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CANADIAN FORCES HEALTH SERVICES GROUP

CANADIAN ARMED FORCES

FORCES ARMÉES CANADIENNES

POSTVENTION GUIDE FOR CAF LEADERSHIP

Directorate of Mental Health
Clinical Programs

Canada

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Postvention guide for CAF leadership

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INTRODUCTION

Suicide prevention is a major public health priority for the Government of Canada. The Joint Suicide Prevention Strategy (JSPS) was implemented as part of the Strong, Secure, Engaged Defence Policy of 2017. The JSPS addresses the unique stressors on members and their families created by military service, both during and after their years served using a framework focused on preventing suicide across the entire military and Veteran community. Due to the unique nature of each organization, both the Canadian Armed Forces (CAF) and Veterans Affairs Canada (VAC) created independent Action Plans to address suicide prevention. The CAF Suicide Prevention Action Plan (SPAP) is the CAF specific plan.

Suicide prevention is complex. Command Teams and leaders at all levels may struggle with difficult situations involving CAF members where there are no easy answers or solutions. Providing guidance to CAF leadership on Suicide Prevention, Intervention and Postvention is a priority for SPAP. This guide will provide guidance to leadership at all levels on issues of Postvention (the response following a suicide). A Guide on Prevention and Intervention will be released at a later date completing the prevention-intervention-postvention continuum.

POSTVENTION

WHAT IS POSTVENTION?

The Suicide Prevention Resource Center defines postvention as an organized response in the aftermath of a suicide to accomplish any one or more of the following:

- To facilitate the healing of individuals from the grief and distress of suicide loss
- To mitigate other negative effects of exposure to suicide
- To prevent suicide among people who are at high risk after exposure to suicide

Postvention efforts can also take place following a suicide attempt.

Leadership action following a suicide is essential to morale, unit cohesion, and continued CAF suicide prevention efforts. Leadership at all levels should familiarize themselves with this guide and prioritize postvention efforts following a suicide or a suicide attempt.

Be Prepared

Create a toolkit with all applicable local resources and make sure it is always accessible.

In addition to this Guide, a toolkit should include the contact information for local resources such as the duty Chaplain, the duty Medical Officer, the CAF Transition Center Service Manager and the Family Liaison Officer.

Helpline numbers such as CFMAP and the Family Information Line can also be included.

SUICIDE AND ITS IMPACT

Suicide rates in the CAF are not statistically different from the rates in the Canadian General Population. Information about suicide rates in the CAF can be found in the Report on Suicide Mortality which is published yearly. According to the Public Health Agency of Canada, about 4000 people die by suicide each year in Canada. Suicide is the second leading cause of death among youth and young adults (15 to 34 years old). Suicide rates are approximately 3 times higher for men than women but suicide attempt rates are higher in women. For each death there are an estimated 20 to 25 suicide attempts.

Thoughts of suicide are reported by 11.8% of Canadians at some point in their lives and by 2.5% of Canadians in the past year. Four percent of Canadians report having made a suicide plan in their lifetime and 3.1% report having made an attempt.

Suicide is complex and multi-factorial. There are usually multiple causes, events and factors that lead up to a suicide. Some suicides are impulsive. Precipitating circumstances for suicide can include stressors such as relationship, family, financial or legal problems, or the death of a loved one.

Suicide may also be linked to a diagnosed mental illness, to an alcohol or substance use disorder or to a physical health problem.

While every sudden death is tragic, a suicide can be particularly difficult to process. A suicide can impact a large number of people such as family, friends, unit members, school communities, first responders, health-care workers and community members. Suicide can have an emotional impact such as having strong, sometimes contradictory emotions. Since suicide can carry a stigma it can also have a social impact. As a result of this, survivors may withdraw from their social support network.

Suicide loss is associated with an increased likelihood of having thoughts of suicide, of experiencing complicated grief, of having symptoms of depression and anxiety as well as post-traumatic stress disorder (for survivors who witnessed the death or discovered the body).

COMMON REACTIONS FOLLOWING A SUICIDE

Although everyone grieves in their own way, some reactions are common following a suicide.

Common Questions:

- Was it really a suicide?
- Why would they want to die?
- Why was this not prevented?
- How did we miss this?
- How could they be dealing with this without us knowing?

Common Emotions:

