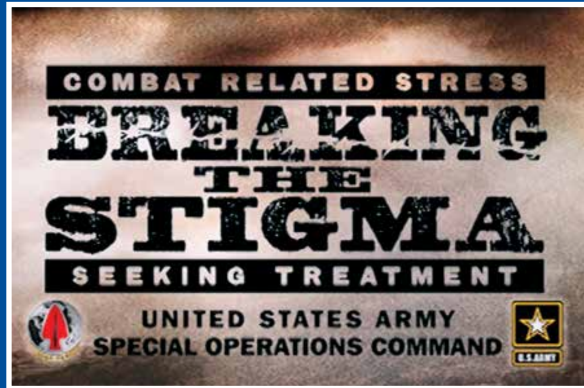

http://www.soc.mil/Stigma/BTSA.html

1-800-342-9647 is available 24/7. http://www.militaryonesource.mil. Military One Source provides up to 12 free counseling sessions per issue, per counselor. Counseling is treated confidentially regardless of rank with exceptions for the duty to report family maltreatment, threats of harm to self or others, substance abuse, and illegal activities. Source: United States Army Special Operations Command.

After more than fifteen years of conflict, the fact that suicide persists as a command issue in the United States Special Operations Command (USSOCOM) is heartbreaking and serves as a clarion call to redouble efforts by individuals and institutions to invest in programs that demonstrate effectiveness in reducing suicide, eroding the stigma associated with seeking treatment, and increasing the use of behavioral health care (BHC). In this monograph, Dr. Craig Lefebvre offers a social marketing perspective that reveals insights and actions to enhance existing programs.

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JSOU Report 17-2 Suicide Prevention Initiatives in USSOCOM Lefebvre

JOINT SPECIAL OPERATIONS UNIVERSITY

A Social Marketing Analysis for Suicide Prevention Initiatives in USSOCOM: A Framework for Future Research and Success

R. Craig Lefebvre, Ph.D.

JSOU Report 17-2

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A Social Marketing Analysis for Suicide Prevention Initiatives in USSOCOM: A Framework for Future Research and Success

R. Craig Lefebvre, Ph.D.

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On the cover. A Special Tactics Special Operations weatherman from the 320th Special Tactics Squadron carries his parachute and gear after performing a HALO jump during exercise Talisman Sabre in Northern Territory, Australia, 10 July 2015. Photo by Senior Airman Stephen G. Eigel.

Back cover. Breaking the Stigma is the United States Army Special Operations Command's (USASOC) comprehensive approach to help dispel the myths of seeking behavioral healthcare. The program employs a full range of training geared towards educating USASOC soldiers, leaders, and family members of primary stigma factors and barriers to care, as well as best practices for mitigating behavioral health stigmas. Source: United States Army Special Operations Command.

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Foreword

Every military leader is ingrained with the dual imperative: *Mission First, People Always*. After more than fifteen years of conflict, the fact that suicide persists as a command issue in the United States Special Operations Command (USSOCOM) is heartbreaking and serves as a clarion call to redouble efforts by individuals and institutions to invest in programs that demonstrate effectiveness in reducing suicide, eroding the stigma associated with seeking treatment, and increasing the use of behavioral health care (BHC). In this monograph, Dr. Craig Lefebvre offers a social marketing perspective that reveals insights and actions to enhance existing programs.

Special Operations Forces (SOF) personnel have long recognized that people make the critical difference in special operations. That wisdom is shared by the individuals and families who live and work within the enterprise, or are life-long members of the SOF community. Their collective experience acknowledges the practical realities of this most important pillar of special operations. Chief among those realities are the frequently fragile qualities of human nature and the need to devote personal and professional attention, time, and resources, to ensure the sustaining fiber of human behavior. Every member of the SOF community plays a role in suicide prevention, but few are aware of how to play those roles.

In terms of BHC and suicide prevention, the operationalizing of this SOF Truth is carried out through various initiatives under the egis of Preservation of the Force and Family (POTFF). But it is in no way accurate to regard suicide prevention as the responsibility assigned to a small number of specialists. Dr. Lefebvre outlines in considerable detail the nature of the suicide problem in ways that inform leadership, colleagues, family members, and individuals and provides clear paths to the most relevant information for each of those roles. The monograph presents the structure and content of a social marketing plan for suicide prevention and its individual components are rich with information for all readers. He provides a comprehensive mosaic of available resources, case studies, and precedents.

Dr. Lefebvre relies on the principles and techniques of social marketing to precipitate behavioral changes. Such modifications strengthen the bonds of the SOF community, including family members that are regularly tested

by the tension, uncertainty, and rigor of operational environments and SOF career requirements. He devotes his first chapter to an overview of social marketing and how this approach draws on the multisource techniques of commercial marketing to focus persuasive messages on audiences of greatest interest or need. What results is a comprehensive program of engagement whose goal is preserving the lives, relationships, and cohesion of the SOF community.

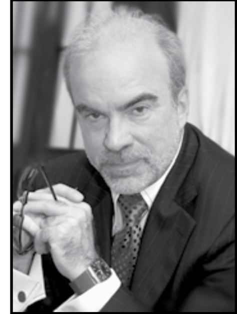
In the subsequent chapters, he provides a vast amount of important information, a navigable path for the way forward, and specific recommendations for steps along the way. Readers will learn early that considerable accessible research has been conducted in both military and civilian environments to identify and understand the psychological and behavioral dynamics involved with suicide. Dr. Lefebvre's detailed survey of that literature performs an important service by identifying and discussing the implications of those sources of assistance.

The fact is that suicide prevention is a responsibility that we all share. A central theme in Dr. Lefebvre's monograph is that no one is powerless if sufficiently aware. But experience shows that the task at hand is more than encouraging individuals to pursue available resources. Assistance and treatment options exist and they have proven to be effective when pursued. The path that emerges in the pages that follow exposes the reader to the context, theory, content, and practical history of suicide and suicide prevention. More than a simple research survey, it provides specific ways forward to assist in sustaining the most compelling of all SOF Truths: "Humans are more important than hardware."

Francis X. Reidy
Interim Director, Center for Special Operations Studies and Research

About the Author

R. Craig Lefebvre, Ph.D. is an architect and designer of public health and social change programs. He is chief maven of socialShift, a social/design, marketing and media consultancy, Lead Change Designer at RTI International, and research professor at the College of Public Health, University of South Florida. An internationally recognized expert in social marketing and social and mobile technologies for behavior change, Craig has been involved in hundreds of projects in global, national, state and community contexts. He is the author of over a hundred articles and chapters, and his recent books include *Social Marketing and Social Change: Strategies and Tools for Improving Health, Well-Being and the Environment* and a six-volume series on social marketing for the Sage Library. He currently serves on the editorial boards of *Journal of Social Marketing and Social Marketing Quarterly*. Dr. Lefebvre received the 2014 Phillip Kotler Social Marketing Distinguished Service Award and the William D. Novelli Award for Innovations in Social Marketing.



Craig is a founding board member of the International Social Marketing Association, a senior fellow in the Society for New Communications Research and an elected member of the American Academy of Health Behavior. His past positions include intervention director of the Pawtucket Heart Health Program, chief technical officer at Prospect Associates, chief scientist at the American Institutes for Research, and chief technical officer at PSI. Dr. Lefebvre received his Ph.D. in clinical psychology from North Texas State University; served in post-doctoral positions in behavioral medicine at the University of Virginia and the University of Pittsburgh; and has held faculty appointments at the University of Virginia, Brown University, Johns Hopkins University, the University of Maryland, Queensland University of Technology and George Washington University. He also produces the blog *On Social Marketing and Social Change* located at http://socialmarketing.blogs.com.

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There are two people at the Joint Special Operations University whose contributions to this project were invaluable.

Doug Jordan initially conceived of the need for a social marketing perspective on the issue and approached me about researching and writing this monograph. His introduction of me to the SOF, and his continual guidance and support as I worked my way through the project, were essential.

Dr. Paul Lieber was my gentle yet ever-prodding mentor for this monograph. His comments and insights for the final drafts of this document were always on-target and greatly improved it.

There are also many staff of the POTFF who met with me and shared information during the project's development. I hope that the ideas in this monograph will be especially useful to them and their colleagues as they continue to identify and implement innovative, valuable solutions across the USSOCOM enterprise to improve the short- and long-term well-being of SOF warriors and their families.

And most importantly, though I did not meet with any of them directly, it is the SOF warriors and their families I always kept in mind with the question: "What's best for helping them meet needs, solve problems and achieve their dreams?"

Introduction

> USSOCOM Preservation of the Force and Family mission: To identify and implement innovative, valuable solutions across the USSOCOM enterprise aimed at improving the short- and long-term well-being of our Special Operations Forces (SOF) warriors and their families.[1]

This report is a detailed inquiry for augmenting the holistic approach of the U.S. Special Operations Command (USSOCOM) Preservation of the Force and Family (POTFF) task force with a social marketing perspective and approach. Social marketing provides paths to insights and actions to address the pressure on the force and families in order to maintain and improve readiness, operational effectiveness, and the immediate and long-term well-being of Special Operations Forces (SOF). This inquiry presents the findings and implications of a review of literature that is framed by the question: How can social marketing help reduce stigma and suicide and increase utilization of behavioral health care (BHC) among SOF and strengthen other programs under the purview of the POTFF? Six chapters present findings from research in USSOCOM, other military settings, and across diverse civilian populations that address issues of suicide including risk and protective factors, especially mental health stigma, and programs that have addressed one or more of these issues. This inquiry was not intended as a systematic review of the literature in each of these areas. Rather, selective reviews and programs are used to highlight some of the core questions that are addressed from a social marketing approach to understanding the determinants and consequences of these behaviors, the theories and evidence that have accrued on how to address them, and their implications for the future.

Chapter 1 serves as an introduction to the field of social marketing. It highlights how social marketing can be used by POTFF to provide: (1) a conceptual approach to link all of its efforts together that are grounded in the realities of the soldier and family, (2) a model to scale-up evidence-informed and best practices, and (3) an approach that considers the criticality of pricing, opportunity, and access to support the achievement of objectives for behavioral health services and communication campaigns. The chapter

continues by describing key terms and concepts in social marketing and how a social marketing strategy and plan are developed. Social marketing strategy and planning processes focus on critical questions that program planners should consider for any initiative designed to address risk and protective factors for suicide and encourage BHC. This model guides to inquiry and recommendations in the next four chapters.

Chapter 2 provides historical and recent data on suicide in the military, and among SOF members in particular. This overview includes several external reviews of stigma reduction and suicide prevention activities in the U.S. military population. These reviews clearly show that stigma is just one of several pathways that lead to the avoidance of labeling and treatment. Another key issue identified across these reports is that theory, research, policy development, and program evaluations lack objective and observable behaviors of what constitutes stigma.

Chapter 3 looks more closely at how mental health stigma is conceptualized in literature. Recent formulations of stigma find that people may avoid being labeled with a behavioral health problem or avoid seeking treatment because of concerns about resulting discrimination due to existing laws or policies (structural stigma), social rejection and other negative reactions (public stigma), reflections that help-seeking may have on family and friends (courtesy stigma), and the undermining of self-esteem (self-stigma). While there is no empirical evidence for which types of stigma may be more prominent, it is generally acknowledged that each type of concern can influence the decision to seek help for one's self or others. To better define objectives for stigma-reduction efforts, and to also separate what is stigma from other determinants of treatment-seeking behavior, it is suggested that a four-tiered approach may provide greater operational clarity.

Recent work has focused on a number of other critical determinants of treatment-seeking behavior and risk for suicide that are reviewed in chapter 4. Some of these determinants and risks include personal beliefs about mental illness, negative attitudes about mental health treatment and its effectiveness, legal and health problems, high combat stress exposure, financial problems, mental health diagnoses—particularly traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and depression—prescriptions of selective serotonin reuptake inhibitors (SSRIs) and sleep prescriptions.

A review of programs to reduce stigma and suicide, especially in military settings, is the focus of chapter 5. Several military suicide prevention

programs have been shown to not only prevent suicide, but also reduce family violence and homicide, underlining that programs focused on risk and protective factors can have far-reaching positive impacts. Multiple component interventions have been found to be the most likely to reduce the risk of suicide, and the U.S. Air Force social marketing program is pointed to as an exemplar of such approaches. In contrast, the evidence for psychosocial interventions following a suicide attempt suggests that they are minimally effective, and there is even less evidence to recommend community-based suicide prevention programs among military populations. There is also little evidence to support the efficacy of mass media campaigns, use of gatekeepers, and general screening for suicidal ideation or depression to reduce suicides. However, efforts in military contexts to overcome barriers to care, make quality improvements in delivering mental health care, and organizational interventions to reduce workplace stress (duration and spacing of deployments, harassment prevention activities, employee assistance programs, dispute resolution services, and financial counseling services) were promising strategies to continue.

In chapter 6, the results and insights from the previous chapters are brought together to present recommendations for POTFF initiatives. Results of the POTFF Wave III Needs Assessment Survey-the 2014 iteration of a survey administered in "waves" since 2010 that assesses the short- and long-term well-being of SOF warriors and their families-provide a data-based context for eight recommendations for future actions. These include:

1. Specify discriminatory behaviors that reflect USSOCOM priorities for reducing stigma.
2. Engage SOF members and civilian spouses more completely in the research and development process for programs aimed to mitigate suicide risk.
3. Utilize formative research in all POTFF messages, services and program development efforts.
4. Perform user preference studies in planning and refining programs and BHC service offerings.
5. Improve measurement of user satisfaction and perceived effectiveness of BHC offerings.

6. Conduct research that is aimed at insights and understanding of the use of 'outside' BHC services.
7. Monitor, enhance, and sustain social connectedness and resilience through programs. This is a promising new approach to suicide prevention and increasing treatment-seeking behaviors.
8. Expand research and evaluation efforts that examine the role of self-stigma and perceptions of BHC effectiveness in mitigating treatment-seeking behaviors.

1. Social Marketing to Reduce Suicides, Mental Health Stigma and Increase Treatment-Seeking Behaviors

Social marketing developed as a response to tackling large-scale environmental, health, and social problems. In the mid-1960s India, the government viewed rampant population growth—more than 12 million births a year—as a signal for more concerted efforts to encourage its 500 million citizens to use family planning methods. Realizing that the scope of their ambitions swamped the expertise and resources available to the government, the Indian Institute of Management recommended a plan that developed and promoted family planning product brands (condoms, intrauterine devices, and birth control pills) supported by advertising and distribution of them through private sector channels rather than only government health clinics.[2] Several years later, two academic marketers in the U.S. looked at the social issues of the late 1960s (racial tensions, the first "Earth Day"), reviewed evidence for the effectiveness of some social advertising campaigns, and suggested the use of a marketing approach using the 4P marketing mix (products, price, place, and promotion) to plan social change efforts.[3] Since those two seminal events, social marketing became a key methodology to address numerous social and health issues in both developed and developing countries.[4,5]

These two starting points focused on very different outcomes. In India, the purchase of family planning products was a key indicator for success. For Kotler & Zaltman,[6] increasing the acceptability of social ideas was their intent, i.e. reducing pollution, improving race relations, preventing drug abuse and increasing use of mass transit. In the 1980s, Lefebvre and Flora[7] presented their work in designing and implementing two of the world's first community-based efforts to reduce a population's risk behaviors for, and subsequent disability and death from, cardiovascular diseases. This marked a shift from social marketing being about changing ideas (knowledge and attitudes) and increasing the purchase of socially beneficial products to one that became more resolutely focused on the "bottom-line" of behavior change.

Within a few years, behavioral outcomes began to dominate the definitions of social marketing.[8]

The implications for USSOCOM behavioral health and suicide prevention actions are that social marketing can be applied to tackle three interrelated issues:

- Refining and scaling up of POTFF evidence-based products and services throughout USSOCOM;
- Addressing issues of stigma and other impediments to seeking treatment for behavioral health issues; and
- Focusing marketing and communication activities on specific behavioral objectives for a variety of priority groups.

