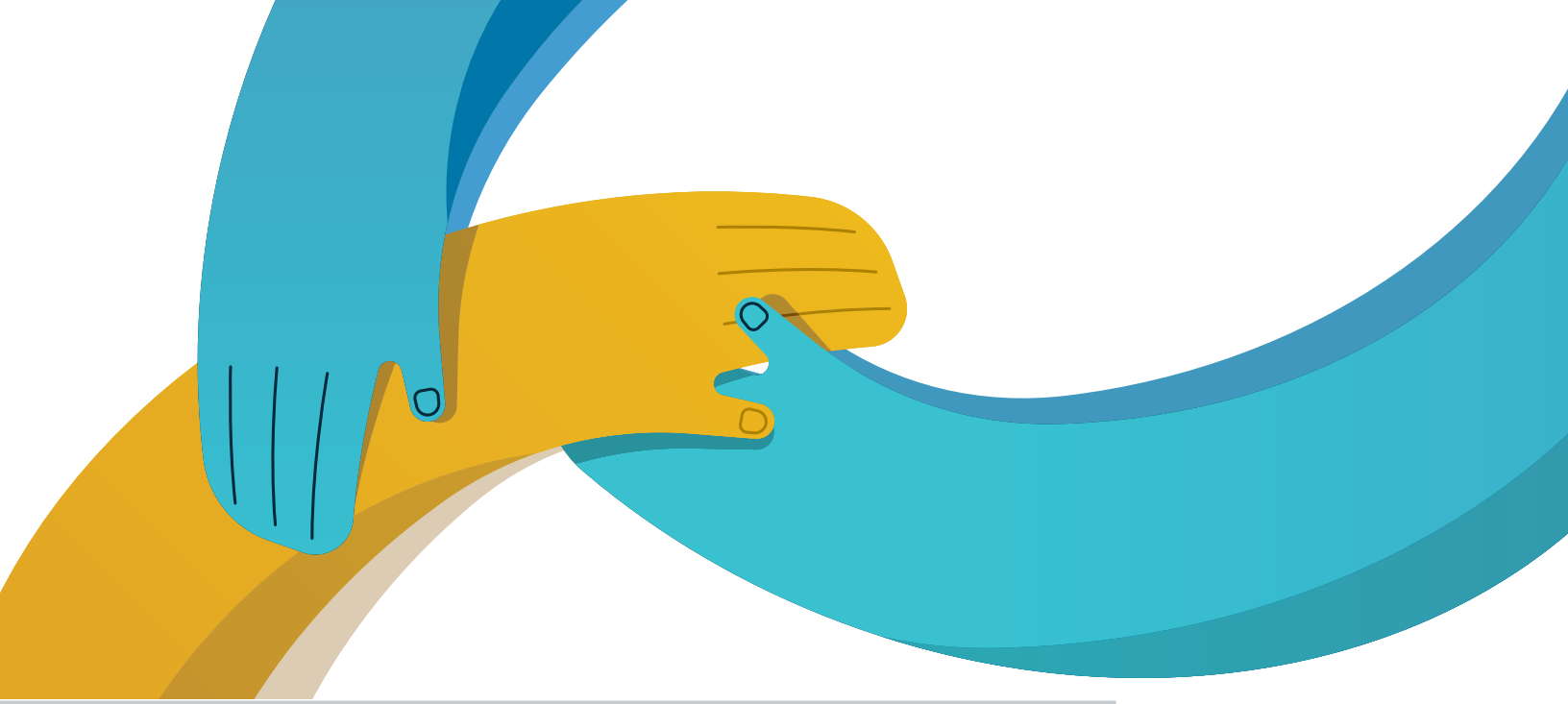

SUICIDE RELATED BEHAVIOR RESPONSE AND POSTVENTION GUIDE

JANUARY 2024

NAVY CULTURE AND FORCE RESILIENCE OFFICE

BROUGHT TO YOU BY: CULTURE OF EXCELLENCE 2.0

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INTRODUCTION

This guide consolidates information from the Defense Suicide Prevention Office (DSPO) Postvention Toolkit for a Military Suicide Loss, the DSPO Leaders Suicide Prevention Safe Messaging Guide and OPNAVINST 1720.4B, Suicide Prevention Program. It is designed to provide a streamlined reference to suicide crisis response, suicide related behavior response, reintegration, and suicide postvention.

Postvention refers to an organized immediate, short-term, and long-term response for local resources in the aftermath of a suicide to mitigate the negative effects of exposure to suicide and to promote healing for suicide loss survivors.

Although response (including reintegration) and postvention are implemented as a crisis is happening, or after the command is notified of a suicide related behavior or suicide death, it is essential that commanders prepare for crisis response and postvention before these events occur.

Commanders should become familiar with the DSPO Postvention Toolkit for a Military Suicide Loss and Leaders Suicide Prevention Safe Messaging Guide which will provide a greater understanding of suicide postvention and safe messaging.

Commanders must also regularly conduct drills (no less than annually) to ensure suicide crisis response plans are up-to-date and executable when they are required.