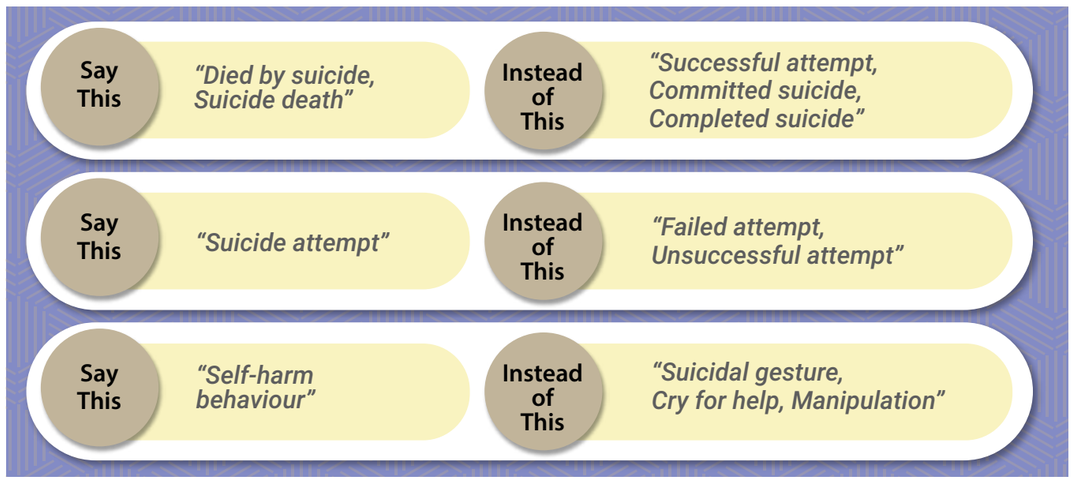
- Sadness, grief
- Confusion or denial
- Shame or guilt. This may be related to thinking one "missed something" or could have somehow prevented the death or it may be related to the societal stigma that surrounds suicide.
- Feeling abandoned or rejected by the deceased
- Anger at the deceased
- Hyper vigilance about suicidality in others
- Relief (especially after a long struggle with suicidality)

Reactions following a suicide may be influenced by some common erroneous beliefs about suicide:

- *Suicide is selfish: While it may seem like the person who died by suicide did not take the impact of their action on loved ones into consideration, it's important to remember that they were not thinking clearly. It is more likely that they held the belief that they were a burden on others and that their death would come as a relief.*
- *Suicide is a choice: The decision to attempt suicide is not made rationally (as opposed to the decision to access medical assistance in dying). A person contemplating suicide is affected by incredible emotional pain that makes it almost impossible for them to generate alternative solutions to their problems. Symptoms of mental illnesses and addictions can also impair thinking and decision making. Because suicide is not a choice, we also cannot say that the person who died by suicide "took the easy way out" or that they were "weak" or "a coward".*

RECOMMENDED LANGUAGE WHEN DISCUSSING SUICIDE

Use of appropriate language when talking about suicide can help reduce the stigma that surrounds suicide and mental illness and can help prevent suicide contagion.

