Interdisciplinary Efforts in Suicide Prevention

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Air Force Special Operations Command (AFSOC)
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Overview

- Evidence-based program (AFSPP)
- Community responsibility
- Leadership matters – SOCOM policy = f2f meetings
- Increase protective factors
- Decrease risk factors
- AF interdisciplinary coordination (IDS)
- SOF interdisciplinary coordination (POTFF)
- SOF embedded professionals
- SOF peer mentor program in development
- Whole greater than sum of parts

References

- AFI 44-153, Disaster Mental Health Response and Combat and Operational Stress Control, 29 May 2014
- AFI 44-172, Mental Health, 14 Mar 2011
- AFI 90-501, Community Action Information Board and Integrated Delivery System, 15 Oct 2013
- AFI 90-505, Suicide Prevention Program, 6 Oct 2014
- DoDI 6490.08, Command Notification Requirements to Dispel Stigma in Providing MH Care to Service Members, 17 Aug 2011
- Air Force Guide to Managing Suicidal Behavior: Strategies, Resources, and Tools
- Airman's Guide for Assisting Personnel in Distress
- USSOCOM Policy Memorandum 14-18, Updated Suicide Prevention Policy, 18 Dec 2014

Air Force Suicide Risk Factors

Active Duty Risk Factors / Stressors (%)

Relationship Problems	45.7
History of Any Mental Health Diagnosis	41.3
Alcohol or Drugs Used During Event	28
Legal / Admin Problems	23.9
Seen by Mental Health in Past Month	15.2
Previous Deployment	10.9
Financial Problems	10.2
Direct Combat History	2.1

AFSPP Checklist

Air Force Suicide Prevention Program (AFSPP) Checklist		
Purpose: This checklist assesses the base level implementation of the 11 elements of the Air Force Suicide Prevention Program, which are described fully in AFPAM 44-160.		
#1 Leadership Involvement:	**Yes**	**No**
1.1 Were policy memos regarding the AFSPP and suicide awareness messages from senior leaders disseminated across the installation?	√	
1.2 Did installation senior leadership address suicide prevention at least once per year during Wingman Day or other community activities?	√ Twice per year	
1.3 Did commanders on the installation publicly encourage early help-seeking behavior?	√	
#2 Addressing Suicide Prevention Through Professional Military Education:	**Yes**	**No**
2.1 Did professional military education courses conducted on base include suicide prevention training as required by AFI 44-154?	√	
#3 Guidelines for Commanders: Use of Mental Health Services:	**Yes**	**No**
3.1 Was training conducted by mental health personnel for commanders and first sergeants on the use of mental health services?	√	
3.2 Did every commander and first sergeant receive this training at least once per assignment?	√	

AFSPP Checklist

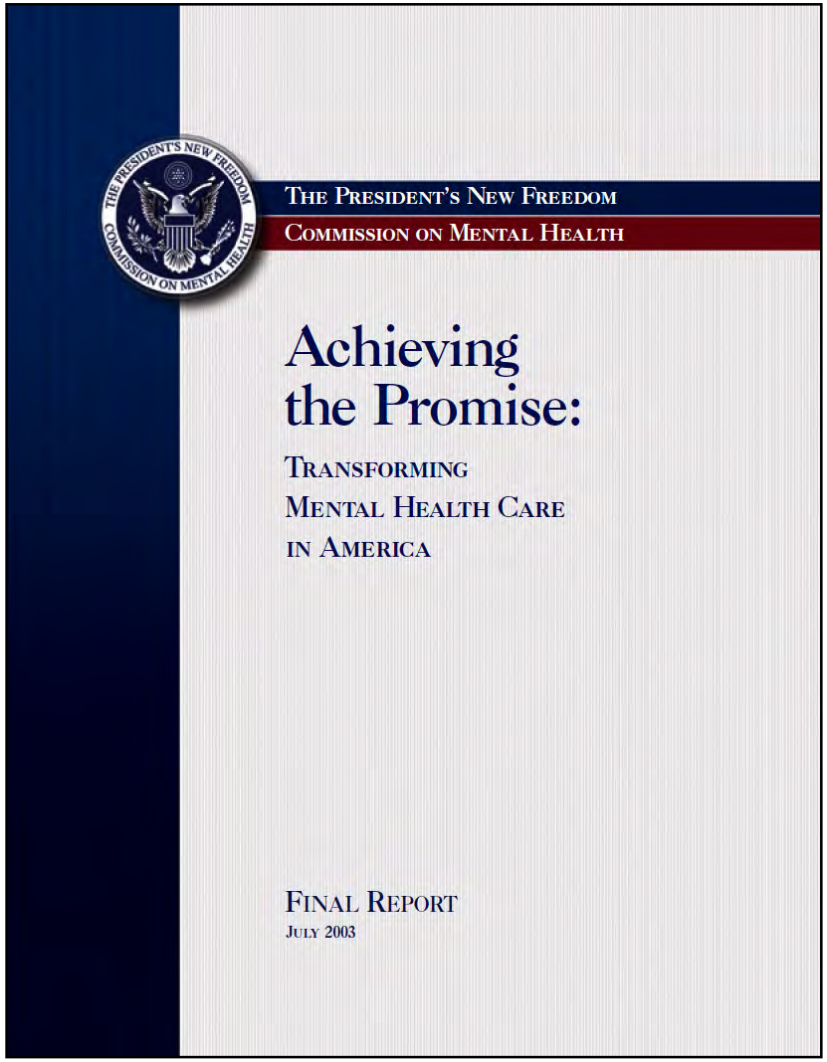
#4 Community Preventive Services:	Yes	No
4.1 Did base mental health personnel code time spent on suicide prevention activities as FAZY in the DMHRSi system for MEPRS reporting?	√	
#5 Community Education and Training:	**Yes**	**No**
5.1 Did all military and civilian personnel (except civilian employees precluded from suicide prevention training requirements by collective bargaining agreements) accomplish required annual suicide prevention training?	√	
5.2 Did units track suicide prevention training and report statistics quarterly to the base suicide prevention program manager?	√	
5.3 Did all supervisory personnel in at-risk AFSCs (1N, 3P, 2A) complete Frontline Supervisor's Training within 90 days of assuming supervisory responsibility? (Starting Jan 2011)	√	
#6 Investigative Interview Policy:	**Yes**	**No**
6.1 Were installation commanders, first sergeants, supervisors, OSI, SFS, IG, EEO, JA, HC, MDG, and Mental Health personnel educated about the AF investigative interview policy at least once per assignment?	√	
#7 Traumatic Stress Response:	**Yes**	**No**
7.1 Did the base have a fully trained Traumatic Stress Response Team IAW AFI 44-153?	√	