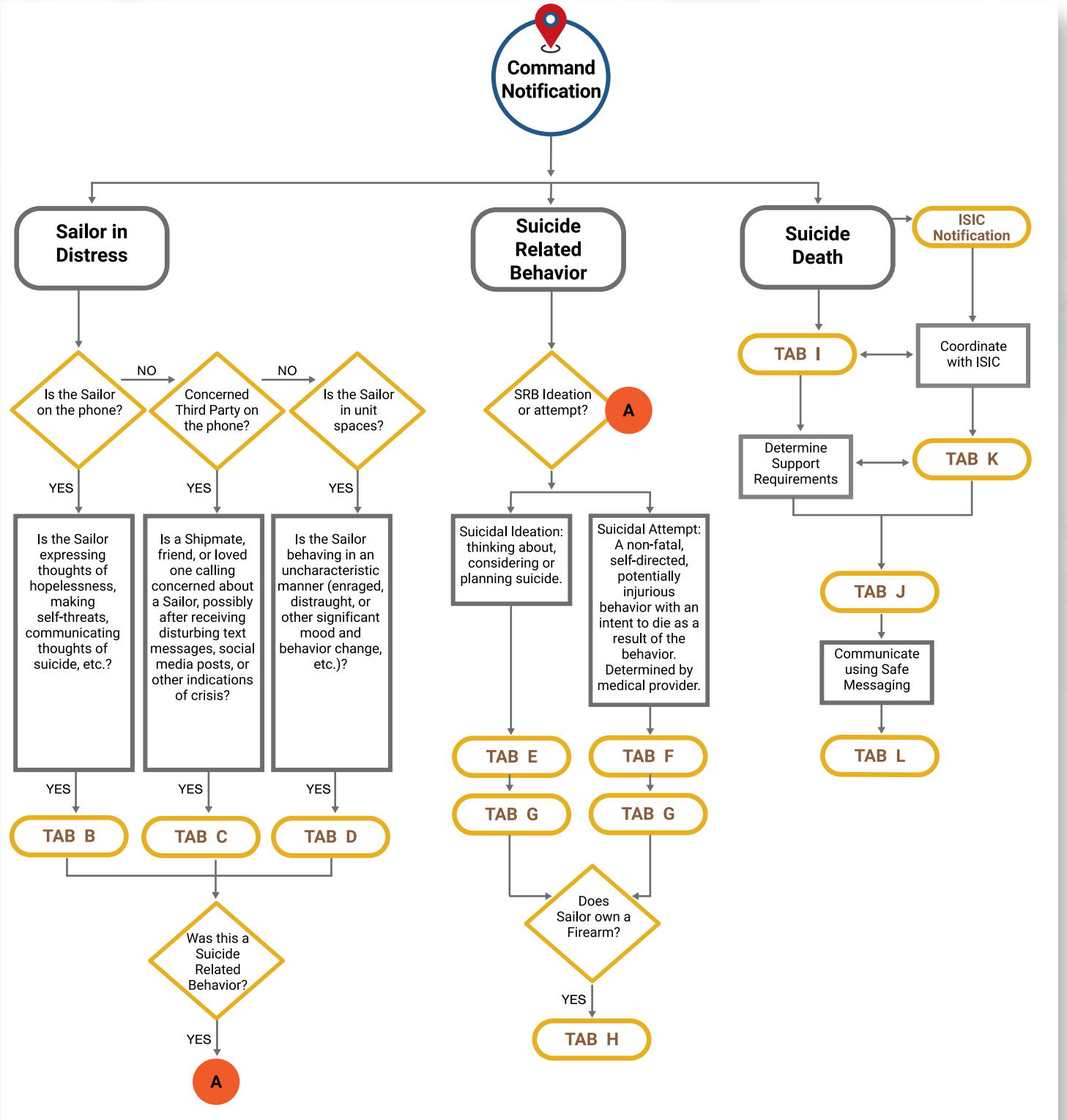
Effective suicide prevention includes prevention, response, and postvention. While our focus is on prevention, we must make response and postvention an integral part of our comprehensive suicide prevention efforts.

HOW TO USE THIS GUIDE

Commanders should view this guide as an augment to the Mental Health Playbook addressing suicidal statements, suicide attempts, and related behaviors that require immediate intervention and actions that must be taken when a command is notified of a death by suicide. The Navy Mental Health Playbook is designed to assist leaders in preventing, mitigating, or addressing mental health issues within your commands. As noted in the Playbook, this work begins well before a mental health issue occurs. It starts with the climate our leaders create and how you lead the people in your care. How we respond to a Sailor in crisis, facilitate their reintegration back into our teams, and react to a suicide death can have a profound and lasting impact on our people.

This guide is designed to flow from crisis response to reintegration and postvention. To that end, we recommend you read this handbook from cover to cover and review the decision tree below. This guide is also designed so individual sections can be removed and used to augment existing crisis response plans, support crisis response teams and inform command triads.

DECISION TREE



TAB A – RESOURCE CONTACT INFORMATION

RESOURCE	NAME	PHONE NUMBER
CO		
XO		
CMC		
SPC		
CACO		
CDO/ QUARTERDECK		
ON-BASE SECURITY DISPATCH		
OFF-BASE BASE SECURITY DISPATCH		
EMERGENCY ROOM		
MENTAL HEALTH		
FLEET AND FAMILY SUPPORT CENTER (FFSC)		
BASE DUTY CHAPLAIN		
ON BASE AMBULANCE		
OFF BASE AMBULANCE		
INSTALLATION DPH		
POISON CONTROL		
SUICIDE PREVENTION PROGRAM MANAGER (SPPM)		

TAB B – DISTRESSED SAILOR PHONE CALL

GUIDANCE FOR ASSISTING A DISTRESSED CALLER (Sailor expressing thoughts of hopelessness, making self-threats, communicating thoughts of suicide, etc.)

ACTIONS

1. ☐ **Listen attentively** to everything that the caller says and try to learn as much as possible about their state of mind, intent, and location.

2. ☐ **ASK FOR THEIR PHONE NUMBER IN CASE THE CALL IS DISCONNECTED.**

   - NAME: _____
   - PHONE NUMBER: _____
   - LOCATION: _____
   - NOTES: _____

3. ☐ Stay calm and be supportive. Let the caller express emotions without negative feedback or invalidating their views.

4. ☐ Avoid giving advice. It is not about how serious the problem is; it is about how badly it is hurting the person.

5. ☐ Ask the caller directly: "Are you thinking about killing yourself?" If the caller answers "yes," let them know that you are concerned about their well-being and will be contacting someone "who can help keep you safe for now".
   - How would you harm yourself?
   - Do you have what you need to do it e.g., gun, pills, etc.?
   - If the person indicates he/she has taken a toxin (pills, medicine, harmful substance), ask what kind, how much and when?
   - If the person has a gun, ask if it is loaded. If yes, where is it?

