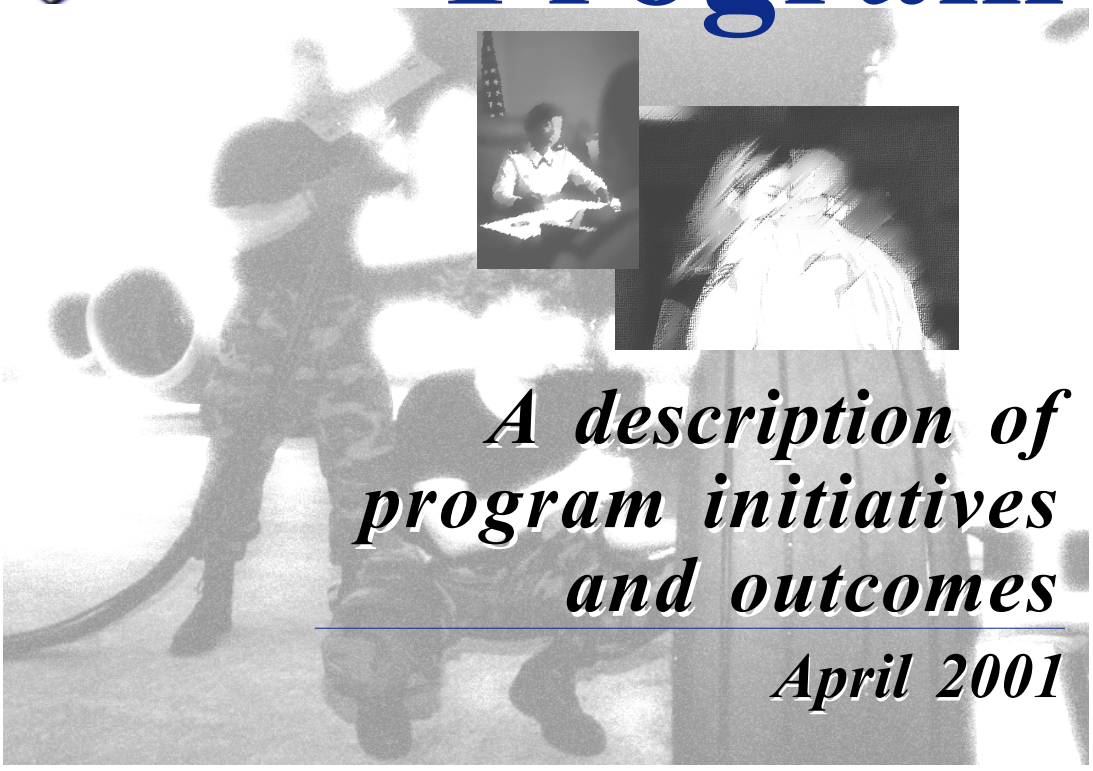
The Air Force Suicide Prevention Program



A description of program initiatives and outcomes

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PREFACE

The United States Air Force is committed to maintaining a fit and healthy force because the health of the Air Force community is crucial to force readiness. In 1996, the Vice Chief of Staff directed the establishment of an integrated product team (IPT) dedicated to reducing the number of lives lost to suicide. With senior leadership support, the IPT developed a plan that marked the inception of the Air Force Suicide Prevention Program.

Since its creation, suicide rates among Air Force members have fallen to record lows. We commend the hard work and dedication of those personnel involved in the development of the Suicide Prevention Program. Toward that end, this document recounts their efforts.

The Air Force Suicide Prevention Program has heightened community awareness of suicide and suicide risk factors. In addition, it has created a safety net that provides protection and adds support for those in trouble. As we move beyond program development and implementation, we must work to sustain the effort. Air Force leadership should continually strive to communicate in words and actions that it is not only acceptable, but also a sign of strength, to recognize life problems and to get the necessary help. As the program matures, it will require continued leadership support and involvement in addressing the needs of Air Force members. Our work is not done. We are fully committed to the Air Force Suicide Prevention Program—now and in the future.

MICHAEL E. RYAN
GENERAL, USAF
CHIEF OF STAFF

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LIEUTENANT GENERAL, USAF
SURGEON GENERAL

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Introduction

David Litts, Colonel, USAF
Office of the US Surgeon General

In the spring of 1996, the Air Force's most senior leaders sensed that the details of far too many suicides were crossing their desks in daily reports of major events. In May of that year, the suicide of Admiral Jeremy Boorda, the top-ranking officer in the US Navy, caused them to take an even closer look. It was time to take more aggressive action against the problem of suicide among Air Force members.

General Thomas Moorman, then the Air Force Vice Chief of Staff, commissioned the Air Force Suicide Prevention Integrated Product Team (IPT), under the leadership of Lieutenant General Charles "Chip" Roadman II. This IPT was to develop a comprehensive plan to respond to the problem. Consonant with the team leader's vision, Air Force suicide would not receive merely a medical response, but rather an Air Force response. To do that, representatives from the entire Air Force community had to be fully invested in the process *and* the result. Many Air Force agencies and individuals—Military and Civilian Personnel, the Chaplains, Safety, Staff Judge Advocate, Commanders, First Sergeants, Child and Youth Programs, Family Support, Family Advocacy, Law Enforcement, Office of Special Investigations, Epidemiology, Mental Health, and Preventive Medicine—participated. From outside the Air Force, the Centers for Disease Control and Prevention (CDC), the Armed Forces Institute of Pathology, and the Walter Reed Army Institute of Research also helped. Altogether, about 75 individuals spent June and July of 1996 assembling all that was known about Air Force suicide victims. From this initial evaluation, a plan emerged, based on expert opinion and the best available scientific knowledge. The goal was to build a prevention program that would, through its implementation, save lives.

At the first few meetings that summer, each team member presented his or her view of the "problem" and the "solution." After numerous briefings on stand-alone databases, suicide theories, and single-faceted solutions, three themes resonated with team members:

— Airmen feared losing their jobs and avoided seeking professional help because of the stigma associated with mental health problems and their treatment.
— Many airmen perceived that commanders and supervisors routinely viewed mental health records, which reinforced the barriers due to stigma.
— The Air Force was losing one of its defining qualities, a supportive interconnectedness that was best described by an old, though oft-repeated, slogan: "The Air Force takes care of its own."

The team established several epidemiological baselines:

— In the first half of the 1990's, suicide had been the second leading killer of airmen, responsible for 24 percent of all deaths.
— The rate of suicide had risen significantly for enlisted males, both African-American and Caucasian, in the years preceding 1996, though still about 40 percent less than the age-, sex-, and race-matched US population.*
— Fewer than one third of the suicide victims had accessed Air Force mental health services before their deaths.

— From 1990 to 1995, 25 percent of suicide victims had legal problems, frequently with the military justice system. A mental health specialist had evaluated fewer than one in five.
— Of the entire constellation of risk factors, problems with relationships, the law, and finances played a part in an overwhelming majority of suicides.

The team identified the risk factors for suicide and, with the exception of previous attempts, observed that all were modifiable. Additionally, it characterized "protective" factors as falling into three categories:
— Social support and interconnectedness
— Individual coping skills
— Cultural norms that promote and protect responsible help-seeking behavior

The team also observed that these protective factors were modifiable, and perhaps much more so even than the risk factors.

During six weeks of briefings, discussions, e-mails, and multiple drafts and redrafts, certain assumptions emerged that would underlie the remainder of the team's work:
— Many, if not most, suicides are preventable.
— Although there were no proven suicide-prevention methods, consensus recommendations from the CDC and World Health Organization were most promising.
— Suicide is not a medical problem, but a problem of the entire Air Force community.
— Suicide is the "tip of the iceberg" of psychosocial problems in the Air Force. A responsible suicide prevention program must address the entire iceberg of afflictions to individuals, families, and their communities.
— A community-based approach to reducing suicide would require committed partnerships by many different professional and social service providers.
— Only the Air Force Chief of Staff and the four-star generals could lead the way for the requisite cultural transformations that would
  -- Strengthen lifesaving social support to *all* Air Force members, especially those in personal crisis, and
  -- Encourage and protect those who responsibly seek mental health treatment.

The chapters that follow provide details of the Air Force Suicide Prevention Plan, which consists of eleven initiatives identified by the Suicide Prevention IPT. The discussion of each initiative generally addresses:
— The reason the team deemed it important.
— The actions taken to implement it.
— The results of those actions.

This document represents a snapshot in time of the general structure of the Air Force Suicide Prevention Program. The Suicide Prevention IPT continues to meet and the program is continually being refined and improved. The goal of this prevention program is to eliminate suicide as a cause of death among active duty Air Force members. When it comes to suicide, there are no "acceptable losses."

I Leadership Involvement

G. Wayne Talcott
Lt Colonel, USAF

Developing an effective suicide-prevention program that will reach over 370,000 airmen stationed around the globe presents significant challenges for training and program maintenance. Another barrier to an effective program is the constantly changing Air Force population, with over 30,000 new airmen entering service every year. Commanders, as well as young airmen, move around the world and in and out of the service. To remain viable and effective, a prevention effort has to remain on the minds of all members of the community, especially commanders and supervisors.

One way in which the Air Force Suicide Prevention Integrated Product Team (IPT) sought to keep the prevention program current and on everyone's mind was to make it a commander's program by obtaining leadership support. The Air Force is structured hierarchically. The Chief of Staff of the Air Force (CSAF) is the senior ranking officer. Under the CSAF are nine major commands, called MAJCOMs, each with its own commander. The MAJCOMs then have Wing commanders (at the installation level), which have Group commanders (organizations on an installation), which, in turn, have Squadron commanders (sections within organizations). Active support from the CSAF meant the team could send information and directives regarding suicide prevention through the chain of command, from the CSAF to Squadron commanders, rapidly.

A primary method for transferring important information from the CSAF to the installations is through the message system. This system disseminates information rapidly throughout the Air Force. The IPT saw it as an ideal method for distributing information about suicide prevention.

