

USAF Suicide Prevention Program:

Lessons for public health prevention in
non-military (“normal”) communities

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Overview

- Air Force Program
- Lessons
- Discussion

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USAF Community

- 350,000 Service Members
- Educated, employed, housed, health care (including mental health care), one language
- Prescreened; low illicit drug use (~1%); discharge for mental illness
- Clearly identified community leaders
- Formal gatekeeper network



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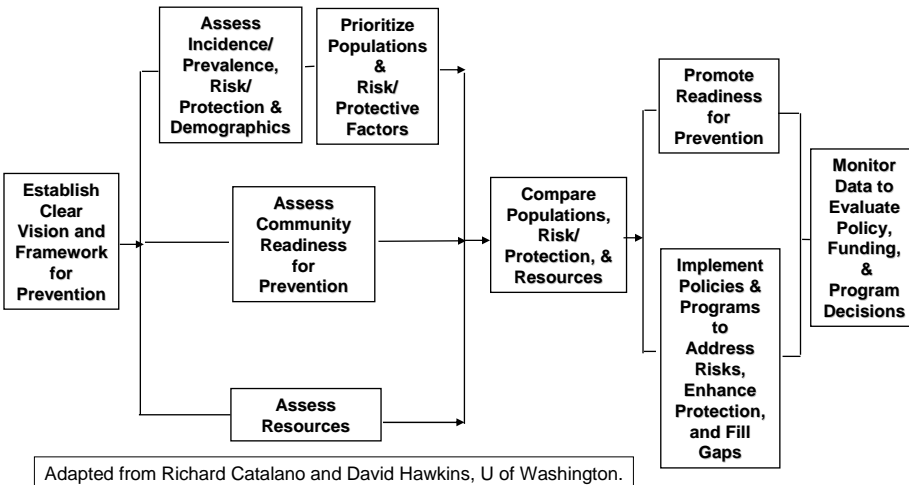
USAF Community Prevention Partners

- Medics-Mental Health
- Public Health
- Personnel
- Command
- Law Enforcement
- Legal
- Family Violence Prevention
- Child & Youth
- Chaplains
- Criminal Investigative Svc. (Medical Examiner)
- CDC
- Walter-Reed Army Inst. Of Research



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Data-Driven Prevention Planning Model*

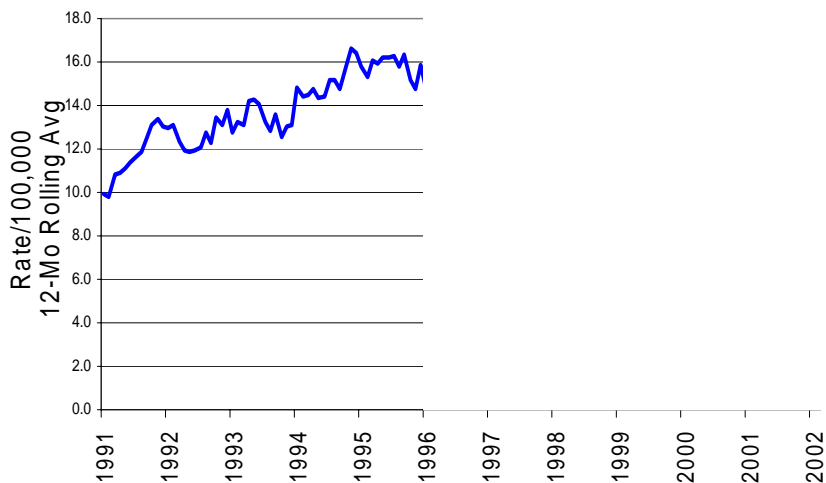


Adapted from Richard Catalano and David Hawkins, U of Washington.

