



**STATEMENT OF**

**KIM RUOCCO**

**CHIEF EXTERNAL RELATIONS OFFICER  
FOR SUICIDE PREVENTION AND POSTVENTION**

**TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS (TAPS)**

**BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
HOUSE OF REPRESENTATIVES**

**May 12, 2016**

**Tragedy Assistance Program for Survivors (TAPS)** is the national organization providing compassionate care for the families of America's fallen military heroes. TAPS provides peer-based emotional support, grief and trauma resources, grief seminars and retreats for adults, 'Good Grief Camps' for children, case work assistance, connections to community-based care, and a 24/7 resource and information helpline for all who have been affected by a death in the Armed Forces. Services are provided to families at no cost to them. We do all of this without financial support from the Department of Defense. TAPS is funded by the generosity of the American people.

TAPS was founded in 1994 by Bonnie Carroll following the death of her husband in a military plane crash in Alaska in 1992. Since then, TAPS has offered comfort and care to more than 50,000 bereaved surviving family members. For more information, please visit [www.TAPS.org](http://www.TAPS.org)  
TAPS currently receives no government grants or funding.

### **Kim Ruocco**

Kim Ruocco is presently the Chief External Relations Officer for Suicide Prevention and Postvention for the Tragedy Assistance Program for Survivors (TAPS). Ms. Ruocco is an international public speaker who has a unique combination of personal and professional experience, education and training that provides a comprehensive understanding of suicide prevention and postvention. Ms. Ruocco has been the keynote speaker at many national events, most notably the Department of Defense (DOD)/Department of Veterans' Affairs (VA) Suicide Prevention Conference, VA Suicide Prevention Month, The LOSS team conference, AAS/AFSP Healing Conference, IAVA Clay Hunt announcement and multiple USMC, Army, ANG and Navy safety stand downs. She has appeared in multiple media outlets including CNN, Fox News, Al Jazeera, NPR and NBC radio. She has been the topic of many magazine articles including Men's Health, Christian Science Monitor, Stars and Stripes and Marine Times. Ms. Ruocco is regularly quoted in national newspapers articles on the topics of Suicide, Military Culture, Mental Illness, PTSD and VA and DOD policy matters.

Ms. Ruocco has been instrumental in raising awareness using the voices of military suicide survivors. She developed suicide survivor panels that testified in multiple venues including the DOD/VA suicide prevention task force, National Action Alliance and DOD/VA conferences. She assisted in the development of the Department of Defense Suicide prevention Office (DSPO) Postvention Toolkit, and was a reviewer for the current national strategy for postvention. Ms. Ruocco assisted in the development of the USMC's "Never Leave a Marine Behind" program and is a participant in the training video. She was the Family Liaison Contact for the USMC/AAS psychological autopsy research project that provided key prevention information for the USMC. She and her sons are also lead participants in the Sesame Street "When Families Grieve" video which is distributed internationally to families who have a recent death. Ms. Ruocco regularly briefs the DSPO and Navy on the family perspective of risk factors and gaps in service. She has also testified before the Senate Committee on Veterans' Affairs and is considered a subject matter expert for suicide pre and postvention.

Ms. Ruocco has developed comprehensive, peer-based programs that offer comfort and care to all those who are grieving the loss of a service member to suicide. She created a team of peer-professionals who provide care and comfort to nearly 5000 survivors of military suicide. The most impactful of these services is the TAPS Annual Survivors of Suicide Loss Seminar, which offers hope and healing to thousands of survivors, and provides a camp and military mentoring for the children of the fallen. Her programming has been ground breaking in the field of postvention and has been incorporated into many civilian postvention programs.

Ms. Ruocco is currently the co-lead on the National Action Alliance Military and Family Task force and a member of the National Expert Advisory Panel for Research.

Ms. Ruocco holds a BA in Human Services and Psychology from the University of Massachusetts and a Masters degree in Clinical Social Work from Boston University. She is also the surviving widow of Marine Corp Major John Ruocco, who died by suicide in 2005.

Chairman Miller, Ranking Member Brown, and other distinguished members of the Veterans Affairs Committee, the Tragedy Assistance Program for Survivors (TAPS) thanks you for the opportunity to share the stories of surviving family members of service members and veterans who have completed suicide and to offer suggestions on how to prevent other families from suffering the same tragedy. We are appreciative of the work this subcommittee has done in the past to improve benefits for the survivors of those who have made the greatest sacrifice for our country.

### **How TAPS Helps Survivors**

The Tragedy Assistance program for Survivors (TAPS) is a national organization providing compassionate care for the families of America's fallen military heroes. TAPS provides peer-based emotional support, grief and trauma resources, grief seminars and retreats for adults, "Good Grief Camps" for children, casework assistance, connections to community-based care, and 24/7 resource and information helpline for all who have been affected by a death in the Armed Forces. Services are provided to families and battle buddies at no cost to them. TAPS does all of this without financial support from the Department of Defense (DoD or the Department of Veterans' Affairs (VA). TAPS is funded by the generosity of the American people.

