**United States Air Force Suicide Prevention Program (AFSPP)**

**Description**
The United States Air Force Suicide Prevention Program (AFSPP) was commissioned in 1996 to develop suicide prevention strategies for all branches of the Air Force. The task force concluded that a community-based program was the most effective way to conduct suicide prevention for Air Force members and that prevention and intervention needed to happen before a person actually became suicidal.

In summary, suicide prevention is the responsibility of each of us. Effective suicide prevention means we create a community that provides assistance long before someone becomes suicidal. ... "We have a responsibility to our active duty members and their families to provide a safety net of support services that ensures a healthy and fit force and assistance to those in need. This is the foundation underlying the Air Force Suicide Prevention Program.” ([http://afspp.afms.mil](http://afspp.afms.mil)).

The AFSPP is comprised of 11 initiatives identified by the task force. In essence, the 11 initiatives provide suicide awareness training at all levels of the Air Force chain of command; empower and require the leadership at all levels to be alert for and react appropriately to signs of suicide and other critical stress; specifically extends the availability and use mental health services for suicidal service men and women; and establishes a trauma and policy monitoring mechanism spanning from individual squads to the Air Force as a whole.

1. **Community Awareness:** Commanders are encouraged to make appropriate use of mental health services and made responsible as gatekeepers for mental health services and as agents of cultural change to make seeking assistance acceptable.
2. **Leadership Involvement:** The program is endorsed and actively supported by the leadership at all organizational levels. Periodic communications are sent to all Air Force leaders discussing various aspects of suicide prevention.
3. **Investigative Interview Policy:** Once determination of suicide risk is made, there is an active assignment of ongoing responsibility and follow-up to the most appropriate superior officer for the at-risk service member.
4. **Professional Military Education:** Suicide prevention training is incorporated into officer and enlisted Professional Military Education and the First Sergeants course.
5. **Epidemiological Database:** Accurate data are essential to understanding and preventing suicide. To support the AFSPP with actual data, the Air Force developed a central surveillance system for tracking fatal and nonfatal self-injuries.
6. **Delivery of Community Preventive Services:** Authorize mental health professionals to receive service credit for engaging in suicide prevention services in non-clinical settings. Prior to this policy, suicide prevention and intervention services outside the clinical setting were not credited or supported as part of the mental health professional’s job.
7. **Community Education and Training:** Established required annual suicide prevention training of all active duty, reserve, guard, and appropriated-funded civilian employees. The focus of the training is that suicide prevention is everyone’s job and service members are individually accountable for each other’s health and well being.
8. **Trauma Stress Response:** Created multidisciplinary trauma stress response teams composed of mental health, medical, chaplain, family support center, and peers to respond to traumatic incidents such as suicide.
9. Integrated Delivery System (IDS): All the helping agencies on a base were brought together to identify the suicide prevention needs of their base and to develop a plan for meeting those needs as a group. Each local IDS also participates in a hierarchy of larger scaled IDSs, the largest being responsible for the entire Air Force. A separate board assists IDS at all levels with situation or problems they cannot resolve and monitors and adjusts the AFSPP as necessary.

10. Limited Patient-Psychotherapist Privilege: Allows a service member under criminal investigation and who is at increased risk for suicide to be seen by a mental health provider who can establish a mental health record not available to law enforcement agencies.

11. Unit Risk Factor Assessment: Adopted a standardized Behavioral Health Survey for use in all behavioral health units.

**Characteristics**
- **Population**
  - Gender – male and female
  - Ages – 18 – 55 years old
  - Races – Unspecific to race
- **Risk, Protective & Causal Factors**
  - Untreated or undetected mental health issues, including suicidality (R)
  - Peer, leadership and community awareness training of suicide signs & symptoms (P)
  - Increased access to mental health services (P)
  - Suicide risk surveillance system & surveys (P)
  - Sanctions for peers of completed suicides (P)
- **IOM Category (level of care)**
  - Universal - institution

**Effectiveness**
Compared to a six–year, pre-intervention control period, Air Force personnel exposed to the program during the six–year intervention period showed:
- a 33% reduction of risk of suicide
- a 41% reduction in severe family violence and a 30% reduction in risk for moderate family violence
- an 18% reduction in risk of accidental death
- a 51% reduction of risk for homicide

**Program delivery**
The AFSPP is an environmental or institutional approach to suicide prevention that focuses on early identification and treatment of those at risk. It is a formal system that incorporates suicide prevention training into all levels of military education. The AFSPP requires service men and women at all levels of leadership from individual squads to Air Force high command to actively monitor and respond appropriately to people exhibiting even minor indicators of suicide risk. The AFSPP specifically authorizes and extends the use mental health services beyond the traditional office setting and provides screening tools, commission guidelines and trauma management services to handle suicidal service personnel. And finally, the AFSPP establishes a pair of hierarchies of interdisciplinary medical, mental health specialists and service men and women to provide direct intervention, resolve problems not covered by AFSPP and direct future policy decisions to maintain and improve the successful impact of the AFSPP.
Considerations for use in Idaho
The program materials are regarded as straightforward and are relatively accessible by non-military people such as those providing suicide prevention in the community or workplace suicide. However, the program is chiefly designed to be conducted within a closed or self-contained institution with clearly delineated lines of command, responsibility and accountability. AFSPP as a whole may be adaptable to prisons, jails, juvenile detention centers, group homes, etc.

The 11 initiatives underlying the AFSPP could be implemented as a subset individually or for specific situations. For example, the leadership elements, such as active and public buy-in and participation in suicide prevention, making early detection a part of the culture and everyone’s responsibility, and willingness to refer to mental health services, could be adapted to many settings. Similarly, an interdisciplinary team of local health care providers could use the AFSPP materials to form their own community based trauma response team to better coordinate service provision for a person at-risk for suicide.

Training & costs
The program design and training materials are available without cost from the AFSPP website (http://afspp.afms.mil/). The program materials are well regarded as straightforward and readable, but they are not really designed for non-military people (cf. MIL-STD 11322-#144-JSFP). A good overview and description of the AFSPP initiatives and outcomes can be found in AFAM 44-160 AF Suicide Prevention Program. Onsite training for people outside of the Air Force does not appear to be available for the AFSPP.

The delivery cost for the AFSPPP as delivered by the Air Force is relatively low, consisting mainly of the administrative staff that maintain, train and revise the program and the increase in mental health service utilization due to increased referrals. The remaining costs are covered by the existing military administrative hierarchy and training branch of the Air Force. An institution with a analogous command and service structure to the military, for example, a prison, could possibly implement the AFSPP with a similar cost model.

Dissemination & support
The program materials include training guides, PowerPoints and briefings about the AFSPP to staff of various administrative levels, guides for recognizing and responding to suicide risk and other mental health crises, screening and case reporting tools, and much more. The Leaders Guide for Managing Personnel In Distress, for example, is a concise and well laid out guide for anyone in a leadership position that covers far more mental and personal crises than suicide alone. Similarly, although designed for military leaders, the AF Guide for Managing Suicidal Behavior is a comprehensive resource for suicide management, covering assessment & decision making, service referral, placement and coordination, post-crisis care and so on.

Ongoing technical support for AFSPP implementation outside of the Air Force does not appear to be available.

Contact information
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Other program synopses


Selected Bibliography