6. ☐ **CALL LOCAL EMERGENCY SERVICES (911) FROM A SEPARATE PHONE OR HAVE SOMEONE ELSE CALL. TRY TO MAINTAIN CONTACT WITH THE CALLER UNTIL FIRST RESPONDERS ARRIVE.**

7. ☐ Provide the caller with all Suicide and Crisis Line information: 988, 1-800-273-8255, text to 838255, and chat available on https://www.veteranscrisisline.net

TAB C - CONCERNED THIRD PARTY PHONE CALL

GUIDANCE FOR ASSISTING A CONCERNED THIRD PARTY (Shipmate, friend, or loved one calls concerned about a Sailor, possibly after receiving disturbing text messages, social media posts, or other indications of crisis)

ACTIONS

1 ☐ If the caller is concerned about someone else who is suicidal, reassure the person that he or she is doing the right thing by reaching out. Stay calm and be supportive.

2 ☐ **ASK FOR THEIR PHONE NUMBER IN CASE THE CALL IS DISCONNECTED.**

- **NAME** (concerned third party): _____
- **PHONE NUMBER** (concerned third party): _____
- **LOCATION** (concerned third party): _____
- **NOTES:** _____

_____

3 ☐ **If co-located with Sailor in distress:**

- If there is any perceived safety threat, contact local emergency services immediately and/or have the caller escort the Sailor to the nearest ER or medical professional.
- Assist caller with the following:
  - Location of Nearest ER:
  - Name of Medical/Mental Health Professional:
  - Phone number of Medical/Mental Health Professional:

4 ☐ **If not co-located with Sailor in distress, attempt to determine the Sailor's location and to get them emergency assistance as soon as possible.**

- Name (Sailor in distress):
- Phone Number (Sailor in distress):
- Location (Sailor in distress):
- Notes:

5 ☐ **AFTER EMERGENCY SERVICES HAVE BEEN NOTIFIED, IMMEDIATELY INFORM THE SPC OF THE INCIDENT**

- Suicide Prevention Coordinator (SPC)
- Name of SPC:
- Phone Number of SPC:

*Follow Command local SOP for watch standing documentation and reporting requirements.

TAB D– CONCERNING CHANGES IN BEHAVIOR

RESPONDING TO AN OBSERVED OR REPORTED CHANGE IN BEHAVIOR Sailor is behaving in an uncharacteristic manner (enraged, distraught, or other significant mood and behavior change, etc.)

ACTIONS

1. ☐ Ensure that all responding personnel are familiar with "Ask, Care, Treat"

2. ☐ Responders should remain calm and nonjudgmental.

3. ☐ Start a conversation with the Sailor to gain more insight as to what may be troubling them and facilitate access to appropriate resources.

4. ☐ **IF THERE IS ANY PERCEIVED SAFETY THREAT TO THE INDIVIDUAL OR OTHERS, IMMEDIATELY CONTACT LOCAL EMERGENCY SERVICES.**
   - Phone number for local emergency services:

5. ☐ If appropriate to the situation, ask the Sailor directly: "Are you thinking about killing yourself?"

6. ☐ If the answer is yes, or when in doubt, **A SAFETY WATCH SHOULD BE CONDUCTED UNTIL GUIDANCE FROM A MEDICAL OR MENTAL HEALTH PROFESSIONAL IS AVAILABLE.** Assume "line of sight" control and supervision, and remove anything that that may be considered a hazard (weapons, belt, bootstraps, drawstrings, razors, alcohol, ropes, window dressings, tools, eating utensils, breakable and sharp objects, etc.). Also monitor medications until seen by a provider.

7. ☐ Commanders and appropriate supervisors who, in good faith, believe that a subordinate Service member may require a mental health evaluation (MHE) are authorized to direct the Service member to a medical treatment facility for an MHE.
   - POC Name for MHE:
   - POC Phone Number for MHE:
   - POC Location for MHE:

8. ☐ Time permitting, Commands should contact their local staff judge advocate (SJA) to ensure they are following up-to-date procedures for making a referral for an MHE.
   - SJA Name:
   - SJA Phone Number:
   - SJA Location:

ACTIONS

9 ☐ **Commander's responsibilities prior to referral for an MHE:**

- **EMERGENCY SITUATIONS:** Focus on the immediate safety of the Service member and any others who may be at risk. Immediately direct and/or transport the Service member to a medical treatment facility. Ensure that the Service member has an appropriate escort who displays maturity, calm, and a supportive nature. Additionally, the escort should be at least one rank higher than the Service member. If time permits, alert the medical treatment facility that a Service member requires an emergency MHE. Document in writing any actions associated with an emergency MHE referral to memorialize why the command directed a Service member for an emergency MHE.

- **NON-EMERGENCY SITUATIONS:** Advise the Service member that there is no stigma associated with obtaining mental health care. Direct the Service member to the MHP, providing the Service member with correct contact and location information for the medical treatment facility, and the date, time, and name of the MHP. If time permits, commands should consult a MHP before directing the referral to ensure that a referral is appropriate under the known circumstances. The order and logistical information directing a member to get a MHE evaluation should be put in writing.

TAB E – SUICIDE RELATED BEHAVIOR: SUICIDE IDEATION (THOUGHTS AND BEHAVIORS)

This guide is designed to assist leaders in addressing Service members that are thinking about, considering or planning suicide, e.g., ideations, preparatory actions, self-directed violence, etc.

ACTIONS

1. ☐ **Notify Chain of Command.** Commander will initiate notification messages as per (list service specific references or requirements). 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.

2. ☐ **Verify Ask Care Treat (ACT)** protocol has been followed, and that the Service member has not been left alone. Contact Behavioral Health and/or medical assets and follow the installation protocol. This usually involves a mental health evaluation at the Mental Health clinic (during duty hours) or Emergency Department (after duty hours).

3. ☐ Submit message in accordance with OPNAVINST 3100 series Serious Incident Report within 24 hours of the ideation, or within 24 hours of becoming aware of the ideation.

4. ☐ If the Service member is not currently a danger to him/herself or others, but needs assistance, or there is a question of fitness for duty, the Commanding Officer can request a Command Directed Evaluation.