AFSPP Checklist

#8 Integrated Delivery System (IDS) and Community Action Information Board (CAIB):	Yes	No
8.1 Did the installation CAIB and IDS monitor suicide statistics, track suicide prevention training, and ensure full implementation of the 11 initiatives of the AFSPP?	√	
#9 Limited Privilege Suicide Prevention Program (LPSP):	**Yes**	**No**
9.1 Were installation commanders, first sergeants, supervisors, OSI, SFS, IG, EEO, JA, HC, MDG, and Mental Health personnel educated about the LPSP Program at least once per assignment?	√	
#10 Unit Assessment Tools:	**Yes**	**No**
10.1., Did commanders consult with local IDS to review the results of unit assessment tools (Support and Resiliency Inventory, Unit Climate Assessment, AF Community Assessment, or other similar instrument) and develop a tailored action plan?	√	
#11 Department of Defense Suicide Event Report (DoDSER):	**Yes**	**No**
11.1 Were all AF (AD, Guard, Reserve) suicides and suicide attempts entered into DoDSER within 60 days?	√	
Installation Name & Key Personnel Signatures:		
Installation Name:	Year of Review:	
IDS Chair:	Date:	
CAIB Executive Director:	Date:	
CAIB Chair:	Date:	

Validated and reported annually to AFSPP Program Manager

AFSPP Best Practice



THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

Achieving the Promise:

TRANSFORMING
MENTAL HEALTH CARE
IN AMERICA

FINAL REPORT
JULY 2003

FIGURE 1.4. MODEL PROGRAM: Suicide Prevention and Changing Attitudes About Mental Health Care

Program	Air Force Initiative to Prevent Suicide
Goal	To reduce the alarming rate of suicide. Between 1990 and 1994, one in every four deaths among active duty U.S. Air Force personnel was from suicide. After unintentional injuries, suicide was the second leading cause of death in the Air Force.
Features	In 1996, the Air Force Chief of Staff initiated a community-wide approach to prevent suicide through hard-hitting messages to all active duty personnel. The messages recognized the courage of those confronting life's stresses and encouraged them to seek help from mental health clinics — actions that were once regarded as career hindering, but were now deemed "career-enhancing." Other features of the program: education and training, improved surveillance, critical incident stress management, and integrated delivery systems of care.
Outcomes	From 1994 to 1998, the suicide rate dropped from 16.4 to 9.4 suicides per 100,000. By 2002, the overall decline from 1994 was about 50%. Researchers also found significant declines in violent crime, family violence, and deaths that resulted from unintentional injuries.[38] Air Force leaders have emphasized community-wide involvement in every aspect of the project.
Biggest challenge	Sustaining the enthusiasm by service providers as the program has become more established.
How other organizations can adopt	The program can be transferred to any community that has identified leaders and organization, especially other military services, large corporations, police forces, firefighters, schools, and universities.
Sites	All U.S. Air Force locations throughout the world

Further, the Commission recommends forming a national level public-private partnership to advance the goals and objectives of the NSSP that proposes local projects in every State. This public-private partnership would emphasize building voluntary coalitions to address suicide prevention in communities and would include local leaders, business and school personnel, and representatives of the faith community.

