Suicide Postvention for Mental Health Professionals

Addressing the Gap in Military Healthcare

Elisha Parkhill Pippin

Despite Department of the Air Force and broader Defense Department efforts to address suicide prevention in the service, the focus has been directed to military members with little attention to the healthcare professionals who care for them. As the demand for clinical mental health services rises, these professionals must receive the appropriate support to maintain their well-being and that of their patients—including postvention resources, which mitigate the impact and cumulative stress following suicide loss. While the Air Force has acknowledged postvention's significance in suicide prevention efforts, it has yet to incorporate practical applications for clinicians. Postvention support for the workforce will reduce adverse outcomes and build the morale of a unified and cohesive healthy team.

The United States Department of Defense has focused on mental health for decades. Its early policy established the rights of service members referred for mental health evaluations, a requirement from the National Defense Authorization Act (NDAA) for fiscal year 1993.[1] The 2006 NDAA enhanced the prioritization of mental health, directing the establishment of a task force to examine mental health.[2] The subsequent report found DOD efforts at the time to be significantly lacking and created actionable recommendations to address the shortfalls, such as providing access to quality care, dispelling stigma, developing psychological resilience, and promoting empowered leadership, culture, and advocacy for psychological health.[3] Since the 2006 legislative document, mental health is mentioned in each subsequent NDAA, reflecting the growing recognition of the importance of mental health support for the military population.

Still, despite this focus, the annual rate of suicide among service members continues to rise, as noted in the Defense Department's recent *Annual Report on Suicide in the Military, Calendar Year 2023*.[4] And with this rise, there is a missing data point not discussed: the state of the mental health community that supports "at-risk" service members. Mental

Lieutenant Colonel Elisha Pippin, USAF, serves as the director of psychological health at the US Air Force Medical Command, Falls Church, Virginia. She has a master of social work from the University of Georgia.

1. National Defense Authorization Act (NDAA) for Fiscal Year 1993, Pub. L. No. 102-484, 106 Stat. 2315 (1992), Sec. 546.

2. NDAA for Fiscal Year 2006, Pub. L. No. 109-163, § 723, 119 Stat. 3136 (2006).

3. Alan Berman et al., *The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives, Final Report of the Department of Defense* [DOD] *Task Force on the Prevention of Suicide by Members of the Armed Forces* (DOD, August 2010).

4. Defense Suicide Prevention Office (DSPO), *Annual Report on Suicide in the Military, Calendar Year 2023* (DOD, Under Secretary for Defense and Personnel Readiness, 2024), https://www.dspo.mil/.

health professionals are indispensable in shouldering the immense emotional burdens of the nearly 3.4 million service members who voluntarily serve this nation.[5] As the demand for clinical mental health services rises, clinicians must receive the appropriate support to maintain their well-being and prevent adverse outcomes.

The Department of Defense continues to invest substantially in suicide prevention and awareness programs with minimal focus on the healthcare community. Response to a death by suicide within the military community is targeted to family, friends, and the unit, without much thought given to the healthcare team. This gap is also apparent in the literature, programming, and resources for clinicians across the healthcare space.

For the clinician, experiencing a patient's death by suicide has significant personal and professional impacts.[6] The range of emotions experienced by impacted clinical teams is often exacerbated by the lack of systematic support available in the aftermath of a patient's death. To address this gap in service, the Defense Department must include vital postvention resources not only to support military healthcare professionals, but also to align enterprise high reliability and readiness priorities. Implementation of such programs will provide measures for a strong organizational culture and climate, preparing the military healthcare community and their organizations to respond appropriately following adverse events and to enable them to support the well-being and readiness of service members.

The Impact of Suicide Loss

The impact of suicide on clinicians has been identified as an unintended consequence of the profession, with no systemic mechanism to support the ramifications of suicide. These consequences leave providers feeling unattended and unsupported, and they are expected to return to work as if nothing has occurred. This creates a community experiencing the toils of burnout, now exacerbated by morally injurious events without the opportunity for healing and growth. The impact following the death of a patient by suicide is comparable with other traumatic life events, and the healthcare system's approach to staff support must be in line with the same level of quality care afforded to the patients they serve.

