EDITORIALS

Suicide Prevention for Veterans and Active Duty Personnel

A considerable body of research has identified correlates of suicide at the genetic, neurologic, psychological, social, and cultural levels. Among risk characteristics identified in existing studies, current or former military service has emerged as a topic of considerable scientific and public interest. Of those who die from suicide, veterans and active duty military personnel represent a select group with considerable heterogeneity in individual characteristics and life histories. Such heterogeneity in individuallevel characteristics and precipitating events carries with it the potential to obfuscate relationships between individual risk factors, experiences uniquely associated with military service, and social and cultural factors. Despite these challenges, results from existing studies suggest that history of military service is an element worthy of consideration in efforts to address the complex and multifaceted nature of intentional self-harm. Given the intricate etiology of suicide and limitations of current data systems, it is not surprising that uncertainty surrounds the exact nature of the relationships between history of military service and suicide.[1] Moreover, the unique experiences of different military cohorts may play a key role as major contextual factors given the diverse range of exposures experienced by different cohorts.

It is our position that an appropriate response to any evidence of increased risk for suicide among veterans and active duty service members include a multifaceted prevention strategy that considers both traditional markers of individual risk for suicide and those that are universally represented, without consideration of individual history.[2,3] Universal strategies, such as public education campaigns and toll-free crisis lines, provide opportunities to increase awareness, facilitate access, and promote use of crisis services among those experiencing distress. At the same time, targeted approaches in those who have served and especially subpopulations who may bear a disproportionate burden of risk are critically needed. We also are keenly aware of the need to identify and provide immediate intervention to those who are in imminent danger of taking their own lives. Taken together, these prevention strategies embody a public health approach to prevention. A public health approach has been shown to be promising because, in part, of the overlapping influence of strategies at each level. At the same time, it avoids piecemeal approaches that may not, by their very nature, be sustainable.[2] By way of example, a public health approach should include universal programs designed to promote seeking help and access to services among those in distress (ideally before they are at imminent risk for suicide), the implementation of systems to inform clinical decisions and understand outcomes among those with demonstrated risk, and the development and evaluation of clinical approaches to reduce risk for self-directed violence among unique clinical groups that have already experienced signs and symptoms (such as suicide attempts and reattempts).

The articles in this issue provide the most current and comprehensive picture of what we know about the epidemiology, assessment, and prevention of suicide from clinical and population-based perspectives. They include a reanalysis of data from the National Health Interview

US Air Force Staff Sgt. William Taylor spends a quiet moment with his mount Dakota before a horseback ride with fellow military families at a Project Sanctuary retreat on November 12, 2011, near Granby, CO. The 6-day retreat is designed to give active duty and veteran families time to reconnect with each other, often after years of separation due to military deployments. Photograph by John Moore. Printed with Permission of Getty Images.

Survey by Miller et al.,[4] accompanying commentaries by Miller et al.[5] and Kaplan et al.,[6] and an editorial by Gibbons et al.,[7] which reflect the ongoing debate regarding both the nature of the data available on suicide in veterans and methodological approaches for calculating estimates of risk associated with veteran status. This debate underscores the need for improved data sources to estimate the burden of suicide and suicidal behaviors in veterans and military populations and the challenges posed by a lack of integration among existing data systems. It is worth noting the difficulty in identifying the incidence or characteristics of suicide among veterans who have not received services from the Veterans Health Administration (VHA), and in ascertaining whether these veterans bear a significantly different risk for suicide than veterans seen within the VHA health care system.

Based on evidence largely from postmortem research using psychological autopsy methods, many who die by suicide bear a tremendous burden of risk associated with psychopathology. However, a study of suicide among veterans who received VHA services also suggested that many of those who died from suicide did not carry a diagnosis at the time of their death,[8] suggesting the need for continued efforts to promote help seeking and treatment among those experiencing distress. There are a number of articles in this supplement that focus on specific risk factors that appear to increase the risk of suicidality among veterans and military personnel, including sleep disorders (Pigeon et al.[9]), substance abuse (Ilgen et al.[10]), and depression (Britton et al.[11]). In an editorial in this supplement, Conner and Bossarte[11] argue that clinical services, rather than being in opposition to public health approaches to suicide prevention, are a fundamental component of public health approaches to reducing deaths and associated morbidity from suicide. Finally, assessment of suicidal behaviors is a constant challenge to the field of suicide prevention in general. McCarthy et al.[12] describe the first use of a clinical assessment tool that resulted in a public health impact through providing early identification and support to airmen that potentially could reduce suicidal behaviors.

In summary, much as the Framingham study found in its early decades, collaborative efforts between clinicians and epidemiologists provide a foundation for changing the cultural norms associated with a major public health problem. Treating groups at high risk for suicide is a necessary, but insufficient response to suicide. Strategies designed to engage entire populations, with and without consideration of individual risk characteristics, may ultimately have the biggest impact.[13] The promise of a population strategy is eloquently discussed by Katz,[14] who provides one hypothesis for how a public health approach may result in reduced mortality because of suicide in veterans. This supplement represents an effort on the part of many to bring together divergent perspectives from those who are working daily to acquire a better understanding of what works for preventing suicide in those who have served our country. The considerable interest shown in this supplement is a tribute to all who have served in the military and we, as do all Americans, thank them for their service. We deeply hope that this supplement will serve as a catalyst for continued research that will improve the lives of our veterans, and reduce the morbidity and mortality because of suicide in those who have served in the military. ■

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