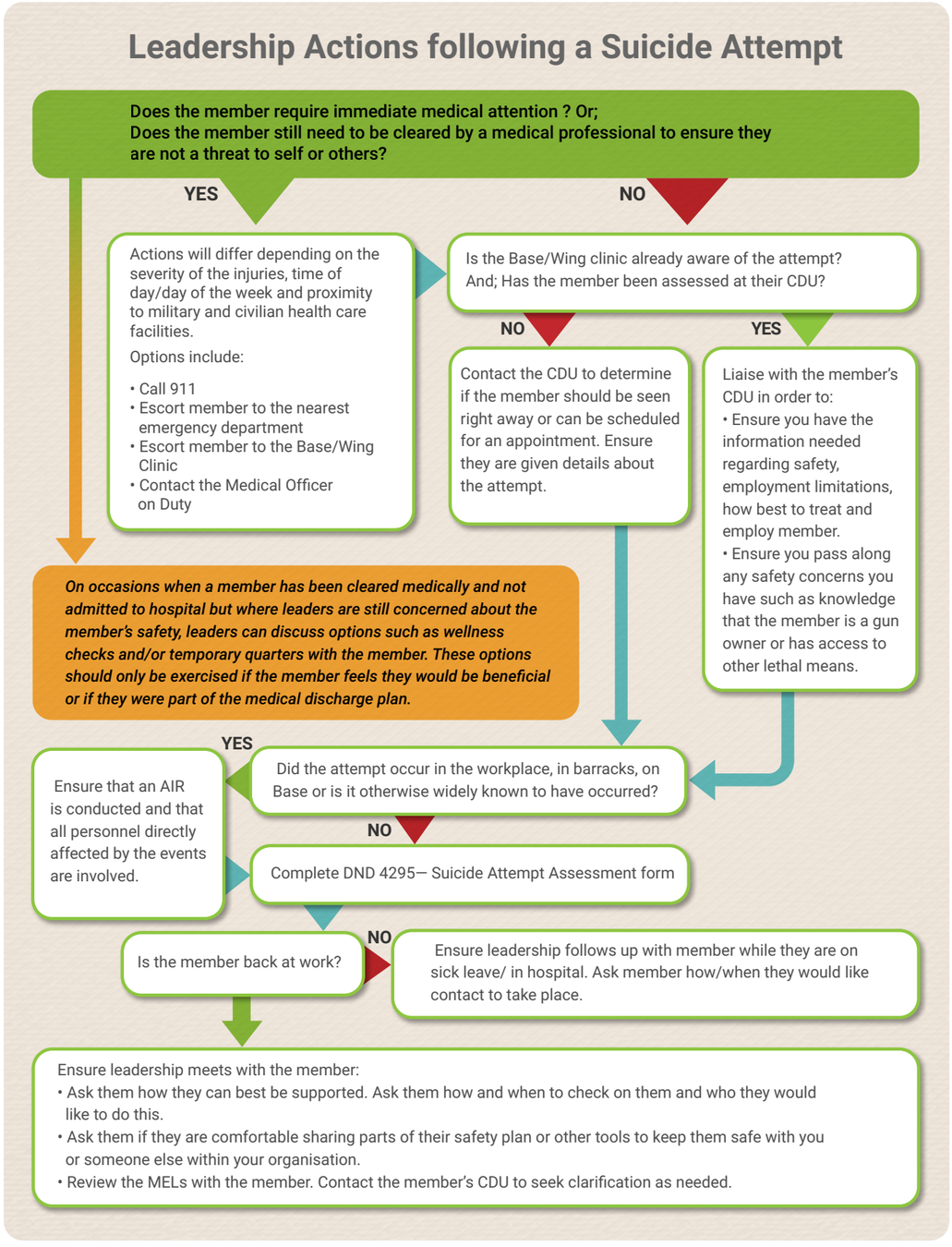


- Avoid discussion of specific details of the suicide. There is no need to discuss the method, specific location of the death, whether or not a note was left or why the service member may have died by suicide. These types of details can increase suicide risk in others. In addition, this information would be considered subject to the Privacy Act and can only be shared in accordance with the Act.
- Avoid simplistic explanations for what has happened such as the suicide arising from a single cause or event. Instead, emphasize that suicide is complex and that there are usually multiple factors involved.
- Avoid any description of death as solving a problem, being quick, easy or painless, relieving suffering or leading to peace. Instead, emphasize alternatives to suicide such as reaching out for help and seeking treatment for mental health problems.

LEADERSHIP ACTIONS FOLLOWING A SUICIDE ATTEMPT

A suicide attempt is an attempt to die by suicide that results in survival. Death may be averted due to the intention to complete suicide having been transient but the intention was clearly present when the attempt was initiated. Death can also be averted because the member was interrupted by someone (for example receiving a phone call from a loved one) or because the member survived the attempt (for example waking up after attempting suicide via overdose). If the means chosen did not have a reasonable expectation (from the member's perspective) of causing death in the absence of intervention, the behaviour is considered to be self-harm and not a suicide attempt.

- Leadership actions following a suicide attempt will vary greatly depending on the circumstances surrounding the attempt. For example, an Ad Hoc Incident Review (AIR, see page 18 of this document) should be conducted for an attempt that occurred in the workplace and that is widely known to have occurred. On the other hand, it would be inappropriate to discuss the attempt with unit members if only the leadership is aware of this occurrence. The flow chart on page 9 of this document can be used to guide leadership actions following a suicide attempt.
- Leadership must protect the personal information of the individual who has attempted suicide. The focus of interventions such as an AIR must be on supporting others and not on the individual who made the attempt.
- Complete DND 4295 – Suicide Attempt Assessment form.
- Health Services will create a "Safety Plan" with the member following an attempt (or with any member who is considered at medium to high risk of suicide). This plan will include reminders of actions members can take if they feel suicidal such as using coping skills or reaching out for help and support. With the member's consent, the safety plan can be shared with trusted unit leadership.
- The Safety Plan will also include safety counselling which is done to temporarily reduce access to "lethal means" such as firearms or medications during a suicidal crisis. While this is a Health Services responsibility, there may be occasions when the Chain of Command is aware that the member has access to lethal means (for example they are a gun owner). In these instances, leadership should contact the member's CDU to ensure this information is passed along.



SUPPORTING A MEMBER FOLLOWING A SUICIDE ATTEMPT

A survivor of a suicide attempt will remain at increased risk for suicide for the rest of their life. If they were hospitalized after the suicide attempt, this risk is particularly high for the first six months after their release from hospital. It is normal to feel uncomfortable with a member following a suicide attempt and to be unsure of how best to interact with them.

- While it is appropriate to pay closer attention to a member following an attempt it is important not to hover over or bring undue attention to them.
- Ask the member how they want to be treated, how and when you can check on them and when you should intervene. Ask them who, within the chain of command, would be their preferred contact.
- Use active listening. Remain present without judgement.
- Be careful when using humour. While this can sometimes be a healthy coping mechanism, it can easily become inappropriate.
- Avoid questions such as:
    - "How could you do this?"
    - "What were you thinking?"
    - "What made you do it?"
- Try statements such as:
    - "I'm sorry you felt that way and wished I could have helped you."
    - "I'm sorry I didn't realize you were in such pain, I can't imagine how bad you must have felt."
    - "I want to help you, tell me what I can do to help you."
- Offering someone support following a suicide attempt can be challenging because of one's own feelings about this attempt. Every individual will experience the situation differently and can express their feelings in a number of ways. It is normal to feel:
    - Sadness and confusion
    - Anger at the person who made the attempt
    - Guilt
    - Anxiety and a sense of insecurity
    - Shame
    - Powerlessness or a lack of control
    - Betrayal
    - Fear of saying or doing the wrong thing
- Taking a moment to identify one's own feelings and reactions will enable leaders to better listen to and support the member. This self-awareness will also help leaders to process the events and assess their need for self-care.

