Suicide among U.S. Military: Expanding on Prevention Program Efficiency

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Introduction

Each day, the United States loses more than 17 brave men and women who served our country to suicide. These suicides are devastating losses for families, friends, and other service members. The suicide rate among service members has increased remarkably over the past several years and now exceeds that of the civilian population. The response to the issue of suicide in veterans over the years has been widespread and varied in prevention program implementations, availability, and accessibility for veterans (Berumen et al.). Despite the extensive research that has been conducted and countless programs put in place, the rates continue to rise. According to a research survey conducted by Mission Roll Call, more than half of Americans do not believe the federal government has been effective in addressing veteran suicide prevention (Pinkston). Among those who know a veteran or service member, this number is higher. This begs the question, how effective are the current suicide prevention programs that are available to US veterans, and how accessible are those programs? An analysis of their efficacy reveals significant gaps in the accessibility and effectiveness of those programs. This article suggests the reevaluation of current strategies and a proposal for more innovative and evidence-based approaches that are tailored to the unique challenges faced by our service members.

Literature Review

Literature found on the prevention of soldier suicide confirms a pattern of an undisputed need for more efficient programs, an insufficient dissemination of information on prevention programs, but ample research for the risk factors associated with soldier suicide. The lack of evidence on prevention programs made recognizing the patterns in preventing suicide and the conduction of a literature review exceedingly difficult. However, the need for prevention and more efficient programs was a common denominator within research topics examined from Nock et al., Sharp et al., Franklin et al., Campbell-Sills et al., Kenzie et al., and Berumen et al. This analysis clearly acknowledges the extensive research done on identification of risk factors while also pointing out the neglect towards research on prevention tactics. All 6 researchers agree that the high rate of suicide among veterans is a significant public health issue and in desperate need of mitigation.

Campbell-Sills et al.'s research focuses on the genetic, environmental, and behavioral correlations of lifetime suicide attempts on U.S. soldiers, while Berumen et al. identifies the types of suicide prevention programs that are currently available to those soldiers and reviews the effectiveness of them. Nock et al. points out the factors that may be important in understanding suicide among soldiers alongside Franklin et al. who researched the risk factors themselves, for suicidal thoughts and behaviors in soldiers. Whereas, Sharp et al. focused her research on the stigmas surrounding acquiring psychological help in the military and highlighted the bureaucracy behind intervention. Similarly, Kenzie et al. researched the red tape and challenges faced by veterans who sought care.

While the research conducted through each piece of literature is thorough, there are some limitations present causing gaps within the data collected. Each researcher operated under the flawed assumption that suicides are associated with mental health diagnosis, as well as focused on individual risk factors rather than environmental stressors. Addressing these gaps will be critical in the future development of prevention programs.

Berumen et al., Sharp et al., and Campbell-Sills et al.'s research are all meticulous in nature, however limitations are present within their data collection. Berumen et al.'s data was collected based on inclusion and exclusion criteria that consequently produced biased results. These criteria excluded studies that were not endorsed by the VA or published in any peer-reviewed journal. This resulted in unequal representation within the sample group, leaving out any studies that were not directly endorsed by the VA, but contained accurate and relevant data. Campbell-Sills et al.'s study only included soldiers of European ancestry, causing the same misrepresentation. Sharp et al.'s research synthesized existing research on the stigma surrounding seeking health care among military personnel, but focused solely

on those with mental health problems, leaving out the population of individuals with suicide attempts that did not have mental health diagnoses. Both Nock et al. and Franklin et al.'s research emphasizes the identification of individual risk factors as well as mental health diagnosis leaving a lack of data coverage on the possibility of environmental factors. Missing data, such as environmental factors associated with soldier suicide, can skew results and cause inaccurate conclusions.