* <http://www.sprc.org/library/datadriven.pdf>

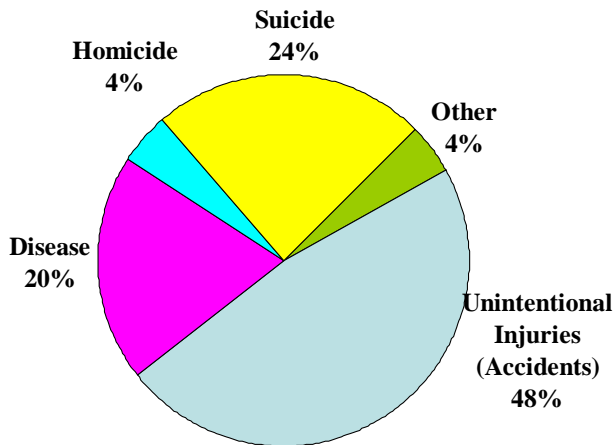
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Suicide Rate -- US Air Force Members by Year



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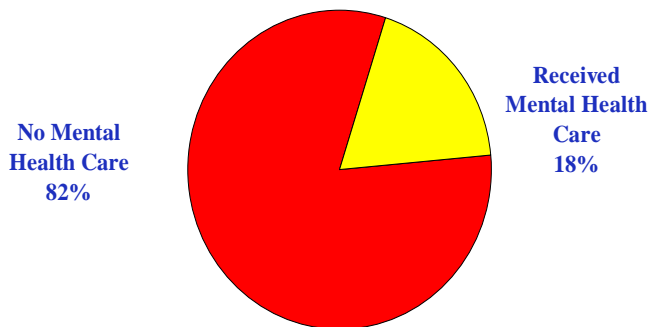
Leading Causes of Death ADAF 1990 -1995



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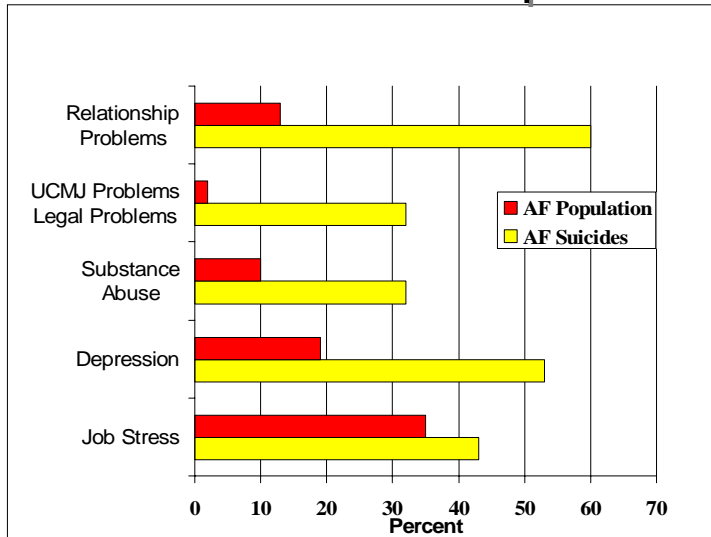
Mental Health Services Utilization