The emerging research demonstrates the value in providing institutional opportunities for effective coping with suicide loss, which can lead to posttraumatic growth. Posttraumatic growth refers to the idea that traumatic experiences can present an opportunity for critical self-reflection and self-improvement.[7] Healing and growth can only be achieved when they are deliberately aligned to help clinicians endure loss, reduce self-blame, and maintain

5. DOD, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, *2022 Demographics Profile of the Military Community* (DOD, 2022).

6. Nina Gutin, Vanessa L. McGann, and John R. Jordan, "The Impact of Suicide on Professional Caregivers," in *Grief After Suicide: Understanding the Consequences and Caring for the Survivors*, ed. John R. Jordan and John L. McIntosh, 1st ed. (Routledge, 2010).

7. Richard G. Tedeschi and Lawrence G. Calhoun, "The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma," *Journal of Traumatic Stress* 9, no. 3 (1996).

a solid professional self-efficacy.[8] This process is captured through postvention, a proactive approach to mitigate the impact and cumulative stress following suicide loss, and is essential for clinicians to cope with the emotional tolls of this loss.[9] Not only can the emotional impact of patient suicide have significant impacts on the professional, but also those impacts have negative implications on military readiness. These personal impacts extend from the emotional toll seen through grief, depression, humiliation, fear, anger, and disordered sleep to professional impacts leading to self-doubt, decreased self-confidence, and further adverse outcomes.[10]

The Military Health System (MHS) continues to adhere to the high reliability framework that is based on process design, building culture and structures that promote safety, and improving outcomes. The principles of a high reliability organization for the MHS are primarily focused on achieving system effectiveness in support of providing a safe and quality patient experience to its beneficiaries. As the intended outcome surrounds the care provided to the patient, there are principles that focus on the healthcare environment and the promotion of a culture of mindfulness and responsibility of the staff. The MHS has taken an admirable approach to achieving top outcomes with a patient-centered focus yet with a nominal focus on the health and wellness of the staff providing quality care.[11] A logical next step for the MHS as continuous process improvement and advancing a ready, reliable workforce must include support and resources to staff. The Defense Department must look to realign its initiatives to properly support the workforce through postvention, thus reducing adverse outcomes and fostering a unified and cohesive healthcare team.

Suicide in the Department of the Air Force

Suicides in the Department of the Air Force have gradually increased since 2011, reflecting the overall trend of the US population. While DAF data shows a lower rate than the matched US population, suicide remains the leading cause of death in the department. The 2023 DOD *Annual Report on Suicide in the Military* indicates a gradual increase from 2011 to 2023 across all branches.[12] The demographics for those who die by suicide have remained consistent, with most of these losses being enlisted males under the age of 30.

The Defense Department captures data following a death by suicide using the DOD suicide event report, which shows that 42 percent of those who died by suicide had one

8. John L. McIntosh, *Clinicians As Survivors of Suicide: Bibliography* (American Association of Suicidology Clinician Survivor Task Force, 2019).

9. Edwin S. Shneidman, *Suicidology: Contemporary Developments*, Seminars in Psychiatry, ed. Milton Greenblatt (Grune & Stratton, 1976).

10. Madison Jupina et al., "Prevalence of Patient Suicide and Its Impact on Health Care Professionals: A Systematic Review," *Psychiatric Services* 75, no. 10 (2024), https://doi.org/.

11. Shari Silverman and Meaghan Meeker, "Ready Reliable Care: The Defense Health Agency's Approach to High Reliability," *Management in Healthcare: A Peer-Reviewed Journal* 8, no. 3 (2024), https://hstalks.com/.

12. DSPO, *Annual Report*.

or more mental health diagnoses. In the year before death, just 39 percent of decedents sought clinical mental healthcare, 33 percent sought support from a non-medical helping agency, and 15 percent sought care with a chaplain.[13] Unfortunately, suicide decedents underwhelmingly utilized available healing resources.

Part of the issue lies with the general stigma associated with mental health issues and suicidal ideation in particular. Per the CY23 *Annual Report*, 42 percent of those who died by suicide had documentation of one or more mental health diagnoses, 44 percent had an intimate relationship problem, and 24 percent had workplace difficulty.[14] Yet, individuals continue not to seek care as they believe it will negatively affect their careers. For example, despite DOD strategic messaging indicating that seeking mental health support does not pose a risk to keeping or gaining a security clearance, some service members and their families remain reluctant to come forward.[15] Those who do seek care are resistant to disclosing the true nature of their risk for fear of career implications.