There are several common features of a social marketing approach. The most consistently described characteristics of social marketing draw from managerial frameworks and approaches and include a consumer orientation, exchange and customer value, market analysis and segmentation (also referred to as selectivity and concentration), the use of the 4Ps marketing mix to develop and implement programs, various types of market or consumer research to test and refine offerings, and monitoring and effectiveness evaluations. Other features often found in programs in which product and service offerings, and not just behaviors, are important elements of the marketing mix include: a customer informed new product or service development process, brand development and management, positioning strategies, demand generation strategies, and management of the distribution or service delivery system.[9,10,11]

While there is much promise in such a comprehensive approach to behavioral health and suicide prevention in USSOCOM, social marketers also identify a number of organizational barriers that can prevent or undercut its full adoption, implementation, and effectiveness. Many of these barriers are characteristics of organizational structures, processes, and policies that can be quite resistant to the challenges and changes a social marketing approach brings to problem definitions and solutions. For example, there can often be an inadequate understanding of the needs and perspectives that people who are being served have of the problem and its possible solution. Often there are pressures in an organization to place professional, policy, and scientific priorities above people's needs, wants, and aspirations. Aligned with these pressures are organizational and professional biases that favor expert- or

evidence-driven efforts. In complex social systems, various stakeholders may impose their own agendas on solutions or modify and dilute customer-based ones. Some people may react to the term "marketing" as signaling attempts to manipulate people, rather than seeing that the cornerstone of the social marketing approach is listening to people and incorporating their views into program development and implementation. Even if accepted as a valid approach to reform current approaches or innovate new ones, organizational structures can impede the design of integrated marketing approaches; there may be a belief that social marketing is incompatible with other approaches, such as community-based efforts, policy development, and advocacy; and, there is a reluctance to tamper with existing programs.[12-15] Throughout this discussion, these concerns will be addressed.

Some people may react to the term "marketing" as signaling attempts to manipulate people, rather than seeing that the cornerstone of the social marketing approach is listening to people and incorporating their views into program development and implementation.

Social Marketing: The Starting Point

A comprehensive framework for using marketing to address behavioral health and suicide prevention objectives in POTFF will have two distinguishing elements: one that expresses the notion of a consumer orientation (listening and being responsive to SOF and family members, USSOCOM behavioral health staff and officers), and a second that embodies the idea that social marketing is designed for large-scale change efforts—not just individual or clinically focused education and behavior change activities.[16] This is not to diminish the critical importance of educational and clinical interventions to assess and address intrapersonal and interpersonal factors, tailor the information to be conveyed to an individual or group, and provide the context to learn and practice the complex skills needed by people to encourage, support, engage in, and improve optimum behavioral health. Indeed, many of these types of services might become more attractive to a larger share of SOF and family members by integrating them into a larger, holistic framework through the use of the social marketing approach.

The social marketing approach takes a systems-level, or social-ecological, perspective on addressing the problem in which individual-focused efforts occur in social, organizational, and policy environments. Social marketing strategy seeks to align these different levels of solutions so that all of them support the initiation, participation, and maintenance of behaviors that improve the short- and long-term well-being of SOF warriors and their families. These behaviors are not just those of the individual seeking assistance, but also the behaviors of people across the USSOCOM enterprise. What social marketing provides is: (1) a conceptual approach to link all these efforts together that is grounded in the realities of the soldier and family, (2) a model to scale-up evidence-informed and best practices, and (3) an approach that considers the criticality of pricing, opportunity, and access to support the achievement of objectives for POTFF initiatives—including behavioral health services and communication campaigns.

An Integrated Model for Social Marketing Practice and Research

Building on these two core concepts, an integrated social marketing approach has four interrelated tasks that revolve around an identified benefit or value proposition for a priority segment of the population—whether it is an operator, a family member, civilian, other service members, behavioral health professional staff, or others (see fig. 1). The first task is to clearly identify and understand the priority group the resources are targeted to serve. However, this does not assume that each of these groups is homogeneous—there may be different groups of operators, family members and civilian workers who have characteristics in common and yet distinguish them from other peers (age or deployment status for example). This idea of segmentation is a critical step early on in the marketing process. It helps to avoid the 'one-size-fits-all' fallacy employed by too many communication, educational and policy interventions. This fallacy makes it difficult to evaluate the outcome of programs: answers to questions about what specific effects, among which sub-populations of soldiers and family members, in what contexts, were facilitated or inhibited by program components is lost in the quest for "an average effect." The idea of discrete segments drives how measurement and monitoring systems are designed: the question shifts from "does this intervention work?" to

"what intervention is most effective with this specific group of people who are experiencing a certain type of problem in a specific context?"

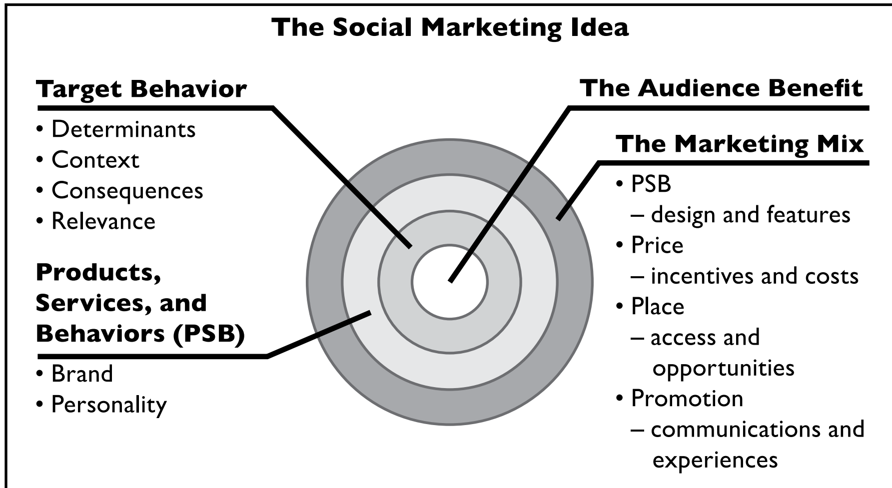

Figure 1. An Integrated Model for Social Marketing.

The second task, shown in the center of figure 1, is to identify the essence of what each of these groups of people want or need, the specific problems they have, and the aspirations they have for themselves and others. The various needs, problems to be solved, and aspirations are the signals for what types of benefits and values are most important to this group. This terminology is important. Addressing people's needs may be appropriate in a limited set of circumstances—such as when they cannot provide for themselves. But it is when marketers become partners in helping people solve their problems and enable them to reach their aspirations that more powerful results are possible. Many times marketers will do their initial segmentation of a priority group, such as operators or spouses, based on the benefits or values they have in common (to keep their family secure, solving problems such as purchasing a new car or finding new housing, educational goals for their children). Tapping into benefits and values also allows the marketer tap into existing motivations to change.

Once these core benefits and values are understood from the perspective of the people served, attention is turned to understanding the determinants, consequences, and context for the current behaviors they engage in that may decrease or compromise behavioral health and/or lead to suicidal

behaviors. Many of these determinants may already be understood from previous research. However, it is also important to elicit the perceptions and ideas of the people being served by the programs. When program planners are considering options and designs for products, services, and behaviors they believe will reduce suicides or improve treatment-seeking behaviors, equal weight is given to peoples' inputs as to what are the most desirable and relevant features for them, what behaviors fit their lives, how confident they are in actually engaging in the behaviors, and their expectations that the proposed solutions will meet their needs, help them solve their problems, or serve their aspirations.

Equipped with this knowledge, the fourth task (the outer ring of the figure) is tailoring a marketing mix that is responsive to group members' unique characteristics and concerns. Program designers consider at this step:

- How the product, whether it is a tangible item, a service offering (educational sessions, BHC), or a behavior is desirable, relevant, and tailored to fit the characteristics, concerns, and daily activities of each priority group.
- How price variables can facilitate or impede product or service use and adoption of new behaviors. Prices may be incentives or costs for change—financial, time/attention, effort, psychological, social, geographic/environmental, and policies among others (in the latter two cases, for example, that create barriers or facilitate access to care). Opportunity costs, or what the person forgoes to use a product or service or engage in a new behavior, are also considered part of the price element.
- The place component when products (tangible items, services, or behaviors) are accessible and available to members of the priority group, and opportunities for trying, practicing, and supporting new behaviors are designed. Place may be thought of as the physical location or proximity to offerings and opportunities; however, mobile and telehealth technologies can be employed to place and/or shift product and service distribution, and virtual reality technologies can be used to create opportunities to practice skills. New technologies have expanded the options for what constitutes a "place" for interventions.
- How these new products, services or/and behaviors, their associated prices, and the access points and opportunities to engage with

> them will be communicated to the priority group is the promotion component of the marketing mix. In social marketing, a message 'to change' in some way is not a promotional element. The purpose of the promotion "P" is to build awareness of the product, service and behavior; build demand for them; facilitate decisions to try them; and reinforce their continued use or sustained engagement in the behavior. This distinguishes social marketing from approaches that rely on various types of persuasive appeals and message design principles to encourage behavioral changes. In the best circumstance, these types of health communication campaigns are found to result in an average of five percentage points change in behavior from baseline.[17] Social marketing may incorporate behavior change messages, but they are augmented and integrated with the other 3Ps. For example, a recent analysis of combining low-cost or free products with media campaigns demonstrated their superiority in achieving behavioral changes compared with mass media efforts alone.[18]

The importance of the initial stage of determining benefits and value for each priority group cannot be overstated. Rangan, Karin, and Sandberg[19] found the lack of short-term, concrete benefits for an individual to be a major barrier to the success of social marketing efforts. They recommended that various types of benefits be considered in social marketing programs, with the choice depending on how people in the priority group perceive the costs for engaging in different behaviors and whether the expected benefits were directly to the individual or for a larger social good. This finding is useful when designing programs intended for SOF families in which each person might have different ideas about what value, benefit, or costs means to them. The notion of 'courtesy stigma,' for example, where a spouse might be more concerned about the stigma they experience than the help-seeker who has few concerns about "self-stigma," is just one example where a larger good (protecting the family) may be inconsistent with individual beliefs. For example: "I don't want to be labeled as the spouse of someone who is mentally ill." Another important consideration is that these benefits or value cannot simply be 'promised;' people must be able to experience these benefits and value by observing or experiencing their 'value-in-use.' One example is that when marketing behavioral health services, users and their spouses need to experience the promoted 'benefits' for themselves, discover their own

unique value for participating, or learn from others what their experiences have been with the program (did the spouse feel treated in ways that suggested "courtesy stigma," or were they relieved to find others like them in a peer support network?).

Finally, social marketing recognizes that the context in which behaviors occur, or not, is an important lever for change efforts. Efforts to reduce stigma, increase help-seeking behaviors, or encourage use of behavioral health services occur in a social context of networks of people that are linked directly or indirectly with each other—a complex web of social determinants. How these networks encourage or discourage help-seeking behaviors, and more importantly can be leveraged to achieve better behavioral health outcomes, should be part of the social marketing plan. As was noted in the discussion of price, policies and procedures play an important role in facilitating or discouraging help-seeking behaviors. Initiating changes in policies and procedures that align with social marketing objectives are important steps in the longer-term support and sustainability of change efforts by the individual, their family, and USSOCOM.[20, 21]

Efforts to reduce stigma, increase help-seeking behaviors, or encourage use of behavioral health services occur in a social context of networks of people that are linked directly or indirectly with each other—a complex web of social determinants.

Creating Social Marketing Strategy

Transforming social marketing ideas into strategies that serve USSOCOM and POTFF objectives involves taking the research findings and inputs from priority groups and stakeholders and deliberately working through a sequence of steps. Each step in the process of developing marketing strategy builds on what is learned at earlier stages and informs ideas for program development or refinement, but does not dictate them (see fig. 2). This iterative process of developing a marketing strategy involves:

1. understanding what the problem is from people's points-of-view,
2. informing those observations with relevant theoretical models and previous research,

3. developing hypotheses about what behaviors may then be of the most value to each segment or priority group,
4. testing these assumptions and prototypes with them—especially their feasibility, relevance and perceived superiority (positioning) to current behaviors or other options, and then
5. refining the concepts and offerings and articulating them in a marketing plan.

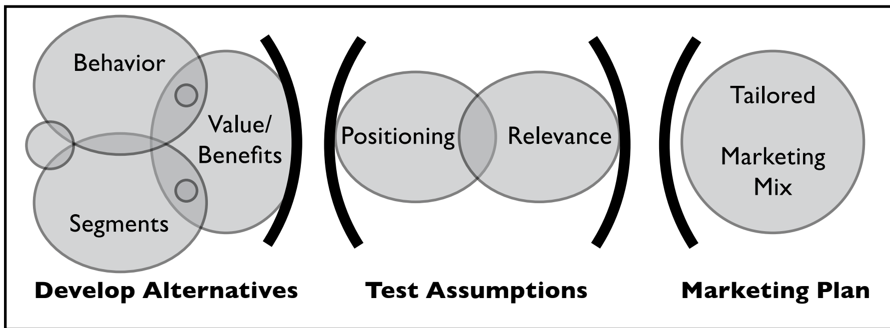

Figure 2. The development process for social marketing strategy.

What distinguishes a marketing approach from other ways of developing interventions is its sole focus on a strategy that delivers a behavior, product, or service that people experience as a value or benefit in their everyday lives. The question the marketing strategist needs to answer is: What is the potential value (benefit) we are offering to people for this new way of meeting their needs, solving their problems, or achieving their goals? Results of literature reviews and surveys can be complemented with face-to-face interactions and conversations with members of the priority group to answer this question. This qualitative research may use anthropological methods, in-depth individual interviews, focus groups or any number of techniques. The outcome of this formative research should be one or more insights that answer the question of "what do they value that is relevant to our objective (of increasing treatment-seeking behavior, for example)" from the priority group's point of view—not according to what the science, policy, or experts might dictate as the right thing to do.

What has been learned about the determinants, context, and consequences of the behavior guides how the value of new products, services, or behaviors is offered to people in ways that fit into their lives, the world around them, and within the resources that are available to them. The strategy needs to link the desired behavior: connecting behavioral health services with what the priority group finds valuable to them, what is feasible for them to do, what opportunities are available to them, and in ways that minimize their costs (financial, time, social and psychological among others). Then, and only then, are communication efforts developed that promote the adoption of the new behavior, product, or service.

The Marketing Plan

The outcome of marketing strategy development is the marketing plan. A social marketing plan is a translation document that considers:

1. The understanding of the problem
2. The context in which the intervention will take place
3. Organizational strengths and competencies
4. Implementers' and partners' capabilities
5. Behavioral determinants of the problem and potential solution
6. Priority group insights

The marketing plan delivers program ideas and approaches to achieve changes among members of priority groups, or segments, and also details the tactics for using the resources available to capitalize on the most vital opportunities and insights from the priority group. To create a marketing plan, the following questions should have clear answers:

Who is (are) the priority group(s)—and what segments within each group are the focal point for the program? For example, are all SOF members the same, or are there different issues and problems that need to be addressed based on rank, gender, civilian or deployment status, length of service, whether they are in support roles, or members of the behavioral health team? The specificity of how priority groups are defined allows the program designer to then articulate the remaining questions and tailor how the program will be desirable, relevant and useful for each one.

What do they do? Specificity of target behaviors is important as programs that set out to encourage self-reporting of behavioral health issues, seeking treatment, or eliminating discriminatory behaviors may have different behavioral targets depending on who is being asked to do something. For example, behaviors associated with encouraging treatment-seeking will be different for various priority groups noted above while those behaviors associated with supporting continued use of behavioral health services are likely different as well. If the formative research is done well, and the marketing strategy well thought through, then these behaviors should be selected because they are high leverage, relatively easy to do, and supported by the social and physical environment in which people live and work. Specifying the behaviors should also be used to guide monitoring and evaluation activities. If there are social and/or structural barriers to engaging in the behavior, then perhaps these issues should be addressed first or initiatives to address them be integrated into the marketing plan.

How will they do it? The process by which people in these different priority groups will incorporate new behaviors into their lives, or stop practicing others, needs to be understood from their point of view, not just in theory. Creating a journey map with representatives of each of these priority groups can help identify the decision points (where, when, and with what resources) that might influence their engagement in behaviors. A journey map can also identify some of the social or structural constraints that may need to be addressed by the program as well.

When are the best times for them to do it? The plan should specify particular times when people may be more open to engaging in new behaviors. Depending on the circumstances and behaviors, these times may present better access to opportunities, may be in a certain frame of mind when the behavior is more relevant, may be certain times in which these new behaviors become more salient to them, or particular moments in their daily lives when adopting the new behavior can become part of established patterns.