Having the CSAF send regular messages serves several purposes. First, it provides a timely way of broadcasting information about suicide prevention throughout the Air Force. Second, it shows that the chief executive officer of the organization is interested in suicide prevention—a powerful message to other leaders. Third, even in an organization with a high job turnover, messages can be sent regularly, to ensure that leadership at all levels remains informed about the importance of suicide prevention.

The messages released by the CSAF not only show top-level support for suicide prevention, but also provide education and guidance to Air Force leaders. Messages are released every three to six months. They generally encourage commanders to

— Actively support suicide prevention.
— Promote protective factors.
— Identify risk factors.
— Recognize suicide prevention as a community effort.
— Encourage airmen not to fear seeking help.
— Provide progress reports and information.

One of the first messages released by the CSAF emphasized the importance of the suicide prevention effort and the need for leadership to take an active role in suicide prevention:

"...Suicide affects the Total Force and causes the loss of our most valuable resource, trained professionals. It is the second leading cause of death among active duty members. As leaders, we must take action to turn the tide on the needless tragedy of suicide..."

General Ronald R. Fogleman
Air Force Chief of Staff (1994-1997)

Protective factors are those efforts that tend to decrease the likelihood someone might contemplate or actually harm themselves. The following excerpt from a message emphasizes social support, which is a powerful protective factor:

"...Please go the extra mile to foster a sense of belonging. Make sure your people feel they are a member of the team at unit functions and other small gatherings. It has been repeatedly demonstrated that social connections save lives...Let's ensure we take care of our own—our Air Force family..."

General Michael E. Ryan
Air Force Chief of Staff (1997-Present)

In addition, commanders want to be vigilant for risk factors that could increase the likelihood of a suicide or an attempt. The following is an example from a message that attempts to increase awareness of suicide risk factors:

"...Since relationship problems are a factor in over half of our suicides, be vigilant for risk signs and respond with help to fellow airmen having problems..."

General Michael E. Ryan
Air Force Chief of Staff

Making suicide prevention a community effort is a central feature of the prevention program. The goal is to heighten awareness of suicide and to create a culture that encourages everyone to take some responsibility for this effort:

"...We are not just another big corporation—we are the United States Air Force, and we 'take care of our own'..."

General Thomas Moorman
Air Force Vice Chief of Staff (1994-1997)

A major goal of the prevention program is to reduce the barriers to seeking help. Therefore, a number of messages encouraged commanders to communicate to their troops that it is appropriate to seek help, even mental health services:

"...Communicate in your words and actions that it is not only acceptable, but a sign of strength, to recognize life problems and get professional help to deal with them constructively. This help may come from chaplains, mental health providers, family support centers, or other providers on-base or off-base. We must support and protect to the full extent possible those courageous people who seek help early, before the crisis develops..."

General Michael E. Ryan
Air Force Chief of Staff

Using the message system provides a way of keeping commanders informed about the progress of the suicide prevention program:

"...Suicides among Air Force members have fallen 37 percent, to the lowest rate since 1989. Since many of the risk factors involved are slow to change (e.g., substance abuse, mental health problems, failures in relationships, etc.), we can assume the decline is due primarily to strengthening protective factors: social support, effective personal skills for handling difficult situations, and policies and cultural norms that encourage and protect those who seek help..."

General Michael E. Ryan
Air Force Chief of Staff

Finally, messages are used to maintain a focus on suicide prevention. Sustaining the program is a major concern as it enters its fourth year. The IPT sees messages as one way of trying to keep suicide prevention a central part of commanders' activities:

"...we have experienced dramatic reductions in the number of Air Force suicides. Our efforts are working. Suicide however, continues to pose a threat to the health and well-being of our community and we cannot afford to relax our efforts..."

General Michael E. Ryan
Air Force Chief of Staff

The Air Force Suicide Prevention IPT believes that having the CSAF send regular messages to other Air Force leaders, encouraging their support and active participation in suicide prevention, will help maintain leadership interest. Some recent findings lend support to this belief. In 1999, the USAF Office for Prevention and Health Services Assessment conducted a survey of Squadron commanders to assess their interest in identifying specific behavioral health problems in their units. The survey had them rank, in order of importance, those behavioral health concerns in their units about which they were interested in knowing more. The number one concern was suicide prevention. This was surprising, considering the Air Force had only 20 suicides in 1999. One explanation for this finding is that suicide prevention is important to the CSAF and, therefore, important to leadership in general.

It is encouraging that Air Force leaders, even at the Squadron level, continue to see suicide prevention as important. Sending regular messages over the past four years from the Chief of Staff of the Air Force is one reason for this sustained interest.

II Addressing Suicide through Professional Military Education

Skip Moe
Colonel, USAF

In reviewing those factors that contributed to suicides, as well as those that seemed to protect against it, it became very clear that suicide was most effectively viewed as a command problem, rather than a mental health problem. One statistic made this point: fewer than one-third of Air Force suicide victims had been seen in a mental health clinic within the last month of their lives. However, they had all been seen at work—typically as recently as the last workday before their deaths. Still, it was not fair or correct simply to point fingers at commanders, first sergeants, or supervisors, and allege that they were somehow not doing their jobs. It was absolutely true that many believed they were not adequately prepared to intervene effectively with a suicidal individual. Education for commanders, first sergeants, and supervisors, seemed to be an appropriate initiative, even though many of them were routinely and successfully managing difficult situations with seriously distressed individuals.

The Air Force Suicide Prevention Integrated Product Team (IPT) developed two educational initiatives to fill any real or imagined gaps in knowledge regarding suicide and helping individuals who were suicidal:

— General community training (see Chapter V of this report)—Annual community training with a limited set of basic learning objectives on identifying individuals in distress and guidelines for taking appropriate action

— Professional military education (PME)—More extensive periodic training for Air Force members, in greater depth and specifically oriented to an individual's rank and level of responsibility. Most individuals who stay in the Air Force beyond their initial obligation attend rank-appropriate PME. Therefore, the IPT determined that PME curricula should be reviewed and, where appropriate, changes and/or additions should be proposed that address suicide prevention.

The IPT developed a comprehensive list of the information and skills that Air Force leaders and members should have regarding suicide and related subjects. Both enlisted and officer personnel reviewed this list, to ensure that it was complete and appropriate. (See the Skills List at Appendix A.) It included information that the lowest levels of supervision and leadership would need, as well as the most advanced information senior leaders would need. The importance of various educational points differs for personnel at different stages in their careers. Consequently, the IPT developed separate lists of desired learning outcomes for each of three levels of enlisted PME and each of three levels of officer PME, as well as for the First Sergeants' Academy. The lists overlapped; specific desired learning outcomes applied to multiple levels of PME. IPT members prepared information that helps meet desired learning outcomes for each level. Additionally, as an aid to course directors and instructors, they wrote a number of test questions for each level. Finally, they developed eight case studies based on actual Air Force suicides as exercises. The IPT intended these products to be information for instructors, as opposed to a set of lesson outlines. This allows instructors to develop instructional sessions appropriate to their setting and student population more easily.

When the IPT completed development of the PME resources, it provided them to the curriculum managers for each PME school, to incorporate into existing curricula. Updated annual statistics have been provided to the PME curriculum managers, to help keep their course material fresh.

Perhaps the most difficult aspect of the educational initiatives has been getting additional information included in PME curricula, which are always very full. There are many and diverse demands to include instructional blocks on specific areas of interest. A typical response from a PME course director is, "Show me what I should drop to make room for your block." Support for the suicide risk-reduction initiatives came from the highest levels of authority on the Air Staff, which helped clear the way.

III Guidelines for Commanders: Use of Mental Health Services

Molly Hall
Colonel, USAF

The Air Force Suicide Prevention program was adapted from seven recommendations from the Centers for Disease Control and Prevention (CDC) for the prevention of youth suicide. The CDC had recommended a dual approach:

— Population-based measures
— Measures targeted at high-risk individuals

The population-based efforts were divided into three subcategories: community training, preventive services, and risk assessment/monitoring. The targeted measures entailed

— Mental health treatment
— Screening programs to identify high-risk individuals
— Crisis centers/hotlines
— Action taken after a suicide to prevent a "contagion" effect

In reviewing the status of community training on suicide prevention in the Air Force, the Suicide Prevention Integrated Product Team (IPT) found that there was no system-wide approach to this effort. The IPT also found there was great variation in the depth and maturity of programs that had been developed. Moreover, people were somewhat confused about how and when to access mental health services. The Boxer Amendment, which had codified active duty members' rights when referred for commander-directed mental health evaluations, appeared to have exacerbated the situation. It seemed as though commanders were reluctant to refer active duty members for mental health evaluations. Consequently, there was concern that some active duty members might not be getting the mental health help they needed.

The IPT provided clear guidance to commanders on the best use of mental health services. The IPT sent a briefing to all Air Force installations and mental health facilities, with a cover letter from the Chief of Staff of the Air Force directing that every commander in the Air Force receive the briefing and put its message into practice. Commanders were to encourage early self-referral to mental health, and unequivocally communicate to subordinates that "It's okay to get help." This message was considered important enough to convene all Air Force commanders and first sergeants for the sole purpose of hearing the briefing.

The 15-slide, fully scripted briefing addresses the issue of the rising rate of suicide in the Air Force since the late 1980's. It establishes that, despite the effectiveness of early intervention, only a third of all cases of Air Force suicide ever received treatment in mental health clinics. The scope of mental health services is reviewed, with an intentional emphasis on the nature of these services, beginning with consultation, education, and training to enhance performance and improve coping skills. This is followed by an overview of the more traditional evaluation and treatment services offered for the full spectrum of mental health disorders, including domestic abuse, alcohol and substance abuse, and administrative recommendations/actions, such as commander-directed evaluations.