For the 39 percent of decedents who did utilize clinical mental healthcare, the aftermath is a healthcare team managing profound sadness, guilt, shame, self-doubt, and fear regarding personal litigation. A systematic review of the impact of suicide on healthcare professionals found that more than half of those experienced a patient suicide.[16] Following the suicide death of a patient, professionals' clinical judgment and confidence can be affected, manifesting through hypervigilance in their clinical documentation, increased hospitalization for at-risk patients, overall avoidance of patients who may be suicidal or deemed at-risk, or succumbing to the burnout and leaving the career field altogether.[17]

The Air Force has made significant strides toward policy and programming for suicide prevention and awareness, as captured in DAF Instruction (DAFI) 90-5001, *Integrated Resilience*.[18] This policy describes postvention as a critical support option for individual and unit resilience and refers readers to a resource created to guide leaders following a unit suicide. Another policy focusing on response to traumatic events is DAFI 44-153, *Disaster Mental Health*, which outlines helping agencies' response capabilities in an all-hazard incident.[19] This policy focuses on supporting the community or unit following the event. Yet despite these policies, postvention within the DAF remains an abstract principle, one lacking resources and guidance on how to enhance relevant knowledge and

13. David Roza, "Air Force Publishes Sweeping Analysis of Suicide Deaths in 2020," *Air & Space Forces Magazine*, 19 March 2024, https://www.airandspaceforces.com/.

14. DPSO, *Annual Report*.

15. Janet A. Aker, "Get the Facts About Mental Health and Security Clearances," DOD [website], 3 October 2024, https://www.defense.gov/.

16. Jupina et al., "Patient Suicide."

17. David M. Sandford et al., "The Impact on Mental Health Practitioners of the Death of a Patient by Suicide: A Systematic Review," *Clinical Psychology & Psychotherapy* 28, no. 2 (2021).

18. Department of the Air Force Instruction (DAFI) 90-5001, *Integrated Resilience* (DAF, 23 July 2024).

19. DAFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control* (DAF, 6 August 2010, certified current 26 August 2014).

skills. Regardless of the postvention resourcing, the current DOD and DAF policy needs to pay more attention to the support of the healthcare team.

Military Mental Health

The DOD mental health community comprises multidisciplinary teams that include social work, psychology, psychiatry, nurse practitioners, nurses, and mental health technicians. Within the Defense Department, these professionals are aligned with military treatment facilities that provide quality care to the beneficiaries in their catchment areas. Due to the growing demand and low supply of manpower, these clinics are relegated to primarily providing outpatient mental health clinical care to service members, with nonuniform beneficiaries being referred for care within the civilian network. The DOD mental health clinics manage patients for a range of mental health conditions and disorders.

A 2023 Defense Health Board report noted that the Department of Defense continues to be challenged by the existing national "mental health crisis" and the Military Health System "lacks the resources it needs, in terms of providers and treatment options" to meet the needs of the military.[20] Similar language appeared in the 2006 DOD task force on mental health recommendations report required by the NDAA.[21] Furthermore, from 2019 to 2023, the armed forces health surveillance division reported anxiety disorders among military members were observed with the largest increase, nearly doubling from previous surveillance periods.[22] The mental health crisis remains present, where access to clinical mental healthcare has doubled over the past decade, while manpower has remained stagnant.[23]

DOD mental health professionals are at the helm of the armed forces' psychological readiness and carry the burdens of those they care for in their communities. In general, mental health professionals face significant challenges in serving their community. Within the military, these professionals confront additional challenges because of their unique circumstances.

Mental health professionals constantly work within a professional space of high emotional burden and heightened vulnerability due to the inherent ambiguity in their work. Unlike their colleagues in family medicine, these professionals lack objective diagnostic tools like laboratory results or X-rays for clinical diagnosis and determination, increasing the complexity and nuance of the profession. They must rely on their clinical judgment, which is inherently subjective. Relying on their expertise and experience, they conduct assessments determining the safety and welfare of a vulnerable population under insur-

20. *Beneficiary Mental Health Care Access* (Defense Health Board, 28 June 2023), 5, https://health.mil/.