5. ☐ The command must initiate a **SAIL referral** (TAB G). For most up to date SAIL process, please refer to **www.suicide.navy.mil.**

REINTEGRATION AFTER SRB: SUICIDE IDEATION (THOUGHTS AND BEHAVIORS)

1. ☐ During periods of extreme stress, it is not uncommon to have thoughts or feelings of suicide but may not meet criteria for admission to a hospital.
   - In these situations, outpatient treatment will be offered to address the suicidal thoughts and behavior, as well as any mental health disorders. It is essential that leaders and providers collaborate.
   - Consider the following leader-provider collaborative opportunities:
     - Working together to develop means for ongoing monitoring of potential risks.
     - Following up jointly (leader and provider) with the Service member.
   - Ensure the Service member is cleared for return to duty by Behavioral Health and their Primary Care Manager. The goal is to gradually return the Service member to full duties, as appropriate.
     - If a Behavioral Health/Medical asset believes that Service member is at an increased risk for suicide, the provider may recommend duty restrictions, such as removal from positions of increased responsibility or temporary change in flying status.
     - If sent a period of Temporary Additional Duty (TAD) is prescribed, ensure MILPERSMAN 1320-307 (PCS / TAD Warm Hand-Off Procedures) is followed.
     - Consultation between Behavioral Health/Primary Care Manager and command can ensure a work schedule that accommodates the Service member and provides additional supervision and support without risk of showing secondary gain for having reported thoughts of suicide.
   - Commands may also be directed by a Mental Health provider to minimize the time a Service member is left alone, as well as, advised to reduce access to lethal means (firearms, medications, etc.).

(CONT...)

TAB E – SUICIDE RELATED BEHAVIOR: SUICIDE IDEATION (THOUGHTS AND BEHAVIORS)

REINTEGRATION AFTER SRB: SUICIDE IDEATION (THOUGHTS AND BEHAVIORS)

2 ☐ Ensure Service member is referred to the SAIL program (TAB G).

3 ☐ Ensure supervisor/designee has frequent check-ins with Service member, especially if the member is TAD away from the command, and that unit leaders meet regularly with the Service member to discuss any safety/coping concerns and provide support.

- Check-ins (daily to 2-3x weekly) may be accomplished in person, via telephone or text at the discretion of the Commander.
- Weekly contact with supervisor/designee should occur face-to-face. Ensure that these contacts are supportive and not punitive by paying particular attention to changes in critical stressors or support.

4 ☐ **If personal safety is a concern:**

- Establish non-weapons bearing duties.
- Encourage the Service member to voluntarily secure personal firearms with local installation procedures (TAB H).
- Consider a "No Drink" order.
- Have Service member and supervisor/designee develop activity plan for off duty time that fosters connections with positive supports.
- Review Service member's leave requests carefully with consideration for potential stressors; requests should involve structured time or planned events that will enhance the Service member as he or she takes time away from the unit.

5 ☐ Be aware of secondary stress to those members and/or family members who are directly involved with the Service member. Refer to the appropriate helping agency.

6 ☐ Ensure the Service member is aware of helping resources, such as the Suicide and Crisis Lifeline (988), FFSC, Chaplain, and MFLCs/Military One Source..

7 ☐ Encourage family/friends to reach out to the unit if they become concerned about the Service member's mental or emotional behavior and any changes that might increase stress.

TAB F – SUICIDE RELATED BEHAVIOR: SUICIDE ATTEMPT

This guide is designed to assist leaders in addressing suicide attempts by those in their unit. Suicide attempt is a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior.

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.

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.

ACTIONS

1. ☐ **Verify** that local law enforcement/Security/Naval Criminal Investigative Service (NCIS) and 911 (situation dependent) have been contacted. Ensure the area of the attempt has been secured.

2. ☐ **Notify Chain of Command.** Commanding Officer will initiate notification messages per OPNAVINST 3100.6 series. Commanding Officer will 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

3. ☐ Submit message in accordance with OPNAVINST 3100 series **Serious Incident Report** within 24 hours of the attempt, or within 24 hours of becoming aware of the attempt.

4. ☐ 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).

5. ☐ If the attempt occurred in the workplace 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.

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. Additionally, it is recommended you contact the medical provider about picking up the Service member when they are discharged from hospitalization.

7. ☐ **The command must initiate SAIL referral.** For most up to date SAIL process, please refer to **www.suicide.navy.mil.**

TAB F – SUICIDE RELATED BEHAVIOR: SUICIDE ATTEMPT

REINTEGRATION AFTER SRB: SUICIDE ATTEMPT

1. ☐ 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.

2. ☐ Consider the following leader-provider collaborative opportunities:
   - Working together to develop means for ongoing monitoring of potential risks.
   - Following up jointly (leader and provider) with the Service member.
   - Ensure the Service member is cleared for return to duty by Behavioral Health and their Primary Care Manager. The goal is to gradually return the Service member to full duties, as appropriate.
     - If a Behavioral Health/Medical asset believes that Service member is at an increased risk for suicide, the provider may recommend duty restrictions, such as removal from positions of increased responsibility or temporary change in flying status.
     - If sent a period of Temporary Additional Duty (TAD) is prescribed, ensure MILPERSMAN 1320-307 (PCS / TAD Warm Hand-Off Procedures) is followed.
     - Consultation between Behavioral Health/Primary Care Manager and command can ensure a work schedule that accommodates the Service member and provides additional supervision and support without risk of showing secondary gain for having reported thoughts of suicide.
   - Commands may also be directed by a Mental Health provider to minimize the time a Service member is left alone, as well as, advised to reduce access to lethal means (firearms, medications, etc.).

3. ☐ Ensure Sailor is referred to the SAIL program.

4. ☐ Ensure supervisor/designee has frequent check-ins with Service member, especially if the member is TAD away from the command, and that unit leaders meet regularly with the Service member to discuss any safety/coping concerns and provide support.

5. ☐ Check-in regularly with Service member (e.g., daily to 2-3x weekly) may be accomplished in person, via telephone or text at the discretion of the Commander.

6. ☐ Weekly contact with supervisor/designee should occur face-to-face.

7. ☐ Ensure that these contacts are supportive and not punitive by paying particular attention to changes in critical stressors or support.

8. ☐ **If personal safety is a concern:**
   - Establish non-weapons bearing duties.
   - Encourage the Service member to voluntarily secure personal firearms with local installation policy (TAB H).
   - Consider a “No Drink” order.
   - Have Service member and supervisor/designee develop activity plan for off duty time, i.e., week- ends, leaves, and holidays.
   - Review Service member’s leave requests carefully with consideration for potential stressors; requests should involve structured time or planned events that will enhance the Service member as he or she takes time away from the unit.

