US Air Force Suicide Prevention Program

I. Overview
We were fortunate to have with us the executive director and lead investigator of the United States Air Force (USAF) Suicide Prevention program, a population-based, community approach to reducing the number of suicides implemented by the US Air Force in 1996. This program is now the largest and longest sustained suicide prevention effort associated with significant reductions in suicide. We began an exploration of the ways in which the USAF program and evaluation might instruct our efforts at Cornell, which will continue at the next meeting of the Council and in the work of the Suicide Prevention Research Working Group.

Our visitors also presented the USAF model to a well-attended public forum (110 staff, faculty, students, community members, including several members of the CMHW) on December 2.

II. Presenters
All three of our visitors are working with the CMHW’s suicide prevention research working group in the development of specific assessment tools and an overall evaluation plan for our efforts.

— David A. Litts, O.D., former Chief of Staff for the Air Force Surgeon General and Executive Director of the Air Force Suicide Prevention Program, is now Associate Director of the Suicide Prevention Resource Center, Newton, Mass.
— Kerry L. Knox, Ph.D., assistant professor of Community and Preventive Medicine, Division of Epidemiology, at the University of Rochester, is the lead author of the study. Dr. Knox is a member of the University of Rochester Center for the Study and Prevention of Suicide.
— Monica Matthieu, Ph.D., senior instructor and fellow, University of Rochester Center for the Study and Prevention of Suicide, will be working closely with Cornell as we consider applications of this approach in our environment.

III. Background
From 1990-1995, suicide rates were rising at a statistically significant pace among Air Force personnel overall, and among both African-American and Caucasian enlisted male subgroups. By the end of the period, the overall rate was reaching all time record high levels for the Air Force, though it remained comparatively lower than that of the U.S. population overall when corrected for age, gender, and race.
Early in 1996, the Air Force Chief of Staff commissioned the Surgeon General to lead a systematic study of the issue and recommend a prevention strategy. The team included representatives of 15 Air Force functional areas and experts from Centers for Disease Control and Prevention and academia. Employing a data-driven prevention model to guide its search of extant community data, it identified nine factors that were frequently associated with victims of suicide and three factors it concluded were protective. Stigma, cultural norms, and beliefs that combined to discourage help-seeking behavior were identified as major hurdles to successful suicide prevention.

IV. The Intervention
With the strong and visible support of the Air Force Chief of Staff, the cross-functional team began the work of implementing eleven recommendations aimed at mitigating risk factors and strengthening the protective factors for suicide. The risk factors identified included problems with the law, finances, intimate relationships, mental health, job performance, and alcohol and other substance abuse. These were often further complicated by social isolation and poor coping skills. The team identified three key protective factors: a sense of social support, effective coping skills, and policies and norms that encourage effective help-seeking behaviors.

A. Changing Social Norms: Promoting Social Support and Help-Seeking Behavior
Through a series of hard-hitting messages to the force, the Air Force Chief of Staff repeatedly and unequivocally communicated the urgent need for Air Force leaders, supervisors, and frontline workers to support each other during the inevitable times of heightened life stress. Whether encountering the break-up of an intimate relationship, financial difficulties, legal problems, or frequently some combination of these, Air Force personnel were encouraged to personally offer assistance where possible and to promote use of community resources when necessary. He specifically encouraged airmen to seek help from mental health clinics and pointed out that when airmen seek help early it is likely to enhance their career rather than hinder it. Further, he instructed commanders and supervisors to support and protect those who responsibly seek this kind of help. Finally, he removed policies that acted as barriers to mental health care for those being charged with violations of military law.

B. Educating Community Members
The team established policy requiring all Air Force personnel to receive annual instruction on suicide risk awareness and prevention. A curriculum outline was provided at the inception of the program, calling on instructors at each Air Force installation to innovatively develop their presentations. In 2000, the best of the "home-grown" programs were carefully reviewed with the help of nationally recognized experts to produce a best practice tool kit for community education. This resource is available at: 
https://www.afms.mil/phsd/PHSO/ToolKits/

Career officers and enlisted members typically complete three professional development courses over the span of their careers. Each of these academic courses were infused with appropriately targeted curricula on suicide prevention to augment their annual training. Students are tested on the curricula.

C. Improving Surveillance
A web-based epidemiological database was established to capture demographic, risk factor, and protective factor information pertaining to individuals who attempted or completed suicide. Highly secure to protect privacy, this tool allows leaders to quickly detect suicide clusters or changes in patterns in suicidal behavior that could inform needed change in policies and practices across the Air Force community.

Additionally, commanders were given a unit-based survey tool to assess aggregate risk among their subordinates. Anonymously administered, the Behavioral Health Survey assesses risk along several validated scales and tells the commander how his or her unit compares with the Air Force as whole. A cross-functional team on each base suggests interventions tailored to specifically address areas of elevated risk.