Where are the best places for them to do it? Even if people want to engage in new behaviors or discontinue other ones, or whether they have access to products and services to help them do it, the physical resources must be available to do so. Strategies to increase opportunities to practice new behaviors, or increase access and accessibility to services and resources,

can also include opportunities to remind them, facilitate engagement and provide support if it needs to be addressed. For behavioral healthcare, place strategies may start with convenient physical access, but may also expand to identify other critical places where, in an SOF member's daily living and work routines, they may come in contact with POTFF staff or initiatives that can be used to connect them with behavioral healthcare (so-called "cross-marketing opportunities"). The admonition to "Just do it!" may make great advertising copy or campaign slogans, but it is not a marketing plan. The environment should be designed to make choices for behavioral healthcare the easy and ubiquitous one for those that may need it.

How much will they be rewarded by new behavior, or how much will it cost them? The marketing plan should address the most relevant incentives and costs that people in each priority group associate with the offering. Note that tangible rewards or incentives are not the same as the internal benefit or value people attach to the behavior, product, or service. In the absence of any internal motivation, using incentives or rewards can become a problem as they lead to short-term adoption and then rapid discontinuation of new behaviors, products, or service—a situation referred to as over-justification or crowding-out effect.[22] This is why the earlier admonition to tap into existing motivations or values is important to successful change efforts.

Why would they do it? This question needs to be answered from the perspective of those in each priority group, and it should be addressed through the program's positioning strategy. The positioning for the program answers the question for the priority group of how new behaviors are different and better from what they currently do or could do instead (are they as feasible as current behaviors, relevant to their daily life, and perceived as superior in some way to current behaviors). Therefore, the question of "why?" can be partly answered by positioning a behavior, product or service as a more satisfying resolution to a need, a better solution for a problem, or an advantage in achieving particular professional or family goals. Positioning can also answer the question by offering lower costs or a higher tangible value as well as being easier or more convenient than current ways of doing things. Finally, the "Promotion P" can be used to provide information to enable or support decision-making by directly addressing the question of "why" and the pros and cons for engaging in the behavior.

Who is going to implement the program elements? A clear outline of responsibilities needs to be detailed and agreed upon. One weakness of some plans is that they presume that people, organizational units, or partners will take on certain responsibilities, for example providing a service, using the materials in their own programs, distributing products to their clients, or constituencies or committing resources to the project. At other times, the program will impose additional burdens on staff that are not offset by reducing other ones or at least recognizing what these might be and how to mitigate them. The most successful marketing organizations are those in which the implementation staff is also a priority group (critical to success). For example, how POTFF encourages and supports many different types of service delivery agents—chaplains, social workers, psychologists, senior leadership, peer mentors, and teammates—who have different expectations for their role in improving the resiliency of SOF and their families, can be addressed through a social marketing approach.

Social Marketing and Other Health Promoting Strategies

Some professionals are concerned that social marketing is a radical, and exclusive, way to think about, plan, and implement health promotion programs such as ones offered by the POTFF. However, the prescription for effective planning of social marketing programs bears a remarkable similarity to health promotion scholars' conceptualization of effective practice. Consider the ten principles for health promotion programs put forth by Freudenberg et al.[23] Effective programs, or interventions, should:

1. Be tailored to a specific population within a particular setting.
2. Involve the participants in planning, implementation, and evaluation.
3. Integrate efforts aimed at changing individuals, social and physical environments, communities, and policies.
4. Link participants' concerns about health to broader life concerns and to a vision of a better society.
5. Use existing resources within the environment.
6. Build on the strength found among participants and their communities.

7. Advocate for the resources and policy changes needed to achieve the desired objectives.

8. Prepare participants to become leaders.

9. Support the diffusion of innovation to a wider population.

10. Seek to institutionalize successful components and then replicate them in other settings.

Indeed, many of these principles for effective health promotion programs are equally relevant to POTFF's initiatives. In particular, an emphasis on involving people from the priority group in planning and implementation, integrating efforts across different levels of the USSOCOM enterprise, utilizing assets and resources already available in the setting and among the priority group, and encouraging diffusion and sustainability are reminders that the successful program designer and manager will hold to closely. Social marketing is a strategic process for planning change programs at the individual, interpersonal, organizational, normative, and policy levels. It is through incorporating people's perspectives, and applying behavioral and social theories of change, that POTFF can develop innovative, evidence-informed, and people-tested programs.

In the rest of this inquiry, a social marketing lens is applied to the many policy, research, and practice-based approaches that have been undertaken to address suicide prevention, stigma reduction and seeking BHC.

2. Background and Overview of the Problem

Historically, the rate of suicides among active duty military personnel has been significantly lower than the rate for a comparable population of Americans. However, since 2001 these rates have risen to the point where members of the armed forces are at higher risk for suicide than the general U.S. population.[24,25] Suicide rates began to increase in 2006, driven primarily by a steady upward trend in the number of suicides in the Army and Marine Corps. In 2009, the Department of Defense (DOD) identified 309 total active duty suicides, for a rate of 18.3 per 100,000. The number of suicides has climbed among service members in the Reserve Component, and by 2010 there were 180, with the Army National Guard having the largest increase in the total number.[26] Recent data from the Department of Veterans Affairs indicates that, on average, 20 veterans a day die from suicide. This rate of suicide is 21 percent greater than it is for a civilian population of comparable age and gender.[27]

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One research review found that service members most frequently used firearms as the means for suicide.[28] Drug overdose was the most frequent method for suicide attempts, and the misuse of prescription medication was more frequent than illegal drugs. Most service members were not known to have communicated their potential for self-harm with others prior to suicide or attempted suicide. The majority of service members who died by suicide did not have a known history of a mental or substance use disorder. Finally, the overwhelming majority of suicides occurred in a non-deployed setting, and more than half of those did not have a history of deployment. However, rates increased among two important groups: veterans who recently returned from service in Afghanistan and Iraq, and those who receive health care services from the Veterans Health Administration.

In its own analyses of these trends, USSOCOM found that from 2012 to 2013, Conventional Forces (CF) suicides decreased from 22.7/100,000

to 18.7/100,000. However, the CF rate showed a slight increase in 2014 to 19.9/100,000. Among SOF there has been a 26 percent decrease in suicides over the same time period (per DOD policy, the number of suicides per year that are less than 25 do not use the per 100,000 comparison rate). SOF suicides have not been more than 25 per year since tracking began in 2007.[29]

Suicide prevention among SOF has the highest levels of attention and concern: the author considers preserving the force and families the SOF community's highest priority. The success of any mission depends on people. While the command has seen a steady decrease in suicides over the past four years, the authors' focus on this problem will not waver. The author hopes to achieve a command climate that views behavioral healthcare as a normal and expected aspect of personal and professional development.[30]

USSOCOM POTFF is charged with building and implementing a holistic approach to address the pressure on the force and families in order to maintain and improve readiness, operational effectiveness, and the immediate and long-term well-being of SOF.[31] POTFF initiatives were developed in response to clear demand signals from the SOF units and components that have been under unprecedented levels of stress during the past few years stemming from the high frequency of combat deployments, high-stakes missions, and extraordinarily demanding environments. An integrated, embedded care model is used to maximize access and minimize stigma to: (1) improve the cognitive and behavioral performance of the force (psychological performance); (2) meet the unique physical needs of SOF operators and maintain their peak performance throughout their careers (human performance program); (3) incorporate family resilience programs to enhance service-provided programs and adapt them to meet the unique needs of the SOF family (social and family performance); and (4) enhance core spiritual beliefs, values, awareness, relationships and experiences (spiritual performance).

POTFF initiatives build upon and complement service programs and are designed to supplement the capacity of service-provided programs by accelerating delivery and standardizing access across the SOF enterprise. All of the initiatives are designed to foster a culture of health and wellness where problems are addressed early and without fear of repercussion or embarrassment. This study supports USSOCOM and POTFF research interests in mitigating SOF suicides through better understanding of susceptibility and risk factors and also addressing the stigma associated with seeking medical

and mental healthcare for SOF. This report reviews relevant research and examines how a social marketing approach—a model for developing large-scale change initiatives in public health and other disciplines—can be applied to improving suicide prevention initiatives.

Current Efforts: DOD and United States Department of Veterans Affairs (VA)

A review by the United States Government Accountability Office (GAO) identified recent milestones in efforts by the DOD and VA to prevent suicide and reduce mental health stigma among military and veteran populations.[32] These milestones are summarized in Table 1.

The Deputy Assistant Secretary of Defense for Readiness leads a collaborative effort across the DOD to address suicide. The *Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces* has served as a catalyst for the DOD to review and assess all policies and programs that relate to suicide prevention. Based on the report and the action plans developed from it, a departmental implementation memorandum was signed by the Under Secretary of Defense for Personnel and Readiness in September 2011 to guide the DOD's ongoing efforts.[33]

Established in November 2011, the Defense Suicide Prevention Office (DSPO) is part of the DOD's Office of the Under Secretary of Defense for Personnel and Readiness. DSPO oversees all strategic development, implementation, centralization, standardization, communication, and evaluation of DOD suicide programs, policies, and surveillance activities. To reduce the impact of suicide on service members and their families, DSPO uses a range of approaches related to policy, research, communications, and behavioral health. DSPO works closely with the Army, Navy, Air Force, Marine Corps, Coast Guard, and National Guard Bureau, as well as other governmental and nongovernmental agencies, to support Service members and strengthen a resilient and ready force. DSPO strives to help foster a climate that encourages Service members to seek help for their behavioral health issues.[34]

A core emphasis of DOD suicide prevention and behavioral health programs is "reducing stigma." The DOD Task Force on the Prevention of Suicide by Members of the Armed Forces noted: "The roots of stigma are anchored in stereotypes—generalizations perceived to be accepted by the population at large—such as 'people with mental health problems are crazy'

Table 1. Milestone Reports of Suicide Prevention and Reducing Stigma Associated with Mental Health in the Military

2007 DOD Task Force on Mental Health. This report states that maintaining psychological health, among other things, is essential to maintaining a ready and fully capable military force; however, stigma in the military remains pervasive and often prevents service members from seeking needed care. Available at: http://justiceforvets.org/sites/default/files/files/Dept of Defense, mental health report.pdf
2008 RAND Corporation Study: *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* This study addresses, among other things, gaps in knowledge about the mental health and cognitive needs of service members returning from Afghanistan and Iraq, the adequacy of the care systems available to meet those needs, and factors, such as stigma, related to whether and how injured service members and veterans seek care. Available at: http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.pdf
2010 DOD Task Force on the Prevention of Suicide by Members of the Armed Forces. The final report of this congressionally mandated task force includes 76 recommendations, including developing a comprehensive stigma reduction campaign plan that attacks the issue of suicide prevention on multiple fronts to encourage help-seeking behavior and normalizes the care incurred by service members. The report stated that DOD's challenge to preventing suicide and sustaining suicide prevention efforts involves addressing the large set of psychological, physical, spiritual, emotional, relational, environmental, occupational and social stressors that exist in a person's life, as well as building resiliency and reducing stigma, which influence the impact of those stressors. Available at: http://www.sprc.org/sites/default/files/migrate/library/2010-08_Prevention-of-Suicide-Armed-Forces.pdf
2011 RAND Corporation Study: *Promoting Psychological Resilience in the U.S. Military.* This study found that without strong leadership, military resilience programs designed to help encourage and support service members in their capacity to adapt successful to risk and adversity cannot be successful. Leadership can play a pivotal role in creating a command climate in which it is okay to get help for psychological health concerns. However, current policy could promote cultural attitudes and beliefs that inhibit acknowledging problems and seeking mental health care. Available at http://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG996.pdf
2013 Institute of Medicine of the National Academies report: *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families.* This report states, among other things, that stigma is a problem for military personnel receiving care or seeking care for mental health or substance abuse problems. According to this report, active duty service members fear that visiting a mental health care provider will jeopardize their careers because of the military's long-standing policy of reporting these types of problems through the chain of command. Available at: http://nationalacademies.org/hmd/~/media/Files/Report Files/2013/Returning-Home-Iraq-Afghanistan/Returning-Home-Iraq-Afghanistan-RB.pdf
2014 RAND Corporation report: *Mental Health Stigma in the Military.* This report contains six findings from a content analysis of DOD policies, including identifying policies that may expose service members to stigma or discrimination because they allow non–mental health professionals to determine mental health fitness. Available at: http://www.rand.org/pubs/research_reports/RR426.html

and 'Service Members who seek behavioral healthcare are weak.'"[35] However, the GAO found that while the term "stigma" is prevalent throughout DOD documents and policies, there is little specificity on what the term means or the behaviors that might be associated with it. Despite this lack of specificity, the GAO identified numerous stigma reduction efforts launched by the DOD including programs and awareness campaigns to change perceptions, develop skills to cultivate personal resilience, and increase mental health coping and awareness skills. Other DOD programs have encouraged help-seeking behavior through training and education on the benefits of mental health care and dispelling myths (for example, the Real Warriors campaign in 2009 that featured benefits of help-seeking through personal stories of successful outcomes from treatment).[36] Based on the results of the Wave III Needs Assessment, POTFF recently concluded that increasing attention on social connectedness might also contribute to strengthening the resilience of SOF.[37]

The VA's suicide prevention program is based on the principle of ready access to high-quality mental health services within the health care system, supplemented by (1) public education and awareness activities promoting engagement for those who need help, and (2) availability of specific services addressing the needs of those at high risk. Activities have included:

1. Creating a national office for suicide prevention
2. Partnering with the Substance Abuse and Mental Health Services Administration and its Lifeline program to add a veterans' call center to its national 800-273-TALK/8255 crisis line
3. Funding suicide prevention coordinators with support staff in each VA medical center
4. Ensuring same-day access for veterans with urgent mental health needs at over 1,000 points of care by the end of calendar year 2016
5. Improving case management and tracking[38,39]

External Evaluations of DOD Stigma-Reduction Activities

The suicide prevention activities of the DOD and VA have undergone several independent reviews over the past few years. These reviews are notable

for the attention they draw to key aspects of suicide prevention activities in the military that are applicable to POTFF initiatives. One major finding from these reviews is that while there is significant focus on reducing the stigma associated with help-seeking and mental illness, there are significant shortcomings. For example, GAO identified and reviewed 13 DOD, service, and joint staff policies that mention "stigma" with regard to mental health care. Although each of the policies reference stigma reduction as a goal or as something to be dispelled or countered, all but two policies used "stigma" as a standalone term with little specificity as to its causes, or how it could be manifested and observed in behaviors or in policies. Its review found that the DOD has not developed a clear and consistent definition for the concept of mental health care stigma, explanations of contributing causes or risk factors for stigma and mental health care, and how stigma is embedded through behaviors and policies. The GAO also noted that DOD did not have goals or performance measures to track progress in reducing barriers or stigma and that inconsistent methods are utilized to measure stigma across multiple DOD and service-sponsored surveys, making it difficult to examine trends over time and determine the effectiveness of stigma reduction efforts.[40]

Without clarity and consistency in the definition of those barriers to care that the DOD understands as mental health care stigma, including the causes or contributing risk factors and ways that stigma is evident through behaviors and policies, the GAO concluded that there may be stakeholders across the department who do not fully understand the concept of stigma to then recognize and take steps to reduce it. Further, the lack of operational definitions means that the department cannot develop specific goals and measures with which to evaluate its initiatives and progress toward reducing stigma.

> Together, the absence of a clear and consistent definition of those barriers to care that DOD generally understands as "mental health care stigma," related goals and measures for reduction of stigma-related barriers to care, and a coordinating authority with oversight prevent the department from positioning itself to evaluate progress and demonstrate efficacy and results from its initiatives.[41]

This lack of specificity of targets or outcomes for stigma-reduction efforts was also discovered in a report on five stigma-reduction programs, three of which were DOD-wide: Military Pathways, Afterdeployment.org, and the Real Warriors Campaign. The remaining two, Breaking the Stigma and

Embedded Behavioral Health (EBH), were Army programs. Acosta et al found that the evaluations lacked the rigor, comprehensiveness, or specificity needed to determine whether these programs are effective.[42] Although each of the five programs collects data, the metrics are largely process measures, such as website visits and satisfaction surveys. These process data are helpful in ensuring that the programs are being used, but they do not provide information on whether the programs are effective in reaching the intended priority groups, reducing stigma or increasing treatment-seeking among those in need of services. The next chapter looks at various definitions and approaches to conceptualizing stigma.

