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Proactive Suicide Prevention in the U.S. Military: Risk Conditions, Access, and Program Design

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Suicide rates in the Active Component of the U.S. military, the full-time active-duty force, increased overall between 2011 and 2024 across all services. In 2024 the Department of Defense (DoD) counted 471 service member suicides, including 302 in the Active Component at a rate of 23.8 per 100,000. That rate was lower than the 2023 rate of 28.2, but the department stated that it is too early to say whether the decline marks a change in the long-term trend.

In 2023 the Suicide Prevention and Response Independent Review Committee (SPRIRC), a panel established in 2022 to review prevention across the armed forces, made 127 recommendations. The Secretary of Defense announced ten for immediate action and referred the other 117 to a working group. Current prevention efforts often intervene only after service members show signs of crisis or seek help, relying on mandatory training, referral to treatment and restriction of lethal means such as firearms.

Public health practice distinguishes between "pulling people out of a river" and "going upstream" to find out why they are falling in. This research brief examines factors and measures that are relevant at those earlier stages: the conditions of military life that commanders can actively change, the obstacles that keep service members from reaching support, and the design of support that does not wait for a service member to ask about it.

It argues for three distinct but mutually reinforcing changes. First, **treating daily conditions under command control as part of prevention**; second, **reducing barriers to existing care**; and third, **piloting proactive, non-clinical support**. This would involve trained peers initiating contact with service members, identifying their needs and connecting them to appropriate resources, including clinical care when needed.

The case for this shift rests on the degree of control the military exercises over service members' lives. The institution decides where junior personnel live, when they work and sleep, where they can eat, how often they move and how much of their time is taken up by administrative requirements. For a civilian employee, most of these would be private matters. For a junior service member, they are largely institutional decisions, which gives military leaders more points of leverage over the conditions that precede mental health crises than most employers have, and a corresponding responsibility for them.

Risk Conditions in Military Life

Sleep shows how daily conditions connect to mental health risks. The SPRIRC reported that service members who report sleep difficulties are nearly three times more likely to report suicidal ideation. The Secretary of Defense's response included a directive that commanders allow seven to eight hours of sleep per 24-hour period, and one of the two high-priority recommendations he accepted called for healthy sleep throughout the department.

Beyond sleep, the everyday conditions of military life — including housing, access to meals, recreational facilities and the predictability of duty schedules — also shape service members' opportunities for rest and recovery. The Government Accountability Office (GAO) observed barracks, the shared housing in which many junior service members live on base, with broken windows, inoperable fire systems and a sewage overflow, found that some did not meet DoD standards for privacy and configuration, and reported that DoD's assessments of barracks condition were unreliable.

The personal garrison experience of one of the authors points to further challenges: dining facilities that close before late duties end, leaving fast food and gas-station meals as the default; the closure of recreation halls and enlisted clubs; and last-minute taskings that consume evenings and weekends. These conditions can restrict access to adequate meals, opportunities for recreation and exercise, and control over personal time, all of which are important for recovery from stress.

A second group of conditions concerns the institution's own conduct. The SPRIRC described administrative systems that "get in the way" of service members. A qualitative Army War College study, based on discussions with Army officers, found that Army requirements exceed what units can complete and that officers respond by reporting some requirements as met. It cites an earlier finding that company commanders faced 297 days of mandatory training requirements in 256 available training days. The study calls the result *ethical fading*, the process by which false reports come to be treated as routine administration rather than as ethical choices.

Moral injury, a concept developed in work with combat veterans, describes the harm caused by a betrayal of what is right by someone with legitimate authority in a high-stakes situation. An essay by an Army officer and a psychiatrist extends the idea to garrison life, arguing that dishonesty, unpunished misconduct and perceived injustice erode trust and cohesion. Work that service members regard as meaningless, and standards they regard as performative, can create the impression that the institution values neither their time nor their integrity.

The relationship between social integration, institutional trust and a sense of belonging offers a framework for understanding how these conditions interact. Sociological research has long treated suicide as shaped by how far people are integrated into a group and guided by shared norms, and a review of that research notes that formal organizations, including the military, are implicated in suicide risk. The classic term for the loss of shared norms and meaning is *anomie*. Military service removes

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recruits from family and home communities, moves them regularly, and relies on unit cohesion to replace those ties.

This can create a condition of "dependence without community" for the modern soldier: reliance on the institution to manage their careers and families, without the relationships that make a person known and needed. Moreover, recruits arrive from a society in which the share of adults saying that most people can be trusted fell from 46 percent in 1972 to 34 percent in 2018 and about half of adults report loneliness.