The briefing repeatedly underscores that effective leaders help their people seek care early, and are instrumental in removing barriers and stigma associated with needing care. An individual life-enhancement, mission-performance opportunity is captured by an early referral. The briefing states that every member of the Air Force community (commanders, first sergeants, supervisors, friends, and family) participate in recognizing and getting help for those who are struggling to cope with difficult life events. Commanders and supervisors, in particular, are in a powerful position to dispel concerns about seeking help. They can also facilitate obtaining such help. Commanders are given data to counteract the perception that seeking mental health care is a career-ending move. There is evidence to suggest that members who refer themselves are unlikely to experience a negative career impact.

A list of circumstances where referral to mental health may be appropriate is provided, highlighting problems with alcohol, the law, finances, job performance, and relationships.

Referral types and options are reviewed, including member self-referral, or commander-directed referral for Mental Health, Substance Abuse, Family Advocacy, or emergency evaluation. A discussion of commander-directed referral briefly reviews the policy, as well as identifying appropriate questions for commanders to ask. Commanders are reminded to take expeditious action in emergencies, or when imminent risk of harm to an individual or others is identified.

The briefing concludes by emphasizing that commanders and mental health professionals are partners in improving duty performance, and reducing negative career impact and the loss of trained personnel through early mental health care. (See Appendix B for a copy of the briefing.)

IV Community Preventive Services

George Nicolas
Lt Colonel, USAF

Historically, prevention services were not officially accounted for on existing manpower standards, and so any agency providing these services was in danger of losing personnel. This "prevention penalty" discouraged the delivery of community preventive services. For instance, in calendar year 1997, the ratio of prevention services to all mental health services was about 0.7 percent, the equivalent of only 8 full-time positions providing prevention services for the entire Air Force.

Getting mental health personnel into the community and performing a prevention role serves many functions. Only about one-third of those who committed suicide had received mental health care or intervention. Many view seeking such help in the military environment as a sign of weakness, at best, and a career killer, at worst. The IPT considered that putting mental health personnel into the community to serve in prevention/non-clinical roles was a first step to removing the stigma associated with seeking traditional mental health care. Second, it allows mental health professionals earlier access to those who are suffering. Third, mental health personnel provide these preventive/educational encounters without record keeping. The hope was that the lack of a written record would encourage an atmosphere where information could be exchanged more freely.

The IPT's requirement to implement the Integrated Delivery System (IDS) (described in detail in Chapter VIII) would further exacerbate the dilemma of providing community-based preventive services at the expense of traditional individual, couple, and family therapy. Mental health personnel comprise one-sixth of the cross-functional IDS, the charter of which is to provide for the bio-psychosocial needs of the installation community, via integrated prevention services. It was clear that the manpower standard for mental health had to change to accommodate prevention activities.

Initial assessment of the status of the standard led to two recommendations:

— A manpower additive to Air Force Manual (AFM) 168-695, Vol. 1, *Medical Administrative Management System-Base Users Manual*, to provide one full-time equivalent (FTE) for every mental health work center. The primary job of this FTE would be prevention.

— A limited-scale pilot project to test the concept of increasing mental health resources in prevention activities.

For the first recommendation, justifying an FTE without compelling data and/or a pilot project was difficult. The existing manpower standard was based on "bean count"—one patient equalled one bean. "X" number of beans equaled one FTE. Prevention activity does not lend itself to bean counting; it is a function of time spent versus the number of patients seen. Initial estimates of time needed to complete preventive mental health services were developed in five major areas:

— Assessment of community needs
— Delivery of interventions for individuals
— Delivery of interventions for units
— Administrative contributions to IDS
— Marketing/networking

We estimated that the amount of time needed was 1,641 hours per year, per installation, or 84 percent of an FTE. If this recommendation had been accepted, it would have added approximately 65 more mental health providers to active duty Air Force units. Reserve and National Guard units would not have been affected. However, this recommendation was not adopted.

The second recommendation, to establish a pilot project to test prevention in practice, would have placed one field-grade FTE to work with the base IDS for three years, at two sites in the US and two overseas. This recommendation ultimately fell into disfavor due to the commitment of resources, length of time for the project, and the need for a more immediate solution to the problem.

As a result, the five preventive mental health service functions and tasks developed for the first recommendation were distilled into the Work Center Description Additive, connecting three functions to provide prevention services with the base-level IDS. These three functions were:

— Preparing and providing education and community training in accordance with AFI 44-154, *Community Education: Suicide Prevention and Violence Awareness Training*[*]
— Consulting
— Performing outreach activities

The manpower standard additive was approved to include prevention services on 15 March 1997, about seven months after the initiative began. The Medical Expense and Performance Reporting System (MEPRS) code "FAZY" was developed to quantify the activity of the additive, so all time spent by mental health personnel in prevention activities could be tracked through this system.

Time spent in prevention activities tripled in 1998 and remained steady through 1999. However, we have not reached the goal of dedicating five percent of all mental health activities to prevention. The rate of activity leveled off at two percent, or the equivalent of 26 FTEs Air Force-wide. Air Force consultants for psychiatry, psychology, and social work monitor this data and establish priorities for prevention activities.

V Community Education and Training

Richard Handley
Lt Colonel, USAF

Although mental health intervention can be very effective, we can only act when we are aware that a problem exists. This places the responsibility on individuals to seek help, or on others to refer them for help. We know from Air Force Office of Special Investigation (AFOSI) studies that, from 1983 to 1993, the Air Force averaged one suicide every five days. We also know, from the AFOSI studies, these facts about the suicide victims:

— 47 percent communicated their intention to kill themselves
— 53 percent gave clear indications of depression at the time of their death
— 76 percent had serious problems in their intimate relationships
— 32 percent had substance abuse problems
— 23 percent had financial problems
— 16 percent had legal problems
— 43 percent had work-related problems
— 60 percent had multiple problems

Despite these facts, two-thirds of the victims in these studies had not come into contact with the healthcare system. Since healthcare providers saw so few of the victims, the Air Force Suicide Prevention Integrated Product Team (IPT) recognized the need to provide community-based training for all Air Force personnel, including civilians.

Air Force Instruction (AFI) 44-154, *Suicide Prevention Education and Community Training*, adapts elements from the Air Education and Training Command (AETC) LINK suicide prevention program. It requires annual training in basic suicide risk factors, intervention skills, and referral procedures for people potentially at risk.

AETC designed the LINK program as a preventive "web" of individuals, supervisors, first sergeants, commanders, the community, and medical professionals to create circles of concern. Most suicidal individuals want to live, but many are unable to see alternatives to their problems. They often view their situations as hopeless. The LINK program "links" people to helping resources and alternatives.

The goal of the LINK program is to improve the early identification and referral of potentially at-risk personnel to prevent the loss of life from suicide, other self-defeating behavior, or behavior that may place others at risk. This program attempts to reach this goal by:

— Decreasing the stigma associated with seeking help
— Promoting early identification and referral of individuals at risk by those who know them best: their friends and co-workers
— Encouraging supervisors to act as gateways to helping resources

"LINK" describes actions each person can take to help prevent suicides, and is the theme of the program:

Look for possible concerns

Inquire about concerns

Note level of risk

Know referral resources and strategies

In 1997, when the AFI was implemented, the required training included four different intervention levels.

Level One—Individual

Level One was buddy care. This involved basic awareness training, with emphasis on stress and suicide risk factors. This training was conducted annually and at all levels of professional military education. The training encouraged the early identification and referral of potentially at-risk individuals to supervisors in Level Two.

Level Two—Unit Gatekeepers

Level Two involved identifying at-risk personnel (triage) and mentoring. This training equipped squadron supervisors with the tools necessary to act as a gateway to help those in need. Mentoring for supervisors would assist this effort and was a natural complement to the "buddy care" concept encouraged in Level One. Referrals were to be made to community resources within Level Three, such as the Family Support Center or chaplains, or directly to Level Four (medical professionals) in emergencies.

Level Three—Community Gatekeepers

Level Three involved those in the helping professions at each base. A base helping-professions team (Family Support Center, Chaplain, Mental Health, Family Advocacy, Child and Youth Services, and Health and Wellness Center) was to be established to network and coordinate service delivery to those in need.

Level Four—Medical Professionals

Level Four involved direct care. All medical providers were trained in identifying, referring, and treating persons at risk.

In 1999, the IPT made several changes to the training requirements of the initial program. Instead of four levels of intervention, the new AFI 44-154 requires only two: non-supervisory "buddy care" training and leadership/supervisory training. The IPT made these changes primarily because community gatekeepers and medical professionals taught the suicide prevention interventions. By 1999, over 90 percent of all active duty and civilian personnel had received some form of suicide prevention training.

VI Investigative Interview Policy (Hand-off Policy)

George Nicolas
Lt Colonel, USAF

Experts in the study of suicide traditionally identify legal problems as a significant contributing risk factor leading to suicidal acts. The Air Force Suicide Prevention Integrated Product Team (IPT) identified legal problems as one of the top three risk factors for suicide by active duty Air Force members. People under investigation can easily feel isolated from their family, friends, and other social supports when they need them most. In mid-1996, over 30 percent of active duty suicide victims had legal problems and most were under some type of investigation. At that time, no policy existed to ensure individuals under investigation were being assessed for suicide potential, or were receiving adequate social and psychological support while undergoing investigation.

In August 1996, the IPT began drafting a policy to assist those individuals under investigation with their emotional and psychological needs. A combined effort over the next several months involving the personnel, legal, security forces, medical, and inspector general communities led to agreement, in November 1996, on the following policy tenets:

- Agencies and unit leaders share responsibility for the safety and well being of individuals who are under investigation and may be experiencing significant stress as a result of the investigation.
- All Air Force investigators (e.g., Inspector General, Equal Opportunity and Treatment, Equal Employment Opportunity, Security Forces, or Office of Special Investigations) will notify/refer an individual's first sergeant, commander, or supervisor, through person-to-person, documented contact, that the individual was interviewed and notified that they were under investigation.
- Individuals appearing emotionally distraught or stunned will be released only to their first sergeant, commander, supervisor, or designee, and are not allowed to depart from an interview or interrogation alone.
- Ensure that those agencies that do not have the legal right to detain an individual make reasonable efforts to "hand off" an individual to a representative from their unit. If that is not possible, they must make notification as soon as possible.
- Unit leaders will take individuals experiencing stress that puts them at risk for suicide to a helping agency for professional care and services.