(CONT...)

REINTEGRATION AFTER SRB: SUICIDE ATTEMPT (CONT...)

9 ☐ Encourage Service member to continue to engage in unit and community activities, if appropriate.

10 ☐ Emphasize how other members in the unit can receive help to cope with the incident. Be aware of secondary trauma to those members and/or family members who are close to the Service member who made the attempt. Refer to the appropriate helping agency.

11 ☐ Ensure the unit is aware of helping resources, such as the Military Crisis Line, FFSC, Chaplain, and MFLCs/ Military One Source.

12 ☐ Encourage family/friends to reach out to the unit if they become concerned about the Service member's mental or emotional behavior and any changes that might increase stress.

TAB G- SAIL REFERRAL PROCEDURES

The command is required to submit a Sailor Asistance and Intercept for Life (SAIL) Referral for all Sailors that have experienced a Suicide Related Behavior (SRB).

SAIL REFERRAL PROCEDURES
Go to (suicide.navy.mil) to review required SAIL Referral information:
OPREP/SITREP DTG:
Date of Incident:
Sailor's Last Name:
Sailor's First Name:
Sailor's Middle Initial:
Sailor's Rank:
Sailor's Work Phone:
Sailor's Email Address:
Sailor's Personal Cell Number:
Sailor's Current Location (City, State, Country):
For Reserve Component Sailors only, indicate status: (FTS, SELRES on orders, SELRES not on orders):
Base/Installation:
Command:
Region:
Commanding Officer's Name:
Commanding Officer's Phone:
Commanding Officer's Email:
Additional Information (Alt Triad's contact info, i.e. XO, CMC)
Submit required information via encrypted email to the SAIL Mailbox - **MILL_N17_SAIL.fct@navy.mil** subject: SAIL REFERRAL
SPCs can access the following link to verify the SAIL Case Manager within your region has made contact: **https://www.milsuite.mil/book/docs/DOC-929099**
SAIL CASE MANAGER SAILOR CONTACTS
Case managers contact a Sailor's command to verify information and incident.
Case managers contact Sailor to explain and offer SAIL services. If member accepts services, caring contacts will be initiated at a minimum of 1, 3, 7, 14, 30, 60, and 90 days following an incident. Caring contacts include updating safety planning as needed and providing resource.

TAB H – FIREARM STORAGE PLAN

PERSONALLY OWNED FIREARM STORAGE Per DoD Instruction 6490.16, Commanding Officers (CO) and health professionals may inquire about, collect and, record information about a Service member's privately-owned firearms, ammunition, or other weapons if the CO or health professional has reasonable grounds to believe the service member is at risk for suicide or causing harm to others. The action must be entirely voluntary for the service member; the request by the Commander may not be accompanied by any command incentives or disincentives.

If the command and Service member decide that temporary storage of a personal firearm is the appropriate measure to take, follow the steps below:

ACTIONS

1 ☐ **Contact Installation Armory POC.**

- Name:
- Phone Number:

---

2 ☐ **Contact Base Security POC to inform them of the intent to bring a personal weapon onto base to store in an armory.**

- Name:
- Phone Number:

---

3 ☐ **Inform Suicide Prevention Program Manager/ Suicide Prevention Coordinator.**

- Name:
- Phone Number:

TAB I – SUICIDE POSTVENTION: UNIT PROCEDURES

This guide is designed to assist leaders in their response to suicides. Research suggests the response by a unit's leadership can either play a positive role in the prevention of additional suicides/suicide related behaviors or, conversely, inadvertently contribute to increased suicides or suicide attempts (suicide contagion). This guide is intended to augment any local policies. It incorporates "lessons learned" from leaders who have experienced suicide deaths in their unit. It is intended to support a leader's judgment and experience. As a checklist, it does not outline every potential contingency which may come from a suicide death.

A suicide death heightens the risk for suicide in others. It's important to provide a "safety net" around those exposed and impacted.

ACTIONS

1. ☐ Contact 911 (if law enforcement is not already involved) and NCIS.
2. ☐ Notify the ISIC and JAG. Release CCIR and OPREP per OPNAVINST 3100.6 series.
3. ☐ Contact CACO for NOK notification.
4. ☐ Notify installation specific resources such as; Chaplain, Embed Mental Health, FFSC and Installation Directors of Psychological Health (iDPH).
   - **iDPH Contact Cards** can be found **here.**
5. ☐ Consult with Chaplain, mental health, and/or PAO to prepare announcement to the command. Announcement should utilize Safe Messaging guidelines provided in TAB L and/or the **DSPO Leaders Suicide Prevention Safe Messaging Guide** (**dspo.mil**).
6. ☐ Make initial announcement to the command. Utilize Safe Messaging guidelines in the **DSPO Leaders Suicide Prevention Safe Messaging Guide** (**dspo.mil**)
   - Have Chaplain and mental health available for support.
   - Protect the privacy rights of the deceased and their loved ones during death notification.
7. ☐ Consult with PAO regarding public statements about the event. Refer to Safe Messaging guidelines **Leaders Suicide Prevention Safe Messaging Guide** (**dspo.mil**)
8. ☐ When speaking to the command about the death, 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. (refer TAB L, to do/do not table)
9. ☐ Consult with Chaplain and mental health for actions considered for a memorial service. Refer to Postvention Toolkit and Navy SP handbook for guidance.

TAB I – SUICIDE POSTVENTION:
UNIT PROCEDURES

ACTIONS

10 ☐ **When engaging in discussions of the suicide:**

- Express sadness at the loss and acknowledge the grief of the survivors.
- Emphasize hope and that help is available.
- Reiterate to the audience to seek assistance when distressed, including those who are presently affected.
- Encourage Sailors to support their shipmates, especially those close to the deceased.
- Provide brief reminder of warning signs for suicide.

11 ☐ After death announcement to the command, consider reinforcing available resources via quarters, 1MC announcements, and/or email.

