



SUICIDE AWARENESS COMMUNITY EDUCATION PROGRAM CURRICULUM GUIDE

*Promoting Suicide Prevention Through Education About Care for Self,
Family, Others, and Community and by Emphasizing
Shared Responsibility to Encourage and Build:*

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Air Force Medical Operations Agency (AFMOA)
Population Health Support Division (PHSD)
Office For Prevention and Health Services Assessment (OPHSA)

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LETTER OF ENDORSEMENT

The United States Air Force is committed to maintaining a fit and ready force. The health of the Air Force community is crucial to force readiness. The Air Force Suicide Prevention Program was initiated in 1996 in response to an increase in the rate of suicide. Since the beginning of the program, suicide rates have fallen to record lows. However, despite these gains, suicide remains the second leading cause of death among active duty personnel.

To help meet the challenge, an updated Suicide Awareness Education program is being implemented. The goal is to enhance community awareness of risk factors associated with suicide and to develop strategies for suicide prevention.

This Guide has been developed to assist personnel who provide the annual suicide prevention briefings. It is designed as a framework upon which to build our efforts. It is not a substitute for good leadership and personal involvement.

The Air Force Suicide Prevention program emphasizes the Chief's aim of "Putting People First and Taking Care of Our Own." As chair of the Air Force Community Action Information Board, I fully support this effort. Increased awareness and improved education and training are key factors in meeting his expectations. I urge all Commanders, Supervisors and Airmen to support this initiative.

//SIGNED//
LANCE W. LORD
Lieutenant General, USAF
Assistant Vice Chief of Staff

ACKNOWLEDGEMENTS

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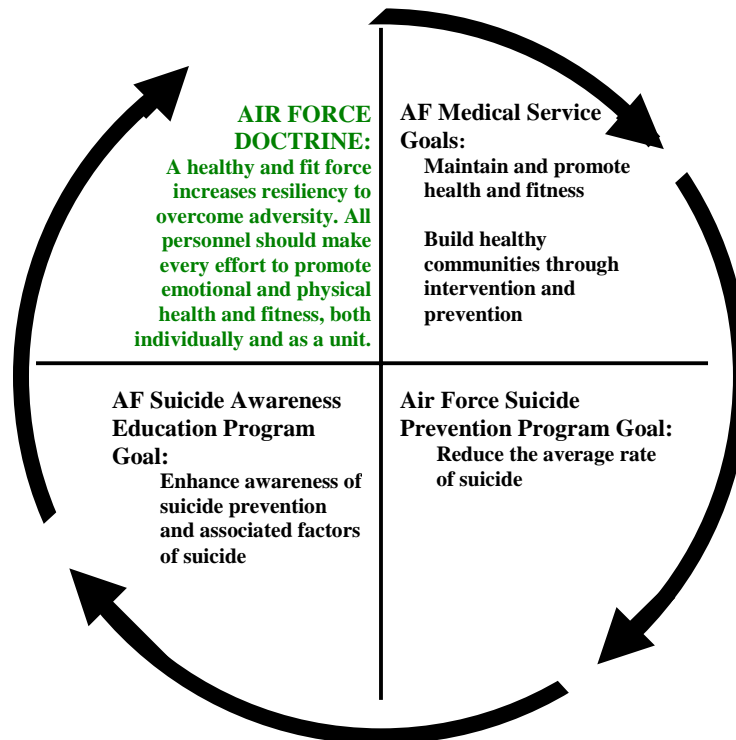
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INTRODUCTION

Suicide continues to be a leading cause of death among active duty Air Force (ADAF) members, surpassed only by unintentional injuries. We cannot ignore the devastating consequences suicide has on our families, co-workers, and mission integrity.

The key to the prevention of suicide is continuously striving to improve our quality of life and our community support programs. Like all successful military efforts, suicide prevention requires a team approach. The goal of the Suicide Awareness Community Education Program is to provide information to enhance the participants' awareness about suicide, suicide prevention, and associated factors (see Figure 1).

Figure 1: Context of Goals for Suicide Awareness Community Education Program



The Chief of Staff of the Air Force gives high priority to the annual Suicide Community Education Program to promote awareness of: 1) suicide as a serious Air Force problem; 2) knowing when and how to seek help and sources of help for personal problems; 3) how to identify Air Force colleagues and others at increased risk for suicide and how to respond and refer them for help; and 4) protective factors and the benefit of engaging in quality of life-promoting activities for optimal functioning.

Senior members of the Air Force Community Action Information Board (CAIB) are committed to the ongoing evaluation, maintenance, and development of suicide prevention programs. This involves a sustained campaign to encourage early, and effective intervention of, life stress and personal/relationship problems. Representatives of the Integrated Delivery System (IDS) are placing special emphasis on building strong community connections among the Air Force members as a means for risk reduction and developing a sense of shared responsibility for the general welfare of the community and for each other.

The perceived stigma associated with mental health problems and fear that receiving mental health care may result in negative career impact are frequently voiced barriers to those who need help. To dispel such myths, it is up to the chain of command to encourage and clearly communicate the expectation that members seek the help they need. The demand for help with personal problems may be met through friends, supervisors, the command structure, and adequate effective community services. Receipt of effective services will reduce prevalence and incidence of modifiable associated risk factors for suicide and suicidal behavior and increase modifiable protective factors in the Air Force community.

This curriculum guide includes a program guide for the Suicide Awareness Community Education Program. The program guide enhances the *Suicide Awareness Training Components* attached to AFI 44-154. The components of the program guide are recommendations for the duration and methods of delivery, statements of goals and objectives for the program and for each of the four core units (content areas), a content outline for each of the core units, and a descriptive summary of content for each area. The curriculum guide also includes relevant background information, definitions of terms and constructs, supplemental materials and resources, and slides for a prototype briefing.

Instructors should cover the **content** noted in the content outline of the program guide. As indicated in the program outline, the *required* method of delivery is **live** presentation.

It is anticipated that these guidelines and the content of the Suicide Awareness Community Education Program will be reviewed and revised annually. A centralized Web site for the community suicide awareness educators has been proposed to facilitate the exchange of information and ideas related to the delivery and revision of this program, and for posting supplemental activities that can be implemented throughout the year to keep the message alive.

OVERVIEW

KEY PREMISES

“The overwhelming majority of individuals who display identified predictors of suicide do not kill themselves.”¹

“Integral to prevention programming are efforts to promote strengths, well-being, and positive developmental outcomes.”²

“While suicides cannot be totally eliminated, the Air Force Community is responsible for monitoring and promoting the health and welfare of individual airmen and civilians and for ensuring that procedures are pursued to help preserve and enhance life.”³

“The ultimate goal to achieve optimal prevention should be to build the principles of prevention into the ordinary activities of everyday life and into community structure.”⁴

“Suicide prevention is everyone’s business.”⁵

The measure of success for the Community Suicide Awareness Education program will be an increase in the participants’ awareness about suicide, suicide prevention, protective factors, and the benefit of engaging in quality-of-life promoting activities.³

“Social connections save lives.”³

“Every person is at some risk for suicide based on their balance of risk factors and protective factors. The key then is to lower the risk for all persons by increasing the protective factors and decreasing the risk factors.”³

BACKGROUND AND RELATED AF TEAMS AND PROGRAMS

This curriculum guide is the result of a re-evaluation of the Suicide Community Education initiative of the Air Force Suicide Prevention Program that began October 2000. This revision was initiated as a project request to the Office for Prevention and Health Services Assessment (OPHSA), Population Health Support Division (PHSD), from the Air Force Medical Operations Agency (AFMOA) Suicide Working Group. This was the first review of the community education program since its launch in 1997.