This policy was not designed to circumvent any legal rights of the individual (e.g., the right to an attorney, the right against self-incrimination), or to create any rights not required by law.

The Air Force Chief of Staff signed a policy letter incorporating those tenets, to be effective immediately, on 4 December 1996. This policy appears to have been effective. To date, no life has been lost because involved agencies did not support it. The policy has been adopted as a requirement in Department of Defense Directive 6490.1, *Mental Health Evaluations of Military Members* (October 1997), and Department of Defense Instruction 6490.4, *Mental Health Evaluations of Military Members* (October 1997), that address the issues of mental health evaluations and the concept of imminent dangerousness.

VII Critical Incident Stress Management (CISM)

Dick Newsome, Lt Colonel, USAF
Saint Louis University

A completed suicide affects not only the one who dies, but also those who survive. This is especially true in an organization such as the Air Force, where there is a strong emphasis on unit cohesion. A death in a unit can be very much like a death in the family. Since the death involves "work environment" relationships, instead of more traditional family relationships, there can be a risk for expecting people to just "suck it up" and go on with the mission.

Experiences with combat veterans throughout the history of war have repeatedly indicated that feelings repressed become feelings expressed, and not always in the best way. Following the Vietnam war, work with veterans from that era led to an improved understanding that exposure to trauma can have long-term effects on an individual's daily functioning. This knowledge resulted in identifying a pattern of behavior now referred to as post-traumatic stress disorder (PTSD).

Recognizing the long-term effects of PTSD is helping prevent people who are exposed to trauma from developing PTSD. Research and literature over the past 20 years have contributed to current PTSD prevention approaches. Investigators got their first exposure to a particular approach to PTSD prevention while watching the extensive coverage of the bombing of the Murrah Federal Building in Oklahoma City, in 1995. This approach is referred to as Critical Incident Stress Management (CISM).

The Air Force Suicide Prevention Integrated Product Team (IPT) surveyed Air Force major commands to assess established procedures for responding to trauma. The survey results revealed a wide range in the levels and types of responses, and an absence of specific Air Force guidance. Understanding the potential impact of a completed suicide on survivors, the IPT determined that an integral part of any comprehensive approach to suicide prevention would include CISM.

The IPT helped develop Air Force Instruction (AFI) 44-153, *Critical Incident Stress Management*,[1] to guide the Air Force in responding to traumatic events, including completed suicides. The AFI addresses the full spectrum of who, what, when, where, and how to respond. For the first time, the Air Force required trained, multi-disciplinary teams at each installation to respond to local traumatic events.

Rather than using only mental health personnel, the AFI established multi-disciplinary teams composed of mental health providers, medical providers, and chaplains, along with senior non-commissioned officers in non-medical positions. The benefits of multi-disciplinary Critical Incident Stress Teams (CIST) include:

— Reducing the impression, and potential stigma, that CISM is only for those who need to see a mental health provider
— Broadening the skills, perspectives, and expertise delivered to participants
— Reducing the impact on any one unit in responding to a traumatic event

The success of the CISM initiative depends on an understanding by commanders, supervisors, and those supervised that responding to a traumatic event is difficult. The goal of CISM is to help survivors identify, through a group experience, the normalcy of their various individual responses. CISM helps replace the internal question of "What's wrong with me," and lessens the impact on feelings of those who might think "I'm the only one feeling this way."

The CISM AFI establishes a CIST responsibility for training peer-support volunteers at each facility. This trained cadre of volunteers can better identify with a particular unit's perspective in helping it respond to a traumatic event.

The CISM AFI also includes a prevention component, which has the goal of providing anticipatory guidance for how to deal most effectively with an anticipated traumatic event. A curriculum for pre-exposure preparation (PEP) is part of the AFI. The curriculum includes core content, facilitator guidance, and material for commanders and supervisors in understanding the purpose and goals of PEP. The PEP training is conducted primarily in two ways:

— Periodic prevention training for initial responder groups, such as security forces, firefighters, and emergency medical technicians

— "Just in time" training for personnel being deployed to potentially threatening environments

The CISM AFI was adopted in July 1997. Within the following year, all Air Force installations had established CISTs composed of members from many disciplines. These teams had responded to a wide variety of events, including completed suicides. Commanders familiar with CISM through their own participation began requesting additional sessions, to address members who worked shifts. Commanders of security forces, firefighters, and emergency medical personnel have continued to request periodic PEP training for their personnel, to enhance the state of force readiness.

VIII Integrated Delivery System (IDS) for Human Services Prevention

John Nelson
Colonel, USAF

The Integrated Delivery System (IDS) is one of the major programmatic recommendations proposed by the Air Force Suicide Prevention Integrated Product Team (IPT). The IPT's specific charter was to examine completed suicides in the Air Force as a community and as a leadership concern. However, it was soon apparent that suicide was just the tip of the iceberg. Initial epidemiological analysis demonstrated that the issues and risk factors that underlie suicide have multiple outcomes; suicide is rare. In fact, these risk factors more often underlie other human problems on which we focus many of our other support programs. These common risk factors include problems with:

— Relationships
— Finances
— Job performance
— Legal system
— Substance abuse and mental health, especially depression

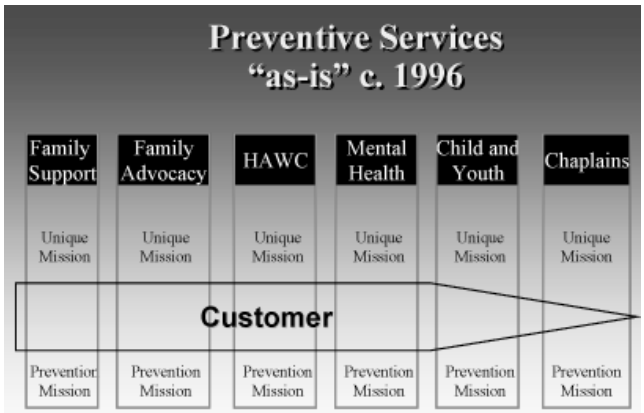
It became clear that addressing these risk factors, using a community strategy designed to prevent suicide, could have a much broader impact on the behavioral health of the community.

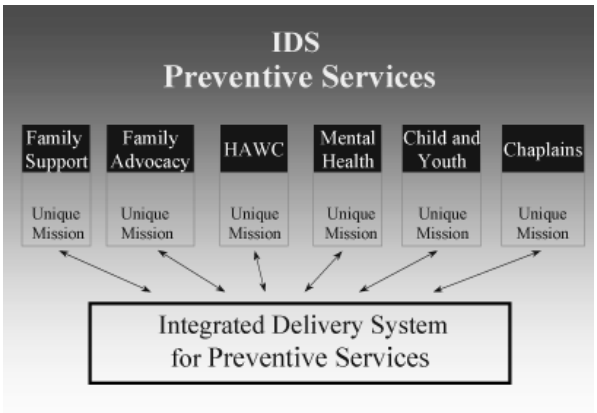
Many Air Force agencies provide broad-based prevention services that focus on these risk factors, reduce stress, and improve the coping skills and general well being of individuals and families. While each agency has a unique mission, they all share a common prevention mission, in which there may be overlaps, duplication, or gaps. Given such a diversity of agencies and programs, customers found it difficult to access and navigate the system. One agency's marketing efforts often inadvertently created a sense of competition with another, which confused the customer. Many bases attempted ad hoc coordination, to increase the availability of programs and services. However, these attempts were not consistent Air Force-wide in addressing wasteful duplications or service gaps. Without a coordinated system, customers (both commanders and members) often did not get the service they desired or needed.

The intent of the IDS is to establish a seamless system of services, made up of collaborative partnerships and coordinated human-service preventive activities for individuals and families. This system streamlines access and establishes new links among participating helping agencies. The six primary IDS agencies that have significant prevention-based resources dedicated to these issues are:

— Chaplains
— Child and youth programs
— Family Advocacy
— Family Support
— Health promotion/Health and Wellness Centers
— Mental health clinics

The IDS organizes and coordinates overlapping prevention missions of participating agencies, while retaining each agency's unique mission. The intent of the IDS is to eliminate duplication, overlap, and gaps in delivering prevention services through the consolidation of existing committees with similar charters. Consequently, the IDS can offer more comprehensive preventive services, which will increase protective factors and decrease behavioral risk factors in the Air Force community.





The IDS has four primary functions:

— Centralized information and referral (I and R)
— Assessment of unit and community behavioral risk factors
— Delivery of prevention services that are targeted to a wide range of individuals and groups within Air Force communities (leaders, active duty members and their families, civilian employees, and Reserve component members and their families)
— Collaborative marketing of IDS I and R and prevention services

The IDS exists as a virtual matrixed function, rather than a traditional agency. As such, it is defined by its activity rather than its location. IDS offers its services at work sites, schools, and community facilities, as well as at any of the member agency facilities.

The IDS is chartered as a standing subcommittee of the installation Community Action Information Board (CAIB). (The CAIB is a cross-functional committee made up of community agencies and chaired by a senior military officer on the installation, usually the Wing Commander or the Vice Commander.) Core membership of the IDS includes, but is not limited to, leadership representatives from each of the six primary agencies. Since prevention is a community-wide concern, any program or agency not specifically mentioned is welcome to participate in collaborating, coordinating, and marketing these efforts. The installation commander annually appoints a representative from one of the primary agencies to act as the IDS coordinator in his or her behalf. In making this appointment, the installation commander ensures the full cooperation of each agency contributing services to the IDS function. As the installation commander's representative, the coordinator is responsible for facilitating and directing collaborative efforts within the IDS team, and between the IDS team and the community. The coordinator reports to the installation commander at least quarterly on the progress of the IDS.

