Arizona Veterans' Services Advisory Commission
1688 W. Adams Street, Phoenix, AZ 85007

March 13, 2025

M I N U T E S

Advisory Commissioners Present
Philip Cushman, Chair (in person)
Gene Crego, Commissioner (virtual)
Chris Gibbs, Commissioner (virtual)
Kathy Gallowitz, Commissioner (virtual)
Charles Byers, Commissioner (in person)

AZ Department of Veterans' Services
Lupita Santellano, Executive Assistant (in person)
Julia Gusse, Legislative Liaison (in person)
John F. Scott II, Director (in person)

Absent
Matthew Kenney, Commissioner
Andrew Meshel, Commissioner

Guests
Patrick Lynch (virtual)
Joshua Rubin (virtual)
Dana Allmond, DES
Marcus, Deputy DES

Call to Order – The Arizona Veterans' Services Advisory Commission (AVSAC) meeting, via Google Meets: https://meet.google.com/jgq-vmsc-uux; Dial-in: (US) +1 475-222-5532 PIN: 275 244 224#. Chairman Cushman called the meeting to order at 10:07 am.

Chairman Cushman led the commission in the pledge of allegiance followed by guest introductions.

Approval of Meeting Minutes

Chairman Cushman called for a motion to approve the AVSAC meeting minutes from January 9, 2025, and January 31, 2025. The commission did not have time to review the minutes and tabled the approval of the minutes until the next Advisory Commission meeting.

Agency Announcements and Updates

Director's Department Update –

The VA Secretary provided a briefing at the NASDVA conference regarding VA layoffs and the effects of the layoffs at both the federal and state levels. Currently, there are no delays in processing payments for the State Veteran Homes. Where the department may see some concerns is in layoffs affection future payment processing. However, the

Secretary of the VA mentioned they are not firing front line workers. No further information could be provided, since the information changes on a daily basis.

The Arizona Department of Veterans' Services has hired a new Regional Administrator, Charles Villafranca. Director Scott promoted Gerardo "Gary" Ochoa to the Deputy Director position and William Glennon was promoted to Assistant Deputy Director-Veterans' Services Division.

The Arizona State Veteran Home –Flagstaff (ASVH-F) resumed admissions. The HVAC system repairs will be completed at the end of March 2025. All four wings of the Arizona State Veteran Home Flagstaff are up and running. The department has also purchased spare HVAC parts and storage containers for the extra parts. There are currently four residents at the ASVH-F; the veteran home requires twenty admissions in order to have survey come out for the initial recognition survey from the VA. The VA contracts surveys of the homes to Ascellon, which is currently under review; this may delay the recognition survey at ASVH-F. The ASVH-F is fully staffed for the admission of twenty veterans.

The Arizona State Veteran Home –Tucson continues to be a five star facility and continue to remain full. Arizona State Veteran Home – Yuma is hiring nursing staff in order to open their last wing, the memory care wing.

Arizona State Veteran Home –Phoenix is struggling with census. Their census is currently 67 out of 104. Director Scott has spoken with the Regional Administrator about placing his focus on that facility. Director Scott has heard that Tohono O'odham Nation is possibly looking at opening a Veteran Home. Director Scott would have to speak with the Governor's office about this possibility, as it could be good for veterans in Arizona. However, if the Phoenix Home no longer provides skilled nursing care, that property will revert to the VA, which again could be good for the veteran community as they are trying to expand.

The National Cemetery Administration is going to be in Tucson on April 2, 2025. The Deputy Undersecretary of Field Programs and Cemetery Operations is going to tour the Marana Cemetery. During the NASDVA conference, the Arizona Veterans Memorial Cemetery – Sierra Vista received recognition for being one of the eleven cemeteries out of 122 state and tribal cemeteries to receive an Operations of Excellence Award.

The Veteran Benefits Counselors (VBCs) will be bringing in 100 million dollars in benefits to veterans in about three months, meeting their goal for the year.

The Starlink kits have been rolled out to Tohono O'odham and San Carlos Apache.

ADVS is currently working with the Navajo Nation legal team, and has a meeting scheduled with Hopi on March 19, 2025.

There is an AZ Hires Vets event scheduled at Wesley Bolin Plaza on March 20, 2025.

Legislative Update –
Representative Blackman and Representative Marquez developed a Veteran Caucus board; each picked three veterans from their parties. They have selected six veterans total. They held a meeting to potentially create a mission statement.

America 250 is the 250th anniversary of the Declaration of Independence. Julia is a Liaison for the America 250 committee, led by Secretary Fontes. The committee is being formed in order to spread the word regarding this celebration, which is happening across the United States of America. The efforts begin this July 4, 2025, through July 4, 2026. The celebration will be held on July 4, 2026.

Julia Gusse provided her legislative report found here.

Old Business

Commission Meeting Planning – Kingman
The Commission has moved the Advisory Commission meeting originally scheduled for May 8, to May 22, 2025. This meeting will be held in Kingman, the location is still to be determined by Chairman Cushman. Chairman Cushman proposes the commission keep the same agenda as other meetings held out of Maricopa County. He would like to hold a Commanders call for local veteran service organizations (VSOs), a lunch with local town managers and dinner with local dignitaries. He suggested the Commissioners plan to stay two nights in Kingman to allow for travel time and to tour local facilities. Vice Chair Byers will reach out to Pat Farrell to tour a local facility. Commissioner Crego will reach out to local VSOs to host the commander's call. Commissioners will reach out to ADVS to make hotel reservations.

Commission Positions and Recruitment Update
There was no response from Boards and Commission in regards to the status of Patrick Lynch and Joshua Rubin's Advisory Commission applications. No response regarding Gene Crego and Kathy Gallowitz's renewal application.

Strategic Policy Objective Issues, Inquiries, and Answers

a) **Update re: data on Veteran Demographics**
b) **Update re: data on Veteran Suicide**
c) **Update re: data on Veteran Employment & Unemployment**

The Arizona Department of Veterans' Services provided the Advisory Commission with data regarding Veteran demographics in Maricopa County, as well as a few data reports related to suicide, Veteran employment and unemployment statistics, and an annual report on homelessness. Commissioner Gallowitz would like the commission to read the data provided and summarize the information.

Commissioner Gallowitz requested an updated census report that contains veteran's age, gender, ethnicity, and county. Julia will pull a report from the 2020 census with the demographics requested by Commissioner Gallowitz.

The Advisory Commission would like Col. Wanda Wright to attend a future Advisory Commission meeting to discuss women veterans' issues within Arizona. Commissioner Gallowitz will reach out to schedule Col. Wright to speak to the Commission at the September 2025 meeting.

New Business

Discuss Vision Statement for Arizona Veteran Community – The Veteran Caucus board would like to create a vision or mission statement for the Arizona Veteran Community. The commission believes the focus should be in the vision statement for the state of Arizona. Commissioner Gallowitz will draft a vision statement with aspirational themes. Commissioner Gallowitz would like to see ADVS' strategic plan.

Implications of Federal Cost Cutting Measures on Arizona Veterans - Vice Chair Byers is concerned about the VA cutting jobs and implementing a hiring freeze. He also mentioned the vetting process is terrible. He would also like to see more community care. Commissioner Gallowitz believes the commission should wait to hear more information from the VA.

Executive Session

AVSAC Chair Meeting Update - The commission ran out of time and did not go into executive session. A separate meeting will be scheduled within March 2025, to hold the executive session.

Outreach Activities for Commission

Commissioner Gallowitz reminded the commission the Arizona Coalition for Military Families annual Symposium is scheduled on April 16 and 17, 2025. The commissioners should have received an email to register free of charge. Vice Chair Byers is hosting a Symposium on March 22, 2025, at the American Legion Post 2 with the VA to assist the aging veteran population navigate healthcare. He also mentioned Senator Kelly and Senator Gallego are holding a panel in Tucson on April 3, 2025, which is also targeted at the aging veteran population.

For the Good of the Order
None.

Open Floor for Comments
None.

Adjournment
Chairman Cushman called for a motion to adjourn the Arizona Veterans' Services Advisory Commission Meeting. Vice Chair Byers motioned to adjourn the meeting. Commissioner Gibbs second the motion. The motion carried unanimously. Meeting adjourned at 12:11 pm.

ARIZONA

DEPARTMENT OF VETERANS' SERVICES

LEGISLATIVE UPDATE MARCH 2025

JULIA R. GUSSE, LEGISLATIVE LIAISON

FIFTY-SEVENTH LEGISLATURE
MONDAY, JANUARY 13, 2025

- Fifty-Seventh Legislature, Start of First Regular Session
- Senate Introduced Bills Deadline 02/03/25.
- House Introduced Bills Deadline 02/10/2025.
- First Legislative Update was posted on AZDVS Website on Monday, January 20th.
- To date we have 25 Senate Bills and 35 House Bills that are “Veteran/Military Related Bills”. Total of 60 Bills

AZDVS Led Legislative Bill

Veterans Donation Fund Bill Revision – SB1704

- Legislative Bill Proposal; language revision to allow 15% of Veteran Donation Fund for AZDVS state homes and an additional budget of not to exceed $150,000 for two FTE's.

- SB1704 "*Veterans' donations fund, annual transfer*" was introduced on 02/03/2025 sponsored by Senator Gowan.

- Military Affairs & Border Security Committee (MABS) approved and moved the bill unanimously on 02/10/2025.

SB1704 Continued

- Fact Sheet Available for any inquiries
- Senate Appropriations Committee approved unanimously on 02-18-2025.
- House Federalism, Military Affairs & Elections will hear this bill on 03-12-2024.
- If approved on the House side, it will move and continue the approval process with eventually being transmitted to the Governor for approval.

Education Related Bills

- SB1021 ROTC cadets; in-state student status

- HB2913 Tuition waivers; ABOR; community colleges

"HAZLEWOOD ACT TUITION WAIVER SCHOLARSHIP PROGRAM IS ESTABLISHED IN THE ARIZONA BOARD OF REGENTS. THE ARIZONA BOARD OF REGENTS SHALL ADMINISTER THE PROGRAM AND AWARD TUITION WAIVER SCHOLARSHIPS TO ANY PERSON WHO MEETS THE REQUIREMENTS IDENTIFIED"

*Follow up meeting regarding ABOR last session SB1174; tuition, family, posttraumatic, suicide

Justice Involved/Veterans Courts Bills

- SB1312 Coordinated reentry; grants; appropriation

An Act amending section 11-392, Arizona Revised Statutes; appropriating monies; relating to coordinated reentry planning services programs. 2025-02-12;Senate – PS DO PASS (Vote; 6-0-1-0).

- HB2617 Processing arrestees; veteran status

An Act Amending title 13, chapter 38, article 7, Arizona Revised Statutes, by adding section 13-3904; relating to arrest. 2025-01-28;House – Second Read. Obligates AZDVS to the recipient of a report gathered by law enforcement.

- HB2843 Veterans' court fund; grant program

An Act Amending title 41, chapter 1, article 5, Arizona Revised Statutes, by adding section 41-200; appropriating monies; relating to the attorney general. 2025-02-12;House – First Read. Grant collaboration with the courts for "veterans courts". No use of Opioid Funds…

HB2030 Impersonation; veteran; armed forces

- Introduced by Representative Blackman
- Bill has been amended with minor changes (punishment, gaining financially or favorably for those who wish to impersonate a veteran, removal from office if found out)
- Bill was introduced with a first read on 01-16-2025 and currently moving to the Senate with support
- AZDVS responsibilities to be determined, input provided; verification of violations will be difficult to prove without veteran consent

Housing/Homeless Veterans Bills

- SB1043 Homeless shelter services fund; appropriation
- SB1513 Housing grants; military; veteran; homeless
- SB1628 Supportive housing pilot program

Above are veteran related and all have 1st/2nd read and not assigned to committee.

Housing/Homeless Veterans Bills Continued

HB2435	homelessness; data; performance audit	Data collected may report on Veterans experiencing homelessness and drug abuse due to their military experiences. This data may cause further homelessness amongst a small population of veterans.
HB2437	drug-free homeless zones	1. introduces penalties for employees 2. "DRUG-FREE HOMELESS SERVICE ZONE" will continue the cycle of homelessness amongst veterans attempting to refrain from drug use. Housing should take priority and these policies will further criminalize homelessness amongst veterans.
HB2803	mixed hoteling; signage; requirements	Veterans Utilize HUD-VASH Vouchers, bridging federal dollars and these polices may jeopardize this vital funding source for homeless veterans.

Claims Bills "AKA Sharks Bills"

- At the end of last session, a suggestion was made to provide an overview of VSAFE to local legislators, pending new VA staffing and Presidential directives. This is no longer an option.

- SB1703 Veterans' benefits; claims; prohibition (introduced by Senator Gowan)
- HB2612 Veterans' benefits; claims; prohibition (introduced by Kupper, Nikolas)
- HB2842 Advising; veterans' benefits; requirements (introduced by Travers, Stacey)

Tax/Financial Bills

- SB1122 Property tax exemptions; inflation adjustment
- SB1155 income tax; subtraction; uniformed services
- SB1158 Property tax; exemption; widows; widowers
- SB1186 Rental housing; income source discrimination
- HB2009 Vehicle license tax; exemption; military
- HB2036 ASRS; temporary personnel service
- HB2077 ASRS; long-term disability
- HB2217 National guard; life insurance
- HB2406 Property tax; exemption; combat veterans
- HB2538 Rental housing; income source discrimination
- HB2672 Property tax; exemption; veterans; disabilities
- HCR2023 Property Tax Combat Veterans

Medical Marijuana Bills

- HB2261 Medical marijuana; fee; exemption; veterans

- HB2245 Appropriation; medical marijuana; veterans; fees ($10M)

Programs/Mental Health Bills

- SB1418 Outdoor-based therapy programs; grants
- SB1555 Psilocybin services; regulation; licensure
- SB1710 Veterans; mental health; grant program
- HB2320 Appropriation; veterans' services; mental health

Miscellaneous Bills

- Immigration/Border involving National Guard (SB1495, HCR2019,HB2146, HB2188)
- Voting Bills regarding active military and deadlines(HB2004)
- VA Police Bill to assure VA may extend services
- Arizona State Parks Free Access for Veterans (SB1267)
- Flags allowed in State/Government offices (HB2113)
- Nuclear Emergency fund (SB1009)
- Emergency Admission Transport (SB1163)
- Animal Bites Owner Info (SB1241)
- Gold Star Families (HCR2010)
- Special Plates Suicide Prevention (HB2111) & Native Veterans (HB2336)
- STRIKER BILL – APPROPRIATIONS PINAL COUNTY VETERANS (HB2933)

Legislative Committee's

APPROPRIATIONS
Tuesday, 2:00 PM, SHR 109
John Kavanagh (R), Chairman

DIRECTOR NOMINATIONS
Day and time to be announced on the floor of the Senate
Jake Hoffman (R), Chairman

EDUCATION
Wednesday, 2:00 PM, SHR 1
David C. Farnsworth (R), Chairman

FEDERALISM
Monday, 2:00 PM, SHR 2
Mark Finchem (R), Chairman

FINANCE
Monday, 2:00 PM, SHR 1
J.D. Mesnard (R), Chairman

GOVERNMENT
Wednesday, 9:00 AM, SHR 1
Jake Hoffman (R), Chairman

HEALTH AND HUMAN SERVICES
Wednesday, 9:00 AM, SHR 2
Carine Werner (R), Chairman

MILITARY AFFAIRS & BORDER SECURITY
Monday, 2:00 PM, SHR 109
David Gowan (R), Chairman

NATURAL RESOURCES
Tuesday, 2:00 PM, SHR 1
Thomas "T.J." Shope (R), Chairman

PUBLIC SAFETY
Wednesday, 2:00 PM, SHR 109
Kevin Payne (R), Chairman

REGULATORY AFFAIRS AND GOVERNMENT REFORM
Wednesday, 9:00 AM, SHR 109
Shawnna Bolick (R), Chairman

RULES
Monday, 1:00 PM, Caucus Room 1
Warren Petersen (R), Chairman

Legislative Liaison Report to the Commission

Veterans Caucus; Presentation by: Rep Blackman and Rep Márquez

America250; https://azsos.gov/az250

- The 250th Anniversary of the Declaration of Independence (July 4, 2025 – July 4, 2026)

Legislative Updates; https://dvs.az.gov/about/legislative-updates

- AZDVS SB1704; Fact Sheet
- AZ Veteran Demographics; SB1267 Veterans; lifetime state park pass

"As of January 10, 2025, there are 37,970 Veterans in Arizona that are 100% service connected. As of 2022 VA is reporting 454,620 Veterans living in Arizona. We should be somewhere around 600,000."

Veterans Suicide Report

Veteran Employment/Unemployment; https://www.bls.gov/cps/demographics/veterans.htm

Director Confirmation

ARIZONA DEPARTMENT OF VETERANS' SERVICES

1688 W. Adams Street
Phoenix, AZ 85007
602.255.3373

KATIE HOBBS
GOVERNOR

JOHN SCOTT
DIRECTOR

Arizona Department of Veterans' Services
SB 1704: Veterans' Donations Fund; Annual Transfer
Senator David Gowan

Background:

The Arizona Department of Veterans' Services (ADVS) operates four skilled-nursing facilities throughout Arizona, in Flagstaff, Tucson, Phoenix and Yuma. These skilled-nursing facilities provide 24-hour care to assist residents with their activities of daily living. The facilities are funded by the United States Department of Veterans Affairs as per diem payments for each evening a resident occupies a bed. ADVS is dedicated to providing the highest level of care for its residents. Access to additional funding through the Veterans' Donations Fund (VDF) will ensure that the highest level of resident care is achieved.

SB1704 Outline:

- The proposal will focus several key care factors for our Veterans.
- SB1704 dedicates 15% of the annual balance in the VDF to a subaccount, which will:
  - Support the various needs of the residents by purchasing equipment
  - Allow for facility improvements and ongoing maintenance of the facilities
  - Enhance the quality of life of residents by affording them more activities
  - Allow for ADVS to hire 2 full time equivalent positions to administer the entirety of the VDF
- There is no impact to the General Fund

Benefits:

- Residents of the Veteran Homes will benefit from living in facilities that can be modernized and be more aesthetically pleasing
- ADVS can purchase specialized equipment for residents to enhance their activities of daily living, ensuring comfort and safety, as well as rehabilitative equipment to ensure a comprehensive recovery if they are admitted for rehabilitation
  - Equipment will be included in the following: resident care including rehabilitative care, dietary equipment and durable medical equipment; recreational; necessary housekeeping equipment, transportation needs and environmental equipment
- ADVS can purchase new kitchen equipment to enhance the dietary needs of residents
- Residents will experience a more robust activities program as ADVS will be able to afford to conduct more activities in the community

Point of Contact:

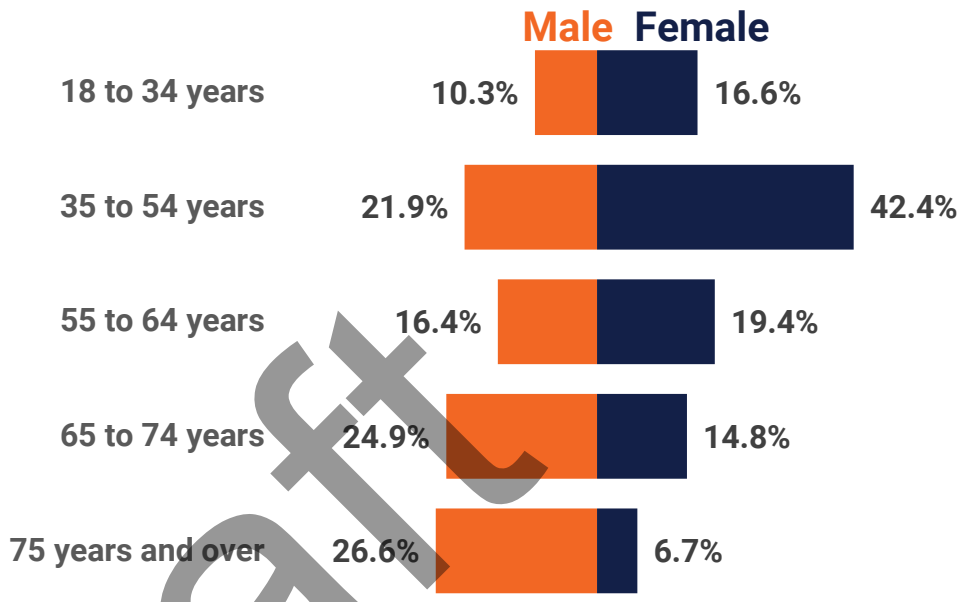
Julia Gusse, Legislative Liaison at jgusse@azdvs or at 480.801.1189

VETERANS IN MARICOPA COUNTY

MARICOPA COUNTY PUBLIC HEALTH

DEMOGRAPHICS

A United States veteran is defined under 38 U.S.C. § 101(2) and states that “The term "veteran" means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.”

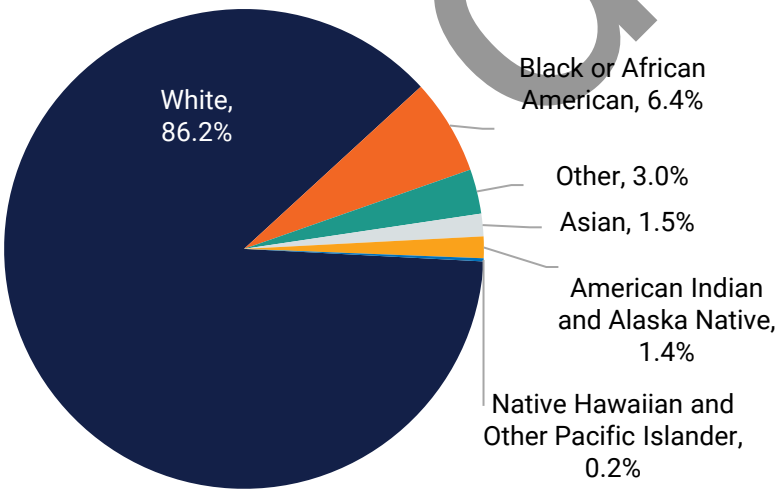


6.8%

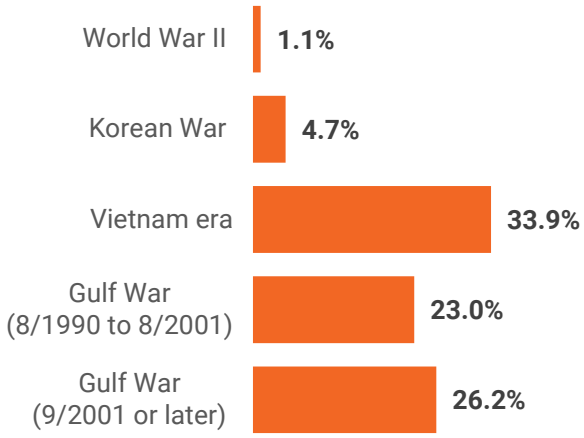
Of Maricopa County residents are veterans

1 in 10 veterans in Maricopa County are **female** with the largest proportion of those aged 35 to 54 years

RACIAL DEMOGRAPHICS



WARS SERVED



6.5%

Of Maricopa County Veterans live below the federal poverty line

1 out of 4

Veterans have at least one service-related disability and 32.7% have a disability rating of 70% or higher. Disability ratings are calculated by the Department of Veterans Affairs and correspond with how a service-connected injury negatively impacts an individual's life.

TOP CAUSES OF DEATH AMONG MARICOPA COUNTY VETERANS
(2018-2021)

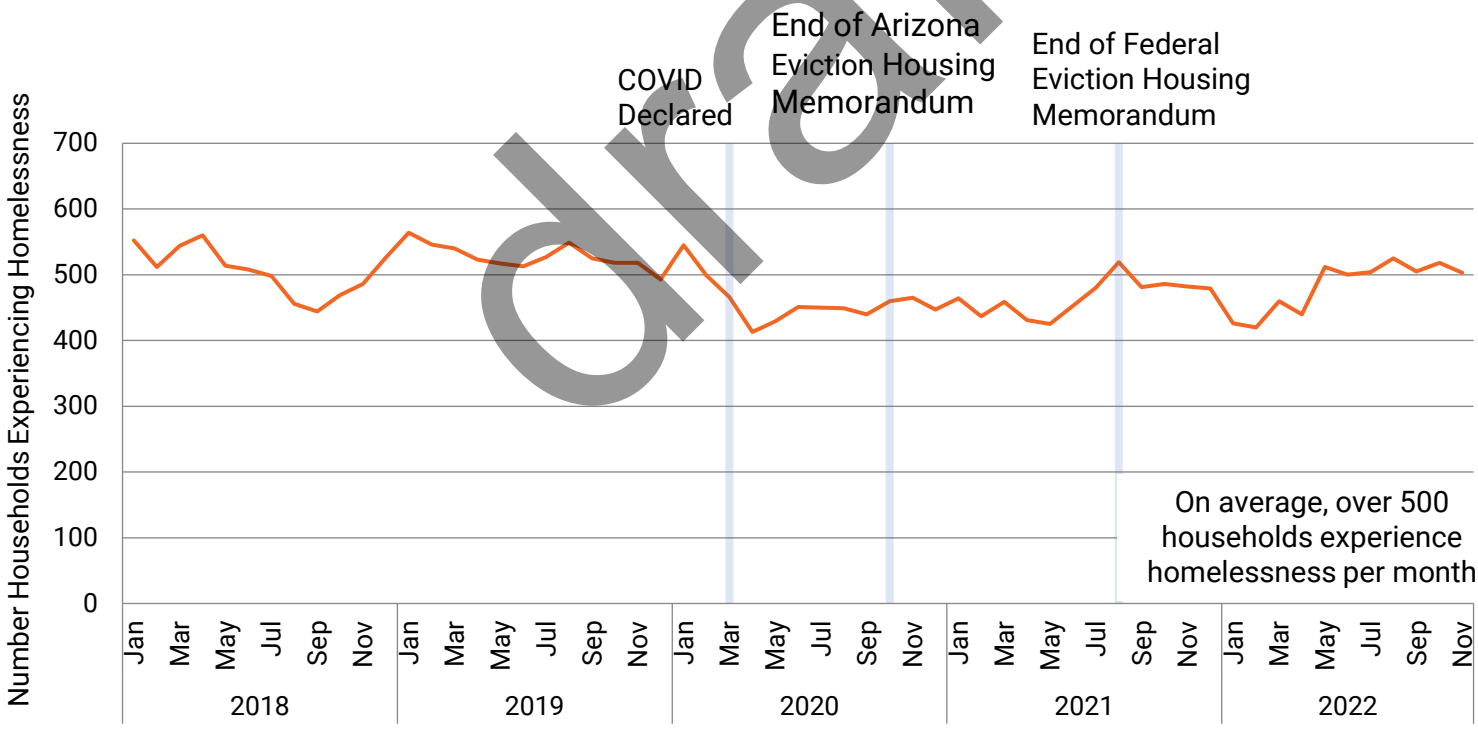
18-64		65+	
1.	Cancer	1.	Heart Disease
2.	Heart Disease	2.	Cancer
3.	Unintentional Injury	3.	COVID-19
4.	COVID-19	4.	COPD
5.	Suicide	5.	Alzheimer Disease
6.	Diabetes mellitus	6.	Cardiovascular Disease
7.	Chronic Liver Disease	7.	Diabetes mellitus
8.	COPD	8.	Parkinson's Disease
9.	Cardiovascular Disease	9.	Falls
10.	Homicide	10.	Renal Disease

BARRIERS TO EQUITY

- Stigma
- Gaps in health literacy for veterans
- Misinformation
- Cultural incompetence
- Unconscious bias from providers
- Dwindling provider capacity at veterans facilities
- Wait times at VA facilities
- Geographic accessibility to care
- Mental illness
- Transitioning back to civilian life
- Substance use

Death data is obtained from the Arizona Department of Health Services and analysis is performed by Maricopa County Department of Public Health Division of Epidemiology & Informatics

TRENDS IN HOMELESSNESS AMONG VETERANS, MARICOPA COUNTY
(2018-Present)



SOURCES: U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Committee on the Assessment of the Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine. Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington (DC): National Academies Press (US); 2013 Mar 12. 9, ACCESS AND BARRIERS TO CARE. Available from: https://www.ncbi.nlm.nih.gov/books/NBK206856/

This publication is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $26,562,053 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

ARIZONA DEPARTMENT
OF HEALTH SERVICES

SUICIDE AND SELF-INFLICTED INJURY IN ARIZONA

2008 - 2018

ARIZONA DEPARTMENT OF HEALTH SERVICES
150 N. 18TH AVENUE
PHOENIX, ARIZONA 85007

Executive Summary

Suicide
According to the Centers for Disease Control and Prevention, suicide was the 10th leading cause of death in the United States in 2017. Nationally, nearly 47,000 persons took their lives in 2017 (a national suicide rate of 14.0 per 100,000 persons in the US). In Arizona that same year, suicide was the 8th leading cause of death, with 1,304 certified deaths attributed to suicide among Arizona residents. The adjusted rate of suicide among Arizona residents in 2017 was 18.0 per 100,000 population. The Arizona 2017 suicide rate was 29 percent above the national rate of suicide that year.

In Arizona, as in the US, suicide rates have been rising. From 2008 to 2017, the state age-adjusted rate increased 21.6 percent while the national age-adjusted rate increased by 20.7 percent.

In 2018, suicide remained the 8th leading cause of death, claiming the lives of 1,432 Arizona residents, and contributing substantially to premature mortality with a total of 39,860 years of potential life lost (YPLL), next to unintentional injuries (98,081), malignant neoplasms (83,979), and diseases of the heart (57,395).

In 2018, based on age-adjusted death rate, suicide was the 6th leading cause of death among males (31.5 per 100,000 residents) but ranked 11th among females (7.4 per 100,000 residents). The majority of suicide fatalities occurred at home. Firearm, strangulation/hanging, and poisoning by drugs were the most common mechanisms of suicide in Arizona. In 2018, 55.9 percent of suicides were completed by use of firearms compared to 26.2 percent by means of strangulation and/or hanging. Arizonans aged 10-14 years had the lowest suicide mortality rates, while residents aged 45-54 years, 55-64 years, and those aged 65 and over have experienced higher rates of suicide death among all age groups.

American Indians and White non-Hispanics, regardless of gender, have consistently experienced the highest age-adjusted suicide death rates compared to the other racial/ethnic groups in Arizona. In 2018, American Indians had the highest age-,adjusted suicide rate (36.5 suicides per 100,000) among racial/ethnic groups, followed by White non-Hispanics (23.7/100,000), while Asians recorded the lowest age-adjusted suicide rate (7.3/100,000). Trends in suicide rates from 2008 to 2018 demonstrate excessive mortality among White males in comparison to all the other groups in each year, except 2013, and 2016 to 2018.

Suicide mortality rates vary significantly across counties in Arizona. In 2018, Gila (60.5/100,000), La Paz (50.0/100,000), Navajo (48.8/100,000), Apache (41.8/100,000), Coconino (32.2/100,000), and Mohave (30.6/100,000) counties recorded the highest suicide death rates in the state, while Graham residents experienced the lowest suicide rates in the state. Urban /rural differences are also apparent, as rural residents were nearly two times more likely to die from suicide than urban residents.

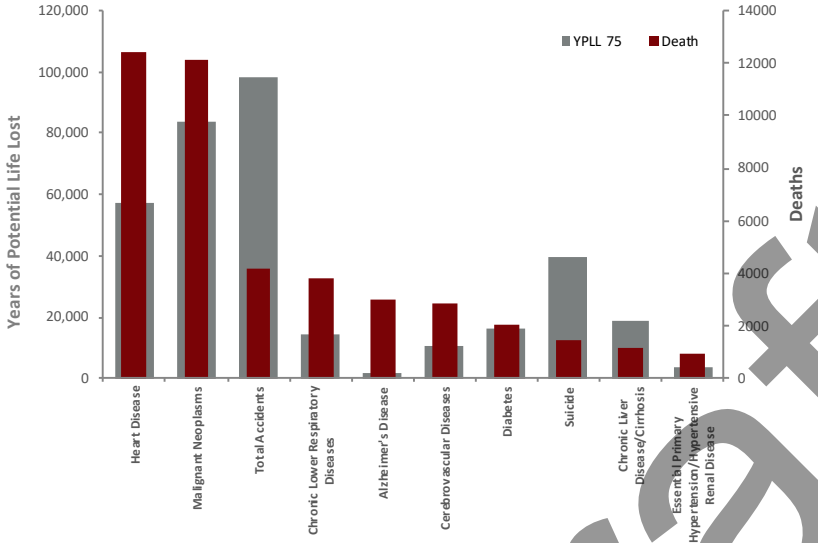
Among Arizona youths, residents aged 20-24 bear more of the burden of suicide mortality than those less than 20 years of age. In 2018, the relative risk of suicide was 6.4 times greater for Arizonans aged 20-24 years compared to their counterparts aged 10-15 years.

Between 2008 and 2018, there were 2,863 certified veteran suicides. Since 2008, both the number of veteran suicides per year, and the rate of suicide per 100,000 Arizona veterans, have increased. Veteran suicide rates in Arizona (including both residents and non-residents who died by suicide in Arizona) are elevated when compared with those in the Arizona general population, and with those among Arizona non-veterans. The rate of suicide among Arizona resident veterans, when compared to the rate among Arizona resident non-veterans, also demonstrates a sustained pattern of elevated risk. In 2018, the age adjusted rate of suicide among Arizona resident veterans was 2.3 times higher than their non-veteran counterparts. White non-Hispanic Arizona veterans had a higher risk of mortality by suicide than the other racial/ethnic groups. Arizona veterans residing in Gila county had the highest rate of mortality due to suicide (109.8 per 100, 000) followed by those living in Mohave county (107.6 per 100,000) and Pima county (60.4 per 100,000). From 2008 to 2018, firearms were consistently the leading mechanism of suicide mortality among veteran residents of Arizona. Non-opioid prescription drugs and poly-drug (more than one drug at once) were the most commonly found substances in suicide cases among Arizona veterans where drug poisoning was the mechanism used.

Self-Inflicted Injury
Self-inflicted injuries result from actions of individuals trying to deliberately harm themselves (i.e. behavior with no suicide intent) or kill themselves (i.e. suicide attempt). In 2018, there were 11,811 hospital discharges (4,040 hospitalizations and 7,771 emergency room visits) due to self-inflicted injuries. Self-inflicted injury-related hospital discharges were higher among females than males. For every self-inflicted injury among males, there were nearly two among females.

Among racial/ethnic groups, American Indians experienced the highest rates of hospital discharges (231.8/100,000) due to self-inflicted injury. Poisoning by drugs was the main mechanism of self-inflicted injury in 2018, accounting for 55.1 percent of all self-inflicted injury-related hospital discharges. Health care cost analysis of self-inflicted injury during the period of 2008-2018 shows the magnitude of the economic burden of self-inflicted injury-related hospital discharges on the Arizona health care system. In 2018, self-inflicted injury-related hospital discharge costs were estimated at $254 million, a two-fold increase from 2008.

Figure 1A
Top 10 leading causes of death and years of potential life lost (YPLL) before age 75 among Arizona residents, 2018

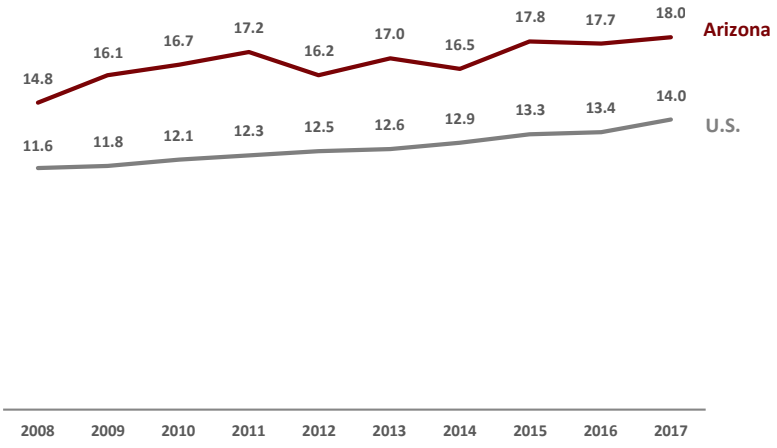


Note: Leading cause of deaths ranking is based on the number of deaths .

Ranking of cause of death is essential in understanding the magnitude of disease/injury in a population. Years of potential life lost (YPLL), a measure of premature mortality, estimates the average years a person would have lived if they had not died prematurely. Reducing YPLL is an important public health goal since it emphasizes preventable death of younger persons.

In 2018, of the 59,206 deaths among Arizona residents, 1,432 deaths or 2.4 percent of all deaths were due to suicide. Suicide ranked 8th among the leading causes of death, but contributed substantially to premature mortality with a total YPLL of 39,860 behind unintentional injuries (98,081), malignant neoplasms (83,979), and diseases of the heart (57,395).