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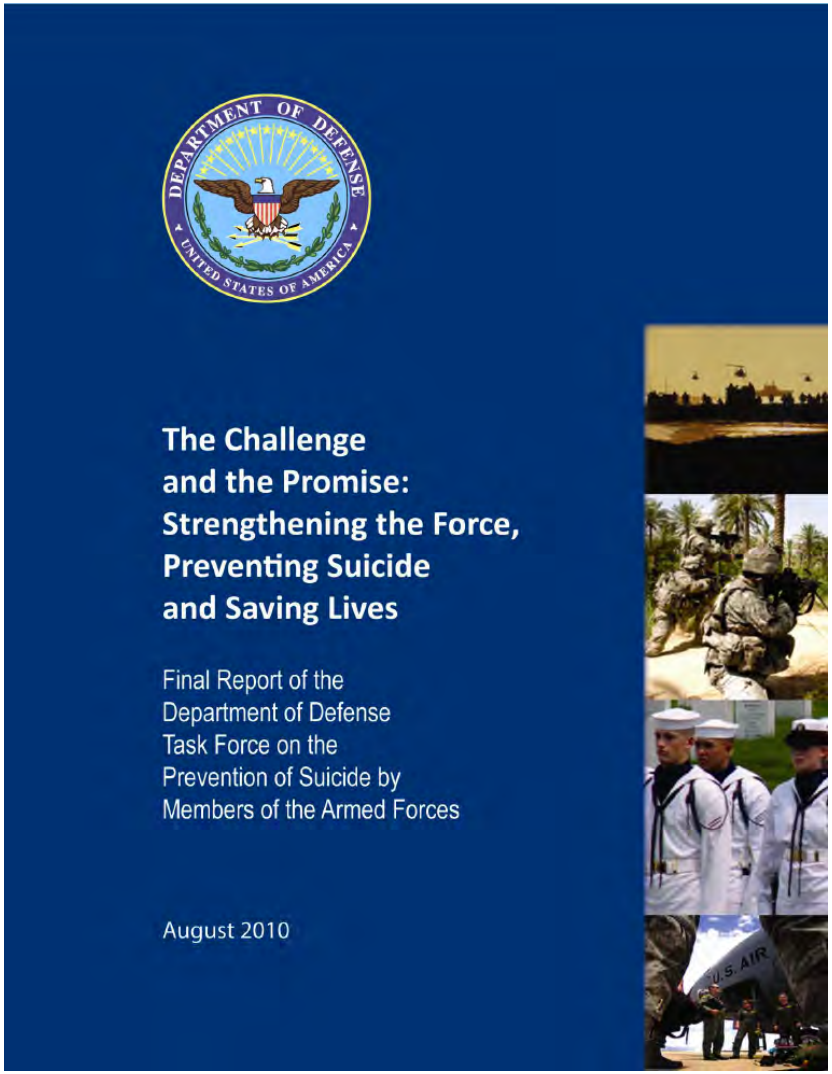
AFSPP Best Practice



were used to frame the "Surgeon General's Call to Action to Prevent Suicide," released in summer 1999, the first time a Surgeon General had issued a report on suicide. About this same time, the Air Force's pioneering suicide prevention program was producing the first empirical evidence that a comprehensive, public health approach could, in fact, reduce suicide across a population. This evidence added an additional measure of optimism to a series of regional public hearings that followed for the purpose of shaping the Reno recommendations into 11 goals and 68 objectives, framed as the 2001 National Strategy for Suicide Prevention: Goals and Objectives for Action (NSSP). The NSSP articulated an extremely ambitious, comprehensive, public health strategy to prevent suicide and suicidal behaviors in the United States. It required a variety of organizations and sectors, both public and private, to become involved in suicide prevention. The NSSP represented the first attempt in the United States to prevent suicide through a coordinated approach by both the public and private sectors.

Since the publication of the NSSP, activities in the field of suicide prevention have increased exponentially. Government agencies at all levels, schools, not-for-profit organizations, and others have initiated programs and campaigns to address suicide risks. Every State now has coordinated suicide prevention plans and initiatives that are implemented at the state level. DoD and each Service branch of the military (along with the VA) are to be commended for being among the first organizations in the United States to make "reducing suicide" a core priority. Beyond embracing this focus, these organizations have made considerable and sustained efforts to reduce suicide and suicidal behaviors for their respective populations.

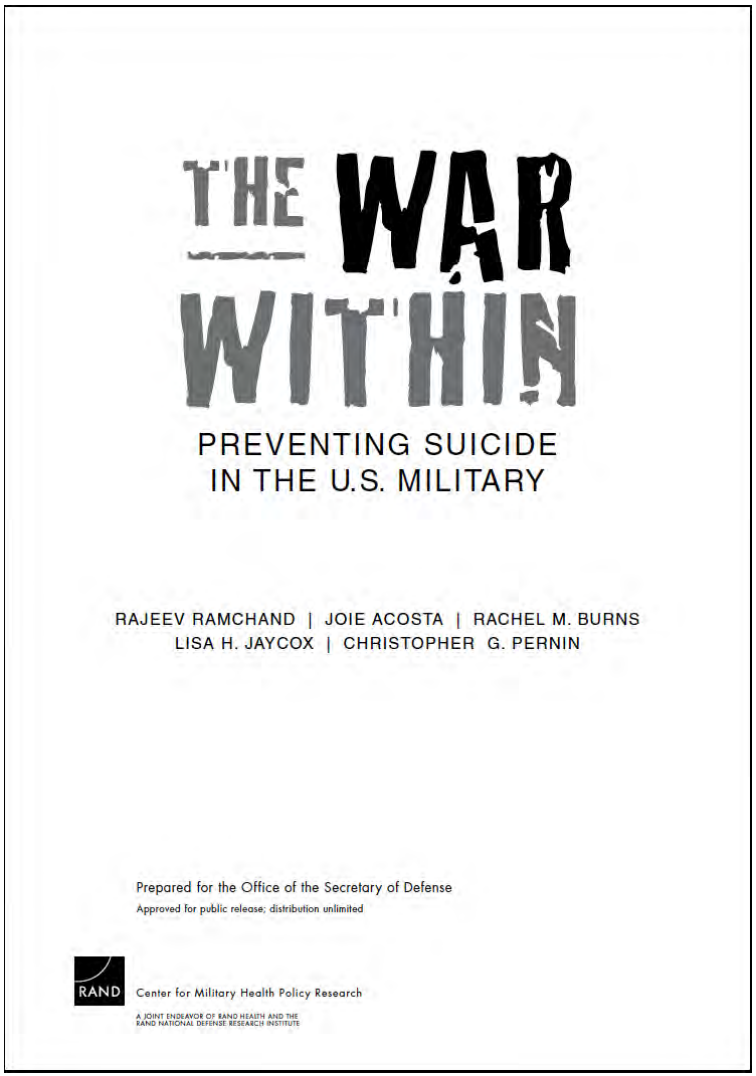
Despite the recent concerted efforts in the field of suicide prevention, much more remains to be done. The Institute of Medicine confirmed in its 2002 analysis of the national suicide problem that significant empirical, clinical, and public health efforts were still needed to meaningfully affect the nation's suicide-related challenges. In 2002, the President's New Freedom Commission on Mental Health also noted considerable gaps in research, surveillance data, treatment, training, and service delivery.