Initial policy guidance to installations in support of this significant effort was broad, rather than prescriptive. It provided for maximum flexibility in meeting local needs, based on local requirements and resources. Rather than specifying a "one-size-fits-all" model for the IDS, the bottom-line requirements are twofold:

— Create a collaborative, integrated, and customer-focused prevention delivery system
— Achieve meaningful and measurable outcomes for the community

One year following their initial development, IDS teams were operational on all Air Force installations. Many innovative best practices were identified. However, the need was apparent for a formal management structure, outside the Suicide Prevention IPT, to provide oversight and ongoing guidance for IDS implementation across the Air Force. The establishment of the Air Force CAIB (Air Force Instruction 90-500, *Community Action Information Boards*), chaired by the assistant vice chief of staff, provided an ideal response to this gap. (Note: The assistant vice chief of staff is the third highest position in the United States Air Force.) The Air Force CAIB elevates IDS issues from functional concerns to Air Force issues, and provides senior Air Force leadership visibility for these important quality-of-life issues.

IX Limited Patient Privilege

George Nicolas
Lt Colonel, USAF

The stigma associated with mental health care in the civilian community takes on added significance in the military. This is due primarily to the nature of military operations and commanders' "need to know" about the mental, and physical, capabilities of their troops to safely and efficiently carry out their missions. The "need to know" can run counter to the concept of confidentiality. In military medical practice, the provisions of the federal Privacy Act govern confidentiality for active duty members and non-active duty personnel. There are instances where confidentiality is not protected, to maintain the integrity of military missions. This military necessity permits commanders to access medical information, to preserve the safety and security of military personnel, dependents, property, or classified information, or to accomplish the military mission. Child abuse or maltreatment and danger to self or others are examples of other exceptions to patient privacy in the military.

With such broad access, military members shy away from military mental health providers because they do not want the commander to have access to information about their personal problems. Members commonly believe that if they seek mental health care, their careers will be adversely affected or terminated. In fact, results from the most recent Department of Defense Survey of Health Related Behaviors Among Military Personnel indicated that 86 percent of Air Force members felt receiving mental health services may or definitely would damage their careers. Fortunately, this view appears to be more perception than fact. One investigation found that nearly 98 percent of those who sought mental health care *on their own* did not experience any adverse effect on their careers. Conversely, 37 percent of those whom the *commander directed* to seek mental health care had negative career consequences.[1]

When these statistics were coupled with the fact that 30 percent of Air Force members who committed suicide never sought mental health care, the Air Force Suicide Prevention Integrated Product Team (IPT) moved to establish a minimum level of confidentiality, as a means to promote help-seeking behavior. Confidentiality was needed not only to encourage help-seeking behavior, but also to mitigate another significant risk factor: approximately 30 percent of those who committed suicide were undergoing disciplinary action (court-martial or administrative non-judicial punishment), or were being investigated for matters that could have resulted in disciplinary action. Mental health intervention during this time is critical.

The IPT chose to address these concerns in the March 1997 revision of Air Force Instruction (AFI) 44-109, *Mental Health and Military Law*.[2] Staff from the offices of the Air Force vice chief of staff, inspector general, judge advocate general, personnel, and surgeon general combined to draft the limited privilege suicide prevention (LPSP) program. The initial version of the LPSP provided the following guidance:

— It applied to members only after charges had been preferred in a court martial, or after notification of intent to impose punishment under Article 15 or Article 30 of the Uniform Code of Military Justice (UCMJ).

— Commanders were responsible for placing members in the LPSP when they became aware they were at risk for suicide and consulted with a mental health professional.
— The privilege lasted as long as the member was suicidal.
— LPSP provided limited protection to enrolled members:
  -- Information revealed to the mental health provider could not be used in UCMJ action.
  -- Information revealed could not be used to characterize service at time of separation.
— Notification of commanders for administrative purposes was allowed for any other purpose authorized by law, AFI 44-109, and other AF instructions and programs (e.g., nuclear personnel reliability program, when danger to persons and property is discovered).
— Members were disenrolled when the threat of suicide no longer existed and such was noted in the medical record.

Although limited in scope, this initiative was groundbreaking for military mental health care by establishing a psychotherapist-patient privilege. Its establishment was not expected to have any impact on the ability to prosecute cases.

After implementation of the 1 March 1997 revision, it became apparent that only about nine percent of cases were eligible for the LPSP program. The Suicide Prevention IPT wanted to broaden protections, so a greater percentage of members would be covered. A second revision of AFI 44-109 was published on 1 March 2000. The newly revised AFI retained the LPSP program, but significantly expanded the period for eligibility. Members are eligible for enrollment in the LPSP program now from the time of official notification that they are under investigation. This change is expected to increase eligibility to 35 percent of cases.

X Behavioral Health Survey

Paul Wilson
Major, USAF

The need for a tool to assess behavioral health aspects of a unit and members of a unit has long been a topic of interest in the Air Force. In 1993, the Air Education and Training Command (AETC) took steps to reduce their suicide rate. One of their initiatives was to develop a tool to help assess behavioral health risks in the workplace. They developed this tool, the Behavioral Health Survey, in 1994-1995, in cooperation with the Johnson Institute of Minneapolis, Minnesota (a civilian contractor). The Behavioral Health Survey was designed to alert commanding officers to behavioral problems in their organization's personnel, and to recommend prevention or intervention programs to reduce areas of risk or loss.

In 1996, the Suicide Prevention Integrated Product Team (IPT) decided that behavioral health assessment was needed as a component of a suicide reduction strategy. The IPT also decided that the Behavioral Health Survey was the best tool available for the Air Force.

The Behavioral Health Survey is composed of 196 items that ask about behaviors in the last 12 months. Most of the responses are in a "yes/no" or "true/false" format. The survey is self-administered, anonymous, and designed for work units of 100 or more. Administration usually occurs in large groups, and may include civilians, as well as active duty members. Since most items ask about behaviors in the last 12 months, it is recommended that the Behavioral Health Survey not be administered more than once a year.

A commander can request administration of the Behavioral Health Survey through the Integrated Delivery System (IDS), a "virtual" organization of helping agencies on each installation. The IDS representative can request survey forms either directly from the vendor (formerly Johnson Institute, now Hazelden), or from an existing supply purchased by the Air Force. Once the IDS representative administers the survey, responses are sent to the vendor for scoring and analysis. The vendor generates two reports of aggregate data that are sent back to the unit's commander (the Commander's Report) and to the IDS representative (the Helping Professional's Report).

The Commander's Report gives information on five main behavioral health factors:

— Alcohol use frequency
— Emotional distress
— Lack of cooperation with partner
— Psychological stress
— Job dissatisfaction (see Table 1)

Table 1. Scales from the Behavioral Health Survey, Commander's Report

Scale Name	Assessment Area
Alcohol use frequency	Drinking alcohol approximately two or more times per week on average
Emotional distress	Preoccupation with problems, depression, and/or a sense of helplessness, failure or shame
Lack of cooperation with partner	Inability of partners to appreciate one another's perspectives and compromise
Psychological stress	Lack of sleep, exercise, healthy diet, or quality time to spend alone or with families
Job dissatisfaction	Lack of information and resources needed for good job performance, difficult working conditions, unrealistic deadlines, and/or job-related stress

These scales have been shown to have adequate reliability and validity (i.e., they give the same results repeatedly and they measure what they purport to measure). In addition, the report gives commanders feedback on

— Aerobic activity
— Height/weight standards
— Cigarette use frequency
— Drinking and driving
— Demographics of their unit (gender, rank, time on station, hours worked per week) (see Table 2)

Table 2. Other Information from the Behavioral Health Survey, Commander's Report

Scale Name	Assessment Area
Aerobic activity level	Frequency of engaging in at least 20 minutes of aerobic exercise per week
Height/weight standards	Meeting current Air Force height/weight standards
Cigarette use frequency	Smoking one-half pack or more cigarettes a day in the past 30 days
Drinking and driving	Driving one or more times while under the influence of alcohol or other drugs during the past 12 months

The report that gives commanders information about these factors compares their unit to others from across the Air Force, weighted to match the gender and rank distribution of the work unit. This allows commanders to see if their unit is significantly different on these factors from a sample of other units across the Air Force.

The Helping Professional's Report includes information on five additional scales:

— Changes at work
— Dissatisfaction with partner
— Feelings of hopelessness
— Lack of unit cohesiveness
— Unresolved partner conflicts

These do not have as good psychometric properties as the five main scales. However, they may be useful to the commander. Also included are detailed item-level analyses of the unit's scores, allowing for hypotheses to be generated about where to focus prevention or intervention efforts (see Table 3).

Table 3. Scales from the Behavioral Health Survey, Helping Professional's Report

Scale Name	Assessment Area
Changes at work	Perceptions of changing responsibilities and threatened or actual reductions in the work force
Dissatisfaction with partner	Dissatisfaction with spouse/partner, perception of a lack of support
Feelings of hopelessness	Hopeless outlook towards the future and a negative view towards self, with possible increased risk for suicidal thoughts/behavior and depression
Lack of unit cohesiveness	Perceptions of poor morale, lack of interpersonal trust and loyalty, and lack of acceptance of new personnel
Unresolved partner conflicts	Anger and arguments in the relationship, with threats of separation

In late 1999, a random sample survey of commanders across the Air Force revealed that 84 percent "agreed" or "strongly agreed" that an instrument providing accurate information about the behavioral health strengths and needs of a unit would be helpful. However, only 14 percent of commanders had actually used the Behavioral Health Survey. The survey also found that most of the behavioral health domains of interest to commanders were not adequately addressed by the existing Behavioral Health Survey. A ranking of the top ten areas of interest to a majority of commanders is provided in Table 4.

Table 4. Top Ten Items of Interest to a Majority of Commanders

Rank	Item
1.	Suicide (thoughts, intent)
2.	Stressors and ability to cope
3.	Unit cohesion/morale
4.	Family problems
5.	Alcohol use
6.	Family separation (deployment, TDY)
7.	Family violence
8.	Depression
9.	Substance use (other than alcohol/tobacco)
10.	Quality of life/general well being

A working group has been formed to determine future directions for the Behavioral Health Survey, a revised Survey, or another assessment instrument, and for the use of behavioral health assessment in the work unit.