LEADERSHIP ACTIONS FOLLOWING A DEATH BY SUICIDE

Upon learning of a subordinate's death by suicide, before taking any action, a leader will need to pause and prepare themselves mentally for the tasks ahead. The coming days will be busy and difficult. Take a breath, ground yourself and identify your feelings and reactions to this event. Ensure you have a fire-team partner with whom you can accomplish the tasks below, support one another and debrief.

Immediately:

- Initiate notification procedures as detailed in the Casualty Admin Manual.
- Contact the Base/Wing Surgeon, unit Chaplain.
- Notify the individuals identified in the member's DND 742 Emergency Contact(s) Notification form (ECN) and, upon request by the ECN, assist with notification of Next of Kin (NOK) if they are different from the ECN (see page 14 of this document).
- Make an initial announcement to the unit (see page 12 of this document).
- Conduct an Ad-hoc Incident Review (AIR, see page 18 of this document).
- If the initial announcement needs to be delayed for any reason (e.g., waiting for the ECN to be notified or for more details about the death), an announcement can be made requesting that unit members not post on social media or speak to each other about the occurrence until such a time that the notification has been completed.
- Notify others as needed such as the deceased's former unit, or unit members who are on leave/Temporary Duty/deployed. It is important to avoid having service members find out about a suicide through word-of-mouth or through social media.
- Select a Designated Assistant (DA) to support the NOK. Give careful consideration to the selection of the DA, while it needs to be someone who knows or is familiar with the deceased, it should not be a close friend. It is also important that the DA is emotionally ready for this difficult task, the same person should not be repeatedly tasked as a DA. In the event that the unit does not have a trained DA, the CAF Transition Group Services Manager can be contacted for individual guidance/coaching of a new DA. Ensure proper supports are provided to the DA such as mentoring and peer support.
- When possible, have the DA be introduced to the NOK by someone that is known to the family such as a colleague, friend or chaplain.

Initial announcement to the unit

All personnel must be notified of the death. While it is important to protect privacy, if the cause of death is not acknowledged, leadership may appear out of touch or disingenuous. A timely and accurate brief focused on facts will help dispel rumours.

It may be inappropriate to declare the death a suicide before the coroner has made this determination and the CFNIS investigation has concluded but leadership can simply state that the death is being investigated as a suicide or that the mechanism of death appears to have been self-inflicted. Leaders are encouraged to review the "Recommended Language when Discussing Suicide" section of this guide (page 7) prior to making the announcement.

The initial announcement of the death to unit members can be done in a number of ways and will vary according to the unit's unique circumstances.

The announcement can be done at a quickly convened town hall meeting with all unit members attending. The AIR can then immediately follow, ideally done in smaller groups. If the initial announcement cannot be done in person, it may be appropriate to do it by email as long as those closest to the deceased are notified in person or by phone. Such an email should include information about support resources and about when an AIR will be conducted.

If unit members are working from multiple locations, the announcement and AIR can be done via MS Teams.

Over the first days to weeks:

- Consider increasing senior leadership presence in the work area unless you discern there is a risk of being perceived as disingenuous. Empower leadership at all levels to take an active role in supporting unit members.
- Provide reminders of available resources such as CFMAP Bereavement Services (for professional counselling) and the HOPE Program (for peer support).

- Consult with a Chaplain regarding memorial/mourning activities. Ceremonies appropriate to the ethnic, cultural or religious identities of the individual should apply but separate permanent suicide-related public memorials such as plaques or trees are not recommended.

  These may inadvertently glorify the manner of death. Consider other ways to memorialize the service member if the unit, family or networks of those closest to the member wishes, such as donating to a non-profit organization.
- Consider reaching out to the NOK prior to unit participation in any funeral or memorial. Although the DA will coordinate the details, it can be beneficial for Leadership to speak with the NOK to walk them through the events, ensure their wishes are met and ensure they are prepared for certain difficult moments during the ceremony such as volleys or presentation of the Canadian flag.
- Be prepared to respond to media requests and consult with a Public Affairs Officer as required. Consider appropriate ways to pass on information about the death (such as details of the mourning activities) on social media platforms. Keep privacy in mind. Limited information can be shared for the purpose of mourning activities but care must be taken when communicating any other information about the deceased.

Over the first weeks to months:

- Participate, as requested, with any investigation or review process such as a Board of Inquiry (BOI) or Medical Professional Technical Suicide Review (MPTSR) (see page 21-22 of this document). Support subordinates as they participate.
- Work with the DA and Chaplain to support the NOK. Provide members with direction on when, how and if contact with the NOK is appropriate.
- Provide mentoring to Supervisors or Sentinels on how to support those who are struggling.
- Pay particular attention to anyone exhibiting a change in behaviour or anyone who is assuming blame or placing blame on others for the suicide. Provide them with information about available resources (see page 25 of this document) and offer to help them access these resources if needed.