2.5 Military Perspective on Suicide and Suicide Prevention

Suicide in the military has existed as long have there have been standing armies. In May 1996, Admiral Jeremy Boorda, the Chief of Naval Operations, took his own life in the wake of allegations regarding the legitimacy of two of his wartime medals. His suicide served as a "wakeup call" to the military that suicide can occur at any level within the organization. Media attention added a sense of urgency, and the Services began to develop formal suicide prevention programs in the mid to late 1990s, collaborating with military and civilian experts. Notably, the Air Force initiated development of a comprehensive suicide prevention program that is now considered one of a very few evidence-based suicide prevention programs. Suicide prevention had also become a focus at the national level, which fostered collaboration between military and civilian communities.

In recent years, suicide in the military has continued to receive attention both nationally and internationally. While many historically known risk factors, such as exposure to trauma and

AFSPP Best Practice



THE WAR WITHIN

PREVENTING SUICIDE IN THE U.S. MILITARY

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Prepared for the Office of the Secretary of Defense

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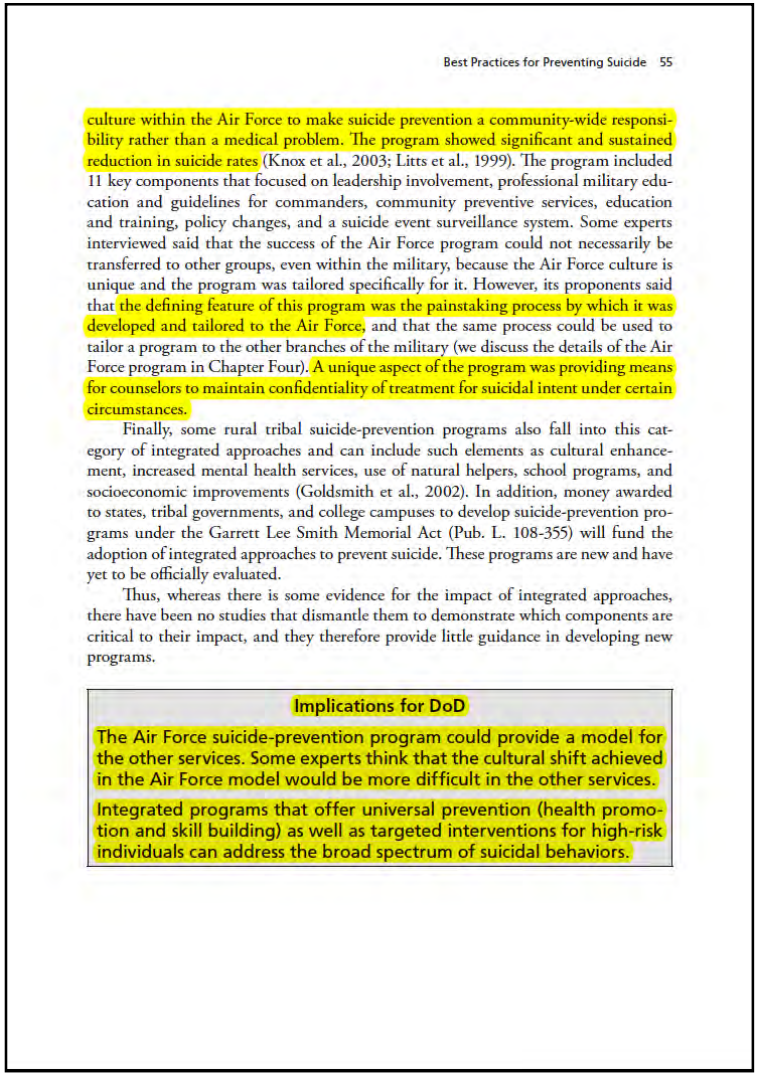


culture within the Air Force to make suicide prevention a community-wide responsibility rather than a medical problem. The program showed significant and sustained reduction in suicide rates (Knox et al., 2003; Litts et al., 1999). The program included 11 key components that focused on leadership involvement, professional military education and guidelines for commanders, community preventive services, education and training, policy changes, and a suicide event surveillance system. Some experts interviewed said that the success of the Air Force program could not necessarily be transferred to other groups, even within the military, because the Air Force culture is unique and the program was tailored specifically for it. However, its proponents said that the defining feature of this program was the painstaking process by which it was developed and tailored to the Air Force, and that the same process could be used to tailor a program to the other branches of the military (we discuss the details of the Air Force program in Chapter Four). A unique aspect of the program was providing means for counselors to maintain confidentiality of treatment for suicidal intent under certain circumstances.