Military leaders should treat sleep, housing, access to meals, predictable duty schedules and opportunities for social connection as matters of personnel well-being, not merely readiness or quality of life. Regular assessments should identify where institutional practices undermine these conditions and assign responsibility for corrective action.

> **Practical Takeaway:** Compare a unit's actual duty schedules and access to essential facilities against established standards. Identify where last-minute taskings, administrative requirements or facility hours routinely prevent personnel from obtaining adequate sleep, meals and opportunities for recovery. When units are assigned more mandatory training than they have time to complete, do not penalize subordinates who report what was not done.

Access to Support

Prevention that relies on treatment cannot reach those who never seek or receive care. A 2024 RAND study on mental health confidentiality in the U.S. military identified persistent tensions between service members' privacy and commanders' operational responsibilities. Among survey respondents, 57.4 percent expressed concern that seeking mental health treatment could harm their careers, while nearly 90 percent indicated that privacy concerns would affect what they disclosed to military mental health providers. Misconceptions about confidentiality were also widespread. 56 percent incorrectly believed that missing a mental health appointment required command notification, while 32 percent believed the same applied to being prescribed mental health medication.

Furthermore, SPRIRC attributed understaffing in behavioral health (the military term for mental health services) to slow hiring processes, and declared relieving pressure on those services a priority. Beyond limited service availability, accessing care can involve a series of practical and institutional obstacles. Service members must first recognize that they need support, weigh potential career consequences, secure time away from their duties and navigate appointment and referral procedures, often requiring private phone calls during working hours.

Even identifying an appropriate service can be difficult since available resource lists may direct personnel to closed offices, disconnected numbers or services with restrictive eligibility criteria. Each additional step creates another point at which someone in distress may disengage, particularly when navigating the process demands the planning and persistence that distress itself can undermine.

The Defense Health Agency (DHA), which runs military hospitals and clinics, has begun to address waiting times. Under its Targeted Care model, a trained mental health professional conducts an initial interview and directs patients to the service that best fits their needs, which reduced the average time to support by 5.3 days. Triage of this kind (sorting patients by need) improves access to care for service members who have already come forward but does not reach those who have not. It still leaves the first step — deciding to seek help — with the individual, which can itself be a significant barrier.

Improving service availability alone is insufficient if personnel face administrative obstacles, uncertainty about confidentiality or perceived career consequences. Access reviews should examine the full pathway to care, verify that advertised resources are operational and correct misconceptions about disclosure and command notification.

> **Practical Takeaway:** Test the support pathway from a service member's perspective: call the numbers on the unit's resource list, verify eligibility and appointment availability, and record the steps required to reach an appropriate provider, including any approvals, waiting periods or confidentiality concerns. Where the pathway fails, revise unit procedures or raise the failure with the office responsible for the service.

Proactive Approaches to Well-Being

An example of proactive prevention comes from the U.S. Army's 3rd Brigade, 82nd Airborne Division. After examining unit climate surveys and trends in suicidal ideation, the brigade introduced the Panther Annual Wellness program, an annual, face-to-face assessment of soldiers' well-being designed to identify emerging difficulties and connect personnel with appropriate support. The program covered approximately 3,700 soldiers. In an optional exit survey, 2,014 respondents gave it an average rating of 9.23 out of 10. The published account also reports concurrent improvements in previously worsening trends in serious incident reports and retention (the share of soldiers choosing to stay in service).

Corioli Institute research, drawing on interviews with 22 Ukrainian veterans, military personnel, medical professionals and volunteers across 18 organizations, offers a complementary perspective on informal support practices under wartime conditions and their potential relevance to U.S. military program design. First, peer credibility: in one special forces rehabilitation program, as one participant put it, a wounded soldier "doesn't come to the psychologist, he comes to the same as him." Second, framing: one unit's running joke made mental health check-ins routine "without naming them as such." Third, timing: support was available by phone or Signal without fixed hours. Fourth, institutional trust: interviewees described gaps in state provision that encouraged organizations to develop support outside official channels.

The interviews also revealed key limitations, as practices spread quickly within units but rarely beyond them, and several units developed similar peer models without comparing results. Despite the differences between wartime Ukraine and U.S.

garrison life, these observations identify features of support delivery that warrant testing: peer credibility, informal framing, access outside fixed hours and trust built independently of official channels.

Evidence from other non-clinical approaches is similarly encouraging — over 90 percent of participants in military non-medical counseling reported positive experiences on most measures, while a 2026 review of six randomized trials found that behavioral activation delivered by trained non-specialists produced small reductions in depressive symptoms. Beyond improving access to care, regular contact with trusted peers and support providers may also help strengthen social relationships, mutual support and a sense of belonging within military communities.