The Suicide Prevention Integrated Product Team (IPT)

The annual requirement for suicide awareness education for all military and civilian personnel falls under Initiative V, “Community Education and Training,” of the 11 major initiatives of the Air Force Suicide Prevention Program. These initiatives were developed and implemented in 1996 as a result of the work of the Air Force Suicide Prevention Integrated Product Team (IPT), commissioned by General Thomas Moorman, then the Air Force Vice Chief of Staff. The program was built in response to three identified themes that resonated with the IPT team members and expert consultants:

- 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” a supportive interconnectedness thought to be best described by the slogan, “The Air Force takes care of its own.”

The IPT gathered epidemiological baseline data, identified risk factors for suicide, identified protective factors, and observed that these protective factors were modifiable, perhaps more easily than risk factors.* From this review, certain assumptions emerged that served as the foundation of the Air Force-wide Suicide Prevention Program. These included:

- Many, if not most, suicides are preventable.
- Suicide is not a medical problem, but rather a problem of the entire Air Force community.
- Suicide is the “tip of the iceberg” for psychosocial problems in the Air Force. A responsible suicide prevention program should 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.
- The Air Force Chief of Staff and other senior leaders must lead the way for the requisite cultural transformations that would strengthen social support, encourage, and protect those who responsibly seek help, including mental health treatment.

*Protective factors were characterized as falling into three categories: 1) social support and interconnectedness, 2) individual coping skills, and 3) cultural norms that promote and protect responsible help-seeking behavior.

Community Action Information Board (CAIB)

The Community Action Information Board (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 vice commander. The Air Force-wide Suicide Prevention Program now falls under the umbrella of the CAIB. The office of primary responsibility (OPR) under the CAIB for suicide prevention initiatives is the AF Surgeon General's Office.

The Integrated Delivery System (IDS)

The Suicide Prevention Integrated Product Team (IPT) recognized that multiple base agencies share common, often overlapping, prevention missions extending beyond suicide. To organize and coordinate efforts among these agencies, thereby streamlining access to the comprehensive range of preventive services they offer, required collaborative partnerships. Thus, the IPT proposed the Integrated Delivery System (IDS) consisting of the following six agencies:

- Chaplain
- Family Member Programs
- Family Advocacy
- Family Support Centers
- Health and Wellness Centers
- Life Skills Support Centers

The IDS has four primary functions: 1) centralize information and referrals, 2) assess unit and community behavioral risk factors, 3) deliver prevention services targeted to a wide range of individuals and groups within Air Force communities, and 4) collaboratively market IDS services. In addition, the IDS develops a Community Action Plan detailing the plan for targeting and meeting specific issues on its installation. 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. The IDS is chartered as a standing subcommittee of the CAIB.

The IDS initiative has been implemented Air Force-wide over the past two years with promising results, particularly at installations where teams embraced this concept with commitment. Increasingly, the IDS is recognized as a successful model for Air Force human service collaboration, although some variability continues to exist across Air Force communities.

AFMOA Suicide Prevention Working Group

In response to concerns that the Suicide Prevention Program was becoming stagnant, the Air Force manager for the Suicide Prevention Program and other AFMOA leaders met in April 2000. Their task was to create a forum to review, develop, and discuss the suicide prevention initiatives, to identify and track specific initiatives needing continued development, and to chart future actions regarding suicide prevention. The group reached consensus on the need to revise the existing suicide awareness briefings. As a result, the SAEG OPHSA project was initiated October 2000 and resulted in the development of this curriculum guide.

Air Force Surveillance Data

In 1996, the IPT called for establishing a central surveillance database for fatal and nonfatal self-injuries. The goal for the development of this database was to not only track events, but also to facilitate the analysis of potential risk factors for a suicide event. The system developed 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, potential associated factors, and use of preventive services, were tracked through AFRESS from 1 January 1997 until 19 January 1999. A 30 October 1998 memorandum by the Air Force Surgeon General addressed reporting requirements, and the SESS became an independent system on 20 January 1999. A key reason for this decision was to allow direct reporting of suicide events by mental health staff to improve patient confidentiality and security of the data.

The SESS system is a World Wide Web-based application and is described in detail in the Air Force Suicide Prevention Program description. Epidemiological and other data used in the Community Suicide Awareness Education Program is obtained directly from the Air Force Institute for Environment, Safety, and Occupational Health Risk Analysis (AFIERA) at Brooks AFB. AFIERA's Epidemiology Services Branch (AFIERA/RSRH) is responsible for maintaining, continuously improving, analyzing, and reporting this data. The data is updated annually and reported for the preceding calendar year, no later than mid-March of the subsequent year. The statistics and data quoted in the content of this curriculum guide are correct for calendar year 2000. All requests for additional statistical or epidemiological information and/or briefing slides should be made directly to AFIERA/RSRH at DSN 240-1821.

GUIDING PRINCIPLES

The following is a summary list of the guiding principles that have continued to serve as the framework for the USAF Suicide Prevention Program from the time of its inception:

- Suicide is a community concern, not just a medical problem.
- Suicide prevention requires cross-functional community agency involvement.
- Encouraging early requests for help increases the opportunity to intervene with modifiable risk factors.
- Suicide is the tip of the iceberg for psychosocial problems in the Air Force.
- Leadership involvement is a critical ingredient for suicide prevention.
- Concern, caring, and compassion equals lives saved.

TERMS AND CONSTRUCTS

This section outlines a core set of terms and definitions, derived from the literature and expert consultation, specific to mental health and suicide prevention programs. They provide a reference for common understanding and discussion about the Air Force Suicide Prevention Program. While the USAF has not officially adopted these terms, the members of the 2001 SAEG Working Group agreed that they are useful for providing a common vocabulary and a conceptual context for the Community Suicide Awareness Education Program.

Suicide

Suicide is defined as the self-inflicted death of a person, based on the victim's intent and an understanding of the probable consequences of his or her actions.

Risk

“For the purposes of prevention, the concept of *risk* is defined epidemiologically *at the population level*. [It is a] conditional statement about the probability that any member of a given population or sub-population will develop a disorder.”¹

Associated factors

Factors that have been found to be directly or indirectly associated with suicide are called *associated factors*. Associated factors can either increase or decrease the probability of suicide.

Risk factors

Risk factors are those associated factors that **increase** the probability of suicide. They are characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder. Risk factors can reside within the individual, family, community or institutions.⁶

Protective factors

Protective factors are associated factors that **decrease** the probability of suicide. They are conditions that are frequently cited as reducing the risk of suicide. They are those things that improve a person's ability to respond to life's challenges in a way that results in an adaptive outcome. The construct of "resilience" is related to the concept of protective factors, but it focuses more on the ability of a single individual to withstand chronic stress or recover from traumatic life events.

