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CASE STUDY

Peer Mentoring, Camaraderie, and Support (PMCS) of Southern New Jersey: Suicide Prevention using Human Experience and Social Determinants of Health

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ABSTRACT

Suicide prevention is a high priority for Veterans Health Administration (VHA). Recent data show an increase in suicide rates, especially among Veterans that had not used VHA health services and nor had received any VHA benefits. Meanwhile, data collected for the past two decades reveals a decline in suicide rates among Veterans who were recent VHA users with mental health or substance use disorders.[1] The objective of the Peer Mentoring, Camaraderie, and Support (PMCS) Program was to explore novel ways to reengage and reintegrate Veterans into their earned VA healthcare benefits, and examine the effectiveness of this new initiative by providing excellent human experience and social support to mitigate Veteran suicide in South New Jersey. The PMCS name is taken from an acronym that is used by the United States Army referring to "Preventative Maintenance Checks and Services," which includes tasks that are completed on a weekly, monthly, or annual basis to ensure the overall combat readiness of military equipment. Thus, PMCS closely resonates with Veterans, *but this time the focus is not on equipment but rather on their overall wellness and mental health readiness.* This case study addresses recruitment, selection, onboarding, and orientation methods, as well as Veterans experience journey with emphasis on the Veterans Social Determinants of Health goals. The results demonstrate significant improvements across multiple clinical and psychosocial measures. Notably, there was a 77.8% reduction in suicidality (C-SSRS), a 35.2% decrease in depression symptoms (PHQ-9), a 23.6% decrease in PTSD symptoms, and a 22.7% reduction in anxiety symptoms (GAD-7). In parallel, participants showed a 33.7% increase in perceived interpersonal support and a 26.8% improvement in psychosocial functioning. As such, PCMS model offers a potential promise for suicide mitigation.

Keywords: Veteran patient experience, Veteran engagement in their health, Suicide mitigation, Peer mentoring and support, Advocacy, Community-based engagement, Social determinants of health for veterans, Quality of life

1. Introduction

According to the 2024 National Veteran Suicide Prevention Annual Report, 17.6 Veterans died by suicide each day in 2022. Notably, there was a significant difference in suicide rates between Veterans who received care through the Veterans Health Administration (VHA) and those who did not. Veterans engaged in VHA care had a lower suicide rate—approximately 7 per day—compared to 10.6 per day among those not utilizing VHA services. The

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2023 National Veteran Suicide Prevention Annual Report,[1] sheds more light on this concerning pattern. According to the report, over 60% of Veterans who died by suicide in 2021, did not received care through the Veterans Health Administration (VHA) in either 2020 or 2021, and more than 50% had no engagement with either VHA or Veterans Benefits Administration (VBA). This includes services, such as compensation, pension, insurance, education, home loan benefits, and other similar services. In contrast, a 20-year trend analysis reveals a decline in suicide rates among Veterans who were recent VHA users, particularly those diagnosed with mental health or substance use disorders.[2] Additionally, patients are at increased risk of self-harm, suicide, and readmission to hospital shortly after discharge from inpatient to community mental health care.[3]

As of 2024, VHA has implemented nearly 30 suicide prevention pilot projects, many of which are centered on the Community-Based Interventions for Suicide Prevention (CBI-SP). These efforts reflect VHA's commitment to making suicide prevention a top priority. The initiative promotes a unified model that bridges national strategies with community-level action, while also fostering innovation, research, and rigorous program evaluation to assess the effectiveness of such interventions.[1]

2. Aims

As such, the overall objective of this innovative project was to explore novel ways to reengage and reintegrate Veterans into their earned VA healthcare benefits, and examine the effectiveness of our new initiative Peer Mentoring, Camaraderie, and Support (PMCS) by the way of providing excellent community-based human experiences and social support to mitigate Veteran suicide in South New Jersey.

3. Background

3.1. Program description

The Peer Mentoring, Camaraderie, and Support (PMCS) Program was developed in response to the critical need to engage and reintegrate Veterans into the VA healthcare system and ensure access to their earned benefits, as supported by data, stated earlier.[1–3] The original question was, what can we do to better reengage Veterans?