21. DOD Task Force on Mental Health, *The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health: Report to Congress* (DOD, 19 September 2007), https://health.mil/.

22. "Diagnoses of Mental Health Disorders Among Active Component U.S. Armed Forces," *MSMR* [Medical Surveillance Monthly Report] 31, no. 12 (2024), https://www.health.mil/.

23. Elisha Parkhill Pippin, "Mental Health Professionals Overlooked in Air Force's Resilience Push," *Air Force Times*, 20 May 2024, https://www.airforcetimes.com/.

mountable uncertainty. Upon conclusion of each appointment, the clinician may wonder if they missed something or if they diagnosed correctly, and the burden of "what if" pertains to the possibility that the patient may exercise free will and engage in self-harming behavior. This emotional burden alone can lead to anxiety, self-doubt, guilt, risk of vicarious trauma, and compassion fatigue.[24]

Unique to the military health workforce is that it encompasses two distinct professions: the profession of medicine and the profession of arms. There is an ethical tension in the duality between these two professions; the profession of medicine focuses on preserving life, and the profession of arms focuses on managing violence, which can involve death.[25] The exceptional, independent profession of military mental health has specialized expertise even within the medical community. Military mental health professionals manage the delivery of healthcare to their patients and the occupational health of the mission. Sometimes, there is a conflict between the two, and providers must use their clinical judgment through a national security lens.

The complexity of this profession and the reliance on clinical judgment alone without objective diagnostic tools create a remarkable challenge, which is often overlooked by those outside the field. Yet over the past decade, the demand for military mental healthcare skills has continuously increased while clinicians have not received support to manage the growing requirements. As the Defense Department falls short of effectively staffing, empowering, and caring for the mental health workforce, these professionals tend to feel neglected.[26] Members of the workforce can feel overwhelmed and unable to meet their basic mission requirements, which is then compounded in the wake of experiencing a patient loss to suicide, where the system lacks a mechanism to provide adequate support. Department-level policy must prioritize these efforts to empower this community to utilize available resources and determine if additional resources are necessary.

Resources for mental health professionals in the military are limited due to conflicts of interest in seeking care within their small professional community. They can utilize the non-medical resources available to all service members—for example, Military OneSource, Military and Family Life counselors, the unit chaplain—but these, too, are also experiencing limitations in capacity. As with most healthcare providers, mental health professionals are historically poor patients in that they delay seeking services for themselves either because they feel they cannot get away from the clinic or they do not have a confidential space to seek care.[27] There is significant literature that suggests healthcare providers often

24. Diarmuid MacGarry et al., "The Impact of Patient Suicidal Behavior on the Personal and Professional Well-Being of Mental Health Providers: A Systematic Review," *Clinical Psychology: Science and Practice* 29, no. 2 (2022): 100, https://psycnet.apa.org/; and Jupina et al., "Patient Suicide."

25. DOD Instruction 6025.27, *Medical Ethics in the Military Health System* (DOD, 8 November 2017), https://www.esd.whs.mil/.

26. See Pippin, "Mental Health Professionals."

27. Karen Jowers, "Services Detail Plans to Beef Up Mental Health Services for Troops, Families," *Military Times*, 31 May 2022, https://www.militarytimes.com/.

neglect their own physical and mental health despite being trained on the negative implications of delaying care.[28]

One study found physicians are hesitant to seek healthcare and have difficulty being in the patient role, leading to inappropriate self-care and pushing through illnesses. Such physicians were less likely to adhere to treatment recommendations for themselves than for their patients, even when they had a chronic illness.[29] Healthcare professionals are at high-risk for stress and burnout and often are caught in the physician-patient paradox, where they prioritize their patients' health over their own. Healthcare systems—and the MHS is no exception—must prioritize the health and well-being of their medical staff and provide resources appropriately to maintain professionalism and deliver high-quality patient care. Training and education throughout a clinician's lifespan to prepare them for the complexity of military mental healthcare are essential.