XI Epidemiological Database and Surveillance System

Jill Feig
Major, USAF

From 1990 to 1994, suicide accounted for an average of 24 percent of all deaths among active duty Air Force (ADAF) members and was the second leading cause of death in 1991, 1992, and 1994, after unintentional injuries.[1] During the same time, the annual suicide rate among ADAF personnel increased significantly, from 10.0 to 16.4 suicides per 100,000 members ($p<0.01$). In 1995, senior USAF leaders initiated prevention programs in several major commands (MAJCOM) because of the increasing suicide rate. Despite these programs, the suicide rate in 1996 was still considered too high by Air Force leadership.

The Air Force Suicide Prevention Integrated Product Team (IPT) called for establishing a central surveillance database for fatal and nonfatal self-injuries.[2] This database would be used not only to track events, but also to facilitate the analysis of potential risk factors for a suicide event. The system used to track the events is called the Suicide Event Surveillance System (SESS).

Initially, the SESS was developed as part of the Air Force Reportable Event Surveillance System (AFRESS), which is used by installation public health staff to track diseases and injuries in Air Force personnel. Suicide data, including personal demographics, event details, and use of preventive services, were tracked through AFRESS from 1 January 1997 until 19 January 1999. A 20 March 1997 memorandum by the Air Force Surgeon General addressed reporting requirements.

The SESS became an independent system on 20 January 1999. This move was made to:

- Alleviate technical incompatibilities with Air Force Office of Special Investigations (AFOSI) computer systems.
- Fill the need for expanded reporting of events to include non-ADAF personnel (Guard, Reserve, dependents, retirees, and DoD civilians).
- Allow direct reporting of suicide events by mental health staff, to improve patient confidentiality.

The SESS also collects data beyond that covered in AFRESS, including psychological, social, behavioral, relationship, and economic factors. Air Force Instruction (AFI) 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, currently in draft, will also include a section on suicide surveillance.

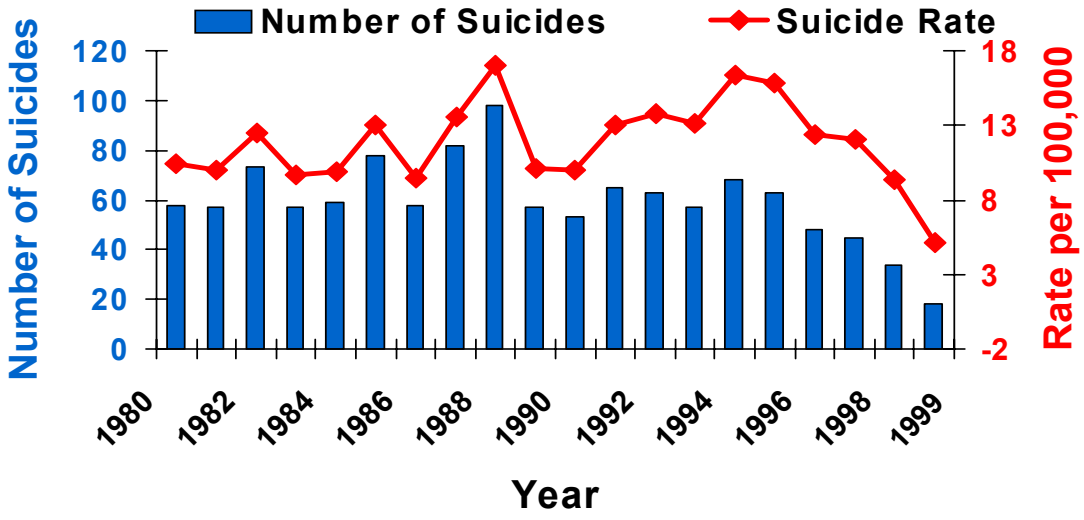
The SESS is a World Wide Web-based application. The system requires Netscape® Communicator version 4.5 or higher, authorization from the user's commander, and a computer with a ".mil" address. All data entered into the database is stored on a high-security server at Kelly AFB, Texas. The data in the SESS is governed by the Privacy Act of 1974. Privacy Act system notice F044 AF SG T, Suicide Event Surveillance System, applies.

There are two authorized mental health users at each base, and four AFOSI users at AFOSI headquarters at Andrews AFB, Maryland. Each user has a unique user name and password with which to enter the system. AFOSI users are responsible for reporting all completed suicides of ADAF members. Installation mental health users enter information on all non-fatal, self-injurious events, or NFSE. The NFSE cover suicide attempts and gestures, and may include ADAF, other military service members, and other non-active duty cases.

After logging onto the SESS Web site, the user can add a new case, update an existing case, or download such information as a user's manual, an investigative worksheet (Air Force Form 4273), or a summary report. A paper copy of the worksheet is not necessary, though some users prefer to use one as a "rough draft" on which to gather information.

The Force Health Protection and Surveillance Branch of the Air Force Institute for Environment, Safety, and Occupational Health Risk Analysis (AFIERA/RSRH) at Brooks AFB, Texas, is responsible for maintaining, continuously improving the quality of, analyzing, and reporting the data. One authorized user at the Air Force Medical Support Agency downloads the data monthly and provides it to a designated AFIERA/RSRH staff member. AFIERA/RSRH then creates routine monthly and yearly reports, as well as addresses requests from users and customers at the Air Force Medical Operations Agency, Office of the Surgeon General, and various mental health leaders at the MAJCOMs.

From 1994 to 1999, the suicide rate significantly decreased, from 16.4 suicides per 100,000 ADAF members to 5.6 ($p < 0.0001$; see figure).



The rate has decreased every year since 1994. One possible explanation may be the various efforts at suicide prevention that the USAF has employed. However, testing this hypothesis is not possible, due to the lack of a control group. Future trend analysis and comparison with rates from other branches of the military may provide more insight on this issue.

For more information about SESS, contact AFIERA/RSRH at:

2513 Kennedy Circle
Brooks AFB, TX 78235-5123
210/536-3471 (DSN: 240-)

Conclusions

Suicide rates have fallen significantly since the inception of the Air Force Suicide Prevention Program. In addition, we have taken a number of positive steps toward making this an effective program:

— Actively involving leadership
— Breaking down traditional "stove pipes" among helping services
— Striving to remove the stigma of seeking help
— Creating the first privileged communication for suicidal personnel who are under criminal investigation
— Encouraging the responsibility of all Air Force members to care for one another—"buddy care"

Although we can temporally relate the drop in suicides to the beginning of the prevention program, we have not established a definitive causal link. This means that it is difficult to prove that the suicide prevention program is the real, or only, reason for the reduction of suicides. When we began to design the program, we found no proven suicide-prevention methods. Therefore, we used consensus recommendations from the Centers for Disease Control and Prevention and other expert consultants in the field of suicidology to identify the basic components of this community-based approach.

Since no causal link has been established, future program initiatives strive to maximize the recommendations of the Air Force Suicide Prevention Integrated Product Team and other consultants. These first few years were very encouraging and, in 1999, the Air Force had one of the lowest rates of suicide in its history. However, even with these impressive results, we have work to do—in 1999, a historically low suicide rate still meant over 20 Air Force members died from self-inflicted injuries.

The Air Force Suicide Prevention Integrated Product Team continues to meet regularly to identify critical areas for program improvement. As the prevention program enters its fourth year, trying to sustain a global program and high quality interventions is challenging. The goal is to maintain the highest quality possible and to keep the program focused on those factors we believe are crucial to its success:

— Leadership involvement
— Education at all levels
— Re-engineering helping services
— Unit behavioral assessment
— Surveillance

REFERENCES

Introduction

Air Force members are screened for mental illness on accession to the force. One hundred percent are employed and housed. There is universal access to health care, including mental health services. All speak one language.

Chapter IV

Air Force Instruction 44-154, *Community Education: Suicide Prevention and Violence Awareness Training*
(See http://afpubs.hq.af.mil/pubfiles/af/44/afi44-154/afi44-154.pdf)

Chapter VII

Air Force Instruction 44-153, *Critical Incident Stress Management*
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APPENDIXES

APPENDIX A: PME SKILLS LIST (CHAPTER II)

Recommended Desired Learning Outcomes
For Professional Military Learning Courses

	Airman Leadership	NCO Academy	Senior NCO Academy	Squadron Officer School	Air Command and Staff College	Air War College	1st Sergeants Academy
1. Background Knowledge							
1.1. Know basic information about how much of problem suicide is for the Air Force	I*	R**	R	I	R	R	R
1.2. Know that suicide represents a failure to find other more effective ways to cope with problems that seem insoluble	I	R	R	I	R	R	R
1.3. Know warning signs of suicide and decreased or impaired emotional status	I	R	R	I			R
1.4. Know the implications of being seen in mental health	I	R	R	I	R	R	R
1.4.1. What if someone who works for you is seen in mental health		I	R	I	R		R
1.4.2. What if you need to be seen in mental health		I	R	I	R		R
1.5. For commanders and first sergeants:							
1.5.1. Know implications of getting help from a chaplain							I
1.5.2. Know implications of getting help from off-base sources							I
1.5.3. Know implications of getting help from a friend							I
1.5.4. Know implications of <u>not</u> getting help at all							I
1.5.5. Know the implications of being seen in mental health							I
2. Personal Coping Skills							
2.1. Know that problem solving, conflict resolution, and building social support are highly valued coping skills.	I			I			
2.2. Know where to go for help with improving these coping skills	I			I			
3. Peer Support Skills							
3.1. Know what to say to and do for a co-worker, friend, family member who appears to need help	I	R	R	I		R	R
3.2. Know what to say to a subordinate who appears to need help			I	I		R	R
3.3. Know where and how to get help	I	R	R	I		R	R