Ongoing:

- Be mindful of anniversary dates or any other significant events or milestones as these are periods of increased risk for those affected by suicide.
- Collaborate with Chaplains and Health Services to coordinate support for unit members.
- Pay attention to those at increased risk of being affected by suicide, specifically, those with:
    - Perceived emotional closeness to the deceased
    - Direct exposure to the suicide or death scene
    - Perceived responsibility for causing/ not preventing the suicide
    - Pre-existing mental health or substance use problems
    - Previous exposure to suicide and suicidal behaviour
    - Personal history of suicidality

Privacy
Personal information of a deceased person under the control of a federal institution is still considered personal information protected under the Privacy Act for 20 years after the date of death and may only be shared in accordance with the Privacy Act. Care must be taken when communicating personal information about a deceased CAF member.

Emergency Contact Notification

Notifying the emergency contact of a loved one's suicide may be one of the most difficult tasks a command team will face in their careers. This is a complex and stressful experience for which it is difficult to prepare. The way the death of a person is communicated can have a profound impact on the bereavement process.

The Command Team and Chaplain will conduct the death notification in person for the person identified as the Emergency Contact Notification (ECN) as per the Commanding Officer Guide.

Research:

- Ensure you have all the information required about the deceased, the ECN, the circumstances surrounding the death, the location of the body and support services available to the NOK.
- Obtain information about the ECN's preferred language and if possible their cultural background.
- Know as much as possible about all who stay/live with the ECN, including their ages and relationship to the ECN and the deceased.
- Be prepared with information about the location of the deceased's body, how it will be released and transported to a funeral home and when the autopsy will be performed.

Check:

- Ensure you have the correct address of the person to be notified and check all original information for accuracy.
- Ensure the notification team has cell phones/chargers, GPS, flashlight and unit contact information such as the chief clerk or duty clerk.

Rehearse:

- Know who will speak and what will be said.
- Practice the script out loud.
- Decide who will occupy and stay with young children/dependents while the ECN is notified.

Notify:

- Take separate vehicles. This can be useful in case of a medical emergency, such as the ECN going into shock. Park on the street not in the driveway.
- Ensure the notification is done in private. Introduce yourself and ask to come inside. Do not make the notification on the porch or in a public place.
- Get to the point quickly.
- Use plain language. Use "dead", "died" or "death" instead of "expired", "passed" or "lost". Avoid acronyms or military jargon.
- Refer to the deceased by name.
- Speak slowly and carefully, give any details that are available. Then, calmly answer any questions the ECN may have (keeping privacy requirements in mind). You may have to repeat the notification statement several times.
- Do not declare the death a suicide before the coroner has made this determination and the police investigation has concluded. You can simply state that the mechanism of death appears to have been self-inflicted.

Assist:

- If you don't know the answer to a question, offer to get back to the NOK when that information is available and ensure to follow through.
- Help the NOK by providing immediate direction in dealing with the death.
- Never try to talk the bereaved out of their grief or offer false hope.
- Don't use statements such as: I understand what you are going though.

  It was God's will/this was meant to be/it was their time to go. They led a full life.
  Time heals all wounds/you will get over this.
- It is normal to feel various emotions, which may present as tears. This is not a sign of weakness but rather a genuine sign of empathy.
- Listen: Let the ECN show their emotions without judgement. It can be tempting to fill silences during these difficult conversations. Respect silences.
- Reassure: Give reassurance that you will do all you can to help.
- Support: Do not initiate holding or embracing unless they initiate it.
- Remember that ECN views/core beliefs about death and dying may be very different from your own.
- Provide assistance as needed or requested such as making calls to a friend or family member who can offer additional support.
- Offer concrete material assistance such as driving them to a friend's house, making coffee or tea and writing information down for them.

Depart:

- A member of the notification team (normally the Chaplain) should stay until a friend or family member arrives to ensure the ECN is not left alone.
- If the DA is not immediately available, advise the NOK that a DA is being assigned and will be in touch shortly. Ask when it would be suitable for the DA to call.
- Provide written contact information for support resources such as the Family Liaison Officer (FLO) but do not overwhelm them with resources. The DA, FLO or Chaplain can provide information and links to resources such as the Hope Program and CFMAP Bereavement Services at a later date.

Debrief:

- Ensure the team debriefs, supports one another and pays attention to self-care after this difficult task.
- Remember that as the messenger you are not the root cause of the pain experienced by loved ones even if the ECN directs their anger at you.

Sample script:

"My name is _____. May we come in and speak with you?"
"Are you the (relationship) of (the deceased)?"
"I'm afraid that I have some very bad news for you."
Pause to give them a moment to prepare.
"(Name) has died of what appears to be a self-inflicted gunshot wound." or
"(Name) has died from hanging" or other statements depending on method of death.
Pause again before expressing your condolence.
"I'm very sorry."