3. What is Meant by "Stigma"

The vast majority of efforts within the DOD and VA, as well as in many efforts directed towards civilian population groups, focus on reducing stigma around mental health problems and treatment-seeking behaviors. However, as noted by the GAO, what constitutes stigma in an operational sense—that is, the observable behaviors and barriers that exemplify 'stigma'—is often missing. Indeed, one GAO recommendation to the Secretary of Defense was to establish a clear, consistent definition of those barriers to care generally understood by DOD as "mental health care stigma." The recommendation also encouraged an articulation of the presumed causes or contributing risk factors of stigma and ways that stigma is apparent in behaviors and policies. A corollary to this recommendation was also to establish goals for initiatives understood by DOD as "stigma reduction efforts," and design performance measures that link to these goals.[43]

The GAO analysis of the most recently available data from a DOD-wide survey found that about 37 percent of active duty service members in 2011 and 39 percent of reservists in the 2010/2011 timeframe responded that they thought seeking mental health care through the military would probably or definitely damage a person's career. Among active duty service members, 22 percent believed their career was affected somewhat negatively or very negatively because they sought counseling or mental health care treatment.[44] Service-sponsored surveys and comments from 26 focus groups conducted by the GAO with service members and with civilian employees of DOD who have deployed or were preparing to deploy reinforced perceptions of stigma about seeking mental health care. Some of their most prevalent specific concerns included: (1) being associated with "malingering," (2) possibly losing job qualifications such as a security clearance or the ability to carry a weapon, and (3) having to live up to the competitive military image.[45] GAO's review of DOD-wide surveys also found that none of them measure deployed civilians' perceptions of mental health care, including stigma. As a comparison, in the POTFF Wave III survey, 5.7 percent of active duty SOF reported beliefs such as "worried about effect on career/clearance," "embarrassed," "leadership will ruin career/poke fun," and negative stigma as reasons for

not accessing BHC.[46] How these specific beliefs are distinct from "negative stigma" was not addressed in the report.

The National Academies of Sciences, Engineering, and Medicine, in a report evaluating the evidence for stigma change, defined stigma as the relationship between an attribute and a stereotype that assigns undesirable labels, qualities, and behaviors to a person. These labeled individuals are socially devalued leading to inequality and discrimination.[47] Further, stigma is a dynamic multi-dimensional, multi-level phenomenon that occurs at three levels of society—structural (laws, regulations, policies), public (attitudes, beliefs, and behaviors of individuals and groups), and self-stigma (internalization of negative stereotypes). Articulating stigma as being a structural concern; one of public attitudes, behaviors and norms; and being centered within the individual's beliefs system leads to very different approaches to measuring and reducing it.

A review of mental health stigma in the military by the RAND Corporation referred to mental health stigma more narrowly as a dynamic process by which a service member perceives or internalizes this brand or marked identity about himself or herself or people with mental health disorders—what the National Academy of Sciences' (NAS) report referred to as "self-stigma." The researchers suggest that this process happens through an interaction between a service member and the key contexts in which the service member resides.[48]

Taking the next step, they proposed a conceptual model that operationalizes their definition of stigma by linking it to the key contexts that create stigma—the public context, the military context, a social context, and the individual context—and the empirically and theoretically derived impacts of stigma (see fig. 3). Four short-term impacts were empirically linked to stigma:

- interpersonal outcomes (e.g., self-esteem),
- coping mechanisms (e.g., hide, withdraw),
- negative attitudes toward treatment-seeking, and
- lowered intentions to seek treatment.

A second set of five long-term outcomes are theoretically linked to stigma: (a) well-being, (b) readiness, (c) quality of life [e.g., productivity], (d) treatment-seeking, and (e) treatment success. However, the investigators were unable to find research evidence that directly links these long-term outcomes to stigma. One of their conclusions was that "despite popular opinion and a

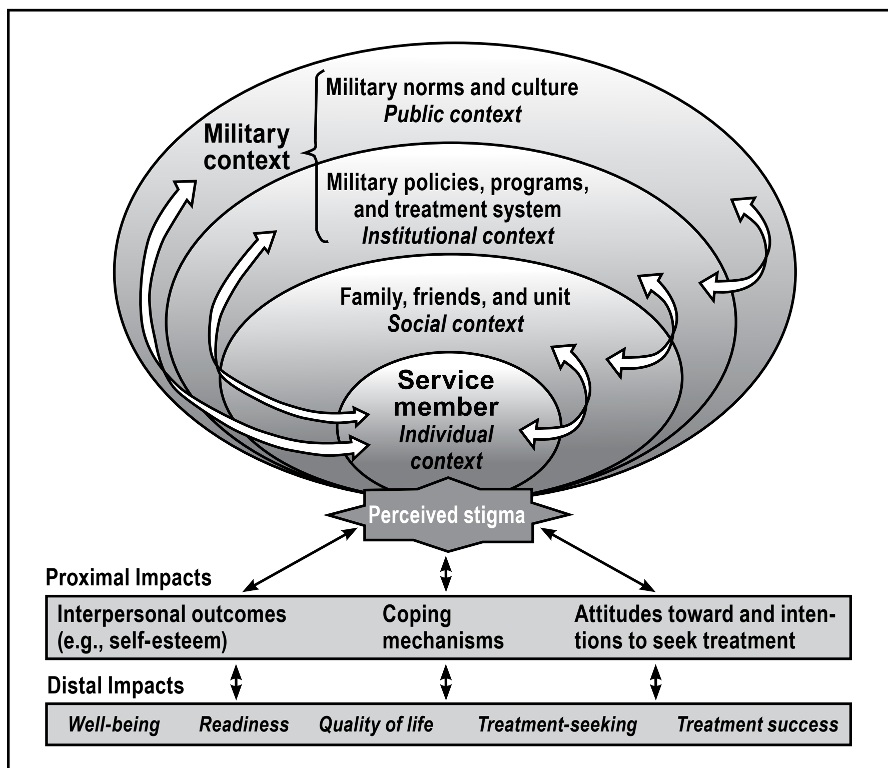


Figure 3. A conceptual model for stigma reduction in the military[49]

strong theoretical base that stigma deters treatment-seeking, we were unable to identify empirical literature to support this link."[50] They did note that a variety of other factors, including the availability of providers and time off of work to seek care, might affect whether intentions to seek treatment translate into actual behavior. Using the NAS model, these factors could be construed as evidence of structural stigma whose mitigation may, or may not, be reflected in one's perception of "stigma." Another review of the research literature attempting to relate mental health-related beliefs, including stigma, to treatment-seeking behaviors among military and veteran populations found that stigma may play a less substantive role in predicting treatment-seeking than personal beliefs about mental illness and its treatment.[51]

Corrigan has been a leading advocate for the idea that stigma is related to the avoidance of treatment-seeking for mental health concerns.[52] He proposes that stigma is one of several reasons why people make such choices;

people are motivated to avoid the label of mental illness that results when people are associated with mental health care. That is, it is the expectations of negative future consequences from being labeled as mentally ill that propels both treatment avoidance and the denial of symptoms. This process of stigmatization involves four processes: cues, stereotypes, prejudice, and discrimination. Corrigan cites literature showing that many people infer mental illness in others from four cues: psychiatric symptoms (inappropriate emotional responses, 'bizarre' behaviors), social-skills deficits (inability to carry on a conversation with others), physical appearance (being disheveled or unkempt), and labels (they must have a 'mental problem'). Such cues may not be accurate in distinguishing people with true mental illness from those who are not (for instance, some people may be very good at concealing their symptoms), but the heuristic of the first three cues often produces the label that leads to stigma. The label becomes reinforced when a health care provider applies a mental illness label to them, or that person is seen in close association with other evidence of 'mental illness'—being with other known people with mental illness, or coming out of a psychologist's office. Stigma elicits stereotypes that are socially learned by people about various categories of people and can be strengthened or mitigated by the social norms and organizational policies that reflect and support them.

This process of stigmatization involves four processes: cues, stereotypes, prejudice, and discrimination.

However, simply having a negative stereotype of a person with mental illness is not stigma.[53] Stigma arises when the stereotype of a person with mental illness leads to prejudicial attitudes with a negative emotional, or judgmental, component. It is this negative stereotype plus the emotional response that leads to behavioral reactions that he refers to as discrimination—usually negative actions including avoidance of associations and interactions with the person. Stigma is the observable, behavioral response to the cues, stereotypes, and prejudices of people to those labeled as 'other' (mentally ill in this example). Thus stigma is manifested by the reactions of others, *not* by the perceptions or reactions of the person. Someone who believes that they will suffer negative consequences for their BHC seeking behaviors is not stigmatized in Corrigan's view. It is the reactions of their peers, family members and others that create stigma. From this point-of-view, decreasing

barriers to BHC does not reduce stigma; reducing consequences of seeking BHC does.

This model for the development of stigma has been incorporated into many evaluations of stigma reduction programs. Corrigan et al[54] report that these studies assume a linear model, depicted in figure 4, in which attitudes and stereotypes lead to emotional responses and prejudices that result in avoidance behaviors.

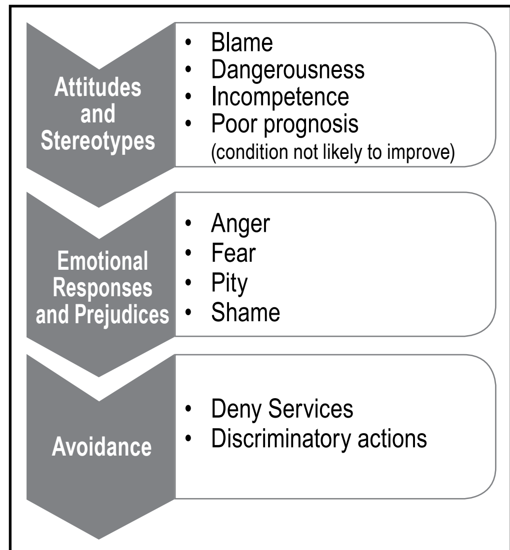


Figure 4. A model for the development of stigma used to guide many stigma reduction programs and their evaluation.

Yet, in their review of 79 studies to reduce stigma, Corrigan et al[55] found few that observed, measured, and reported changes in discriminatory actions or behaviors. The most typical outcomes of these studies are attitudinal or emotional changes and perhaps change in self-reported intentions to behave differently.

Corrigan also makes a distinction between "public stigma," what a naive public does to the stigmatized group when they endorse the prejudice about that group, and "self-stigma"—what members of a stigmatized group may do to themselves if they internalize the public stigma.[56] While public stigma will deprive people of social and career opportunities through the actions of others, self-stigma impacts the labeled person's sense of self, or self-esteem. Avoiding self-stigma may be a critical driver for people to avoid seeking treatment and the consequences of labeling that then unfold, including the experience of shame. Indeed, much of Corrigan's later work has focused on combatting the element of self-stigma through the Coming Out Proud approach[57,58] that will be reviewed in greater detail in chapter 4.

Recent literature on stigma articulates three major interrelated types touched on in this section: structural (laws, regulations and policies), public (attitudes, beliefs, behaviors as described above), and self-stigma

(internalization of negative stereotypes). Another type of mental health stigma is referred to as "courtesy stigma" that is directed towards family and friends of those with a mental or substance use disorder (see fig. 5). People may avoid being labeled with a behavioral health problem or seeking treatment because of concerns about resulting discrimination due to existing laws or policies (structural stigma), social rejection and other negative reactions (public stigma), reflections that help-seeking may have on family and friends (courtesy stigma), and the undermining of self-esteem (self-stigma). While there is no empirical evidence for which types of stigma may be more prominent, it is generally acknowledged that each type of concern can influence the decision to seek help for one's self or others.[59]

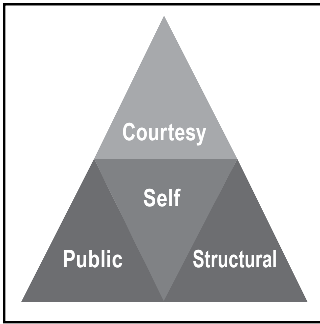


Figure 5. Four forms of stigma.

This review of how stigma is conceptualized is important in discovering ways forward to increase treatment-seeking behaviors and to reduce suicides in USSOCOM. There are two contrasting views of stigma: one approach views stigma as primarily residing in the person in response to interactions in his/her environment[60] while the other sees stigma as primarily an attribute of one's social environment.[61] The former viewpoint might be better described as 'self-stigma'—one of at least four types of stigma that may require different articulations of their associated determinants, behaviors, and solutions (see fig. 5). Yet, from a social marketing vantage point, there is little research evidence that stigma, however defined, leads to avoidance of treatment or that stigma reduction programs lead to changes in behavior. It is also clear that in theory, research, and program evaluations, objective and observable behaviors of what constitutes stigma are often lacking. This lack of explicit behavioral objectives and measurement constitutes a vital missing link in designing effective programs and policies. What is clear is that stigma is just one of several pathways that may lead to the avoidance of labeling and treatment. Other possible pathways are presented in the next chapter.

4. Other Factors that Contribute to Avoidance of Treatment-Seeking Behaviors and Suicide

As noted in the last chapter, several recent reviews of the relationship of mental health stigma to treatment-seeking behaviors find the evidence is insufficient to conclude that stigma is a singular determinant of treatment-seeking behavior for mental illness or suicide.[62-64] Yet, stigma seems to remain the target for most DOD suicide prevention efforts. For example, the RAND report on developing a strategy for suicide prevention in the DOD made a number of recommendations to enhance and refine stigma reduction efforts. Although "stigma reduction" was referred to throughout this document, there was no attempt to define what was meant by the term. RAND recommendations include:

1. Explore interventions that directly increase treatment-seeking. Focusing primarily on a single barrier to care, such as stigma, may neglect other potential interventions to increase treatment-seeking and reduce barriers to mental health care.

2. Consider evidence-based approaches to empowering service members who have mental health concerns to support their peers.

3. Design new or adapt existing intervention and delivery mechanisms to minimize operational barriers for service members seeking treatment. Especially noted here were programs that could appeal to service members with a preference for self-management.

4. Embed stigma-reduction interventions in clinical treatment.

5. Implement and evaluate stigma-reduction programs that target service members who have not yet developed symptoms of mental illness.

6. Provide better guidance for policies in which a mental health disorder (MHD) or treatment prohibits job opportunities or actions. A large number of the policies we reviewed prohibited specific job opportunities or actions if a service member had an MHD or sought mental

health treatment. For many of these policies, the language is unclear, stating only that a service member is prohibited if he or she has a mental health issue. It is imperative that DOD provide additional guidance that clarifies what is meant by having a mental health issue and that is more attentive to the continuum of mental health.

7. Continue to improve and evaluate the modifications made to existing programs that begin to address stigma and other barriers to care.[65]

As suggested by the first recommendation, shifting from a singular focus on stigma may enhance suicide prevention efforts. These other facets of the problem are the focus of this section. Having a broad understanding of the factors that increase or reduce treatment-seeking behaviors and suicide are important to then explore how to enhance existing POTFF initiatives and design new ones using social marketing principles.

If mental health stigma is to change among military forces, one question that arises is: Can perceptions of mental health stigma, however they are measured, change? Data concerning the stability of mental health stigma over time was tracked as part of the fourth cohort of the Marine Resiliency Study (n=892).[66] In this cohort, perceptions of mental health stigma were assessed with the Barriers to Care scale at 1 month pre-deployment and at 1, 5 and 8 months post-deployment. The 6-item stigma subscale included the following items to which respondents could respond on a 5 point scale with 1="Strongly Disagree" to 5="Strongly Agree:"

- It would be too embarrassing.
- It would harm my career.
- Members of my unit might have less confidence in me.
- My unit leadership might treat me differently.
- My leaders would blame me for the problem.
- I would be seen as weak.

The investigators found that perceptions of stigma were low and fairly stable, with a slight decrease noted over time. Among covariates of changes in perceptions of stigma, at least one mental health visit in theater did not predict the stability of perceptions of stigma over time, while lower PTSD symptoms and greater perceived vertical and horizontal cohesion predicted decreases in perceptions of stigma. This latter finding, they note, is consistent with other research that has demonstrated the importance of cohesion and

leadership in mitigating stigma. It should also be noted that this research tracked perceptions of stigma (self-stigma) and not any of the external cues or behaviors that would be indicative of structural, social or courtesy stigma.