To address the question above, in December 2021, we were invited by Vince Kane, former Director of the Wilmington VA Medical Center, to assist in developing a program aimed at reengaging and reintegrating Veterans with the Veterans Health Administration (VHA). The initiative began by partnering with VA peer specialists to reach out to Veterans in Atlantic and Cape May Counties, New Jersey, who had a history of missed or canceled appointments, or who had not been seen at a VA facility in over 24 months.

The Veteran Peer Suicide Prevention Program (VPSPP) officially launched on December 14, 2022, in Somers Point, New Jersey. Following the kick-off event, the program hired its first employee in February 2023 and began receiving referrals shortly thereafter from both VA and community partners. Referral activity was steady in the early months, and by July 2023, the VPSPP had enrolled 24 active participants.

3.2. Name change

As stated earlier, the program was formerly known as the *Veteran Peer Suicide Prevention Program* (VPSPP). Based on the feedback from the program participants, the team decided on a program name change to "*Peer Mentoring, Camaraderie, and Support*" (PMCS). This change emanated by program participants who felt that there is a stigma associated with the name "Suicide Prevention." Stigmatizing language is being most often associated with reduced help-seeking,[4] and language is one of the potential sources and predictors for suicidal thoughts and behaviors.[5] In addition, it was important that our participants felt comfortable with the name of the program they were engaged in.

The PMCS name is taken from an acronym used by the United States Army referring to "Preventative Maintenance Checks and Services," which resonates with Veterans. This phrase includes tasks that are completed on a weekly, monthly, or annual basis to ensure proper functioning and the overall combat readiness of military equipment. Working along that same thought process, the PMCS Program guides veterans to ensure their overall wellness and mental health readiness. In other words, we won't be performing maintenance on military equipment, however we will be providing you with the tools to conduct PMCS on mental health and overall wellness. Thus, was born *the Peer Mentoring, Camaraderie, and Support* Program of Atlantic, Cape May, and Cumberland Counties of southern New Jersey.

3.3. The team

The team typically consists of five employees, including two Licensed Clinical Social Workers (LCSWs), two Peer Specialists, and one Supervisory

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Peer Specialist. One of the LCSWs serves as Program Coordinator and the other LCSW as a therapist. The team also benefits from the support of current leadership at the Wilmington VA Medical Center and others.

3.4. Program resources and leadership support

Leadership support, funding, and availability of resources are critical for maintaining a successful program.[6] Fortunately, these foundational elements were already in place within the Department of Veteran Affairs. With the full backing of the Wilmington VA Director, the program was launched with strong institutional support. Personnel costs were already covered, and a robust network of community partners was actively engaged. Staffing needs were met through the medical center's budget, and we had access to a comprehensive database of Veterans already enrolled in VA health care. These advantages positioned us well to identify and support Veterans most in need—helping them pursue recovery, fulfillment, and overall well-being.

4. Rationale

Peer Mentoring, Camaraderie, and Support (PMCS) is a Veteran-Centered program that operates with a focus on four fundamentals all supported by evidence-based research:

1. Community Setting
2. Peer Mentoring
3. Camaraderie
4. Peer Support, Advocacy, and Education (Peer SAE)

4.1. Community setting

Our model is centered on social impact, and powered by a function of community support and engagement. Beehler, et al.[7] in a study of a conceptual model of community-based veteran peer suicide prevention concluded that, "Community-based veteran peer efforts are a promising public health approach to preventing veteran suicide." They also recommended that key organizational, relational, and practical elements are needed to achieve positive outcomes. In the same vein, a comprehensive literature review by Robertson,[8] suggests that peer-to-peer approaches in community setting can: a) reduce stigma, b) increase connections and reduce isolation, and c) increase access to services. Klee,[9] studied the evolving roles of peer specialists and education going back to 30 years, suggesting that, "peer specialists promote recovery, foster resilience, and build on patients' strengths to support community integration and help them lead more fulfilling lives."