Modifiable risk or protective factors

Some of the risk and protective factors associated with suicide cannot be changed, while others can be changed with intervention (see table). When an associated factor can be changed, it is called a *modifiable* risk or protective factor. To decrease the probability of suicide, the USAF has a goal of targeting interventions that are likely to decrease modifiable risk factors and/or increase modifiable protective factors.

Table: Examples of Modifiable and Non-Modifiable Protective and Risk Factors for Suicide

PROTECTIVE FACTORS	
Modifiable	Non-modifiable
Physical activity Healthy intimate relationships Social supports Willingness to seek help when needed Well-developed coping skills	Female
RISK FACTORS	
Modifiable	Non-modifiable
Alcohol misuse Depression or other mental illness Tobacco use Financial problems Easy access to a firearm Poor impulse control Social isolation	Male Family history or personal history Age

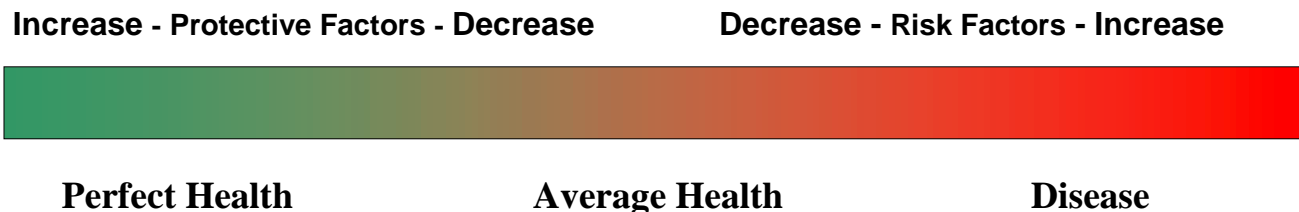
The modifiable associated factors for suicide can also be thought of as *intermediary outcomes* for suicide; that is, many of them exist along the pathway to suicide. As such, these associated factors can, and should, be effectively targeted with intervention as a comprehensive approach towards suicide prevention. For any given outcome, the objective of the intervention can be to:

- **Prevent** a certain outcome in persons at risk, but in whom the outcome has not yet occurred
- **Detect** the outcome in persons not yet identified
- **Minimize** the adverse effects of the outcomes and increase functioning/health-related quality of life

Probability of suicide

The *probability of suicide* is applied to groups of individuals who share associated factors, rather than to specific individuals. Overall health encompasses both behavioral and physical components, which are highly interrelated. Health and illness exist along a continuum; elements of both always exist in every person (see Figure 2). It is the relative amounts of each that determine where an individual falls along this continuum at any time. Individuals move back and forth along this continuum based on a complex and dynamic interaction of many factors.

Figure 2: Health Continuum



The *probability of suicide* increases as individuals move along this continuum, from the direction of good health towards ill health. Typically, the shift towards ill health is a gradual one, with many opportunities for intervention along the way. Therefore, by modifying the balance of risk and protective factors, the probability of suicide changes. For example, increasing protective factors, relative to risk factors, will move an individual along the continuum towards better health, thereby decreasing the probability of suicide.

Prevention

Prevention refers to different levels of intervention activities that vary according to the goals they are designed to achieve. These include:

- **Universal interventions**, which are designed for all segments of a population. The annual Community Suicide Awareness Education Program is an example of a universal intervention.

- **Selected interventions**, which are designed to target subpopulations that are characterized by shared exposure to some established risk factors. These interventions target individuals or groups of individuals who are not deemed to be overtly suicidal, but who are demonstrating behaviors or group aggregate assessment survey results indicative that they might be at higher risk for suicide.
- **Indicated or early interventions**, which are targeted to specific individuals who are already displaying pre-clinical levels of disorder, and/or who have been identified through screening procedures. Direct intervention service is initiated by, or initiated on behalf of, an individual in response to behavior indicating a high probability of suicide. This level of intervention is most often referred to as “treatment.”

The objective of the intervention is critical in determining the type of prevention. Equally critical to achieving effective and efficient intervention is to match the objective of the intervention with the desired outcome.

The annual Community Suicide Awareness Education Program is an example of both a *universal intervention* and *primary prevention*. For primary prevention, the objective is to prevent a specific outcome (suicide) among a targeted group of individuals in whom the outcome has not yet occurred. It is important to note that not all universal interventions are primary prevention. This would be the case when a universal intervention is applied to a population in which some of the individuals have already experienced the outcome. For example, one could deliver a universal intervention such as a “Don’t Drink and Drive” briefing, but this would not be primary prevention because some individuals in the target population would have already experienced the outcome (i.e., driving while under the influence).

Suicide prevention can occur every day, in every thing that we do – that is, the classification of preventive efforts also depends on the perspective taken. It is important to recognize that treatment for depression or alcohol problems can also be primary prevention of suicide. Detecting and treating any associated modifiable risk factor, or enhancing any associated modifiable protective factor, along the pathway to suicide is, in fact, suicide prevention!

KNOWLEDGE BASE

GENERAL

There is a vast body of information available to answer the question, “What do we know about suicide?” In the years since Emile Durkheim, a French sociologist, first published *Le Suicide* in 1897, innumerable research studies conducted world-wide have greatly broadened the theoretical and epidemiological understanding of causation and the conditions of risk. A multitude of factors may be culled from this mass of literature and research, to the extent that “it would be difficult to find some life experience, adaptive demand, or psychological difficulty that has not been shown to relate to suicide to one degree or another.”¹

A review of the literature has found that the following conditions are consistently cited as being associated with suicide. However, it must be noted and emphasized that these conditions **are not exclusively associated with suicide**, but are also conditions of vulnerability **for a variety of other mental and physical problems**.

Risk factors (associated with suicide)

- Severe, prolonged, or unmanageable stress
- Major life transitions
- A sense of powerlessness/helplessness/hopelessness
- A history of past abuse
- Substance abuse
- Mental health problems
- Family of origin problems
- Negative social interactions
- Academic and other life failures
- Legal problems
- Recent loss
- Firearm in the home

Protective factors are equally important to emphasize.

Protective factors (examples)

- A personal sense of self-efficacy
- Optimistic outlook
- Sense of personal control
- Sense of belonging to a group and/or organization
- Well-developed coping and problem solving skills
- Social/community/family support and interconnectedness
- Marriage
- Spiritual/religious affiliation
- Easily accessible helping resources
- Membership in a community that encourages participation
- Belief that it is okay to ask for help

MILITARY

The military is not exempt from the problem of suicide. It is difficult to compare military suicides with those in the civilian sector because the military active duty population is not necessarily representative of the larger civilian population. Military and civilian groups can vary significantly. For example, Air Force members are screened before entering active duty, resulting in a population that is above average in both physical and mental health.