Methods

Literature reviews are conducted to explore the extent of literature available on a topic and are used to summarize and disseminate findings, identify research gaps, and/or make recommendations for future research on the topic. The sources utilized for the collection of research for this article came from a variety of academic and national health databases, including Google Scholar, Oxford University Press, The Department of the Army database, The American College of Neuropsychopharmacology, the National Institute of Health databases, along with other peer reviewed databases. Keywords used throughout the search were "soldier suicide," "military suicide prevention programs," and "risk factors associated with soldier suicide." The sources included were peer reviewed articles in scientific journals, written compositions associated with the topic, and electronic sources located on the VA.gov website. The search resulted in 141 peer-reviewed articles from Google Scholar and 177 articles from the National Institute of Health database. 12 sources were cited, and 8 peer reviewed articles were selected for analysis after refining the search based on relevance to the information needed for the research question: how effective are the current suicide prevention programs that are available to US veterans, and how easily are those programs accessible?

In the conduction of this research, patterns arose between all the cited sources that provide a framework for analysis. Studies were chosen based on inclusion and exclusion criteria. Studies that met the inclusion criteria were those that focused on suicide prevention programs with a target audience of US Army veterans and those that described suicide prevention programs currently available to those veterans. Studies that were excluded were those that were not currently available to US military veterans and those that included all populations and not just that of US army veterans.

Findings

1. Undisputed Need for Policy Update and Government Funding

Despite the programs and process in place, the military has failed to reduce the number of annual suicides since 2012 (Isenhower and Webb). In September of 2024, Maj. Gen. James P. Isenhower III of the U.S Army and Maj. Allison Webb, MD,

of the U.S. Army Reserve published the article entitled 'Reconsidering Our Approach to Suicide Prevention'. The article discusses the operation's flawed assumptions surrounding suicide, as well as the need for immediate action. These flawed assumptions include believing that MDMP (Military Decision-Making Process) will help address suicide, identifying the risks of suicide will reduce completed suicides, and persuading a person suffering from a behavioral health emergency to seek care will prevent suicide. Medical clinicians have associated the army's failed attempt to prevent suicide with the relentless application of these assumptions.

Accompanied by these flawed assumptions, the strain placed on our military mental health system is unprecedented. Our current military mental health system is under-resourced, under-staffed, and frankly under-trained in cognitive behavioral therapy and dialectical behavior therapy, which both have been proven to directly reduce suicide (Isenhower and Webb).

To combat this profound exigency, policy changes and legislation, combined with federal funding, should be enforced to encourage the continued development of suicide prevention programs for our military. Additional funding from the U.S. Government along with supplemental funding for research and innovative programs would alleviate the burdens faced in U.S. military mental health care system.

2. Red-Tape Surrounding Getting Help

Approximately 60% of military personnel who experience mental health problems do not seek help, yet many of them could benefit from professional treatment (Sharp et al.). Across military studies, one of the leading causes of not reporting a mental health crisis is the stigma that is attached to seeking help as well as the bureaucracy behind getting the care they need. Many veterans become frustrated by the experiences they face with specific medications, equipment, or services not being covered by the VA, processes for getting care covered become confusing or delayed, and many complain of VA providers giving substandard care. When a health care provider determines a soldier to be at risk of immediate self-harm, they will provide or cover the cost of care if, and only if, the soldier is able to meet at least 1 of the following requirements: the individual was the victim of sexual assault, battery, or harassment while serving in the Armed Forces; he or she served on active duty for more than 24 months and didn't get a dishonorable discharge; or he or she served more than 100 days under a combat

exclusion or in support of a contingency operation (Sage). For those who do not meet those criteria, help is not so readily available despite federal policies over the last decade relaxing the requirements.

Transportation, inconsistent staffing, administrative needs, and insurance gaps are also well documented barriers faced by veterans. One quarter of US veterans–approximately 4.7 million in total–live in rural areas and are more likely than their urban counterparts to be older, less financially secure, and have more significant health needs that require more frequent, ongoing, and costly care (Kenzie et al.). While veterans have access to a plethora of health benefits through the U.S. Department of Veterans Affairs, statistics provided in the 2024 National Veteran Suicide Prevention Annual Report show that 40% of completed suicides in 2022 were veterans who had sought help through the VA (Office of Suicide Prevention). There are substantial gaps in insurance coverage as to what is covered and what is not. This gap is considerable in relation to mental health and substance use. These gaps include limited coverage for specific therapies and long wait-times for treatment. While the Choice Act established in 2014 allowed VA benefits to be used with non-VA providers in some circumstances (community care), veterans who enroll in Medicare or another private insurance often use that coverage when seeking care from a non-VA provider due to convenience. Consequently, in doing so they often face higher costs than with VA community care.