12 ☐ Unless you discern there is a risk of being perceived as disingenuous, consider increasing senior leadership, Chaplain, and/or mental health 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.

- Offer time, permission, and support for Sailors to take care of themselves. Encourage Sailors to take care of themselves and model this behavior for them.
- **NOTE:** Triads may be impacted by the tragic loss and in need of support. Consider talking to each other about the impact, reaching out to peers who have lost a Sailor to suicide, or initiating contact with support resources.

13 ☐ Public memorials such as plaques, trees, or flags at half-mast are not recommended.

14 ☐ Refer to resources, such as Chaplains, FFSC, 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). The Tragedy Assistance Program for Survivors (TAPS) is available for anyone who has lost a family member, friend, and/or shipmate to suicide: 800-959-TAPS (8277).

15 ☐ The OPNAV Suicide Prevention Office will normally contact the command within 7 days of receiving notification of the suicide death. OPNAV offers assistance, administrative guidance, and provide tools as listed:

- Command Letter
- Department of Defense Suicide Event Report (DoDSER) survey and DoDSER Checklist
- OPNAVINST 1720 series Suicide Prevention Program
- DSPO Postvention Toolkit for a Military Suicide Loss
- DSPO Leaders Suicide Prevention Safe Messaging Guide
- Navy Suicide Event Review Board Charter Form

16 ☐ OPNAV gathers additional information to create a Summary of Preliminary Information to include a brief overview of any known stressors, including if the Sailor was:

- Under mental health care
- On altered duty status (e.g., LIMDU, medical board, administrative separation, etc.)
- Showed any signs of distress (e.g., isolation, withdrawal, impulsive behaviors, personality changes, etc.)
- Had a previous SRB (ideation or attempt)
- Had any known relationship difficulties

(CONT...)
►►►

ACTIONS

16 (CONT...) ☐
- Had any work performance difficulties
- Had Involvement with Legal or pending Legal actions
- Had any financial difficulties or changes
- Made any comments or had a preoccupation with death
- Giving away possessions
- In transition (e.g., PCS, promotion, separation, retirement, deployment, new job, temporary placement unit, etc.)

17 ☐ Conduct the Suicide Event Review Board as a collaborative effort to provide a responsive, coordinated and comprehensive DoDSER after a suicide. The SERB has three main deliverables:
- To provide a complete and comprehensive DoD Suicide Event Report (DoDSER) within 60 days of Armed Forces Medical Examiner System's determination that the manner of death is suicide.
- Develop "Lessons Learned" and "Best Practices" to be shared locally as well as with OPNAV N17 (submit to suicideprevention@navy.mil).
- Share information and observations that will assist in improving the Navy Suicide Prevention Program.

18 ☐ Be mindful of periods of increased risk at certain timelines (1 month, 6 month, and 1 year), as well as during holidays and birthdays.

UNIT LEADER CHECKLIST FOR SUPPORTING NEXT-OF-KIN

1. ☐ Consult with Casualty Assistance Officer and the Chaplain to understand how Next-of-Kin (NOK) and family are doing after official notification of death and if there are any special needs.

2. ☐ Consider calling NOK to express condolences within a week of official notification.

3. ☐ Send condolence letter.
   - Check for typos. Pay particular attention to the spelling of the Service member's name. Despite best efforts, NOK still receive letters with misspelled names.
   - Avoid a form letter by personalizing the message as much as possible. Express appreciation of the deceased's service to the country, include specific detail, and point out that their service/contribution will NOT be forgotten.

4. ☐ Review guidelines for speaking at the memorial or consult with the Chaplain or Behavioral/Mental Health provider to understand what is or is not appropriate to say. These guidelines also apply to the funeral or anytime you speak publicly about the death.
   - Comfort the grieving by acknowledging their grief and loss.
   - Memorialize the deceased by recognizing the member's life, service, accomplishments, and contributions.
   - Avoid focusing on the manner of death and discussing suicide prevention at length.
   - Encourage Service members and family members to seek help.

5. ☐ Work with the Casualty Assistance Officer to invite family members to the unit-sponsored memorial service. If not appropriate or possible, consider working with Casualty Assistance Officer to communicate information to NOK. If possible, meet with the family to express condolences.

6. ☐ Attend hometown/military funerals whenever possible.

7. ☐ Support connection and communication between family and unit members.

8. ☐ Coordinate with the Casualty Assistance Officer (CACO) and the investigative organization (i.e., local law enforcement or Military Criminal Investigative Organization) if the command investigation report is shared with NOK. NOK may not understand that there may be several investigations that occur and this could impact their understanding and acceptance of the results of the death investigation completed by law enforcement/investigative organization. If the command investigation is shared with NOK, consider having someone review and explain its contents to the family.

TAB J – SUICIDE POSTVENTION: EXTERNAL RESOURCES

RESOURCE	WHEN TO USE	CRITERIA FOR REQUEST	WHO PAYS	HOW TO REQUEST	ADDITIONAL NOTES
Installation Director for Psychological Health (iDPH)	Anytime command has a question re: local mental health resources	N/A	NO COST TO COMMAND	Installation Resource Contact Cards - All Documents (navy.mil)	SECNAVINST 6520.1
Fleet & Family Support Centers (FFSC)	To request grief counseling and additional counseling support	If multiple Sailors at the command are in need of grief counseling support	NO COST TO COMMAND	Through iDPH and/or contact local FFSC to request support	FFSC supports if they are able, no payment required but facilities (private office and/or group room) would be required.
Specialized Psychiatric Intervention Team (SPRINT)	SPRINT provides short-term mental health support to a requesting command shortly after a traumatic event with the goal of preventing long-term psychiatric dysfunction and promoting maximum psychological readiness.	When all other mental health resources (e.g., Embedded Mental Health and non-medical counseling resources) are "overwhelmed or unavailable"	COMMAND FUNDED - Requesting commands will reimburse NMFL for additional costs (travel, etc.) associated with SPRINT team or response deployment.	Any Navy command can request SPRINT assistance by sending a message to CNO (N931) via operational chain of command (may be completed verbally in emergency situations). As decision authority, CNO (N931) approves SPRINT request and directs BUMED to provide appropriate team. Upon CNO tasking, BUMED will notify the designated command(s) to support the mission followed by a message with copies to the appropriate echelon 2 and responsible line Commanders.	BUMEDINST 6520.4 SPRINT is available for rapid activation (24 to 48 hour mobilization) in coordination with the impacted unit's Commander, SPRINT officer in charge (OIC), and regional senior mental health executive (SMHE). The organization or activity that receives and supports the SPRINT must provide the following minimum support: shelter, berthing, utilities, laundry facilities, space for debriefings, messing, security, administrative and communication support.