There is very little research in the literature that is specific to conditions of suicide risk among military members across the Department of Defense. However, the available literature and data consistently note the following indicators of risk of suicide:

- History of abuse, neglect, or rejections
- Symptoms of depression (with a relatively low percentage receiving mental health services)
- History of alcohol abuse

- Lower performance evaluations and/or work-related problems
- History of military or legal problems
- Financial problems
- Difficulties in intimate relationships

AIR FORCE

Although some active duty suicides are impulsive, most are not. Typically, the victim first comes upon the idea of suicide as a hypothetical solution to his or her problems and gradually focuses on it as the only solution. As this process evolves, the victim comes to see life in increasingly narrower terms, until his or her problems are seen as hopeless, and suicide is viewed as the only way out. During this process, the individual is likely to drop suicidal hints, both verbal and behavioral. One goal of this program is to increase the participants' awareness of these hints, and of the situational and life factors that may indicate an increased vulnerability to suicide.

Suicide is a serious Air Force problem. During calendar year (CY) 2000, there were 128 deaths out of a population of approximately 350,000 active duty Air Force (ADAF) members.⁷ Thirty (30) of these were due to suicide, making suicide second only to unintentional injuries as a cause of death. The overall rate for suicide was 8.7/100,000 in CY 2000.⁸

The top factors associated with suicide events (all occurring in ≥ 40 percent of suicides)* specific to the Air Force population during CY 2000 were:

- Relationship problems (87 percent)
- Financial problems (56 percent)
- Criminal acts (47 percent)
- History of alcohol abuse (47 percent)
- Under investigation (43 percent)
- Military legal problems (40 percent)

The factors most frequently associated with completed suicides in the Air Force during CY 2000 were:

- White, male, age 25-34, by number
- No longer married (divorced, widowed, or separated)
- Multiple indicators of vulnerability (e.g., legal problems, alcohol abuse, relationship problems)
- Most do not seek mental health services, but might receive treatment at a medical treatment facility for expressed physical concerns (six of the victims did so one month prior to suicide)

Firearms were the most frequent method (43 percent) used, hanging the second most frequent (23 percent), with vehicle exhaust and poisoning the third and fourth most frequent. A majority (83 percent) occurred off base, with 55 percent of the total number of suicides occurring in the victim's personal residence.

Variables most recently found to be associated with acts of non-fatal self-injurious behavior within the ADAF are:

* These factors add up to more than 100% because all that apply to each case are counted.

- Student status (e.g., Air Education and Training Command)
- Female
- Lowest rank and youngest age group
- Hispanic, by rate
- Mood disorder
- Work or relationship problems
- Having sought mental health or medical treatment facility care in the year prior to their event

KEY POINTS

It is of utmost importance that the Community Suicide Awareness Education Program educator emphasize that risk factors are **indicators of increased vulnerability**, rather than being **predictive of** a probability of suicide. This is important because, although suicide risk factors have relevance for identifying populations at risk, they do not specify those *individuals* most likely to commit suicide.

Risk factors must be placed in the context of the limitations in our ability to predict individual future behavior based on statistical factors. Studies have demonstrated that an enormous number of people do not kill themselves (false positives), even though they have risk factors associated with even the highest suicide rates. Similarly, studies have demonstrated that a high percentage of individuals who actually committed suicide were not detected, even by screening measures (false negatives).⁹

The bottom line is that despite everyone’s best efforts, some still take their lives. “In a sense, no one deserves to be blamed for something that cannot ultimately be controlled – the volition and acts of another autonomous human being.”¹⁰

As previously indicated, the information and statistics gleaned from the SESS database are updated annually. Slides and other media used for educational programs that include this data should be updated annually, in accordance with significant changes. This curriculum guide will be revised annually to reflect these changes.

SUICIDE AWARENESS COMMUNITY EDUCATION PROGRAM

PROGRAM GUIDE

*Promoting Suicide Prevention Through Education About Care for Self,
Family, Others, and Community and by Emphasizing
Shared Responsibility to Encourage and Build:*

Community and individual capacity

Awareness of protective and modifiable
risk factors

Resilience, health promotion, and early
help-seeking

Engagement of peers supervisors and leaders

GENERAL INFORMATION

Program Description

The overall goal of the Suicide Awareness Community Education Program is to provide information to enhance the participants' awareness about suicide, suicide prevention, and associated factors. The underlying premises for the Air Force-wide suicide briefings are:

- Knowledge is necessary for changes in behavior. Specifically, increased knowledge about suicide and suicide prevention, about how and why to seek help, and about how to help others in need may result in more AF personnel seeking help earlier in the development of their inevitable life problems.
- The demand for help with personal problems may be met through peers, supervisors, the command structure, and adequate and effective community services.
- Receipt of effective services will reduce prevalence and incidence of modifiable associated risk factors for suicide and suicidal behavior and increase modifiable protective factors in the AF community.

Program Objectives

Upon completion of this training program, the participant should be able to:

1. Identify key premises, protective factors and the benefit of engaging in quality-of-life promoting activities for optimal health functioning (Instructional Unit 1)
2. Identify suicide as a serious AF problem (Instructional Unit 2)
3. Identify when and how to seek help and sources of help for personal problems (Instructional Unit 3)
4. Identify AF colleagues and others at increased risk for suicide and obtain knowledge about how to respond and refer them for help (Instructional Unit 4)

Evaluation

It is considered feasible and cost-effective to evaluate how well briefings change the knowledge of AF personnel. This curriculum guide includes a set of pre-briefing and post-briefing test questions that may be used for evaluating the knowledge gained (refer to Appendix A). At present, evaluation is optional.

It is more complicated and expensive to evaluate the extent to which change in knowledge results in changes of behavior, increased community capacity, utilization of community services, or suicidal behavior.

Frequency of Delivery

Annual

Time Needed

The Suicide Awareness Education Program is intended to last approximately 30 minutes.

Instructional Methods

The required method for presentation, especially for new airmen, is a live presentation using slides, with a group size of 50 to 100. A live presentation allows it to be tailored to the audience and enables interaction between the instructor and attendees. It is anticipated that a program for instructor training will be initiated to develop the skills and ability to provide effective presentations. These presentations should promote the Air Force values of shared responsibility for the general welfare of the community and for building strong community connections.

Attendance/Help Card

It is recommended that all participants be given an attendance card at the conclusion of the Community Suicide Awareness Education Program. It is suggested that this card be printed such that one side provides a notation of the date attended, with verification by the instructor's signature, while the other side provides key symptoms/indicators of vulnerability for suicide and help contact numbers, individualized by base. A sample card may be found in Appendix C.

CONTENT OUTLINE

The content outline for the Community Suicide Awareness Educational Program begins with an introduction and overview of the program and key premises. The three core instructional units then follow. Each has identified aims and objectives, an outline of the content to be presented, and a summary description of the content.