**Suicides 1990 - 1995 with Criminal Problems
(n = 92)**

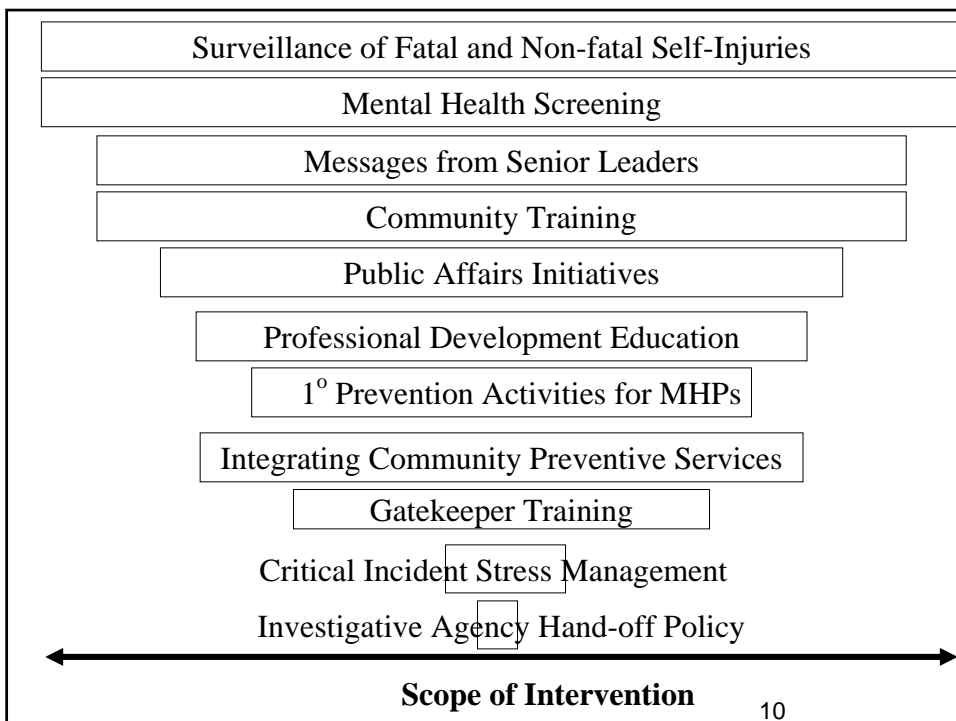


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Risk Factors AF Suicides vs AF Population*

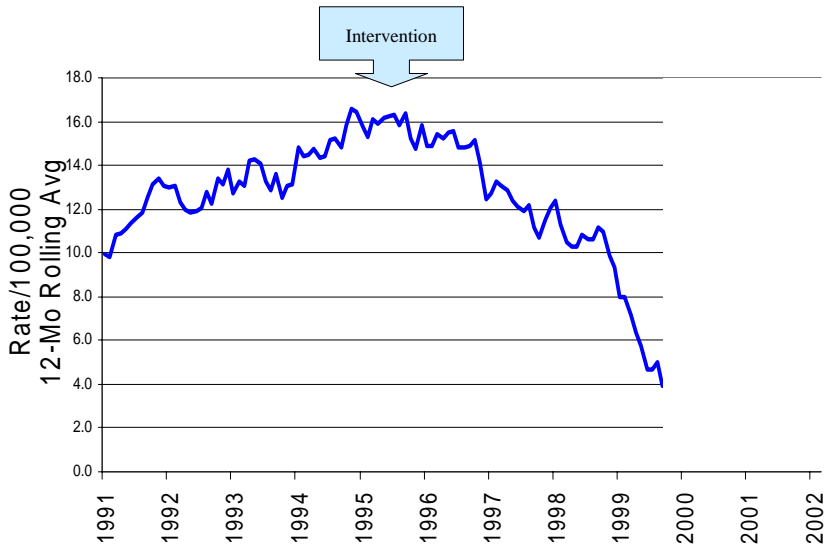


*Data from various sources, covering various timeframes between 1990 and 1995



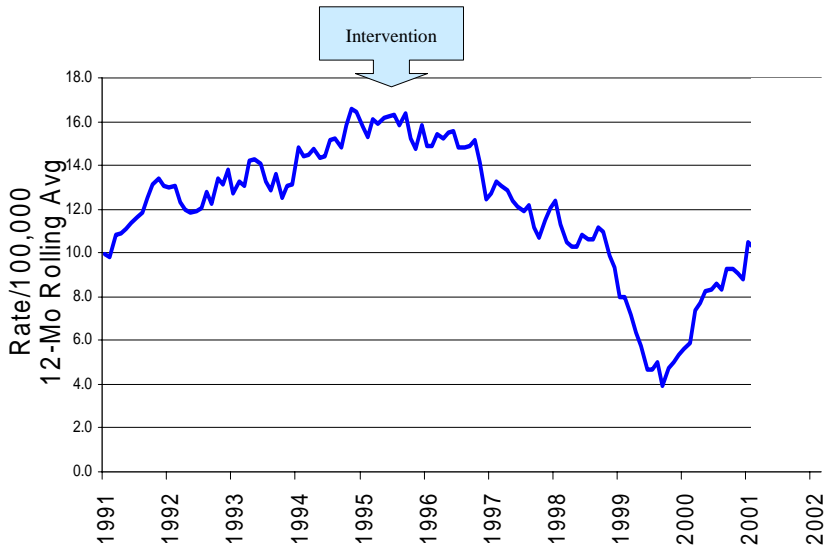
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Suicide Rate -- US Air Force Members 1990-2002