> **Practical Takeaway:** Compare existing peer-support and wellness initiatives across units, documenting how personnel are approached, who delivers support, when contact occurs and how relationships are maintained. Identify promising practices and differences in implementation before considering their wider adoption.

Principles for Designing Proactive Support

While existing evidence supports the potential of proactive, non-clinical "upstream" approaches, their effectiveness in reducing suicide risk has not been established. Rigorously evaluated pilots are therefore needed to determine whether these approaches improve engagement, well-being and access to care. The four principles below set out what such a pilot involving trained peer supporters should include and how its results should be interpreted.

1. Delivery should be frictionless, proactive and regular. **Proactive contact** would remove the need for service members to initiate help-seeking, potentially reaching those who would not otherwise come forward. **Regular engagement** could identify emerging difficulties before they escalate, while continuity with the same supporter could build trust, strengthen social connections and sustain participation.

An opt-out model, in which service members are enrolled unless they decline, could raise participation further. However, service members may treat enrollment arranged through the chain of command with suspicion, and they are less likely to use a resource they believe could be used against them. Any pilot must therefore set clear disclosure rules, explain them before participation and ensure that service members understand the limits of confidentiality. Trained peer supporters should sit outside the chain of command, with lines of coordination and oversight defined in advance. They should have no access to personnel or medical records and should keep no recordings or notes that identify a participant beyond what follow-up requires.

2. Trained peers should provide an accessible first point of contact. Clinical care is essential to any comprehensive response to military suicide, but behavioral health services are stretched in part because they serve as the first response to a wide range of psychological difficulties. Peers could take on that first contact, with clinicians remaining responsible for assessment and treatment. Peer support may be particularly relevant to moral injury, which originates in the conduct of the institution rather than in a clinical condition.

Clinical care is also constrained by administrative requirements that reduce caseloads and add steps for the patient, and by rules on when and where clinicians can provide care. A pilot could test whether non-clinical peer supporters with manageable caseloads, defined training, escalation protocols and clinical supervision can remain in contact with a service member in crisis until another provider takes over. Operating outside the military's clinical and command structures could allow peer supporters to reach service members who avoid existing services for fear of career consequences.

3. Programs should connect participants with existing support. Peer supporters need rehearsed procedures for connecting service members with appropriate, validated care. Where clinical care is needed, a **warm handoff** — maintaining contact until the person receives appropriate services — could improve referral completion. Chaplains, legal aid, financial counselors, housing managers and local nonprofit organizations should also be checked and offered where relevant.

Garrison stakeholders will need to agree and approve risk-reduction procedures. Under DoD policy, military mental health providers must notify commanders in specified circumstances, including serious risks of self-harm or harm to others. Disclosure thresholds for a peer program must be set in accordance with these and any other applicable legal, professional and military reporting requirements, and agreed before implementation. Supporters should rehearse the crisis call path at their installation, and follow-up should continue after a crisis or handoff, particularly after a suicide attempt, when risk remains elevated.

4. Program leadership should give military leaders the information to drive upstream change. A confidential support channel could identify recurring institutional pressures, such as lost sleep, poor access to meals, substandard barracks and administrative friction, including problems obscured by inaccurate official reporting. **Anonymized feedback to commanders** could reveal these gaps and inform corrective action, supported by relevant research and established practices. What the program may capture and report should be approved in advance by the relevant classification authorities.

> **Practical Takeaway:** Evaluate each component of a proactive support pilot against a defined outcome: contact by reach, engagement by continued participation, peer continuity by trust, referrals by successful connections to care, and institutional feedback by improvements in working and living conditions. Assess suicide-related outcomes separately, without treating improvements in these intermediate measures as proof of reduced suicide risk.

The following figures illustrate how a pilot based on these principles could operate, from regular contact and referral to institutional feedback. They also set out the safeguards, evaluation measures and potential implementation failures that should be considered before wider adoption.

How a proactive peer-support pilot would work

1 IDENTIFY UPSTREAM CONDITIONS
under command control

2 ELIMINATE BARRIERS
to existing care

3 BEGIN PROACTIVE SUPPORT (BELOW)
via program-initiated contact

4 CONDUCT EVALUATION
See next page

feedback loop: **fix the conditions that precede crisis**

1 REACH

Proactive, regular contact

- The program, not the chain of command, makes an opt-out offer.
- The supporter reaches out; no one has to ask for help.
- Same supporter each time, reachable outside duty hours.