Bonnie Carroll, following the death of her husband in a military plane crash in Alaska in 1992 founded TAPS. Since then, TAPS has offered comfort and care to more than 50,000 bereaved family members worldwide.

### **TAPS Special Care for the Survivors Whose Loved Ones Complete Suicide**

My name is Kim Ruocco and I came to TAPS seeking support in 2006 following the death of my husband, Marine Corp Major John Ruocco. John died by suicide after suffering for years with untreated depression and PTSD. He was an attack helicopter pilot who flew 75 combat missions in Iraq and died three months after he returned. When John died, I was overcome with emotions and questions. I was desperate to talk to others who had experienced this kind of loss. I had a lot of questions like "How do I tell my two boys, who were 8 and 10, that their Dad made it safely back from combat and then took his own life?" I had questions about spirituality and increased risk for my children and myself and a need to know why someone dies by suicide. I realized that a death by suicide required a different kind of grief journey than other military deaths.

In 2007 Bonnie Carroll and I developed a comprehensive Suicide Loss Survivor Program. The program is divided into three parts:

- **POSTVENTION**-postvention is prevention. Those who are exposed to suicide, especially those who were intimately connected to the deceased, are at higher risk of suicide themselves. Postvention is an intervention that provides care to all those who are grieving a death by suicide in hopes of decreasing risk and providing a path to healing. TAPS has developed a program that allows peer professionals to connect immediately with new survivors. New survivors are offered peer based support, resources and referrals to trauma care and seminars designed specifically for healing after suicide.
- **INTERVENTION**-survivors of traumatic loss are at increased risk for suicide, mental health disorders and addiction. Whether killed in action, illness, accident or suicide, survivors may be at risk for suicide. TAPS staff is trained in Applied Suicide Intervention Skills Training (ASIST). This training allows our staff to identify those at risk and connect them with the care they need.
- **PREVENTION**-with each suicide comes a story of a service member or veteran who did not survive his or her injury or illness. These stories provide us with an extraordinary amount of information that can be used in prevention efforts. TAPS has been the voice of suicide survivors for over a decade. Information from our survivors has informed policy and protocols for each of

the services as well as the DOD and VA. We are grateful to be asked once again to testify on behalf of these surviving families.

### **Surviving Family Members of Military Suicide Share Their Stories**

One of the largest growing populations in our TAPS family is our surviving families of military suicide. TAPS presently has over 7000 suicide loss survivors and 700 survivors of murder-suicide. We average 3 to 4 new suicide survivors everyday.

For the purpose of today's hearing, I would like to focus on the suicide loss population within TAPS. Survivors of military suicide hold a wealth of information on the multiple factors that lead up to a death by suicide. They are on the front lines of a service member's or veteran's battle with PTSD, mental illness, moral injury and the multiple stressors associated with military life. They are witness to the challenges of stigma associated with mental health and the barriers to care for those who are suffering. Survivors of veteran suicide loss can provide us with a picture of the potential impact of challenges within the VA system. Today's testimony is a summary of information gathered from our survivors' journeys. I have narrowed it down to two prominent and consistent themes.

### **Barriers To Care**

We know from research that treatment works and that those who are in the care of the VA have a lower rate of suicide. In each case of a TAPS family whose loved one died by suicide, the veteran was not enrolled in a consistent, effective, evidence based treatment at the VA. In most cases the veteran struggled to get the care they needed in a timely fashion. In some cases the veteran himself became the first barrier to good care because of their cultural beliefs and stigma regarding mental health. This reluctance to share their true story, in combination with institutional barriers, can become the perfect storm for a veteran who is suffering. Families of these veterans struggled to help their loved one and often became frustrated and overwhelmed with navigating the system. Many of them expressed frustration with the lack of their involvement in assessment and treatment. They claim that part of the veteran culture is to not complain or admit to emotional or physical pain and to downplay how serious the issues actually are. Families feel strongly that if they were present for intakes and evaluations there would have been a more accurate diagnosis and treatment plan. Additionally these families long for a network of peer support where they could share information ideas about what helped and offer support to one another.

Here are some stories from TAPS families whose service member or veteran faced barriers to care:

#### **PCS Edward Michael Gilkes**

"Eddie", was stationed at Ft Benning Ga. training to be an Airborne soldier. Just before graduation he was accidentally blown up by a claymore mine. He spent two years in and out of Army hospitals trying to recover from debilitating migraine headaches, blurred vision, ringing in his ears and nausea. Despite his pain and multiple doctor visits, Eddie never gave up trying to reach his dreams. He attempted to complete Ranger training three times but in each case he failed due to his ongoing medical issues.