Need for Postvention

Postvention is a mechanism to provide this critical training and support for mental health professionals. It is an aspect of suicide prevention and is a requirement for this vulnerable population of clinicians who are managing caseloads of high acuity and at-risk patients. First defined in 1968, postvention is an intervention conducted with survivors who experience patient suicide.[30] Postvention is essential to the MHS priority of being a high reliability organization, as it directly aligns with organization principles. For example, developing a comprehensive postvention protocol aligns with prioritizing safety. With the implementation of postvention, healthcare organizations experience improved safety and reliability by identifying and addressing potential risks and vulnerabilities, enhanced transparency and accountability through standardized procedures and protocols for sentinel events, and promotion of continuous improvement.[31]

Throughout postvention literature, most suicide postvention initiatives are focused on family and friends of the deceased, and within the Department of Defense, such initiatives are also focused on the inclusion of the unit—with interventions geared toward

28. Jo Best, "What's It Like to Be a Patient as a Doctor?," *BMJ: British Medical Journal* 387 (2024), https://doi.org/; and Hui Wang et al., "What Determines Healthcare Workers to Seek Professional Psychological Support? A Cross-Sectional Study," *Journal of Advanced Nursing*, ahead of print, 7 October 2024, https://doi.org/.

29. William T. Thompson et al., "Challenge of Culture, Conscience, and Contract to General Practitioners' Care of Their Own Health: Qualitative Study," *BMJ* 323, no. 7315 (2001): 728, https://doi.org/.

30. Matthew D. Erlich et al., "Why We Need to Enhance Suicide Postvention: Evaluating a Survey of Psychiatrists' Behaviors After the Suicide of a Patient," *The Journal of Nervous and Mental Disease* 205, no. 7 (2017), https://doi.org/.

31. Dorothy E. Stubbe, "When Prevention Is Not Enough: The Importance of Postvention After Patient Suicide," *Focus* 21, no. 2 (April 2023), https://doi.org/; and "Provide for Immediate and Long-Term Postvention," Suicide Prevention Resource Center, accessed 3 March 2025, https://sprc.org/.

commanders and unit members—without a focus on healthcare teams.[32] A 2015 RAND report identified a lack of evidence on how to approach clinician-focused postvention best.[33] As one review notes, "Clinician postventions' primary purpose is to mitigate adverse outcomes and enhance growth among clinician survivors" with the secondary focus "on preventing future patient suicide loss."[34] To support a system of clinicians, a formalized and comprehensive approach is needed to implement protocols focused on training and emotional support for those impacted by patient loss.

Currently, in DAFI 90-5001, the DAF has identified postvention as one of the 15 elements of its suicide prevention program, which is focused on the impact of suicide on coworkers, families, and friends.[35] The Defense Suicide Prevention Office (DSPO) has created a *Postvention Toolkit for a Military Suicide Loss* as a guide highlighting resources available when responding to deaths by suicide.[36] This has provided a comprehensive approach for military leaders, unit, and community members to navigate a loss and the complexities of now being a survivor of suicide loss. There are commonalities related to the emotional response of all survivors, but there are unique challenges experienced by clinicians engaged in the treatment of a patient who died by suicide. These include professional boundaries, which can make it difficult to process emotions; a sense of responsibility, which can lead to guilt, shame, and self-doubt; an investigative nature following sentinel events—or unanticipated events that result in death or other serious harm to patients—which can exacerbate stress; and the organizational response, which includes policies and procedures that often facilitate a return to normal behavior and approach.

There is no debate that the DOD clinical community faces a gap in postvention. Yet the gap can be filled with effective policy and programming that drives a community of care, compassion through education, and informal and formal support.

Postvention Program Development

The development of a clinician-focused postvention program must be conducted with the understanding that there are specific and different staff needs based on one's closeness to the decedent. Approaches to clinician-focused postvention can be outlined and organized in various manners, either focused on the program component, intended audience, or timeline post-incident. This article's outline is based on critical elements. It then captures a time-based approach, serving as a guide for a useful program that can be implemented across the Military Health System.