4.2. Peer mentoring

Studies by Gillard, et al.,[10] have shown that peer mentoring is different from other forms of mental health support and conventional patient-clinician relationships. Though complimentary, evidence-based research shows peer support services have a positive impact on levels of hope, empowerment, and quality of life.[11] Beyond suicide prevention, peer connections, peer spaces, and peer-delivered anti-stigma interventions has shown other benefits, such as employment and education pathways.[12] Bowersox, et al.[13] based on the review of 84 randomized and controlled studies concluded that: a) peers of individuals at risk for suicide play important roles in suicide prevention, and b) peer support interventions show promise in addressing suicide risk. As such, peer mentoring has been one of the important components of the PMCS Program.

4.3. Camaraderie

Unit cohesions developed among Veterans during a war have shown reduced symptoms in posttraumatic stress disorder (PTSD) later in life.[14] In addition, engaging veterans in community activities creates space for veterans to re-experience the purpose and camaraderie they often miss after their time in the military.[15] Given the challenges of veterans reengaging in civilian life after separation from the army, recreating a familiar culture of camaraderie helps instill feelings of connectedness and contribution to their respective civilian communities.[16] As such, peer support and camaraderie events provide a familiar space for the Veterans to connect.

4.4. Peer support, advocacy, and education (Peer SAE)

Being a Department of Veteran Affairs program, the PMCS Program possesses advantages, such as extended resources, and established infrastructure as compared to other charity Peer-SAEs. First, most charities rely on the volunteerism of its members, where we have hired employees to keep the program running. Second, the PMCS Program doesn't require fundraising in order to provide its programming. Finally, operating under the Department of Veteran Affairs further facilitates that the patients we serve are also easily reached, whereas the nonprofits yearn to recruit in order to provide services for them. The

following paragraphs summarize each element of the *Peer SAE:*

4.4.1. Peer support

Many charity organizations have used similar approaches outside of the VA, and have found incredible success with them.[17,18] Peer-support programs connect patients and caregivers to others with similar health issues; offer informational and psychosocial support; and reduce social isolation.[19] Particularly, peer support involves people who are rarely reached by organized healthcare services.[20] As such, peer support has been introduced into mental health services internationally, leveraging the unique value of shared experiences and diverse perspectives. This approach often is seen as alternative or complement to traditional mental health support.[21]

According to Mutschler et al.[22] there are many elements that contribute to the effectiveness of peer mentoring programs within mental health services. Among them are: a precise and accessible policy mandates, appropriate funding, an organizational culture that accepts peer support, available resources, and leadership engagement. Other variables include: an engaged implementation climate; health professionals that are educated on their roles, scope, and ideology; the priority of the intervention; and Peer Support Workers (PSWs). As we discussed earlier, many of these elements are available for the PMCS Program in the New Jersey region.

4.4.2. Advocacy

According to the VA Core-Values,[23] advocacy is defined as, "Be truly Veteran-centric by identifying, fully considering, and appropriately advancing the interests of Veterans and other beneficiaries." Advocacy is a VA Core Value, and traditionally patient advocates utilize the Patient Advocate Tracking System (PATS) to document, track, and report patient-related issues. In contrast, PMCS's major focus is on *Social Determinants of Health*, such as housing, occupation, education, wellness tools, information, and most importantly personal experiences that assist the veteran in self-advocacy skills for healthcare and personal settings, including vital involvement in their treatment team discussions.

The Beryl Institute[24] sheds light on the fundamental roles of patient advocates: "Patient advocates bring knowledge to healthcare; they bring information, they bring comfort and understanding, they tackle tough issues, some painful, and work to resolve opportunities that elevate joy and hope." In sum, they are a bridge between healthcare providers and Veterans. Patient advocacy not only ensures equitable access, but also excellent patient experience, customer service and satisfaction through a comprehensive training and education.

4.4.3. Education

Peer Specialists employed by the Department of Veterans Affairs are required to hold a peer support training certificate. These certifications can be obtained either through the VA or through a state-recognized agency in the state where the Peer Specialist will be working. For the PMCS Program, Peer Specialists have completed the New Jersey Certified Recovery Support Practitioner (CRSP)[25] credential, which is administered by Consumer Connections and certified by the Certification Board, Inc.