D. Critical Incident Stress Management
Critical incident stress management teams were established to serve personnel at every installation, with deployable teams available to provide additional resources to installations hard hit by potentially traumatizing events. These teams respond to events such as combat deployments, serious aircraft accidents, and natural disasters as well as suicides within the military unit.

E. Integrated Delivery System for Human Services
The Chief of Staff required the principal agencies at each geographical location to work together to assess the
needs of the population they serve, develop a consolidated plan targeting their collective resources to a prioritized list of those needs, collaboratively market the resources to the community, and evaluate the effectiveness of their plan. Several of the agencies’ headquarters contributed funding for training in support of this new initiative. Leaders from the Chapel programs, mental health services, Family Support Centers (providers of financial counseling, career counseling, support services for families of deployed service members, and others), Child and Youth Programs, Family Advocacy (domestic violence prevention), and Health and Wellness Centers are involved on each installation.


F. Results
When the project began in 1995, suicide was the second leading cause of death among the 350,000 Air Force members, occurring at an annual rate of 15.8/100,000. Since then, the suicide rate declined statistically significantly over three consecutive years, and for the first six months in 1999 the annualized rate fell below 3.5/100,000. This is more than fifty percent less than the lowest rate on record prior to 1995 and an 80 percent drop from the peak rates in the mid-90s. The suicide rates increased in ’00 and early ’01, but have declined again since April ’01 and have remained much lower than rates prior to 1995. Statistically significant declines in violent crime, family violence and deaths due to unintentional injuries have also been measured concurrently with the intervention. Air Force leaders have emphasized community-wide involvement in every aspect of the project. The providers of community-based human services have made significant progress in coordinating their resources for the purpose of building stronger individuals and more resilient communities.

V. Discussion
A. Council members were impressed with this comprehensive, environmental approach. Most of their comments were questions about logistics:

1. Q. What do we need to do to get the resources behind this?
   A. Leadership from Cornell’s version of the “top brass” is essential. Values/direction must come from the top. Policies must follow. Implementation comes after leadership and policies are in place.

2. Q. How long did it take?
   A. In the Air Force, the problem was defined and a solution proposed in eight weeks; specific policy changes and implementation plans were ready to go in ten months.

3. Q. What did you mean when you said “it’s not a medical problem”?
   A. I meant to say it’s not only a medical problem. After decades of enhanced understanding, treatment modalities, and psychopharmacological options, there is no evidence to suggest that we can treat our way out of this. The pathway to suicide is usually long and complex. The farther away from the suicide we can intervene, the less serious the intervention needs to be. If an individual has a mental illness in the context of a caring supportive community, that individual is more likely to have a better outcome than if s/he is in an uncaring, unsupportive community, or if s/he is socially isolated. In every public health issue we have to ask: how can we prevent this from becoming a more serious problem? how can we keep someone with a mental illness from dying.

4. Q. How many new positions were created?
   A. Apart from David Litts position as executive director of the USAF suicide prevention program, no new line items in the budget were created. The USAF looked at the resources they already had and created a plan that would make the best use of them. They used people they already had (chaplains, mental health providers, family support services, etc.). Job descriptions were reconfigured to support the priority.

5. Q. How were you able to motivate people in a position to reassign/reconfigure staff time?
   A. Suicide was the second leading cause of death in the USAF. We couldn’t afford those costs. And that is just the deaths, the tip of the iceberg. If you consider the costs of the rest of the iceberg (e.g., family violence, homicide, accidental death, DUI, stress at work, relationship problems, legal problems), the costs are enormous. The AF Chief of Staff made the priority clear to all levels of leadership.

B. At Cornell, we are dealing with people who are preparing for the rest of their lives—we have a tremendous opportunity to help them establish good mental health and skills for dealing with the difficulties that inevitably come (balance, resiliency).

C. The priority at a research university often seems to be productivity. This can be a conflict with a priority of well-being.

D. We are challenged to figure out how to get the individual to make the choice to spend time dealing with mental health rather than in the lab—that’s where the faculty come in.
E. What does it mean to advocate/teach good mental health? Is this the responsibility of the academic community? We must make it clear to faculty that better mental health will (often) result in better academic performance (also increased positive feeling about Cornell upon graduation).

F. In addition to concern for the mental health of students, Cornell must consider the mental health of employees. These communities draw from separate resources, but are very interconnected.

G. At Cornell, we don’t have a “structure of command.” However, it is clear the political will must come from the top. Mental health must be a principal priority for the President and Provost, who must articulate a vision (“Caring Community Statement”?). In turn, they must get the Deans behind it, as the actual changes must be implemented from within the academic units. We need leadership to make this a shared responsibility (across academic, as well as student services departments) and support the needed resource allocation. It is necessary but not sufficient to add more mental health staff.

The powerpoint slides used for this presentation are available on the CMHW web page: http://www.gannett.cornell.edu/campushealth/CMHW.html

This summary of the presentation is drawn from a description of the program on the U.S. Office of Public Health and Science website showcasing best practices in public health.

Minutes taken by Sharon Dittman