Be prepared for almost any initial reaction:

- Everyone is different and a wide range of reactions is considered normal.
- The ECN may be immediately triggered by seeing military members in dress uniforms coming to their doors with a chaplain. Some may lock their doors, others may run away. Plan for how the notification team will handle such occurrences.
- Survivors may be quiet or stoic. They may stare into space and show no response. They could cry, scream, fall to the floor or break things. They may be angry and could direct this anger at the notification team. They could also retreat and go to another room.
- Other possible reactions include inappropriate laughter, resigned acceptance, surprise that it has not happened sooner, happiness that the person has died or lack of concern.

Notification of children:

- If there are young children present, you should ask to speak with the adults away from the children. Offer to tell children separately if that is desired by the adult(s).

- Notification of children should not be done in their bedroom or in the kitchen because they may associate the death and their reactions with these places and that association may later interfere with sleeping or eating habits.
- Sit down with the child. Give them a blanket or stuffed animal to hold on to if age appropriate. Tell them you have something sad to talk with them about. Use short, factual statements.

  For example: “Your father has died. He shot himself with a gun. It is very sad. Your mother is very sad.” Ask them if they have questions and listen carefully to their concerns. Try to immediately begin to dispel any distortions or feelings of guilt or self-blame.

Notification in a workplace:

- If the notification needs to be done in the ECN’s workplace, ask their supervisor to arrange for a private room in which to make the notification. Allow them time to react then offer to transport them home. Let the ECN determine what they wish to tell the supervisor regarding the death. Offer to notify the supervisor for them if that is what they prefer.

AD HOC INCIDENT REVIEW (AIR)

Ad Hoc Incident Reviews (AIRs) are the CAF’s preferred leadership response to critical incidents including suicides. The AIR is simply a leadership tool to structure a supportive intervention with a group or individual following exposure to potentially traumatizing events and reduce any potential distress. An AIR is done in 3 steps: 1. Acknowledge and Listen, 2. Inform and 3. Respond.

All leaders should be trained in conducting AIRs as part of the Road to Mental Readiness (R2MR) curriculum. AIRs should always be conducted by unit personnel and not by invited professionals such as mental health clinicians or outside chaplains. Additional guidance on conducting AIRs can be found in the Senior Leadership Guide to Mental Health.

The AIR should be conducted as soon as possible after the initial announcement is made to the unit. It should be conducted in a group small enough to allow members a chance for discussion should they wish to do so. Everyone affected should be included. It is recommended to review the “Recommended Language when Discussing Suicide” section of this guide (page 7) prior to conducting an AIR.

1. Acknowledge and listen

- Approach the situation with compassion for the bereaved.
- Review the information that was provided in the initial announcement to the unit. Acknowledge that this is a terrible event and answer any questions that may arise.
- Listen carefully to member needs as individual reactions will differ.
- Expect that some members may want to talk about it, while others may not.
- Be prepared for leadership to be a target of anger or blame.
- Provide an opportunity for discussion. The “common reactions following a suicide” from page 6 of this document can be used as a guide.

2. Inform: Normalize reactions and reinforce positive coping strategies

- Normalize reactions as they are brought up in discussion. In these early stages of grief, it is normal for different people to experience a wide range of different thoughts, emotions and other reactions.
- Provide a reminder on the importance of self-care and give examples of healthy coping strategies such as exercise, time with family and friends, proper nutrition and sleep, and limiting the use of cannabis and alcohol.
- Provide information about expected mourning activities.
- Provide information about how members can help (for example, help for the NOK can be coordinated through the Assisting Officer, Chaplain or through peer support such as Sentinels).
- Prepare members for upcoming investigations. They can be briefed on Boards of Inquiry (BOIs) and Medical Professional Technical Suicide Reviews (MPTSRs) using information from page 21-22 of this document.
- Make a commitment to touch base over the coming weeks to see how they are doing and ensure you follow through.
- Provide information about resources that are available to members such as

  CFMAP Bereavement Services and the HOPE program (see page 25 of this document). If the group includes public servants, include information about the Employee Assistance Program.

3. Respond: Observe and follow-up

- Grief is a normal reaction that varies greatly between individuals. Initially some members may struggle to maintain focus or productivity but most will soon get back to their healthy routine.
- Model healthy coping.
- Pay attention to verbal signs as well as behavioural signs that someone may be struggling (the Mental Health Continuum Model and the Spiritual Health and Well Being Continuum on page 23 and 24 of this document can be used as a guide). Remember that grieving someone who died by suicide may increase suicidal ideation. If you have doubts, ask the member directly if they are having thoughts of suicide.
- Anticipate reactions to anniversary dates, events and milestones.
- Encourage those experiencing difficulties to follow through with support resources or make the appropriate referral to Mental Health services.

INVESTIGATIONS FOLLOWING A SUICIDE OR SUICIDE ATTEMPT

Command Teams, supervisors and unit members may be interviewed as part of various investigations following a suicide attempt or suicide. In addition to investigations by the Police (Civilian Police, Military Police or the National Investigation Service), a Summary Investigation (SI) may be conducted after a suicide attempt and a Board of Inquiry (BOI) and Medical Professional Technical Suicide Review (MPTSR) may be conducted following a suicide.