Figure 2A
Age-adjusted suicide mortality rates,[a] Arizona versus United States, 2008-2017[b]

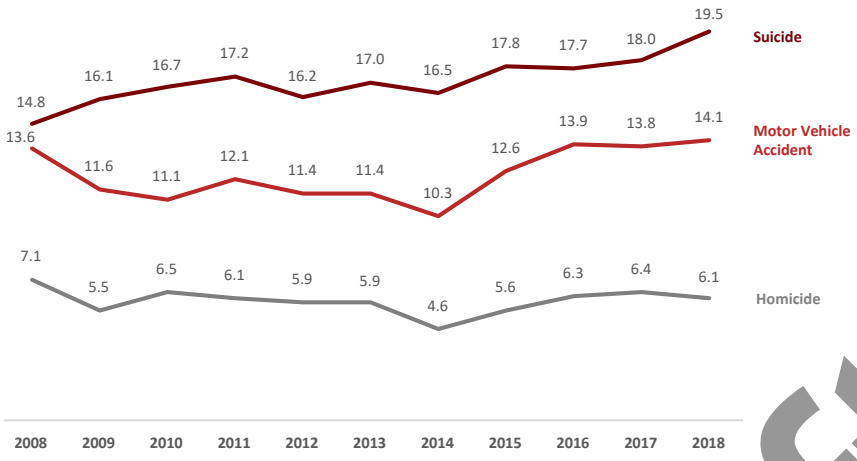


Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.
[b] 2018 National data not currently available

Suicide mortality has been on the rise both statewide and nationally. From 2008 to 2017, the overall US rate increased 20.7 percent, while the Arizona rate increased 21.4 percent during the same period.

Arizona suicide mortality rates have been generally higher than national rates. In 2017, the suicide rate among Arizona residents (18.0/100,000) was 28.8 percent higher than the national rate (14.0/100,000).

Figure 3A
Age-adjusted mortality rates[a] for suicide, motor vehicle accident, and homicide: Arizona, 2008-2018



Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

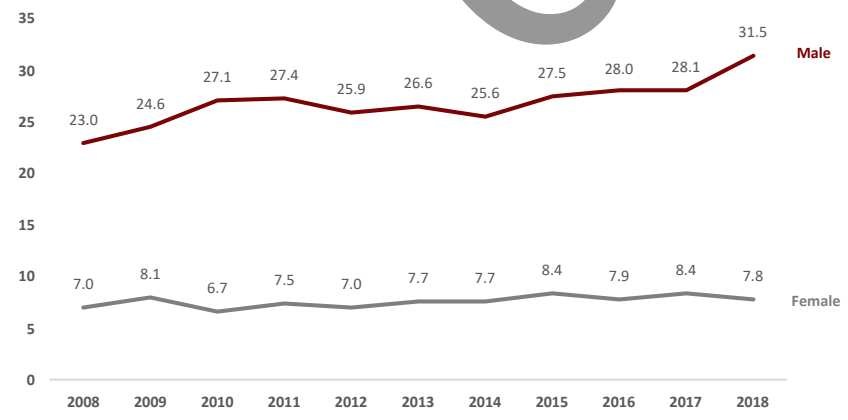
In 2018, more Arizonans died of suicide (n=1,432) than motor vehicle crashes (n=1,032) and homicides (n=416), making suicide the leading cause of violent death in Arizona for that year.

Prior to 2008, suicide rates were consistently higher than homicide rates, but interestingly were lower than motor vehicle traffic mortality rates.

Largely due to declines in motor vehicle traffic death rates, the suicide rate surpassed, and has remained higher than the rate of motor vehicle traffic death.

In 2018, 19.5 out of 100,000 Arizonans died of suicide, compared to 14.1 per 100,000 who died in a motor vehicle accident, and 6.1 per 100,000 who died from homicide.

Figure 4A
Age-adjusted mortality rates[a] for suicide by gender and year: Arizona, 2008-2018



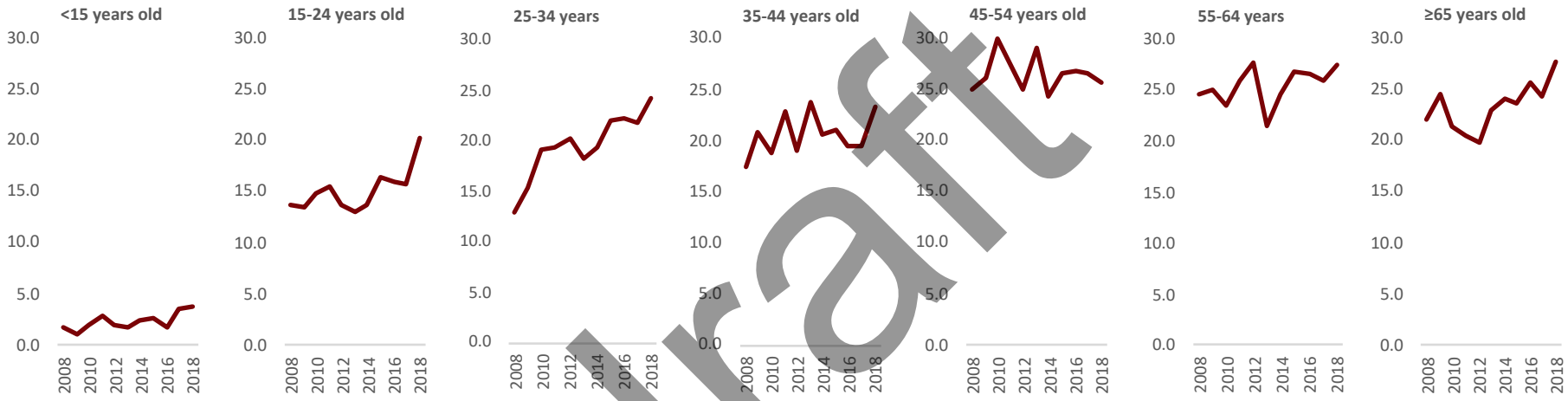
Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

Historically, suicide mortality in Arizona has been consistently higher among males than females. The general trend during the period under study shows an excess of male suicide mortality compared to female suicide death. From 2008 to 2018, on average, for each female suicide, there were nearly four male suicides.

The relative risk of suicide (i.e. male to female ratio) has increased from 3.3 in 2008 to 4.0 in 2018. This demonstrates that suicide rates have increased for both genders from 2008 to 2018, but more so for males (37.0 percent increase) than females (11.4 percent).

In 2018, more males (1,146) than females (286) lost their lives to suicide, making suicide the sixth leading cause of death among males and the 11th leading cause among females. During the same year, the male suicide death rate (31.5/100,000) was four times higher than the female rate (7.8/100,000).

Figure 5A
Age-specific suicide mortality rates[a] by age group: Arizona, 2008-2018



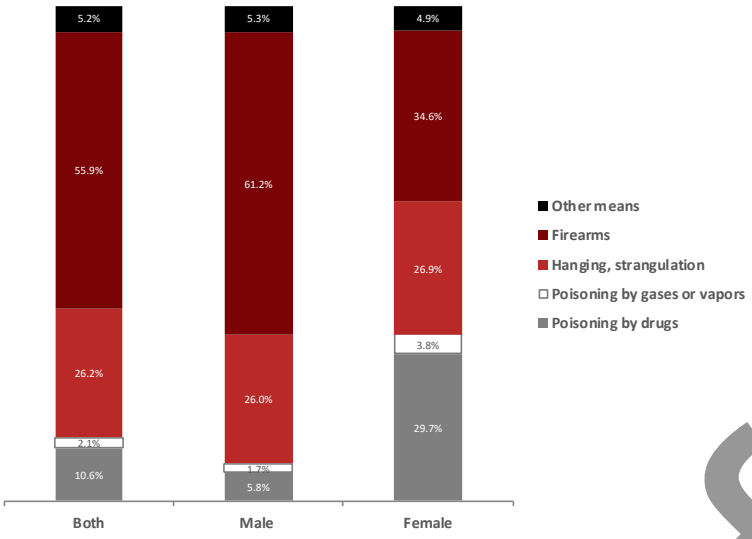
Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

In Arizona, residents aged 10-14 years had the lowest suicide mortality rates while residents aged 45-54 years, 55-64 years, and those aged 65 and over had higher rates of suicide death among all age groups.

From 2008 to 2018, suicide death rates have been rising for all age groups. Children under age 15 have seen a 2-fold increase in suicide rate, followed closely by adults aged 25-34 (1.9 fold). All the remaining groups experienced an increase of 1.5 or less.

Detailed information on counts and suicide rates during the period 2008-2018 is provided in Table 1 **(Appendix)**.

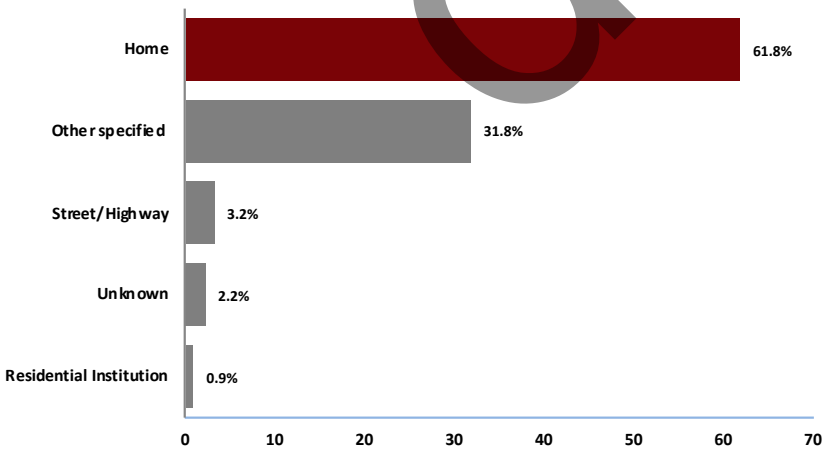
Figure 6A
Mechanisms of suicide mortality by gender: Arizona, 2018



In 2018, firearm, suffocation/hanging and poisoning by drugs were the most common mechanisms of suicide in Arizona. Of the 1,432 suicide deaths reported among Arizona residents, over 55.9 percent of suicides were completed by use of firearm (n=800) compared to 26.2 percent by means of strangulation and/or hanging (n=375), and 10.6 percent by means of drugs (n=152).

In 2018, firearm was the leading mechanism of suicide among both Arizona males and females. However, the use of firearms was greater among male suicides (61.2 percent) than female suicides (34.6 percent). There are significant gender differences in the other most common methods of suicide. Females tend to more frequently use methods such as poisoning by drugs (29.7 percent) and hanging or strangulation (26.9 percent) than males.

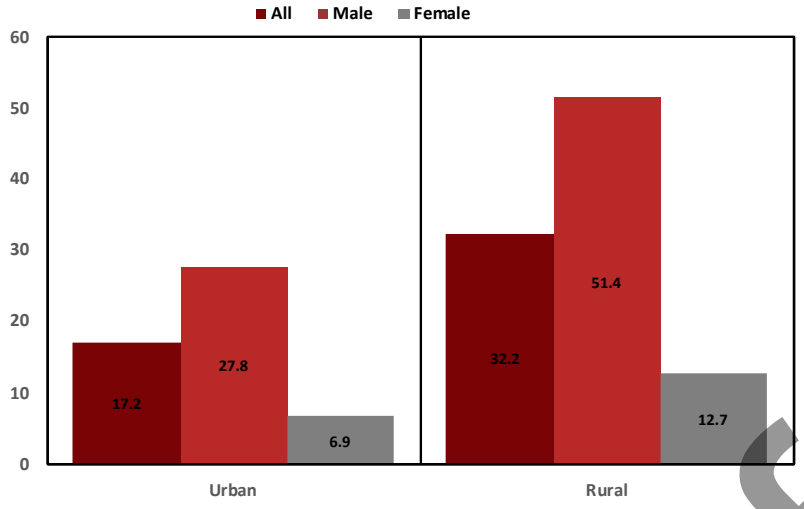
Figure 7A
Suicide death by place of occurrence: Arizona, 2018



The place where the event that caused the death occurred is recorded on the death certificate to provide context to mortality from external causes such as suicide. In 2018, of the 1,432 suicide deaths recorded among Arizona residents, 61.8 percent occurred at home.

Approximately one-third of suicide fatalities were classified under the category “Other specified” which includes areas such as farms, fields, sports and athletics spaces, and schools.

Figure 8A
Age-adjusted mortality rates[a] of suicide by urban/rural areas: Arizona, 2018

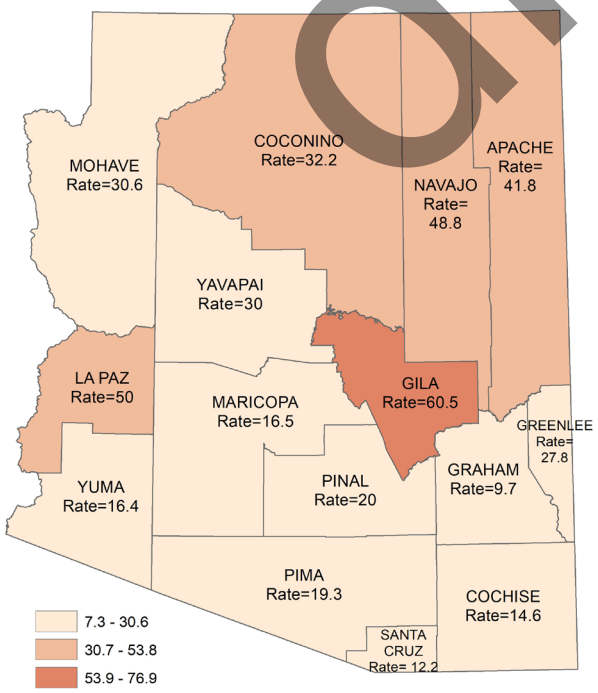


Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

In Arizona, suicide mortality rates are generally higher in rural settings than urban areas. In 2018, rural residents died of suicide at increasingly higher rates (32.2/100,000 population), nearly two-fold greater than their urban counterparts (17.2/100,000 population).

Across the board, rural males experienced the highest rate of suicide death (51.4/100,000 population), while urban females had the lowest suicide mortality rates (6.9/100,000).

Figure 9A
Age-adjusted mortality rates[a] of suicide by county of residence: Arizona, 2018

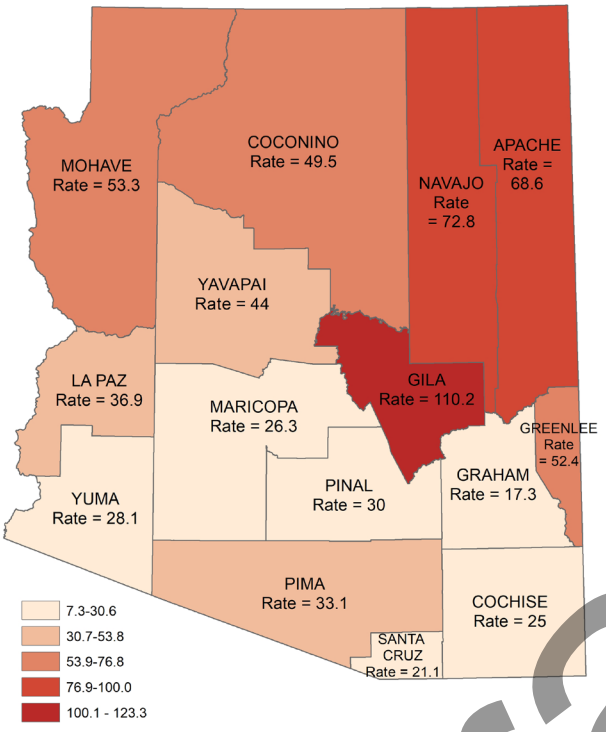


Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

Suicide mortality rates vary significantly between counties in Arizona.

In 2018, only 6 out of 15 counties recorded age-adjusted suicide death rates lower than the state rate of 19.5 per 100,000 population. Gila (60.5/100,000), La Paz (50.0/100,000), Navajo (48.8/100,000), Apache (41.8/100,000), Coconino (32.2/100,000), Mohave (30.6/100,000) Counties recorded the highest suicide death rates compared to the rest of the state. Graham residents experienced the lowest suicide rates in the state.

Figure 10A
Age-adjusted mortality rates[a] of Male suicide by county of residence: Arizona, 2018



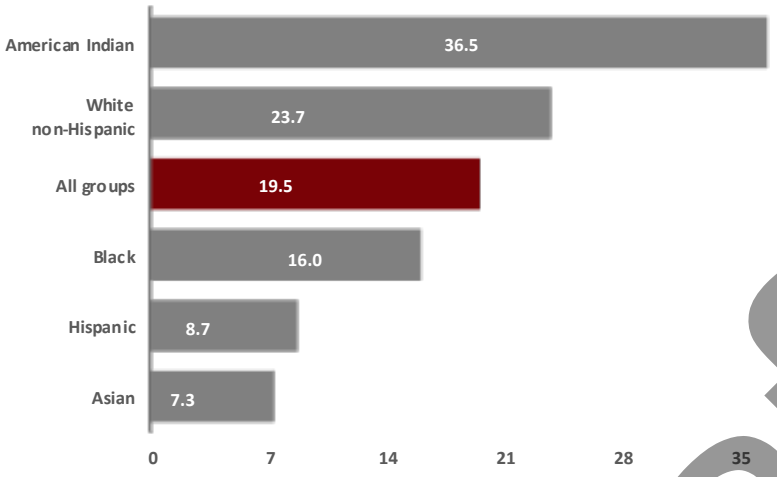
Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

In Arizona, males have been found to have an excessively higher rate of suicide compared to females. We were particularly interested in identifying significant patterns in male suicide in Arizona by county of residence.

County analysis reveals that in 2018 male suicide rates were the highest in Gila (110.2 per 100,000 population), Navajo (72.8 per 100,000 population), Apache (68.6 per 100,000 population), Mohave (53.3 per 100,000 population), Greenlee (52.4 per 100,000 population), and Coconino (49.5 per 100,000 population). The lowest suicide rate recorded in 2018 was in Santa Cruz with an age-adjusted rate of 21.1 per 100,000 population.

B. Suicide: Race/Ethnicity Disparities

Figure 1B
Age-adjusted mortality rates[a] of suicide by race/ethnicity: Arizona, 2018



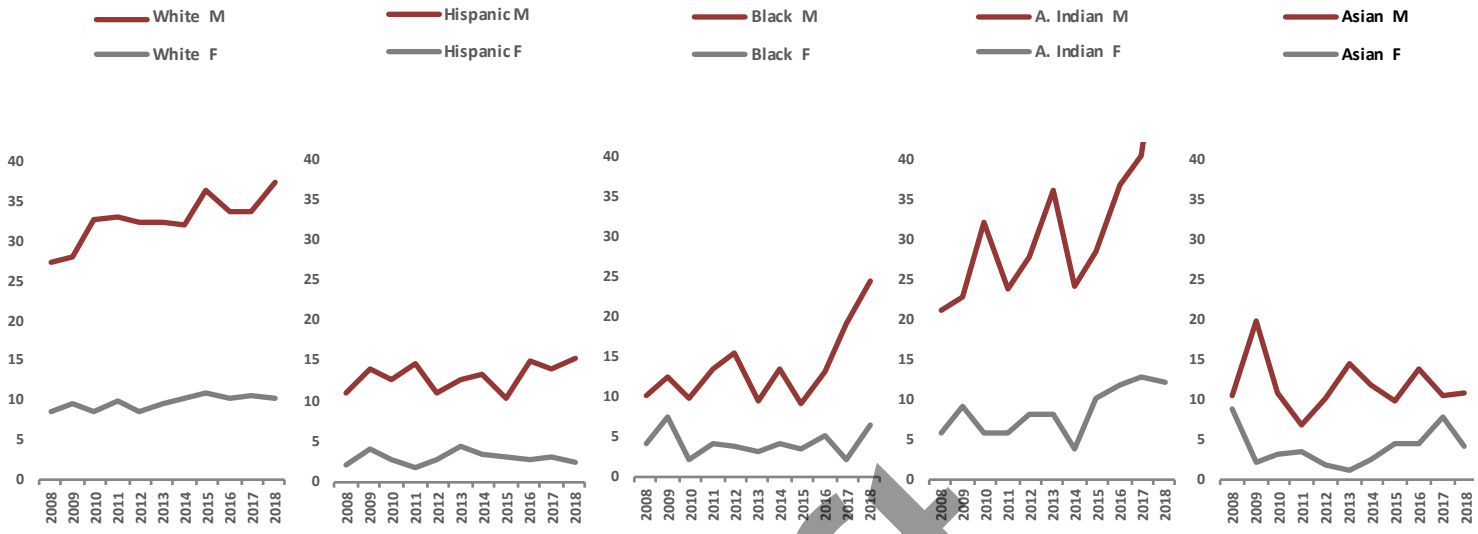
Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

As in mortality from any cause, race/ethnicity disparities are apparent in suicide mortality.

In 2018, suicide death rates for American Indians (36.5 suicides per 100,000 population) were the highest of any racial and ethnic group in Arizona. A similarly high rate is observed among White non-Hispanics with a suicide mortality rate of 23.7 deaths per 100,000 population.

In contrast, Asians recorded the lowest age-adjusted suicide rate (7.3/100,000).

Figure 2B
Age-adjusted mortality rates[a] of suicide by race/ethnicity and gender: Arizona, 2008-2018



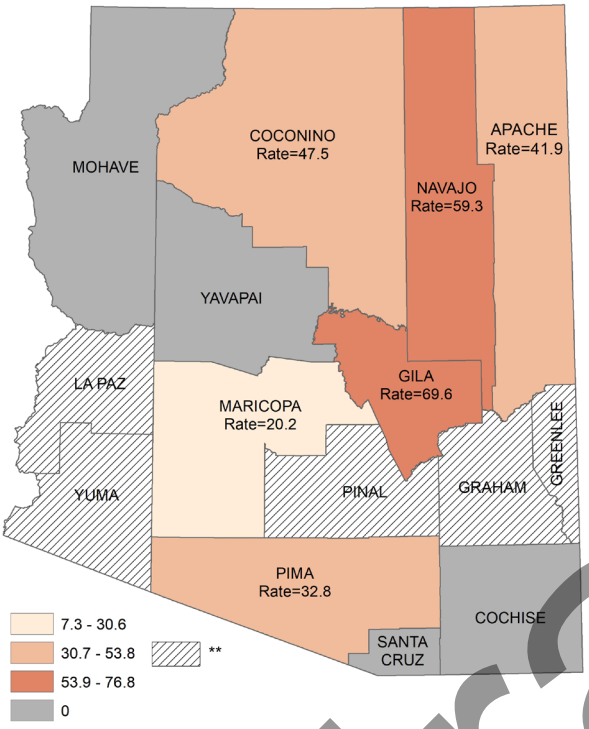
Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

White non-Hispanics and Native Americans, regardless of gender, have consistently experienced the highest age-adjusted suicide death rates compared to the other racial/ethnic groups in Arizona. During 2008-2018, the highest suicide death rates were recorded among White males, except in 2013, and 2016-2018 when the highest rates were observed among Native American males (Figure 2B).

From 2008-2018, suicide mortality rates have been rising among most of the race/ethnic groups and increases were observed for both males and females. Further details on the historical suicide counts and age-adjusted mortality rates by race/ethnicity and gender are provided on Table 2 and Table 3, respectively **(Appendix)**.

Between 2008 and 2018, American Indians have recorded the greatest increase in suicide mortality rates among all the groups. During the same period, suicide mortality rates among this group have increased by near three-fold among males, and by two-fold among females.

Figure 3B
Age-adjusted mortality rates[a] of suicide among American Indians by county of residence, Arizona, 2018

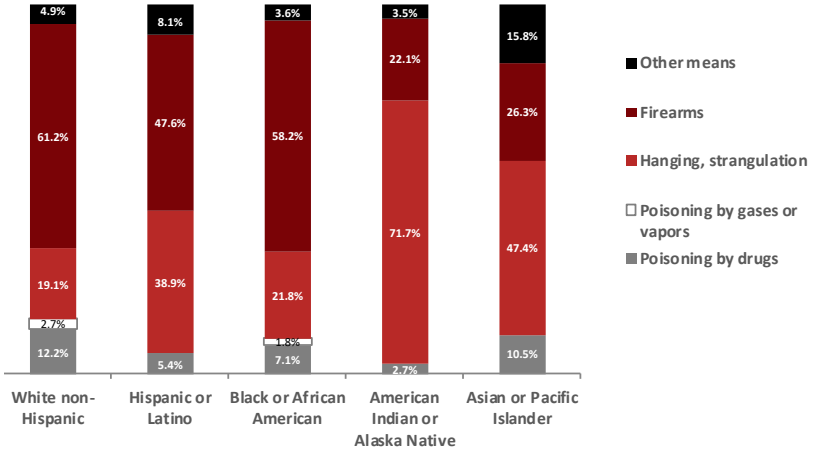


Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard;
** Rate suppressed due to non-zero suicide count less than 6.

The geographic distribution of suicide rates in Arizona was particularly important to analyze among American Indians to understand the magnitude and variations of the issue among this racial/ethnic group.

In 2018, American Indians living in Gila county had the highest rate of suicide, at 69.6 deaths per 100,000 population, followed by those residing in Navajo county (59.5 per 100,000), Coconino (47.5 per 100,000) and Apache (41.0 per 100,000).

Figure 4B
Mechanisms of suicide mortality by race/ethnicity: Arizona, 2018



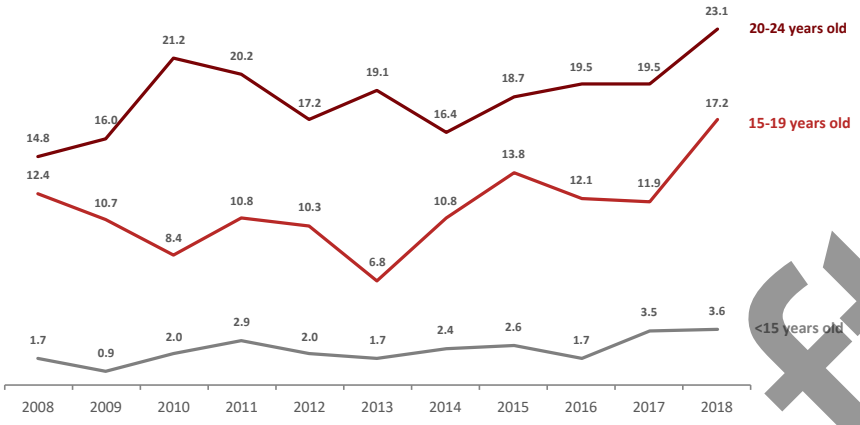
In 2018, of all the suicides recorded, most involved the use of firearms (55.9 percent) and suffocation (hanging or strangulation) methods (26.2 percent).

Firearms were the most common method of suicide among White non-Hispanics, Black or African Americans, and Hispanic or Latinos, while strikingly, strangulation was the leading mechanism of suicide among American Indians and Asians or Pacific Islanders.

White non-Hispanics account for the greater proportion of suicide deaths where poisoning by drugs was involved.

C. Youth Suicide

Figure 1C
Age-specific suicide mortality rates[a] among youth aged 10-24 years: Arizona, 2008-2018



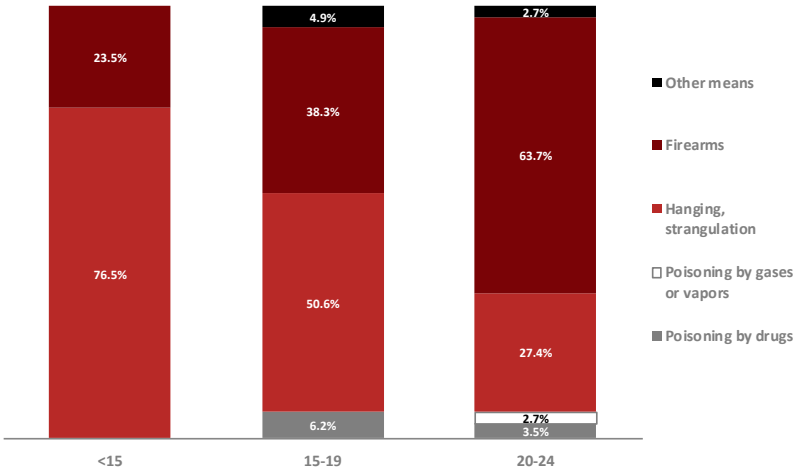
Note: [a] Number of deaths per 100,000 population in a specified age group.

From 2008-2018, residents aged 20-24 years had consistently higher rates of suicides than their younger counter-parts.

In 2018, the relative risk of suicide among Arizonans aged 20-24 years was 6.4 times greater than the suicide death rate of those aged 10-15 years, but 1.3 times higher than Arizonans aged 15-19 years.

Compared to older Arizonans (aged 20 years or older), suicide death rates of those under 20 years of age, remained the lowest.

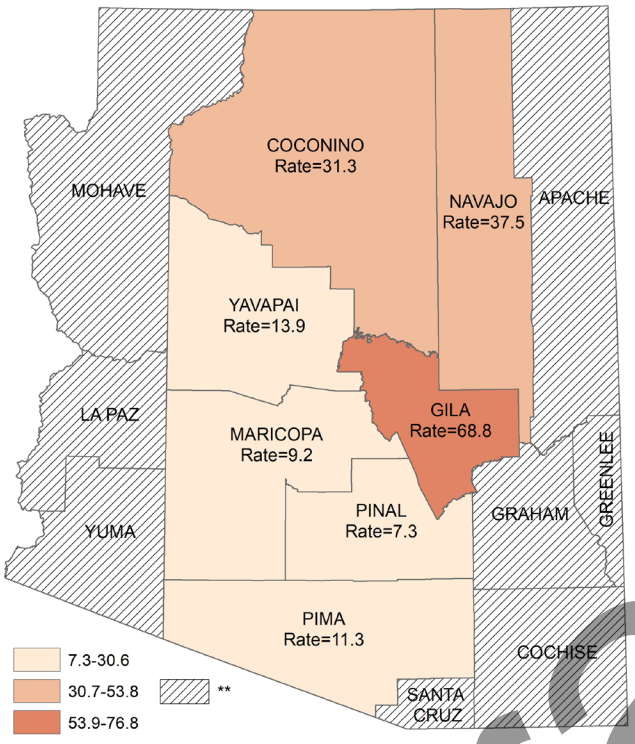
Figure 2C
Mechanisms of suicide mortality among youth aged 10-24: Arizona, 2018



Methods of suicide in Arizona differ by age groups among youth. In 2018, hanging or strangulation was the leading mechanism of suicide among Arizona children under age 15, while 23.5 percent occurred by means of firearms.

Among youth aged 15-19 years, hanging or strangulation was also the leading mechanism of suicide, while among those aged 20-24 years firearms were used more frequently.

Figure 3C
Age-specific suicide mortality rates[a] among youth aged 10-24 years by county of residence, Arizona, 2018



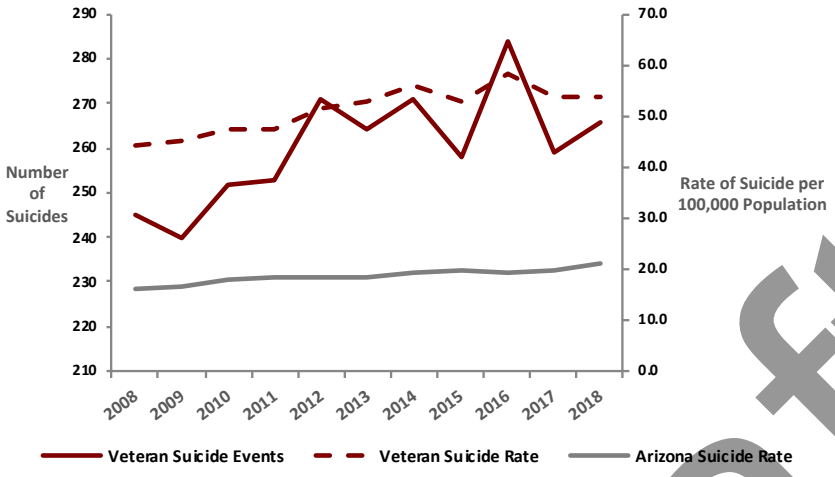
Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard;
** Rate suppressed due to non-zero suicide count less than 6.

Detailed analysis of youth suicide in 2018 demonstrates large differences of suicide mortality risk by county of residence.

In 2018, the risk of suicide mortality among Arizona youth was disproportionately higher in Gila county than any other county in the state. There were 68.8 suicide deaths per 100, 000 among young Arizonans residing in Gila, 37.5 suicide deaths per 100,000 among those living in Navajo county and 31.3 suicide deaths per 100,000 in Coconino county for that same age group.

D. Veteran Suicide

Figure 1D
Number of suicides and rates of suicide among Veterans[a] in Arizona: 2008-2018

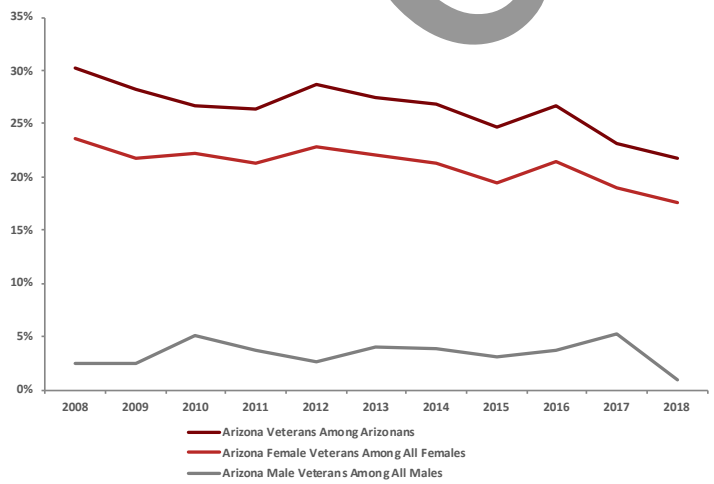


Note: [a] Count include both residents and non-residents.

Veteran suicide rates in Arizona (including both residents and non-residents who died by suicide in Arizona) are elevated when compared with those in the Arizona general population. Detailed information on suicide counts and rates during the period 2008-2018 is provided on Table 4 (Appendix).

Between 2008 and 2018 there were 2,863 certified veteran suicides recorded in Arizona. During the same period, the number of veteran suicides has increased by 8.6 percent, while suicide rate among this group has witnessed a 20.4 percent surge.

Figure 2D
Proportion of Arizona veteran suicides among all suicides[a] occurring in Arizona, 2008-2018

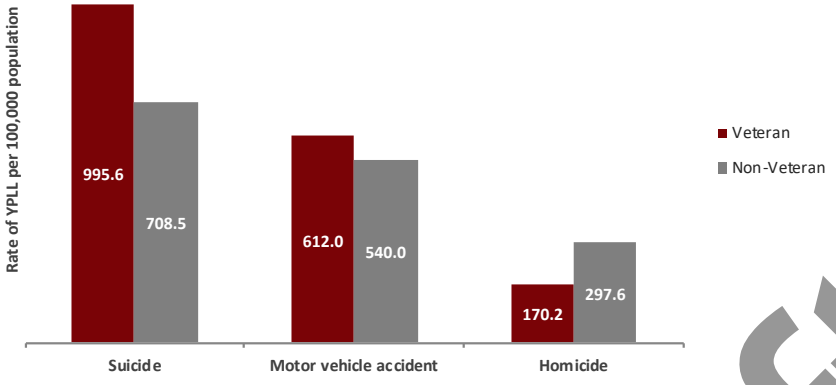


Note: [a] Count include both residents and non-residents.

While estimates of the Arizona veteran population differ, the proportion of veteran suicides among all Arizona suicides has declined. According to the American Community Survey (U.S. Census Bureau), the population of Arizona veterans has declined from 551,053 (8.5% of Arizona population) in 2008 to 496,239 (6.9% of Arizona population) in 2018.

The rising rate of Arizona veteran suicides is accelerated by both an increase in the number of Arizona veteran suicides, and a declining overall population of Arizona resident veterans. The increasing number of Arizona veteran suicides is reflective of similar, larger increases in the total number of Arizona suicides, explaining the slowly declining proportion of Veteran suicides among all Arizona suicides.

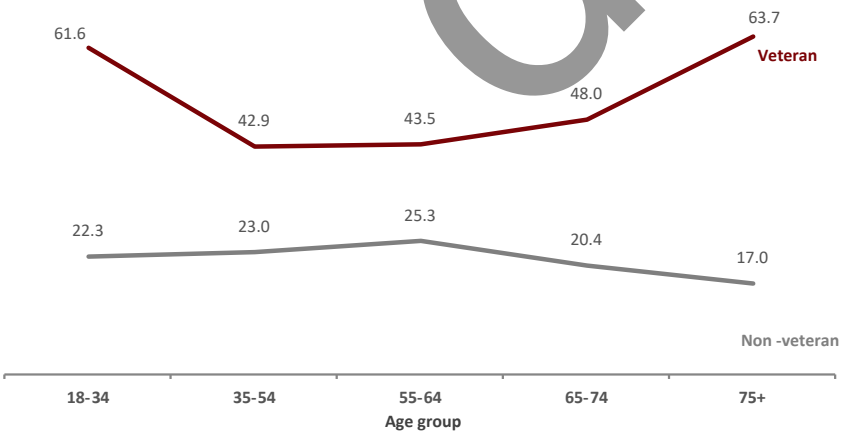
Figure 3D
Years of potential life lost due to suicide by veteran status: Arizona, 2018



Years of potential life lost (YPLL) measures the importance of premature mortality. Figure 3D shows the burden of premature death due to suicide by veteran status, in juxtaposition to other violent deaths. In 2018, suicides accounted for more premature deaths than motor vehicle accidents and homicides. The rates of YPLL due to suicide were the highest of all violent deaths, regardless of veteran status.

