to as command directed behavioral health evaluation, command directed evaluation, or command directed mental health evaluation). If attempt was by a civilian: The installation Medical Treatment Facility or Mental Health Clinic can provide guidance on options available, however, if emergency personnel responded to the attempt, the civilian attempter will most likely be taken to the nearest emergency room. Generally, civilian authorities and hospitals will be the lead agents for response to the attempts by civilians.
5	If the attempt occurred in the workplace: Notify local law enforcement (if they were not already notified) and the Chain of Command. Ensure the area of the attempt has been secured and contact the Service member's primary care manager, unit physician, or on-call medical provider for consultation. Consider care available for co-workers of the individual; consult with the Chaplain, non-medical counseling department, Behavioral Health Office, or Mental Health Clinic staff on options available.
6	A suicide attempt requires formal assessment and often results in hospitalization to stabilize the individual, as well as ensure their safety. If the member is hospitalized, it is recommended you consult with the Service member's primary care manager, or unit physician, regarding visiting the individual while they are in the hospital.

	Returning to work: A person who has experienced a crisis may find returning to work to be comforting (a sense of normalcy) or distressing. Help maintain a sense of purpose and belongingness within the unit for the returning member. Work may need to be tailored to accommodate for follow-up appointments and assessed abilities of the person upon their return. The goal is to gradually return to full duties, as appropriate.
7	If attempt was by an Active Duty member: Ensure Active Duty Member is cleared for return to duty by their Primary Care Manager or unit physician. Consultation between Primary Care Manager/unit physician and Command can ensure a work schedule that accommodates the Service member and provides additional supervision/support, without risk of appearing to show secondary gain for having attempted suicide. Recommendations: - "No Drink" order - Non-weapons related duties - Secure personal weapons, providing an alternative (i.e., installation armory, friend's house, etc.)

	If attempt was by a civilian: Recommend discussing alcohol and weapons. Engage with employee to ensure they provide documentation indicating they are medically cleared, by their treating provider, to return to the work environment. If out for extended period of time, have the employee report to Occupational Health to be cleared for return to work. Coordinate with the local Civilian Personnel Office on accommodations (if required) to work schedule and work environment.
8	A returning Service member should not be treated as fragile or "damaged". If they sense they are being "singled out" or treated differently in the presence of peers, it can damage the recovery process. Freely speak with the employee about being receptive to their thoughts on returning to work and how to avoid either their, or your, perception of "walking on egg shells."
9	Consider leave requests carefully. Support the employee by ensuring leave requests involve structured time or planned events that will enhance them as they take time away from work.
10	Ensure all members of the unit are aware that seeking help is a sign of strength and helps protect mission and family by improving personal functioning instead of having personal suffering.
11	Never underestimate the power of the simple statement: "What can I do to be helpful to your recovery process?" or "How can I help?"
12	Consult with non-medical counseling department, Behavioral Health Office, or Mental Health Clinic providers to develop a supportive plan to re-integrate the Service member into the workplace.
13	Engage family and support networks to increase support and surveillance of the Service member. Encourage family and friends to reach out to the unit if they become concerned about the Service members emotional state.

NOTES:

Adapted from Defense Suicide Prevention Office "Leaders Guide and Postvention Checklist" which can be found at www.dspo.mil