Acosta et al analyzed data from the Army's Mental Health Advisory Team surveys and found indications that there may have been declines in stigma over time and differences across populations of Operation Iraqi Freedom (OIF) soldiers.[67] Even though OIF soldiers seeking mental health treatment reported higher perceived levels of stigma, subsequent regression analysis showed that stigma did not predict initiation of treatment-seeking. The author noted that one of their expert panelists was not surprised that "changes in knowledge and attitudes [which are two of the key outcomes targeted by stigma-reduction programs] do not result in changes in behavior." The expert proceeded to reference a large body of research on prevention programs that suggest that explicit behavioral changes need to be specified, modeled, and practiced before behavior can be expected to change.[68] Indeed, when the researchers used microsimulation models to estimate the effect of decreasing or eliminating mental health stigma entirely they discovered that it would not significantly increase the number of service members seeking mental health treatment.

There has been remarkable progress in reducing stigma to seeking treatment for behavioral health problems in many branches of the military, to the point where stigma may no longer be the determinant to focus on with a social marketing program or POTFF initiatives. This is not to declare victory and move on. For example, Acosta et al found of the 444 DOD policies identified as being related to stigma (or structural stigma), 121 of those policies may contribute to stigma reduction, and 209 policies may contribute to its persistence.[69] Concerns about certain DOD policies that may contribute to mental health care stigma have been long-standing issues identified in DOD-sponsored studies about mental health and suicide prevention. These studies have linked such policies with prevalent beliefs among service members that mental health care will end or limit their careers in the military, and they recommended clarifications and updates. For example, in 2007 the DOD Task Force on Mental Health reported that revisions to command notification policies were necessary to combat stigma caused by perceptions that mental health care services are costly to career progression. More recently, in 2013 the Institute of Medicine of the National Academies recommended that DOD review its policies on mental health care with regard to confidentiality

and the relationship between treatment-seeking and career advancement due to service members' fears that seeking mental health care will jeopardize their career. Changes in policies are vital to eliminating stigma at the institutional level. However, at the social and individual level of SOF, the data lead to the question of whether social marketing might be more usefully employed by POTFF to target other predictors of suicide prevention and treatment-seeking.

Changes in policies are vital to eliminating stigma at the institutional level.

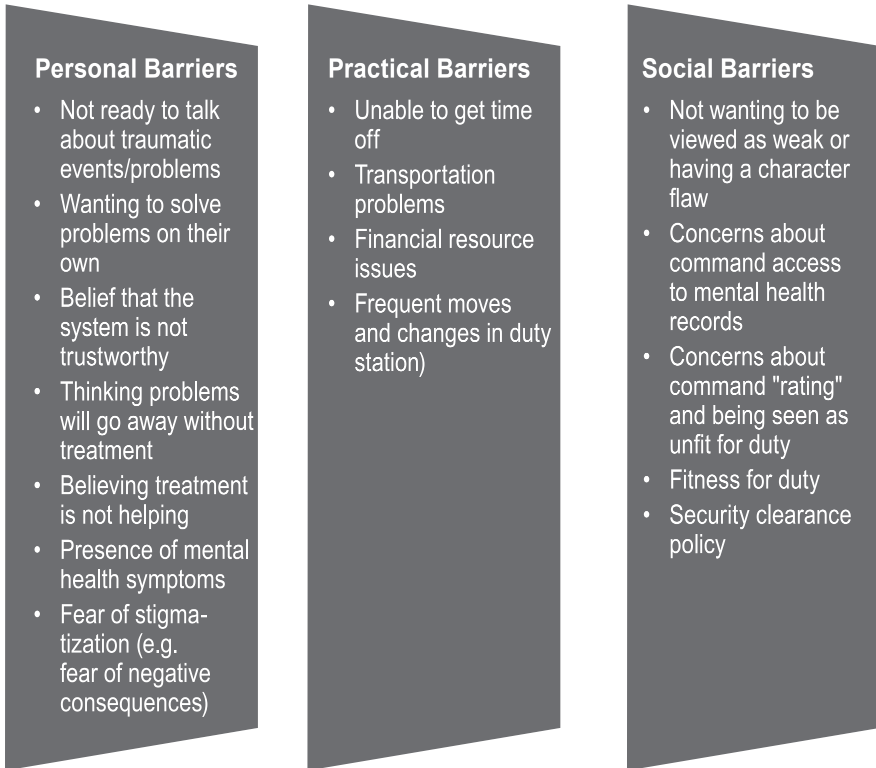


Figure 6. Personal, practical, and social barriers to mental health care for service members

Addressing other Threats to Treatment-Seeking Behavior

Gibbons and colleagues, while still endorsing a view of treatment-seeking behavior largely driven by fear of stigma, presented a model of personal, practical and social barriers to BHC among service members.[70] Figure 6 shows the key issues subsumed under these three categories. What is important in these lists are that none of the barriers concern "stigma."

In another review of literature related to this issue, Vogt looked at 15 articles on beliefs about mental health in regard to service utilization among military and veteran populations.[71] These studies demonstrated that personal beliefs about mental illness and mental health treatment may be the important predictors of service use, not perceptions of stigma. These personal beliefs were:

- Belief that one should be able to handle mental health problems him/herself
- Pride in self-reliance
- Negative beliefs about the nature of mental health care
- Concerns about breaches of confidentiality and documentation of health problems in medical records

Vogt cites one study that found among those who recognized a need for mental health treatment, 45 percent reported perceived lack of effectiveness as a reason for not seeking treatment.[72]

Kim and colleagues examined the role of stigma and negative attitudes about treatment on the utilization of mental health services among soldiers.[73] The investigators conducted a survey of 2,600 soldiers in 2008-2009, 6 months post-deployment from Afghanistan or Iraq. In a factor analysis they identified three distinct clusters of barriers to care: stigma, negative attitudes towards treatment, and organizational barriers (see Table 2). When they looked at how these scales predicted subsequent use of health services, they discovered that stigma and organizational barriers were not predictive of treatment utilization of any type of care. Negative attitudes toward treatment were the only factor associated with treatment seeking. Soldiers endorsing negative beliefs were significantly less likely to report using any type of mental health service. Negative attitudes toward treatment were also associated with less use of military mental health providers. A perhaps not so surprising finding was that increased perceptions of organizational barriers were positively associated with the use of civilian mental health care.

Table 2. Items loading on each of three factors affecting utilization of care[74]

Stigma	Negative Attitudes	Organizational Barriers
It would be too embarrassing. It would harm my career. Members of my unit might have less confidence in me. My unit leadership might treat me differently. My leaders would blame me for the problem. I would be seen as weak. It might affect my security clearance.	I do not trust mental health professionals. My leaders discourage the use of mental health services. Psychological problems tend to work themselves out without help. Getting mental health treatment should be a last resort. A fellow soldier's mental health problems are none of my business. I would think less of a team member if I knew he or she was receiving mental health counseling.	Mental health services are not available. I do not know where to get help. It is difficult to get an appointment. There would be difficulty getting time off work for treatment.

There is also the possibility that mental health related beliefs and their impact on service use may differ across different subgroups of military personnel and veterans (including, for example, women versus men and younger versus older service members). Vogt cites studies showing that: negative attitudes towards treatment seeking are more prevalent among males, public stigma (especially family reactions to seeking treatment) is a stronger predictor of service use among women, and concerns about public stigma and mistrust of the mental health care system is a particular issue among white males.[75]

In their review of interventions to address stigma, Dickstein et al concluded that future efforts aimed at reducing stigma in the military and the VA should focus on five targets: (a) perceptions that care utilization is a sign of weakness; (b) stereotypes about mental illness and mental health diagnoses (e.g., indicative of incompetence, dangerousness, or "craziness"—what might be considered "public stigma"); (c) self-blame (e.g., feeling responsible for having a mental illness); (d) uncertainty about the signs and symptoms of mental illness; and (e) uncertainty about the nature of treatment.[76] Therefore,

while stigma is not meant to be cast aside as unimportant to solving the problem of increasing treatment-seeking behavior and reducing suicides (the behavioral outcomes of most interest), the evidence suggests that there are other important determinants of these behaviors that might be targets for social marketing efforts.

Risk and Protective Factors for Suicide

The National Strategy for Suicide Prevention summarized the literature on known risk and protective factors to guide suicide prevention actions. As shown in figure 7, 9 protective and 10 risk factors are aligned along 4 levels of social ecology: the individual, his/her relationships, community and societal. This is not a comprehensive listing of all risk and protective factors, but these were highlighted in the report for their robustness across different groups of people and contexts.

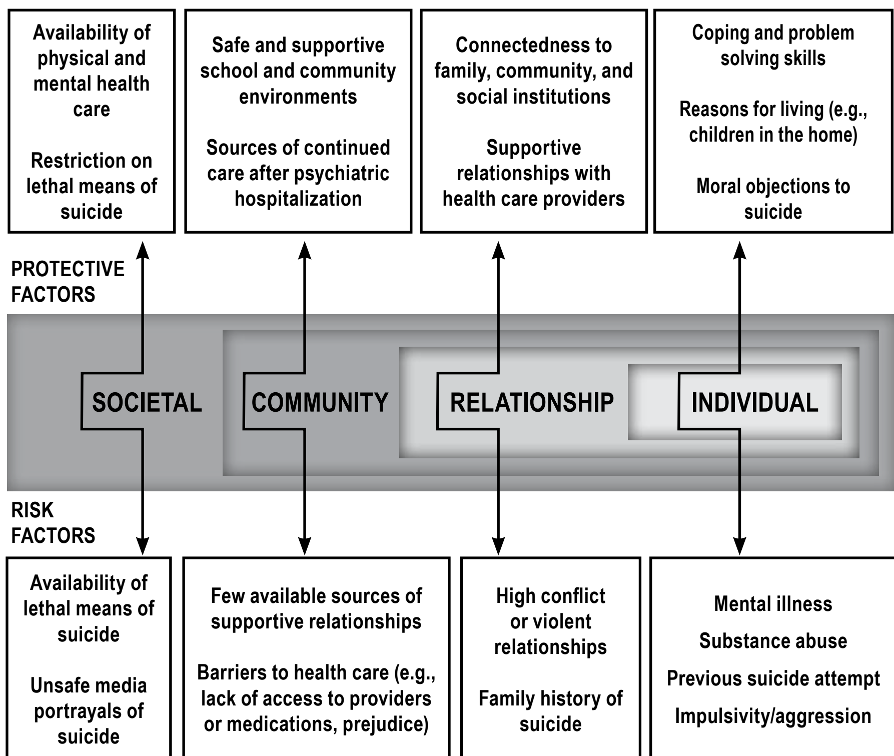


Figure 7. Protective and risk factors for suicide[77]

The strategy also identified a number of population groups that are at an elevated risk for suicide where risk and protective factors may be less salient, or different from those in figure 7. Table 3 presents several of these groups, and their known risks, that should be priority groups for the POTFF.

York et al compiled a set of risk factors for suicide among military personnel and veterans. In addition to the ones above, legal and health problems, high combat stress exposure, long and multiple deployments, exposure to traumatic events, availability of weapons, skills using firearms, and relationship or financial problems were found to be risk factors for suicide among veterans.[79] In another study of all active duty military personnel, mental health diagnoses (especially TBI, PTSD, and depression), suicidal ideation, suicide attempts, mental health visits, prescriptions of selective serotonin reuptake inhibitors, sleep prescriptions, deployed time in Operation Enduring Freedom or Operation Iraqi Freedom, reduction in rank, enlisted rank, and separation or divorce were associated with elevated suicide risk.[80]

Despite a large number of risk and protective factors identified by researchers, it is not yet possible to predict who will attempt or complete suicide.[81] The inability to identify individuals most in need of interventions is one of the reasons a public health approach with a focus on force-level interventions is necessary for effective suicide prevention. However, as noted earlier, programs that focus on at-risk population groups, as well as clinical interventions for those identified at high risk, should integrate with and support population-wide approaches.

Group	Surveillance Data
Members of the Armed Forces and Veterans	For calendar year 2010, service members who were white and under the age of 25, junior enlisted (E1–E4), or high school educated were at increased risk for suicide relative to comparison groups in the general population. Service members most frequently used firearms as the means for suicide, while prescription drug overdose was the most frequent method for suicide attempts. Most service members were not known to have communicated their potential for self-harm with others prior to suicide or attempted suicide. The majority of service members who died by suicide did not have a known history of a mental or substance use disorder. Finally, the overwhelming majority of suicides occurred in a non-deployed setting, and more than half of those who died by suicide did not have a history of deployment.
Individuals Bereaved by Suicide (or survivors of suicide loss)	It has been estimated that a successful suicide affects at least five or six family members and up to 30 to 60 people in that person's larger social network. These survivors may have an increased risk of suicide themselves. Research suggests that many of these individuals may not know where to find services and/or have difficulty in seeking help.
Traumatic Injuries of the Central Nervous System	Spinal Cord Injury (SCI): People with SCI attempt suicide more frequently than those in the general population. As many as 45 percent of people with SCI are diagnosed with depression following a traumatic spinal cord injury, and 10-13 percent of SCI patients suffer from anxiety and high levels of post-traumatic stress disorder. TBI: People with TBI have an increased risk of death by suicide (three to four times greater for those with severe TBI), a higher frequency of attempts, and 21-22 percent have clinically significant suicidal ideation.
Individuals With Mental and/or Substance Use Disorders	Mental and substance use disorders are widely recognized as important risk factors for suicidal behaviors in all age groups. Alcohol and drug abuse are second only to depression and other mood disorders as the most frequent risk factors for suicide. People having both substance use and mood disorders may be at particularly increased suicide risk.
Men in Midlife	Adult men in their early 20s through 50s, account for the bulk of suicides. However, there has been little research on protective and risk factors among this demographic group. Research points to mood and substance abuse disorders, as well as access to lethal means. Other factors that have been suggested include a reluctance to seek help, engaging in interpersonal violence, economic hardships, and the end of intimate relationships.
Lesbian, Gay, Bisexual, and Transgender Populations (LGBT)	Research suggests that LGBT individuals may have an elevated risk for suicide ideation and attempts (2-4 times the risk of heterosexuals). Because of incomplete surveillance data about a decedents' sexual orientation or gender identity, it is not known whether LGBT people die by suicide at higher rates than comparison groups from the general population.

Table 3. Groups with increased suicide risk[78]

5. Programs that Address Suicide Prevention and Stigma Reduction

The Congressional Research Service report on suicide prevention among veterans outlines how approaches to suicide prevention are not mutually exclusive. The "public health approach" intervenes with populations (e.g., distributing educational materials about mental illness and mental health services), whereas the "clinical approach" intervenes with individuals (e.g., prescribing antidepressant medication to a person diagnosed with depression).[82] The individual focus of the clinical approach limits its reach to those who access the health care system and thus may be necessary but not sufficient to address broader issues of suicide prevention (for example, institutional and social stigma). In contrast, the population-based public health approach, to include social marketing, is considered essential to address the broader problem of suicide, including reaching people who may not currently be in contact with the health care system.[83] This latter approach was developed as part of the U.S. Department of Health and Human Services' National Strategy for Suicide Prevention,[84] and consists of three interrelated pieces:

1. surveillance,
2. risk and protective factors, and
3. prevention interventions.

Suicide surveillance involves collecting data on completed (i.e., fatal) suicides to define the scope of the problem. Data collected in surveillance can also be used to identify risk factors (i.e., characteristics associated with higher suicide risk) and protective factors (i.e., characteristics associated with lower suicide risk). The annual POTFF Needs Assessment Survey that is examined in more detail in chapter 6 is one example of this type of risk factor surveillance system. Prevention interventions may progress through a series of research and development actions that include the design of pilot studies; implementation of interventions assessed to be feasible, viable and effective in their pilot tests; and evaluation of these larger scale efforts. The objectives for specific programs might aim to reduce risk factors and/or enhance protective factors among the entire SOF population, focus on at-risk

subgroups (those with known risk factors, see below for more discussion of these) or concentrate on high-risk individuals—those diagnosed with TBI and PTSD or who have had recent suicide attempts.