These investigations can be a significant source of stress for members who are grieving and may be feeling anxiety and/or guilt about their actions leading up to the events being investigated. Providing accurate information on what to expect from these interviews and the purpose of the investigations can help alleviate these reactions. The information below can be used by leaders to brief members who will be interviewed as part of one of these investigations. Leaders should check-in and offer to debrief with their members following their participation as a witness in these investigations.

SUMMARY INVESTIGATIONS (SI)

- A SI may be conducted following a suicide attempt of a RegF member or a ResF member when on duty at the time of the attempt. The completed DND 4295 helps the Administrative Investigation Support Center (AISC) determine whether or not a SI will be required following a suicide attempt.
- SIs are governed by DAOD 7002-2.
- A SI has no power to administer oaths, solemn affirmations or to compel testimony or evidence.
- A SI is a tool to gather information, determine facts and make recommendations in a timely manner.

BOARD OF INQUIRY (BOI)

- BOIs are normally conducted for suicides of RegF members, and ResF members when on duty at the time of the death.
- BOIs are governed by DAOD 7002-1.
- A BOI is an administrative tool of the Chain of Command to investigate and report on any matter connected with the CAF.
- The BOI cannot, by law, go beyond the narrow area of inquiry specifically authorized by the Convening Order (cause of death, service-related contributing factors to the death, whether the death was attributable to military service and whether the member was on duty at the time of death).
- BOI witnesses testify under oath or solemn affirmation and their answers are recorded.
- Witnesses are not subject to cross-examination but can be asked clarifying questions.
- All Board members will be present to question witnesses, advisors to the Board may also be present.
- One or more members of the family of the deceased may attend the testimony of witnesses at the discretion of the Board President.
- Legal counsel to a witness may attend the testimony of that witness.
- Only the members of the Board may ask questions of any witness.
- A BOI can include adverse content concerning a person in its report only if it is necessary to satisfy the requirements of the convening order.
- A BOI can't recommend that a charge be laid or an administrative action be taken against anperson.
- BOIs have access to a medical advisor, a legal advisor as well as a Chaplain. The Chaplain can provide pastoral support to BOI witnesses as needed.

MEDICAL PROFESSIONAL TECHNICAL SUICIDE REVIEW (MPTSR)

- MPTSRs are normally conducted for all RegF suicides and will sometimes be conducted for ResF suicides. The decision to conduct an MPTSR for a reservist will depend on multiple factors including the class of service, whether they were on duty at the time of death, whether they had recently received health care services from the CAF and whether they had an injury related to their service such as an operational stress injury or exposure to military sexual trauma.
- MPTSRs are governed by CF H Svcs Gp instruction 5100-11.
- MPTSRs are a quality management tool. They are conducted by a 2 person Health Services team consisting of a General Duty Medical Officer and a Mental Health Clinician.
- They are intended to be a timely and rigorous review of the health care provided to the deceased.
- The review process is not designed to find fault or assign blame but rather to provide a better understanding of what occurred and to make recommendations to the Surgeon General that may assist in reducing the risk of future suicides.
- The MPTSR team does not have the authority to compel evidence, nor to take statements under oath. The MPTSR team will simply document and summarize the information that is provided.
- Interviews conducted with the deceased's Chain of Command and peers greatly contribute to the MPTSR team's understanding of the suicide.
- MPTSR reports are forwarded to the Director of Mental Health and are usually also requested by the BOI.

PROVINCIAL AND TERRITORIAL INQUIRY OR INQUEST

- Death investigations are typically the responsibility of each individual Canadian province and territory. As a result, each jurisdiction has developed its own system and legislation to fulfill the mandate of investigating deaths that are unexpected, unexplained or meet other criteria as set by them.
- In certain circumstances the death of a CAF member or former member may be investigated in accordance with provincial or territorial systems. This may be particularly relevant for class A reserve members whose death is not attributed to military service.
- Participation by the federal government in provincial or territorial inquiries or inquests is a complex issue and any individual who receives a request for information or to participate shall inform their chain of command and seek advice from legal advisors.

The IMPACT OF SUICIDE ON LEADERS

Managing the aftermath of any critical event as a leader can be stressful but suicides can be especially difficult as leaders will need to manage their own reactions and strong emotions to the tragic event as well as monitor their subordinates' reactions. Self-monitoring and self-care is crucial to a leader's effectiveness in supporting others through a crisis. Managing stress is also essential to preventing burnout and empathic strain.

Loneliness in leadership can increase during times of crisis such as following a subordinate's death by suicide. Feeling isolated and lonely, despite being surrounded by people, is to be expected in these moments. Leaders need to reach out to their peers, mentors or care teams to ensure proper support.

Leaders are encouraged to assess where they are on the Mental Health Continuum (see below). Signs that it is time to seek help include: negative feelings that persist over an extended period of time, decreased enjoyment, changes in performance, ongoing sleep problems, physical symptoms of stress, and problems that are negatively impacting relationships in your life.