---

32. See, for example, Kelly A. Daly et al., "Scoping Review of Postvention for Mental Health Providers Following Patient Suicide," *Military Medicine* 189, no. 1–2 (2024); and Rajeev Ramchand et al., *Suicide Postvention in the Department of Defense: Evidence, Policies and Procedures, and Perspectives of Loss Survivors* (RAND Corporation, 2015).

33. Ramchand et al.

34. Daly et al., "Scoping Review."

35. DAFI 90-5001.

36. DSPO, *Postvention Toolkit for a Military Suicide Loss* (DOD, 2020).

There is no specified model for postvention, as the most effective method may vary depending on the situation, population, need, individual, and organizational context; however, key components are critical for implementing an effective, comprehensive postvention program within a suicide prevention program. These include policy and processes capturing formalized education and training, relational support, and organizational culture.

Formalized Education and Training

The first component of formalized education and training is critical for clinicians to offer universal preparedness for patient suicide. This preparedness should capture varying scopes of the professional to ensure the variety of roles clinicians serve are covered. For example, a clinician supervisor versus the decedent's clinical provider will require different support and resources. Gaining an understanding of the personal impact of patient suicide focuses on the emotional toll that is commonly expressed through grief, guilt, shame, and self-doubt. Also, appreciating the professional impact of suicide can lead to a change in how a clinician conducts their practice, such as becoming more cautious, using consultations more frequently, documenting at-risk patients, or avoiding them altogether. The impact, personally and professionally, can be so significant that they elect to leave the profession.

Being able to recognize and manage secondary traumatic stress is critical for both individual and supervisory awareness to protect the health of the staff from stress that may occur following patient loss. Throughout postvention education and training, the Defense Department must provide the overarching knowledge and skills that eliminate assumptions of what the signs, symptoms, and risk factors of secondary traumatic stress are; how to self-assess, monitor, and address this stress; and how to create an environment of care and compassion, where staff feel supported and encouraged to heal and move through their grief.[37] Training these clinical teams on posttraumatic growth skills where they experience positive transformations regarding self-perception, interpersonal relationships, and overall well-being provides a window of hope for those who have the unfortunate experience of patient loss to suicide.

Relational Support

The next component of relational support has been shown to reduce the impact of grief. Social connections are vital for emotional healing and recovery.[38] Traumatic events often leave individuals feeling isolated, lonely, and disconnected, and relational support provides a safe space to process emotions and reduce this isolation. Postvention research frequently promotes a peer-support model, a defined support system founded on respect, shared

37. *Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision* (National Child Traumatic Stress Network, 2018), https://www.nctsn.org/.

38. Tina M. Mason, Cindy S. Tofthagen, and Harleah G. Buck, "Complicated Grief: Risk Factors, Protective Factors, and Interventions," *Journal of Social Work in End-of-Life and Palliative Care* 16, no. 2 (2020), https://doi.org/.

responsibility, and mutual agreement. Providing peer support requires a certain amount of skill, knowledge, and self-awareness surrounding one's capacity to adequately support someone in need. Another component of relational support is the role of the supervisor, who has a unique opportunity to guide and direct during challenging days. Critical competencies for supervisors of clinical teams include providing a safe, nonjudgmental space, supporting performance management by adjusting their workload and responsibilities, being transparent about roles and responsibilities, and monitoring their well-being while connecting to resources as appropriate. Respectfully navigating these competencies, a supervisor can support the impacted individuals while cultivating an organizational culture that values care and compassion.

Organizational Culture

The third component captures the complexities of healthcare settings, which require a strong organizational culture, referring to the shared values, beliefs, and assumptions that shape organizations.[39] Through culture, an organization gains a sense of purpose and unity, which provides a foundation for being more equipped to cope with complex and dynamic challenges when they arise. The mental health clinical setting is complex, with misaligned staffing ratios, rising demand for clinical services, and a move toward pathologizing the human experience, thus further driving demand, clinician burnout, and other challenges. Navigating these challenges requires leadership that prioritizes and understands the need for a positive organizational culture. Prioritizing employee well-being, open communication, community, and colleague connection drives the quality of life and care.