TAB J – SUICIDE POSTVENTION:
EXTERNAL RESOURCES

RESOURCE	WHEN TO USE	CRITERIA FOR REQUEST	WHO PAYS	HOW TO REQUEST	ADDITIONAL NOTES
Army Behavioral Health (BH) Epidemiological Consultation (EPICON)	BH EPICONs are typically used when there is a perceived increase in BH concerns (e.g., suicidal behavior, aggression/violence) and related issues (e.g., alcohol and drug use, sexual assault). EPICONs provide targeted findings from investigations of behavioral and social health outcomes of Service members to inform implementation of related policies and programs.	A command can request a BH EPICON for any increase in BH concerns, but must consult with the Army BH EPICON Team to refine the specific nature of the request.	COMMAND FUNDED	Though requests are usually made by U.S. Army stakeholders and further negotiated between the chains of command, EPICONs have been requested and completed for other Services. For more information about BH EPICONs, please contact the Division of Behavioral and Social Health Outcomes Practice. **Phone:** 410-436-5426 **Email:** usarmy.apg.medcom-phc.list.eds-bshop-ops@mail.mil	Website: **https://phc.amedd.army.mil/topics/healthsurv/bhe/Pages/default.aspx**
Naval Health Research Center (NHRC)	To primarily conduct a unit assessment with surveys and focus groups, may overlap with EPICON capabilities	Any increase in BH concerns and willingness to participate in survey/focus group data collection	COMMAND FUNDED - note that NHRC is in San Diego	EA/Admin Group: usn.point-loma.navhlthrschcensan.list.admin@mail.mil Administration (619-553-8400) EA (619-553-8428)	
Organizational Incident Operational Nexus (ORION)	ORION is used following unit-level, non-combat incidents that involve unexpected loss of life or potential loss of life. ORION tracks Service members and conducts targeted outreach (Caring Contacts) to those at elevated risk for psychological injury after unit-level, non-combat trauma exposure.	The unit Senior Medical Department Representative (SMDR), in consultation with the unit CO, must determine if a unit-level, non-combat trauma meets criteria required to utilize ORION. For traumatic incidents that do not meet these criteria, ORION can be activated at the discretion of the CO after consultation withthe ORION point of contact.	NO COST TO COMMAND	ORION point of contact at usn.ncr.bumedfchva.mbx.orion@mail.mil or (619) 532-7484. After activation, the chain of command works with the Naval Center for Combat & Operational Stress Control (NCCOSC) to determine which of their command Service members may have been most affected by the event.	**BUMEDINST 6010.33**

TAB K – SUICIDE POSTVENTION: ISIC PROCEDURES

AS AN ISIC, WHEN A DEATH BY SUICIDE OCCURS AT A SUBORDINATE COMMAND:

1. ☐ Ensure the Command has everything they need to navigate the way-forward: taking care of the family of the deceased and the needs of the command members.
2. ☐ Identify and take action if there are ongoing controllable factors that may have had an impact on the death by suicide. Examples include a Quality of Service issue (e.g. living/work conditions) or a leadership issue (e.g. hostile/toxic leader or climate).
3. ☐ Report to your administrative and/or operational Commander about any controllable factors, or lessons that should be shared between commands in the area or community.

To assist in carrying out these responsibilities, conduct the following as soon as practicable:

1. ☐ Review the most recent unit Command Climate Assessment (CCA), Defense Organizational Climate Survey (DEOCS), ISIC debrief and plan of action and milestones to ensure the command is addressing any areas of concern that are within its control.
2. ☐ Coordinate with the unit Commander to identify (via pulse surveys, unit risk inventory (URI) or focus groups) any stressors or contributing factors which may be either inside or outside of the commander's control that are not addressed in the CCA. Address or elevate these concerns up the chain of command for support.
3. ☐ Confirm the unit has implemented the Command Resilience Team, Human Factors Council, Warrior Toughness/Expanded Operational Stress Control and is familiar with the Mental Health Playbook.
4. ☐ Ensure the unit coordinates with installation Director of Psychological Health (iDPH) to identify and request additional clinical and non-clinical support if required. (See C.4 TABLE for a list resources).
5. ☐ Periodically check in with the command triad for a personal wellness check. Be aware that, while there is no set timeline for recovering from a suicide loss, common difficult periods include holidays and anniversaries of deaths.
6. ☐ Ensure the unit and your broader command revises crisis response and postvention procedures to incorporate any lessons learned from this experience as applicable.
7. ☐ Ensure the unit completes the Suicide Event Review Board (SERB) no later than 60 days after Armed Forces Medical Examiner determination of death by suicide.

TAB K – SUICIDE POSTVENTION: ISIC PROCEDURES

The actions below MUST be taken if a second suicide death occurs within 30 days. However, strong consideration should be given to taking these actions outside the 30-day window when necessary to help to identify and address any common casual factors or connections between cases and ensure identification and referral of persons who may be at a higher risk of suicide.

ADDITIONAL REQUIREMENTS IF A COMMAND EXPERIENCES MORE THAN ONE SUICIDE DEATH IN 30 DAYS

1. ☐ Conduct on-site assist visit to ensure optimal implementation and use of unit personnel support programs (see item 3 above) and external support programs.