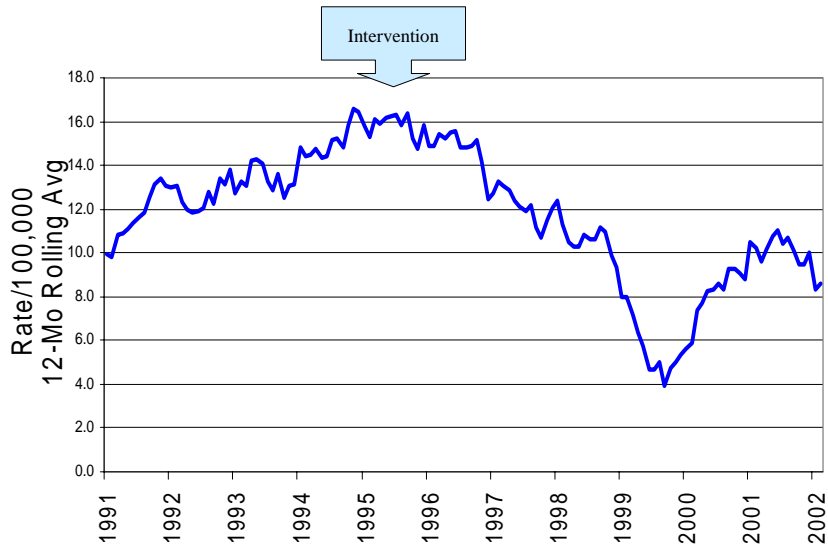
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Suicide Rate -- US Air Force Members 1990-2002



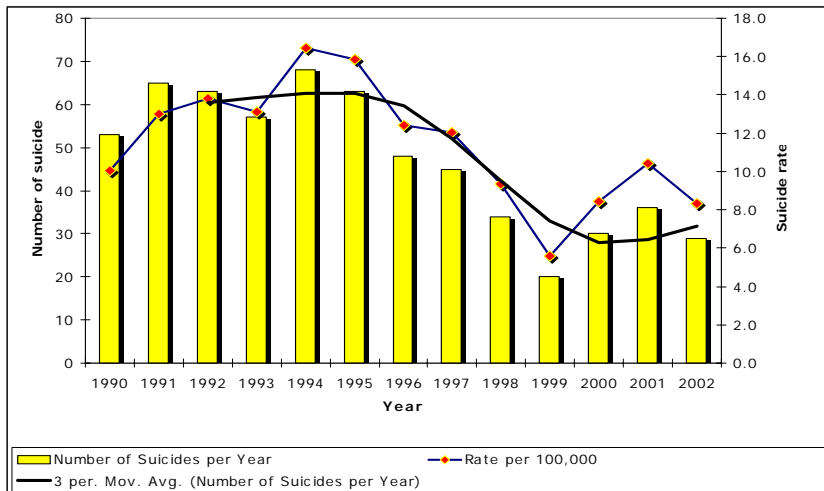
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Suicide Rate -- US Air Force Members 1990-2002



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Suicide Among Airmen



Knox, K, et al., Risk of Suicide and related adverse outcomes after exposure to a suicide programme in the US Air Force: cohort study. British Medical Journal, December 13, 2003.

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“Addressing risk factors across the various levels of the ecological model may contribute to decreases in more than one type of violence.”

— *Violence: A Global Public Health Problem*,
World Health Organization, 2002.

Results

Comparison of the effects of risk for suicide and related adverse outcomes in the USAF population prior to implementation of the program (1990-1996) and after implementation (1996-2002).

Outcome	Relative Risk (RR) and 95% CI	Risk Reduction (1-RR)	Excess Risk (RR-1)
Suicide	.67 [.5702, .8017]	↓ 33%	--
Homicide	.48 [.3260, .7357]	↓ 51%	--
Accidental Death	.82 [.7328, .9311]	↓ 18%	--
Severe Family Violence	.46 [.4335, .5090]	↓ 54%	--
Moderate Family Violence	.70 [.6900, .7272]	↓ 30%	--
Mild Family Violence	1.18 [1.1636, 1.2040]	--	↑ 18%

Knox, et al., 2003.