Suicide surveillance data among active duty service members, veterans, and SOF were presented in the first chapter. Risks and protective factors were presented in chapter 3. In this chapter we focus of efforts to modify risk factors in primarily military settings and with social marketing approaches.

Suicide Prevention and Stigma Reduction Programs in Military Settings

There are a number of published studies that examine the effects of interventions to prevent suicide and reduce the stigma of BHC among members of the military. The design of these interventions, and their results, when available, provide a context for answering the questions of what works, with whom, and when?

A comprehensive suicide prevention program implemented by the U.S. Air Force (USAF) beginning in 1996 was found to not only prevent suicide but also reduce family violence and homicide.[85] This self-described social marketing program involved 11 initiatives that aimed to enhance understanding of mental health, decrease stigma, strengthen social networks, promote effective coping skills, and change policies and norms to encourage effective help seeking behaviors. Among these initiatives were suicide awareness, education, and training courses for squadron commanders; incorporation of suicide prevention into professional military education curriculums; guidelines for commanders on the use of mental health services; provision of one full time equivalent member of staff for community-based preventive services at every mental health work center; non-supervisory "buddy care" training for all personnel; elimination of duplicative, overlapping, and gaps in the delivery of prevention services; and establishment of psychotherapist-patient privilege for individuals at risk for suicide.

A quasi-experimental design used the 1990-1996 populations of personnel as the comparison group and the 1997-2002 populations (after implementation of the program) as the "exposed" group. Analysis of trends showed a 33 percent relative risk reduction of suicide in the exposed cohort; risk reductions for accidental death, homicide, and moderate and severe family violence ranged from 18-54 percent. There were also no differences in the

proportion of the two groups that were assigned a mental health diagnosis that could have represented an unintentional consequence of the program.

Acosta et al identified five stigma reduction programs that were funded by the DOD.[86] Breaking the Stigma is a U.S. Army Special Operations Command (USASOC) stigma-reduction program that aims to build resiliency and optimize performance by reinforcing the importance of maintaining psychological fitness and seeking mental health care when needed. The program is built around a 24-minute video in which senior-ranking and respected SOF personnel share their stories of dealing with combat- and deployment-related issues and the consequences to their units, careers, and families of seeking or not seeking help. The program consists of viewing the video, a presentation by two of the video participants, an overview of available resources, a briefing from unit providers, and a briefing from commanders (who share their own connections and experiences).

The Real Warriors Campaign is a multimedia communication campaign to increase awareness and encourage help-seeking behavior among service members, veterans, and military families. The campaign's messages address the barriers and motivators to seeking care for psychological health:

- Reaching out for help is a sign of strength that benefits the individual, his or her family, and the entire military community.
- It is possible to seek care for psychological health concerns and maintain a successful military or civilian career.
- Warriors are not alone in coping with psychological health concerns, and every service member, veteran, and his or her family members should feel comfortable reaching out to his or her unit, chain of command, fellow warriors, and community resources for support.
- Experiencing psychological stress as a result of deployment is common, and successful care and positive outcomes are greatly assisted by early intervention.

The campaign includes video profiles of service members of varying ranks, services, and components sharing their stories of coping with and successfully seeking care for psychological health concerns. It also features perspectives from leaders, peers, and family members. The Real Warriors Campaign includes social and traditional media that are intended to reach a broad audience including leaders, families, providers, and the public at large.

Other programs noted by Acosta et al include the Military Pathways program that operates through a web portal and includes outreach to military middle and high school students in the DOD Education Activities system (DODEA); Afterdeployment.com that is also a web-based effort targeting psychological health and TBI with videos and an interactive resource booklet; and The Embedded Behavioral Health (EBH) program that employs 13 behavioral health and support personnel per brigade combat team to establish working relationships between behavioral health providers and key battalion personnel. However, Acosta et al noted that the evaluations of all five of these programs lacked the rigor, comprehensiveness, or specificity needed to determine whether or not they were effective, relying instead on process measures such as web metrics and satisfaction surveys. Whether any of these programs reduced stigma, increased treatment-seeking behaviors, or reduced suicides remains an open question.[87]

Hurtado et al reported on the usefulness and helpfulness of a 2-hour stigma-reduction program for 52 senior enlisted leaders and officers in the Marines.[88] The goals of the training were to provide discussion tools highlighting the experiences of seven Marines seeking help for stress concerns, improve communication between leaders and their Marines around the issue of help seeking, and familiarize Marines with behavioral health treatment and resources. In a pre-post test assessment, four of 10 stigma-reduction awareness items improved. However, the authors point out that the lack of a comparison group renders any causal attribution of these changes to the program tenuous. There is also no indication of whether these immediate effects were sustained and/or carried over to real-life encounters.

A multiple component suicide prevention program was developed and implemented for Israeli Defense Forces (IDF) in which suicide is the leading cause of death.[89] The program included a new directive to reduce weapon availability by requiring soldiers to keep their weapons locked in storage when on leave; new procedures for access and transfer of medical records; critical periods in a soldier's life, especially basic and initial training and the year prior to discharge from service were identified and focused on with additional screening and coping skills education; use of Medical Health Officers (MHOs) who were trained and qualified to identify, treat, and prevent suicides; embedding these MHOs in each unit; and "psycho-educational" programs for commanders and soldiers to detect and identify symptoms of

mental illness or overwhelming stress, as well as guidance on how to deal with them.

Using a similar quasi-experimental method to the USAF study cited earlier, soldiers were either not exposed (pre-implementation, 1992-2005) or exposed to the program (2006-2012). The authors reported a 57 percent decrease in the suicide rate between these two cohorts. Their analysis suggested that the intervention components that most contributed to this reduction effect were related to reduced access to weapons during leave and being able to benefit from improved help-seeking and de-stigmatization. However, the authors also noted the importance of using multiple strategies.

A review of interventions to prevent suicide among military personnel identified seven studies—including the USAF report cited earlier. The authors concluded from their review that multiple component interventions "probably" reduce the risk of suicide, and cite the USAF as the strongest evidence in support of their finding.[90] They noted that programs similar to the USAF have been implemented in Yugoslavia, the U.S. Navy and Marine Corps. They call for more research in this area in order to strengthen the evidence for these effects. In contrast, they found the evidence for psychosocial interventions following a suicide attempt supported a conclusion that they are, at the very best, minimally effective. There was even less evidence to draw any conclusions as to the effectiveness of community-based suicide prevention programs among this population. Finally, they found no studies that assessed the specific effectiveness of hotlines, outreach programs as primary prevention interventions, peer counseling, treatment coordination programs, and counseling programs.

Zamorski also reviewed the literature for suicide prevention in the military.[91] His key recommendations came from the Canadian Forces Expert Panel on Suicide Prevention, which he also authored, and included as priorities:

- Developing a protocol for mitigating suicide for personnel who are under investigation for legal or disciplinary problems.
- Exploring opportunities for means reduction for suicides with service firearms and medications.
- Invigorating efforts at media engagement to promote responsible reporting of military suicides.

He also noted that while the USAF program could be considered a benchmark for suicide prevention activities in the military, there was little evidence to support the efficacy of mass media campaigns, use of gatekeepers, and general screening for suicidal ideation or depression to reduce suicides in this population. He was more positive about potential contributions from clinician education components, systematic follow-up with people who have attempted suicide, more restrictive firearms access policies, media engagement to encourage more responsible reporting of suicides (to avoid any imitative or contagion effect), efforts to overcome barriers to care, quality improvements in delivering mental health care, and organizational interventions to reduce workplace stress (duration and spacing of deployments, harassment prevention activities, employee assistance programs, dispute resolution services, financial counseling services).

A relatively new approach to issues of destigmatization is a National Consortium on Stigma and Empowerment program called Coming Out Proud which focuses on the issue of self-stigma.[92] Proponents of this approach and related ones suggest that people who internalize stigma about their illness (also known as self-labeling) experience significant losses in self-esteem and self-efficacy that, in turn, interfere with the course of their illness and participation in evidence-based services—what they refer to as the "why try?" effect.

Coming Out Proud is based on research findings of several different stigmatized groups that individuals who identify with their stigmatized group may report less stress arising from prejudice and better self-esteem. However, this identification must also be accompanied by the rejection of the legitimacy of the stigma for positive benefits to occur. Identification then may be followed by telling no one about their mental illness, keeping it secret from most people but others who also have the illness (for example, in self-help or peer-led groups), selective self-disclosure to a few, indiscriminant disclosure where there is no active concealment from anyone, or "broadcasting" their experience through personal testimonials and advocacy. The Coming Out Proud program is facilitated in a community that disdains stigma and endorses affirming attitudes such as recovery and empowerment. Corrigan et al[93] also note that in order to

The Coming Out Proud program is facilitated in a community that disdains stigma and endorses affirming attitudes such as recovery and empowerment.

have programs maximize the use of face-to-face contacts to counter stigma in others, people with mental illness need to be supported in order to share their stories and experiences to others. However, there are no published studies documenting the feasibility or effectiveness of this approach with military populations.

Suicide Prevention Programs in Other Settings

It is beyond the scope of this work to conduct a systematic review of suicide prevention and stigma reduction programs in other settings. However, several reviews of this literature are reviewed here for context. A review of 41 interventions for suicide prevention in which suicides, suicide attempts, and/or suicidal ideation were outcome variables identified 7 different strategies that were used:

1. limitation of access to lethal means (n=7);
2. preservation of contact (with individuals at risk for recurrence of suicide; n=5);
3. implementation of emergency call lines and centers (n=6);
4. training of general practitioners (n=4);
5. school-based programs (n=7);
6. reorganization of care (n=9); and
7. public information campaigns (n=3).

Their analyses found that limiting access to lethal means was an effective feature of reducing suicide in all seven studies, whether this occurred through national laws and regulations, securing at-risk environments such as prisons and psychiatric hospitals, or limiting access at the individual level. Three of the five programs that assessed the effects of preservation of contact with people who had been hospitalized for a suicide attempt reported reductions in either completed suicides or attempted suicide. Instituting call lines and emergency centers were found to reduce suicide rates and suicidal ideation in five of the six studies. Training of general practitioners and/or nurses in identifying depression and suicide risk was found to be effective in half of the studies. Interventions in schools reduced suicide attempts among children in one of three reports, and two of the four studies that concentrated

on at-risk youth reported reduced suicidal ideation. Interventions that were built around the reorganization of care for people at-risk for suicide achieved the best results when they focused on care during in-patient treatment (the use of cognitive behavioral therapy, brief family therapy, or referral to a specialist). Social assistance for people who have attempted suicide based on reports from others in their social networks (social workers, healthcare and educational professionals, and youth leaders) was shown to have only limited efficacy on suicide attempts and suicidal ideation. The only intervention that showed an impact on suicide attempts was based on individualized, proactive, intensive, and long-term (six weeks) follow-up provided by a personal counselor. Public information campaigns in Japan, in which the elderly were the priority group for a ten year project, and Germany, where the general population campaign was combined with professional training and patient/family support, both showed significant reductions in suicide rates and attempted suicides (the later in Germany only). An annual suicide prevention week general population campaign conducted in Canada showed no impact on suicide or suicide attempts.[94]

Corrigan et al conducted a meta-analysis of 79 studies that set out to change public stigma through public education and other efforts. Over three-quarters of the studies targeted adolescents, adults, and college students, and while not conducted in the military context, have implications for POTFF activities to change the normative environment in SOF. The authors categorized the programs as following one of three strategies:

- Educational approaches that challenge stereotypes and myths about mental illness and seek to replace them with factual information through public service announcements, books, flyers, movies and videos, web pages, and other audio-visual materials.
- Interpersonal contact with people who have a mental illness to lessen fears and prejudices and counter existing stereotypes.
- Social activism and advocacy that highlight injustices of various forms of stigma and call to account people who hold stereotypic and/or discriminatory attitudes and exhibit behaviors consistent with those beliefs.

Summarizing the evidence for each of the three strategies, they concluded that both interpersonal contact and education strategies significantly improved attitudes and behavioral intentions toward people with mental

illness (social activism and advocacy approaches were rarely evaluated). Yet, interpersonal contact seemed to yield significantly better change among adults while, among adolescents, the data indicated the relative superiority of education over interpersonal contact. What they describe as their most important finding is that face-to-face contact had a much greater impact on stigma reduction than videotaped presentations. They hypothesize that creating in-person contacts allows for greater local control and involvement in anti-stigma efforts than are feasible though more centrally planned and managed marketing campaigns.[95] We will see some support for this assertion in the results of the English Time To Change (TTC) campaign presented in the next section.

A NAS review of interventions to reduce public stigma reached similar conclusions. They found that contact-based interventions alone and contact-based education programs have the strongest evidence base for reducing stigma. Educational programs alone were not found to be effective for adults, but were useful in changing younger people's attitudes. Communication campaigns can be effective, they concluded, but often failed to identify goals and objectives for the campaign and did not reach the intended audience or audiences in a sustained or adequately frequent manner. They also cautioned about unintended consequences of anti-stigma campaigns that may include increased perceptions of differences between people with and without mental illness, fostering disbelief in the likelihood of recovery by concentrating on biological and genetic determinants of mental illnesses, and the potential negative effects of disclosing mental illness in a highly stigmatizing context (such as with contact-based interventions).[96]

Educational programs alone were not found to be effective for adults, but were useful in changing younger people's attitudes.

Social Marketing Approaches to Reducing Stigma and Preventing Suicide

Only one program developed and implemented in a military setting, the USAF study,[97] explicitly acknowledged social marketing in formulating their approach. In this section we review other social marketing efforts to reduce mental health stigma that have been implemented in other contexts and with different priority groups. It is important to point out that while these

programs self-label as social marketing efforts, and many of them follow the planning principles outlined in chapter 1, their execution is almost entirely based on communications activities alone. That is, few make full use of products and services, distribution channels (other than for messaging), and pricing elements of the marketing mix.

Kirkwood and Stamm described two social marketing programs to reduce stigma about mental illness and physical disabilities in Idaho.[98] Both programs formed a campaign work group that included adult and teens with mental illness or a disability, providers, family members, and advocates who guided the design, implementation and evaluation of each campaign. It is important to note here that the social marketing plan came out of the experiences and discussions about stigma with people who have been stigmatized—not just the expert opinions of professionals. Part of these discussions centered on three critical questions: identifying (a) who are the priority groups and how have they been stigmatized; (b) what persuasive messages might counteract the stigma: and (c) what behavior and/or attitude changes are desired? The campaigns, despite using a social marketing approach to planning, only focused on communications or persuasive messages that were pretested in focus groups with members of the priority groups. Process and outcome measures for the mental health stigma campaign showed that trainings in interpersonal communications with gatekeepers, caregivers, and teenagers occurred in 66 percent of Idaho towns that together accounted for 90 percent of the state's population. Levels of satisfaction, knowledge, and attitude gains were reportedly high, but there were no indications of outcomes among the general population or among people with mental illness and their caregivers (for example, were they aware of the campaign, had they noticed any differences in attitudes, media coverage, or conversations about mental health).

The second campaign work group selected family physicians, housing providers, employers, and mental health providers as its priority groups as they were identified as people more likely to stigmatize against people with disabilities. A general audience campaign was also planned using four television and radio advertisements and distribution of 15,000 brochures. A pre-post survey of Idaho adults showed no changes in attitudes or a measure or social distance (being comfortable working or going to school with, living next door to, or living with someone with a physical disability). The authors reported that only 9 percent of respondents reported seeing or hearing about

the campaign, signaling the limited reach and penetration of the advertising effort.

The TTC mental health stigma reduction program in England had a priority group of men and women in their mid-20s to mid-40s, from middle-income groups.[99] Based on insights during the campaign-development phase, these individuals were segmented into groups termed active discriminators, subconscious stigmatisers, and those who are unaware of mental illness. The campaign design began with a survey of almost 400 people with direct experience with mental health problems. The survey was followed up by workshops with over 100 of the survey participants in which discussions were held about the types of situations people with mental health problems experienced stigma and discrimination, from whom they experienced it, and what should be done. Focus groups and interviews with the priority groups were conducted throughout the campaign period, and campaign messages were tailored according to what resonated best with each group.