A detailed comparison by veteran status, confirmed that suicide represents a serious public health problem among veterans. The 2018 rate of premature mortality due to suicide among veterans (995.6 YPLL per 100,000 veterans 18 years or older) was 40.5 percent higher than that of civilians (708.5 YPLL per 100,000 per 100,000 non-veterans 18 years or older).

Figure 4D
Age-specific mortality rates[a] due to suicide by veteran status: Arizona, 2018



Note: [a] Number of deaths per 100,000 population in a specified age group.

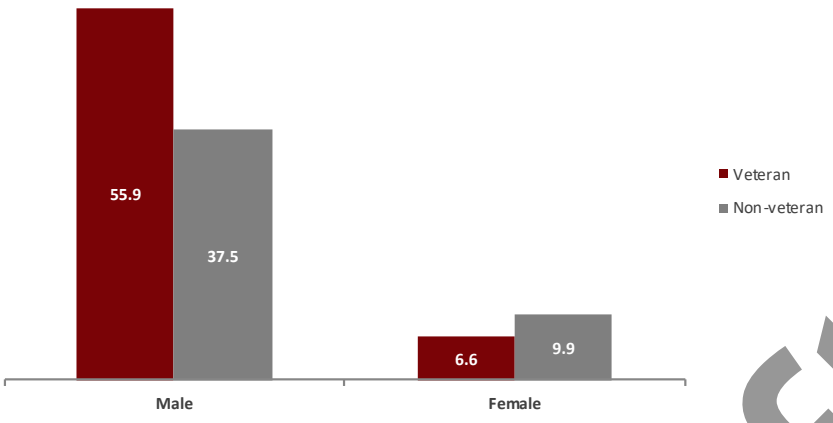
Across the life span, the risk of mortality due to suicide is generally higher among veterans than non-veterans.

In 2018, the relative risk of suicide was 3 times higher among veterans aged 18-34 years compared with the same age group among non-veterans.

The relative risk of suicide was on average 1.8 for those aged 35-54 years and 55-64 years, then increased to 2.4 among those aged 65-74 years and 3.7 among those aged 75 years or older.

In 2018, the oldest veterans (75 years or older) had the highest risk of suicide (63.7 per 100,000), whereas the highest risk of suicide among non-veterans was for those aged 55-64 years (25.3 per 100,000).

Figure 5D
Mortality rates[a] due to suicide by gender and veteran status: Arizona, 2018



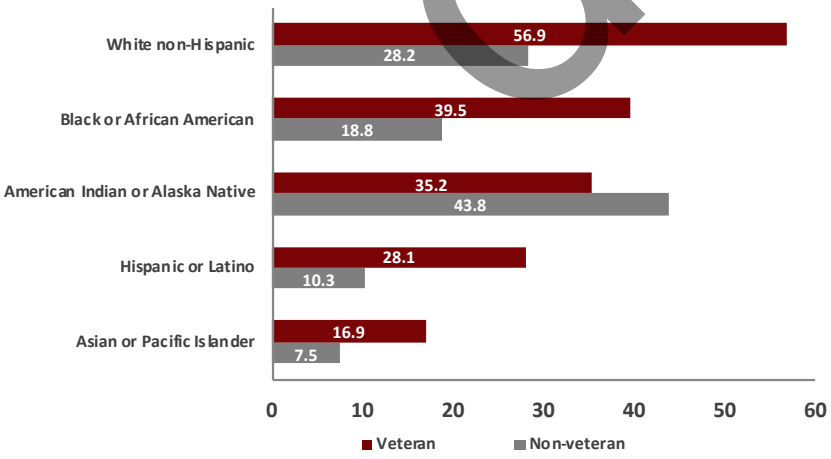
Note: [a] Number of deaths per 100,000 population aged 18 years or older.

Various analyses on gender disparities in suicide mortality show higher a death rate among males than females.

Comparison based on veteran status, underlines the elevated rate of male suicide among Arizona residents, veterans, and civilians alike.

In 2018, males recorded the highest percentage of all suicide fatalities, approximately 99 percent among veterans and 76 percent among civilians. Male veterans experienced markedly higher mortality than did male civilians. Suicide mortality rate for male veterans (55.9 per 100,000) was 49 percent higher than that of their non-veteran counterparts (37.5 per 100,000).

Figure 6D
Mortality rates[a] due to suicide by race/ethnicity and veteran status: Arizona, 2018

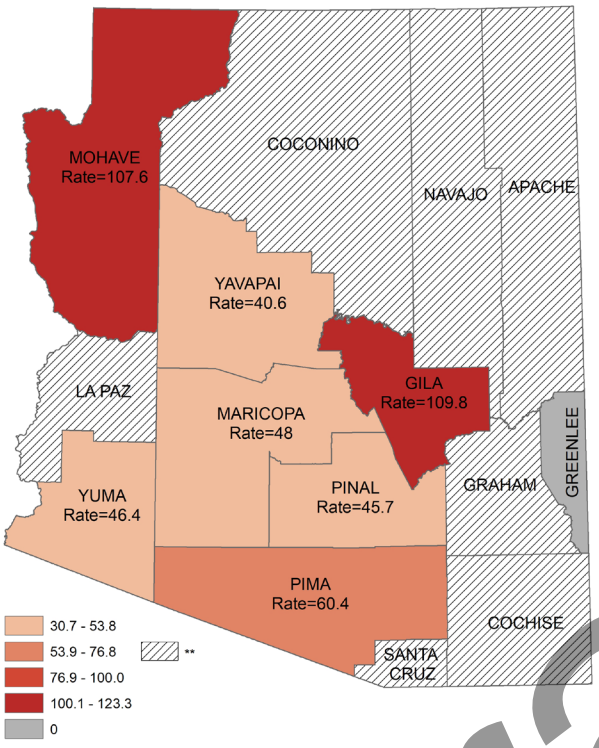


Note: [a] Number of deaths per 100,000 population aged 18 years or older.

Race/ethnicity analysis among Arizona resident veterans shows consistent disparities in mortality rates. In 2018, across all racial/ethnic groups, veterans had higher suicide death rates than non-veterans, except among American Indians, where civilian mortality rates due to suicide were higher than that of veterans.

Analyzing racial/ethnic inequalities in suicide rates among veteran suicides demonstrate that White non-Hispanic veterans were more likely than any other racial ethnic groups to die by suicide.

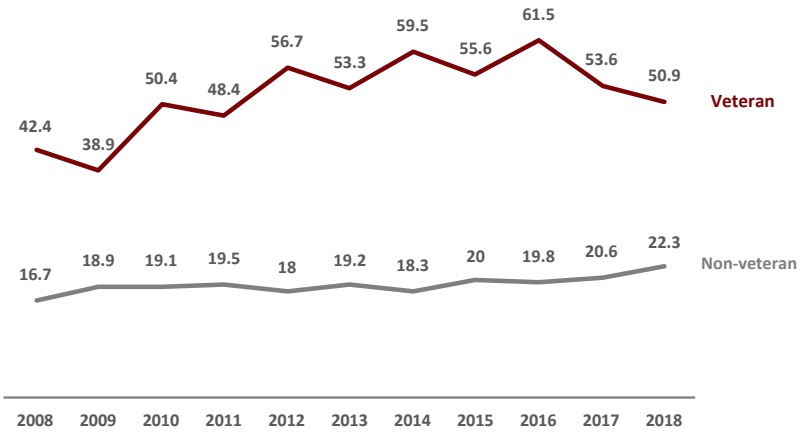
Figure 7D
Age-adjusted mortality rates[a] of suicide among Arizona resident veterans by county of residence: 2008-2018



Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard;
** Rate suppressed due to non-zero suicide count less than 6.

Geographic distribution of suicide death among veterans revealed counties with the greatest burden of suicide mortality among veterans. Arizona veterans residing in Gila county had the highest rate of mortality due to suicide (109.8 per 100,000) followed by those living in Mohave county (107.6 per 100,000) and Pima county (60.4 per 100,000).

Figure 8D
Age-adjusted mortality rates[a] of suicide by veteran status: Arizona, 2008-2018

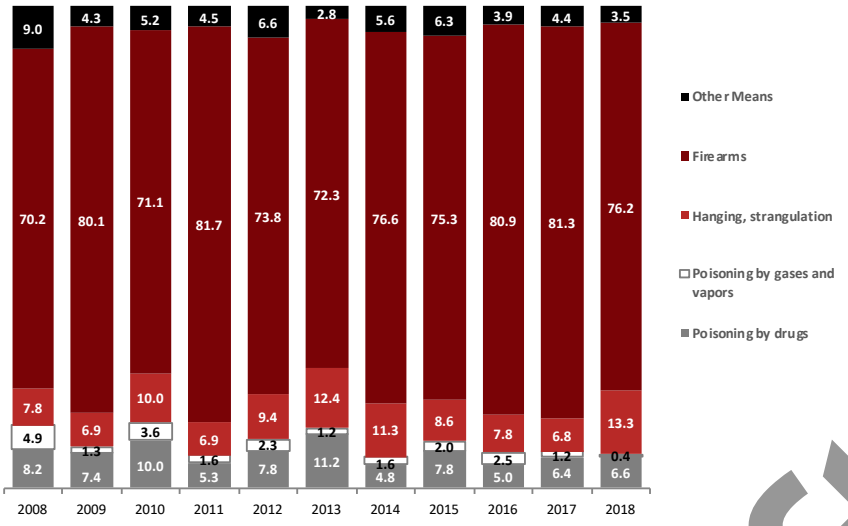


Note: [a] Number of deaths among persons aged 18 years or older per 100,000 population age-adjusted to the 2000 U.S. standard.

Suicide mortality by veteran status among Arizona residents was examined to assess the extent of differences in suicide risk among veterans and non-veterans during the 11-year period from 2008-2018.

In each year since 2008, the age-adjusted veteran suicide rate was consistently two to three times higher than that of their civilian counterparts.

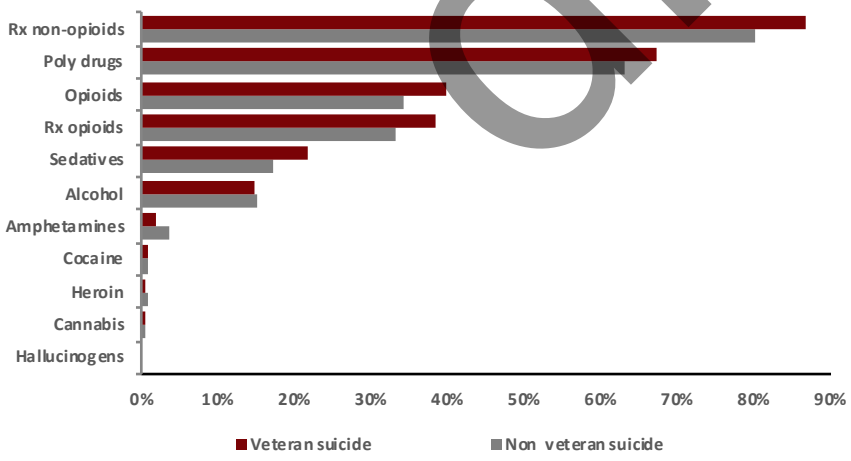
Figure 9D
Mechanism of suicide mortality among veterans: Arizona, 2008-2018



From 2008 to 2018, firearms were consistently the leading mechanism of suicide mortality among veteran residents of Arizona. The use of firearms in suicide was at its peak in 2011 as a firearm was the mechanism for 81.7 percent of suicides.

During the 11-year study period, the proportion of suicides by means of hanging or strangulation was largest in 2018, while the share of suicide deaths involving drug poisoning was at its largest in 2013.

Figure 10D
Substance use in suicide mortality by veteran status: Arizona, 2008-2018



A closer look at substance use and suicide from 2008 to 2018, revealed the common types of substances involved in suicide among Arizona resident veterans. These include alcohol, amphetamines, cannabis, cocaine, hallucinogens, heroin, opioids, prescription opioids, prescription medications, and sedatives.

From 2008 to 2018, the analysis shows that non-opioid prescription drugs and poly-drug were on average the largest categories observed in suicide cases among Arizona veterans and non-veterans alike.

Opioids and prescription opioids were present in 39.8 percent and 38.6 percent of veteran suicide deaths, respectively.

Figure 11D
Distribution of veteran suicide deaths by occupation: Arizona, 2008-2018

Veteran suicide mortality was analyzed by occupation to provide insight on its burden in the workplace. Combined 2008-2018 veteran suicide deaths were used to examine the distribution of veteran suicides by broad occupation categories.

Of all veteran suicides recorded during the 11-year study period, the highest percentage of veterans who died by suicide were in the professional management/ supervision/ direction category (11.2 percent), followed by building remodeling/construction industry (8.9 percent), technical/engineering/electronic (7.7 percent), and industrial/manufacturing (7.1 percent). During the same period, the lowest percentages of suicides among veterans were in religious worker/minister group (0.2 percent) and mining/minerals group (0.2 percent).

Veteran suicide risk assessment

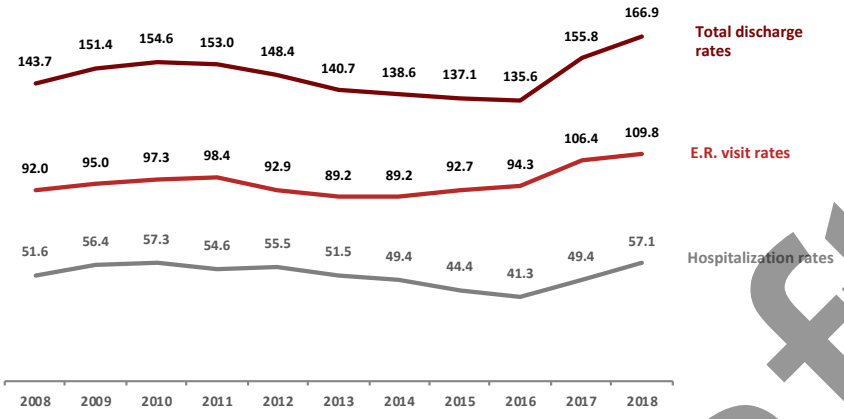
Using multiple linear regression, an analysis of risk factors of suicide among veterans was attempted to predict veteran suicide mortality using variables such as population density, educational attainment rate, unemployment rate, poverty rate, disability status, percent of white non-Hispanics, and percent of American Indians within the state. It was particularly interesting to look at population density as a possible risk factor in order to inform suicide prevention services within the state.

The findings of the analysis revealed that veteran suicide rate is associated with disability status. The risk of suicide is significantly higher when disability is present.

All the remaining variables did not appear to explain veteran suicide mortality as their effects were not statistically significant.

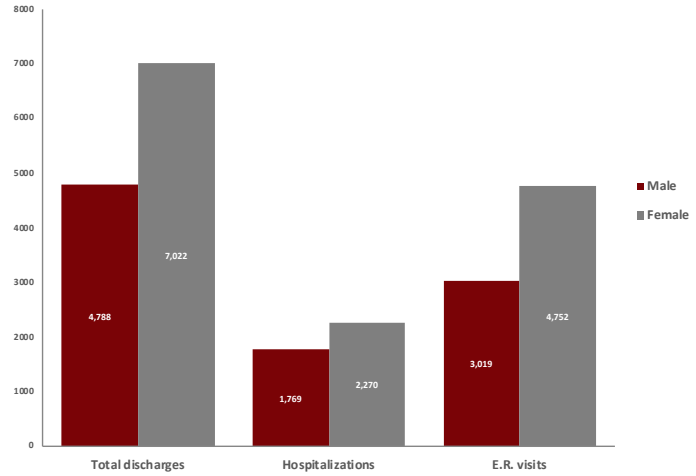
E. Self-inflicted Injuries

Figure 1E
Hospital discharge rates[a] due to self-inflicted injury by type of encounter[b]: Arizona 2008-2018



Note: [a] Rate per 100,000 population. [b] On October 1, 2015, a new revision of the International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding Systems (ICD-10-CM/PCS) was implemented in replacement of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) for reporting medical diagnoses in healthcare settings. The transition to ICD-CM has some impact on comparability of hospital discharges data and continuity of statistical trends. Any comparison of hospital discharge events between 2015 and previous years should take into account the differences between the classification systems.

Figure 2E
Hospital discharge rates[a] due to self-inflicted injury by gender: Arizona 2018



Note: [a] Rate per 100,000 population.

Self-inflicted injuries result from actions of individuals trying to deliberately harm themselves (i.e. behavior with no suicide intent) or kill themselves (i.e. suicide attempt).

In 2018, there were 11,811 hospital discharges (4,040 inpatient stays and 7,771 emergency room visits) due to self-inflicted injuries. Compared to the number of Arizonans who died from suicide (n=1,432) in 2018, this translates to 1 suicide for every 8 self-inflicted injuries.

Trends in annual rates of hospital discharges due to self-inflicted injury have been increasing. Between 2008 and 2018, there was an increase of 16 percent in total self-inflicted injury-related hospital discharge rates, with a 10.1 percent increase in hospitalization rates and 19.3 percent increase in E.R. visit rates due to self-inflicted injury.

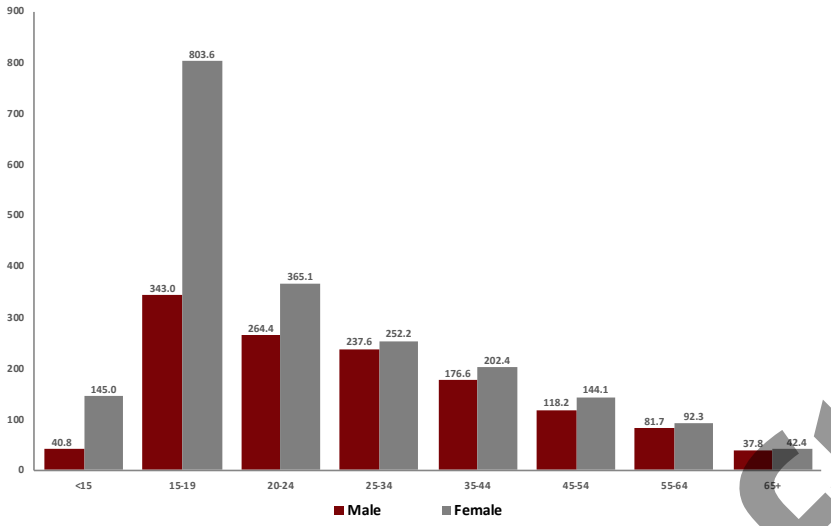
Rates of self-inflicted injury-related hospital discharges throughout 2008-2018, do not mirror rates of suicide mortality during the same period.

Gender-specific analysis of self-inflicted injury revealed differences in the frequency of hospital encounters. In 2018, self-inflicted injury resulting in hospital stays or E.R. visits were remarkably higher among Arizona females than their male counterparts. Out of 11,810 total hospital discharges, 59.5 percent were recorded among female residents.

Arizona females comprised 56.2 percent of hospitalizations due to self-inflicted injuries, a proportion that is 1.3 times higher than that of Arizona males.

Similarly, the frequency of E.R. visits was almost twice as great for female residents (61.2 percent) than male residents (38.8 percent).

Figure 3E
Hospital discharge rates[a] due to self-inflicted injury by age and gender: Arizona, 2018



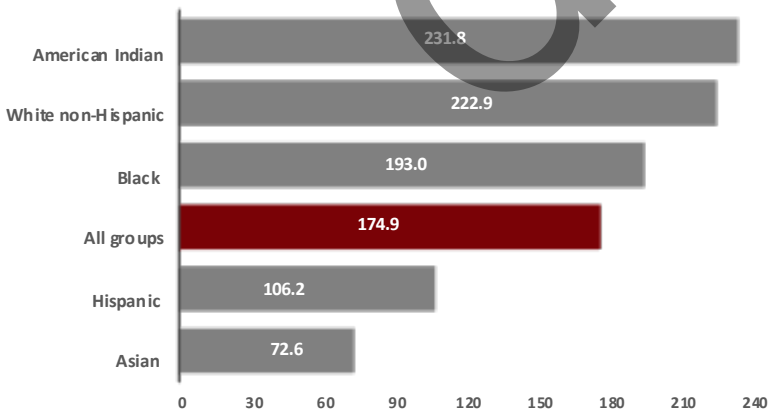
Note: [a] Rate per 100,000 population.

In 2018, the rates of hospital discharges due to self-inflicted injuries were consistently greater in Arizona females than their male counterparts throughout the life span, except for residents aged 65 years or older.

For both genders, the rate of hospital discharges due to self-inflicted injury noticeably peaked at ages 15-19 years and 20-24 years.

However, gender disparity in hospital utilization resulting from self-inflicted injury was most striking among Arizonans aged less than 15 years. The gender gap for that age group can be translated to a ratio of 4 female self-inflicted injury hospital discharges for every male self-inflicted injury hospital discharge.

Figure 4E
Age-adjusted hospital discharge rates[a] due to self-inflicted injury by race/ethnicity: Arizona, 2018



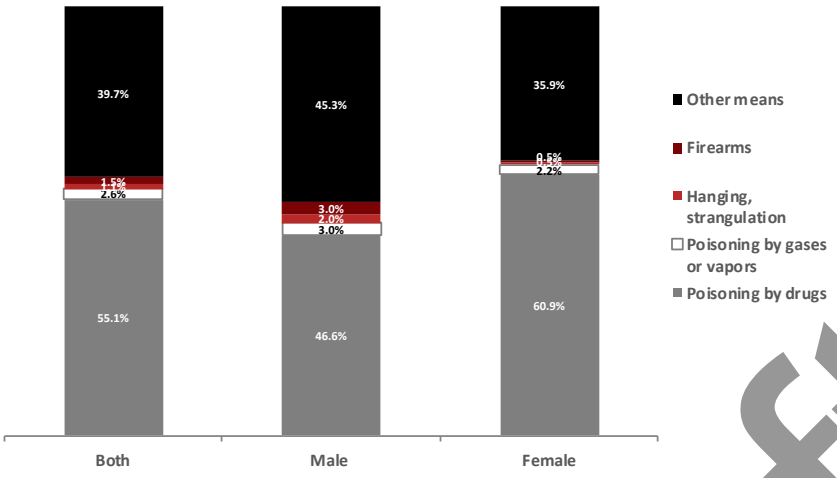
Note: [a] Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.

In 2018, self-inflicted injury hospital discharge was higher among American Indians (231.8 discharges per 100,000 population) than any racial/ethnic groups in Arizona.

Similarly, white non-Hispanics and Blacks exhibited higher rates of self-inflicted injury-related hospital discharge, compared to other racial/ethnic groups.

In contrast, Asians recorded the lowest self-inflicted injury-related hospital discharge rate (72.6/100,000).

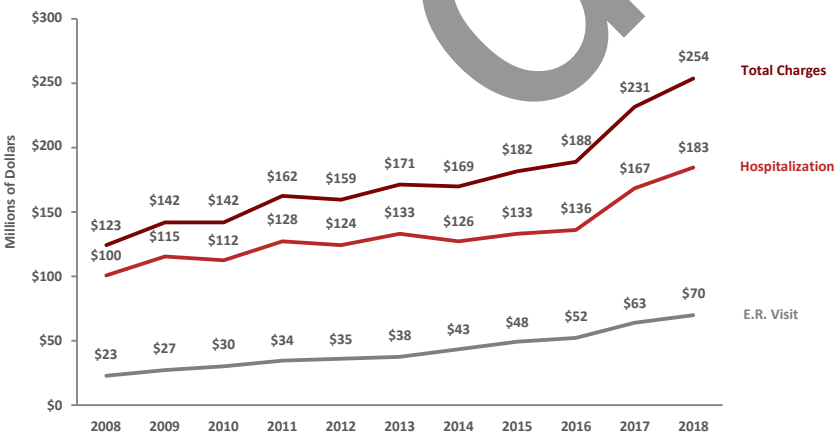
Figure 5E
Percentage of hospital discharges due to self-inflicted injury by mechanism: Arizona, 2018



In 2018, poisoning by drugs was the leading mechanism of self-inflicted injury, accounting for 55.1 percent of all self-inflicted injury-related hospital discharges in Arizona. For both genders, poisoning by drugs was involved in most self-inflicted injury-related hospital discharges. Collectively, the proportions of hospital discharges due to self-inflicted injuries involving other means - including but not limited to drowning, jumping from high place, crashing of a motor vehicle and stabbing - were also noticeably high.

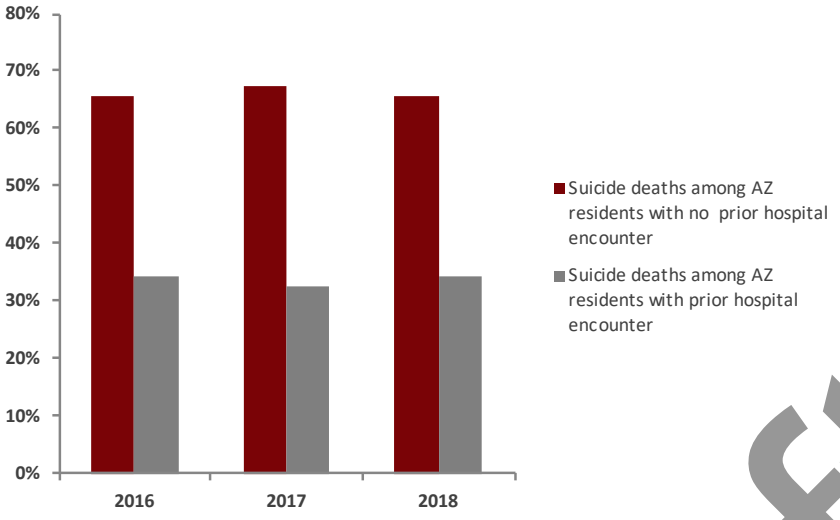
Expectedly, firearms and hanging – the most lethal methods of suicide – were the least likely to be involved in the total number of hospital discharges resulting in self-inflicted injuries. Distinctively, males recorded the highest proportion of self-inflicted injury-related hospital discharges involving firearms (3.0 percent) and strangulation (2.0 percent).

Figure 6E
Total charges for hospital discharges due to self-inflicted injury by type of encounter: Arizona, 2008-2018



In 2018, the annual reported charges of self-inflicted injury-related hospital discharges were estimated to be $254 million, with 72.3 percent of these costs attributable to hospitalizations. Trend analysis shows an increase in the total estimated health care costs of self-inflicted injury. From 2008 to 2018, the burden of health care costs has increased by approximately two-fold. E.R. visit charges due to self-inflicted injury have increased the most during 2008-2018 (3-fold increase) compared to the hospitalization charges resulting from self-inflicted injury (1.8-fold increase).

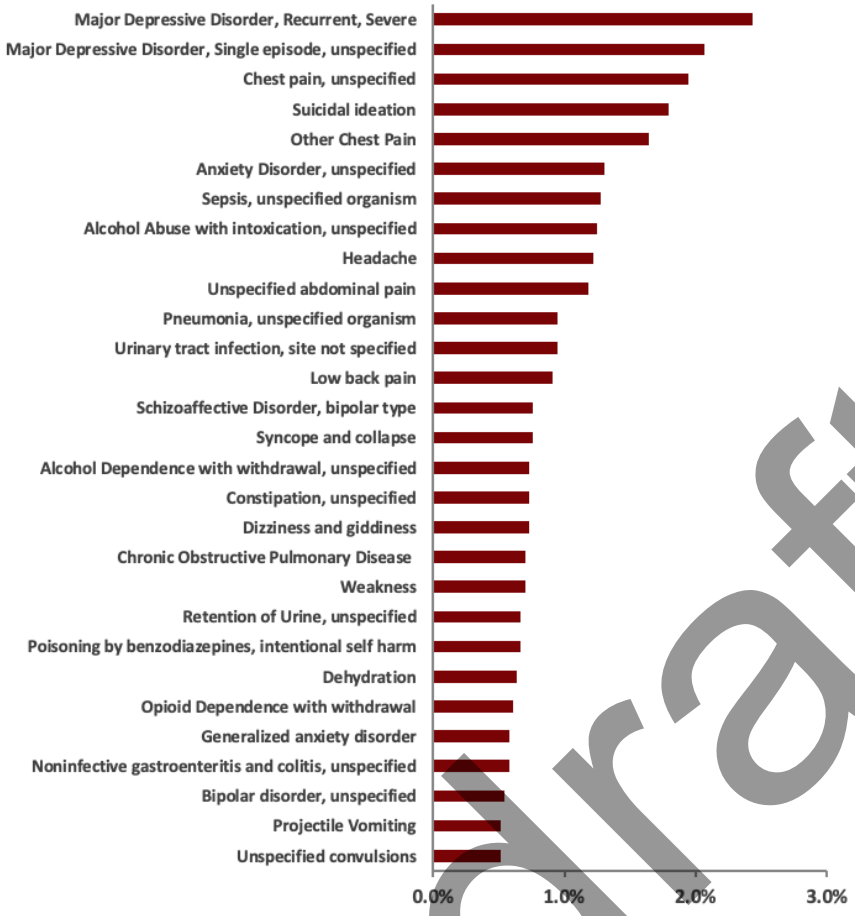
Figure 7E
Suicide mortality by recent medical history: Arizona, 2016-2018



An analysis of the medical history of Arizona residents who died by suicide was conducted from 2016 to 2018.

In each year during the study period, the highest proportion of residents who died by suicide was observed among those with no prior hospital encounter in the past 6 months preceding death. These results may be linked to the limitations of the hospital discharge data (HDD). The HDD lacks information on patients' encounters to non-hospital providers such as physicians and ambulatory surgery. Because of this, morbidity burden may be underestimated. Further, only hospitals that operate under a license issued by the Arizona Department of Health Services are required to participate in the discharge reporting system. Thus, the HDD may be incomplete due to non-inclusion in the data collection of Veterans Affairs hospitals, department of defense healthcare services, and medical facilities located on tribal lands. Noticeably, these non-reporting facilities are dedicated for use by the very groups with the highest suicide rates. The lack of discharge data from these medical facilities limits the significance of the current analysis.

Figure 8E
Most frequent diagnoses among Arizona residents who died by suicide: Arizona, 2016-2018



A pooled analysis of data from 2016 to 2018, shows that among Arizona residents with prior medical encounters, depression appeared to be the most common reason for hospitalization and/or ER visits before their suicide. Depression, either chronic or episodic, is a serious mood disorder, which interferes with all areas of a person's life. Chest pain followed by suicidal ideation, other chest pain, anxiety disorder, sepsis, alcohol abuse, headache and unspecified abdominal pain was among the 10 most common diagnoses among Arizona who died by suicide.

Appendix

TABLE 1
NUMBER OF SUICIDES AND SUICIDE MORTALITY RATES BY AGE GROUP AND YEAR, ARIZONA RESIDENTS, 2006-2018

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015		2016		2017		2018	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
<15[a]	11	2.4	5	1.1	8	1.7	4	0.9	9	2.0	13	2.9	9	2.0	8	1.7	11	2.4	12	2.6	9	1.7	16	3.5	17	3.6
15-24	149	16.8	127	14.3	123	13.6	122	13.4	133	14.7	140	15.4	126	13.7	121	12.9	129	13.7	155	16.4	151	15.9	160	15.8	194	20.2
15-19	57	13.0	38	8.5	56	12.4	49	10.7	39	8.4	50	10.8	48	10.3	32	6.8	49	10.8	63	13.8	56	12.1	62	11.9	81	17.2
20-24	92	20.6	89	20.0	67	14.8	73	16.0	94	21.2	90	20.2	78	17.2	89	19.1	80	16.4	92	18.7	95	19.5	98	19.5	113	23.1
25-34	131	14.5	179	19.2	122	12.8	147	15.3	164	19.1	167	19.3	175	20.2	158	18.2	171	19.3	199	22.1	204	22.3	236	21.8	233	24.2
35-44	165	19.1	164	18.6	157	17.5	188	20.7	154	18.7	190	22.9	157	18.9	198	23.7	171	20.5	176	21.0	164	19.5	180	19.3	201	23.2
45-54	170	21.5	213	25.6	209	24.8	222	26.1	251	29.8	230	27.1	208	24.9	242	29.0	204	24.2	224	26.6	225	26.7	189	26.5	218	25.5
55-64	125	20.4	137	21.1	162	24.7	167	25.1	171	23.5	190	26.0	208	27.8	164	21.6	192	24.6	213	26.7	216	26.5	224	25.9	234	27.4
65+	196	24.5	161	19.3	187	22.0	209	24.4	188	21.3	182	20.5	187	19.9	224	22.8	246	24.0	254	23.6	287	25.6	299	24.3	335	27.6
65-74	88	20.3	81	19.1	85	19.7	89	20.4	74	14.9	83	16.6	94	17.4	112	19.8	137	23.1	138	22.1	153	23.4	150	22.3	186	26.3
75-84	71	26.3	59	19.5	72	23.5	88	28.4	84	29.9	63	22.3	62	21.1	82	27.2	77	24.7	81	25.0	92	27.3	99	26.0	108	29.4
85+	37	38.6	21	19.4	30	27.2	32	28.8	30	29.0	36	34.6	31	28.6	30	26.7	32	26.7	35	27.9	42	32.1	50	30.5	41	29.7
	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate	Count	Age-adjusted Rate
TOTAL[b]	948	15.2	986	15.3	968	13.4	1,060	16.1	1,070	16.7	1,113	17.3	1,070	16.5	1,116	17.0	1,124	16.9	1,233	18.2	1,256	18.4	1,304	18.0	1,432	19.5

TABLE 2
SUICIDE COUNTS BY RACE/ETHNICITY AND GENDER, ARIZONA, 1998-2018

	All groups			White non-Hispanic			Hispanic or Latino			Black or African American			American Indian or Alaska Native			Asian or Pacific Islander		
	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F
1992	621	512	109	508	409	99	66	59	7	11	10	1	32	30	2	4	4	0
1993	717	581	135	580	463	116	78	68	10	13	10	3	43	38	5	3	2	1
1994	752	607	145	588	467	121	92	81	11	16	14	2	46	39	7	10	6	4
1995	788	619	169	648	502	146	82	69	13	16	13	3	39	34	5	3	1	2
1996	721	584	137	580	460	120	86	79	7	11	10	1	38	29	9	6	6	0
1997	732	592	139	587	466	121	81	76	5	17	13	4	36	29	7	11	8	3
1998	802	635	167	644	495	149	99	93	6	10	7	3	40	33	7	9	7	2
1999	760	595	165	594	459	135	101	82	19	18	18		41	32	9	6	4	2
2000	756	608	148	604	471	133	94	84	10	10	10	0	41	36	5	7	7	0
2001	600	485	115	462	367	95	73	64	9	15	13	2	43	36	7	6	5	1
2002	855	692	163	684	542	142	103	89	14	12	12	0	50	43	7	5	5	0
2003	807	647	160	624	499	125	105	84	21	23	19	4	47	41	6	6	2	4
2004	854	674	180	662	511	151	120	105	15	20	17	3	47	37	10	4	3	1
2005	915	723	192	694	542	152	147	126	21	7	5	2	56	45	11	11	5	6
2006	948	743	205	735	562	173	128	113	15	21	18	3	49	40	9	13	9	4
2007	986	773	213	774	599	175	150	123	27	15	13	2	35	28	7	11	9	2
2008	968	737	231	772	580	192	105	90	15	20	15	5	53	41	12	16	9	7
2009	1,060	792	268	811	602	209	144	114	30	27	18	9	56	38	18	15	13	2
2010	1,070	846	224	832	651	181	125	103	22	18	15	3	57	48	9	14	10	4
2011	1,113	866	247	873	666	207	135	117	18	24	18	6	56	45	11	10	7	3
2012	1,070†	837	230†	849	665	184	122	94	28	30†	22	*	60	46	14	10†	10	*
2013	1,120†	860	260†	863	667	196	151	110	41	20†	15	*	69	55	14	10†	13	*
2014	1,120†	857	270†	883	663	220	138	110	28	31	24	7	53	45	8	20†	15	*
2015	1,233	941	292	1,002	770	232	133	101	32	22	16	6	58	42	16	18	12	6
2016	1,256	976	280	955	739	216	173	143	30	28	20	8	75	56	19	25	18	7
2017	1,300†	1000	300†	973	738	235	177	144	33	30†	30	*	78	58	20	23	13	10
2018	1432	1,146	286	1049	825	224	185	159	26	55	44	11	113	94	19	19	13	6

Notes: * Cell suppressed due to non-zero count less than 6; † Sum rounded to nearest tens unit due to non-zero addend less than 6.