To earn the NJ CRSP certification, individuals must complete an 18-hour Wellness Recovery Action Plan (WRAP) training, an 84-hour CORE training, and 500 hours of supervised, on-the-job peer support services.

The Department of Veterans Affairs has also a Peer Specialist Toolkit,[26] which provides a set of competency list and skills that are required of all peer specialists. Additionally, the PMCS specialists are educated on veteran benefits, available community services, and relevant geographical social supports. This knowledge enables them to provide veterans with options for achieving wellness.

5. Program design

To promote organizational structure and simplify the process, PMCS incorporates VA's Own-the-Moment guiding principles: Emotional Connection, Effectiveness and Ease (3Es). In alignment with these principles, PMCS has developed a comprehensive Program Handbook to guide both staff and participants through each stage of the program.

Once a Veteran is referred to PMCS, the journey begins with a structured five-phase process:

1. **Phase 1 & 2 – Selection:** The committee conducts a thorough review and selection process that includes Consult phase and Discussion phase.
2. **Phase 3 – Onboarding:** Selected Veterans undergo a comprehensive orientation.
3. **Phase 4 – Participation:** Veterans actively work toward personalized goals established during orientation.

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Table 1. Five phases of patient journey.

Phases	Description
1. Consult Phase	• Veterans are screened for suicidality risk • Medical records are evaluated for appropriateness for the program
2. Discussion Phase	• Recommendations are made after deliberation by no less than 2 members of the PMCS leadership team, and 1 additional LCSW or Peer Lead • Upon approval, contact is made with the Veteran by a member of leadership team, typically by the supervisory peer specialist • Topics include program description, activities, the Veteran's ability to participate in the program, QAs
3. Onboarding Phase	• Discuss the Veteran's interests, goals, and agree upon peer-to-Veteran engagement frequency • Review the importance of attending camaraderie events, and face-to-face engagement during the Veteran's time with the PMCS Program • Veteran's time with the PMCS Program • PMCS disqualifiers related to misconduct
4. Participation Phase	Set SMART goals using acronym, "HOME R & R" outlined as follows: • Housing-related goals • Occupation-related goals • Medical • Educational • Rest & Relationship goals **Additional Goals:** • Interests and issues • "Everyone Who Loves Them," a program that encourages love, and close relationships with spouse and others
5. Alumni Phase	• The Veteran Alumni will be invited to attend camaraderie events hosted by PMCS Program • Develop ways to be active in supporting others in the community

4. **Phase 5 – Alumni:** Upon successful completion, Veterans graduate and transition into the alumni phase, where continued engagement is encouraged.

Table 1 provides a summary of these five phases, outlining the key milestones in the Veteran's journey through the PMCS Program in more details.

6. Methods

The following sections will detail the methods used to recruit and select Veterans for the program, outline the onboarding process, and describe the overall Veteran experience throughout their journey in PMCS.

6.1. Patient recruitment

Recruitment into the PMCS Program involves both *internal* and *community-based* referrals:

Internal Referrals: These referrals come from a variety of VHA providers or from a VA employee, which follows national and local VA policy and Standard Operating Procedures (SOPs) including Computerized Patient Record System (CPRS) and Consult Tracking Manager record systems.

Community-Based Referrals: Community referrals primarily come from local emergency rooms/hospitals and local law enforcement. When the originator of contact is a local police department, engaged with an actively suicidal veteran already enrolled and vested with Wilmington VA Medical Center, the referral is also considered a "community referral" even if the veteran's consult is in CPRS (VA's electronic data system).

6.2. Selection

Once eligibility is confirmed, PMCS utilizes comprehensive assessment tools to evaluate risk levels, track participant progress, and determine disqualifying factors.

6.2.1. Eligibility

Following referral to the program, Veterans must satisfy the eligibility criteria for receiving benefits through the Veterans Health Administration (VHA). This includes individuals currently serving on active duty, those who have been honorably discharged, and Veterans eligible to receiving Veteran Health Administration benefits. (A complete eligibility conditions are highlighted in the PMCS Program Handbook).