Mental Health Continuum Model

	HEALTHY	REACTING	INJURED	ILL
MOOD	Normal mood Fluctuations Calm & takes things in stride	Irritable/Ipatient Nervous Sadness/Overwhelmed	Anger Anxiety Pervasively sad/Hopeless	Angry outbursts/Aggression Excessive anxiety/Panic Depressed/Suicidal thoughts
ATTITUDE & PERFORMANCE	Good sense of humor Performing well In control mentally	Displaced sarcasm Procrastination Forgetfulness	Negative attitude Poor performance/Workaholic Poor concentration Poor decision-making	Overt insubordination Can't perform duties, control behaviour or concentrate
SLEEP	Normal sleep patterns Few sleep difficulties	Trouble sleeping Intrusive thoughts Nightmares	Restless disturbed sleep Recurrent images Recurrent nightmares	Can't fall asleep or stay asleep Sleeping too much or too little
PHYSICAL HEALTH	Physically well Good energy level	Muscle tension Headaches Low energy	Increased aches and pains Increased fatigue	Physical Illness Constant fatigue
SOCIAL WELL-BEING	Physically and socially active	Decreased activity Reduced socializing	Avoidance Withdrawl	Not going out or answering phone
SUBSTANCE USE & GAMING	No or low risk use of alcohol/ cananabis/gambling/gaming	Alcohol/cannabis/ gambling/gaming increasingly used to relieve tension/cope with stress	Difficulties limiting use of alcohol/cannabis/ gambling/gaming	Unable to control use of alcohol/cannabis/ gambling/gaming

It is important to take appropriate action if you are experiencing symptoms. This can include: reaching out and seeking social support, setting boundaries, making time for family and friends, taking time to relax and exercise, focusing on healthy sleep and eating, and focusing on your spiritual needs. Seek professional help if you are in the orange or red zone on the Mental Health Continuum Model

Suicide loss can also have an effect on one's spiritual health. Leaders are encouraged to use the Spiritual Health and Well-Being Continuum below to help assess how this loss has affected their sense of meaning, hope and forgiveness. Seek help from a Chaplain, a faith leader or from Mental Health Services if you are in the orange or red zone on the Spiritual Health and Well-Being Continuum Model. Civilian leaders can get support through their family physician or by contacting the Employee Assistance Program.

Resources

CAF Mental Health Services: Contact your local CAF medical clinic to access psychosocial or mental health services.

Royal Canadian Chaplain Services: CAF Chaplains can meet your needs by providing spiritual and/or religious care, guidance and counselling, by providing an active, personal and supportive presence, and by assisting in understanding and clarifying one's theological, moral, and ethical views.

CFMAP Bereavement Services: Bereavement Services is a 24-hour, 1-800 bilingual telephone service. It is available 365 days a year to any person of significance to CAF personnel who died while serving. You can access a professional counsellor by telephone from anywhere at anytime. An appointment will be arranged within a maximum of 48 hours. Short and long term counselling options are available and are free of charge.

The Helping Our Peers by providing Empathy (HOPE) program offers CAF members and their families with peer support services by matching those who have recently experienced the loss of a loved one with a trained peer volunteer.

The Shoulder to Shoulder network provides access to important information and links to services and supports for families affected by the death of a CAF member. Direct professional help can be accessed by contacting the Family Information Line.

Contact your local Military Family Resource Center or Mental Health Clinic for information on local bereavement support groups. Local resources can also be found through the Canadian Association for Suicide Prevention's Support Services Directory.

The Transition Group provides a number of casualty support programs and services. Their publications include the Casualty Admin Manual, the Commanding Officer Guide and the Designated Assistant Guide.

The Senior Leadership Guide to Mental Health contains information on CAF leadership roles and responsibilities with regards to mental health and provides further information on AIRs.

The Mental Health Commission of Canada has created a Toolkit for people who have been impacted by a suicide.

The US Department of Defense's Defense Suicide Prevention Office has created a Postvention Toolkit for Military Suicide Loss.

The Suicide Prevention Resource Center has created A Manager's Guide to Suicide Postvention in the workplace, 10 Action Steps for Dealing with the Aftermath of a Suicide.

The Canadian Psychiatric Association's Media Guidelines for Reporting on Suicide contains helpful information on appropriate language when discussing suicide.

Resources for reservists

It's important for leaders to understand which resources are available to reservists when supporting members who may meet a variety of eligibility criteria. Supervisors can consult CAF Mental Health Services, a Chaplain or their local Military Family Resource Center for information on local resources.

All reservists, no matter the class of service, can access CFMAP Bereavement Services or the HOPE program. They can also be seen by CAF Mental Health Services for an initial assessment and referral to appropriate resources. If a reservist is experiencing mental health difficulties following a member's suicide, this may be attributable to service, especially if they witnessed a death which occurred in the workplace.

Reservist on class A or B (less than 180 days) can also receive mental health benefits from VAC for 2 years starting when a disability benefit application is submitted, regardless of whether it is ultimately approved.