Although described as a social marketing venture, TTC relied extensively on mass communication channels (television, print, radio, cinema, outdoor and online advertising) and social media (Facebook, Twitter, and YouTube). Advertising carried a call-to-action to visit or click on the TTC website, and social channels focused on behavior change targets such as starting a conversation about mental illness with a friend or help to organize a local event. Evaluation results included documentation of a modest level of self-reported campaign exposure (38-59 percent across survey waves), no changes in overall knowledge or intended behavior change over the three years of TTC, and a spurious finding (unplanned) that self-reported contact with someone who had a mental illness had a significant effect on attitude change and feeling more confident about challenging mental health stigma (intentions).

Ten years of experience and a body of research evidence in changing stigma about mental illness is summarized in the Strategic Stigma Change (SSC) model and revolves around real-life contact between people in recovery and priority members of the public.[100] Based on the SSC model, the author identifies five principles for social marketing campaigns to reduce stigma:

1. Contact. Contact with people with mental illness is fundamental to public stigma change

2. Targeted. Rather than focusing on the population as a whole, contact is more effective when it targets key groups

3. Local. Programs tailored to local conditions and issues (assets, barriers) are more effective
4. Credible. Contacts should be similar to targets in demographics and role and should be in recovery
5. Continuous. Multiple contacts should occur, and the quality of the contact should vary over time (not be carbon copies of each other)

As demonstrated above, one of the prevailing strategies in many stigma reduction and suicide prevention efforts is the use of messaging (see the review of mass media campaigns to reduce stigma and increase referrals and treatment-seeking behaviors[101]). Langford and colleagues, in a commentary about "looking for a few good messages," point out that the DOD and VA create only a small proportion of messages disseminated about military and veteran suicide.[102] Each service, suicide prevention coordinators, and other veteran- and military-related organizations independently create the messages that are developed for military populations. Still other materials and messages are conveyed by civilian entities operating at multiple levels—the U.S. Department of Health and Human Services, state and local health agencies, nonprofits—as well as by various media outlets. They review literature to show that mass media campaigns that follow established principles of health communication and social marketing will yield small to moderate effects on the targeted behavior. These principles, which link to both anti-stigma and suicide prevention efforts, include:

1. Systematic planning that involves an analysis of the context, causes, and potential solutions to stigma, suicide prevention, and treatment-seeking behaviors.
2. Setting behavioral objectives (not simply knowledge and attitudinal ones), supporting changes in policies and promoting existing programs and services.
3. Defining priority groups and the actions that are feasible and relevant for them to take.
4. Conducting research with members of priority groups to understand and develop insight into their perceptions of the problem and desired behavioral or policy changes.

5. Formulating a creative brief that identifies the priority group and the desired behavior, the audience's perceived benefits and barriers for engaging in the new behavior, and supportive statements that make the benefits credible.

6. Designing message content that is relevant, credible, and culturally appropriate for the priority group (not the clearance officers) and contains a call-to-action.

7. Pretesting the messages and materials with representatives of the priority group before final production and distribution.

In their report on the evidence for stigma change, they also called attention to the importance of the principles of science-based health communication strategies that are informed by behavioral theories.[103]

This brief overview of program effectiveness to reduce stigma and suicide, and increase treatment-seeking behaviors, highlights that there are many programs that are not well-evaluated, others that focus narrowly on one or two strategies that have varying levels of efficacy, and that multi-component programs appear to have positive impacts beyond the target of suicide reduction—for example, rates of suicide and domestic violence are also reduced.[104]

Research will continue to build our knowledge about the effectiveness of specific messages for particular audiences and goals, but the information needed to plan safer and more effective communications efforts is already available. We owe it to service members and veterans to apply it.[105]

In the final chapter, data from the POTFF Needs Assessment Wave III are highlighted, and based on the evidence reviewed in the previous chapters, recommendations are made for programs and initiatives to reduce stigma, increase behavioral healthcare-seeking, and reducing suicide.

6. Social Marketing Recommendations for USSOCOM Suicide Prevention, Stigma Reduction and Increasing BHC-Seeking Activities

The special operations community is unique in that it includes a more experienced, older population who are expected to meet exceptionally high standards of maturity, stability, and readiness. SOF and their families face consistently high Personnel Tempo and short notice deployments that are unique in both scope and mission requirements. Many of USSOCOM's forces are geographically isolated and have sensitive mission sets that limit their ability to seek support outside of the unit. With the high demand for special operations, it is important that we have systems in place that keep our forces in the fight and return them to duty quickly when they experience illnesses and injuries.[106]

This chapter integrates the social marketing principles outlined in chapter 1 with what has been learned about the determinants of suicide and treatment–seeking behaviors among military personnel, and the research evidence from programs in the military and other settings to reduce suicide and stigma. It concludes with recommendations for enhancing or designing new POTFF initiatives in these areas.

Data Source: The POTFF Needs Assessment Survey Wave III

The key resource for this inquiry is the annual POTFF Needs Assessment Survey that is administered on an annual basis to assess the short-and long-term well-being of SOF warriors and their families and to evaluate the impact of POTFF activities on wellness levels, identify necessary improvements to maximize program success, and predict future needs.[107] The Wave III data were collected from 5 January 2015 to 9 February 2015: 14,074 USSOCOM active duty (AD) SOF, civilian spouses, civilian employees, and contractors responded to the survey. Among those who responded to the survey, 11,615 (87.7 percent) identified themselves as AD, which represents about 17 percent of USSOCOM's authorized strength. Additionally, 1,631 (12.3 percent)

identified themselves as civilian spouses. This leaves 828 respondents who were either USSOCOM civilian employees or contractors. The analyses of the data in the report focused on AD operators and support personnel and civilian spouses. Discussion of these findings is limited to those that provide context for suicide prevention-related efforts; opportunities to link these efforts (or cross-market) with other POTFF initiatives should also be explored from the point-of-view of the operators, support personnel and spouses.

The survey results provide a view of SOF operators in which measured resilience is high (average score of 4.12/5), though there were reported significant differences between USASOC and other SOF, compared to Naval Special Warfare (NSW) and Marine Corps Forces Special Operations Command (MARSOC), and between USASOC and Air Force Special Operations Command (AFSOC). The primary drivers of resilience were increased social connectedness, reduced post-traumatic stress (PTS), and lower depression.

While 85 percent of AD SOF reported few symptoms of PTS, there was a significant increase in high PTS from Wave II to Wave III (to 8.6 percent). The report authors note that some of this increase may be attributable to the change in the PTS instrument. In addition to being less resilient, having more reported symptoms of depression and being less socially connected, this high PTS group was also at a higher risk of alcohol use/dependence and averaged fewer hours of sleep a night. Even if their PTS symptoms were not severe, 77 percent of AD respondents agreed that they could access services. What the other 23 percent thought or believed about access did not appear to be captured or was not reported.

Among AD SOF, 5.9 percent of operators and 6.3 percent of support personnel reported signs of depression at major or severe levels; however, treatment rates within these groups were only 2.26 percent and 4.07 percent, respectively. The majority (>93 percent) of AD SOF scored low in depression.

In Wave III, 9.4 percent of AD SOF (11 percent of operators and 7.9 percent of support personnel) and 5.1 percent of spouses had Alcohol Use Disorders Identification Test (AUDIT) alcohol screening scores that could indicate problematic or highly problematic drinking. Yet, just 3.80 percent of operators and 3.38 percent of support personnel reported treatment for alcohol abuse and dependence.

The average level of reported social connectedness (friendship scale) has remained high, or in the positive direction, over the past two years. However, enlisted and support personnel were reported to have scored significantly

lower than operators—though this difference was less than 0.5 scale points (18.86, 18.90 and 19.29 respectively).

In assessing the Psychological Performance Program in particular, the survey documented a significant 4 percent increase in use of BHC services by AD SOF over the previous year. Data from the three waves of the survey for both AD SOF and civilian spouses are shown in figure 8.

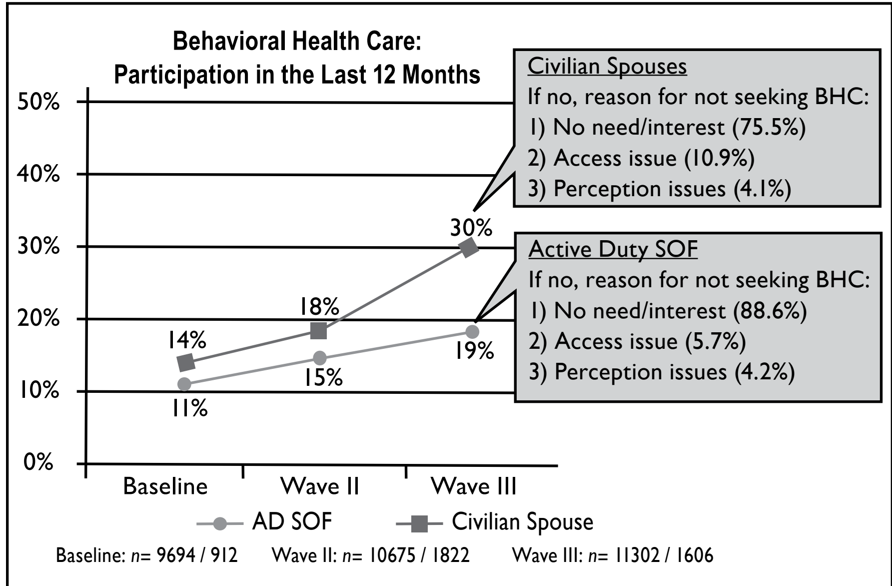


Figure 8. Participation in past 12 months in behavioral health care by AD SOF and civilian spouses[108]

Among AD SOF, 5.7 percent reported "worried about effect on career/clearance," "embarrassed," "leadership will ruin career/poke fun," and negative stigma as reasons for not accessing BHC. "Access issues" were reported for not seeking BHC by another 4.2 percent of AD SOF (down from 5.1 percent the year before). Further analysis of these findings suggested that they were more common among AD SOF who scored significantly higher in depression, potential alcohol abuse, and PTSD. Lower resilience and lower social connectedness were also more characteristic of AD SOF who cited access issues. Perhaps paradoxically, AD SOF who did access BHC scored significantly higher on resilience and lower on depression than those who did not. Figure 9 shows that levels of BHC care by AD SOF vary by component,

with MARSOC clearly separating from other components in the past year with the highest utilization rate (27 percent) as compared with the lowest BHC rate of 13 percent among TSOC. For AFSOC and USASOC, BHC use significantly increased every year over the last three waves. Following no change in Wave II, MARSOC, NSW, and other SOF indicated significantly higher utilization rates in Wave III. However, whether these utilization patterns align with perceived needs, or reflect discontinuities between need and BHC use, are not known. Combined with the results noted above, these data suggest that there may be reasons for POTFF to specifically focus research and programs on discrete SOF segments, including AD, civilian spouses and by component, to understand and respond to these differences.

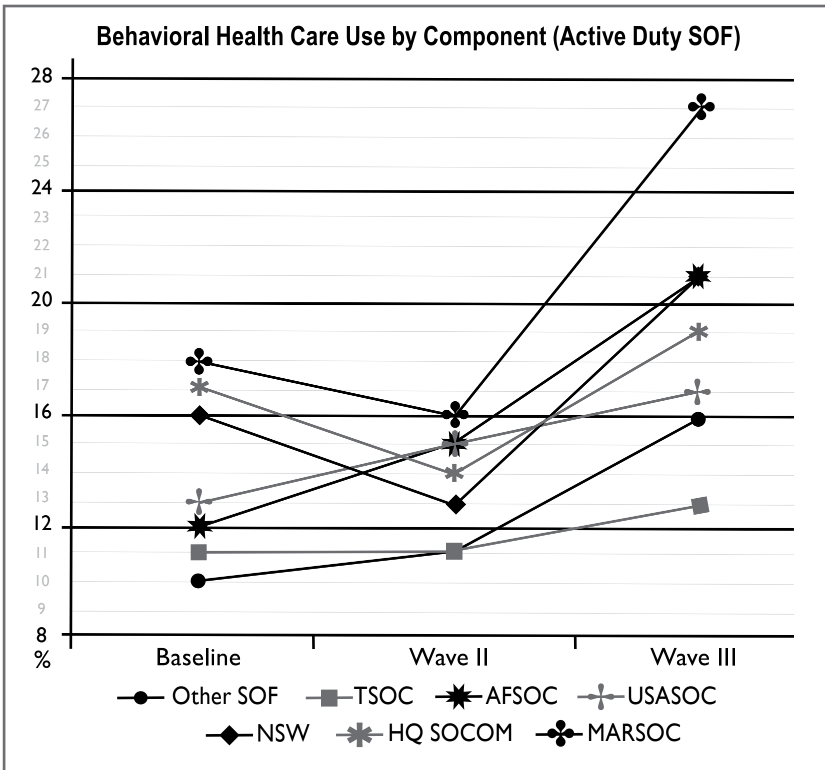
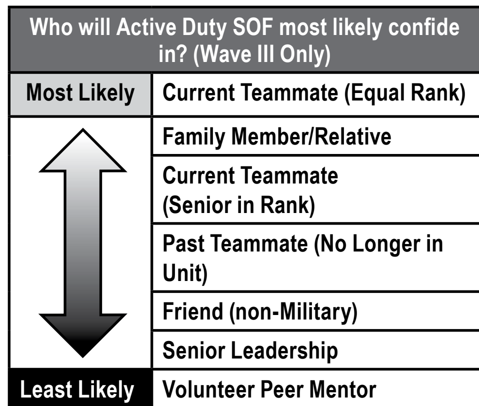


Figure 9. BHC use by AD SOF by component[109]

Among those AD SOF who reported using BHC in the past year, off-base Counselors, MTF Psychiatrists, MTF Psychologist, on-base Counselor, and TRICARE were the top five services given. They rated the importance of BHC significantly higher than in the previous year, and reported the most useful resources as unit social workers, unit psychiatrists and unit psychologists. As the report authors noted: "These findings lend initial evidence to the effectiveness of the embedded approach to behavioral healthcare."[110]

The Community Program and Peer Network Coordinators (CPPNC) pilot program was initiated in 2014. CPPNC was designed to embed peer mentors in SOF units to decrease suicidal behaviors and increase resilience by increasing social connectedness and enabling SOF members to ask for support when they are in distress. What was found is that 46 percent of AD SOF report having a mentor, and 80 percent find the mentor to be an important or extremely important element in their professional development—64 percent view it as important to extremely important for their personal development. When asked who they would be most likely to confide in when faced with difficult situations, overwhelming support was expressed for current teammates who are equal in rank to them (82.3 percent) and family members/relatives (77.6 percent). Peer mentors were the ones least likely to be confided in (see figure 10). Here again, social marketing research could be useful in better understanding this finding and uncovering insights that could be used to strengthen or redesign the CPPNC.



Who will Active Duty SOF most likely confide in? (Wave III Only)	
Most Likely	Current Teammate (Equal Rank)
	Family Member/Relative
	Current Teammate (Senior in Rank)
	Past Teammate (No Longer in Unit)
	Friend (non-Military)
	Senior Leadership
Least Likely	Volunteer Peer Mentor

Figure 10. Rated likelihood to confide in someone when faced with difficult situations[111]

The active duty SOF who were least likely to confide in a mentor (regardless of who the mentor was) scored significantly lower in resilience and social connectedness and higher in PTS and depression compared to those who were more likely to choose a mentor.

The Unit Family Readiness Programs that are part of Social Performance Programs (SPP) were used by 43 percent of civilian spouses and 17 percent of

AD SOF (fig. 11). It is unclear how this use rate compares with any program objectives. If this utilization rate is below POTFF expectations, this would be another set of programs that could benefit from a social marketing approach to revise the programs, build demand and improve satisfaction with them.