Lessons

- Leadership
- Coalition
- Data-driven planning
 - Assessment:
 - Understanding the problem
 - Readiness
 - Resources
 - Choosing interventions
 - Evaluation
- Sustainability

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Leadership

- Necessary ingredients for prevention
 - Evidence base
 - Social Strategy
 - Political will

Lesson: Political will is the *most essential*

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Coalition Leadership

- May stem from the grassroots
- Has authority
 - Moral, political, economic, social, scientific
- Continuity
- Inclusive of diverse viewpoints
- Shares power

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Coalition - Partnership

“Problems are complex and go beyond the capacity, resources, or jurisdiction for any single person, program, organization, or sector to change or control.”

Lasker R., Weiss E., Broadening Participation in Community Problem Solving: A Multidisciplinary Model to Support Collaborative Practice and Research. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. Vol 80, No 1. March 2003. p.5.

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Coalition - Partnership

- Turning competitors into collaborators
 - Unavoidable, hard work: price of admission
- Leadership challenge
- Burying generational hatchets
- Good will
- Incentives
- Crisis-driven
 - Sustainability after the crisis?

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Understanding the Problem

- Job 1: Reaching a common understanding
 - Patients
 - Suspects/defendants/inmates
 - Congregants
 - Troops/future civilians
 - Clients
- Making sense of scarce/disparate data
- Overcoming stigma & preconceptions
- Grasping a population view
 - Understanding the *centrality* of culture (values, norms)

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A population strategy of prevention is necessary where risk is widely diffused through the whole population.

Rose, Geoffrey, The strategy of preventive medicine. Oxford (Oxford University Press), 1992, 14

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Stages of Readiness

- **Tolerance/no knowledge**
- **Denial**
- **Vague awareness**
- **Preplanning**
- **Preparation**
- **Initiation**
- **Institutionalization/stabilization**
- **Confirmation/expansion**
- **Professionalization**

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Resources

"The best and most effective prevention programs are ones that are directed toward using resources which are indigenous to a particular community... external programs generally don't work as well, as they don't recognize the values of the culture.

--Sherry Davis Molock, M.Div., Ph.D., *Preventing Suicide*, 2003

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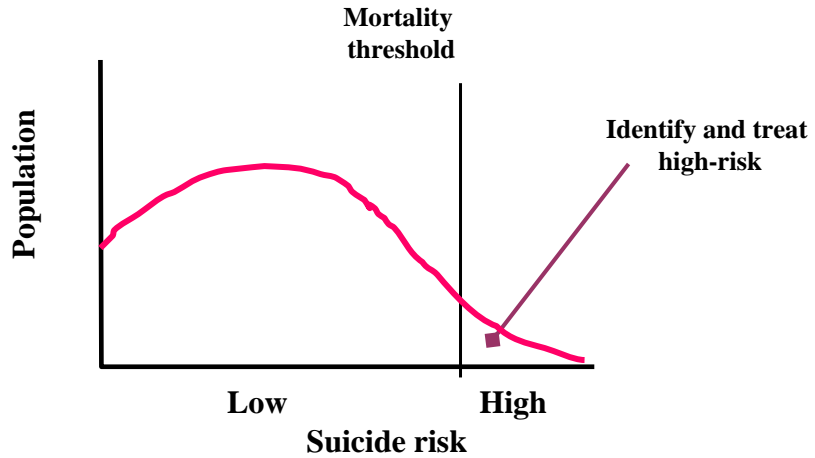
Rose's Theorem

"A large number of people at small risk may give rise to more cases of a disease than a small number who are at high risk."

Rose, G., *The Strategy of Preventive Medicine*. 1991; Oxford, Oxford University Press

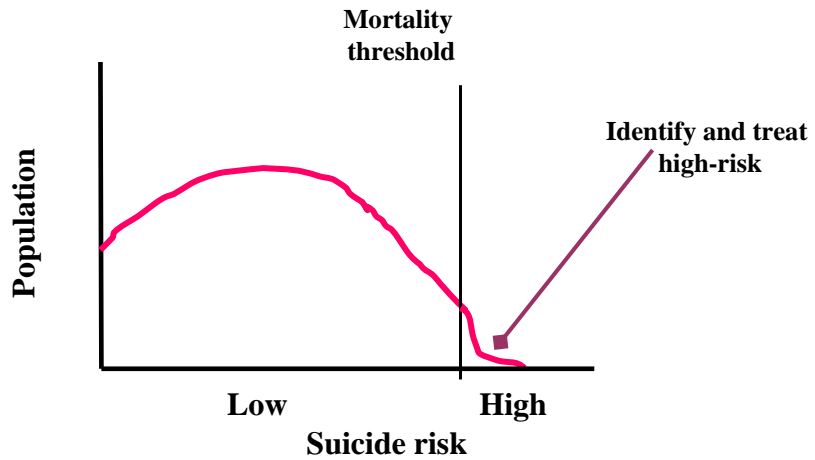
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High-risk Approach