Finally, some rural tribal suicide-prevention programs also fall into this category of integrated approaches and can include such elements as cultural enhancement, increased mental health services, use of natural helpers, school programs, and socioeconomic improvements (Goldsmith et al., 2002). In addition, money awarded to states, tribal governments, and college campuses to develop suicide-prevention programs under the Garrett Lee Smith Memorial Act (Pub. L. 108-355) will fund the adoption of integrated approaches to prevent suicide. These programs are new and have yet to be officially evaluated.

Thus, whereas there is some evidence for the impact of integrated approaches, there have been no studies that dismantle them to demonstrate which components are critical to their impact, and they therefore provide little guidance in developing new programs.

Implications for DoD

The Air Force suicide-prevention program could provide a model for the other services. Some experts think that the cultural shift achieved in the Air Force model would be more difficult in the other services.

Integrated programs that offer universal prevention (health promotion and skill building) as well as targeted interventions for high-risk individuals can address the broad spectrum of suicidal behaviors.

AFSPP Best Practice

SPRC · Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

Section I: Evidence-Based Programs

Section I of the Best Practices Registry (BPR) lists evidence-based programs, that is, interventions that have undergone rigorous evaluation and demonstrated positive *outcomes* (as opposed to Section III programs, whose *content* is reviewed). It is accurate to say Section I programs are effective, although their effectiveness may not hold true for all audiences or settings. (See "NREPP Description: and "Guidance for NREPP Users" below for more details.)

Section I: Evidence-Based Programs combines programs from two sources:

National Registry of Evidence-Based Programs and Practices (NREPP)

NREPP is SAMHSA's online registry of interventions that have demonstrated effectiveness in the prevention or treatment of mental health and substance use disorders, including some interventions that address suicide. While NREPP is independent of the BPR, all suicide-related interventions listed in NREPP are also included in Section I of the BPR.

SPRC/AFSP Evidence-Based Practices Project (EBPP)

The EBPP was a previous effort to identify evidence-based suicide prevention practices. Interviews for the EBPP were stopped in 2005 when SAMSHA began reviewing suicide-related interventions for NREPP. Based on expert review, the EBPP included 12 evidence-based programs that were classified as either effective or promising. These 12 programs continue to be included in Section I of the BPR (most are now also listed in NREPP.) For more information about the EBPP, see EBPP Project Description (PDF) and List of Programs Identified by the EBPP (PDF).

Section I Listings: Evidence-Based Programs

The list below includes suicide-related interventions currently listed in NREPP and those previously identified by the EBPP. (Several programs are listed in both registries.) NREPP-listed programs are linked to the program description on the NREPP website. EBPP program information is provided in a program fact sheet (PDF format).

Title	Type of Program	Organization
USAF Suicide Prevention Program	**Educ & Tng**	**US Air Force**

***United States Air Force Suicide Prevention Program* is a multi-faceted public health program that demonstrated decreased suicide deaths, among other positive outcomes, in young adults and adults. The program manual is available from the SPRC online library at no charge.**

AFSPP Best Practice

NREPP SAMHSA's National Registry of Evidence-based Programs and Practices

United States Air Force Suicide Prevention Program

The United States Air Force Suicide Prevention Program (AFSPP) is a population-oriented approach to reducing the risk of suicide. The Air Force has implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. AFSPP's 11 initiatives include:

- Leadership Involvement
- Suicide Prevention in Professional Military Education
- Guidelines for Use of Mental Health Services
- Community Preventive Services
- Community Education and Training
- Investigative Interview Policy
- Critical Incident Stress Management
- Integrated Delivery System (IDS)
- Limited Privilege Suicide Prevention Program
- Behavioral Health Survey
- Suicide Event Surveillance System

Descriptive Information

Areas of Interest	Mental health promotion
Outcomes	**Review Date: July 2006** 1: Suicide prevention
Outcome Categories	Suicide
Ages	18-25 (Young adult) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Data were not reported/available.
Settings	Workplace
Geographic Locations	No geographic locations were identified by the developer.
Implementation History	The U.S. Air Force first implemented the program with active-duty personnel in late 1996. Reported results are based on data from the exposed cohort (1997-2002) and an unexposed cohort (1990-1996). A follow-up study examined data through 2007.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: No
Adaptations	No population- or culture-specific adaptations of the intervention were identified by the developer.
Adverse Effects	Relative risk for mild family violence, defined as exposure to potentially harmful behavior with no readily apparent physical or emotional harm, increased 18% in the AFSPP study. This may have been related to increased identification due to an emphasis on outreach and earlier identification of distress.
IOM Prevention Categories	Universal

Quality of Research

Review Date: July 2006

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Knox, K. L., Litts, D. A., Talcott, G. W., Feig, J. C., & Caine, E. D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the U.S. Air Force: Cohort study. British Medical Journal, 327, 1376-1381.

Supplementary Materials

Air Force Suicide Prevention Program. (2001). The Air Force Suicide Prevention Program: A description of program initiatives and outcomes. [AFPAM 44-160]. Washington, DC.

Air Force Suicide Prevention Program: 11 initiatives [Handout]

Air Force Suicide Prevention Program Web site, http://afspp.afms.mil/

Litts, D. A. (2002). Air Force Suicide Prevention Program: A population-based, community approach. U.S. Department of Health and Human Services Best Practice Initiative.

New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America.

Pflanz, S. (n.d.). Air Force Suicide Prevention Program. Unpublished manuscript.