3. Standardized Dissemination of Resources

A known gap for the veteran population is being aware of available suicide prevention programs (Berumen et al.). There is a range and variety of Suicide Prevention resources available to US Soldiers and veterans with more to come. However, for suicide prevention programs to be successful, they need to be readily accessible. There are over 28 peer-reviewed and studied suicide prevention programs offered to soldiers and veterans. All sources agree that it is imperative that the available suicide prevention programs be disseminated to a widespread standard. Veterans and their healthcare providers must be aware of these programs and the process through which to utilize them.

Berumen et al.'s review of preventative programs demonstrated there is a wide variety of suicide prevention programs available for US veterans. The review also indicated that (a) suicide prevention programs in use by the VA are not being widely disseminated in the peer-reviewed literature and (b) there is significantly more dissemination on the study of causes of suicidality than programs being implemented to prevent suicidal behavior. They also state that "awareness of the availability of preventative programs are vital components of suicide prevention in both the veteran and general population" (Berumen et al. 146). Likewise, research within *Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors*, states the

need to create prevention programs that train soldiers to develop preventative skills, evaluate the effectiveness of such programs, and if effective, should disseminate to all soldiers (Nock et al.). Standardizing the dissemination of these resources is instrumental to the success of suicide prevention.

Discussion

1. A.C.E versus S.A.V.E

The overall effectiveness of current suicide prevention programs that are available to US veterans and active-duty soldiers is inadequate. Going forward updating the current policy (ACE Base +1) is crucial in the comprehensive success of suicide prevention in the U.S. Military. ACE was created in 2009 and is the U.S Army's current suicide prevention strategy emphasizing 'Ask, Care, Escort' (*Army Suicide Prevention Program*). Its primary goal was to increase suicide awareness and improve the capabilities of Soldiers to identify others who may be suicidal and get them to help. ACE is a four-hour training course that provides soldiers with the skills deemed necessary to effectively decrease suicide attempts. A.C.E by military standard is described as 'Ask, Care, Escort'. A more in-depth description reveals A.C.E, as: Asking the soldier directly if they are considering a suicide attempt; Caring for them by providing sympathy and support; and Escorting them to a behavioral health care provider.

In 2022, ACE was updated to include 'base +1' modules. These modules were added as additional elective training provided to commanders to address specific needs within the unit. These modules include fighting stigma, active listening, practicing ACE, and lethal means. While this program fulfills the criteria set forth by the Department of the Army's *Army Suicide Prevention Program* and provides soldiers with a basic understanding, ACE is not ultimately lacking in effectiveness. It operates under the listed flawed assumption that escorting a soldier to behavioral health will effectively reduce suicide rates. This assumption has no evidence-based studies to support itself. More time and further research is needed to determine the effectiveness of the recently added 'base +1' modules.

While the ACE initiative has been in place for years, there is a promising and more effective program trending upwards that could be integrated within the ACE program. SAVE is currently a pilot program adapted by the Department of Veterans Affairs that encompasses a comprehensive course that highlights compassion and care. The SAVE acronym is defined as 'Signs, Ask, Validate, Encourage." Under this suicide prevention strategy, soldiers are taught the Signs that might indicate suicidal ideations; Asking a soldier directly if he or she is suicidal; Validating their experience and mental state; Encouraging treatment; and Expediting help. While SAVE is still in its early days of implementation, it demonstrates positive momentum. By integrating

SAVE within ACE, The Department of the Army would be taking a substantial step forward in the battle against suicide.