6.2.2. Screening for suicidality: Risk assessment instruments

A targeted and systematic approach to screening and risk assessment is essential for identifying the most suitable candidates, while also ensuring the responsi-

ble use of limited resources. We identified the use of Columbia-Suicide Severity Rating Scale (C-SSRS)[27] as a critical criterion for selecting Veterans for the PMCS Program and assessing suicide risk. Research by Thom[28] and colleagues supports the C-SSRS's strong psychometric properties, demonstrating high convergent and divergent validity, as well as high sensitivity and specificity in detecting both actual and interrupted suicide attempts. Priority enrollment is given to veterans who score 3 or higher on the C-SSRS, indicating elevated risk. This threshold reflects specific indicators, such as:

- Had thought about suicide.
- Had the means to complete suicide.
- Had a plan to die by suicide.

In additions, we also included the following two criteria:

- Veteran having attempted suicide in the past 12 months, and/or
- participated in preparatory suicidal behaviors.

Veterans meeting all of the above five criteria will be first to be enrolled in the program.

6.2.3. Disqualifiers

A) Sex offenders: Because of our diverse group of veterans that we serve in the PMCS Program, those who are currently on a sexual abuse registry are not accepted to the program.
B) Non-responders for the initial contacts: If a referred Veteran does not respond after three attempts, the Veteran's consult will be closed and their provider will be notified.

7. Onboarding

7.1. Orientation phase

If a positive decision is rendered and the veteran accepts entry into the program, the Veteran is then contacted by the veteran's assigned peer specialist. The purpose of this contact is to schedule a program orientation with the Veteran. Orientation discusses the veteran's interests, goals, and agreed upon Peer-to-Veteran engagement frequency. They also discuss the importance of attending camaraderie events and face-to-face engagements during the Veteran's time with the PMCS Program. This session also includes a discussion of PMCS Program disqualifiers related to any misconduct.

7.2. Documentation

One of the important components of onboarding is signing the Patient/Provider agreement that includes program overview, policies and expectations, group support, consent for asynchronous assessments, attendance, confidentiality and other information. If appropriate, the Veteran is formally accepted to the program with an intake completed by one of the LCSW staff members.

7.3. Goal setting

As explained earlier, at the heart of the Veteran's onboarding is setting SMART goals based on ***Social Determinants of Health*** that typically includes the acronym of ***"HOME ROE,"*** which stands for any goals pertaining to: *Housing, Occupation, Medical, Education and Rest & Relaxation, Other Goals relating to issues and interests of the Veteran, and Everyone they love, e.g., the veteran would like to stop fighting with their spouse and become closer with their friends*. It is important to note that these goals are not necessarily treatment plan related, but rather emphasize the *Veterans PMCS Journey*, which also enable the veteran to more easily achieve their treatment goals with their licensed mental health providers.

8. Veterans experience journey

To enhance the veteran experience, PMCS uses a variety of methodologies including:

- *one-on-one engagements with VA Peer Specialists,.*
- *physical activities, peer support groups, and.*
- *community gatherings*.

These encounters provide each participant to engage with allies that are experiencing the same or similar circumstances, creating a sense of camaraderie. The journey also includes the veteran's care team, family, and friends. The highlights of the events include:

8.1. Weekly one-on-one engagements

The criteria for weekly one-on-one engagements are established during the Veteran's orientation with their assigned Peer Specialist. While initial engagement days are set at this stage, they remain flexible and may be adjusted throughout the Veteran's participation in the PMCS Program. These engagements may occur in person, by telephone, or through virtual platforms. *Consistent weekly engagement is a mandatory*

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component of the program and is required for continued participation.