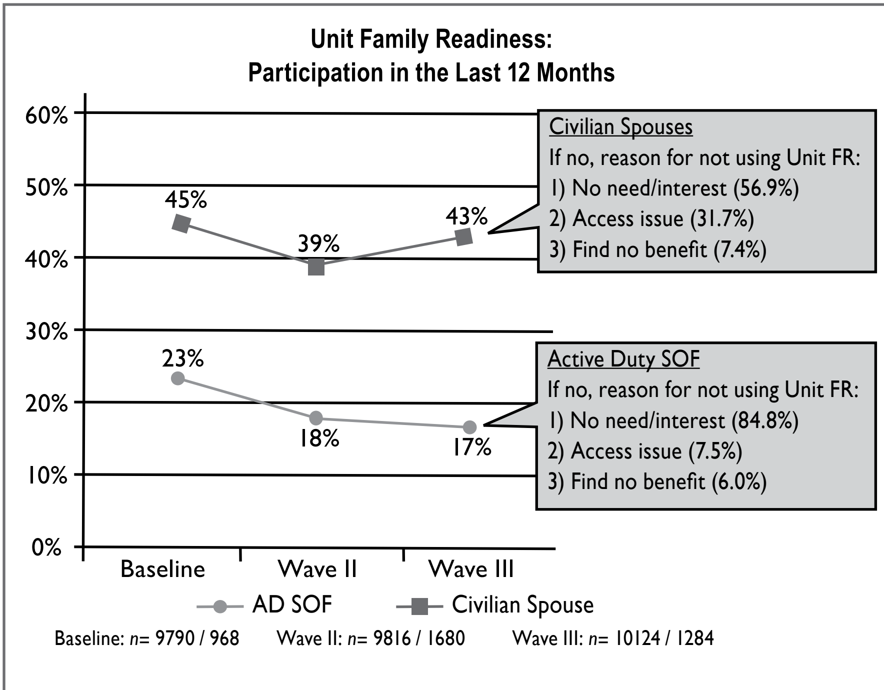


Figure 11. Participation by civilian spouses and AD SOF in unit family readiness in the past 12 months[112]

As noted in the call-out boxes in figure 11, access issues were cited by nearly 1/3 of spouses and 7.5 percent of AD SOF as reasons for not using the program, while finding no benefit in it was given by 7.6 percent and 6 percent respectively. The questions these data surface include: (1) How are these programs not perceived (or experienced) as relevant or useful? Are they addressing spouses' and AD SOF 'real' problems and aspirations? (2) How can access issues be addressed, especially among spouses? And, (3) how can unit family readiness programs be better positioned to each of the groups (and are their segments of spouses and AD SOF more or less likely to use

them)? The 'branding' and marketing implications noted in the conclusions of the report seem premature without addressing these questions first.

In light of the findings above, increasing attention on social connectedness may prove beneficial to the resilience of the force. According to the path models, the programs which have the greatest impact on resilience, and inherently are social or foster social connectedness, are Human Performance Programs (HPP) and SPP. Improving access and the availability to these programs, especially for support personnel who are less socially connected, may have an additional impact on resilience.

Last, clear and consistent branding of POTFF programs, continuously marketing those programs, and accurately identifying those who participated in POTFF programs will be important for accurately assessing the impact of the POTFF initiatives.[113]

It is important to take into account when interpreting these data that they are all collected at the same point in time and are correlational, not causal, in the relationships they depict. This makes it difficult to ascertain whether certain factors 'cause' AD SOF and others to use or avoid BHC, and whether some determinants such as social disconnectedness lead to alcohol abuse and depression, or if the causal path may be in the opposite direction. The items that are selected for inclusion in the survey represent a broad mix of variables; but due to logistical and time constraints, not every question can be asked, answers have limited response options, and the selection of the items represents a judgment of what issues are deemed most important to track and analyze (for example, satisfaction with services items do not provide much latitude in response, expectations for BHC are not elicited). Also, it is unknown whether the 17 percent of the eligible AD SOF population that responded to the survey differ in important ways from the entire eligible population. What is reported is that the composition of survey respondents was fairly representative of the USSOCOM components.

Provide a Ready and Resilient Force and Family

> Future SOF capabilities are directly dependent upon our ability to maintain the unique and high-level capabilities of our most valuable resource: our people… We should engage and support research that contributes to our understanding of human behavior and performance, identify additional and emerging resources to assist our force

> and families, and continue to work on reducing the stigma associated with seeking care when necessary. The Enterprise should seek out and establish a process to explore new authorities or modifications that will increase SOF's ability to provide complete care across the medical spectrum while viewing the SOF family as a unique "force provider." Wherever possible, we must mitigate suicide risk within the SOF community. This mitigation can be done through developed analysis and understanding of suicide risk factors as well as investigating how societal and generational differences may affect SOF subjected to high stress environments.[114]

Recommendations for Preventing Suicide, Reducing Stigma, and Increasing Access to BHC

This inquiry was limited to a data review only. How POTFF programs are developed, tested and implemented in actual practice was not part of this scope. Also, how SOF members and citizen spouses perceive, evaluate, and talk about these services—and the facilitators, barriers, and value of using them—were not elicited in any way (for example, through individual interviews, focus group discussion or other qualitative methods). Yet, based on the literature review and the data available, there are a number of insights and recommendations for improving access and availability of current POTFF programs, enhancing the marketing of them, and assessing their impact. The recommendations discussed below speak to future research and practices for preventing suicide, reducing stigma, and increasing access to BHC services.

1. Specify discriminatory behaviors that reflect USSOCOM priorities for reducing stigma. It is apparent that USSOCOM has invested many resources in tackling the issue of mental illness stigma. The results of POTFF surveys demonstrate the program is having a positive impact on SOF members and spouses. Throughout the literature, and especially in the reviews of DOD stigma-reduction activities,[115] it is noteworthy how often the lack of behavioral anchors, or reference points, as to what constitutes "stigmatic" behaviors is mentioned. Several reviews of the literature for the effectiveness of stigma reduction efforts also comment on the lack of behavioral outcomes or other clear markers of success. "Stigma" seems to have become a catch-all phrase to signal institutional and/or social and/or individual attitudes,

judgments, policies, perceptions and behaviors that separate a labeled group from mainstream society. This loose use of the term, or its specific subcomponents, hinders efforts to reduce stigma through policy change, institutional culture change, changes in social interactions and individual attitudes and judgments, and, most importantly, behaviors.[116]

It is recommended that identifying these stigmatic behaviors in the USSOCOM context would best be done through conversations with SOF members and their families and not through literature reviews. The USSOCOM community is unique, and it should not be overlooked that this uniqueness may transfer to how discriminatory behaviors (stigma) are expressed in policies, culture, relationships and individual actions. For example, some research suggests that female members of the military are sensitive to family sources of stigma and SOF civilian spouses cite 'perceptions' as a reason to not access BHC services. Unfortunately, surveys that are constructed from previous research to ensure their reliability may inadvertently not provide examples of discriminatory or judgmental behaviors that are experienced in the USSOCOM environment. The implication from this inquiry is whether the most relevant (to SOF members) behaviors are being addressed by anti-stigma efforts.

2. Engage SOF members and civilian spouses more completely in the research and development process for programs aimed to mitigate suicide risk. The idea of engaging potential users of products and services in their design has taken hold in many industries and within marketing. Co-creation, or co-production of BHC services should become a model for research and development. POTFF content experts should consider how they could bring SOF members and/or civilian spouses (depending on the user population they have in mind) to the planning table early and consistently throughout the process, and shift away from just testing nearly completed messages or prototypes in focus groups (assuming that they are tested prior to implementation). A co-creation paradigm for POTFF research and development can remove barriers among experts and users, gather insights as to the relevance and perceived effectiveness of the proposed activities throughout the development process, and also nurture ambassadors for new programs from those who have actively participated in their creation.

3. Utilize formative research in all POTFF messages, services and program development efforts. It was beyond the scope of this review to do an

in-depth examination of the development process for POTFF programs and services. This recommendation is based on the consistent finding from both health communication and social marketing research that formative research methods are found to be a critical effective ingredient in any program aimed at changing behaviors.[117-119] Formative research is more than pretesting; in best practices of marketing the formative research phase also involves testing the concepts and assumptions underlying a campaign or program—what will (really) get people's attention, engage them in the process (build on what motivations they have to consider the behavior or service being offered), offer user-relevant value or benefits, and the potential fit of the behavior or use of the service into existing work-life patterns. This 'concept testing' occurs before any decisions are made as to the content, structure, and branding of a new campaign or service. Indeed, the goal of formative research is to build as many touchpoints with potential users through the research and development process as possible to assure that resources have been directed towards crafting messages, products, and services that meet needs, help solve problems, and support achieving people's aspirations.[120]

4. Conduct user preference studies. User preference studies are ubiquitous in certain industries, notably pharmaceuticals and medical devices. User preference studies are empirical attempts to understand how potential users weigh the potential features, benefits and risks of using a product or service before the product or service is designed.

Conjoint analysis is a quantitative method often used in these studies. It is useful when there is access to relatively large samples of the priority group: that is, more than just would be available for a few focus groups. Patient preference studies using conjoint analysis allow program planners and designers to assess how features and benefits, are valued when considered jointly, rather than one at a time. When faced with making trade-offs between program access, availability, costs (broadly construed), and features, these types of studies can be employed to make decisions with user input. The results can help designers make decisions about what are the most important elements to include in a program, how prices (or costs) are weighed in comparison to benefits, how best to design and package (or redesign and repackage) a product or service to meet the needs of intended users, how location and time commitments may affect anticipated demand for a product or service, and which features and benefits should be emphasized in promoting a behavior,

product, or service to specific segments of a population. Preference studies have the advantage of being more generalizable to the larger population of SOF members and civilian spouses than a few focus groups might be.

As one illustration of how this approach has been used, Spoth reviewed the smoking cessation literature, captured adult smokers' preference ratings on potential program attributes, and conducted interviews with smoking cessation clinic facilitators and worksite benefit managers to develop a set of program components and attributes for a revision of a smoking cessation program (for example, various price points, program duration, inclusion of stress management or weight loss components, method of nicotine reduction, reward techniques, flexibility of the format, recommended behavioral alternatives to smoking, methods of support, and sources of program endorsements).[121] A telephone survey of worksite benefit managers, the decision makers for purchasing the program, was used to get one reference point for attribute preferences. Telephone interviews were also conducted with smokers to gain their perspective on the relative importance and combination of activities. The results of these conjoint analyses were then used to guide revisions of the existing program and the introduction of new program components. Similar approaches with both users and implementers might be employed by POTFF when it initiates or revises program offerings.

5. Improve measurement of user satisfaction and perceived effectiveness of BHC offerings. Results from the POTFF Wave III survey found that 30 percent of civilian spouses and 19 percent of AD SOF reported using BHC services in the past year. Of those who did not seek BHC services, about 76 percent of spouses and 89 percent of AD SOF endorsed the item that they had no need or interest. The remainder of respondents attributed not using these services to reasons that were aggregated as perception and access issues. As was shown in the literature review, perceptions of effectiveness and attitudes towards BHC treatment may be as important, if not more so, than stigma-related beliefs and attitudes in predicting which military personnel use these services. We recommend that more attention be given to these types of issues in future research and survey work.

Survey respondents rated BHC services on 4-point scales of satisfaction, importance and usefulness. Both groups of respondents, on average, rated each attribute at a "3" or higher (corresponding to very satisfied, extremely important and very useful). The literature on the measurement of service

quality and user satisfaction suggests that perceived quality leads to user satisfaction and that the level of satisfaction then influences intentions to use the service.[122] We recommend that POTFF devote more resources to understanding perceived quality of its services (both its technical quality as well as how it is delivered, or its process quality), expand the range of responses from the current 4-point to a 7-point scale, and specifically ask questions of BHC service users about whether they would recommend that service to a friend or colleague (see Fan et al, 2005 in VA medical center settings).

6. Conduct research that is aimed at insights and understanding of the use of 'outside' BHC services. One premise of the social marketing approach is that competition is inherent in all product and service offerings as well as in adopting new behaviors. In the context of BHC services, a better understanding of what the perceptions, attitudes and satisfaction levels are for SOF members and civilian spouses who utilize external resources could lead to insights into how to better structure and position POTFF services. In concert with the service satisfaction inquiries noted immediately above, this research could help to attenuate the negative perceptions and access issues documented in the POTFF Wave II survey. In seeking not only to reduce barriers, but actually attract those SOF members to BHC services, the POTFF should consider the investment in marketing research activities that can provide better articulation of barriers and drivers to BHC service use beyond the idea of 'stigma-related concerns.' As SOF continue to make significant headway in reducing these latter concerns at the policy, cultural, and social levels of the enterprise, we suggest that the incremental gains in converting the small numbers of SOF members who need help to actually seek it will take place in the way BHC services are structured and delivered to enhance perceived usefulness, satisfaction and continuity of use.

7. Monitor, enhance, and sustain social connectedness and resilience through programs. This is a promising new approach to suicide prevention and increasing treatment-seeking behaviors. The actions USSOCOM has taken to reduce stigma-related attitudes and behaviors have been found to be quite effective in lowering these concerns in AD SOF and their civilian spouses. Recent research suggests that the directions of enhancing social connectedness and resilience are important new steps to take and build upon the stigma-reduction activities. However, to avoid the opaqueness seen around the use of "stigma," these resilience and social connectedness goals

should be articulated into behavioral actions and options that can be more accurately assessed and tracked, much as physical performance is characterized by 'what do you do?' For example: "how much time do you spend participating in … strength training, vigorous exercise, moderate or light exercise?" rather than, "how do you feel or think about exercising?"

On a broader level, the positioning of BHC as a suite of services to solve problems or as a series of experiences that build behavioral and cognitive assets could be explored with POTFF staff and SOF members. Again, some perceptions of BHC that stop people from accessing them involve issues of self-stigma, perceived weakness or vulnerability, and low expectations for treatment success. One design challenge for POTFF could be: What if people viewed participation in Psychological Performance Programs (PPP) in the same way they view their participation in HPP? What changes in PPP would be necessary to align with perceptions and utilization of HPP?

8. Expand research and evaluation efforts that examine the role of self-stigma and perceptions of BHC effectiveness in mitigating treatment-seeking behaviors. The theory and research on stigma and mental health has rallied around the ideas that stigma is composed of structural (laws, regulations and policies), public (attitudes, beliefs, behaviors as described above), and self-stigma (internalization of negative stereotypes). The research has also identified "courtesy stigma" that is directed towards family and friends of those with a mental or substance use disorder. People avoid being labeled with a behavioral health problem and possibly associating with them because of concerns about resulting discrimination or social rejection, and this can influence their decision to seek help for themselves or others.

To enhance efforts to completely eliminate stigma-related behaviors and attitudes in USSOCOM, self-stigma and "courtesy stigma" appear to be two targets for more research and programmatic activity. Both of these stigmas could be addressed through the 'contact' types of interventions reviewed earlier in which in-person contacts, not just videos, might be tested. Program evaluations and surveys should assess the prevalence of self-stigma and courtesy stigma to understand their prevalence and nature in the USSOCOM enterprise and if and how they could be addressed by POTFF services.

Finally, the lessons of the comprehensiveness and effectiveness of the USAF[123] and IDF programs[124] should be considered benchmarks in assessing suicide-prevention activities across the USSOCOM enterprise. When

attempting to address multiple levels of stigma (structural, social, self and courtesy), multiple risk and protective factors for suicide, and improved BHC treatment-seeking, a management approach that considers the perspectives of priority groups and building ubiquity and synergy among initiatives for large-scale change—not a search for the "magic wand"—is important for success. In both auditing current efforts, and seeking innovative ways forward to improve upon them, a social marketing approach provides the POTFF with a large toolbox from which to draw inspiration and action.

Appendix: Acronym List

AD	active duty
AFSOC	Air Force Special Operations Command
BHC	behavioral health care
CPPNC	Community Program and Peer Network Coordinators
CF	conventional forces
DOD	Department of Defense
DSPO	Defense Suicide Prevention Office
EBH	Embedded Behavioral Health
GAO	United States Government Accountability Office
HPP	Human Performance Programs
IDF	Israeli Defense Force
LGBT	Lesbian, Gay, Bisexual, and Transgender
MARSOC	Marine Corps Forces Special Operations Command
MHD	Mental Health Disorder
MHO	Medical Health Officer
NAS	National Academies of Sciences
NSW	Naval Special Warfare
OIF	Operation Iraqi Freedom
POTFF	Preservation of the Force and Family
PPP	Psychological Performance Programs
PSB	Products, Services, Behaviors
PTS	Post-Traumatic Stress

PTSD	Post-Traumatic Stress Disorder
SCI	Spinal Cord Injury
SOF	Special Operations Forces
SPP	Social Performance Programs
SSC	Strategic Stigma Change
SSRI	Selective Serotonin Reuptake Inhibitors
TBI	traumatic brain injury
TTC	Time To Change
USAF	United States Air Force
USASOC	United States Army Special Operations Command
USSOCOM	United States Special Operations Command
VA	United States Department of Veterans Affairs

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