TABLE 3
AGE-ADJUSTED[a] MORTALITY RATES OF SUICIDE BY RACE/ETHNICITY AND GENDER, ARIZONA, 1998-2018

	All groups			White non-Hispanic			Hispanic or Latino			Black or African American			American Indian or Alaska Native			Asian or Pacific Islander		
	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F
1990	19.0	32.6	6.5	20.9	36.1	7.2	9.4	16.6	2.8	12.5	17.2	7.7	20.1	39.1	2.6	7.9	4.6	10.1
1991	18.0	30.8	6.4	19.1	32.8	6.7	12.1	20.3	4.6	17.8	23.6	12.3	18.9	35.1	4.0	2.5	5.5	0.0
1992	17.3	29.0	6.5	18.8	31.1	7.5	10.4	19.2	2.6	10.3	17.8	2.4	19.6	34.7	5.6	4.8	10.5	0.0
1993	18.9	32.2	6.9	21.2	35.7	8.2	8.8	14.9	2.4	8.0	12.4	3.0	21.7	39.1	5.5	5.2	7.7	3.2
1994	19.4	32.2	7.4	21.2	34.9	8.3	11.1	19.6	2.2	8.7	13.9	2.9	20.8	33.0	8.8	16.7	18.9	15.4
1995	19.5	31.1	8.6	22.2	35.1	10.2	9.7	15.8	3.4	14.4	24.6	5.8	16.3	30.0	3.5	4.1	5.0	4.0
1996	16.9	28.4	6.2	19.1	31.8	7.5	9.0	16.2	1.8	7.3	11.7	2.2	15.9	25.6	6.8	4.7	9.9	0.0
1997	17.2	28.7	6.3	19.4	31.8	7.7	8.8	16.3	1.3	12.3	21.5	3.5	18.7	30.5	7.4	11.0	18.2	5.7
1998	17.5	28.7	7.1	20.1	32.2	8.9	9.5	18.4	0.8	6.5	8.7	3.9	16.1	28.1	5.0	6.8	9.1	3.9
1999	15.7	25.5	6.5	16.7	27.1	7.0	10.5	17.8	3.7	12.8	26.1	0.0	16.6	27.6	6.4	6.4	10.3	3.4
2000	14.6	24.7	5.2	16.7	27.6	6.8	7.2	12.7	1.4	6.5	12.2	0.0	16.2	29.7	3.7	5.7	12.3	0.0
2001	14.9	24.6	5.6	12.8	21.0	5.1	5.9	9.9	1.6	9.2	15.2	2.4	15.4	26.4	5.2	9.4	15.4	4.7
2002	15.9	26.4	6.0	18.3	30.0	7.4	8.3	14.2	2.5	6.2	11.4	0.0	17.9	31.7	4.9	4.1	9.1	0.0
2003	14.6	24.0	5.8	16.4	27.1	6.4	8.2	11.8	4.2	11.3	16.6	4.8	15.2	27.4	3.6	6.0	7.0	5.9
2004	14.9	24.1	6.3	16.6	26.4	7.5	9.8	17.5	2.2	12.1	17.3	5.1	17.0	28.5	6.5	4.0	7.0	2.7
2005	15.4	24.9	6.5	16.6	26.7	7.3	10.5	17.8	3.0	3.3	4.7	1.8	17.5	28.7	6.8	11.7	8.9	14.1
2006	15.4	24.7	6.6	17.8	27.9	8.5	8.2	14.2	2.0	8.3	13.9	2.3	13.7	23.4	4.5	8.4	13.2	4.3
2007	15.4	24.4	6.7	18.7	29.4	8.3	9.2	14.7	3.6	6.2	10.1	1.7	9.8	16.3	3.6	6.1	9.2	2.4
2008	14.8	23.0	7.0	17.6	27.3	8.5	6.5	10.8	1.9	7.5	10.3	4.2	13.5	21.2	5.9	9.9	10.7	8.8
2009	16.1	24.6	8.1	18.4	28.0	9.5	9.0	14.0	3.9	10.5	12.7	7.7	15.9	22.9	9.3	9.9	19.9	2.3
2010	16.7	27.1	6.7	20.6	32.8	8.7	7.4	12.5	2.6	6.4	9.9	2.2	18.7	32.3	5.7	6.8	11.0	3.2
2011	17.2	27.4	7.5	22.0	33.1	10.1	8.1	14.8	1.8	9.1	13.7	4.3	14.9	24.0	5.8	5.3	6.9	3.5
2012	16.2	25.9	7.0	20.2	32.2	8.7	6.8	11.1	2.9	10.0	15.5	4.0	17.9	27.9	8.1	5.7	10.2	1.8
2013	17.0	26.6	7.7	20.8	32.4	9.6	8.4	12.8	4.2	6.7	9.7	3.1	21.9	36.1	8.1	7.0	14.5	1.1
2014	16.5	25.6	7.7	21.0	31.9	10.4	8.3	13.4	3.4	9.0	13.6	4.2	13.9	24.3	3.7	7.0	12.0	2.7
2015	17.8	27.5	8.4	23.6	36.4	11.1	6.7	10.4	3.2	6.6	9.2	3.7	19.0	28.4	10.0	7.0	9.9	4.5
2016	17.7	28.0	7.9	21.7	33.6	10.2	8.8	15.0	2.9	9.0	13.1	5.2	24.2	36.7	11.9	9.3	14.0	4.7
2017	18.0	28.1	8.4	22.1	33.8	10.8	8.5	14.1	3.0	10.5	19.1	2.3	26.2	40.4	12.7	9.3	10.6	7.8
2018	19.5	31.5	7.8	23.7	37.5	10.2	8.7	15.2	2.4	16.0	24.6	6.6	36.5	61.8	12.3	7.3	11.0	4.1

Note: [a] Adjusted to the 2000 standard U.S. population.

TABLE 4
RATES AND COUNTS[a] OF SUICIDES RECORDED IN ARIZONA BY VETERAN STATUS, 2006-2018

Year	Overall State Suicide Rate	Overall State Suicide Count	Veteran Suicide Rate	Veteran Suicide Count	Non-Veteran Suicide Rate	Non-Veteran Suicide Count
2008	15.9	1,041	44.5	245	13.3	796
2009	16.8	1,107	45.1	240	14.3	867
2010	17.8	1,136	47.6	252	15.1	884
2011	18.5	1,192	47.4	253	15.9	939
2012	18.3	1,191	51.5	271	15.4	920
2013	18.2	1,197	52.9	264	15.3	933
2014	19.1	1,274	56.1	271	16.2	1,003
2015	19.7	1,329	52.8	258	17.1	1,071
2016	19.4	1,325	58.5	284	16.4	1,041
2017	19.6	1,364	53.9	259	17.0	1,105
2018	21.3	1,510	53.6	266	18.9	1,244

Note: [a] Statistics compiled on the basis of where the deaths actually occurred; Counts include residents and non-residents.

REPORT: Arizona Zip Codes where 100% of the Reported Suicides were Veterans

Prepared by: Elinor McCarthy
for the Arizona Department of Veterans' Services

June 2021

Introduction

This report contains every zip code in the State of Arizona where 100% of the reported suicides were Veterans from the years of 2015-2018. These zip codes are considered areas of elevated risk. For each zip code, the city, county, population, land area in square miles, and percentage of that population that are veterans is listed towards the top of the page.

Then listed are all known resources found within zip code limits. This includes Federal, State, and Local government entities. Also included are Community Centers, Veteran service organizations/resources, and any other places where people may congregate, for potential outreach purposes. Each zip code's proximity to the nearest Veterans Affairs Healthcare System and Community Based Outpatient Clinic and the availability of public transportation are recorded as well.

A table on page three summarizes the data collected on every zip code. More in depth descriptions, including the street addresses of resources, can be found on each individual zip code's page.

Three of these zip code areas contain U.S. Military installations: 85613 is Fort Huachuca, 85707 is Davis-Monthan Air Force Base, and 85309 is Luke Air Force Base. Also out of the eighteen zip codes, only four have public transportation systems, which equates to approximately 22%. Maricopa County is the county with the greatest number of zip codes on this list, followed by Gila County and Apache County.

The zip code 85724 is not included in this report although it was given to ADVS on the original data list. 85724 is the mailing zip code for the Arizona Medical Center Building. It does not contain any residences and is contained inside the bigger zipcode of 85719.

According to the Arizona Department of Health Services 2020 Suicide Report, Yuma county had the overall higest rate of veteran suicides in the state of Arizona in aggregate from 2009 to 2019, with a rate of 79.2 per 100,000. Santa Cruz and Greenlee counties both had a total rate of 0 per 100,000 veteran suicides. The data from six counties; La Paz, Coconino, Gila, Navajo, Apache,

and Graham, were suppressed in the report, so these countries were not accounted for in the final analysis.

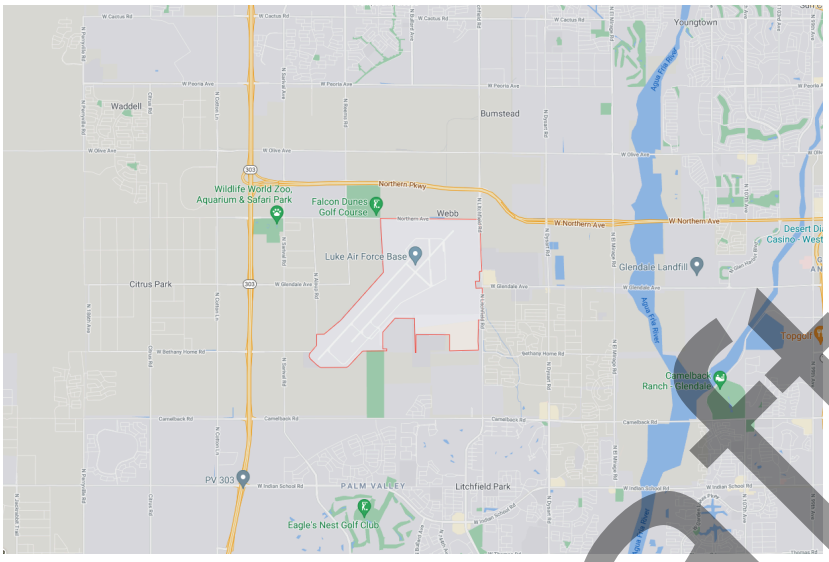
Also in aggregate from the years 2009 to 2019, the occupations with the highest percentages of veteran suicides were the Construction Industry and the Armed Forces. The occupation with the lowest rate was Religious Workers (Arizona Department of Health Services, 2020, p. 20).

Firearms were the leading cause of death since 2009 in veteran suicides, accounting for an average of 77.14% of veteran suicides annually. The rate of suicide by drug poisoning was much lower, with an average of 7.03% annually since 2009. Opioids and prescription opioids were present in 75% of veteran drug-related suicides, while prescription non-opioids were present in over 80% of veteran drug-related suicides.

Zip Code	City	County	Population	Population of Veterans in Zip Code	Percent of Veterans	Land Area (sq mi)	Public Transportation
85932	Nutrioso	Apache	365	60	16%	130.9	No
85940	Vernon	Apache	1,443	208	14%	82.11	No
86544	Red Valley/ Teec Nos Pos	Apache	118	26	22%	246.55	No
85613	Fort Huachuca	Cochise	5,644	538	10%	46.9	Yes
85620	Naco	Cochise	751	24	3%	1	No
85501	Globe	Gila	13,345	Unknown	Unknown	433	Yes
85545	Roosevelt	Gila	583	110	19%	390.5	No
85554	Young	Gila	778	113	15%	760	No
85543	Pima	Graham	3,822	317	8%	596.81	Yes
85309	Glendale	Maricopa	1,485	158	11%	3.42	No
85034	Central City/ South Phoenix	Maricopa	5,582	131	2%	11.42	Yes
85263	Rio Verde/ Scottsdale	Maricopa	2,111	394	19%	337.82	No
85264	Fort Mcdowell/ Scottsdale	Maricopa	1,249	35	3%	213	No
86431	Chloride	Mohave	403	99	25%	58	No
85707	Tucson	Pima	658	49	7%	5	No
85631	San Manuel	Pinal	3,630	517	14%	116.62	No
85194	Casa Grande	Pinal	6,721	Unknown	Unknown	75.87	No
85637	Sonoita	Santa Cruz	1,268	204	16%	120	No
86237	Dewey	Yavapai	8,858	Unknown	Unknown	148	No

85309, Glendale (Central)

Number of veterans: 158



- County: Maricopa
- Population: 1,485
- Area: 3.42 mi^2
- 11% of the population are veterans

Federal Government Entities:

United States Postal Service, 14032 W Mustang St

Luke Air Force Base, 14185 Falcon St, Luke AFB

Community Centers/Resources:

Luke AFB Education Center, 7325-7499 N Litchfield Rd

Luke AFB Library, 7424 N Homer Dr

Veteran Service Organizations/Resources:

Navy Operational Support Center, 14160 Marauder St

Additional Potential Outreach Locations:

Bryant Fitness Center, 14053 W Shooting Star

Public Transportation: Not available

VA Healthcare System: Phoenix VA Health Care System, 18 miles away

CBOC: Northwest VA Health Care Clinic is 6 miles away

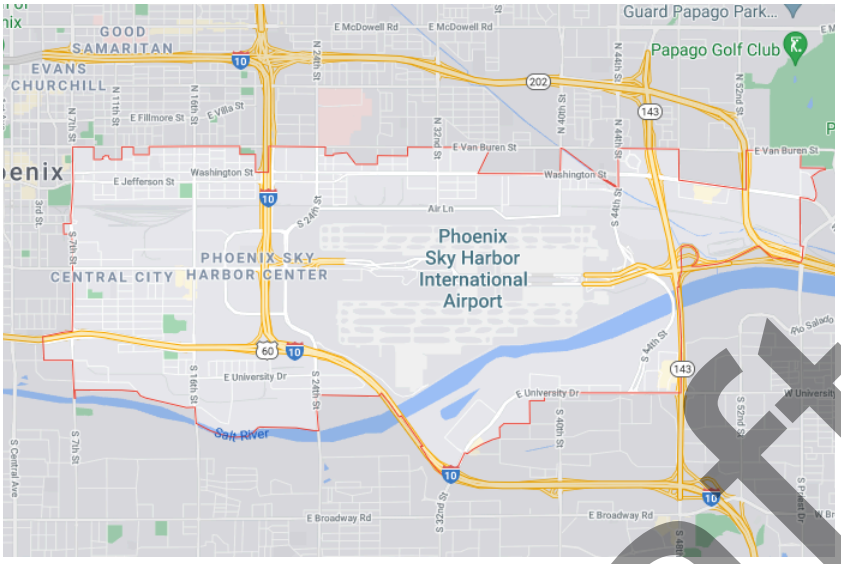
Other notable information:

97% of the population is in between the ages of 15 and 29

It was ranked the lowest income zip code in Arizona

85034, Central City/ South Phoenix (Central)

Number of veterans: 131



- County: Maricopa
- Population: 5,582
- Area: 11.42 mi²
- 2% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 1441 E Buckeye Rd Lbby

U.S. Citizenship and Immigration Services District Office, 1330 S 16th St

U.S. Marshals Services, 111 W Monroe St

State Government Entities:

Arizona Air National Guard Recruiting, 3200 E Old Tower Rd

County/City Government Entities:

Phoenix Police Department Central City Precinct Station, 1902 S 16th St

Community Assistance Program And Training Center, 4056 E Washington St

Community Centers/Resources:

Eastlake Park Community Center, 1549 E Jefferson St

Additional Potential Outreach Locations:

Barrios Unidos Park, 1501 E Mohave St

Green Valley Park, 2243 S 14th St

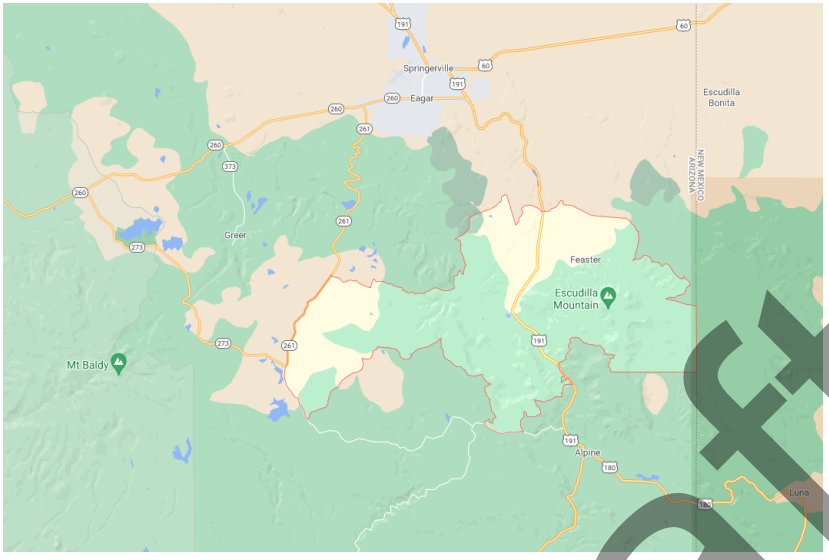
Public Transportation: Yes, Valley Metro Rail

VA Healthcare System: Phoenix VA Health Care System, 5 miles away

CBOC: Phoenix VA Clinic, 5 miles away

85932, Nutrioso (Central)

Number of Veterans: 60



- County: Apache
- Population: 365
- Area: 130.9 mi²
- 16% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 1 Co Rd 2013

Community Centers/Resources:

Nutrioso Community Center, Co Rd 2016 #8

Additional Potential Outreach Locations:

Nutrioso Bible Church, 41568 US-180

Public Transportation: None available

VA Healthcare System: Southern Arizona VA Health Care System, 160 miles away

CBOC: Show Low VA Clinic, 54 miles away

Other notable information:

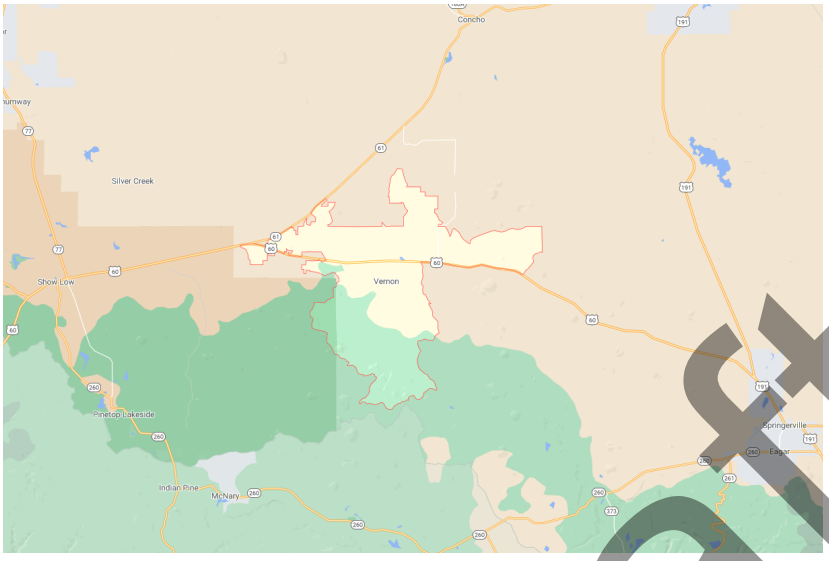
Approximately 45% of the population is over the age of 60

Very small number of permanent residents, majority of the houses are used for seasonal and recreational purposes

Very secluded, most land area is mountainous

85940, Vernon (Central)

Number of Veterans: 208



- County: Apache
- Population: 1,443
- Area: 82.11 mi²
- 14% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 1688 Apache Co Rd 3140

County/City Government Entities:

Vernon Fire District, Station 25, 25 N3142, Vernon, AZ 85940

Community Centers/Resources:

Vernon Public Library, 10 N3142

Additional Potential Outreach Locations:

Bannon Springs Assisted Living, Co Rd 3398

Angel Wings Assisted Living, 86 Co Rd 3148

Vernon Mission Church, 1579 Co Rd 3140

The Church of Jesus Christ of Latter-day Saints, 1570 Co Rd 3140

Public Transportation: None available

VA Healthcare System: Phoenix VA Health Care System, 146 miles away

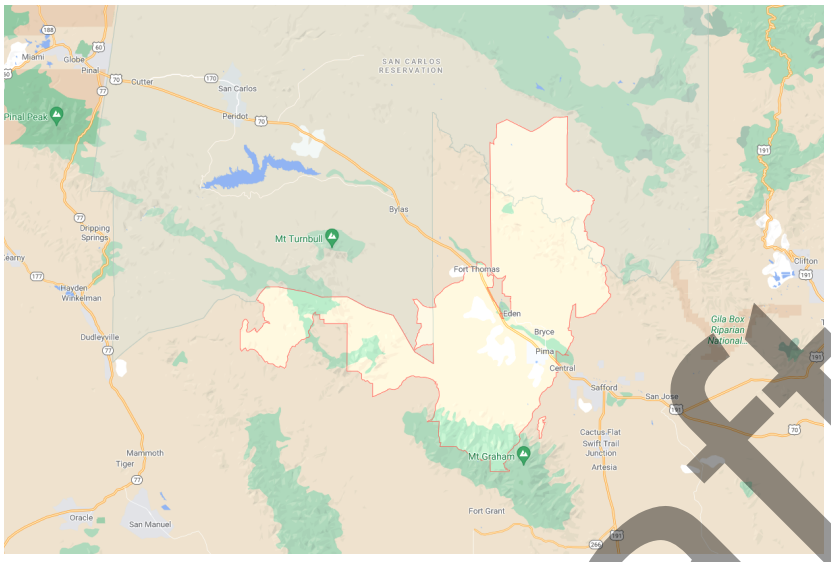
CBOC: Show Low VA Clinic, 22 miles away

Other notable information:

32% of the population is over 60

85543, Pima (South)

Number of Veterans: 317



- County: Graham
- Population: 3,822
- Area: 596.81 mi²
- 8% of the population are veterans

County/City Government entities

Pima Public Library, 70 200 W

Pima Police Office, 136 W Center St

Pima Town Hall, 110 W Center St

Pima Town Office, 401 N Main St

Additional Potential Outreach Locations:

Pima Park, 338-398 S 200 E

The Church of Jesus Christ of Latter-day Saints, 341 450 S

Public Transportation: Yes, limited lines. Stops in Pima to continue on to other cities, but does not circulate within Pima.

VA Healthcare System: Southern Arizona VA Health Care System, 83 miles away

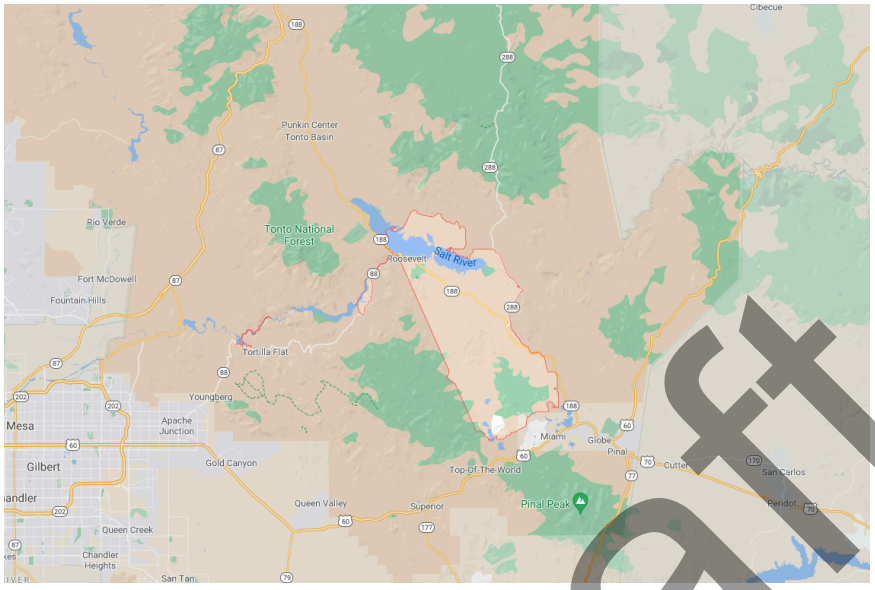
CBOC: Safford VA Clinic, 8 miles away

Other notable information:

Only a small portion of this zip code is populated, a large amount of its land is mountains

85545, Roosevelt (Central)

Number of Veterans: 110



- County: Gila
- Population: 583
- Area: 390.5 mi^2
- 19% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 18762 AZ-188

County/City Government Entities:

Tonto Ranger Station

Additional Potential Outreach Locations:

Roosevelt Baptist Church, AZ-188

Public Transportation: Not available

VA Healthcare System: Phoenix VA Health Care System, 62 miles away

CBOC: Globe VA Clinic, 20 miles away

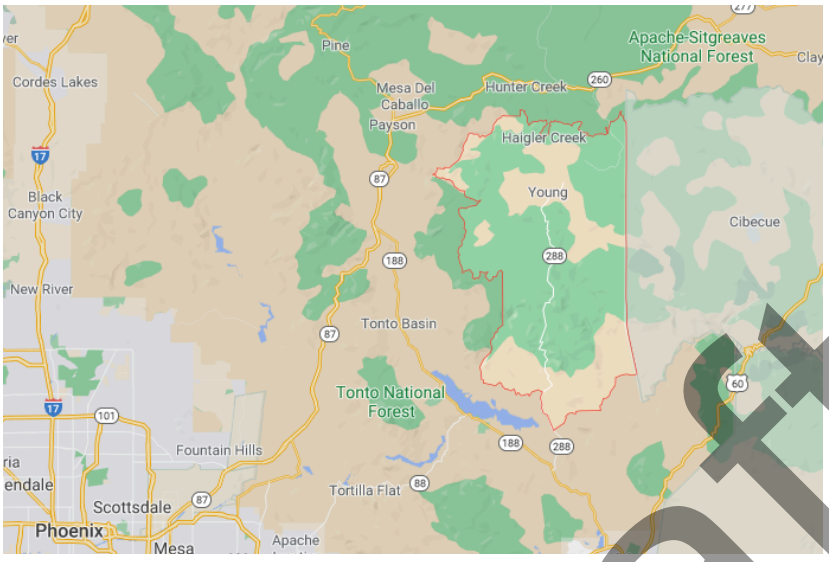
Other notable information:

Median age is 61, aprox 50% of the total population is above 60 years old

Small clusters of residential lots surrounded by national park/camping land

85554, Young (Central)

Number of Veterans: 113



- County: Gila
- Population: 778
- Area: 760 mi^2
- 15% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 48951 AZ-288

Pleasant Valley Ranger District Office

County/City Government Entities:

Young Public Library, 150 Community Center Rd

Additional Potential Outreach Locations:

Pleasant Valley Cowboy Church, 48412 AZ-288

The Church of Jesus Christ of Latter-day Saints, Desert to Tall Pines Hwy

Public Transportation: Not available

VA Healthcare System: Phoenix VA Health Care System, 65 miles away

CBOC: Payson VA Clinic, 10 miles away

Other notable information

Very sparse population, only about one person per square mile

Mostly mountains and national parks with one small central town

85613, Fort Huachuca (South)

Number of Veterans: 538

- County: Cochise
- Population: 5,644
- Area: 46.9 mi²
- 10% of the population are veterans

Federal Government Entities:

US Army Reserve Forces Office, 2520 Healey Ave

Military Police Station, Building 22336

Raymond W Bliss Army Health Center, 2240 Winrow Ave

Community Centers/Resources:

Murr Community Center, 51301 Cushing St

Thunder Mountain Activity Center, 70525 Kelsay Ave

Veteran Service Organizations/Resources:

Army Community Service, Smith Ave

Soldier for Life Transition Assistance Program Office, 22420 Butler Rd

Marine Corps Detachment Office, 2630 Cushing street Bldg 51001

United Service Organizations (USO) Office

Public Transportation: Yes, public bus, but only on/around the academic campus, it does not extend to the entire zip code

VA Healthcare System: Southern Arizona VA Health Care System, 59 miles away

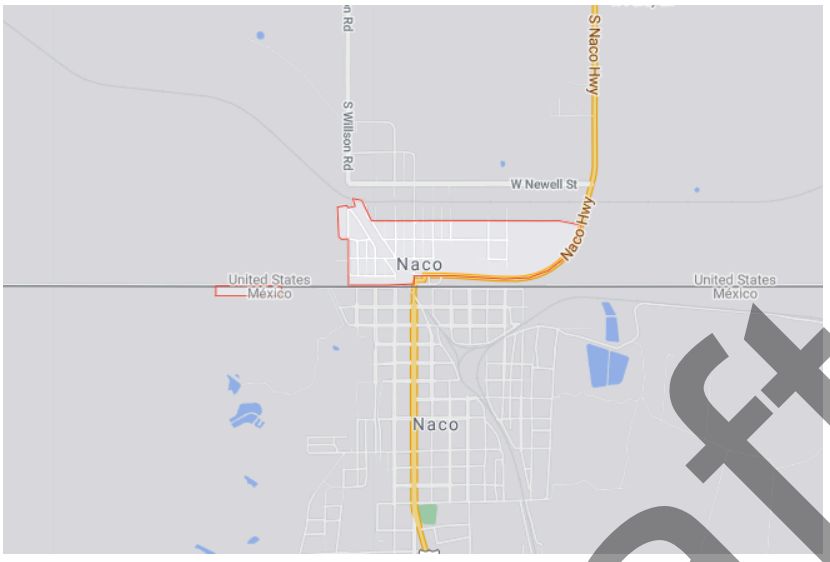
CBOC: Cochise County VA Clinic, 5 miles away

Other notable information

Contains a USAICoE NCO Academy; most of the population is concentrated on campus

85620, Naco (South)

Number of Veterans: 24



- County: Cochise
- Population: 910
- Area: 1 mi²
- 3% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 3833 S Giesler Ave

U.S. Customs and Border Protection Naco Port of Entry, 3867 S Towner Ave

Additional Potential Outreach Locations:

Saint Michael Mission Catholic Church, 2090 W Martinez St

Naco Estates Mobile Home Park, 3786 S Willson Rd**C:** Cochise County VA Clinic, 23 miles away

Public Transportation: Not available

VA Healthcare System: Southern Arizona VA Health Care System, 86 miles away

CBOC: Cochise County VA Clinic, 23 miles away

Other notable information:

On the Mexico and United States border

86431, Chloride (North)

Number of Veterans: 99

- County: Mohave
- Population: 403
- Area: 58 mi²
- 25% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 4961 Tennessee Ave

Veteran Service Organizations/Resources:

VFW Post 2190, 5134 W Tennessee Ave

Additional Potential Outreach Locations:

Chloride First Baptist Church, 4941 Pay Roll Ave

Public Transportation: Not available

VA Healthcare System: Northern Arizona VA Health Care System, 100 miles away

CBOC: Kingman VA Clinic, 23 miles away

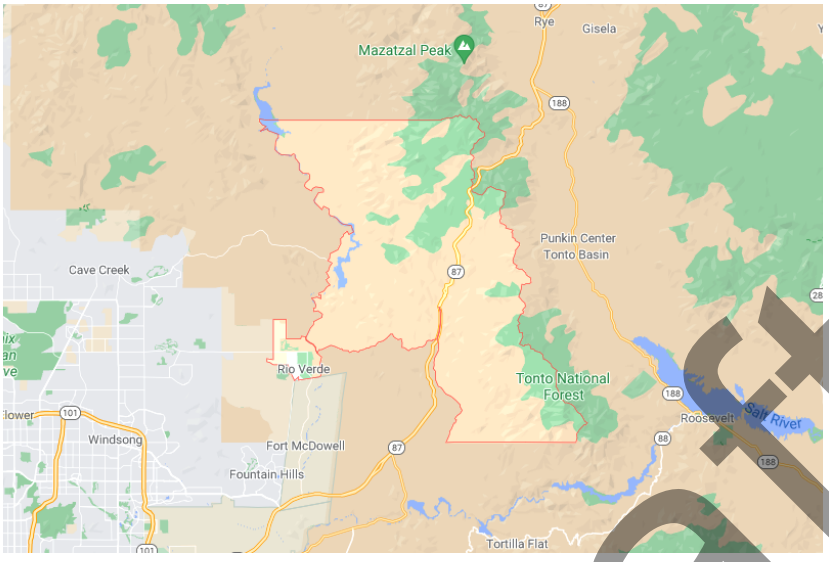
Other notable information:

Median age of population is 62

Whole population is concentrated in the town of Chloride, the rest of the zipcode is rural/mountain land

85263, Rio Verde / Scottsdale (Central)

Number of Veterans: 394



- County: Maricopa
- Population: 2,111
- Area: 337.82 mi²
- 19% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 25609 N Danny Ln UNIT 6

County/City Government Entities:

Maricopa County Sheriff's Department Bartlett Lake, E Bartlett Dam Rd

Rio Verde Fire Station, 25608 Forest Rd

Community Centers/Resources:

Rio Verde Community Association, 18816 E 4 Peaks Blvd

Additional Potential Outreach Locations:

Rio Verde Country Club, 18731 E 4 Peaks Blvd

Tonto Verde Homes & Golf Club Community Clubhouse, 18401 El Circulo Dr

Bartlett Lake Marina, 20808 E Bartlett Dam Rd

Public Transportation: Not available

VA Healthcare System: Phoenix VA Health Care System, 27 miles away

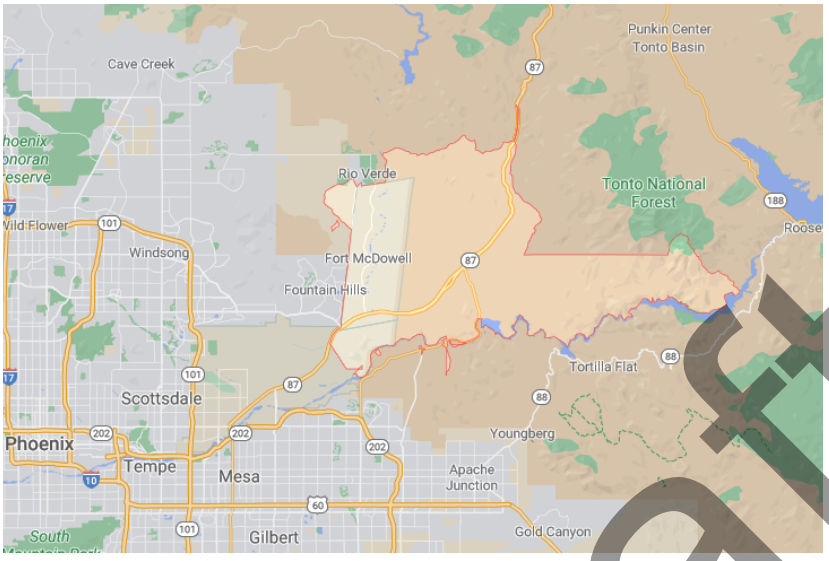
CBOC: Northeast Phoenix VA Clinic, 12 miles away

Other notable information:

Approximately 50% of residents are 69 years old or older

85264, Fort Mcdowell / Scottsdale (Central)

Number of Veterans: 35



- County: Maricopa
- Population: 1,249
- Area: 213 mi²
- 3% of the population are veterans

County/City Government Entities:

Fort McDowell Tribal Police, 10755 N Fort McDowell Rd #3

Community Centers/Resources:

Fort McDowell Recreation Center, 16402 N Fort McDowell Rd

Additional Potential Outreach Locations:

Butcher Jones Recreation Site, E Butcher Jones Beach Rd

Fort McDowell Historic U.S. Army Post, Salt River, Fort McDowell

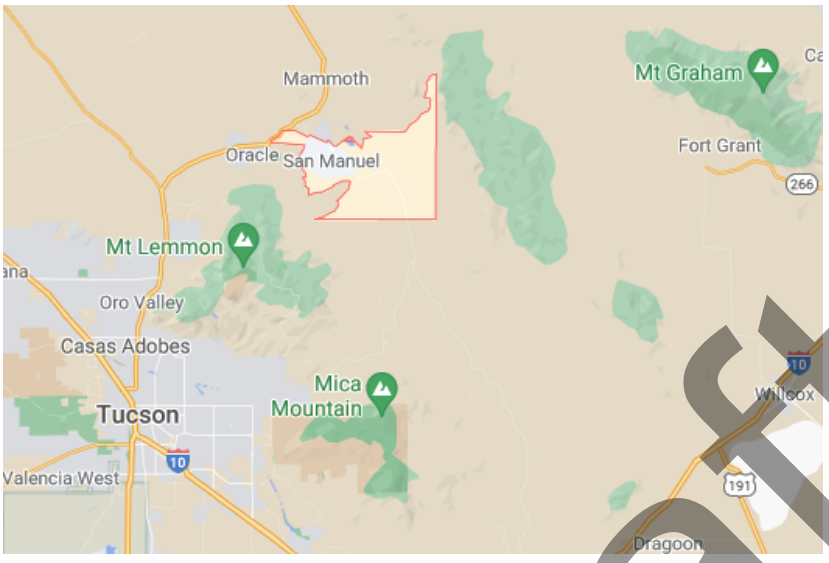
Public Transportation: Not available

VA Healthcare System: Phoenix VA Health Care System, 25 miles away

CBOC: Northeast Phoenix VA Clinic, 9 miles away

85631, San Manuel (South)

Number of Veterans: 517



- County: Pinal County
- Population: 3,630
- Area: 116.62 mi²
- 14% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 430 S Ave A

Additional Potential Outreach Locations:

City Park, 111 W 5th Ave

St Bartholomew Catholic Church, 609 W Park Pl

Public Transportation: Not available

VA Healthcare System: Southern Arizona VA Health Care System, 36 miles away

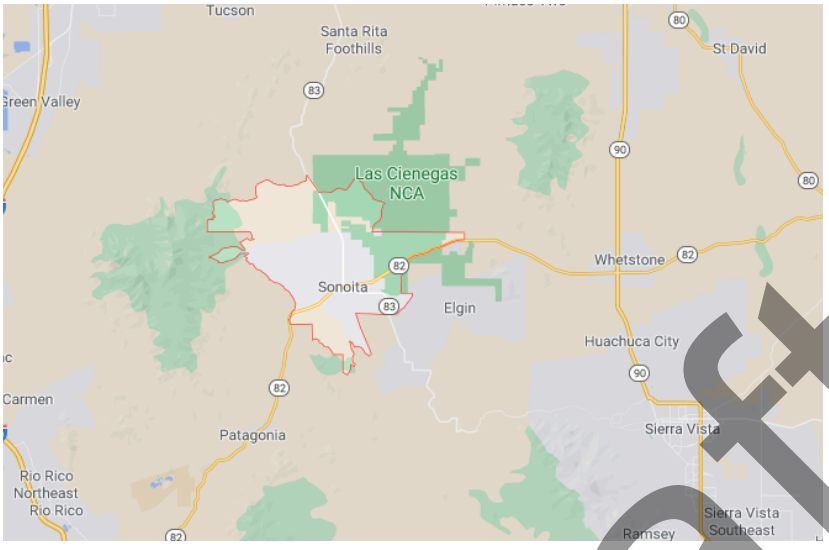
CBOC: Northwest Tucson VA Clinic, 30 miles away

Other notable information:

Most of the population is concentrated in about 5 square miles, in the company town created for the San Manuel copper mine, mill and smelter complex

85637, Sonoita (South)

Number of Veterans: 204



- County: Santa Cruz
- Population: 1,268
- Area: 120 mi²
- 16% of the population are veterans

Federal Government entities

U.S. Postal Service, 3166 AZ-83 Ste 1

County/City Government entities

Sonoita Library, 3147 AZ-83

Santa Cruz County Constable Office, 3147 AZ-83

Veteran Service Organizations/Resources:

Boulder Crest Arizona Retreat, 415 Gardner Canyon Rd

Additional Potential Outreach Locations:

Santa Cruz County Fair & Rodeo Association, 3142 AZ-83

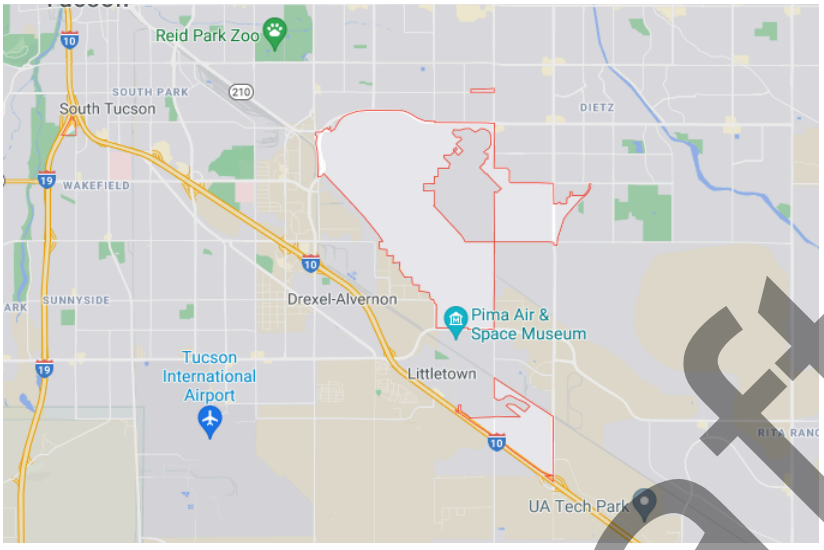
Public Transportation: Not available

VA Healthcare System: Southern Arizona VA Health Care System, 43 miles away

CBOC: Green Valley VA Clinic, 24 miles away

85707, Tucson (South)

Number of Veterans: 49



- County: Pima
- Population: 658
- Area: 5 mi²
- 7% of the population are veterans

Federal Government Entities:

U.S. Postal Service, 5450 E Madera St

Davis-Monthan Air Force Base, 5285 E Madera

Davis Monthan MPF, 3200, 3515 5th St #118

Veteran Service Organizations/Resources:

Navy Operational Support Center (NOSC) Tucson, 3655 S Wilmot Rd

Additional Potential Outreach Locations:

BAMA Park

Davis Monthan AFB FamCamp (Campground), 6170 Quijota Blvd Bldg. 6015

Benko Fitness Center, 5200 Ironwood St Bldg. 2301

Public Transportation: Not available within the zip code (because it is a military base) but is available in all the surrounding areas

VA Healthcare System: Southern Arizona VA Health Care System, 8 miles away

CBOC: Southeast Tucson VA Clinic, 12 miles away

Other notable information

US Military Base, includes parts of the airplane boneyard

86544, Red Valley / Teec Nos Pos (North)

Number of Veterans: 26

- County: Apache
- Population: 118
- Area: 246.55 mi²
- 22% of the population are veterans

Community Centers/Resources:

Cove Chapter House

Additional Potential Outreach Locations::

Cove Veterans/Uranium Miners Memorial Park (next to Cove Chapter House)

Public Transportation: Not available

VA Healthcare System: Northern Arizona VA Health Care System, 167 miles away

CBOC: Chinle VA Clinic, 43 miles away

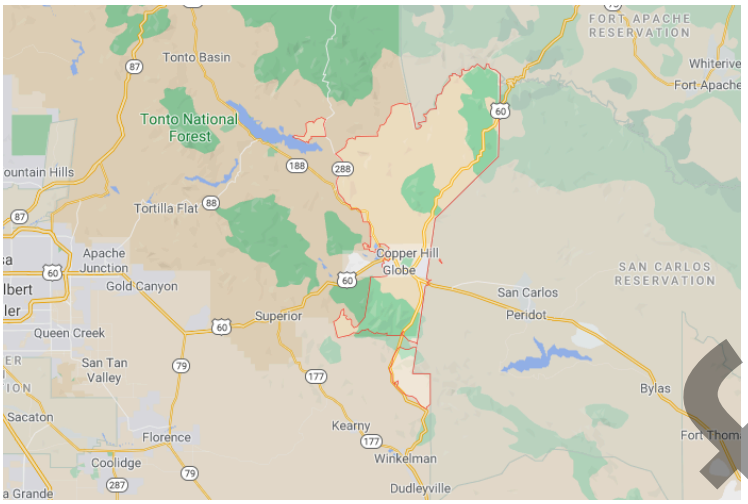
Other notable information:

Secluded, with no concentrated town area

Mostly made up of natural land, sparse houses

85501, Globe (Central)

Number of Veterans: Unknown



- County: Gila
- Population: 13345
- Area: 433 mi²

Federal Government Entities:

United States Postal Service, 101 S Hill St
US Agriculture Department Forest Services
Globe VA Clinic, 5860 N Hospital Dr #111

State Government Entities:

Arizona Department of Economic Security, 605 S 7th St

County/City government Entities:

Globe Police Department, 175 N Pine St
Gila County Health Department, 5515 S Apache Ave
City of Globe Building, w 85501, 200 W Ash St
Gila County Clerk of the Court/Gila County Library District Offices, 1400 E Ash St
Globe Ranger Station, 7680 6 Shooter Canyon Rd

Community Centers/Resources:

Globe Community Center, 1370 S Jesse Hayes Rd

Additional Potential Outreach Locations:

Globe Public Library, 339 S Broad St, Globe

Veteran Service Organizations/Resources:

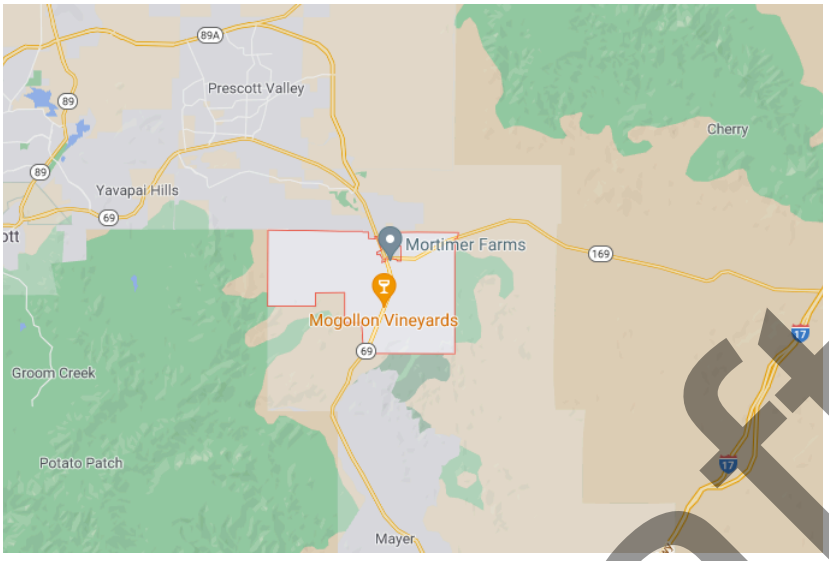
Vfw Post 1704, 707 S Broad St
American Legion, 645 S Broad St

Public Transportation: Yes, but is available only in the city of Globe
VA Healthcare System: Phoenix VA Health Care System, 75 miles away
CBOC: Globe VA Clinic, 0 miles away
Other notable information

The original zip code given to us for this area was 85502, which is the mailing address zip code for a P.O. Box that is located inside zip code 85501. So, we looked at the zipcode of 85501 to get a better idea of the surrounding area.

86237, Dewey (North)

Number of Veterans: Unknown



- County: Yavapai
- Population: 8858
- Area: 148 mi²

Federal Government Entities:

United States Postal Service, 12420 Kachina Pl

Community Centers/Resources:

Quailwood Community Center, 12725 Bradshaw Mountain Rd

Additional Potential Outreach Locations:

Quailwood Park, 380 Vidal St

Prescott Golf Club, 1030 Prescott Country Club Blvd

Quailwood Greens Golf Course, 12200 AZ-69

Orchard ranch RV park, 12500 AZ-69

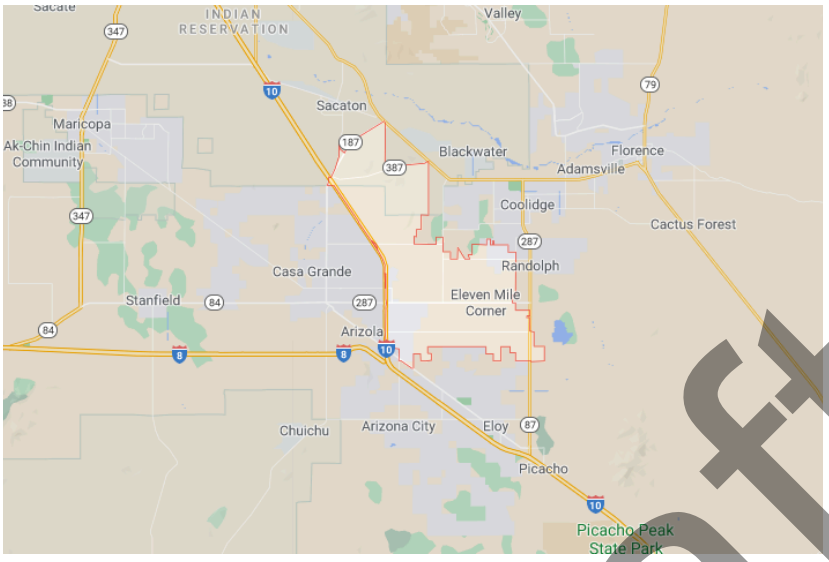
Public Transportation: Not available

VA Healthcare System: Northern Arizona VA Health Care System, 14 miles away

CBOC: Cottonwood VA Clinic, 19 miles away

85194, Casa Grande (Central)

Number of Veterans: Unknown



- County: Pinal
- Population: 6721
- Area: 75.87 mi²

Federal Government Entities:

Eleven Mile Corner Post Office, 788 11 Mile Corner

State Government Entities:

Central Arizona College Police Department, 8470 N Overfield Rd # I 200

County/city Government Entities:

Pinal County Housing Authority, 970 11 Mile Corner

Pinal County Fairgrounds, 512 11 Mile Corner

Community Centers/Resources:

Food Distribution Center - Pinal Gila Council Of Senior Citizens, 8969 W McCartney Rd

Additional Potential Outreach Locations:

Central Arizona College, 8470 N Overfield Rd

Tierra Grande Golf, 813 W Calle Rosa

Mission Royale Golf Course, 11 Mission Pkwy

Mission Royale II Park, S San Marino Loop

Public Transportation: Not available

VA Healthcare System: Phoenix VA Health Care System, 49 miles away

CBOC: Casa Grande VA Clinic, 7 miles away

Other notable information:

This zipcode was originally reported as 85294. Reliable data could not be found, so this report is on the nearest neighboring zip code.

Not included:

85724: This is the mailing zip code for the Arizona Medical Center Building. It does not contain any residencies and is a small pocket inside the bigger zipcode of 85719.

Proposed Responses

After reviewing the data outlined in this report, the Arizona Department of Veterans Services (ADVS) has several proposed plans of action in response.

One of these options is conducting proactive outreach to these zip code areas where 100% of reported suicides from 2015 to 2018 were Veterans. This data shows areas of Arizona where additional Veteran support is needed, and ADVS can use this information to know where to focus suicide prevention resources in the future.

ADVS also advocates for increasing the awareness of Veteran Benefits Counselors in Arizona and the aid they can bring to Veterans who are in need. Many Veterans may not know about this resource ADVS offers that is available to them, and by leading more Veterans to VBCs in these zip codes more Veterans will have the support they are lacking in the isolated areas of the state.

ADVS also notes that there is a significant lack of public transportation in many of these zip codes. Public transportation is essential for Veterans to access the resources they are offered, especially in rural parts of Arizona where the nearest CBOC can be up to 54 miles away. In addition, increasing the availability of internet access in isolated zip codes will give more opportunities to Veterans to find support groups and other help through organizations such as ADVS.

Proactive outreach to non profit organizations who are eligible for grants will offer the funding necessary to increase resources such as public transportation and internet access in these zip codes. While ADVS cannot make these improvements on their own, with collaboration with other organizations a crucial change can be made to prevent the findings of this data.

ANNUAL REPORT ON SUICIDE IN THE MILITARY

CALENDAR YEAR 2022

Including the Department of Defense Suicide Event Report (DoDSER)

DEPARTMENT OF DEFENSE

UNDER SECRETARY OF DEFENSE
FOR PERSONNEL AND READINESS

IF YOU OR SOMEONE YOU KNOW NEEDS HELP:

Veterans Crisis Line
Military Crisis Line
DIAL 988 then PRESS 1

IN CASE OF AN EMERGENCY, DIAL 911 or your local emergency number for immediate assistance.

FREE and CONFIDENTIAL | AVAILABLE 24/7
Qualified and caring responders understand the challenges that Service members and their loved ones face, and they are ready to assist Service members and their families in crisis.

CALL 988 then press 1
CHAT www.MilitaryCrisisLine.net
TEXT 838255

Europe
Call **00800 1273 8255** or **DSN 118**

Japan/Korea
Call **0808 555 118** or **DSN 118**

Philippines
Call **#MYVA** or **02-8550-3888** and **press 7**

For the latest overseas calling information, please check www.MilitaryCrisisLine.net/

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NONCRISIS SERVICES ARE FREE, CONFIDENTIAL, AND AVAILABLE 24/7.

Service members, including the National Guard and Reserve, and eligible family members can get support for noncrisis concerns, such as relationship, family, or financial challenges.

Face-to-face, phone, online, or video counseling sessions are available.

TABLE OF CONTENTS

ABOUT THIS REPORT

THE PUBLIC HEALTH APPROACH STARTS WITH DATA

The U.S. Department of Defense (DoD) Annual Report on Suicide in the Military serves as the **official source for annual suicide counts and rates for DoD**.

In addition, this report contains the calendar year (CY) **2022 Department of Defense Suicide Event Report (DoDSER) System Data Summary**, which provides contextual information related to Service member suicide deaths and attempts.

This annual report also highlights key current and ongoing Department-wide efforts to reduce suicide risk among Service members and their families.

TRANSPARENCY, ACCOUNTABILITY, COMMITMENT, AND COLLABORATION

The Department's transparency, accountability, and commitment to preventing suicide is reflected in this report. It was developed in collaboration with the Military Departments, Military Services, National Guard Bureau, Joint Chiefs of Staff, Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs, Office of the Assistant Secretary of Defense for Health Affairs, Office of the Assistant Secretary of Defense for Readiness, and the Defense Human Resources Activity.

SAFE REPORTING ON SUICIDE

Words Matter in Suicide Prevention
The Department follows best practices for safe reporting on suicide.

Report Icon Guides

KEY TAKEAWAY

IMPORTANT CONTEXT

CAUTION

Executive Summary | Data

Service Members | 2022

492 Total Service members died by suicide

331 Active | **64** Reserve | **97** Guard

Suicide rates per 100,000 Service members

- **25.1** Active Component Service members
- **19.1** Reserve Service members
- **22.2** National Guard Service members

Family Members | 2021*

168 Total Family Members died by suicide

114 Spouses | **54** Dependents

Suicide rates per 100,000 family members

- **6.5** Family Members spouses and dependents
- **11.2** Spouses
- **3.4** Dependents**

*Latest year of available data
**Includes minor (<18 years) & non-minor (18-22 years)

KEY TAKEAWAYS

SERVICE MEMBERS

Active Component suicide rates gradually increased from 2011 to 2022. Although, rates in the last two years appear slightly lower than in 2020.

Reserve and National Guard suicide rates did not have an increasing or decreasing trend between 2011 and 2022, although they fluctuated year to year.

Military suicide rates were similar to the U.S. population in most years between 2011 and 2021,* after accounting for age and sex differences.

Use of a firearm was the most common method of suicide across Components and Services. **69%**

Most Service members who died by suicide were young, enlisted men. However, other Service members can still be at risk for suicide.

HEALTH AND LIFE STRESSORS

45% Select behavioral health diagnoses
42% Relationship problems
26% Workplace issues
26% Administrative/legal issues
10% Financial issues

Behavioral health problems are treatable, and **seeking help is a sign of strength.**

* 2021 was the latest year of available U.S. population data.

FAMILY MEMBERS

Suicide rates for family members (spouses and children) appear slightly lower than in previous years.

Of note, suicide rates for male spouses and dependents appear lower in 2021 versus 2020.

In 2021, suicide rates for spouses and dependents were similar to the suicide rates in the U.S. population when accounting for age and sex differences.

Use of a firearm was the most common method of suicide for spouses and dependents.

Spouses **61%** Dependents **56%**

SPOUSES

52% Female
84% < 40 years old
48% Service history

DEPENDENTS

30% Female
69% < 18 years old
<5% Service history

WHAT THIS TELLS US:

Suicide is multifaceted, and suicide prevention needs a comprehensive and integrated approach. Thus, DoD aims to:

- ► Foster supportive environments.
- ► Address stigma as a barrier to care.
- ► Improve delivery of mental health care.
- ► Promote a culture of lethal means safety.
- ► Revise suicide prevention training

Executive Summary | Current and Ongoing Efforts

Foster a Supportive Environment

Quality of life is key to suicide prevention and force readiness.

Delivered key benefits to the military community through the Taking Care of Our People initiative, including pay raises, basic allowance for housing increases, additional commissary savings, military spouse employment opportunities, and childcare program improvements.

Hired and trained over 400 members of a dedicated, specialized prevention workforce to work with leaders to build healthy and harm-free environments.

Through 2023, conducted On-Site Installation Evaluations (OSIE) at 19 sites and 12 ships that reviewed best practices and improvement areas for prevention of harmful behaviors.

Expanded a yearlong suicide prevention communication campaign to include new resources, outreach efforts, expanded platforms, and evaluation measures.

Address Stigma as a Barrier to Getting Help

Stigma is a long-standing barrier, and addressing it is a priority to improve access to care.

Reviewed over 600 policy documents in an ongoing effort to identify and remove stigmatizing language. DoD Components continue to review and work toward eliminating stigmatizing language to change perceptions toward seeking behavioral health services, to increase help-seeking, and to improve access to care.

Revitalized the Real Warriors Campaign, which aims to reduce stigma associated with mental health and to support the military community's psychological health and readiness.

Created resources to support parents and educators. Topics included discussing feelings with elementary-age children and sharing healthy relationship and military care resources.

Improve Delivery of Mental Health Care

DoD aims to deliver the highest-quality clinical health care services.

Implemented the ability for Service members to request referrals for mental health evaluations for any reason, improving the process for Service members to confidentially seek mental health and wellness support.

Oversaw studies that examined clinical and implementation intervention methods. Ongoing efforts will help translate knowledge more rapidly into clinical practice and advance evidence-based clinical practice guidelines to reduce the risk of suicide.

Implemented programs that help address unique challenges in accessing mental health services among the National Guard and Reserve.

Promote a Culture of Lethal Means Safety (LMS)

In crisis, time and space from lethal means can be lifesaving.

Partnered with federal agencies to examine a policy for safe storage and lethal means messaging, advancing the White House's strategy to reduce military and veteran suicide.

Enforcing existing restrictions on private firearms in barracks and promoting secure storage of privately owned firearms when residing on installation in barracks/dormitories and in family housing when children reside in the home.

Initiated pilot programs to explore appropriate settings and effective communication for safe storage of lethal means in early military career training across all Services.

Published an updated policy on program evaluation and supported Service-level lethal means safety (LMS) program evaluation capabilities.

Way Forward

"We all share a profound responsibility to ensure the wellness, health, and morale of the Total Force."

— Secretary Lloyd J. Austin III, March 2023

The Department is pursuing a campaign with the five lines of effort listed below, which will guide suicide prevention moving forward. In September 2023, Secretary Austin approved a series of key enabling tasks within each line of effort, adopted and modified from the Suicide Prevention and Response Independent Review Committee (SPRIRC) recommendations.

Foster a Supportive Environment. The Department will implement 26 approved SPRIRC recommendations to enhance well-being, including:

- Invest in Taking Care of People priorities.
- Improve morale, welfare, and recreation activities and facilities to enhance quality of life, holistic health, and wellness.
- Empower leaders to improve schedule predictability.

Improve the Delivery of Mental Health Care. The Department will begin implementing 24 additional SPRIRC recommendations to improve mental health service delivery and achieve the following priorities:

- Expand training programs and actions to better recruit, support, and retain mental health providers.
- Remove obstacles to improve coordination of care.
- Eliminate barriers to provider pay equity, timely hiring, and efficient onboarding.
- Increase appointment availability by revising mental health staffing models to ensure that mental health clinics have the administrative and case management support they need.

Address Stigma and Other Barriers to Care. The Department will begin implementing 14 approved SPRIRC recommendations to advance the following objectives:

- Expand availability of confidential services, including non-medical counseling for suicide prevention.
- Increase mental health services in primary care.
- Expand availability of tele-health care and other digital tools.
- Provide additional resources to support unit leaders in reducing stigma.

Revise Suicide Prevention Training. The Department will begin implementing 20 approved SPRIRC recommendations to revise the Department's suicide prevention and postvention training intended to:

- Modernize content, delivery, and dosage of suicide prevention training.
- Train behavioral health technicians in evidence-based practices.
- Integrate leaders at all levels into suicide prevention training.
- Centralize the core suicide prevention training curriculum.

Promote a Culture of Lethal Means Safety. The Department will begin implementing eight approved SPRIRC recommendations, including the following next steps to promote lethal means safety:

- Launch a comprehensive public education campaign.
- Offer funding incentives for safer ways to store firearms.
- Provide additional on-base secure storage options for personal firearms.
- Enforce existing restrictions on private firearms in barracks.
- Make improvements to reducing risk in barracks and dormitories.

Service Members

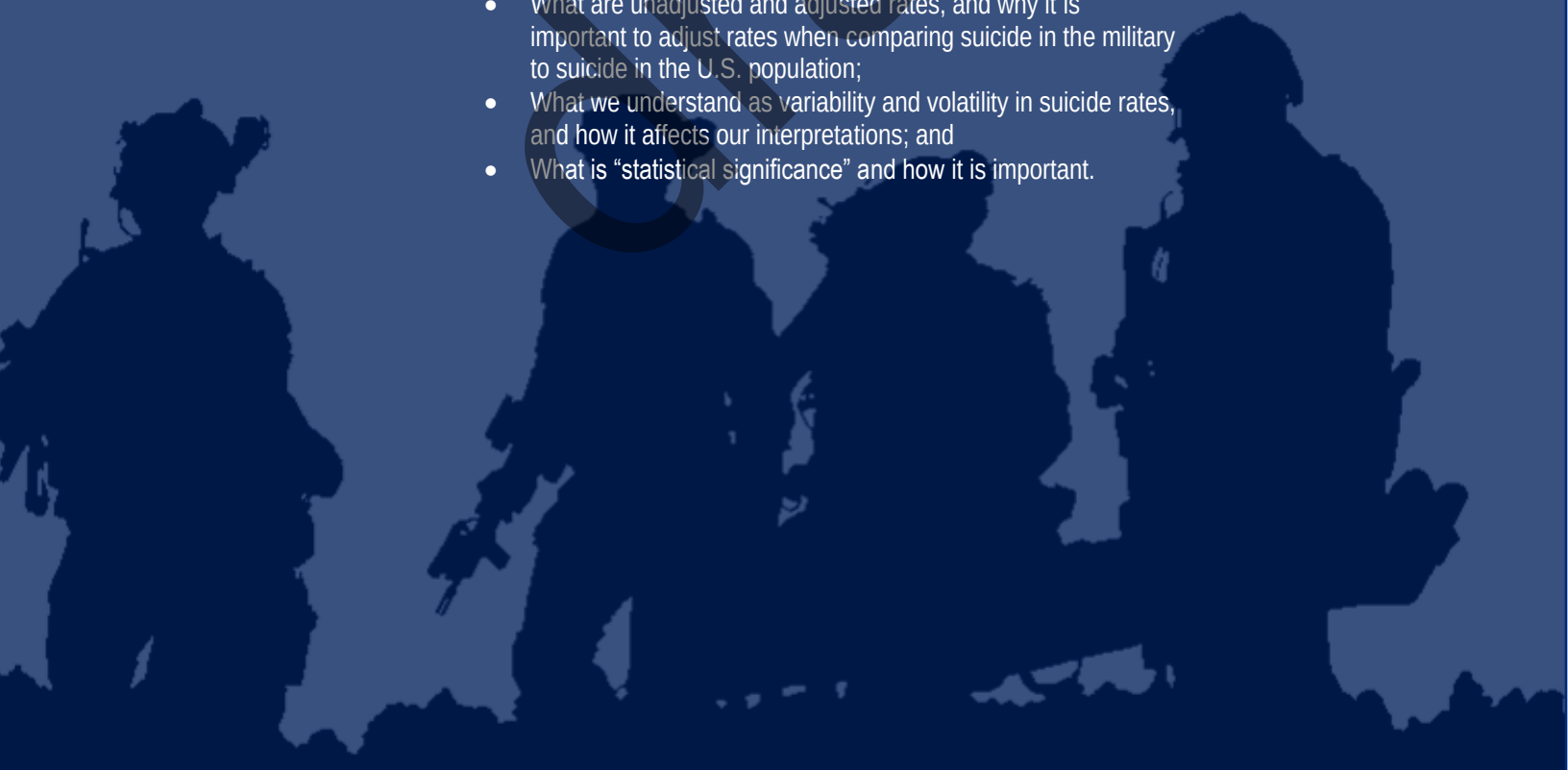
Key Data

IN THIS SECTION

This section includes counts and rates for CY 2022 and updated counts and rates for CY 2021 and CY 2020. These results are organized by military population and Service branch. This section also includes rate comparisons across time within military populations, rate comparisons between the military and U.S. general populations, demographic and military characteristics, and method of suicide in 2022.

See Appendix A for additional information on the following:

- Who verifies and reports suicide deaths for Service members;
- What are suicide counts and rates, and why understanding both is important;
- Who reports counts and rates;
- Why counts are not enough to understand suicide trends;
- What are unadjusted and adjusted rates, and why it is important to adjust rates when comparing suicide in the military to suicide in the U.S. population;
- What we understand as variability and volatility in suicide rates, and how it affects our interpretations; and
- What is "statistical significance" and how it is important.



OVERVIEW | Service Member Suicide Counts and Rates per 100,000, CY 2020 2022

Table 1. Annual Suicide Counts and Unadjusted Rates per 100,000 Service Members in the Active Component, Reserve, and National Guard and by Service, CY 2020–2022

	CY 2020		CY 2021		CY 2022	
	Rate	Count	**Rate**	Count	**Rate**	Count
Active Component	***28.6***	383	***24.3***	328	***25.1***	331
Army	***36.2***	174	***36.1***	175	***28.9***	135
Marine Corps	***34.5***	63	***23.9***	43	***34.9***	61
Navy	***19.0***	65	***17.0***	59	***20.6***	71
Air Force	***24.3***	81	***15.3***	51	***19.7***	64
Space Force	--	NA	--	NA	--	0
Reserve	***21.7***	77	***21.8***	76	***19.1***	64
Army	***22.2***	42	***24.8***	46	***20.8***	37
Marine Corps	--	10	--	14	--	6
Navy	--	13	--	10	--	7
Air Force	--	12	--	6	--	14
National Guard	***27.5***	121	***27.0***	120	***22.2***	97
Army	***31.5***	105	***31.2***	105	***24.8***	82
Air Force	--	16	--	15	--	15

Notes: Data sourced from Armed Forces Medical Examiner System (AFMES). The table includes both confirmed and suspected suicides *as of March 31, 2023*. Both confirmed and suspected suicides are included so that counts and rates are not underestimated as investigations continue. Per DoDI 6490.16, rates are not reported ("--") when the number/count of suicide deaths is under 20, because those rates are considered unstable and would not be reliable due to statistical instability.[1] Only DoD Services are reported here. The Coast Guard is under the U.S. Department of Homeland Security—unless operating under the Department of the Navy—therefore, the suicide rates of Coast Guard uniformed members are not included in this report.

Although Table 1 shows updated counts and rates for the last three years, it is not enough to understand how suicide rates in the military have changed over time (i.e., whether they are increasing, decreasing, or staying the same) and how they compare to the suicide rates in the U.S population. These additional analyses are presented in the next sections.

MORE IN THE NEXT SECTION

1 Trend: 2011–2022

Presents trend analysis of military suicide rates from 2011 to 2022 to see if there is an increasing, decreasing, or no trend over time.

2 Year-to-Year Comparison

Compares military suicide rates in 2022 to last year and the year before. Limited reliability

3 Compared to the U.S. Population

Assesses if the suicide rates in the military are different from the suicide rates in the U.S. population for each year between 2011 and 2021.

Active Component

KEY TAKEAWAY

Suicide rates for **Active Component Service members gradually increased from 2011 to 2022**.* Although in the **last two years, the rates were lower** than in 2020.†

In most years, the Active Component suicide rate was **similar to the suicide rate in the U.S. population,**† except in 2020 when the Active Component suicide rate was higher.*

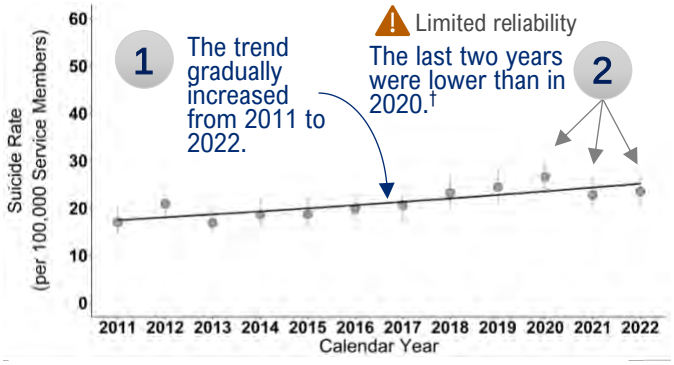


Figure 1 | Active Component Suicide Rates Over Time

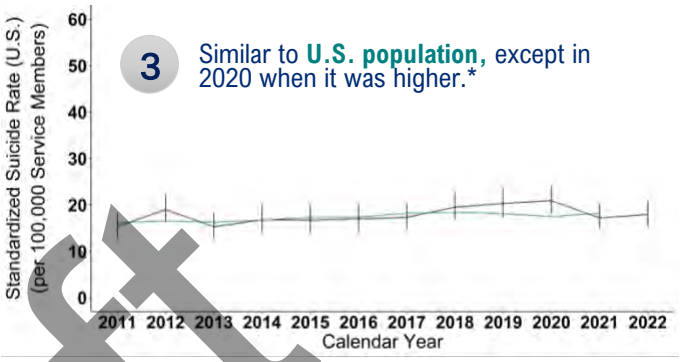


Figure 2 | Active Component versus U.S. Population Suicide Rates
CY 2021 was the latest year of available U.S. population data.

KEY TAKEAWAY

Suicide rates for each Service in 2022 had different year-to-year changes (see Figure 3). Suicide rates for **all Services gradually increased from 2011 to 2022**.*

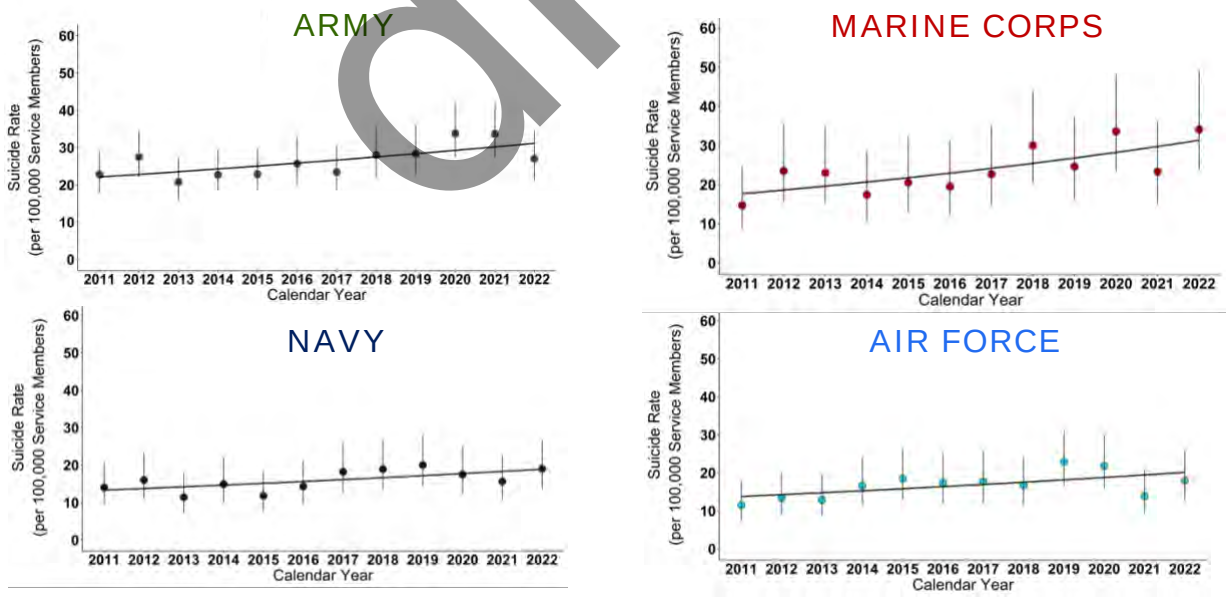


Figure 3 | Active Component Suicide Rates Over Time by Service, 2011–2022

Notes: Data sourced from AFMES (military populations) and the Centers for Disease Control and Prevention (CDC; U.S. population), ages 17–59. All rates are sex and age adjusted to account for differences within the military over time. Figure 2 shows the Active Component suicide rates, adjusted to age and sex differences, between the military and the U.S. population. The Space Force was established in 2019 and had no suicides from 2020 to 2022. Vertical bars around each rate are 95% confidence intervals.
*Statistically significant—high confidence this is a true difference and not due to chance.
†Not statistically significant—low confidence this is a true difference (e.g., likely due to chance or normal variation).

Active Component

Table 2. Demographic and Contextual Characteristics of Active Component Service Members Who Died by Suicide in CY 2022 (Rate per 100,000, count, percent)

	Rate	Count	Percent
Total	--	331	100%
Sex			
Male	28.3	308	93.1%
Female	9.9	23	6.9%
Age Group			
17–19	--	16	4.8%
20–24	31.9	135	40.8%
25–29	23.8	73	22.1%
30–34	24.0	51	15.4%
35–39	23.6	38	11.5%
40–44	--	16	4.8%
45–49	--	2	0.6%
50+	--	0	0.0%
Race			
White	26.3	237	71.6%
Black/African American	22.5	51	15.4%
Asian/Pacific Islander	--	18	5.4%
Am. Indian/Alaskan Native	--	4	1.2%
Other/Unknown	22.8	21	6.3%
Rank			
E (Enlisted)	28.2	301	90.9%
E1–E4	28.1	153	46.2%
E5–E9	28.3	148	44.7%
O (Commissioned Officer)	11.1	24	7.3%
W (Warrant Officer)	--	5	1.5%
Cadet	--	1	0.3%
Marital Status			
Never Married	27.6	165	49.8%
Married	22.4	147	44.4%
Divorced	--	19	5.7%
Widowed	--	0	0.0%

Notes: Data sourced from AFMES. Per DoDI 6490.16, rates are not reported ("--") when the number/count of suicide deaths is under 20, because those rates are considered unstable and would not be reliable due to statistical instability. Percentages may not add up to 100% due to rounding. Table 15 provides the Total Force demographics.