Trust sustains participation →

2 IDENTIFY AND GUIDE

Trained peers identify needs and appropriate pathways

- Clinicians remain responsible for treatment and diagnostics — peer support must not overstep.
- Defined training, escalation protocols, credentialed supervision.
- At each contact, the supporter identifies the appropriate pathway under agreed protocols.

At every contact →

3 CONNECT

Four routes under agreed protocols

Within peer scope	Continue regular contact.
Practical need	Connect with a validated resource: chaplain, legal aid, finances, housing, nonprofit.
Clinical need	Warm handoff: supporter stays in contact until the first appointment.
Disclosure threshold met	Follow the installation crisis call path; notify as applicable rules require.

↻ Continue regular contact after each route, with intensified follow-up after a crisis or suicide attempt.

Patterns across contacts →

4 INFORM

Pooled feedback to leaders

- Recurring pressures — such as poor sleep, inadequate housing or administrative obstacles — are logged without identifying individuals.
- Patterns are reported only above a minimum group size, within approved disclosure limits.
- Feedback remains within security classification guidance and is tied to actionable recommendations and best practices.

SAFEGUARDS

- Participation is voluntary; declining or withdrawing ends contact without repercussions.
- Supporters operate outside the chain of command and cannot access personnel or medical records.
- Disclosure thresholds are agreed before launch and comply with applicable legal, professional and military requirements.

Source: Corioli synthesis of the pilot design set out in this brief, drawing on the SPRIRC final report (2023), the RAND study of mental health confidentiality in the U.S. military (2024), DoD guidance on command notification and Corioli Institute interviews in Ukraine. The routes and safeguards are a design for piloting, not a validated program model.

How to evaluate a proactive peer-support pilot: what to measure and where it could fail

BEFORE LAUNCH

1. Test whether participants understand they can decline, what stays confidential and when disclosure is required
2. Agree confidentiality limits, disclosure thresholds and crisis-response procedures with garrison stakeholders
3. Check every listed service and rehearse the crisis call path at each installation
4. Identify suitable comparison units, establish baselines and document remaining differences

EVALUATE EACH MECHANISM SEPARATELY

What each part should change, and one way to count it

Mechanism	What it should change	Example indicator
Proactive contact	Reach: people who would not otherwise seek help	Share of participants reporting no support-service contact in the preceding year; indicates reach among previously unserved personnel, but not additional reach attributable to the pilot
Regular engagement	Continued participation and early detection	Share still engaged at 3, 6 and 12 months; share of problems first raised at a routine check-in rather than in crisis
Peer continuity	Trust and social connectedness	Change in belonging on a validated scale (e.g., Interpersonal Needs Questionnaire); participants' reported trust in their supporter
Referral and handoff	Successful connections to care	Share of referrals that end in an attended first appointment; days from referral to first appointment
Institutional feedback	Improvements in working and living conditions	Share of reported institutional pressures resulting in documented corrective action; time from reporting to fix
Overall pilot outcomes	Suicide-related risk, assessed separately	Suicidal ideation and attempts on a validated screen (e.g., C-SSRS), compared with matched units outside the pilot and adjusted for baseline differences between them

WHERE IT CAN BREAK

What the pilot team should track to catch each failure early

Stage	Likely failure	What to track
Enrollment	Arranged or recorded through the chain of command; participants misunderstand what stays confidential	Decline and withdrawal rates by unit; share who can state correctly when disclosure is required
Regular contact	Contact lapses after the first meeting, supporters change, or contact is available only in duty hours	Contacts per participant over time; share retaining the same supporter; share of contacts outside duty hours
Service Referral	The listed service is closed, unreachable or does not accept the participant	Share of referrals accepted by the receiving service; date of last service availability check
Warm handoff	Contact ends at referral, or the wait for a first appointment is long enough to disengage	Days from handoff to first appointment; share of first appointments attended
Crisis	Supporters are unsure of the call path, or follow-up stops once the immediate crisis passes	Whether the call path is rehearsed at each installation; follow-up contacts in the weeks after a crisis or attempt
Feedback to command	Patterns from small units identify individuals, or pressures are reported with no one assigned to resolve them	Minimum group size applied before reporting; share of pressures with a named owner and resolution date

Why not count suicide deaths alone? At the 2024 Active Component rate of 23.8 per 100,000, a pilot involving approximately 3,700 soldiers — comparable to the Panther program — would expect fewer than one suicide death per year. This is too few to reliably detect an intervention effect. Measure suicidal ideation and attempts separately, and treat intermediate outcomes as indicators of potential benefit, not proof of reduced suicide risk.