INSTRUCTIONAL UNIT 1

INTRODUCTION AND OVERVIEW

Program Objective 1 To provide a brief overview of the program and to identify key premises, protective factors, and the benefit of engaging in quality-of-life promoting activities for optimal health functioning

- Unit Aims**
- Provide a brief overview of program & key premises
 - Enhance awareness of the benefit of engaging in quality-of-life promoting activities for overall health functioning
 - Increase knowledge of protective factors and community-based resources for health promotion

- Objectives**
- 1.1 Identify goals for AF-wide Suicide Prevention Program
 - 1.2 Identify goals for this Community Suicide Awareness Education Program
 - 1.3 Introduce emphasis on responsibility to self and community
 - 1.4 Recognize what is meant by the continuum of quality-of-life and factors that affect one's ability to cope
 - 1.5 Identify key introductory points about suicide, risk and protective factors, and predictability

Content Outline

A. Goals for AF-wide Suicide Prevention Program

1. Air Force Doctrine
2. AF Medical Service Goal
3. AF Suicide Prevention Program Goal

B. Goals for Community Suicide Awareness Education Program

C. Responsibility to self and community

1. "Suicide prevention is everyone's business" (Satcher, 2001)
2. "Social connections save lives" (General Ryan, 2000)
3. Early requests for help for self and others

D. Quality-of-life exists on a continuum

1. All persons experience problems
2. Ability to cope and problem-solve:
 - a. Extent, duration, and intensity of problem
 - b. Nature of problem
 - c. Social support network
 - d. Spiritual beliefs
 - e. Personal resilience
 - f. Physical health
 - g. Emotional reserves

E. Protective factors

1. Coping skills and problem-solving skills
2. Self-efficacy
3. Optimistic
4. Sense of personal control
5. Sense of belonging to a group and/or organization
6. Social/community/family support and interconnectedness
7. Marriage
8. Spiritual/religious affiliation
9. Easily accessible helping resources
10. Membership in a community that encourages participation
11. Belief that it is okay to ask for help

F. Risk factors

1. Severe, prolonged, or unmanageable stress
2. Major life transitions
3. A sense of powerlessness/helplessness/hopelessness
4. A history of past abuse
5. Substance abuse
6. Mental health problems
7. Family of origin problems
8. Negative social interactions
9. Academic and other life failures
10. Legal problems
11. Recent loss

G. Key points

1. Indicator of vulnerability vs. being predictive of a probability of suicide
2. Conditions of vulnerability may indicate a variety of other mental/physical problems
3. The balance between protective factors and modifiable risk factors
 - a. Every person is at some risk
 - b. Key for suicide prevention: increase protective, decrease risk

Summary Description

The goal for the Air Force-wide Suicide Prevention Program is to reduce the average rate of suicide in the Air Force. This goal supports the Air Force Doctrine that all personnel should make every effort to promote emotional and physical health, and the Air Force Medical Service Goals to 1) maintain and promote health and fitness, and 2) build healthy communities through intervention and prevention. The goal for the Community Suicide Awareness Education Program is to enhance awareness of suicide prevention and associated factors of suicide.

The United States Surgeon General has stated that suicide prevention is everyone's business. The Air Force agrees with this and sees suicide as a problem of the entire Air Force community. The prevention of suicide must be recognized and solved at the community level through the development of awareness about suicide, the associated risk factors of suicide, and how to modify these risk factors. The ultimate goal is to build this awareness and the principles of prevention into the ordinary activities of everyday life and into community structures. Early requests for help for self, and encouraging others to do the same, is the key to increasing the opportunity for intervention to help prevent suicide. The Air Force is committed to building a strong community among its members. Social connections save lives.

Quality-of-life exists on a continuum for each person. This means that, at different times, everyone will experience problems in living and emotional distress, to some degree. A person's ability to cope and solve problems depends on a combination of many things, such as the extent, duration, and intensity of the problem; the nature of the problem; the number and type of co-occurring problems; the presence of a social support network; spiritual beliefs; personal resilience; physical health; and the person's emotional reserves.

Protective factors are those things that reduce the risk that problems in living will result in serious health consequences, such as physical illness, injury, depression, anxiety, and suicide. Examples of protective factors are the person's coping skills; the person's confidence in their own ability to manage and solve problems; the person's social competencies; self-efficacy; optimistic outlook; sense of personal control; sense of belonging to a group and/or organization; social, community, and family support and interconnectedness; marriage; spirituality; easily accessible helping resources; membership in a community that encourages participation; and a belief that it is okay to ask for help.

Risk factors are those things that increase the probability that a person will be more vulnerable to developing serious behavioral or physical health problems. Some are modifiable (able to be altered or changed) and some are not.

The following set of risk factors are associated with suicide: severe, prolonged, or unmanageable stress; major life transitions; a sense of powerlessness/helplessness/hopelessness; a history of past abuse; substance abuse; emotional or psychological problems; family of origin problems; negative social interactions; academic and other life failures; legal problems; recent loss; and a firearm in the home. It is important to note that these conditions **are not exclusively associated with suicide**, but are also conditions of vulnerability **for a variety of other behavioral and physical problems**.

Protective factors help keep the effect of the risk factors in balance. Every person is at some risk for experiencing a serious behavioral health problem based on their balance of risk and protective factors. The key for suicide prevention is to increase the protective factors and to decrease those risk factors that can be modified.

INSTRUCTIONAL UNIT 2

BASIC INFORMATION

Program Objective 2 To identify suicide as a serious AF problem

Unit Aim Enhance awareness of suicide as a serious community problem among Air Force personnel

Unit Objectives 2.1 Increase knowledge about suicide in the AF
2.2 Identify characteristics associated with suicide risk in the AF

Content Outline

A. Suicide in the Air Force (Unit Objective 2.1)

1. Percentage of ADAF deaths attributed to suicide
2. Number and rate of USAF AD suicides
3. Suicide events by rank group
4. Suicide events by age group
5. Suicide events by marital status
6. Suicide events by gender

B. Top factors associated with completed suicide events by ADAF (Unit Objective 2.2)

C. Variables most recently found to be associated with non-fatal self-injurious behavior

Summary Description

(Note: All of the following information is from CY 2000 data from the SESS. It provides a snapshot of the *current* nature of the problem of suicide in the Air Force. Comparative data with previous years may be added at the instructor's discretion, as time allows. Past data should be obtained directly from AFIERA/RSRH, in consultation with the POC for the SESS.)

Suicide is a serious Air Force problem, second only to unintentional injuries as a cause of death. Of the 128 deaths during CY 2000, 30 were due to suicide. With a population of approximately 350, 000 active duty members, the suicide rate was 8.7/100,000.^{7,8}

Males had a suicide rate twice that of females. Those ADAF members who were classified as separated, divorced, or widowed were significantly more likely to have died by suicide than those classified as single or married. The length of time since separated, divorced, or widowed for this group is not known.

There was no statistically significant difference in suicide rates among rank groups. There was also no statistically significant difference in suicide by age group.

The factors most frequently associated with completed suicides in the Air Force during CY 2000 were:

- White, male, age 25-34, by number
- No longer married (divorced, widowed, or separated)
- Multiple indicators of vulnerability (e.g., legal problems, alcohol abuse, relationship problems)
- Most do not seek mental health services, but might receive treatment at a medical treatment facility for expressed physical concerns (six of the victims did so one month prior to suicide)

Variables associated with acts of non-fatal self-injurious behavior within the ADAF are student status (e.g., AETC); female; lowest ranks and youngest age group (17-24); Hispanic, by race; the presence of a mood disorder; work or relationship problems; and having sought mental health or medical treatment facility care in the year prior to their event.

Certain factors associated with suicide during CY 2000, such as E1s and E2s having a higher rate of completed suicide than other ranks, were not statistically significant. The inability to detect a statistically significant difference is partially due to the small sample size. Significant differences in the demographics may become apparent as more suicide data is collected.