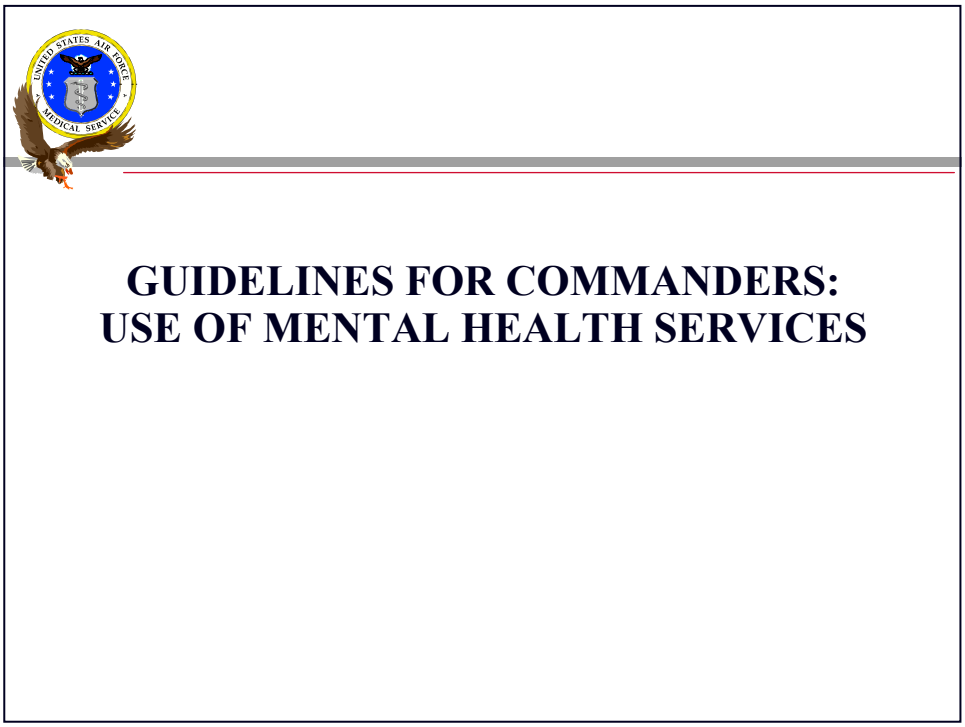
* I indicates that this information is first introduced at this level of Professional Military Education
** R indicates that this information is reviewed at this level of Professional Military Education

Recommended Desired Learning Outcomes
For Professional Military Learning Courses

	Airman Leadership	NCO Academy	Senior NCO Academy	Squadron Officer School	Air Command and Staff College	Air War College	1st Sergeants Academy
4. Leadership Skills							
4.1. Know prevention steps senior NCOs, OICs, and commanders should be taking			I*	I		R**	R
4.1.1. Know importance of facilitating social support and how to do that			I	I			R
4.1.2. Know relationship of marital problems to suicide and what to do about marital and other relationship problems within the unit			I	I			R
4.1.3. Know relationship of suicide to investigations and legal problems and how to provide support to members under investigation or with legal problems			I	I			R
4.2. Know prevention steps commanders should be taking				I	R	R	
4.2.1. Understand relationship of work environment to help-seeking				I	R	R	
4.2.2. Understand what policies promote and discourage help-seeking				I	R	R	
4.2.3. Know when and how to refer for a mental health evaluation				I	R	R	
4.3. First sergeants and commanders: Know, in great detail, where and how to get help							R
4.3.1. Know how to get help through mental health							R
4.3.2. Know how to get help from a chaplain							R
4.3.3. Know how to get help from off-base sources							R
4.3.4. Know how to get help from a friend							R
4.3.5. Know implications of <u>not</u> getting help at all							R
4.4. Know what to do for your unit following a suicide						R	R

* I indicates that this information is first introduced at this level of Professional Military Education
** R indicates that this information is reviewed at this level of Professional Military Education

Appendix B: Guidelines for Commanders Briefing (Chapter III)



CONTEXT OF BRIEFING

Suicide rates are rising among segments of AF population (enlisted males)

Suicide has risk factors that are prevalent among general population

Use of Commander Directed Evaluations (CDEs) has decreased markedly since implementation of Boxer Amendment

The purpose of this briefing is to provide clear guidance to commanders on the best use of mental health services. The issue was raised by senior leadership in the context of addressing the suicide problem in the Air Force. Although suicide is a rare event, it was the second leading cause of death for active duty Air Force between 1990 and 1995 after unintentional injury. The rate of suicide has risen from roughly nine per 100,000 to 15 per 100,000 AF-wide since the late 1980's. This rising trend is most evident among enlisted males.

Suicide occurs at the end of a long road of personal suffering and turmoil. Along the way, though, there are usually multiple signs which point to a need for help and present an opportunity for effective intervention. These can include a range of symptoms: poor coping skills, relationship problems, legal difficulties, decreased job performance, emotional distress. Only a third of all cases of suicide had received treatment in mental health clinics. Many individuals have risk factors, and while only a very small number will attempt or complete suicide, all exhibit decreased functioning contributing to lost workdays and reduced productivity. We must get our people help when they first show signs of distress.

A commander-directed evaluation is often a late intervention, but an intervention nevertheless. Commander-directed evaluations are occurring less frequently since the Boxer Law guaranteed certain legal rights to members being directed to the evaluation. The reason for the decline in this referral process is not known, but we should be concerned that this decline may mean some members are not getting the mental health help they need.

BRIEFING OUTLINE

Scope of Services provided by Mental Health

Considerations for referral

How to refer

- **Outpatient Evaluation/Treatment**
- **Commander Directed Evaluation**
- **Emergencies**

In this briefing we will review the range of services provided by AF Mental Health Clinics; we will provide an overview of the kinds of warning signs that should prompt commanders and supervisors to refer an individual for an evaluation; and finally, we will discuss the best approach to ensure a successful referral and intervention.

Mental Health Services are best used early when the opportunity for a positive outcome is highest. Unfortunately, there are social and personal barriers that inhibit many Americans from seeking mental health care—the stigma associated with needing this kind of help and the fear that seeking such help may negatively impact their life or work. Military members struggle with the same fears, and because of the unique aspects of the military culture, may be even less likely to use Mental Health Services first.

Mental Health Clinics offer a variety of programs targeted to improving individuals' coping through anger management, assertiveness training, communication skills, as well as marital and parenting groups. Effective coping skills are the key to resilience and problem solving. Inadequate and inappropriate problem solving skills lead to occupational and social dysfunction, and individual suffering. Almost all patients with serious mental health disorders, and particularly suicide victims, demonstrate a lifelong pattern of poor coping skills. Early intervention can mean the difference between a productive, fulfilling life and a life of chronic suffering, dependence or death.

Mental Health professionals offer consultation to units to identify causes of stress in the workplace that may degrade unit and individual performance.

After a traumatic event—such as a suicide in the unit—Mental Health Services can help ensure unit members have the necessary coping skills. These services are provided in the unit and are called Critical Incident Stress Debriefings.

SCOPE OF MENTAL HEALTH SERVICES (cont'd)

- Evaluation and treatment of mental health disorders
- Evaluation and treatment of domestic abuse or violence
- Evaluation and treatment of alcohol and substance abuse
- Administrative recommendations and actions
  - Commander-directed evaluations

Of course, Mental Health offers comprehensive evaluation and treatment for the full spectrum of mental health disorders. Additionally, Family Advocacy Services and the Substance Abuse programs are offered through the Mental Health Clinic.

GENERAL GUIDANCE

REFER EARLY: Mental Health Services are front-line interventions

REFER TO ENHANCE: Mental Health Services enhance individual and unit performance

CALL WITH QUESTIONS: Get advice on best approach

We have already emphasized that early referral is critical. Unfortunately, regardless of how accessible help is, many people struggling with such serious problems as family maltreatment or substance abuse simply will not seek help on their own. Referral by a concerned, caring family member, friend, coworker, or supervisor may make all the difference in enabling someone to seek help.

In order to prevent individual suffering and loss of performance due to mental health problems, it is ***essential*** that every member of the Air Force community identify people having difficulty coping with life events and refer them to help. In the extreme case, this may mean taking someone in crisis to what for them is lifesaving help. A recent study* estimated that one half of Air Force suicides in 1993 might have been prevented if the victims had been referred for mental health treatment. If this is true, we lose an opportunity to save twenty Air Force lives each year. Moreover, by not making early referrals to mental health, we lose the opportunity to enhance an individual's life, and ultimately the unit's performance. The key to timely referrals rests in the hands of commanders, first sergeants, supervisors, friends, and family.

Commanders can discuss a situation with Mental Health providers before making a referral and get advice on the best approach for the individual.

*"Active Duty Suicides 1983-93", Investigative Operations Center, AFOSI, August 1994

BACKGROUND DATA

Self-referral rarely results in negative career impact- 97% receive no duty limitation

Commander directed evaluation more likely (36%) to have negative career impact

Younger, lower ranking members less likely to self- refer

Need to promote early self-initiated help-seeking

Supervisors/commanders can target group less likely to seek help--debunk myths about help-seeking with facts

There is very little data on the factors which influence mental health help-seeking in the military. One thing is clear—members who self-refer, either on their own or through a recommendation from someone else, are much less likely to experience a negative impact to their career. In contrast, when commanders direct members for an evaluation, they are ten times more likely to have a negative career impact.[1]

Clearly, younger and lower ranking members (E1-E4) are less likely to self-refer.[2] So are individuals with security clearances and those who carry weapons. A study at Goodfellow AFB found that 99 percent of members who self-referred to Mental Health were recommended for continued SCI clearances. Only 46 percent of a commander-directed group were recommended for continued security clearance.[3]

Commanders should use these facts to counter the myth that voluntary help-seeking is a career-ending move. The facts should also motivate commanders to more closely attend to the youngest members of our Air Force family and members with a special duty status who may feel the risks of seeking help are too high. The advantages of early referral in a young population cannot be overemphasized. Interventions in this group are likely to have the most effective outcomes, because their behavioral patterns are more easily changed.