KEY TAKEAWAYS

Service members who died by suicide in 2022 were largely enlisted (91%), male (93%), white (72%), and under the age of 30 (68%).

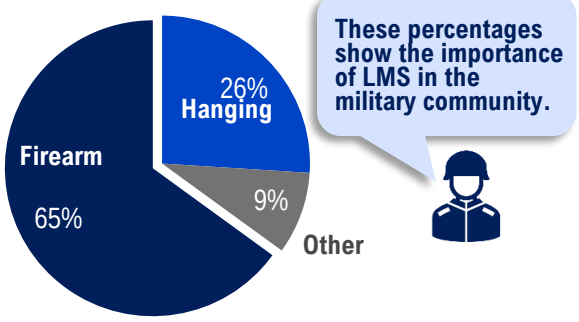
These characteristics are largely similar to previous years and to the overall demographic profile of the total force.

Service members in every demographic group can have suicide risk factors even if they do not make up the highest-percentage group.

KEY TAKEAWAYS

In 2022, use of a firearm was the most common method of suicide death (65%), which is consistent with previous years.

The percentage of suicide deaths by firearm was higher in the military than among the U.S. population (age/sex adjusted).



These percentages show the importance of LMS in the military community.

"Other" includes overdose, poisoning, blunt/sharp objects, and falling/jumping.

Active Component

KEY INFORMATION FROM THE CY 2022 DoDSER

From the data submitted to the DoDSER system for
Active Component Service Members who died by suicide in 2022:

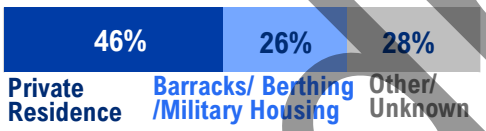
- 45% Reported select behavioral health diagnoses
  alcohol use disorder, depressive disorder, anxiety, trauma- or stressor-related disorder, sleep–wake disorder (one or more)
- 42% Reported intimate relationship problems
- 26% Reported workplace difficulties
- 26% Reported administrative/legal problems
  nonjudicial punishment, under investigation, administrative separation
- 10% Reported financial difficulties
  (within a year before death)

Experiencing different health or life stressors does not mean that someone is suicidal. Behavioral and mental health problems are treatable. **Seeking help for any of these problems is a sign of strength.**

Location information for 2022:

87% Reported suicide deaths occurred in the Continental U.S. (CONUS). Suicide deaths typically occur where there are large concentrations of Service members; for example, in California, Texas, Virginia, and North Carolina.

Most suicide deaths occurred in either private residences or military barracks/berthing/housing.



New in the DoDSER:

4% Identified as **gay, lesbian, or bisexual**

14% **Experienced abuse** before age 18

Over time, this new information from the DoDSER may help shape understanding of suicide risk.

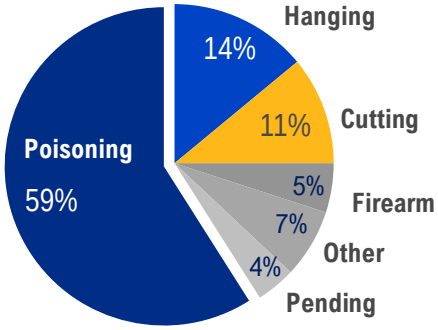
From the data submitted to the DoDSER system for the
1,278 reported suicide attempts among Active Component Service members in 2022:

319 Army | 274 Marine Corps | 282 Navy | 403 Air Force

31% of attempts were among **female** Service members.

69% of attempts were among **male** Service members.

- 48% Reported select behavioral health diagnoses
  (one or more – see above)
- 38% Reported intimate relationship problems
- 26% Reported workplace difficulties
- 20% Reported administrative/legal problems
  (see above)
- 11% Reported experiencing assault or harassment
- 10% Reported financial difficulties
  (within a year before the reported attempt)



Poisoning (drug and nondrug) was the most common method among those who experienced a nonfatal suicide attempt.

Reserve and National Guard

KEY TAKEAWAY

Suicide rates for the **Reserve and National Guard did not have an increasing or decreasing trend from 2011 to 2022.**† The suicide rates fluctuated year to year, and in 2022, suicide rates for both groups appear slightly lower† than in the previous two years.†

Between 2011 and 2021, **Reserve suicide rates were similar to suicide rates in the U.S. population.**† In the same time frame, the **National Guard suicides rates were similar**† **to the suicide rates in the U.S. population,** except in 2012 and 2013 when National Guard rates were higher.*

RESERVE

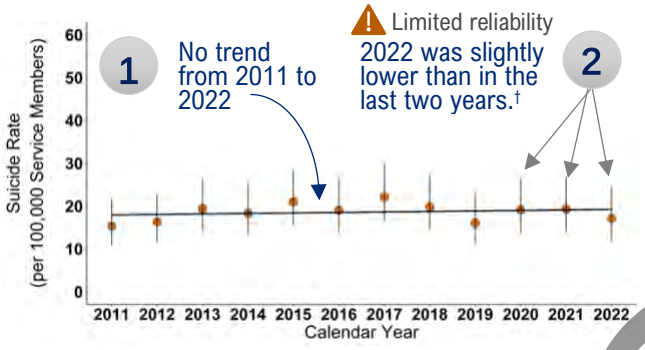


Figure 4 | Reserve Suicide Rates Over Time

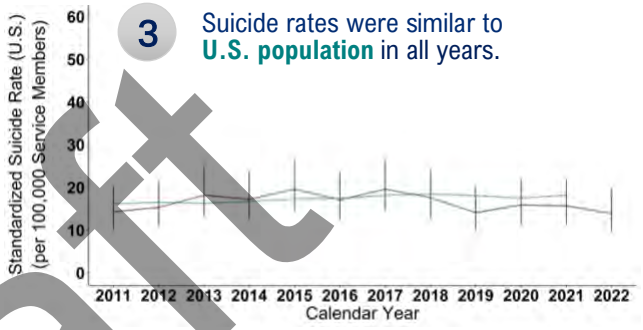


Figure 5 | Reserve versus U.S. Population Suicide Rates
⚠ CY 2021 was the latest year of available U.S. population data.

NATIONAL GUARD

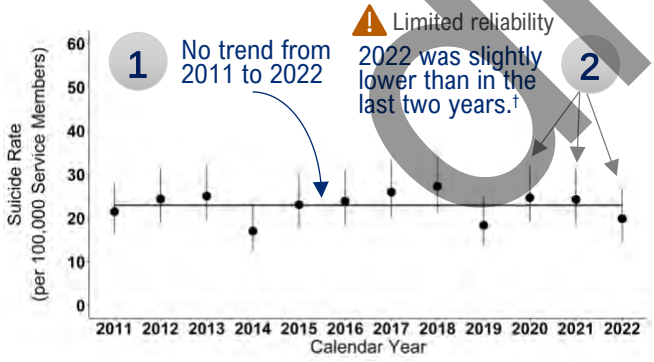


Figure 6 | National Guard Suicide Rates Over Time

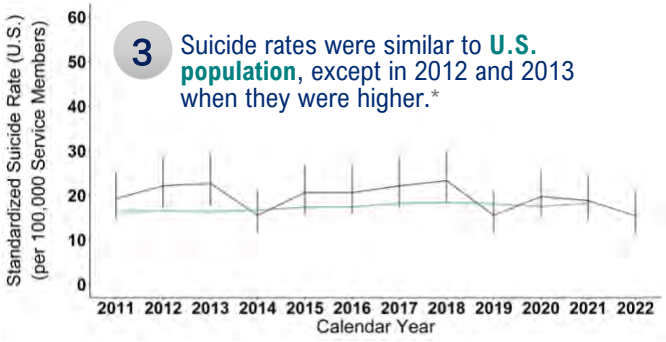


Figure 7 | National Guard versus U.S. Population Suicide Rates
⚠ CY 2021 was the latest year of available U.S. population data.

By Service | Army Reserve rates followed the same near- and long-term pattern as the overall Reserve (data not shown). Army National Guard rates followed the same near- and long-term pattern as the overall National Guard (data not shown). Marine Corps Reserve, Navy Reserve, Air Force Reserve, and Air National Guard rates/trends over time were not reported due to low Service-specific counts (DoDI 6490.16).

Notes: Data sourced from AFMES (military populations) and CDC (U.S. population), ages 17–59. All rates are sex and age adjusted to account for differences within the military over time. Figures show suicide rates, adjusted for age and sex differences, between the military and the U.S. population. Vertical bars around each rate are 95% confidence intervals.
*Statistically significant—high confidence this is a true difference and not due to chance.
†Not statistically significant—low confidence this is a true difference (e.g., likely due to chance or normal variation).

Reserve and National Guard

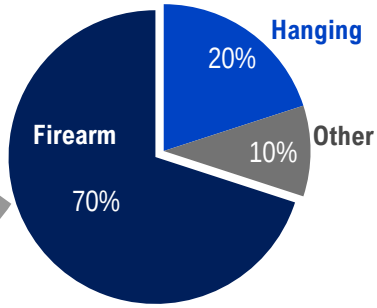
KEY TAKEAWAYS

- Reserve and National Guard Service members who died by suicide in 2022 were largely enlisted, male, White, and under the age of 30.
- These characteristics are largely similar to previous years and to the overall demographic profile of the total force.
- In 2022, use of a firearm was the most common method of suicide death among the Reserve and National Guard, which has remained consistent over time.
- The percentage of suicide deaths by firearm was higher in the military than among the U.S. population (age/sex adjusted).*

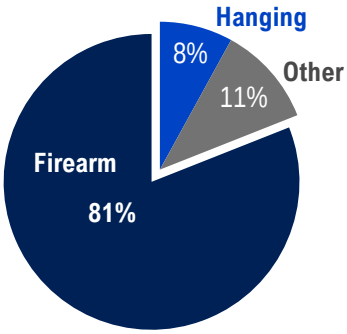
Table 3. Demographic Characteristics of Reserve and National Guard Service Members Who Died by Suicide in CY 2022 (Rate per 100,000, count, percent)

	Reserve			National Guard		
	Rate	Count	Percent	Rate	Count	Percent
Total	--	64	100%	--	97	100%
Sex						
Male	21.9	56	87.5%	25.2	88	90.7%
Female	--	8	12.5%	--	9	9.3%
Age Group						
17–19	--	5	7.8%	--	2	2.1%
20–24	--	15	23.4%	40.8	45	46.4%
25–29	--	18	28.1%	--	15	15.5%
30–34	--	8	12.5%	--	15	15.5%
35–39	--	9	14.1%	--	11	11.3%
40–44	--	5	7.8%	--	2	2.1%
45–49	--	3	4.7%	--	3	3.1%
50+	--	1	1.6%	--	4	4.1%
Race						
White	18.3	41	64.1%	22.7	77	79.4%
Black/African American	--	14	21.9%	--	14	14.4%
Asian/Pacific Islander	--	5	7.8%	--	3	3.1%
Am. Indian/Alaskan Native	--	3	4.7%	--	1	1.0%
Other/Unknown	--	1	1.6%	--	2	2.1%
Rank						
E (Enlisted)	22.7	58	90.6%	24.3	91	93.8%
E1–E4	30.8	37	57.8%	29.3	55	56.7%
E5–E9	14.6	21	32.8%	19.3	36	37.1%
O (Commissioned Officer)	--	6	9.4%	--	5	5.2%
W (Warrant Officer)	--	0	0.0%	--	1	1.0%
Cadet	--	0	0.0%	--	0	0.0%
Marital Status						
Never Married	25.0	38	59.4%	26.5	62	63.9%
Married	--	18	28.1%	14.6	26	26.8%
Divorced	--	8	12.5%	--	8	8.2%
Widowed	--	0	0.0%	--	1	1.0%

RESERVE



NATIONAL GUARD



"Other" includes overdose, poisoning, blunt/sharp objects, and falling/jumping.

Shows the importance of lethal means safety in the military community.

Notes: Data sourced from AFMES. Per DoDI 6490.16, rates are not reported ("--") when the number/count of suicide deaths is under 20, because those rates are considered unstable and would not be reliable due to statistical instability. Percentages may not add up to 100% due to rounding. Table 15 provide the Total Force demographics.

See the DoDSER enclosure for more contextual information for the Reserve and National Guard. In instances where there is incomplete information or a low number of events, some of the descriptive data, like percentages, may not be representative or may have limited reliability.

Family Members

Key Data

IN THIS SECTION

For this report, military family members are limited to spouses and dependent children (minor and nonminor) who are eligible to receive military benefits under Title 10 and who are registered in the Defense Enrollment Eligibility Reporting System (DEERS; a database of military sponsors and dependents who have registered to receive military benefits). For ease of reporting, dependent spouses are referred to as "spouses, and dependent children are referred to as "dependents. Appendix A describes why three data sources are used; Section 1072(2) of Title 10, U.S. Code provides a definition of a dependent with respect to a uniformed Service member (or former member).

The Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2015, Public Law 113 291 requires DoD to collect and report suicide data involving military family members. Data sources include (1) DEERS, (2) each Military Service, and (3) the CDC National Center for Health Statistics National Death Index (NDI; a database of death record information compiled from state offices). Data from all three sources were available starting in 2017. Due to the time it takes to process NDI data, these data lag one year relative to military data sources.

Military Family Members

OVERVIEW | Family Member Suicide Counts and Rates per 100,000, CY 2019 2021 (latest available)

This is the fifth year reporting on suicide data for military family members (spouses and dependents). Family member data sources were available starting in 2017 and lag one year relative to military data sources. U.S. population data from the NDI are available through 2021.

KEY TAKEAWAYS

The number (or count) of family members who died by suicide in 2021 was lower than in the previous two years. Similarly, the 2021 rate (total force) appears slightly lower than in 2019 and 2020.†

The same was true for spouses and dependents separately.

Suicide rates were similar for Active Component, Reserve, and National Guard family members.

Table 4. Military Family Member Suicide Rates per 100,000 Individuals by Their Service Member's Military Population, CY 2019–CY 2021

Military Population	CY 2019		CY 2020		CY 2021	
	Rate	Count	Rate	Count	Rate	Count
Total Force	**7.7**	202	**7.7**	202	**6.5**	168
Spouse	**12.6**	130	**13.0**	133	**11.2**	114
Dependent	**4.5**	72	**4.3**	69	**3.4**	54
Active Component	**7.1**	117	**7.9**	130	**6.4**	103
Spouse	**12.6**	85	**13.0**	87	**11.7**	78
Dependent	**3.3**	32	**4.4**	43	**2.6**	25
Reserve	**8.7**	40	**8.4**	38	**8.1**	36
Spouse	--	17	**15.0**	25	**12.3**	20
Dependent	**7.9**	23	--	13	--	16
National Guard	**8.5**	45	**6.5**	34	**5.6**	29
Spouse	**14.6**	28	**11.1**	21	--	16
Dependent	--	17	--	13	--	13

Table 5. Military Spouse and Dependent Suicide Rates per 100,000 Individuals by Sex, CY 2019–CY 2021

SPOUSES	CY 2019		CY 2020		CY 2021	
	Male	Female	Male	Female	Male	Female
Total Force	**51.2**	**6.8**	**47.4**	**7.7**	**39.6**	**6.7**
Active Component	52.0	7.0	47.5	7.9	42.2	7.1
Reserve	--	--	--	--	--	--
National Guard	--	--	--	--	--	--
DEPENDENTS						
Total Force	**6.7**	**--**	**6.2**	**--**	**4.8**	**--**
Active Component	4.4	--	5.9	--	4.3	--
Reserve	--	--	--	--	--	--
National Guard	--	--	--	--	--	--

Notes: Data sourced from DEERS, Military Services, NDI, Defense Manpower Data Center (DMDC; denominators only). Rates for groups with fewer than 20 suicides are not reported because of statistical instability (DoDI 6490.16). Only DoD Services are reported here; therefore, Coast Guard family member suicide rates are not included in this report. The table includes family members who were themselves Service members to capture the full extent of suicide among military family members (22.8% currently serving in CY 2021, 18.8% in CY 2020, 27.7% in CY 2019).

*Statistically significant—high confidence this is a true difference and not due to chance.
†Not statistically significant—low confidence this is a true difference (e.g., likely due to chance or normal variation).

KEY TAKEAWAYS

SPOUSES

In 2021, suicide rates for male and female spouses appear lower than in prior years.†

In 2021, suicide rates for female and male spouses were similar to their female and male counterparts in the U.S. population ages 18 to 60 (data not shown).†

DEPENDENTS

The CY 2021 suicide rate for male dependents appears lower than in prior years.†

Suicide rates for male dependents were similar to the male suicide rates in the U.S. population under 23 years old.

Military Family Members

KEY TAKEAWAYS

SPOUSES

- Male spouses accounted for about 48% of spouse suicides but made up about 14% of all military spouses across the DoD.
- About 84% of spouses who died by suicide were under 40 years old (similar to overall military spouses).
- About 48% of spouses who died by suicide had prior or current service history (78% of men and 20% of women; data not shown).
- Like in previous years, use of a firearm was the most common method of suicide death.
- About 44% of female military spouses who died by suicide used a firearm, whereas about 35% of women ages 18 to 60 in the U.S. population used a firearm (data not shown).

Table 6. Military **Spouse** Suicide Counts and Percentages by Demographics, CY 2021

Demographic	Count	Percent
Sex	**114**	**100%**
Male	55	48.2%
Female	59	51.8%
Age Group	**114**	**100%**
<40	96	84.2%
≥40	18	15.8%
Service History	**114**	**100%**
Any Service History	59	48.2%
Prior Service (Not Currently Serving)	29	25.4%
Currently Serving	26	22.8%
No Service History	55	51.8%
Method of Death	**114**	**100%**
Firearm	70	61.4%
Hanging/Asphyxiation	25	21.9%
Poisoning (Drugs/Alcohol/Nondrug)	13	11.4%
Sharp/Blunt Object	--	--
Falling/Jumping	--	<1%
Other	--	<2%
Unknown	--	<3%

Notes: Data sourced from DEERS, Military Services, NDI, DMDC (denominators only). Per CDC requirements, counts under 10 are suppressed, and corresponding percentages are suppressed or masked (i.e., < 1.0%) to protect the confidentiality of military family members. Only DoD Services are reported here; therefore, Coast Guard family member suicide rates are not included in this report. The table includes family members who were themselves Service members to capture the full extent of suicide among military family members (22.8% currently serving in CY 2021, 18.8% in CY 2020).

Table 7. Military **Dependent** Suicide Counts and Percentages by Demographics, CY 2021

Demographic	Count	Percent
Sex	**54**	**100%**
Male	38	70.4%
Female	16	29.6%
Age Group	**54**	**100%**
<18	37	68.5%
18-23	17	31.5%
Method of Death	**54**	**100%**
Firearm	30	55.6%
Hanging/Asphyxiation	15	27.8%
Poisoning (Drugs/Alcohol/Nondrug)	--	<14%
Sharp/Blunt Object	--	--
Falling/Jumping	--	<4%
Other	--	--
Unknown	--	--

Notes: Data sourced from DEERS, Military Services, NDI (suicide counts), DMDC (denominators). Per CDC requirements, counts under 10 are suppressed, and corresponding percentages are suppressed or masked (i.e., < 1.0%) to protect the confidentiality of military family members. Only DoD Services are reported here; therefore, Coast Guard family member suicide rates are not included in this report.

KEY TAKEAWAYS

DEPENDENTS

- Male dependents accounted for about 70% of dependent suicide deaths.
- About 69% of dependents who died by suicide were under 18 years old.
- Less than 5% of dependents who died by suicide had prior or current service history (data not shown).
- Like in previous years, use of a firearm was the most common method of suicide death.

Current and Ongoing Department Efforts

The DoD advanced and strengthened its comprehensive and integrated prevention approach to reduce suicide risk factors and amplify protective factors. This approach included a continuous internal review of existing initiatives and programs and a rigorous external review through the Secretary of Defense directed SPRIRC. The reviews resulted in deeper insights into the evolving needs of Service members and their families, thus enabling the DoD to better develop and deliver relevant and sustainable solutions.

Foster a Supportive Environment

Quality of life is key to suicide prevention and force readiness.

Military service can lead to unique life stressors, such as longer work hours, deployments, extended family separations, and unique financial issues. DoD works to create an environment that encourages personal and professional growth, provides assistance where and when needed, and promotes well-being for Service members and their families to support them through any of life's challenges.

Quality of life is a key component of suicide prevention. DoD empowers Service members and their families to access support options across key aspects of well-being, such as financial stability, employment opportunities, interpersonal relationships, housing conditions, health care, education, leisure activities, safety, and matters of religion or spirituality.

DoD also continues to deliver key benefits to strengthen quality of life through the Taking Care of Our People initiatives (Taking Care of Our People [defense.gov]), which includes pay raises, higher housing allowances, better employment opportunities for military spouses, and improving childcare programs.[2]

DoD regularly engages with installations and local communities to understand the needs of the military community and develops resources and programs to support overall force fitness and quality of life. In 2021, the Department began fielding a specialized and dedicated prevention workforce, hiring and training over 400 individuals to work with leaders to build healthy and harm-free environments (Prevention | Workforce). Through 2023, the Department also conducted OSIEs at 19 sites and 12 ships, in addition to the sites visited in 2021. The OSIE reviewed best practices and areas of improvement across DoD installations in the prevention of sexual assault, harassment, suicide, domestic abuse, and other harmful behaviors. The OSIE allows for the sharing of best practices between installations and across the Military Services, which strengthens integrated capabilities in the prevention of these harmful behaviors.

Service- and installation-level initiatives also support the quality of life of Service members and their families. The Services offer programs that aim to reduce relationship and family stressors and to increase a sense of belonging. Select examples of these programs include the Strong Bonds Program, which is offered by the Air National Guard, and Building Strong and Ready Teams, which is offered by the Army National Guard. The purpose of these programs is to enhance relationships between intimate partners and spouses. The Navy's Naval Air Station North Island opened an off-base Child Development Center in partnership with the City of San Diego. The partnership promotes increased access to childcare for a military community that faces unique childcare challenges due to their geographic location.[1] The Army's Better Opportunities for Single Soldiers is designed to enhance morale and welfare of single Soldiers on their first or second duty assignment. The program also supports increased retention and sustained combat readiness.

These combined efforts contribute to total force readiness by supporting the daily lives of Service members and their families and by addressing many common suicide risk factors.

Address Stigma as a Barrier to Getting Help

Stigma is a long-standing barrier, and addressing it is a priority to improve access to care.

Stigma is the fear that acknowledging one's struggles or seeking help for them may lead to negative career or social impacts.[1] It is a dynamic process in which a person's identity is shaped by perceived negative attitudes or beliefs toward people with mental health disorders (e.g., perceived ability to complete one's mission). Stigma may contribute to adverse outcomes such as discrimination and isolation, may serve as a barrier to seeking care and treatment, and may exacerbate symptoms. By challenging the stigma associated with seeking mental health support, DoD strives to create an environment where Service members and their families feel empowered to prioritize their mental well-being without judgment—an environment where mental health is health.

Efforts aimed at reducing stigma are central to DoD's integrated primary prevention approach to suicide prevention. The American Psychological Association (APA) reports that Generation Z (generally defined as Americans born between 1997 and the early 2010s), which represents our youngest and future military force, views behavioral health and associated care differently from previous generations. For example, compared to older age groups, Generation Z is more open about their behavioral health, less reluctant to report experiencing poor behavioral health, and more likely to seek health care.[3]

One way DoD is working to change negative perceptions toward clinical services is through policy change. As an ongoing effort, the DoD has reviewed over 600 policy documents, working toward removing language that stigmatizes stress reactions, mental health issues, and treatment.[4] Also, help-seeking is not limited to clinical services. DoD actively promotes a broad spectrum of supportive options, both clinical and nonclinical, that are available to Service members and their families, including chaplaincy and financial and life skills counseling. The motivation for implementing service-led policies that embed mental health providers and other behavioral health extenders in military units is to reduce stigma, increase help-seeking behavior, and improve access to care.

Senior leadership can also shape attitudes toward mental health and help-seeking.[1] For example, research shows that Service leaders who share their own personal struggles with mental health help reduce stigma and increase positive perceptions of help-seeking.[1]

Members of the military community themselves play a key role in reducing stigma and improving attitudes toward help-seeking. DoD and Service-led education and training programs (e.g., Ask, Care, Escort [ACE]) teach community members how to access care for themselves and for others, destigmatize psychological distress, and portray help-seeking as a sign of strength.

The DoD, based on a partnership between the Psychological Health Center of Excellence (PHCoE) and the Defense Suicide Prevention Office (DSPO), revitalized the Real Warriors Campaign (Real Warriors Campaign | Health.mil) to reduce stigma associated with mental health and to support psychological health and readiness. The Real Warriors Campaign promotes a culture of support and emphasizes that mental health care is health care – that psychological fitness is as much of a priority as physical fitness. The campaign serves to anchor the message that reaching out for help is a sign of strength.

Taken together, such efforts are a framework for eliminating stigma by normalizing help-seeking and mitigating misconceptions related to these efforts.[5]

Improve Delivery of Mental Health Care

DoD aims to deliver the highest-quality clinical health care services.

Elevating high-quality, evidence-informed clinical support services is critical to DoD's suicide prevention program. DoD is committed to delivering top-tier clinical support services coupled with effective screening to Service members and their families to identify and aid those at increased risk of suicide.

Clinical services are standardized across all Military treatment facilities (MTFs). Support services are based on clinical practice guidelines and were co-developed with the U.S. Department of Veterans Affairs (VA).[6] These guidelines represent the gold standard in evidence-based care for suicide risk as well as for certain clinical conditions that increase suicide risk, such as substance use disorder, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and depression. To ensure accessibility, Service members and their families can, in some situations, also access care through community providers.

As part of its integrated approach to suicide prevention, DoD also actively uses nonclinical options to supplement clinical services. For example, community-based prevention is especially important for Service members experiencing increased exposure to risk factors (e.g., geographic isolation) and decreased access to protective factors (e.g., social connections). These efforts serve to strengthen relationships between Service members in need with military leaders and chaplains, as well as their families, peers, and spouses.

The DoD has implemented the ability for Service members to request referrals for mental health evaluations for any reason, which improves the process for Service members to confidentially seek mental health and wellness support. More specifically, the DoD published a directive-type memorandum (DTM), "Self-Initiated Referral Process for Mental Health Evaluations of Members of the Armed Forces," allowing Service members to initiate a referral for a mental health evaluation from a commanding officer or supervisor who is in a grade above E-5 on any basis, at any time, and in any environment.[7] This guidance expands to other avenues available to Service members, so they can easily and readily access behavioral health care.[8]

The Defense Health Agency's administrative instruction, "Suicide Risk Care Pathway for Adult Patients in the Defense Health Agency," establishes procedures to screen, assess, manage, track, and treat patients for suicide risk.[9] Military members are screened for behavioral health challenges annually as well as routinely with each primary care visit, during other health care visits when clinically indicated, at pre-deployment, and twice following post-deployment. This administrative instruction also includes guidance for training on suicide risk care, measuring outcomes, and reporting suicide deaths and attempts identified in Service members.

The National Guard implemented the Star Behavioral Health Providers (SBHP) program to provide continuing education programs to enhance behavioral health providers' knowledge and skills for treating Service members, veterans, and their families. SBHP maintains an online registry to make it easy to find trained, local support. This program helps address unique challenges in accessing mental health services; for example, a lack of available providers in remote locations and civilian community providers with military cultural literacy.

Additionally, DoD oversaw two noteworthy studies in CY 2022. The first study examined "Caring Contacts," an intervention involving periodic and personalized contact (e.g., sending a brief note) to someone who sought help indicative of increased suicide risk. The intent is to facilitate a sense of connection and to increase perceptions of social support. The results indicated a protective effect against attempting suicide.[10] The second study examined 73 different interventions following a nonfatal

suicide attempt.[11] These studies help translate knowledge into evidence-based health care guidelines and services focused on reducing the risk of reattempting suicide. Other resources can be found on the Psychological Health Center of Excellence (PHCoE) website: https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence.

Promote a Culture of Lethal Means Safety (LMS)

In crisis, time and space from lethal means can be lifesaving.

LMS is crucial to reducing suicide deaths. Lethal means is defined as a "method for suicide that has a high likelihood of resulting in death (e.g., firearms, drugs, and poisons)."[1] In the case of Service members and their families, firearms—especially privately owned—are the leading method of suicide death.

LMS is intended to put time and distance between a person in crisis and a lethal means. This strategy decreases the ability for a person in crisis to make a fatal suicide attempt.[12]

LMS continues to be a key national priority for reducing suicide in the military and veteran communities and features prominently in the White House's *Military and Veteran Suicide Prevention Strategy* and the *White House Report on Mental Health Research Priorities*.[13] The Department continues to prioritize LMS through multiple efforts, including partnering with federal agencies, such as the VA and the U.S. Department of Health and Human Services (HHS), to further the White House's LMS goals, and through examining the Department's internal policies and directives to ensure safe messaging is communicated throughout all DoD issuances. The Department is working with internal stakeholders to examine how to improve safe storage practices throughout the Department.

Through pilot programs, the Department is exploring appropriate settings and effective conversations on safe storage of firearms in early military career training across all Services. The Department is also supporting the Services in increasing LMS program evaluation capabilities, which is underpinned by the newly published policy update (DoDI 6490.16) directing the Services to engage in program evaluation for suicide prevention related activities and efforts (see more on program evaluation below).

Available DoD resources for educating the wider military community on LMS include the Lethal Means Safety Suite of Tools, which discusses how to safely store firearms and medications (available at Defense Suicide Prevention Office [dspo.mil]). Another resource is Counseling on Access to Lethal Means (CALM), a training program for mental health and medical professionals (Counseling on Access to Lethal Means | Zero Suicide [edc.org]). CALM teaches counseling strategies to promote safe use and storage of firearms. LMS training is now also actively promoted throughout the Services.

Fostering a culture of LMS is a cornerstone of DoD's integrated primary prevention approach. Proper storage of lethal means creates a barrier to an impulsive act and promotes an overall safe environment for Service members and their families.

Additional and Service-Specific Efforts

Evaluating the Effectiveness of Suicide Prevention Programs

The long-term goal of all DoD suicide prevention initiatives is to reduce suicide risk factors and increase protective factors. Program evaluation is a systematic way to assess whether an initiative has been successful in achieving these intended outcomes.

The evaluation process allows stakeholders to continuously develop lessons learned, identify best practices, and build infrastructure for programs. In 2023, DoD Instruction 6490.16 for the "Defense Suicide Prevention Program" was updated to outline a framework to evaluate the effectiveness of suicide prevention efforts.[1] This includes:

- Relevance and utility—to ensure the evaluation supports the needs of stakeholders.
- Rigor—to ensure adherence to scientific principles and standards.
- Independence and objectivity—to support the integrity of the findings.
- Transparency—to enable appropriate accountability throughout the evaluation lifecycle.
- Ethics—to safeguard the rights of those being served.

Adherence to these standards ensures reliable data to systematically evaluate the effectiveness and outcomes of an intervention. Such data supports the development, implementation, and dissemination of initiatives in real-world settings.[12]

Real-world implementation of suicide prevention programs requires sensitivity to the diversity of backgrounds and identities in the military community. The *White House Report on Mental Health Research Priorities* includes a call for addressing disparities in health care across different demographic groups and for ensuring a diverse and culturally competent mental health work force.[13] Thorough evaluation of these programs and services will help DoD meet its commitment to ensuring that all Service members have equitable and inclusive access to suicide prevention programs and services.

Put into practice, DoD is currently involved in a two-year effort to develop, distribute, and evaluate a version of CALM that has been adapted to the needs of nonclinical military gatekeepers. "CALM-Adaptation for the Military" intends to teach this group of gatekeepers how to effectively engage in conversations about lethal means with Service members in distress. Another example is the Real Warriors Campaign, an ongoing public health awareness campaign established in 2009 that is aimed at reducing stigma and, more recently, amplifying suicide prevention initiatives. This campaign is conducted in collaboration with other federal agencies and includes a formal evaluation plan.

Program evaluation is an important component of any suicide prevention effort. DoD is committed to systematically evaluating and continuously improving the safety, effectiveness, usability, accessibility, and scalability of all the support options it provides to Service members and their families.

Highlighted Service specific Suicide Prevention Efforts

The following section includes highlights of select Service-specific suicide prevention efforts and initiatives, which is newly added to the report this year. This is not an exhaustive list of efforts.

U.S. Army Suicide Prevention Initiatives (Highlighted efforts not exhaustive)

Ask, Care, Escort (ACE) Suicide Prevention Pilot Program

- The goal of this pilot program is to increase awareness of suicide risk and protective factors, strategies for intervention, and prevention resources.
- This training is comprised of four modules. A base module and selected "+1" additional modules will complete the Army's annual suicide prevention training requirement.
- This pilot program enables participants to successfully lead suicide prevention with interactive activities and discussions to prompt critical thinking. Additionally, the modular format allows leaders to select the best prevention education for their Soldiers, supported by current research and academic literature on suicide prevention and instructional best practices.
- Website: https://www.armyresilience.army.mil/suicide-prevention/pages/about.html

Lethal Means Safety (LMS) Toolkit

- LMS plays an important role in preventing suicide. The Army has initiated efforts to integrate LMS across the enterprise.
- From September to November 2022, Headquarters Department of the Army (HQDA) successfully piloted the CALM training with chaplains. Twenty-three chaplains were effectively trained to educate Soldiers and family members on safe firearm storage practices.
- The Army established a LMS microsite (https://www.armyresilience.army.mil/Lethal-Means/LMS-Home.html) with a communications toolkit, an LMS catalogue, and a community of practice for Army professionals.
- Website: https://www.armyresilience.army.mil/lethal-means/lms-home.html

Spiritual Readiness Initiative Pilot Program

- Army chaplains and behavioral health professionals partnered to develop the Spiritual Readiness Initiative to build Army spiritual readiness and to reduce harmful behaviors and negative outcomes, like suicide and self-harm.
- From November 2021 to December 2022, the chief of chaplains hosted 13 Spiritual Readiness training events that were conducted at multiple Army installations with approximately 2,500 participants.
- The initiative informed the new Spiritual Readiness Training, which covers the science of spirituality and the policy and doctrine concerning spirituality. It is a 3-hour course for the Chaplain Corps and was published and distributed in March 2023.

Wellness Checks for Soldiers Pilot Program

- The Wellness Checks for Soldiers initiative requires Soldiers of all ranks to complete a wellness check to support personal resilience, promote personal development, and introduce Soldiers to the counseling process.
- In 2022, Walter Reed Army Institute of Research (WRAIR) and leadership at Fort Riley implemented the Wellness Checks initiative. Approximately 7,800 Soldiers participated in mandatory, confidential 30- to 60-minute counseling sessions with Military and Family Life Counseling (MFLC) counselors.
- Participating Soldiers reported being more likely to seek help when needed and increased levels of resilience and thriving. The initiative advances the larger goal of reducing stigma toward help-seeking.

Commander Suicide Prevention Training

- The United States Reserve Command (USARC) executes a virtual command team suicide prevention training. This training assists commanders in building prevention programs that empower Soldiers and leaders at all levels to identify and address high-risk behavior early on.
- Soldiers—down to the squad-leader level—are empowered to escort any Soldier in crisis to immediate lifesaving care. Soldiers who perform these duties and those who need help are authorized paid duty status.

U.S. Marine Corps Suicide Prevention Initiatives (Highlighted efforts not exhaustive)

Integrated Training and Education

- The U.S. Marine Corps (USMC) is focusing on Marine Corps Total Force Fitness from a holistic wellness approach of mental, physical, spiritual, and social influence.
- The Marine Corps is partnering with the USMC Safety Division to test a new initiative that provides a cognitive behavioral therapy (CBT) curriculum and evidence-based activity boxes to a small number of participants quarterly over the course of the year.
- The Marine Corps is developing a public-facing online interactive Suicide Prevention Resource space for Active Duty, families, and those who love and support their Marines.
- The Marine Corps gathered a senior leader advisory group from across the Marine Corps operational forces, installations, Chaplain Corps, and medical personnel to inform recommendations to senior leaders.

Death by Suicide Review Board (DSRB)

- The DSRB meets annually to review every death by suicide among Active Component Marines.
- The purpose of the DSRB is to identify common individual and community factors, systems-level gaps, and opportunities to improve the Marine Corps Suicide Prevention System.
- Findings and operational recommendations are provided and distributed across the fleet in an annual report.
- For more information, contact behavioral.programs.research@usmc.mil.

Suicide Prevention Research Reports

- Headquarters Marine Corps (HQMC), Behavioral Programs, Program Evaluation and Research, summarizes existing military and non-military research findings for use by commanders and professional staff working in suicide prevention.
- Reports also provide actionable prevention strategies and tips to commanders and professional staff to reduce suicide risk factors, enhance protective factors, and deal with substance abuse issues.
- For more information, contact behavioral.programs.research@usmc.mil.