The organizational climate reflects the staff's perception of the organizational culture. Both culture and climate are critical to the healthcare setting as they are connected to morale, adverse action rates, burnout, turnover, and overall patient safety and quality care.[40] An organization communicating cultural aspects increases the likelihood of a cohesive and stable workforce. Clinical leaders are responsible for influencing organizational culture and designing strategies to operationalize it, forming the climate. This influence toward a positive organizational culture and climate comes through clear and consistent messaging of the values and principles, creating an environment that promotes wellness and resilience.

The abovementioned components are not exhaustive but capture foundational information for postvention policy and programming to be built upon. The DSPO postvention model takes a three-phased approach, developed by the Tragedy Assistance Program for Survivors, an organization that offers resources to those grieving the loss of a military member.[41] This approach guides those who engage with survivors of suicide to move

39. Richard Chalmers and Grace D. Brannan, *Organizational Culture* (StatPearls Publishing, 2020).

40. Janet C. Berry et al., "Improved Safety Culture and Teamwork Climate Are Associated with Decreases in Patient Harm and Hospital Mortality Across a Hospital System," *Journal of Patient Safety* 16, no. 2 (2020), https://doi.org/.

41. DSPO, *Postvention Toolkit*.

through their grief journey with the primary focus on stabilization, on the facilitation of healthy grieving, and then finally toward achieving posttraumatic growth. Within this framework (table 1), time-based tasks can be added to clarify critical tasks, such as notification, initial support, risk assessment, peer support, and follow-up. A military clinician-focused postvention program that has an evidence-based, trauma-informed policy and provides the flexibility to achieve the outcome of supporting mental health professionals will enhance the morale, retention, and overall readiness of this critical workforce.

Table 1. Postvention approach for military health professionals

CLINICIAN FOCUSED POSTVENTION FRAMEWORK			
Postvention Component	**Formalized Education and Training**	**Relational Support**	**Organizational Culture**
Purpose	Offer universal preparedness and overarching knowledge and skills.	Peer and supervisor role and responsibility to provide safe, non-judgmental support.	Shared values, beliefs, and assumptions that shape organizations and provide sense of purpose and unity.

Implementation of a postvention program requires effective policies and processes to support individuals and organizations following a traumatic event. Through effective policy, organizations are prepared because of the planning efforts to address individual and organizational needs. This framework guides individuals and organizations in the wake of a patient's loss and allows for a consistent approach regardless of who is involved. A policy that captures postvention bolsters the workforce's well-being and prioritizes the value of engagement and support toward healing. Additional elements of effective policy to consider are clearly defining terms and goals of postvention, identifying a clear scope and roles and responsibilities with specific response procedures outlining support services and communication plans, and allowing evaluation and review of program effectiveness while identifying areas for improvement.

Implementing such a program is limited by manpower constraints and available resources. Producing this program at an enterprise level alleviates some of these constraints, providing a plug-and-play model for DAF installations to implement. The workload can be manageable and effective with collaboration and coordination across helping agencies. This framework is currently being used by the author to develop a clinician-focused program for the Air Force surgeon general office. This program will serve as a stepping stone toward deliberate attention of providing support and resources to the healthcare community.

Conclusion

The well-being of DOD mental health professionals is more than a human capital issue. There are direct implications for national security, and for the Department of the Air Force, there are implications for its overall readiness posture. The DAF relies on these professionals to provide quality care to Airmen and Guardians involved in national security efforts, and they deserve investment. Airmen and Guardians are experiencing stress,

and although this may be a normal part of the human experience and may not directly equate to being at risk for suicide, it is important to remember that the identified needs of those who die by suicide are treatable mental health concerns. This is a primary talking point of DAF suicide prevention training.

Postvention offers a mechanism for the enterprise to leverage evidence-based trauma-informed practices to support highly specialized professionals who voluntarily carry a heavy emotional burden on behalf of the nation's service members. As the DAF begins to align expectations of mental health with readiness, the next right thing requires systematic policy and programming efforts to support the mental health community intentionally and deliberately when they need help, especially after experiencing the loss of a patient. The lethality of the Air Force will be enhanced when it invests in its mental health community. With the optimization of the mental health community, the force will receive the high-quality care it deserves and requires to be successful.

The need for postvention resources is a readiness issue: readiness of the mental health community directly impacts the readiness of the force. Investment in the mental healthcare workforce is an investment benefiting the entire Air Force. ✈