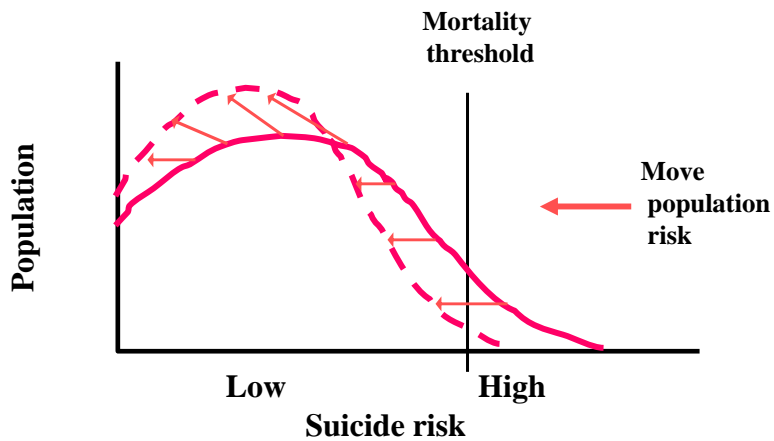
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High-risk Approach



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Population-based Approach



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Choosing Interventions

- Complete list of model suicide prevention programs (1996 - 2004)

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Choosing Interventions

“The impulse to invest only in proven approaches should not be an obstacle to supporting promising ones. Promising approaches are those that have been evaluated but require more testing in a range of settings and with different populations.”

“Violence is far too pressing a problem to delay public health action while waiting to gain perfect knowledge.”

Violence – A global public health problem, World Health Organization, 2002, p. 16.

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Evaluation Issues

- Scarcity of expertise
- Planning time
- Population size
 - Intermediate outcomes/proxies
- Data reliability
- Program fidelity
- Control/comparison groups

Evaluation:

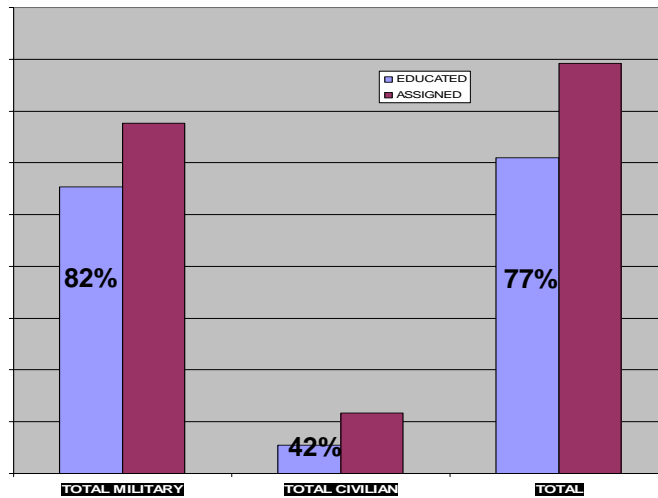
Build it in

Keep it practical

Focus on prevention, not research

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Annual Training Rates - 1998



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Sustainability

- Get it in writing (policy, laws, etc.)
 - Accountability
- Plan ahead for sustainability challenges
- Continue to broaden coalition
- Continue to seek additional and new resources
- Groom new leadership
- Welcome late adopters
- Continuity in leadership
- Feedback to implementers
 - Emphasize a population perspective

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"Most local programs that we examined have a history of episodic, uneven development during which periods of intense activity and interest alternate with periods when the local programs or initiatives lay virtually dormant. The key ingredient in all these endeavors has been the presence of committed leaders, as the Tillamook case illustrates."

H Leichter, J tyrens, *Achieving Better Health Outcomes: The Oregon Benchmark Experience, Milbank Memorial Fund, 2002.*

Challenges Challenges
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Discussion