2. *Identifying 'Life Stressors' and Tailoring Intervention Services*

The US Military and the Veterans Affairs Department currently use various screening techniques to identify soldiers who are more likely to contemplate or commit suicide. Changes in behavior, loss of a loved one to suicide, financial issues, substance abuse, anxiety or depression, and changes in relationships are all considered to be risk factors associated with suicide (Franklin et al.). Any soldiers who are found to have demonstrated any of those risk factors are considered 'High-Risk' for suicide. Recent study shows, approximately 146 suicides in 2022 occurred by those who were identified as high risk by means of substance abuse or mental health disorder (Office of Suicide Prevention). Rather than training soldiers and healthcare providers to characterize others as a risk, more training is necessary to identify life stressors associated with suicide vulnerability and link those stressors to the corresponding resources available.

Suicide is not always about mental health. For example, a soldier undergoing financial issues and viewing suicide as the only solution, may not need behavioral health, but a consultation with finance to assist in achieving financial stability and an appointment with an Army Emergency Relief liaison. An article from the American College of Neuropsychopharmacology suggests that in the presence of environmental risk factors, a soldier with high suicide attempt risk score is predicted to have more than twice the risk of lifetime suicide attempt relative to a soldier with average environmental and behavioral risks (Campbell-Sills et al.). By tailoring prevention and intervention services to meet the individual needs of soldiers and advancing suicide prevention into non-clinical support, such as resources that provide guidance on everyday life stressors, will enhance the military suicide prevention program.

3. Reallocation of Government Funding

Limited access to high-quality treatment is a challenge for many veterans, particularly those living in rural or secluded areas where VA facilities are distant or non-existent. There are countless non-profits and organizations in associations with the VA that have the capacity to aid in the burdens veterans face, as well as a network of 1,380 VA Community Based Outpatient Clinics (Kenzie et al.). However, veterans and their healthcare providers must be aware of these programs to utilize them. The lack of local, specialized programs for substance use and mental health for these soldiers is despairing.

To address this hardship placed on veterans, an organization managed and regulated similar to the VA that houses all the available resources to veterans along with added resources tailored to everyday life stressors, such as financial counseling, childcare support, housing assistance, and employment opportunities could be placed at each military base in the United States. An organization built with the sole purpose of disseminating these resources does not exist. Accompany that with the burden of limited access to these resources and veterans become disinterested in seeking help.

A federally funded account dedicated to introducing new along with enhancing existing prevention programs would benefit the overall suicide prevention policy. According to the US Department of Veterans Affairs Budget Submission for fiscal

year 2025, $369.3 billion has been requested and the submission lists the prevention of suicide as a top priority. However, as a top priority, $583 million of the requested budget will be designated to the advancement of the administration's Veteran Suicide Prevention programs with only $30 million dedicated to more research into Suicide Prevention ("Fiscal Data"). That is approximate to 0.0016% of the overall budget submission.

With the help of professional financial advisors, the reallocation of federal funds could allow these suicide prevention centers to be placed outside all major military bases and provide veterans and active-duty soldiers with readily accessible resources to aid in the burdens of everyday life. As a result, it could effectively reduce suicide by reducing burden. Additional research from the Treasury Department and the Financial Stability Oversight Counsel is needed to determine the reallocation of funding in order to provide these facilities in an economic and equitable approach.

Conclusion

The overall effectiveness of current suicide prevention programs that are available to U.S. veterans is inadequate. Results show that there are numerous suicide prevention resources available to veterans. However, for these resources to be successful and achieve the objective of preventing suicide, veterans and their providers must be aware of the resource's existence and the prevention programs must be readily accessible to ALL veterans and soldiers who seek help despite their experiences and discharge status. There should be no exclusion criteria for those who have served our country and are seeking suicide prevention.

Additional research needs to be conducted to address the increasing rates of soldier suicide. New studies of suicide will best advance the understanding of reactions to life stressors by carefully specifying and testing the nature of the relation between the life stressors identified and the soldier's reaction to those identified stressors. Questions that should be asked are: Is the identified stressor a known vulnerability? Did this stressor contribute to the suicidal outcome and if so, how? Did the soldier respond to the stressor in the same manner as a civilian would? This should include updating policies combined with the reallocation of federal funding to improve the development of suicide prevention programs for military veterans.

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