8.2. Scheduled weekly gatherings

Peer Specialists coordinate weekly gatherings with their assigned Veterans, open to all participants in the program. While attendance is encouraged, participation is not mandatory. However, unexcused absences (no call/no shows) may negatively impact a Veteran's standing in the program. Our current offerings are:

- **Mondays:**
  - 9:30 a.m. at Birch Grove Park in Northfield, NJ.
  - 1:00 p.m. weekly golf outing, Egg Harbor City, NJ.
- **Tuesdays:**
  - 10:00 a.m. Advanced Safety Planning Therapy Group, Northfield, NJ.
- **Wednesdays:**
  - 9:30 a.m. South Vineland Park, Vineland, NJ.
- **Thursdays:**
  - 9:00 a.m. Golf Range Wellness, Egg Harbor Township, NJ.
  - 12:00 p.m. Veteran X Peer Support Group, Northfield, NJ.
  - 4:30 p.m. Role Modeling & Social Skills Group, Mays Landing, NJ.
- **Fridays:**
  - 9:30 a.m. Ockie Park in Rio Grande, NJ.
  - 10:00 a.m. Disc Golf Day which rotates between many different disc golf courses in Atlantic and Cape May Counties.

Table 2 provides a sample of current PMCS Program activities:

Table 2. Peer and community service activities weekly/monthly.

Social Gatherings	Physical Activities
Arts and Crafts	PGA Hope golf Seminars
Coffee Socials	Golf Outing
Trivia Nights	Disc Golf
Project Refit	Cornhole
Holiday Dinners	Batting Cages
Fire Side Discussions	Hiking
Dungeons & Dragons	Fantasy Sports Leagues
	Archery
Peer Support Groups	**One-on-One Engagement**
Veteran X	VA Location*
Role Modeling & Social Skill Group	Community Locations*
Project Life Force – Advanced Safety Planning	VA Location*

*Indicates the type of location the Peer Specialist and the Veteran complete their engagement.

8.3. Camaraderie events

Camaraderie events organized by the PMCS Program are not held on fixed weekly or monthly schedule. Instead, these events are planned well in advance, with invitations extended to all program participants. Selected events are also designed to include Veterans' families, fostering a broader sense of community and support. While attendance is voluntary, all participants and their families are strongly encouraged to partake in these opportunities.

9. Discussions

9.1. Instrumentations and progress evaluations

In addition to the Columbia Suicidality Severity Rating Scale (C-SSRS),[27] which is used to primarily identify high risk patients for suicide, five additional follow- up measures are utilized to further evaluate patient progress while participating in the program. These assessments include:

- Patient Health Questionnaire-9 (PHQ-9):[29] To assess depression, determine depression severity, assist with diagnosis and identification of problem symptoms.
- General Anxiety Disorder (GAD-7):[30] Used in screening to assess the severity of anxiety symptoms.
- PTSD Checklist (PCL-5):[31] Posttraumatic-Stress Disorder Checklist is used to assess the presence and severity of symptoms.
- Brief Inventory of Psychosocial Functioning (B-IPF):[32] Measures psychosocial functional impairment within previous 30-days across seven domains including: relationships, family, work, socializing, parenting, education, and self-care.
- The Interpersonal Support Evaluation List (ISEL-12):[33] Twelve item assessment is used to measure perceived availability of social support on a four-point scale.

It is important to emphasize that Veterans participating in the PMCS Program may continue receiving care from their established providers within VA Behavioral Health or other applicable healthcare systems. The PMCS team does not replace those clinical services, rather, it complements them by offering additional support through targeted programs that enhance the Veteran's overall journey and well-being.

Table 3. Pre- and post-assessment results.

Mean Reductions in Scores		
C-SSRS (Suicidality Scale)	Reduction in Suicidality	–77.8%*
PHQ9 (Depression Scale)	Reduction in Depression Symptoms	–35.2%
PCL-5(PTSD Symptoms):	Reduction in PTSD Related symptoms	–23.6%
GAD7 (Anxiety Scale)	Reduction in Anxiety	–22.7%
Mean Increases in Scores		
ISEL-12 (Interpersonal Supports)	Increase in Perceived Social Supports	+33.7%
B-IPF (Psycho Social Functions)	Increase in Psycho Social Functioning	+26.8%

*To establish a measurable approach for assessing suicidality, we implemented a 5-point scoring system for the Columbia-Suicide Severity Rating Scale (C-SSRS). Each of the five primary questions was assigned a value: a response of 'No' was scored as 0 points, while a response of 'Yes' was scored as 5 points. This means a Veteran who answered 'Yes' to all five questions would receive a total score of 25, indicating higher risk, whereas a Veteran who answered 'No' to all questions would receive a score of 0, indicating no reported suicidality.