INSTRUCTIONAL UNIT 3

SELF CARE

Program Objective 3 To identify when and how to seek help and sources of help for personal problems

Unit Aim Enhance understanding of when to seek help and sources of help for personal problems

Unit Objectives

- 3.1 Increase knowledge about sources and types of help available
- 3.2 Increase knowledge of the advantages and consequences of seeking help
 - 3.2.1. Identify misconceptions about seeking help
 - 3.2.2. Understand the limits of confidentiality
- 3.3 Increase knowledge about when “I” might want to seek help

Content Outline:

A. Sources and types of help available (Unit Objective 3.1)

1. Chaplain
2. Family Support Center
3. Health and Wellness Centers
4. Life Skills Support Center
5. Family, friends, supervisors/leaders

B. Advantages and consequences of seeking help (Unit Objective 3.2)

1. The benefit of dealing with stress and life’s problems early
2. Common concerns
 - a. Security status
 - b. Special duty status (e.g., flying, Personnel Reliability Program [PRP])
 - c. Weapons bearing status
 - d. Confidentiality

C. Indicators that “I” might want to seek help (Unit Objective 3.3)

1. High or persistent stress leading to problems in everyday living
 - a. Types of stress
 - b. Symptoms of distress
 - c. Difficulty coping
 - d. Difficulty functioning
2. Behavior and/or feelings (problem signs)
3. Self-assessment, self-management, and serious problems/distress *

* The instructor may distribute an optional handout, The Goldberg Well-being Scale. This is a 12-question self-assessment tool, self-scored, that gives the individual feedback about their perceived changes in general well-being.

Summary Description

There are many different sources and types of help available for getting assistance with personal or life situational problems. These include the Chaplain; the Family Resource Center; Health and Wellness Centers; Life Skills Support Centers; and talking with family, friends, supervisors and leaders.

The benefit of dealing with stress and life's problems early cannot be emphasized enough. Taking care of concerns and dilemmas when they are just beginning helps prevent the development of more serious problems and consequences. This is sometimes referred to as the snowball effect, when something very small can gather momentum and take on a life of its own, getting bigger and more out of control. Once problems get to this point, people often feel that there is no solution. This is what we want to avoid.

When treated early, and especially when an individual requests help on their own, things like depression, marital problems, and even problems with alcohol rarely have permanent negative career impacts. By getting help early, the quality of life, and consistency and productivity of the individual's work is maintained or increases. By not requesting help early, you may make choices or act in a way that makes the problem worse instead of better. The consequences of these choices and behaviors **may** hurt your career. The alternative of solving the problem by asking for assistance more than likely will **not** hurt your career.

In seeking help, people are most concerned about confidentiality, especially with how this might affect special duty status or security clearances, and how this might affect eligibility for promotion and career advancement. "Some people are afraid to seek help because they 'don't want it in their record.' They confuse medical record entries with Personnel Information File (PIF) entries. The foot stomp here is that it is misbehavior the unit enters into a PIF, not visits to medical providers (including Behavioral Sciences). Additionally, there are concerns that any potentially disqualifying information, or "PDI," may somehow interfere in current or future duty performance. However, in one study of over 500 personnel looking at the effect of PDI on the attainment of special security clearances or entrance into the Personnel Reliability Program (PRP), only two percent were non-recommended."¹¹

The importance of watching out for others in the Air Force community and becoming aware of the signs that a buddy or colleague may need your assistance is one of the primary keys to preventing suicide. Being willing to ask for help or assistance for oneself is just as important, and is considered an act of great personal strength and self-protection.

There are many different kinds of stress. One kind of stress keeps us feeling challenged and motivated. Other kinds cause us to feel distress, such as relationship problems, financial problems, and illness in the family. Distress can drain our ability to cope and deplete our sense of physical well-being. If distress continues too long, or when there is too much at one time, the ability to function optimally in our work and everyday life can become difficult.

There are many early signs of distress. You might notice feeling preoccupied, or not being able to think or concentrate as clearly as you usually do, or make decisions as easily. This often first shows up at work. It is common for people to feel irritable or angry when stress is beginning to become unmanageable. However, some people become quieter and don't want to interact with their friends or family as much.

Other early signs of distress include not enjoying normal day-to-day activities, not feeling as useful or confident as usual, having trouble falling asleep or staying asleep, sleeping too much, feeling restless, becoming easily frustrated, tearfulness, a reduction in energy level or feeling tired, feeling bummed out or sad, drinking or smoking more than usual, eating more or less than usual, and feeling rundown or not well physically.

Our jobs and personal commitments can keep us so busy that it can sometimes be difficult to recognize the beginnings of distress. If you notice early signs of distress, ask yourself, "What is the problem?" Other important questions to ask yourself are, "What would I like to have happen?"; "How can I solve or get out of the problem?"; and "Have I ever been in a situation like this before, and if so, what did I do, what happened, and how was it resolved?"

The early indicators of distress vary greatly from person to person. The key is to know what your own personal early distress signs are and to stop and pay attention to them. If your problems and level of distress have become very serious, you want to ask yourself the same question you would ask someone else you are concerned about: "Do I have any plans to do anything harmful to myself, and what might I do?" If you or a buddy or colleague acknowledges having thoughts of self-harm, it is very important to seek help immediately. Another good question to ask if thoughts of self-harm are present is, "What will it take to keep me (or my friend, buddy, colleague, etc.) alive?"

Even if you don't have thoughts of self-harm, it is also very important that you seek help as soon as possible if you don't see a future without pain; can't get out of a depression; see yourself as worthless; can't seem to get control of your life; feel intolerably agitated or restless; feel all alone; feel hopeless, that there's no good solution to fix your problem; are experiencing a tremendous amount of guilt; or can't stop thinking about the same bad things.

INSTRUCTIONAL UNIT 4

BUDDY CARE

Program Objective 4 To identify AF colleagues and others at increased risk for suicide and obtain knowledge about how to respond and refer them to help

- Unit Aims**
- Enhance the ability to identify AF colleagues and others at risk for suicide
 - Enhance knowledge about how to respond and refer them to help

- Unit Objectives**
- 4.1 Increase knowledge about when to be concerned about a colleague/buddy
 - 4.2 Increase knowledge of approaches to communicating with someone at risk
 - 4.3 Increase knowledge about how to get urgent help for a colleague/buddy
 - 4.4 Increase knowledge about importance of restricting availability of lethal means (fire-arms, lethal doses of medications or drugs, etc.)