In May of 2012, Eddie was honorably discharged from the Army following a medical board review. He was not given a disability rating or sequential pay. Eddie moved in with his parents because he could not afford to live on his own. He spent one year waiting to be assessed for care by the VA. During this time he was riddled with pain and started to lose hope that he would ever get better. When his assessment was complete, Edward waited another 6 months for an appointment with the doctor. At the appointment he was given painkillers, a brain scan and was told to come back in 3 months. Edward returned in 3 months and waited all day in the waiting room. At the end of the day he was told that

he would have to reschedule because there was no longer time to see him. The next appointment he could get was 2 months away.

During this period Edward was also waiting for a disability rating from the VA. His diagnosis was TBI and PTSD along with chronic pain related to the training accident. Despite documentation of all these conditions, disability was denied with one of the reasons being that he “had not had enough visits with the VA.” Eddie became so frustrated and hopeless that he gave up trying to get care from the VA. He began looking for a job and was hired to work on the pipeline. This work was very difficult for him. He had to take frequent breaks because of his pain and he had difficulty concentrating. Co-workers often had to cover for him. After a little over a year, he was laid off. Eddie moved in with his brother and applied for unemployment but his spirit was broken. On October 26th, 2015 PCS Edward Michael Gilkes died by suicide. He left a note saying “I have no purpose in life.”

### **CPL Kevin Schranz**

Kevin was a Marine Corp machine gunner who served two combat tours in Afghanistan. During his second tour he received a couple of minor injuries from explosions. He experienced ringing in his ears and a minor eye injury that could develop into a more significant injury in the future. He was honorably discharged in 2014. He and his wife moved to Connecticut where he enrolled in college and he tried to transition to the civilian world. During this time Kevin began to have some anxiety and sleep problems. He told his wife that he had seen some “intense things” and couldn’t get them out of his mind. Kevin started counseling at the Vet Center and put in a VA claim for his eye injury, tinnitus and anxiety.

Kevin’s wife, Abby says her husband became more anxious and paranoid. He started to be afraid to be alone and carried his gun with him. She encouraged him to go to the VA and be assessed for PTSD. Abby says that her husband “trusted the system” and was anxious to find out “what was wrong with him.” Kevin did go to the VA and was tested for PTSD. Months later Kevin was denied benefits for his eye injury and was told that he did not have PTSD. This finding was devastating to Kevin. He said to his wife that this was just a problem with him. He wrote a letter to his wife stating that everyone would be better off without him. He also left a suicide note that said, in part “This is my own fault, this is not a PTSD problem so please do not politicize it.” Abby looked at his records, after he died, and was surprised to see that he denied many of the issues that she witnessed him having, such as driving recklessly. Abby expressed regret that she was not involved in the assessment. She also wished her husband was immediately enrolled in the VA and given treatment for his combat exposure without having to “prove” he was sick.

### **Sgt. Raymond Burnside**

Ray was a Special Ops medic for the Army. He had one tour in Iraq and another in Afghanistan. Ray enlisted right out of high school when he was just 18 years old. He was determined to do something important with his life and also wanted to avoid ending up like his Dad, who was a veteran who died by suicide in the early 90s. Ray was honorably discharged from the Army in 2012. He claimed that he was fine and did not need help with the things he had seen and done in combat. His mom was concerned because she could see that he was drinking a lot and seemed to isolate himself frequently. Ray started school but found it very challenging. He would tell his Mom that no one understood him and he would get really angry at things the professors would say. He seemed more and more agitated and angry and his drinking increased. He dropped out of school and went

on what his mom described as “a quest to fit in and calm his emotions.” At one point he disappeared saying he was going to join the French foreign legion. He came back weeks later saying that he was so drunk that he lost his way. His friends and family became very concerned about him. They asked if he might be suffering from PTSD and he would respond, “No, I am just a loser, it is all my fault.”

In July of 2014 Ray was finally convinced to go to the VA. He went by himself saying, “I can handle it.” Ray returned home, after his first visit, enraged. He said that they treated him like he was just trying to get attention. He said that he was told that he is not as bad as other guys they had seen. Ray told his family that this is exactly what he feared that he wouldn't be believed and that people would think he is weak and making up his symptoms. His family felt helpless. They wondered if Ray had shared just how bad his symptoms were because he had so much shame about them. For the next couple of years Ray would self-medicate with alcohol and periodically become suicidal. His mom would call the VA asking for help and didn't know how to get the help her son needed. Once she was able to get him committed to inpatient care but he left after three days saying he couldn't “be confined like that because it brought him back to a place he didn't want to go.” The day before Ray died he cut his wrist very badly. His Mom found him trying to stitch it closed by himself. She convinced him to go to the ER only by convincing him that they could tell the hospital that he cut his arm on a broken window. They went to the VA emergency room and he was stitched up and released. He went home and began drinking. By the next day he was saying that he was going to kill himself. His mom was desperate to save him and was able to convince him to get in the car with her. Unfortunately at a stop sign he jumped out of the car and ran. He was found hours later, hanging in a hotel room.