REFER TO MENTAL HEALTH WHEN:

Occupational/academic performance change
Relationships with others at work change
Relationships with family/friends change
Alcohol use shows poor judgment
Other substance abuse problem is suspected
Financial difficulty is not managed
Serious change in physical health occurs
Emotional symptoms appear
Legal difficulty is present
Disciplinary action is pending/taken

This list contains no surprises. There are many areas where signs and symptoms of stress can surface. When they do, commanders and supervisors must take action to support the member in crisis.

People with these problems may also have underlying risk factors for suicide: poor coping, social, or communication skills; substance abuse; and problems with the law, finances, job performance and relationships. A Mental Health history and previous suicide attempts are also identified as suicide risk factors. A military member in legal difficulty or facing disciplinary action may be particularly sensitive to experiencing shame and guilt in a setting of isolation from the community, all of which heightens the risk of suicide.

Commanders and supervisors are in a powerful position to dispel many concerns about seeking help from Mental Health. Everyone in the community, but especially commanders and supervisors, need to be alert to members who are in need of help and take action to ensure that members get help.

Members who are struggling or in distress may feel that they should be able to master things alone. Hearing directly from a figure of authority that getting help is a number one priority—not only for the individual but for the unit—can make a big difference. Commanders should emphasize that their goal is to keep that individual employed at their fullest potential. The best way to achieve that goal is for the member to self-refer early.

COMMANDERS' OPTIONS ARE:

Strongly encourage self-referral

Commander-directed mental health evaluation

Commander- directed evaluation by Substance Abuse Program, Family Advocacy

Emergency referral

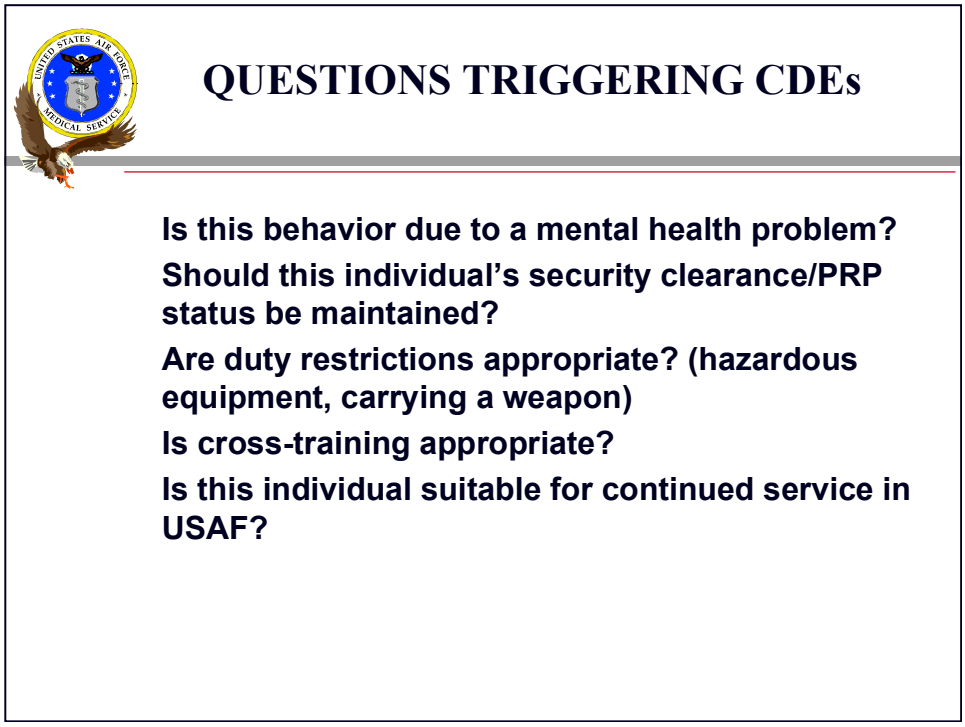
Self-referral is the intervention with the highest probability of the best outcome for the individual and the unit. Early self-referral may eliminate the need for the later, and often more costly, interventions, listed below it here. There are circumstances, though, when commanders must direct a member to the Mental Health Clinic, whether for a mental health evaluation, substance abuse, family advocacy issues, or bona fide emergencies.

COMMANDER DIRECTED EVALUATIONS (CDEs)

- **Commanders are responsible for safety of their units**
- **Commanders' prerogative to direct military member for mental health evaluation**
- **Requests for CDEs have decreased since implementation of Boxer Amendment (AFI 44-109: *Mental Health and Military Law)***
- **Questions used as basis for CDE in past are still applicable**
- **AFI 44-109 establishes procedural steps to obtain CDE**

Commander-directed mental health evaluations are necessary whenever mission effectiveness and unit safety are at risk.

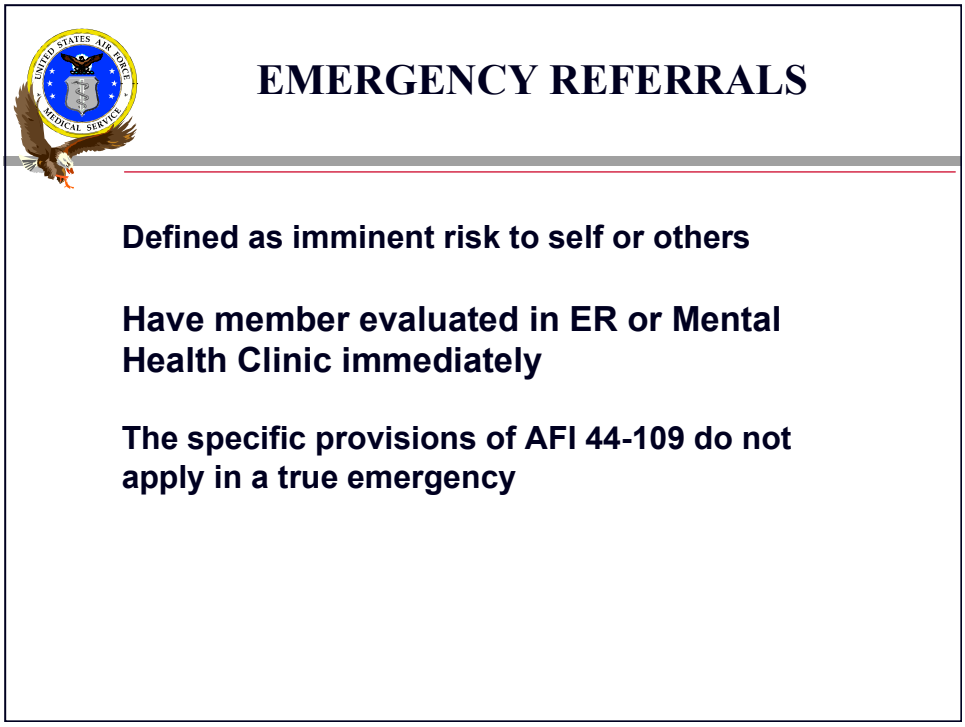
The recent decline in commander directed evaluations is disturbing. At one of our largest training centers, CDEs have decreased by 60 to 70 percent since implementation of the Boxer Amendment. Prior to the Boxer Amendment, 35 percent of individuals seen for CDEs required mental health treatment or hospitalization.(1) Air Force is concerned that the decrease in CDEs may indicate that people who clearly need mental health care are not getting it. The Boxer Law seems to be inhibiting commanders from making referrals for a CDE. This was not the law's intention. The circumstances that required a CDE in the past should do the same today.



Specifically, commander-directed referrals are appropriate when the commander needs answers to these questions:

- Is the member's behavior due to a mental health problem?
- Should this individual's security clearance/PRP status be maintained?
- Are duty restrictions appropriate? (hazardous equipment, carrying a weapon)
- Is cross-training appropriate?
- Is this individual suitable for continued service in USAF?

Use these as guidelines. Feel free, though, to call for expert advice from your local mental health professionals.



If early self-referrals and timely command directed referrals are occurring, the need for emergency referrals should be rare. However, when emergency situations arise, by all means, take immediate action. A member should be evaluated immediately when he or she expresses an intention of harming self or others, or behaves in a manner which would lead you to conclude that there was imminent risk of this harm. The Boxer provisions do not apply to emergencies.

BOTTOM LINE

Early Mental Health Care is *key* to enhanced unit performance

Early and effective mental health interventions

- **Improve duty performance**
- **Reduce negative career impacts**
- **Reduce loss of trained personnel**

We have discussed the circumstances that should lead commanders to make referrals to Mental Health. Mental Health providers offer a broad array of services to the AF community. They are uniquely qualified to provide prevention services at the unit level. These include teaching skills that enhance individual performance and address important areas of dysfunction. These are the same skills that reduce key risk factors associated with suicides and suicide attempts. Here is the take home—individuals evaluated and supported early have the best chance of achieving their full potential at work and at home.

A partnership between commanders and mental health professionals can get members to help earlier, lead to more successful interventions, and enhance the unit's overall performance. Commanders should feel free to call their mental health clinic for professional advice at any time.

REFERENCES

1) Crosby RC, Hall MJ: Psychiatric Evaluation of Self-Referred and Non Self-Referred Active Duty Military Members, *Military Medicine*. Vol 157:224-229, 1992

2) Rowan AB: Demographic, Clinical, and Military Factors Related to Military Mental Health Referral Patterns, *Military Medicine.* Vol 161: 324-328, 1996

3) Rowan AB: Studies at Goodfellow AFB, *The Military Psychologist,* 1994, 1995.

AFI 44-109 *Mental Health and Military Law*

AFI 36-3212 *Physical Evaluation and Retention, Retirement, and Separation*

AFI 36-2104 *Nuclear Weapons Personnel Reliability Program*

AFI 31-501 *Personnel Security Management Program*

AFI 36-3207 *Administrative Separation of Airmen*

The Air Force Suicide Prevention Program

A Community Solution to a Community Problem