Content Outline

A. When to be concerned about a colleague/buddy

1. Misconceptions/myths
2. Indicators of vulnerability
 - a. Factors associated with suicide in the AF
 - i) Multiple co-occurring problems
 - ii) Relationship problems
 - iii) Financial problems
 - iv) Problem drinking
 - v) Under investigation
 - vi) Military legal or work problems
 - vii) Experienced a recent or severe loss

- b. Indicators of distress
 - i) Pessimism; believes there is no solution, no way out
 - ii) Hopeless/helpless
 - iii) Anxiety/agitation
 - iv) Angry
 - v) Withdrawn/irritable
 - vi) Having trouble eating and/or sleeping
 - vii) Unusual or sudden change in behavior
 - viii) Loss of interest in work and usual activities
 - ix) Talks about death/dying
 - x) Putting themselves down; feeling worthless
 - xi) Problems with mood (sad, depressed, crying)
- c. Key points to remember
 - i) Difficult to predict suicide
 - ii) Most people with key indicators of distress do not commit suicide
 - iii) Signs of distress indicate need for support & assistance

3. LINK

- a. L – Look. Be aware of indicators
- b. I – Inquire. Talk with the colleague/buddy
- c. N – Note the seriousness of their concern
- d. K – Know how to get help

B. Approaches to communication

- 1. Do(s)
 - a. Share your concerns
 - b. Ask about thoughts/plans for suicide
 - c. Be direct and honest
 - d. Use open-ended questions
 - e. Listen
 - f. Express caring and hope
- 2. Don't(s)
 - a. Give advice
 - b. Be judgmental
 - c. Lecture or debate
 - d. Dare them to do it
 - e. Act shocked
 - f. Leave them alone
 - g. Keep a promise of secrecy

C. How to get urgent help

- 1. Notify their chain of command
- 2. If immediate danger, call 911 or base emergency number*
- 3. Escort to emergency department or counseling services
- 4. For advice after hours, call emergency counseling services line or emergency room

* A recommendation has been forwarded to the Air Force Medical Operations Agency to make the IDS number the same across all bases (similar to the purpose of having 911 serve as a universal emergency number).

5. Involve security, if necessary
6. Do not leave person alone for any reason
7. Remove means of self-harm
 - a. Firearms
 - b. Pills
 - c. Automobiles
 - d. Knives
 - e. Ropes/sheets/belts or other means of strangulation

Summary Description

There are many common misconceptions or myths about suicide. First, people sometimes believe that people who talk about suicide won't do it, or that most suicides occur with little or no warning. This is not true. Almost everyone who commits or attempts suicide has given some clue or warning. No matter how casually or jokingly someone makes a comment such as "you'll be sorry when I'm dead," or "I can't see any way out," this may indicate serious suicidal feelings. It is also not true that most suicidal people are "crazy." They may be upset, grief-stricken, depressed, highly anxious or agitated, depressed, or despairing, but extreme distress and emotional pain may be experienced by all people at some time in their lives, and are not necessarily signs of mental illness.

Some people believe that if a person is determined to kill himself or herself, nothing will stop them. This is not true. Even the most severely depressed person has mixed feelings about death, and wavers until the last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The desire to end it all, however overpowering, does not last forever.

It is also not true that people who commit suicide were unwilling to seek help. Studies of suicide victims have shown that more than half had sought medical help within six months before their deaths. It is important to talk about suicide with someone who is demonstrating clues or warnings. It will not give them the idea to kill themselves. The opposite is true. Bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

The factors that have been found to most indicate that a person may be vulnerable to suicide in the Air Force are multiple co-occurring problems, to have relationship or financial problems, to be under investigation and having military legal or work problems, to have problems with alcohol abuse, or to have experienced a recent or severe loss.

If these factors are present in a colleague/buddy, take notice. Look for other indicators of distress such as expressing pessimism and belief that there is no solution or way out of their dilemma; stating that they feel hopeless and/or helpless; appearing to be highly anxious or agitated, angry, withdrawn, or irritable; having trouble eating and/or sleeping; or experiencing a sudden change in behavior (e.g., going from being careful about appearance to dressing sloppily, with poor hygiene). Other things you might notice are a loss of interest in work and usual activities; obsessing or talk about death, dying, violence, guns, knives; putting themselves down and expressing feelings of worthlessness; and problems with mood (e.g., feels sad, depressed, restless or "hyper", crying).

Remember that it's very difficult to predict suicide, and most often many of these factors and indicators do **not** mean that the person is suicidal. However, this should not lessen your concern for your buddy, or your willingness to listen and inquire about the possibility of suicide. Anyone who has signs of distress needs support or assistance of some kind in solving their problems.

The most important thing is to **LOOK**. This means to be aware of the indicators of potential vulnerability for suicide. If you become concerned about a buddy/colleague, **INQUIRE**. This means to talk with them about what is going on and to **NOTE** the seriousness of their concern. Ask them directly, if it seems they might be considering suicide, and **KNOW** how to get help. By remembering to **LINK**, and by encouraging early requests for help, we build awareness and prevention into the activities of everyday life and community structures. This is key to increasing the opportunity for intervention to help prevent suicide.

Some people are uncomfortable talking to others about what is going on with another individual. A common fear is that they might make a mistake and "say the wrong thing." Saying nothing would be a mistake. The approaches to communicating with someone who is suicidal or very upset are the same as those we use with our close family and/or friends. First, share your concerns. Ask about whether they have thoughts or plans for suicide. Be direct and honest. Use open-ended questions like, "How are things going?" Most of all, it is important to listen, and to express caring and hope.

Approaches to communicating with someone who is suicidal that are **not** considered helpful are being judgmental, lecturing or debating with the individual, daring them to do it, acting shocked, leaving them alone, and keeping a promise of secrecy.

If you are with someone who has thoughts of suicide and a plan to carry out their wish to die, do not leave them alone for any reason. Remove all potential means of self-harm from their proximity, such as firearms, pills, automobiles, knives, and sheets, ropes, belts, or other means of strangulation. Immediate action is required to get help. If there is imminent danger, call 911 or your base emergency number. If you must step aside, assign a capable person to stay with the individual until assistance arrives. Notify their chain of command.

For non-emergency situations, remember who, what, and where your community-based resources are for seeking assistance. Encourage you buddy/colleague to get help. Offer to accompany them, if need be.

REFERENCES

1. Silverman MM, Felner RD. The place of suicide prevention in the spectrum of Intervention: definitions of critical terms and constructs. In Silverman MM and Maris RW, editors. *Suicide & life-threatening behavior*. New York: Guilford Press, 1995; p. 70-80.
2. Cowen EL. In Rappaport J and Seidman E, editors. *Handbook of community psychology*. New York: Plenum Press; 1995.
3. Suicide Awareness Community Education Guide working group meeting. Office for Prevention and Health Services Assessment, Brooks AFB, Texas. 7-8 February 2001.
4. Institute of Medicine. *Reducing risk for mental disorder: frontiers for preventive intervention research*. Washington, DC: National Academy Press; 1994. p. 298-299.
5. National Strategy for Suicide Prevention, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. 2001. Available at URL: (<http://www.mentalhealth.org/suicideprevention/>)?
6. The Surgeon General's Call to Action to Prevent Suicide, Virtual Office of the US Surgeon General, US Public Health Service. 1999. Available at URL: (<http://www.surgeongeneral.gov/library/reports.htm>)
7. Casualty Statistics Site. Air Force Personnel Center, Randolph AFB, TX. Available at URL: <http://www.afpc.randolph.af.mil/sascasstats/>
8. Air Force Institute for Environment, Safety, and Occupational Health Risk Analysis (AFIERA), Epidemiology Services Branch, Brooks AFB, Texas, July 2001.
9. C.M. Miller (1999). Harvard Medical School, *Guide to Suicide Assessment and Intervention*, p. 463.
10. Jobs DA. In the wake of suicide: survivorship and postvention. In Maris RW, Berman AL, Silverman MM, editors. *Comprehensive textbook of suicidology*. 2nd ed. New York: Guilford Press; 2000. p.536-61.
11. Budd F. *Suicide awareness handbook*. Charleston Air Force Base, SC: 437th Medical Operations Squadron, p.9. The study referenced was by Lt Col Budd at Whiteman AFB, MO, 1995-1996.