### **PEER-BASED SUPPORT**

In each case the family tells TAPS that their veteran only wanted to talk to someone who has “been there.” The veteran had shame and guilt about the symptoms they were feeling and thought these symptoms were a weakness in them, not an illness. This false belief became a barrier to getting a good assessment and to finding appropriate treatment and staying in treatment. Peer support can be used to build trust that eventually leads to an understanding that their symptoms are real and valid and that there is treatment available that works. Peers serve as a beacon of hope for those who are struggle and can offer a road map on navigating the system.

The Fisher family shared their thoughts about how peer-based support could have helped their son Fritz.

#### **Fritz Fisher**

Fritz Fisher was a Marine veteran who had served two tours in Iraq and was honorably discharged from the Marine Corp in 2004. Fritz was a field operator in Iraq and had to leave mid tour because his commitment was up. He married Amanda soon after discharge from the Marines. Within days of his discharge he experienced extreme guilt for leaving his buddies in a war zone and had nightmares and flashbacks related to his tour. Amanda encouraged him to go the VA and get assessed. At first he refused saying, “I need to suck it up” and “it wouldn't look good.” Fritz resisted care and at the same time his symptoms continued to escalate. He was having angry outbursts and panic attacks. He self-medicated with alcohol which just increased his problems. Finally Amanda was able to convince him to go to the VA. According to Amanda, it took two years for Fritz to get a PTSD disability rating of 30% and many months to see a doctor. When he finally saw the doctor, he was given medication and not offered counseling for his emotional pain and

PTSD. Fritz dropped out of treatment telling his wife that it wasn't helping and he didn't feel better. In 2010 Fritz became a government contractor and deployed back to Iraq. He told his wife that this would help him and that it is where he feels most comfortable. In 2011 Fritz returned from Iraq and started having problems. He had chest pain and panic attacks. He was drinking and smoking marijuana to ease his symptoms. He didn't want to go back to the VA because "he didn't just want to be drugged like my buddies." Amanda was desperate to help him but didn't know how. Their life became a cycle of anxiety, angry outbursts, addiction and crisis. When Fritz was in crisis Amanda would take him to the VA ER. She states that many times they would wait all day and sometimes not get an appointment. On several occasions Fritz stormed out yelling "no one gives a shit." In 2012 Fritz had hit rock bottom. He had started huffing air dust. He became suicidal and called his parents. His parents drove and picked him up. They also did not know how to help him so they drove him to the VA. They were told they would see him when they could fit him in. They waited for several hours and Fritz stormed out. Fritz only tried to get treatment one more time before his death. He went to a civilian, mental health provider and they told him that he needed to go to the VA. Fritz over-dosed on air dust on October 2, 2014. His wife wishes that her husband had more peer support to encourage treatment and normalize his symptoms. She also wishes she had a place to get answers on how to help him.

A veteran recently told me "I was homeless and living out of my truck when I met my peer support specialist 3 years ago. He helped me in all areas of my life and I am proud to say that tomorrow I am closing on a home."

### **Recommendations**

1. Increase number of mental health care providers who are trained in evidence based best practice for treatment of injuries and illnesses related to these conflicts. At each contact a veteran should be able to get appropriate mental health care in a timely manner. This is especially crucial for entry points during crisis, such as emergency rooms and outpatient clinics.
2. Develop family advocacy and information groups that can offer support and guidance to those who are supporting a veteran.
3. Develop an avenue for family members to call for professional advice on how to help their loved one.
4. Make peer support specialist a line item. Peer support is an invaluable tool and a reciprocal relationship that adds value to all involved. Peer support specialist can be used to reach out to veterans where they are and build a bridge toward the professional mental health care they need. Peer professionals can be used in numerous impactful ways including navigating paper work, running support groups, normalizing symptoms and validating that treatment works.
5. Increase incentives for and streamline process for becoming a peer mental health professional. In the field of social work we often say "there is no better clinician than one who has personal experience and professional training". In the case of veterans, personal experience adds a level of trust and credibility that greatly increases the probability of a veteran seeking treatment and staying in treatment.

We hope you will consider our recommendations as you consider the ways that the Department of Veterans Affairs can reach out and help those veterans who are contemplating suicide. Our families shared their stories so that all may learn and identify what brought their loved one to take their lives. TAPS stands ready to work with you to end this national epidemic.