2. ☐ Request a Military Health System report. Data will allow comparison to Navy, Unit Type and Individual Unit which may enable identification of outlying or unknown issues and inform additional support requests or postvention actions. Contact information: Defense Center's for Public Health – Portsmouth (DCPH-P), Epi Data Center at **usn.hampton-roads.navmcpubhlthcenpors.list.nmcphc-epi-plls@health.mil**

3. ☐ Ensure the unit coordinates with installation Director of Psychological Health (iDPH) to identify and request additional clinical and non-clinical support if required. (See C.4 TABLE for a list resources). Department of the Navy installation Director of Psychological Health (iDPH) Program Roster can be found **here: https://esportal.med.navy.mil/bumed/rh/m3/M33/Pages/DPHProgram.aspx**

4. ☐ Consider requesting a Special Psychiatric Rapid Intervention Team (SPRINT). SPRINT provides short-term mental health support to a requesting command shortly after a traumatic event with the goal of preventing long-term psychiatric dysfunction and promoting maximum psychological readiness (TAB J and BUMEDINST 6520.4 for more information). Examples of scenarios in which a SPRINT response may be beneficial include:
   - Natural or man-made disasters that result in loss of life, threatened loss of life, or displacement
   - Mishaps, accidents, or other traumatic events incidents involving loss of life or threatened loss of life
   - Fatalities witnessed by members of the command

5. ☐ Consider requesting a Behavioral Health Epidemiological Consultation (BH EPICON) or Naval Health Research Center (NHRC) Post Surveillance Report (TAB J).

TAB L – SUICIDE POSTVENTION:
SAFE MESSAGING COMMUNICATION

Leaders play an important role in reducing the conscious or unconscious stigma towards risk factors associated with suicide and help-seeking behaviors. Consider your language when talking about suicide and mental health — it has the ability to change misperceptions and can pave the way for Service members in your unit and their families to get the help they need. These guidelines are developed to help leaders communicate safely and effectively.

COMMUNICATING ABOUT SUICIDE

- Use language that is objective, precise, and avoids judgment or assumptions about how an individual's mental health condition affects them.
- Use objective language about substance use disorders (e.g., misusing substances vs. addict),
- Encourage help-seeking and self-care by providing options available for Service members and sharing supports you may have used across your career.
- Avoid suggesting a death by suicide was preceded by a single event because it implies an overly simplistic and misleading perception of suicide.
- Avoid inflammatory or sensationalizing language that may unintentionally glamorize suicide
- Avoid explicitly describing the suicide method (how or where an individual died), as this increases the risk of suicide in others.
- Avoid talking about mental health or mental health conditions in unrelated situations.

INSTEAD OF THIS...	TRY THIS...	WHY?
Referring to suicide as **"successful," "unsuccessful," "failed attempt,"** or **"committed"**	Describe as **"died by suicide"** or **"suicide death"**	The term "committed suicide" implies the act is considered a sin or a crime. Similarly, "successful suicide" or "unsuccessful attempt" are considered poor choices because they connote an achievement or something positive even though they result in a tragic outcome. Conversely, "died by suicide" describes the outcome.
Focusing on **one or two factors** in the person's life that **"drove"** them to suicide	Discuss suicide as a public health issue instead of focusing on the details about the person who died. Note risk and protective factors and **"what to do if you think someone might be in trouble."** Providing information and resources, such as crisis lines, can help correct misconceptions, and offer hope, healing, and recovery.	Talking about a person's mental health disorder, or other singular factor, may oversimplify or speculate on the reason for the suicide. For most individuals, suicide is a result of a culmination of many factors.
Glamorizing or romanticizing suicide by **focusing on methods of death or using images that illustrate grief, anguish, and isolation**	**Focus on the facts of the event.** If there was a message from the deceased, do not detail what the note contained or refer to it as a "suicide note."	Glamorizing the outcome of suicide may lead to contagion within a group. Refer to the tools in the **DSPO Tools Download Library** (www.dspo.mil/) to familiarize yourself with the recommended post-vention guidelines. Use the Postvention Toolkit for a Military Suicide Loss.

TAB L – SUICIDE POSTVENTION:
SAFE MESSAGING COMMUNICATION

INSTEAD OF THIS...	TRY THIS...	WHY?
➤ Describing a suicide as inexplicable or **"without warning"**	➤ Most, but not all, people who die by suicide, exhibit warning signs. Include information about non- crisis and crisis resources such as the 24-hour **Suicide and Crisis Life Line — available at 988, Press 1.**	➤ It is important to understand and communicate objectively about the risk and protective factors associated with suicide.
➤ **Presenting suicide as a common** or acceptable response to hardship	➤ **Emphasize that suicide is preventable.** Report that proactive self-care, coping skills, support, and treatment work for most people who have thoughts about suicide.	➤ Being a leader means being an advocate for your team. Suicide is preventable and advocating for connectedness is a protective factor.
➤ Overstating the issue of suicide by using descriptors like **"epidemic"** or **"skyrocketing"**	➤ Familiarize yourself with the public health approach to suicide and use **data points** provided by the DoD and other industry leaders to ensure your language reflects facts.	➤ Suicide is a public health issue that affects communities everywhere and requires an understanding of the complex interaction of biological, psychological, environmental, and social influences that affect outcomes. It is important for leaders to communicate about it objectively.
➤ Using outdated terminology like **"mental disease"** or **"mental institution"**	➤ Ensure you use current terminology like **"mental health disorder"** or **"inpatient treatment facility."**	➤ Certain words or phrases can be offensive, increase stigma, and spread myths about suicide.
➤ **Using labels like** "she is depressed" or **"he is an addict,"** to describe the Service member	➤ Use clinical terminology like **"she is showing signs of depression"** or **"he is misusing substances."**	➤ Labeling a Service member as their condition makes it a defining trait or characteristic. Using clinical descriptions emphasizes a condition can be evaluated and treated.
➤ Words that express pity or distress, such as: Do you know your treatment options as a **victim of PTSD?** You shouldn't **suffer** this anxiety alone. Talking with someone is always an option.	➤ Use objective descriptions, such as: Do you know your treatment options as **someone who has a PTSD diagnosis?** You shouldn't **experience** this anxiety alone. Talking with someone is always an option.	➤ Talking about a mental health disorder as an affliction can contribute to stigma. It also assumes about a Service member's inner experience of their condition or symptoms. Keeping language objective and precise avoids judgment or assumptions about how someone's diagnosis affects them.

Reference: DSPO Leaders Suicide Prevention Safe Messaging Guide