Pflanz, S. (n.d.). Air Force Suicide Prevention Program (AFSPP) Overview. Unpublished manuscript.

Taylor, G. P. (2003). Air Force Instruction 44-154: Suicide and violence prevention education and training.

Outcomes

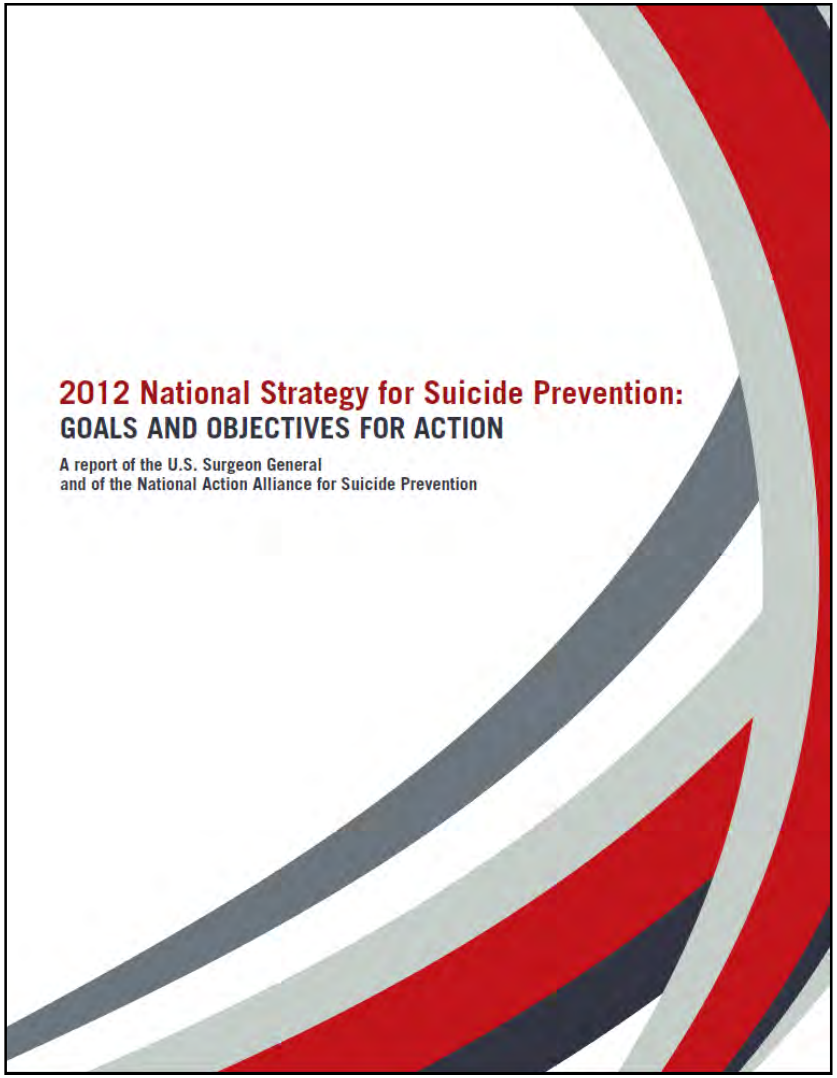
Outcome 1: Suicide prevention	
Description of Measures	Suicide prevention was indicated by epidemiological surveillance. Relative risk was assessed using mortality data routinely collected for other purposes.
Key Findings	Personnel exposed to the program experienced a 33% reduction of risk of committing suicide compared with personnel prior to implementation ($p < .001$). Compared with Air Force personnel during the 1990-1996 time period, personnel exposed to the program in 1997-2002 also experienced: • A 54% reduction of risk for severe family violence ($p < .0001$) • A 51% reduction of risk for homicide ($p = .05$) • A 30% reduction of risk for moderate family violence ($p < .0001$) • An 18% reduction of risk for accidental death ($p = .05$)
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	18-25 (Young adult) 26-55 (Adult)	84% Male 16% Female	Data not reported/available

AFSPP Best Practice



Evidence-Based and Promising Practices

Advances in research and practice have created new opportunities for suicide prevention. For example, new evidence suggests that a number of interventions may be particularly useful for helping individuals at risk for suicide. Some of these proven strategies are: the use of cognitive behavior therapy,[40, 41] crisis lines,[42] and efforts that promote continuity of care for individuals being treated for suicide risk.[43] More is also known about the effectiveness and risks associated with antidepressant use by some groups with high suicide risk.[44] These tools and approaches need to be refined and made more available and accessible.

Recent evaluations have identified system-wide interventions that combine multiple suicide prevention strategies and that are sustained over time as being particularly promising. For example, the experience of the U.S. Air Force Suicide Prevention Program (AFSPP)[16] (see box) has shown that leadership, policy, practices, and accountability can combine to produce very impressive successes. These findings should be shared and adapted for use in different settings.