Suicide Prevention Awareness

- HQMC Behavioral Programs released Public Service Announcements (PSA) from Senior Leaders in September in support of Suicide Prevention Month and partnered with the regional leadership teams and Marine Corps Association (MCA) for suicide awareness summits with junior leaders.
- HQMC Behavioral Programs continue to focus on ongoing monthly communication through various media (e.g., podcasts, publications, articles) to educate Marines and families on how to access services to navigate the stressors of life, support command and leadership, and encourage alignment with core values.
- Website and USMC Suicide Prevention Podcasts: Suicide Prevention Capability (usmc.mil)

U.S. Navy Suicide Prevention Initiatives (Highlighted efforts not exhaustive)

Lethal Means Safety (LMS)

- Fleet and Family Support Centers (FFSC) and Navy Operational Support Centers (NOSC) distributed 413,400 gun locks to Sailors and their families.
- More than 1,500 suicide prevention coordinators are trained to support their commands in preventing and reporting suicide-related behaviors.
- Bases are increasingly providing access to safe storage of lethal means for Sailors who voluntarily surrender their firearms during times of stress.
- The Navy partnered with DSPO and the Centers for Naval Analyses to conduct a formal evaluation of LMS programs.
- The Navy is collaborating with academic partners to increase the depth and breadth of LMS programs.
- Website: https://Suicide.Navy.mil

Expanded Avenues for Care

- Sailor Assistance and Intercept for Life (SAIL) is an evidence-based program for reintegration assistance following suicide ideation or a suicide attempt. Since inception in CY 2017, over 8,000 Sailors have voluntarily participated in SAIL. In CY 2022, over 2,400 Sailors voluntarily accepted and participated in SAIL, which, to date, is the highest number enrolled in a given year.
- The Expanded Operational Stress Control (E-OSC) program leverages Command Resilience Teams and deckplate leadership to provide more accessible, collaborative resources and real-time assessments of unit culture. The E-OSC is designed to inform and empower Sailors to identify signs of distress and difficulty coping within themselves and others and to know where to turn to get help.
- The Embedded Mental Health (EMH) provider program places trained mental health professionals within operational units to reduce barriers to seeking help and to improve timely access to care. Approximately 35% of all Navy mental health officer and enlisted billets are embedded.
- The Navy's suicide prevention strategy includes deploying more chaplains as regular crew members on more ships.
- Website: https://Suicide.Navy.mil

Project 1 Small Act (P1SA)

- This toolkit is designed to provide those engaged in Navy suicide prevention with materials (e.g., graphics, talking points, event ideas) and resources to refresh local engagement on suicide-related topics such as risk factors, LMS, help-seeking, and Navy support resources.
- The toolkit is customized to fit unique command needs, including the Reserve Force.
- Website: https://navstress.wordpress.com/

U.S. Air Force & Space Force Suicide Prevention Initiatives
(Highlighted efforts not exhaustive)

Time-Based Prevention (TBP)

- Time-Based Prevention (TBP) focuses on promoting safe storage of personal firearms to put time and space between an Airman or Guardian who is at risk for suicide and access to lethal means.
- TBP was implemented across the Department of the Air Force (DAF) in March 2022 and included the "Go SLO" campaign, LMS videos for social media, training materials, and a Firearm Retailer Toolkit.
- A centralized contract was established to facilitate the purchase and distribution of cable-style gun locks. To date, more than 280,000 locks have been distributed across the Department of the Air Force.
- Website: https://www.resilience.af.mil/Time-Based-Prevention/

Wingman Connect/Guardian Connect (WC/GC)

- Wingman Connect/Guardian Connect (WC/GC) is a primary prevention program that strengthens protective relationship networks and skills for managing career, family, and personal challenges. It is the only universal prevention program associated with reduced suicidal ideation and depressive symptoms within a nonclinical population. Through peer-to-peer activities, Airmen and Guardians learn to grow and sustain four protective strengths: (1) healthy relationships and accountability, (2) meaning and value in work and life, (3) informal and formal help-seeking, and (4) activities that give strength and maintain perspective. While learning together, participants develop group connections/cohesion and shared, healthy norms. WC/GC is an interactive group training, based on research-validated strategies, including (1) high-energy activities that maintain interest, motivation, and personal meaningfulness; (2) drawing out real-world strengths from participants as primary teaching method; and (3) exercises inside and outside of training that reinforce the application and retention of skills.
- WC/GC will expand to include Airmen and Guardians during Technical Training School. The effects of this expansion will be formally evaluated.
- Additional evaluation studies will take place at operational bases located throughout Air Force Global Strike Command from mid-2023 to 2026.

Suicide Prevention Virtual Reality Training (SPVR)

- Suicide Prevention Virtual Reality Training (SPVR) is intended to provide Airmen and Guardians the tools to enable them to recognize a distressed individual, to have a difficult conversation with the distressed individual, and to guide that person to safety.
- Trainees interact with a distressed Service member in a realistic and safe virtual environment, receive real-time feedback, and learn to apply the ACE model.
- Initial results from a study with over 8,000 Airmen found increased confidence, preparedness, and willingness to intervene, with 97% of participants willing to recommend the training to others.
- A study examining the effectiveness of SPVR relative to training as usual is currently underway with results expected in 2024.
- Website: https://vimeo.com/549063799

Uniformed Services University of the Health Sciences Department of the Air Force (DAF) Standardized Suicide Fatality Analysis (DAF StandS)

- The first standardized, unified, scientific, and public health-driven methodology for suicide death reviews in the DAF were completed in CY 2020.
- Comprehensive reviews of all suicide deaths since CY 2018 will be conducted to improve prevention programming.
- Each year, installations will be required to review the DAF StandS analysis report and identify suicide prevention priority actions that should be taken to reduce suicide risk.

True North Program

- True North is an Air Force initiative to build resilient forces and families by providing direct, in-unit access to behavioral and spiritual care.
- In-unit services include education and team-building activities, resources and referrals, mental health counseling (Active Duty only), and confidential spiritual counseling (ID cardholders/authorized dependents).
- Website: https://www.resilience.af.mil/True-North

National Guard Suicide Prevention Initiatives (Highlighted efforts not exhaustive)

Project SafeGuard (PSG)

- Project SafeGuard (PSG) provides training on LMS, peer counseling, and gun locks to Service members. The program incorporates principles of motivational interviewing to encourage voluntary safe storage practices and to promote protective environments.
- Trained Service members deliver the initiative to Service members as a peer-to-peer program.
- Currently available in three states.

Start Training

- Start is an online training for gatekeepers to improve their ability to identify and respond to Service members at risk for suicide. The program includes a database of resources to easily connect Service members with support.
- The National Guard Bureau (NGB) partners with Start to distribute the training broadly to Service members, spouses, leaders, and community partners.
- Start has trained more than 1,400 National Guard participants since FY 2019 and has shown evidence for improving confidence in gatekeeper skills immediately after the course.
- Website: https://www.livingworks.net/start

Connectedness and Relationship Education (CARE) Program

- The Connectedness and Relationship Education (CARE) program is designed to build trust through counseling and relationship skills training for first-line leaders.
- CARE provides first-line leaders with advanced training for conducting effective individual counseling with Service members by building professional relationships with subordinates and facilitating unit cohesion.
- The main pillars of CARE are communicating skills, trust, and identifying and using Service members' diversity as a leader.
- Statistical analysis shows positive trends and substantial change in leadership, interpersonal relationships, knowledge, and connectedness.

APPENDIX

Appendix A: Methodology Approach

This appendix describes common questions about suicide surveillance in the military and provides a brief overview of the analytic methods used within this report.

Suicide Data and Interpretation

Reporting Suicide Deaths for Service Members

By policy, the Armed Forces Medical Examiner System (AFMES) determines the counts and rates for Service member suicide deaths. This includes cadets and midshipmen. AFMES verifies and reports suicide deaths for all Active Component Service members and Reserve Component Service members that are on active duty at the time of death.[a] Reserve Component Service members not on active duty status at the time of death are reported to AFMES by individual Service branches. Suicide counts and rates for the Reserve and National Guard include members of the Selected Reserve (SELRES) with active-duty status and non-duty status.

Reporting Suicide Deaths for Military Family Members

DSPO compiles data from three data sources to determine the counts and rates for military family member suicide deaths. Data sources include (1) the Defense Enrollment Eligibility Reporting System (DEERS; a database of military sponsors and dependents who have registered to receive military benefits), (2) Military Services, and (3) CDC National Center for Health Statistics National Death Index (NDI; a database of death record information compiled from state offices). Data from all three sources were available starting in 2017 and lag one year relative to Service member data due to the time lag in collection of NDI data. No single data source fully captures suicide deaths. The majority of military family members are civilians whose deaths do not occur on a military installation and DoD does not have visibility of or jurisdiction over these deaths. Therefore, it is necessary to combine multiple data sources for DoD to ensure it is capturing the most complete information possible from both military and civilian data sources. This may not account for all suicide deaths included in the 10 U.S.C. 1072(2) definition, and suicide counts and rates presented in this report may be underestimated for this population.

Defining Military Family Member

The definition of "dependent" (also referred to as "military family members") for the purposes of this report is individuals who are sponsored by a Service member, are enrolled in DEERS, and meet the requirement for a military dependent as defined by Section 1072(2) of Title 10, U.S. Code, which defines a dependent with respect to a uniformed Service member (or former member) as a/an:

1. Spouse;
2. Un-remarried widow or widower;
3. A biological, step-, foster, ward, pre-adoptive, or adopted child who is:
   a. Unmarried and under the age of 21;
   b. Physically or mentally incapable of self-support (regardless of age); or
   c. Enrolled in full-time course of study at an institution of higher learning, dependent on the Service member for over one-half of their support, and under the age of 23;
4. Un-remarried former spouse of a current or former Service member;

[a] Service member deaths occur in both military and civilian jurisdictions. AFMES conducts about 15%–20% of all death investigations (for suicide and all other causes). All other investigations are completed by civilian medical and legal authorities and are reported to AFMES by the Military Services.

5. Unmarried person who is placed in the legal custody of the Service member as a result of a court order (e.g., a sibling);[b] and
6. Parent or parent-in-law who is dependent on the Service member for over one-half of his/her support and residing in his/her household.

In this report, "dependent spouses" are referred to as "spouses" and "dependent children" as "dependents." To align with CDC standards on reporting suicide deaths, the present analysis only considers suicide deaths among dependents aged 10 years and up.[14]

Counts versus Rates

Suicide death counts represent the number of people that died by suicide (also known as absolute magnitude). Suicide death rates represent the number of people that died for every 100,000 people in that group/population in a year. Counts alone are not enough to compare two groups or to understand if suicide is changing over time. In fact, counts alone can be misleading. Using a rate ensures that any observed differences in suicide are not the result of one group being larger than the other. For this report, to calculate a crude rate, the number of deaths is divided by the size of the group, and multiplied by 100,000. Although rates account for differences in size, they do not explain why changes occur over time and do not account for many other factors that may affect suicide rates. Comparing suicide rates between groups that do not have the same proportion of people with those characteristics would be misleading. To fix that, suicide rates are adjusted during analysis to make the two groups more like each other based on the chosen characteristics. In the case of this report, rates are adjusted for the age and sex composition of each group. A rate that is not adjusted is called an unadjusted or crude rate.

Understanding Variability in Suicide Rates

All data related to human behavior have some natural variability. This can include, for example, a basic change in the frequency of the behavior or outcome (e.g., decrease in suicide deaths in a given year). It can also reflect variability in how standardized criteria are applied in examining the behavior (e.g., medical examiners determining suicide as the cause of death). This results in natural variability from year to year in the rates being examined. Variability can happen in either direction, resulting in adding or removing suicide deaths. If adding or removing a small number of suicide deaths (e.g., two or three) changes the rate noticeably (at least within one decimal place), then the rate is considered volatile. This is true for suicide rates in the military for which the number of suicide deaths is mathematically small compared to the size of the entire military population.

Both of these situations can apply to suicide rates in the military and in certain instances make it difficult to reliably understand what is real change ("signal") and what is a natural variation in data ("noise"). This does not automatically mean that suicide rate data are unreliable or unusable. It means that interpretation of this data, especially for short timeframes or smaller groups, should be made with caution and with as much context as possible in order to reliably inform policy, programs, or decision-making.

Understanding Statistical Significance

Statistical significance is a scientific term that describes how confident we are that a result of a comparison is not purely due to chance or natural variability. A statistically significant result does *not* tell the reader whether a result is subjectively important.

A result can be statistically significant while still only representing a *small* difference or effect; on the other hand, an observation may suggest a *large* difference or effect, but the data may be too limited to say that the result is statistically significant—in these cases, more data or observations may be required to confirm any findings.

Statistical tests—as part of larger study design, sampling, and conceptual considerations—help researchers answer a variety of questions. For example, some tests can help us determine the extent to which findings are

[b] Additional criteria may apply (see section 1072(2) of Title 10, U.S. Code).

generalizable (e.g., whether a survey about the attitudes of young, male Service members can be generalized to all Service members). Statistical tests can also tell us about the strength of particular relationships (e.g., how strong the relationship is between adverse childhood experiences and risk for mental illness) or how meaningful these relationships are (e.g., how well a medication works at reducing depression symptoms).

In this report, statistical significance is determined in two ways: (1) by interpreting results using *p* values—a predetermined level of probability, and (2) by examining whether 95% confidence intervals do not overlap.

What are *p* values?

The probability with which the result could have occurred due to chance or natural variability. A common threshold for determining significance is $p < 0.05$. This means, if a result is significant (or in other words $p < 0.05$), the chances of obtaining this result when no real difference exists is less than 5%.

What are 95% confidence intervals?

A level of uncertainty is associated with suicide rates due to random error and volatility, such as the possible misclassification of a suicide. Confidence intervals provide a range of possible values for the suicide rate that accounts for this uncertainty. With a 95% confidence interval, one can be 95% confident the range of values covers the true suicide rate.

Analysis

Calculating Unadjusted and Adjusted Suicide Rates

In this report, anytime suicide rates were compared, an **adjusted suicide rate** was used. Unadjusted suicide death rates represent the number of people that died for every 100,000 people in that group/population in a year. Adjusted rates are estimated using a generalized log-linear regression model based on the Poisson distribution (i.e., change is linear in the log of the rate) and a large matrix or contingency table with decedent and population totals by strata (e.g., year, age category, sex, Component or Service). When adjusting for age and sex, the model also uses weighted effects coding.[c] A Poisson distribution is well suited to estimate counts or rates for rare or low base rate events, such as suicide. See **Figure 1** for an example showing age- and sex- adjusted rates for each year.

Estimating Change Over Time in Suicide Rates

A line of best fit using log-linear modeling, which is well suited for rate data with a low base rate, was calculated to describe trends in suicide rates over time. This approach models the observed event count, with consideration for the population size, and uses the distribution as a weight, which is well suited to account for high variance in low-count data. More specifically, the log-linear model is achieved by using a Generalized Linear Model (GLM) with a log-link function and is used to account for population size as well as suicide death counts. The estimated rates are obtained by exponentiating the log rates from the trend analysis, and the trend of the rates is then a slight curve. This approach assumes that change over time is log-linear in nature and that it follows a Poisson distribution. A Poisson distribution is used to determine the probability of rare events and allows for contingency tables or a matrix to adjust for multiple variables, such as age and sex. This method was applied to describe trends from CY 2011 to CY 2021 (see the Service Member Suicide Data section) and was the same analytic approach that was used in CY 2019 and the prior DoDSER Annual Reports. To describe shorter or more near-term changes, this report compared the rate for a given year to each of those for the last two years using a pair-

[c] Description of weighted effects coding: https://journal.r-project.org/archive/2017/RJ-2017-017/RJ-2017-017.pdf

wise comparison approach. The result of the trend analysis, for both the near and long term, was a single estimated rate of change for the period, also known as the incidence rate ratio. A statistical test was then performed to determine if the trend direction (increasing or decreasing) was statistically significant for the period of interest. Rates were adjusted to account for age and sex differences across the period of interest.

Assessing Risk for Death by Suicide Among Specific Demographics Groups

Rate ratios between the rate for each demographic group (listed in Table 2) and the average population rate were calculated to assess suicide risk for specific demographic groups. Rate ratios are used to assess whether a given demographic group is at a higher risk of dying by suicide relative to another group. Rate ratios are a measure of association which can be used to quantify the relationship between two groups in the occurrence of suicide. For the purposes of the analyses in this report, the suicide rate for decedents from a specific demographic group was compared to the overall suicide rate for the Component in which they served. An overall, combined suicide rate was calculated for the Reserves and National Guard to ensure meaningful interpretation of findings. This was done owing to the relatively small number of decedents in each of these groups.

A generalized log-linear regression model based on the Poisson distribution was used to obtain the rate estimates for each group that was compared. Weighted effects coding was applied to each of the demographic groups to ensure the rate ratios reflected a risk relative to the population average. The model's parameter estimates (regression coefficients) describe the ratio of the suicide rate of any given demographic group to that of the population average (i.e., the rate ratio). For example, see the "Demographic and Military Characteristics" section within the Service Member Suicide Data section of this report for an assessment of whether male Service members have a higher risk for suicide in the military population.

Comparing Military Suicide Rates to the U.S. Population

Accounting for sex and age is vital when comparing suicide rates between the military and the U.S. population because the military has more men and more young people (i.e., under 30). This requires standardizing for age or sex differences between the military and U.S. population, then adjusting for age and sex differences in suicide rates within the military. Without such standardization and adjustment, the comparisons between the unadjusted or crude rates in the military and the U.S. population suicide rates would be misleading or distorted.

When making comparisons between the military and U.S. populations, we used **indirect standardization** to account for differences in the demographic makeup because the number of suicide deaths within subsets of the military population are very small. A Poisson distribution along with the military age- and sex-specific stratum population size was then used to estimate the standardized mortality ratio between the military and U.S. populations. This mirrors the approach used in CY 2019 and prior DoDSER Annual Reports. For more details, see CY 2019 DoDSER Appendix D (DoD, USD[P&R], 2021).

An indirectly standardized rate for the military can be compared with the U.S. population rate, but not to another indirectly standardized rate. The 95% confidence interval associated with the indirectly standardized rate was used to test for a significant difference between the military and U.S. populations. If the span of the confidence interval for the military population did not cover the U.S. population rate, then the probability of observing no true difference was less than 5%—in other words, one can be 95% confident that the two rates are statistically different. For an example of this analysis, see the "Suicide Rates Over Time" section within the Service Member Suicide Data section of this report. U.S. population data were obtained using CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER).

Appendix B: Unadjusted and Adjusted Rates Over Time

Tables 9–11 present unadjusted and adjusted rates for the CY 2011–CY 2022 trend analyses presented in the **Service Member Suicide Data** section of this report. A rate is considered unadjusted when it is calculated using only the raw number of suicide deaths that occurred and the total size of the population. However, Service member populations fluctuate over time. The number of Service members of a certain age or sex can vary across years (e.g., 2019 compared to 2020). Since both age and sex are associated with suicide risk, when making comparisons across years, it is important to adjust rates for age and sex differences (i.e., adjusted rates). This avoids potentially misleading comparisons of unadjusted rates.

Suicide rates from the CY 2011–CY 2022 trend analyses were adjusted for age and sex over the defined time period. The unadjusted rates, presented below, may not match the unadjusted rates in **Table 1** of the report because the unadjusted suicides rates for the CY 2011–CY 2022 trend analyses were limited to ages 17–59 for the purpose of these analyses. Additionally, as new years of data are added to the analysis (e.g., CY 2022), the adjusted rates will change to incorporate the population (and their associated demographic characteristics) from that year. See **Appendix A** for more information about adjusting for age and sex.

Table 9. Service Member Suicide Rates by Component, Rates per 100,000 Service Members, CY 2011–CY 2022

	Active Component		Reserve		National Guard	
Year	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	18.7	17.0	18.1	15.3	24.9	21.5
2012	22.9	20.9	19.3	16.3	28.2	24.4
2013	18.4	16.9	23.1	19.4	28.9	25.1
2014	20.2	18.6	21.6	18.3	19.6	17.1
2015	20.2	18.7	24.8	21.0	26.4	23.1
2016	21.5	19.9	22.3	19.0	27.3	23.9
2017	22.2	20.6	25.8	22.1	29.6	26.0
2018	24.9	23.2	22.9	19.8	30.8	27.3
2019	26.2	24.4	18.5	16.1	20.5	18.4
2020	28.5	26.6	21.7	19.1	27.5	24.7
2021	24.4	22.8	21.8	19.3	27.1	24.3
2022	25.1	23.5	19.1	17.1	22.2	19.9

Notes: Data sourced from AFMES. Unadjusted rates are age bound to 17–59. Adjusted rates are age bound to 17–59 and adjusted for age and sex.

Table 10. Active Component Service Member Suicide Rates per 100,000 Service Members by Service, CY 2011–CY 2022

	Army		Navy		Marine Corps		Air Force	
Year	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	24.8	22.8	16.0	14.0	15.4	14.7	12.9	11.5
2012	29.8	27.5	18.1	16.0	24.3	23.5	15.0	13.4
2013	22.5	20.8	12.8	11.4	23.6	23.0	14.4	12.9
2014	24.4	22.7	16.6	14.9	17.9	17.4	18.5	16.6
2015	24.4	22.9	13.1	11.8	21.2	20.5	20.6	18.4
2016	27.4	25.7	15.9	14.3	20.1	19.5	19.4	17.4
2017	24.9	23.4	20.1	18.2	23.4	22.7	19.6	17.7
2018	29.9	28.0	20.7	18.9	30.8	30.0	18.5	16.7
2019	30.5	28.4	21.8	20.0	25.3	24.6	25.1	22.8
2020	36.2	33.8	19.0	17.5	34.5	33.6	24.0	21.8
2021	36.1	33.7	17.0	15.6	23.9	23.3	15.3	13.9
2022	28.9	27.0	20.7	19.0	34.9	34.1	19.7	18.0

Notes: Data sourced from AFMES. Unadjusted rates are age bound to 17–59. Adjusted rates are age bound to 17–59 and adjusted for age and sex. No suicide deaths for Space Force were recorded in 2022 and thus no rates were calculated

Table 11. Reserve and National Guard Suicide Rates per 100,000 Service Members by Service, CY 2011–CY 2022

	Army Reserve		Army National Guard	
Year	Unadjusted	Adjusted	Unadjusted	Adjusted
2011	21.4	18.4	27.4	23.8
2012	24.7	21.2	30.8	26.8
2013	29.6	25.4	33.7	29.5
2014	21.4	18.4	21.5	18.8
2015	27.2	23.5	28.7	25.1
2016	21.1	18.3	31.6	27.7
2017	32.1	28.0	35.5	31.3
2018	25.3	22.4	35.6	31.6
2019	19.4	17.2	22.9	20.6
2020	22.2	19.8	31.5	28.4
2021	24.8	22.3	31.3	28.1
2022	20.8	18.7	24.8	22.3

Notes: Data sourced from AFMES. Unadjusted rates are age bound to 17–59. Adjusted rates are age bound to 17–59 and adjusted for age and sex. Marine Corps Reserve, Navy Reserve, Air Force Reserve, and Air National Guard rates are not reported due to low Service-specific counts (DoDI 6490.16).

Appendix C: Demographics of Suicide Decedents by Service

Tables 12–14 present the counts, percentages, and rates of suicide decedents by demographic subgroups for each Service and Component. All data are sourced from AFMES.

Table 12. Active Component Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2022

	Army			Navy			Marine Corps			Air Force		
	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent
Total	28.9	135	100%	20.6	71	100%	34.9	61	100%	19.7	64	100%
Sex												
Male	32	126	93.3%	23.8	65	91.5%	37.2	59	96.7%	22.7	58	90.6%
Female	--	9	6.7%	--	6	8.5%	--	2	3.3%	--	6	9.4%
Age Group												
17–19	--	5	3.7%	--	6	8.5%	--	5	8.2%	--	0	0.0%
20–24	32.2	46	34.1%	30.1	31	43.7%	42.4	35	57.4%	24.7	23	35.9%
25–29	32.2	36	26.7%	--	10	14.1%	--	9	14.8%	--	18	28.1%
30–34	32.6	25	18.5%	--	9	12.7%	--	3	4.9%	--	14	21.9%
35–39	--	14	10.4%	--	9	12.7%	--	8	13.1%	--	7	10.9%
40–44	--	8	5.9%	--	5	7.0%	--	1	1.6%	--	2	3.1%
45–49	--	1	0.7%	--	1	1.4%	--	0	0.0%	--	0	0.0%
50–54	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
55–59	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
60–74	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Race												
White	29	92	68.1%	20.6	44	62.0%	35.6	50	82.0%	22.6	51	79.7%
Black or African American	28.4	28	20.7%	--	14	19.7%	--	6	9.8%	--	3	4.7%
American Indian/ Alaska Native	--	2	1.5%	--	0	0.0%	--	0	0.0%	--	2	3.1%
Asian/ Pacific Islander	--	8	5.9%	--	5	7.0%	--	3	4.9%	--	2	3.1%
Other/Unknown	--	5	3.7%	--	8	11.3%	--	2	3.3%	--	6	9.4%
Rank												
E (Enlisted)	33.3	123	91.1%	23.0	65	91.5%	35.9	55	90.2%	22.3	58	90.7%
E1–E4	30.1	57	42.2%	21.9	28	39.4%	34	35	57.4%	26.7	33	51.6%
E5–E9	36.7	66	48.9%	23.9	37	52.1%	40	20	32.8%	18.3	25	39.1%
O (Commissioned Officer)	--	8	5.9%	--	5	7.0%	--	5	8.2%	--	6	9.4%
W (Warrant Officer)	--	4	3.0%	--	0	0.0%	--	1	1.6%	--	0	0.0%
Cadet	--	0	0.0%	--	1	1.4%	--	0	0.0%	--	0	0.0%
Marital Status												
Never Married	29.5	58	43.0%	24.9	41	57.7%	35.1	35	57.4%	23.2	31	48.4%
Married	28.6	70	51.9%	15.8	26	36.6%	30.2	21	34.4%	17.4	30	46.9%
Divorced	--	7	5.2%	--	4	5.6%	--	5	8.2%	--	3	4.7%
Widowed	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%

Table 13. Reserve Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2022

	Army Reserve			Navy Reserve			Marine Corps Reserve			Air Force Reserve		
	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent	Rate	Count	Percent
Total	20.8	37	100%	--	7	100%	--	6	100%	--	14	100%
Sex												
Male	22.5	30	81.1%	--	6	85.7%	--	6	100.0%	--	14	100.0%
Female	--	7	18.9%	--	1	14.3%	--	0	0.0%	--	0	0.0%
Age Group												
17–19	--	4	10.8%	--	0	0.0%	--	1	16.7%	--	0	0.0%
20–24	--	8	21.6%	--	1	14.3%	--	3	50.0%	--	3	21.4%
25–29	--	9	24.3%	--	3	42.9%	--	1	16.7%	--	5	35.7%
30–34	--	6	16.2%	--	1	14.3%	--	0	0.0%	--	1	7.1%
35–39	--	6	16.2%	--	0	0.0%	--	0	0.0%	--	3	21.4%
40–44	--	2	5.4%	--	1	14.3%	--	1	16.7%	--	1	7.1%
45–49	--	1	2.7%	--	1	14.3%	--	0	0.0%	--	1	7.1%
50–54	--	1	2.7%	--	0	0.0%	--	0	0.0%	--	0	0.0%
55–59	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
60–74	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Race												
White	18.2	21	56.8%	--	3	42.9%	--	6	100.0%	--	11	78.6%
Black or African American	--	11	29.7%	--	2	28.6%	--	0	0.0%	--	1	7.1%
American Indian/ Alaska Native	--	1	2.7%	--	1	14.3%	--	0	0.0%	--	1	7.1%
Asian/ Pacific Islander	--	4	10.8%	--	1	14.3%	--	0	0.0%	--	0	0.0%
Other/Unknown	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	1	7.1%
Rank												
E (Enlisted)	24.4	34	91.9%	--	6	85.7%	--	5	83.3%	--	13	92.9%
E1–E4	31.8	23	62.2%	--	0	0.0%	--	5	83.3%	--	9	64.3%
E5–E9	--	11	29.7%	--	6	85.7%	--	0	0.0%	--	4	28.6%
O (Commissioned Officer)	--	3	8.1%	--	1	14.3%	--	1	16.7%	--	1	7.1%
W (Warrant Officer)	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Cadet	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%
Marital Status												
Never Married	24.9	21	56.8%	--	4	57.1%	--	4	66.7%	--	9	64.3%
Married	--	10	27.0%	--	3	42.9%	--	1	16.7%	--	4	28.6%
Divorced	--	6	16.2%	--	0	0.0%	--	1	16.7%	--	1	7.1%
Widowed	--	0	0.0%	--	0	0.0%	--	0	0.0%	--	0	0.0%

Table 14. National Guard Service Member Suicide Counts by Service, Rates per 100,000 Service Members and Percentages, CY 2022

	Army National Guard			Air National Guard		
	Rate	Count	Percent	Rate	Count	Percent
Total	24.8	82	100%	--	15	100%
Sex						
Male	27.3	73	89.0%	--	15	100.0%
Female	--	9	11.0%	--	0	0.0%
Age Group						
17–19	--	2	2.4%	--	0	0.0%
20–24	44.5	42	51.2%	--	3	20.0%
25–29	--	12	14.6%	--	3	20.0%
30–34	--	12	14.6%	--	3	20.0%
35–39	--	7	8.5%	--	4	26.7%
40–44	--	1	1.2%	--	1	6.7%
45–49	--	2	2.4%	--	1	6.7%
50–54	--	4	4.9%	--	0	0.0%
55–59	--	0	0.0%	--	0	0.0%
60–74	--	0	0.0%	--	0	0.0%
Race						
White	25.1	64	78.0%	--	13	86.7%
Black or African American	--	12	14.6%	--	2	13.3%
American Indian/ Alaska Native	--	1	1.2%	--	0	0.0%
Asian/ Pacific Islander	--	3	3.7%	--	0	0.0%
Other/Unknown	--	2	2.4%	--	0	0.0%
Rank						
E (Enlisted)	27.5	78	95.2%	--	13	86.7%
E1–E4	30.3	49	59.8%	--	6	40.0%
E5–E9	23.7	29	35.4%	--	7	46.7%
O (Commissioned Officer)	--	3	3.7%	--	2	13.3%
W (Warrant Officer)	--	1	1.2%	--	0	0.0%
Cadet	--	0	0.0%	--	0	0.0%
Marital Status						
Never Married	26.5	52	63.4%	--	10	66.7%
Married	20.4	24	29.3%	--	2	13.3%
Divorced	--	5	6.1%	--	3	20.0%
Widowed	--	1	1.2%	--	0	0.0%

Table 15. Service Member Suicide Rates per 100,000 Service Members, Counts, Percentages, and Total Force Counts and Percentages by Demographic Characteristics, CY 2022

	Active Component					Reserve					National Guard				
	Suicide			Total Force		Suicide			Total Force		Suicide			Total Force	
	Rate	Count	Percent	Count	Percent	Rate	Count	Percent	Count	Percent	Rate	Count	Percent	Count	Percent
Total	--	331	100%	1,318,363	100%	--	64	100%	335,650	100%	--	97	100%	436,612	100%
Sex															
Male	28.3	308	93.1%	1,086,715	82.4%	21.9	56	87.5%	255,729	76.2%	25.2	88	90.7%	349,738	80.1%
Female	9.9	23	6.9%	231,648	17.6%	--	8	12.5%	79,921	23.8%	--	9	9.3%	86,875	19.9%
Age Group															
17–19	--	16	4.8%	85,647	6.5%	--	5	7.8%	13,291	4.0%	--	2	2.1%	31,611	7.2%
20–24	31.9	135	40.8%	422,660	32.1%	--	15	23.4%	65,054	19.4%	40.8	45	46.4%	110,169	25.2%
25–29	23.8	73	22.1%	306,694	23.3%	--	18	28.1%	61,087	18.2%	--	15	15.5%	82,748	19.0%
30–34	24.0	51	15.4%	212,866	16.1%	--	8	12.5%	57,382	17.1%	--	15	15.5%	70,455	16.1%
35–39	23.6	38	11.5%	161,318	12.2%	--	9	14.1%	54,539	16.2%	--	11	11.3%	58,330	13.4%
40–44	--	16	4.8%	82,648	6.3%	--	5	7.8%	38,400	11.4%	--	2	2.1%	38,197	8.7%
45–49	--	2	0.6%	31,420	2.4%	--	3	4.7%	21,209	6.3%	--	3	3.1%	20,803	4.8%
50–54	--	0	0.0%	11,849	0.9%	--	1	1.6%	16,135	4.8%	--	4	4.1%	15,841	3.6%
55–59	--	0	0.0%	2,815	0.2%	--	0	0.0%	7,892	2.4%	--	0	0.0%	7,906	1.8%
60–74	--	0	0.0%	441	0.0%	--	0	0.0%	662	0.2%	--	0	0.0%	552	0.1%
Race															
White	26.3	237	71.6%	902,185	68.4%	18.3	41	64.1%	223,854	66.7%	22.7	77	79.4%	339,525	77.8%
Black/African American	22.5	51	15.4%	226,824	17.2%	--	14	21.9%	63,303	18.9%	--	14	14.4%	62,664	14.4%
Am. Indian/Alaskan Native	--	4	1.2%	14,155	1.1%	--	3	4.7%	2,966	0.9%	--	1	1.0%	3,010	0.7%
Asian/Pacific Islander	--	18	5.4%	83,025	6.3%	--	5	7.8%	24,655	7.3%	--	3	3.1%	19,583	4.5%
Other/Unknown	22.8	21	6.3%	92,175	7.0%	--	1	1.6%	20,873	6.2%	--	2	2.1%	11,830	2.7%
Rank															
E (Enlisted)	28.2	301	90.9%	1,068,940	81.0%	22.7	58	90.6%	263,320	78.4%	24.3	91	93.8%	373,691	85.6%
E1–E4	28.1	153	46.2%	545,114	41.3%	30.8	37	57.8%	119,967	35.7%	29.3	55	56.7%	187,557	43.0%
E5–E9	28.3	148	44.7%	523,826	39.7%	14.6	21	32.8%	143,353	42.7%	19.3	36	37.1%	186,134	42.6%
O (Commissioned Officer)	11.1	24	7.3%	217,113	16.5%	--	6	9.4%	68,391	20.4%	--	5	5.2%	53,956	12.4%
W (Warrant Officer)	--	5	1.5%	19,210	1.5%	--	0	0.0%	3,938	1.2%	--	1	1.0%	8,965	2.1%
Cadet	--	1	0.3%	13,100	1.0%	--	0	0.0%	0	0.0%	--	0	0.0%	0	0.0%
Marital Status															
Never Married	27.6	165	49.8%	597,205	45.3%	25	38	59.4%	152,066	45.3%	26.5	62	63.9%	233,779	53.5%
Married	22.4	147	44.4%	655,613	49.7%	--	18	28.1%	159,153	47.4%	14.6	26	26.8%	177,923	40.8%
Divorced	--	19	5.7%	63,977	4.9%	--	8	12.5%	23,819	7.1%	--	8	8.2%	24,333	5.6%
Legally Separated	--	0	0.0%	671	0.1%	--	0	0.0%	147	0.0%	--	0	0.0%	174	0.0%
Widowed	--	0	0.0%	897	0.1%	--	0	0.0%	464	0.1%	--	1	1.0%	403	0.1%

Appendix D: Glossary

Acronyms

AFMES – Armed Forces Medical Examiner System

CALM – Counseling on Access to Lethal Means

CDC – Centers for Disease Control and Prevention

CONUS/OCONUS – Continental United States/Outside Continental United States

CY – Calendar Year

DEERS – Defense Enrollment Eligibility Reporting System

DHRA – Defense Human Resources Activity

DMDC – Defense Manpower Data Center

DoD – Department of Defense

DoDI – Department of Defense Instruction

DoDSER – Department of Defense Suicide Event Report

DSPO – Defense Suicide Prevention Office

FY – Fiscal Year

MCL – Military Crisis Line

NDAA – National Defense Authorization Act

NDI – National Death Index

OSIE – On-Site Installation Evaluation

SELRES – Selected Reserve

SPARRC – Suicide Prevention and Risk Reduction Committee

SPGOSC – Suicide Prevention General Officer Steering Committee

USD(P&R) – Under Secretary of Defense for Personnel and Readiness

VA – Department of Veterans Affairs

WONDER – CDC Wide-ranging ONline Data for Epidemiologic Research

Terms and Definitions[d]

Active Component: Refers collectively to the active duty segments of the Army, Navy, Air Force, Space Force, and Marine Corps that are funded directly from DoD active duty military personnel appropriations pursuant to Section 115(a), Title 10, U.S. Code (DoDI 1120.11[15]).

Active Duty: Full-time duty in the active military service of the United States. This includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty (10 U.S. Code § 101(d)(1)).

Adjusted and Unadjusted Suicide Rates: A rate is considered *unadjusted* when it is calculated using only the raw number of suicide deaths that occurred and the total size of the population. However, Service member populations fluctuate over time. For this reason, to ensure accurate comparisons across years or subpopulations, it is important to account or *adjust* for differences between the groups being compared. In this report, rates were adjusted for sex and age.

Armed Forces Medical Examiner System (AFMES): The AFMES is established as a subordinate element of the DHA to: (1) Perform forensic pathology investigations in accordance with Section 1471 of Title 10, U.S.C. (2) Exercise DoD scientific authority for the identification of remains of DoD-affiliated personnel in deaths from past conflicts and other designated conflicts as provided in Section 1509 of Title 10, U.S.C. (DoDI 5154.30).[16]

Defense Enrollment Eligibility System (DEERS): A computerized database of military sponsors (active duty, retired, or member of the Reserve Component) and their eligible family members. DEERS registration is required for certain military benefits, including TRICARE (https://www.tricare.mil/deers/).