APPENDIXES

(NOTE: Some appendixes are links to files. For them to work properly, you must store this document and all linked files on the same drive on your computer.)

APPENDIX A: PROTOTYPE BRIEFING

A prototype briefing for a Community Suicide Awareness Education Program is provided. Click the file name.

[Prototype Briefing](#)

APPENDIX B: EVALUATION MEASURES: PRE-BRIEFING/POST-BRIEFING TEST ITEMS BY OBJECTIVE AND CONTENT (OPTIONAL)

Sample pre-briefing/post-briefing test items are provided.
Click the file name.

[Pre-/Post Test Items](#)

APPENDIX C: SAMPLE ATTENDANCE/HELP CARD (RECOMMENDED)

A sample Attendance/Help Card is provided as an elective resource.
Click the file name.

[Attendance/Help Card](#)

APPENDIX D: RESOURCES

Pertinent Air Force Documents

Air Force Doctrine Document 2-4.2., *Health Services*. 13 November 1999.

Air Force Instruction 36-34, *Air Force Mentoring Program*. Personnel. 1 July 2000.

Air Force Pamphlet 36-2241, Volume 1, *Promotion Fitness Examination Study Guide*. 1 July 1999.

Air Force Instruction 44-109, *Mental Health and Military Law*. Medical. 1 March 1997.

Air Force Instruction 44-154, *Community Training: Suicide and Violence Awareness Education*. Medical. 1 July 1999.

Air Force Pamphlet 44-160, *The Air Force Suicide Prevention Program: a Description of Program Initiatives and Outcomes*. June 2000.

Health Safety Inspection Element OPS.7.1.2, *Suicide and Violence Awareness Education*.

Links and Supplementary Materials

AETCPAMs 101 – 106 on suicide prevention. HQ AETC/SCMY, Randolph AFB.

URL: <http://www.aetc.randolph.af.mil>

High Risk Personnel and High Risk Log. Memorandum for 437 Behavioral Sciences Staff. 437th MDOS/SGOH. Charleston Air Force Base, SC: 437 Medical Group Instruction 40-14, 27 September 1999.

Holiday Season Suicide Awareness. Memorandum for All Squadron Commanders from 437 AW/CC. Charleston Air Force Base, SC: Headquarters, 437 Airlift Wing (AMC), December 1999.

Improvement Effort: Encouragement of help-seeking or “destigmatizing help-seeking.” Charleston Air Force Base, SC: 437 Medical Group Instruction 40-14, 27 September 1999.

Linehan M. Guidelines for interacting with an individual in suicidal crisis. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco: Jossey-Bass, 1999; p. 146-187.

National Institute of Mental Health. *Frequently Asked Questions about Suicide*. Available at URL: <http://www.nimh.nih.gov/research/suicidefaq.cfm>

National Strategy for Suicide Prevention, Center for Mental Health Services. Available at URL: (<http://www.mentalhealth.org/suicideprevention/>)

Neimeyer RA, Bonelle K. The Suicide Intervention Response Inventory: a revision and validation. *Death-Studies* 21(1): 59-81. Developed to assess the ability of paraprofessional counselors to recognize appropriate responses to suicidal individuals.

Suicide Awareness Voices of Education (S.A.V.E.). Available at URL: <http://www.save.org/>

Suicide Information and Education Centre. Suicide help card example. Available at URL: <http://www.lollie.com/helpcard.html>

Suicide Prevention Services, Batavia, IL. Sample Flyer. Available at URL: <http://www.spsfv.org/>

University of Notre Dame Counseling Center. An example of an outreach model. Available at URL: http://www.nd.edu/~ucc/outreach_package.html

Select Bibliography

Air Force Handbook 36-2235, *Information for Designers of Instructional Systems*. Volume 10, 1 November 1993.

Air Force Manual 36-2236, *Guidebook for Air Force Instructors*. Personnel. 15 September 1994.

Allebeck P, Allgulander C. Psychiatric diagnoses as predictors of suicide: A comparison of diagnoses at conscription and in psychiatric care in a cohort of 50,465 young men. *British Journal of Psychiatry* 157: 339-344.

Bloom BS. Taxonomy of educational objectives: *Handbook I: Cognitive domain*. New York: Longman, 1956.

Fawcett J. Profiles of completed suicides. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco: Jossey-Bass, 1999.

Hemenway D, Solnick SJ, Colditz GA. Smoking and suicide among nurses. *Am J Public Health* 83(2):171-2.

Higgett A. Suicide reduction: policy context. *International Review of Psychiatry* 12:15-20

Hough D. A suicide prevention advisory group at an academic medical center. *Military Medicine* 165:97-100.

Jacobs D, Brewer M, Klein-Benheim M. Suicide assessment: An overview and recommended protocol. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco: Jossey-Bass, 1999.

Kapur N, House A. Against a high-risk strategy in the prevention of suicide. *Psychiatric Bulletin* 22: 534-536.

Mager RE. *Preparing Instructional Objectives for Instruction*. (2nd Ed.). CA: Fearon, 1962.

Marttunen M, Henriksson M, Pelkonen S, Schroderus M, Loennqvist J. Suicide among military conscripts in Finland: a psychological autopsy study. *Military Medicine* 162:14-18.

Mercy J, Rosenberg M. Building a foundation for suicide prevention: the contributions of Jack C. Smith. *Am J Prev Med* 19: 26-30.

Miller M, Hemenway D, Bell NS, Yore MM, Amoroso PJ. Cigarette smoking and suicide: a prospective study of 300,000 male active-duty Army soldiers. *Am J Epidemiol* 151(11):1060-3.

Miller M, Hemenway D, Rimm E. Cigarettes and suicide: a prospective study of 50,000 men. *Am J Public Health* 90(5):768-73.

Rogers A. Adult learning maps and the teaching process. *Stud Educ Adults* 25(2): 199-220.

Rose Geoffrey. *The Strategy of Preventive Medicine*. New York: Oxford University Press, 1992.

Silverman MM, Felner RD. Suicide prevention programs: issues of design, implementation, feasibility, and developmental appropriateness. *Suicide & life-threatening behavior*. 25(1):. New York: Guilford Press, 1995; p. 92-104.

Singh B, Jenkins R. Suicide prevention strategies – an international perspective. *International Review of Psychiatry* 12:7-14.

Tanskanen A, Tuomilehto J, Viinamaki H, Vartiainen E, Lehtonen J, Puska P. Smoking and the risk of suicide. *Acta Psychiatr Scand* 101(3):243-5.

Wisconsin Department of Public Instruction. *The Power of Teaching: Characteristics of Effective Classroom Instruction on Health and Safety Issues*. Student Services/Prevention and Wellness Team, John T. Benson, State Superintendent. Madison, Wisconsin. Bulletin No. 99061, September 1998.