U.S. Air Force Suicide Prevention Program (AFSPP)

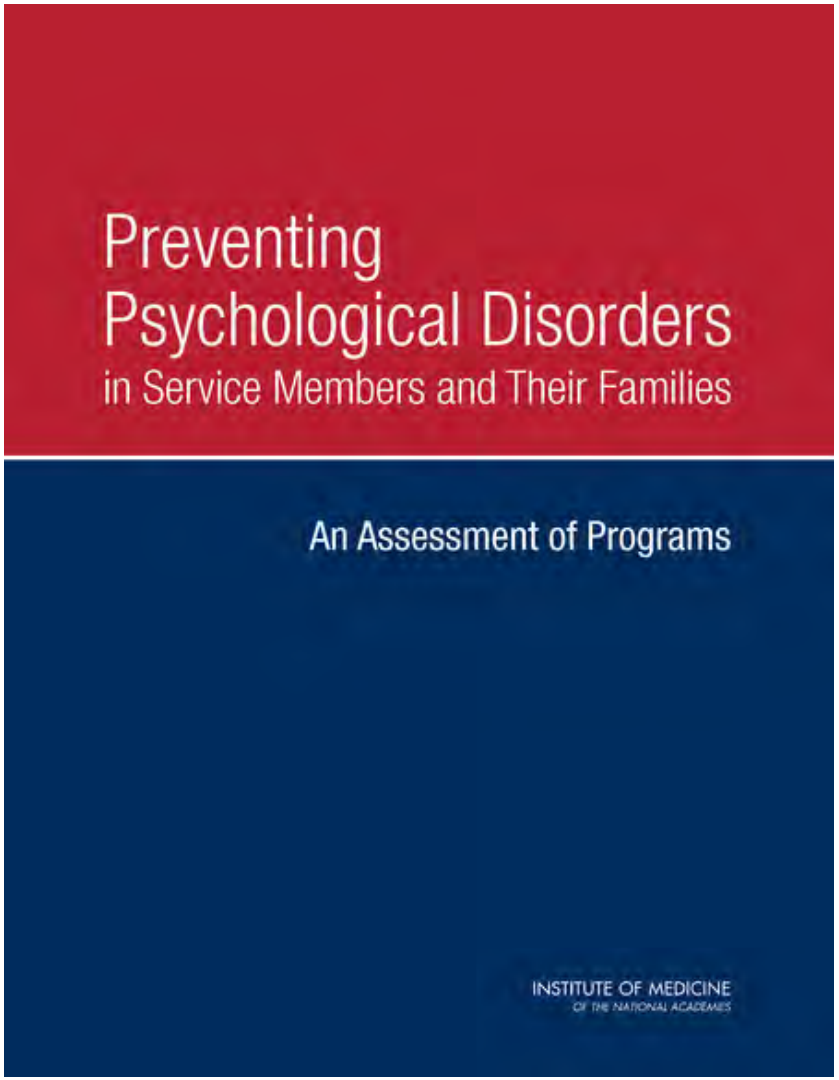
Since 1996, the U.S. Air Force has implemented a community-based suicide prevention program featuring 11 initiatives. Strategies include:

- Increasing awareness of mental health services and encouraging help-seeking behaviors;
- Involving leadership;
- Including suicide prevention in professional training;
- Developing a central surveillance system for tracking fatal and nonfatal self-injuries;
- Allowing mental health professionals to deliver community preventive services in nonclinical settings;
- Establishing trauma stress response teams; and
- Conducting a behavioral health survey to help identify suicide risk factors.

Evaluation findings indicate that the program reduced the risk of suicide among Air Force personnel by one-third.[16] Participation in the program was also linked to decreases in homicide, family violence (including severe family violence), and accidental death.

Research has also helped clarify the link between early childhood adverse events and suicide later in life, and of the role of connectedness in protecting individuals from a wide range of health problems, including suicide.[45] Efforts that promote overall health and that help build positive relationships can play an important role in suicide prevention. As a result, suicide prevention must be integrated into the work of a broad range of partners that provide programs and services in these areas. Suicide prevention is everyone's business.

AFSPP Best Practice



program stands out among all other military prevention efforts for its comprehensiveness and for its evidence-based approach to reducing the suicide rate.

BOX 5–1
Initiatives of USAF Suicide Prevention Program

1. Leadership participation in suicide prevention activities
2. Provision of suicide prevention education in all formal training
3. Education of commanders to encourage help-seeking by subordinates
4. Increasing preventive functions performed by mental health personnel
5. Annual suicide prevention training for all military and civilian employees
6. Changes in policies to ensure that individuals under investigation for legal problems are assessed for suicide potential
7. Trauma stress response teams established to respond to terrorist attacks, serious accidents, or suicide
8. Establishment of a seamless system of services and Community Action Information Board to achieve a synergistic impact on community problems and reduce risk of suicide
9. Increased confidentiality when seen by mental health providers
10. Use of the IDS (Integrated Delivery System) Consultation Assessment Tool to enable commanders to assess unit strength and areas of vulnerability
11. Reliance on Suicide Event Surveillance System that tracks suicide events and facilitates analysis of potential risk factors

SOURCE: Knox et al., 2003.

Army STARRS

Although it is not a program intervention per se, Army STARRS (Study To Assess Risk and Resilience in Servicemembers) is a 5-year research study of risk and protective factors for suicide whose objective is to better understand psychological resilience, psychological health, and risk for self-harm among soldiers. Launched in 2009 through a partnership between the Army and the National Institute of Mental Health, Army STARRS supports an interdisciplinary team of investigators working on five separate study components: the Historical Administrative Data Study, New Soldier Study, All Army Study, Soldier Health Outcomes Study, and Special Studies (NIMH, 2013; U.S. Army, 2013a). Findings from these studies will be used to inform ongoing health promotion, risk reduction, and suicide prevention efforts.