9.2. Data collection

Since the program's launch in December 2022, the PMCS Program has received a total of 151 referrals from both VHA and community providers. Of those, 97 veterans have been accepted into the program, resulting in a selection ratio of 64%. To date, 30 Veteran have successfully graduated, while 38 have been discharged for various reasons, including relocation out of state, non-compliance, or declining services. As of July 7, 2025, the program's retention rate stands at 62%.

As stated earlier, the PMCS Program utilizes six distinct mental health evaluations to determine each veteran's progress during their time with the PMCS Program. These measurements help identify both improvements and ongoing challenges related to common psychological difficulties experienced after military service. As of July 7, 2025, we have collected pre- and post-assessments on 45 participants who have been enrolled in the PMCS Program for more than 6 months. The findings to date, have been highly promising, including meaningful progress among many participants. Table 3, summarizes the results of pre- and post-assessments.

9.3. Data analysis

An analysis of pre- and post-assessment data from 45 Veterans who completed all six mental health evaluations reveals positive outcomes across all measures. Participation in the PMCS Program requires a positive result on the Columbia-Suicide Severity Rating Scale (C-SSRS) at intake, indicating a risk of suicidality. The most significant improvement was observed in suicidality, with a 77.8% reduction in C-SSRS scores, a highly encouraging indicator for suicide prevention. Depression symptoms decreased by 35.2%, a critical outcome given that depression accounted for over one-third of Veteran suicide fatalities in 2020, according to the 2022 National Veteran Suicide Prevention Annual Report.[2] Additionally, PTSD-related symptoms declined by 23.6%, and anxiety scores dropped by 22.7%. These results underscore the program's effectiveness in addressing key mental health challenges faced by Veterans.

Additional positive outcomes included a 33.7% improvement in psycho-social functioning and a 26.8% increase in perceived social support. These gains are particularly significant, as a lack of social support and a diminished sense of belonging have been identified as key risk factors contributing to suicide.[34]

9.4. Graduation

As of July 7, 2025, a total of 30 Veterans have successfully graduated from the PMCS Program. As previously noted, successful completion is based on progress toward individualized SMART goals established during orientation and refined throughout each Veteran's journey. While these goals vary and are often difficult to quantify, several key indicators are used to assess readiness for graduation. These include reductions in suicidality scores, increased protective factors, development of a personalized safety plan, enhanced social engagement, employment attainment, improved physical health, reduced or eliminated substance or alcohol use, involvement with service organizations, and strengthened family relationships.

Graduation does not signify the end of support. Veterans are strongly encouraged to continue participating in PMCS Camaraderie events. The primary change

post-graduation is that peer staff no longer conduct weekly check-ins, though the connection to the PMCS community remains open and ongoing.

10. Conclusions

Acknowledging that even saving one life is invaluable, early trials of PMCS Program demonstrates its effectiveness in reducing suicide risk and enhancing overall quality of life, as supported by collected data. The program's success hinges on several key factors, most notably, strong leadership support, adequate financial resources, and a culturally attuned model that resonates deeply with Veterans. To ensure sustained engagement and responsible use of limited resources, we recommend a careful selection process, comprehensive risk assessment, thorough orientation, and carefully defined boundaries. Ultimately, the program thrives when individuals are empowered to set SMART goals that incorporate Social Determinants of Health. Finally, our experience shows that meaningful changes are more likely to occur organically through real-world, community-based events rather than through a sole focus on illness management.

Limitations

First, the program participants were all Veterans, which limits the generalizability of the findings to broader population. However, the PMCS model offers valuable insights into how peer mentoring, camaraderie, education (Peer SAE) can be integrated to other settings. Second, the absence of control group prevents direct comparison with individuals who did not participate in the program. Additionally, the sample size was insufficient to conduct more meaningful statistical analyses of demographic variables or to perform a systematic review of attendance patterns. Finally, the limited number of participants restricted the ability to collect reliable and representative patient experience scores.

Conflict of interest

The authors declare no conflicts of interest.

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