Summary

DOD sponsors numerous types of suicide prevention programs, most of which vary by service (Ramchand et al., 2011). The USAF has the strongest program, and it is the only comprehensive program. Although it is commendable that DOD supports many programs, few have been evaluated. From the civilian literature it is clear that many programs being used by the military—involving gatekeepers, educational campaigns, and hotlines—have some limited evidence of effectiveness. The type of suicide prevention with the strongest evidence of effectiveness—restricting access to lethal means such as firearms and psychotropic medications—is not being undertaken by the military, in spite of the fact that firearms,

Public Affairs Guidance

For Official Use Only (For Internal Use Only)

U.S. AIR FORCE

Suicide Prevention Communication Guidance Card

1 April 2011

When in doubt, call SAF/PA, (703) 695-0640

U.S. AIR FORCE

A Shift in Messaging

When discussing suicide publically, researchers have found strong evidence that certain practices are associated with suicide clusters, copycat suicides and increased suicide rates. The Air Force believes that some communication may inadvertently glorify suicide rather than discourage it. This may make suicide appear to be a more appealing option for some Airmen in crisis. In response, the Air Force is switching its messaging from an emphasis on suicide to a focus on overall airman fitness, strength, and resilience. Air Force leaders believe using a strength-based approach for suicide prevention may help Total Force Airmen (Active duty, AF Civilians, Reserve and Guard) consider and pursue positive options instead of self-defeating behaviors.

Strength-based Messages

- Airmen with strong mental, physical, social and spiritual fitness have the ability to withstand, recover and/or grow in the face of stressors.
- The Air Force provides multiple programs that enhance the capacity of Airmen to effectively manage stress.
- The Air Force has traditionally provided tools and support to face the challenges of military life.
- Family support programs provide valuable education and social opportunities, as well as transition assistance for those leaving active duty.
- The Air Force is committed to building a strong Air Force community whose members are capable and have a sense of belonging.
- The Air Force provides on-time preparation and support to Airmen during all stages of deployment.
- Strength in all areas of fitness is critical for military readiness and personal wellbeing.
- The Air Force wants its Airmen to thrive in good times and bad.
- ***Although there has been a recent upward trend in suicide rates, the majority of our Airmen effectively manage challenges every day.***
    - It is a sign of strength to seek help.
    - Good Wingmen ask for help when they are in crisis.
    - Strong Airmen take care of themselves so they are available to support the mission as well as their family, friends, and fellow Wingmen.
    - Responsible Wingmen use all resources at their disposal to maintain optimal physical and psychological mission readiness.
    - Real Wingmen take personal responsibility for their actions.
    - Every loss affects us all. I am disappointed when an Airman takes their own life because of the impact it has on their family, friends, and mission.
    - The Air Force is committed to building a community that recognizes Airmen in distress and intervenes appropriately to provide resources.

Suicide Prevention Guidance

DO

- Focus on the majority of Airmen who are handling stressors appropriately
- Highlight examples of individuals in crisis who sought help and recovered
- Promote responsible help seeking
- Promote personal responsibility
- Discuss risk factors for those in crisis
- Promote healthy behaviors as coping mechanisms (physical activities, meditation)
- Express disappointment in the decision of Airmen who choose to die by suicide rather than utilize the available helping resources.
    - eg. "It is always disappointing when an Airman decides to give up on seeking help and chooses to take their own life."

DON'T

- Overuse the term "suicide". When possible refocus the discussion on strength and resilience.
- Glorify suicide by focusing on the positive qualities of the deceased
- Over represent prevalence of suicide—suicide is a rare phenomenon
    - Use using alarming words (eg. "epidemic", "sky-rocketing")
- Put suicide in the headline of a news article
- Cite suicide statistics—they are rarely understood
- Use the term "successful" suicide
- Use suicide prevention videos highlighting individual suicides

Programs That Can Help

- Recovery Care Program
- Fitness Centers
- MarriageCare Retreats
- Personal Financial Counselors
- AF Youth Programs
- Stress Management Classes
- New Parent Support Program
- Intramural Sports Leagues
- Airman/Family Readiness Centers
- Airman Ministry Centers
- Mental Health Programs
- Yoga Classes

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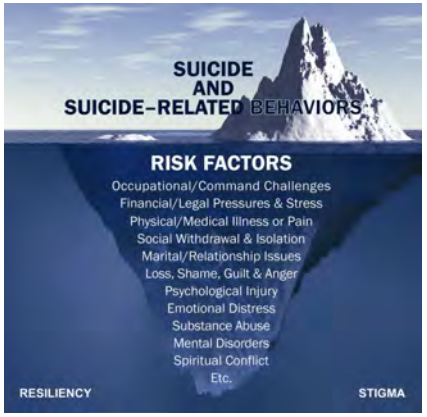
Messaging Matters

- Don't Confuse Suicide Promotion with Suicide Prevention
  - Social Learning Theory: We get the behaviors we focus on
  - Social Norms Theory: Behaviors become more common when perceived to be common…suicide is a low-probability event
  - "Raising awareness" of suicide is NOT evidence-based
  - Tie risk factors to desired behaviors, not suicide
- Communicate strength-based messages…Don't focus on suicide
- Promote and model healthy behaviors and choices



Connectedness

- Supervisors required to connect regularly, personally with subordinates
- Peer mentor program about relationship, not information
- Connection to meaning, purpose, and community key factors in spirituality
- Develop ways to train spiritual fitness (may include but not limited to religion/religious principles)

Summary

- Evidence-based approach
- Increase protective factors
- Decrease risk factors
- Community/connectedness matter
- Whole greater than sum of parts

Questions

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