Department of Defense Suicide Event Report (DoDSER) System Data Summary: A report that characterizes Service member suicide data through a coordinated, web-based data collection system (DoDI 6490.16).

Integrated Primary Prevention: Refers to prevention activities that simultaneously address multiple self-directed harm and prohibited abusive or harmful acts or the inclusion of prevention activities across self-directed harm and prohibited abusive or harmful acts into a cohesive, comprehensive approach that promotes unity of effort, avoids unnecessary duplication, and lessens training fatigue (DoDI 6400.09).

Military Family Members (or Military Dependents): For the purpose of this report, military family members (also known as military dependents) are those who are sponsored by a Service member, are enrolled in DEERS, and meet the requirement for a military dependent as defined by Title 10 U.S. Code, Section 1072(2). In this report, “dependent spouses” are referred to as “spouses” and “dependent children” as “dependents” (DoDI 6490.16).

National Death Index (NDI): A centralized database of death record information on file in state vital statistics offices (DoDI 6490.16).

Postvention: Response activities that should be undertaken in the immediate aftermath of a suicide that has impacted the unit. Postvention has two purposes: to help suicide attempt survivors cope with their grief and to prevent additional suicides. It also may provide an opportunity to disseminate accurate information about suicide, encourage help-seeking behavior, and provide messages of resilience, hope, and healing. It is also known as “tertiary prevention” (DoDI 6490.16).

[d] Definitions lacking a parenthetical source reference were developed by the authors for the purposes of this report.

Primary Prevention: Stopping a self-directed harm and prohibited abusive or harmful act before it occurs. Can be implemented for an entire group or population without regard to risk (universal primary prevention) or can be implemented for individuals, groups, or a population that is at risk (selected primary prevention) (DoDI 6400.09).

Protective Factors: Individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events (e.g., inclusion, help-seeking behavior, financial literacy). These factors increase the ability to avoid risks and promote healthy behaviors to thrive in all aspects of life (DoDI 6400.09).

Public Health Approach: A prevention approach that impacts groups or populations of people versus treatment of individuals. Public health focuses on preventing suicidal behavior before it ever occurs (primary prevention) and addresses a broad range of risk and protective factors. The public health approach values multi-disciplinary collaboration, which brings together many different perspectives and experiences to enrich and strengthen the solutions for the many diverse communities (DoDI 6490.16).

Reserve Component (Reserves): Refers collectively to the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the Coast Guard Reserve, when the Coast Guard is operating as a Service of the Department of the Navy (DoDI 1225.08).[17]

Risk Factors: Factors caused by stress, trauma, or other circumstances that cause a schism in protective factors. Factors that make it more likely those individuals will develop a disorder or pre-dispose one to high-risk for self-injurious behaviors. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment (DoDI 6490.16).

Selected Reserve (SELRES): Those units and individuals within the Ready Reserve designated by their respective Services and approved by the Joint Chiefs of Staff as so essential to initial wartime missions that they have priority over all other Reserves (DoDI 6490.16).

Statistically Significant: A comparison is considered statistically significant if the probability of observing that difference, or a more extreme difference, is less than 5% if there is no actual difference in the population.

Stigma: The negative perception that seeking mental health care or other supportive services will negatively affect or end their careers; a set of negative and often untrue beliefs that a society or group of people have about something (DoDI 6400.09). In the military context, this is often the negative perception that seeking mental health care or other supportive services will negatively affect or end their careers (DoDI 6490.16).

Suicidal Behaviors: Behaviors related to suicide, including preparatory acts, suicide attempts, and death (DoDI 6490.16).

Suicide: Death caused by self-directed injurious behavior with an intent to die as a result of the behavior (DoDI 6490.16).

Suicide Attempt: A non-fatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior (DoDI 6490.16).

Suicide Decedent: An individual who died by suicide.

Suicide Event Status (Pending and Confirmed) (DoDI 6490.16):

- **Pending Confirmation of Suicide:** A designation by AFMES as the manner of death when the circumstances are consistent with suicide but the determination is not yet final. Final determination may take many months. Importantly, suspected suicides are included by DSPO and AFMES when reporting suicide counts.
- **Confirmed Suicide:** A designation by AFMES that assigns suicide as the final determination of the manner of death.

Suicide Rate: The average number of deaths by suicide in a fixed population per unit of time. As suicide is relatively rare, the suicide rate is commonly standardized to deaths per 100,000 persons per year. As presented in this report, suicide rates are calculated by dividing the number of deaths by suicide in the unit of time (in DoD, typically a calendar year) by the size of the population (in DoD, the average of 12 monthly totals of the number of personnel in that population [i.e., end-strengths]).

ENCLOSURE

Calendar Year 2022 DoDSER System Data Report

Calendar Year 2022 Department of Defense Suicide Event Report

The following tables contain summary data from the Department of Defense Suicide Event Report (DoDSER). Tables 1–8 display data for Active Component events, and tables 9–12 display data for National Guard and Reserve events. Only events with a form submitted by March 31, 2023, are included in the tables. The total event counts may not correspond to the official event counts used to calculate rates.

The tables display percentages corresponding to affirmative responses to selected items in DoDSER event forms. In the tables, negative responses include instances in which information was not available or not provided. When possible, data for nested response options are provided. We did not provide data for items or categories with low counts of affirmative responses (fewer than 20 across services or overall for the National Guard and Reserve) or when there were concerns about individual-level identification. In some circumstances, we provide partial data for an item or response category and suppress low event frequencies with an asterisk (*).

The Space Force uses the DoDSER for event reporting. For calendar year (CY) 2022, there were zero deaths by suicide and five suicide-attempt forms. These forms were not included in the tables below because of the low event count.

The Defense Suicide Prevention Office (DSPO) incorporated DoDSER data and analysis into the Annual Suicide Report for CY 2022. The tables below provide reference data. The Psychological Health Center of Excellence, Research Support Division, Research & Engineering Directorate, Defense Health Agency prepared this document.

Table 1. Demographic characteristics, suicide forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Sex					
Female	7.5	7.1	3.3	9.8	10.6
Male	92.5	92.9	96.7	90.2	89.4
Identify as gay, lesbian, or bisexual	3.7	*	*	*	*
Age					
17–24	48.1	39.7	65.6	54.1	40.4
25–29	22.0	26.2	14.8	16.4	27.7
30–34	14.2	18.3	4.9	11.5	19.1
35–59	15.6	15.9	14.8	18.0	12.8
Race					
Asian/Pacific Islander	5.4	*	*	*	*
Black/African American	16.6	21.4	9.8	21.3	6.4
White/Caucasian	74.2	70.6	85.2	63.9	83.0
Other/Unknown	3.7	*	*	*	*
Hispanic ethnicity	21.7	21.4	21.3	23.0	21.3
Education					
High school graduate or less	80.0	73.8	91.8	80.3	80.9
Some college	9.8	*	*	*	*
4-year degree	10.2	*	*	*	*
Marital status					
Never married	49.2	41.3	57.4	57.4	48.9
Married	44.1	51.6	34.4	37.7	44.7
Separated/Divorced/Widowed	5.8	*	*	*	*
Unknown	1.0	*	*	*	*
Rank/grade					
E1–E4	47.1	42.1	59.0	41.0	53.2
E5–E9	42.7	47.6	32.8	50.8	31.9
Officer	8.1	*	*	*	*
Unknown	2.0	*	*	*	*
Number of contingency operations[a]					
0	56.9	52.4	67.2	62.3	48.9
1	21.4	24.6	14.8	18.0	25.5
2	11.2	11.9	9.8	11.5	10.6
3 or more	10.5	11.1	8.2	8.2	14.9
Time since end of last contingency operation					
0–24 months	8.8	6.3	4.9	8.2	21.3
25 or more months	34.2	41.3	27.9	29.5	29.8
History of direct combat	16.3	28.6	11.5	*	*

Note: Percentages based on 295 total forms (126 Army, 61 Marine Corps, 61 Navy, and 47 Air Force).
[a]Number of contingency operations outside the U.S. based on the Contingency Tracking System.
*Data not presented because of small counts.

Table 2. Event characteristics, suicide forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Occurred in the continental United States	86.8	84.1	83.6	91.8	91.5
Event setting					
Barracks/Berthing	16.6	16.7	26.2	11.5	10.6
Other military housing	9.8	11.9	4.9	8.2	12.8
Private residence	45.8	44.4	36.1	54.1	51.1
Other/Unknown	27.8	27.0	32.8	26.2	25.5
Mechanism of injury					
Firearm	66.8	69.0	60.7	63.9	72.3
Suffocation/Asphyxiation/Hanging	25.8	22.2	37.7	27.9	17.0
Other/Unknown	7.5	8.7	1.6	8.2	10.6
Communicated intent for self-harm					
Yes[a]	29.5	29.4	29.5	31.1	27.7
Mental health staff	10.5	7.9	11.5	14.8	10.6
Friend	7.8	6.3	6.6	14.8	4.3
Spouse/Partner	10.2	15.9	6.6	4.9	6.4
No	70.5	70.6	70.5	68.9	72.3
Evidence event was planned	20.3	20.6	18.0	19.7	23.4
Event observable	29.2	28.6	29.5	29.5	29.8
Left a suicide note	25.4	23.0	27.9	27.9	25.5
Residence at time of event					
Barracks/Berthing	29.2	27.0	52.5	18.0	19.1
Other military housing	9.8	11.1	4.9	9.8	12.8
Private residence	54.6	54.0	41.0	62.3	63.8
Other/Unknown	6.4	7.9	1.6	9.8	4.3
Duty environment[a]					
Garrison	78.6	81.0	82.0	67.2	83.0
Training	5.1	3.2	8.2	9.8	0.0
Other/Unknown	26.8	25.4	26.2	36.1	19.1

Note: Percentages based on 295 total forms (126 Army, 61 Marine Corps, 61 Navy, and 47 Air Force).
[a]Subcategories are not mutually exclusive.

Table 3. Behavioral health characteristics, suicide forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Any behavioral health diagnosis					
Yes[a]	45.4	44.4	50.8	39.3	48.9
Alcohol use disorder	17.6	19.0	23.0	9.8	17.0
Depressive disorder	25.4	18.3	32.8	29.5	29.8
Anxiety disorder	16.9	15.1	24.6	16.4	12.8
Trauma- or stressor-related disorder	14.2	16.7	13.1	11.5	12.8
Sleep–wake disorder	11.2	10.3	16.4	9.8	8.5
No/no known history	54.6	55.6	49.2	60.7	51.1
Psychotropic medication prescription at time of event					
Yes	29.2	23.8	29.5	29.5	42.6
Antidepressant	22.0	19.0	23.0	18.0	34.0
No/No known history	70.8	76.2	70.5	70.5	57.4
Family history of mental illness	15.3	17.5	6.6	13.1	23.4
Prior self-harm	12.5	16.7	9.8	9.8	8.5
Ever inpatient for mental health	21.0	23.8	16.4	16.4	25.5
Outpatient mental health services, last year	45.8	50.8	39.3	41.0	46.8

Note: Percentages based on 295 total forms (126 Army, 61 Marine Corps, 61 Navy, and 47 Air Force).
[a]Subcategories are not mutually exclusive.

Table 4. Contextual factors, suicide forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Intimate relationship problems, last year	42.4	42.1	57.4	29.5	40.4
Death by suicide of friend or family member, last year	5.8	*	*	*	*
Administrative/legal problems, last year					
Yes[a]	26.1	28.6	29.5	21.3	21.3
Nonjudicial punishment	8.5	13.5	*	*	*
Under investigation	14.2	18.3	16.4	4.9	12.8
Administrative separation	7.8	10.3	*	*	*
No/No known history	73.9	71.4	70.5	78.7	78.7
Financial difficulties, last year	9.8	10.3	9.8	8.2	10.6
Workplace difficulties, last year	26.1	20.6	39.3	18.0	34.0
Experienced abuse before age 18					
Yes[a]	13.6	15.9	13.1	8.2	14.9
Physical	9.2	12.7	8.2	*	*
Sexual	5.1	6.3	*	*	*
Emotional	9.8	13.5	*	*	*
No/No known history	86.4	84.1	86.9	91.8	85.1

Note: Percentages based on 295 total forms (126 Army, 61 Marine Corps, 61 Navy, and 47 Air Force).
[a]Subcategories are not mutually exclusive.
*Data not presented because of small counts.

Table 5. Demographic characteristics, suicide-attempt forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Sex					
Female	31.1	29.8	19.0	34.8	38.0
Male	68.8	70.2	81.0	64.9	62.0
Unknown	0.1	0.0	0.0	0.4	0.0
Age					
17–19	11.3	17.2	17.5	6.4	6.0
20–24	55.9	50.8	64.2	56.4	54.1
25–29	20.0	19.4	13.1	25.2	21.6
30–34	6.8	6.6	2.9	8.2	8.7
35–59	5.6	5.6	2.2	3.5	9.2
Unknown	0.3	0.3	0.0	0.4	0.5
Race					
Asian/Pacific Islander	5.6	4.4	4.4	9.6	4.7
Black/African American	25.7	30.7	16.1	27.7	27.0
White/Caucasian	63.8	61.8	76.6	56.4	61.8
Other/Unknown	4.9	3.1	2.9	6.4	6.5
Hispanic ethnicity	21.8	17.2	29.9	23.0	19.1
Education					
Up to high school graduation	87.0	82.8	96.7	91.1	80.9
Some college	7.4	10.3	*	*	11.4
4-year degree	5.5	6.6	*	*	7.7
Unknown	0.2	0.3	0.0	0.4	0.0
Marital status					
Never married	61.0	65.8	69.3	61.7	51.1
Married	34.6	30.1	28.8	34.0	42.4
Separated/Divorced/Widowed	4.2	3.8	1.8	3.9	6.5
Unknown	0.2	0.3	0.0	0.4	0.0
Rank/grade					
E1–E4	74.5	74.6	85.8	68.8	70.7
E5–E9	21.8	20.7	12.4	29.1	24.1
Officer	2.2	2.2	1.1	1.8	3.2
Unknown	1.5	2.5	0.7	0.4	2.0
Number of contingency operations[a]					
0	76.2	78.1	86.9	77.3	66.7
1	14.2	15.0	8.8	16.0	15.9
2	4.6	3.4	3.3	3.9	6.9
3 or more	5.0	3.4	1.1	2.8	10.4
Time since end of last contingency operation					
0–24 months	4.5	3.8	2.2	3.2	7.7
25 or more months	19.2	18.2	10.9	19.5	25.6
History of direct combat	5.2	7.8	4.4	1.4	6.2

Note: Note: Percentages based on 1,278 total forms (319 Army, 274 Marine Corps, 282 Navy, and 403 Air Force). Five Space Force events are not included in this table because of small event counts.
[a]Number of contingency operations outside the U.S. based on the Contingency Tracking System.
*Data not presented because of small counts.

Table 6. Event characteristics, suicide-attempt forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Occurred in the continental United States	76.3	70.5	82.1	80.1	74.2
Event setting					
Barracks/Berthing	40.4	51.1	60.9	36.5	20.6
Other military housing	11.0	11.3	7.3	4.3	17.9
Private residence	33.1	20.4	22.6	39.7	45.7
Other/Unknown	15.6	17.2	9.1	19.5	15.9
Mechanism of injury					
Cutting/Piercing	11.1	10.7	12.0	11.0	10.9
Falling	2.7	1.3	4.0	3.2	2.5
Firearm	5.4	5.3	4.0	2.1	8.7
Transportation	4.1	3.8	2.9	2.8	6.0
Poisoning	58.8	58.6	58.8	62.4	56.6
Suffocation/Asphyxiation/Hanging	14.0	16.0	16.4	12.1	12.2
Other/Unknown	3.9	4.4	1.8	6.4	3.2
Communicated intent for self-harm					
Yes[a]	16.4	21.0	11.3	9.6	20.8
Mental health staff	4.5	4.1	2.2	3.2	7.4
Friend	7.1	9.1	6.9	4.3	7.7
Spouse/Partner	5.6	7.8	3.3	2.5	7.4
No	83.6	74.6	69.7	60.3	77.2
Evidence event was planned	12.4	14.4	11.3	6.4	15.9
Event observable	29.5	25.7	32.8	23.0	34.7
Left a suicide note	11.1	14.1	7.3	9.2	12.7
Residence at time of event					
Barracks/Berthing	42.7	60.5	55.5	33.7	26.3
Other military housing	10.5	9.1	6.6	3.2	19.4
Private residence	30.0	20.4	16.1	26.2	49.9
Other/Unknown	16.7	10.0	21.9	36.9	4.5
Duty environment[a]					
Garrison	71.6	73.7	67.2	56.4	83.6
Training	6.1	11.9	7.7	0.7	4.2
Other/Unknown	26.1	16.0	29.6	45.7	17.9

Note: Note: Percentages based on 1,278 total forms (319 Army, 274 Marine Corps, 282 Navy, and 403 Air Force). Five Space Force events are not included in this table because of small event counts.
[a]Subcategories are not mutually exclusive.

Table 7. Behavioral health characteristics, suicide-attempt forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Any behavioral health diagnosis					
Yes[a]	48.4	54.9	34.3	33.3	63.5
Alcohol use disorder	10.7	14.4	10.6	7.8	9.9
Substance use disorder	4.1	7.8	2.6	2.5	3.5
Depressive disorder	31.6	30.4	24.1	24.1	42.9
Anxiety disorder	20.9	25.1	14.6	16.0	25.3
Trauma- or stressor-related disorder	20.7	24.5	13.1	15.2	26.8
Personality disorder	5.9	2.5	3.6	6.0	9.9
Sleep-wake disorder	4.1	7.8	*	*	4.5
No/No known history	51.6	45.1	65.7	66.7	36.5
Psychotropic medication prescription at time of event					
Yes[a]	35.0	37.0	25.5	24.5	47.1
Antidepressant	31.5	32.3	21.5	22.3	44.2
Anxiolytic	11.0	11.0	8.8	7.8	14.6
No/No known history	65.0	63.0	74.5	75.5	52.9
Family history of mental illness	28.8	31.0	16.4	22.0	40.2
Prior self-harm					
Yes	24.1	28.5	16.4	23.8	26.1
One prior event	14.5	16.9	8.0	13.5	17.6
More than one prior event	8.0	10.0	6.6	8.2	7.2
No/No known history	75.9	71.5	83.6	76.2	73.9
Ever inpatient for mental health	21.5	22.3	17.9	16.7	26.8
Outpatient mental health services, last year	50.9	64.6	36.5	32.3	63.0

Note: Percentages based on 1,278 total forms (319 Army, 274 Marine Corps, 282 Navy, and 403 Air Force). Five Space Force events are not included in this table because of small event counts.
[a]Subcategories are not mutually exclusive.
*Data not presented because of small counts.

Table 8. Contextual factors, suicide-attempt forms, Active Component, percent

Item	Total	Army	Marine Corps	Navy	Air Force
Intimate relationship problems, last year	38.3	37.9	24.8	27.0	55.8
Death by suicide of friend or family member, last year	7.4	11.6	5.8	5.3	6.5
Administrative/Legal problems, last year					
Yes[a]	20.2	30.1	15.3	12.1	21.3
Nonjudicial punishment	8.5	12.9	5.8	6.0	8.4
Under investigation	7.7	9.7	4.4	3.9	11.2
Administrative separation	7.3	13.8	6.2	3.2	5.7
Civil legal action	3.4	4.4	4.0	*	4.2
No/No known history	79.8	69.9	84.7	87.9	78.7
Financial difficulties, last year	10.8	16.0	3.6	8.2	13.4
Workplace difficulties, last year					
Yes	25.6	27.3	13.5	20.9	35.7
Poor performance review	7.3	8.2	4.7	3.9	10.7
Limited duty	7.2	8.2	3.3	2.8	12.2
Increase job duties	5.1	5.3	3.6	5.7	5.5
Conflict with coworkers	7.6	9.1	4.7	5.3	9.9
Conflict with command	8.8	9.7	4.4	6.4	12.9
No/No known history	74.4	72.7	86.5	79.1	64.3
Experienced abuse before age 18					
Yes[a]	32.0	40.8	20.4	18.1	42.7
Physical	17.5	24.1	9.9	10.3	22.6
Sexual	17.1	23.8	9.5	8.9	22.8
Emotional	24.4	31.7	14.6	12.4	33.7
No/No known history	68.0	59.2	79.6	81.9	57.3
Experienced assault or harassment, last year					
Yes[a]	11.3	14.7	7.3	8.9	13.2
Physical assault	5.0	8.8	3.3	2.1	5.2
Sexual assault	7.4	8.5	4.7	7.1	8.4
Sexual harassment	3.4	5.0	2.6	3.5	2.5
No/No known history	88.7	85.3	92.7	91.1	86.8

Note: Note: Percentages based on 1,278 total forms (319 Army, 274 Marine Corps, 282 Navy, and 403 Air Force). Five Space Force events are not included in this table because of small event counts.
[a]Subcategories are not mutually exclusive.
*Data not presented because of small counts.

Table 9. Demographic characteristics, National Guard (NG) and Reserve (R), percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Service				
Army	76.6	15.4	29.0	31.1
Marine Corps	NA	19.2	NA	13.3
Navy	NA	26.9	NA	22.2
Air Force	23.4	38.5	71.0	33.3
Sex				
Female	*	*	31.9	33.3
Male	*	*	66.7	66.7
Unknown	0.0	0.0	1.4	0.0
Identify as gay, lesbian, or bisexual	*	*	8.7	11.1
Age				
17–24	40.4	30.8	42.0	37.8
25–29	19.1	34.6	20.3	24.4
30–34	21.3	11.5	17.4	6.7
35–59	19.1	23.1	18.8	31.1
Unknown	0.0	0.0	1.4	0.0
Race				
Black	14.9	19.2	15.9	26.7
White	83.0	73.1	78.3	46.7
Other/Unknown	2.1	7.7	5.8	26.7
Hispanic ethnicity	10.6	15.4	14.5	13.3
Education				
High school graduate or less	63.8	73.1	34.8	64.4
Some college	27.7	15.4	56.5	20.0
4-year degree	8.5	11.5	7.2	15.6
Unknown	0.0	0.0	1.4	0.0
Marital status				
Never married	61.7	69.2	50.7	57.8
Married	27.7	26.9	42.0	35.6
Separated/Divorced/Widowed	10.6	3.8	5.8	6.7
Unknown	0.0	0.0	1.4	0.0
Rank/grade				
E1–E4	48.9	46.2	52.2	46.7
E5–E9	40.4	38.5	43.5	44.4
Officer	*	15.4	*	*
Unknown	*	0.0	*	*
Number of contingency operations[b]				
0	55.3	53.8	65.2	57.8
1	27.7	23.1	13.0	22.2
2 or more	17.0	23.1	21.7	20.0
History of direct combat	19.1	19.2	7.2	20.0

Note: Data based on 47 death and 69 attempt forms (National Guard) and 26 death and 45 attempt forms (Reserve). NA indicates that a category was not applicable.

[a]Number of contingency operations outside the U.S. based on the Contingency Tracking System.

*Data not presented because of small counts.

Table 10. Event characteristics, National Guard (NG) and Reserve (R), percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Event occurred at a private residence	76.6	61.5	59.4	44.4
Mechanism of injury				
Firearm	83.0	84.6	14.5	8.9
Poisoning	0.0	0.0	36.2	51.1
Suffocation/Asphyxiation/Hanging	10.6	15.4	18.8	11.1
Other/Unknown	6.4	0.0	30.4	28.9
Communicated intent for self-harm				
Yes[a]	38.3	15.4	17.4	24.4
Friend	29.8	*	*	11.1
Spouse/Partner	21.3	*	10.1	6.7
No/No known history	61.7	84.6	82.6	75.6
Evidence event was planned	29.8	26.9	15.9	15.6
Event observable	31.9	30.8	37.7	40.0
Left a suicide note	25.5	34.6	10.1	13.3
In a duty status at the time of the event	34.0	*	49.3	82.2

Note: Data based on 47 death and 69 attempt forms (National Guard) and 26 death and 45 attempt forms (Reserve).
[a]Subcategories are not mutually exclusive.
*Data not presented because of small counts.

Table 11. Behavioral health characteristics, National Guard (NG) and Reserve (R), percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Any behavioral health diagnosis				
Yes[a]	48.9	38.5	52.2	55.6
Depressive disorder	34.0	23.1	44.9	40.0
Anxiety disorder	25.5	23.1	27.5	26.7
Trauma- or stressor-related disorder	29.8	*	24.6	37.8
No/no known history	51.1	61.5	47.8	44.4
Psychotropic medication prescription at time of event	23.4	26.9	34.8	42.2
Family history of mental illness	*	*	27.5	26.7
Prior self-harm	27.7	*	23.2	28.9
Ever inpatient for mental health	17.0	*	15.9	22.2
Outpatient mental health services, last year	25.5	34.6	44.9	51.1

Note: Data based on 47 death and 69 attempt forms (National Guard) and 26 death and 45 attempt forms (Reserve).
[a]Subcategories are not mutually exclusive.
*Data not presented because of small counts.

Table 12. Contextual factors, National Guard (NG) and Reserve (R), percent

Item	NG, Suicide	R, Suicide	NG, Suicide attempt	R, Suicide attempt
Intimate relationship problems, last year	40.4	26.9	33.3	26.7
Death of friend or family member, last year	10.6	0.0	*	13.3
Administrative/Legal problems, last year	19.1	19.2	17.4	13.3
Financial difficulties, last year	14.9	23.1	27.5	20.0
Workplace difficulties, last year	29.8	19.2	26.1	31.1
Experienced abuse before age 18				
Yes[a]	14.9	0.0	17.4	37.8
Physical	10.6	0.0	7.2	17.8
Sexual	*	0.0	7.2	22.2
Emotional	12.8	0.0	14.5	26.7
No/No known history	85.1	100.0	82.6	62.2
Experienced assault or harassment, last year	*	0.0	*	11.1

Note: Data based on 47 death and 69 attempt forms (National Guard) and 26 death and 45 attempt forms (Reserve).
[a]Subcategories are not mutually exclusive.
*Data not presented because of small counts.

Methods

Suicide Case Definition

"Death by suicide" includes all deaths where the manner was confirmed or suspected (pending confirmation) as suicide. This report does not include events that occurred among Service members in a permanent absent-without-leave or deserter status. The Armed Forces Medical Examiner System (AFMES) maintains a case list of deaths by suicide among Service members in the Active Component or active-duty National Guard and Reserve. Service-specific Suicide Prevention Program Managers provide information on deaths by suicide that occur among members of the National Guard and Reserve who were not in a duty status at the time of death.

Suicide Attempt Case Definition

Per the Centers for Disease Control and Prevention, a suicide attempt is defined as a self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence of intent to die.

Data Collection

Trained behavioral health providers and command officials on military installations and at medical treatment facilities collect data for each case of suicide and suicide attempt. Common sources of data for these cases include medical, personnel, and investigative records. Form completers may interview the Service member (suicide attempts). If authorized, form completers may conduct interviews with spouses, extended family, friends, and/or peers.

Other Data Sources

The AFMES provides data about the official manner and cause of death. These data come from military or civilian autopsy reports, death certificates, written reports from military investigative agencies, or a verbal report from a civilian death investigator or coroner.

DMDC provides demographic data from the Defense Enrollment Eligibility Reporting System for all events submitted to the DoDSER system. DMDC also provides contingency operations data from the Contingency Tracking System, the repository of official deployment-related information.

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DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

State of Homelessness Services

Homelessness in Arizona Annual Report 2023

Arizona Department of Economic Security

December 2023

Governor Katie Hobbs

Executive Deputy Director, Angie Rodgers

State of Homelessness Services

Homelessness in Arizona Annual Report 2023

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Pursuant to Arizona Revised Statutes § 41-1954, the following Homelessness in Arizona Annual Report provides information about the status of homelessness in Arizona, and efforts to prevent and alleviate homelessness during State Fiscal Year (SFY) 2023, including trends, demographics, and recent efforts designed to prevent and alleviate homelessness across Arizona.

EXECUTIVE SUMMARY

Arizona has experienced a rise in homelessness. As of January 2023, it is estimated that 14,237 Arizona residents were experiencing homelessness, which is a 29 percent increase from the January 2020 estimate of 10,979.

There are a multitude of factors that contribute to homelessness, many of which were exacerbated by the pandemic, including job loss and underemployment, mental or behavioral health challenges, substance use issues, experiences of interpersonal violence, and the overall lack of affordable housing across the state. Much like the diversity of Arizona's rural and urban communities, Arizona's homeless population is also diverse. Demographic factors, such as gender, race, and ethnicity, are over or under-represented in the homeless population relative to the general population. Among the subgroups of Arizona's homeless population, data shows that men are more likely to experience homelessness than females, representing nearly 65 percent of those counted as experiencing homelessness in 2023[1].

Race is another significant factor, with historically marginalized groups such as Black Americans, tribal populations, and Hispanic/Latino populations being more likely to experience homelessness due to higher unemployment rates, lower incomes, less access to healthcare, and higher rates of justice system involvement and/or incarceration. Of the over 14,000 people experiencing homelessness in January 2023, nearly 22 percent of those experiencing homelessness identified as Black or African American, which is disproportionate compared to the percentage of total population in the United States, which is 14.2 percent according to a United States Census Bureau 2022 American Community Survey (ACS) estimate[1].

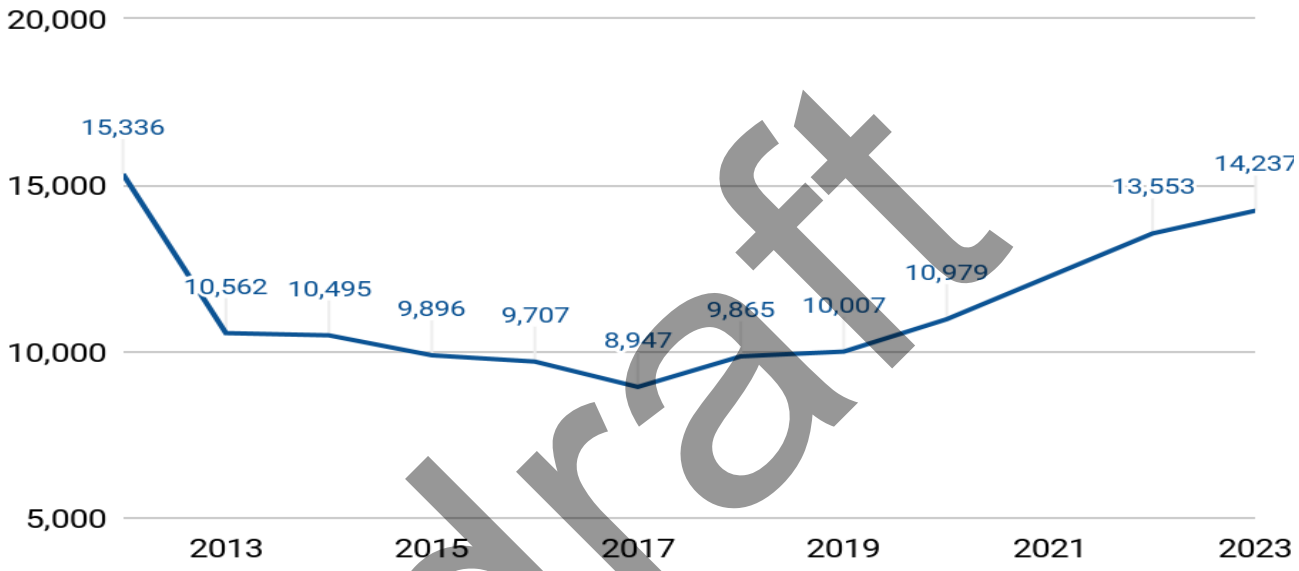
In SFY 2023, nearly 40,000 individuals identified through a federal assessment as at risk of or experiencing homelessness received intervention services. Historically, permanent housing programs like Rapid Rehousing (RRH), Permanent Supportive Housing (PSH), and Housing Choice Vouchers have provided the best outcomes for individuals and families. However, Arizona's lack of affordable housing has limited the ability to use these options effectively. Likewise, the pandemic negatively impacted communal living for the homeless. Many shelters continue to operate at reduced capacity levels, and/or with limited staff compared to pre-pandemic services. These conditions have unearthed

[1] U.S. Census Bureau 2022 American Community Survey: https://www.census.gov/programs-surveys/acs/data.html

new and different challenges for many service providers in effectively reaching and serving individuals and families in need.

Between 2012 and 2020, Arizona's total homeless population decreased by 33 percent, from 15,336 Arizonans experiencing homelessness in 2012 to 10,979 in 2020. However, homelessness has been steadily rising and has increased by over 29 percent since 2020. Specifically, Arizona's unsheltered populations have greatly increased. Those who are unsheltered are categorized as sleeping in a place not designed for or ordinarily used as a regular sleeping accommodation (e.g., abandoned buildings, train stations, or camping grounds) as "unsheltered" homeless. In the last five years, unsheltered homelessness has increased by almost 73 percent, from 3,549 in 2019 to 7,615 in 2023[2].

Figure 1: Number of individuals experiencing homelessness in Arizona, 2012-2023



**NOTE: 2021 Point-in-Time count has been excluded due to the COVID-19 Pandemic*

In continued efforts to combat sheltered and unsheltered homelessness, the Arizona Department of Economic Security (ADES/Department) partners with other state agencies, local governments, and

[2] National Low Income Housing Coalition report, The Gap: A Shortage of Affordable Rental Homes: https://nlihc.org/housing-needs-by-state/arizona

nonprofits across all 15 counties to implement statewide strategies, approaches, and coordination to assist individuals and families experiencing homelessness in finding housing, and regaining and sustaining independence.

AFFORDABLE HOUSING CRISIS

The United States Department of Housing and Urban Development (HUD) defines affordable housing as a permanent dwelling, including utilities that a household can obtain for no more than 30 percent or less of its annual income (although this percentage varies slightly by city). Expending more than the 30 percent standard creates living instability, as households may then be unable to afford other basic necessities such as food, clothing, transportation, and medical care.

In Arizona, and across the nation, affordable housing remains a scarcity. According to annual data released by the National Low Income Housing Coalition, there is a nationwide shortage of 7.3 million affordable and available homes for renters with extremely low incomes, which is considered incomes at or below either the federal poverty guideline or 30 percent of their area median income, whichever is greater. In Arizona, 20 percent of renters are extremely low income, with a maximum income of $26,500 per year for a four-person household. Meanwhile, it is estimated that the annual income needed to afford a two-bedroom rental home at HUD's Fair Market Rent is $62,252 annually, resulting in a shortage of 136,282 affordable rental homes available to one-fifth of Arizona's lowest-income renters. This leaves 80 percent of these vulnerable low-income households severely cost-burdened, meaning more than half of their monthly household income is spent on housing. This has played a significant role in causing unstable housing situations and leading to increased rates of evictions and foreclosures across Arizona, and nationwide.

POINT-IN-TIME COUNT AND VULNERABLE POPULATIONS

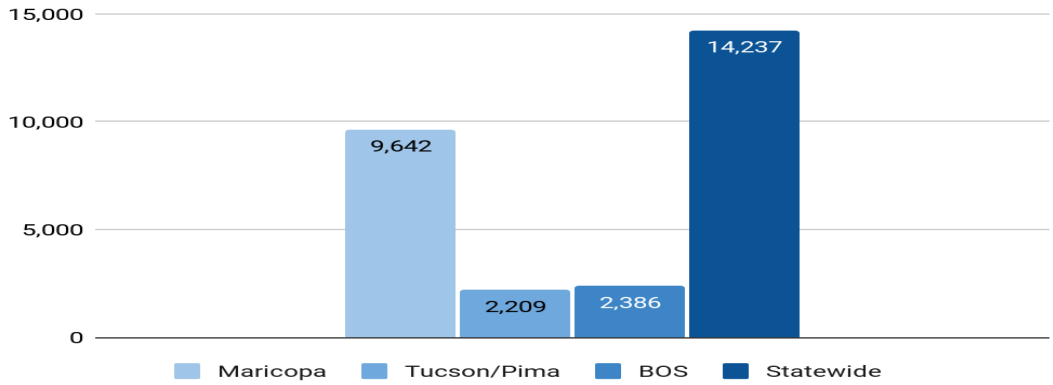
Arizona's homeless services are divided into three service areas referred to as Continuums of Care (CoC). The Maricopa Regional CoC serves Maricopa County, the Tucson Pima Collaboration to End Homelessness serves Pima County, and the Balance of State (BOS) Continuum, managed by the Arizona Department of Housing, serves the remaining 13 counties of the state.

Estimates of the number of people experiencing homelessness in Arizona vary. One of the tools utilized to estimate the number of homeless individuals in Arizona is the annual Point-in-Time (PIT) Homeless Count. On a single day in late January, the PIT count is conducted by regional CoCs each year nationwide as a requirement of the United States Department of HUD to identify the extent of homelessness across the country. The PIT count includes a survey to help communities and providers identify the needs and characteristics of those experiencing homelessness.

In 2023, the PIT count of sheltered individuals statewide was 7,615, and the unsheltered PIT count was 6,622, for a total of 14,237 people experiencing homelessness across Arizona. This represents a nearly 35 percent increase from the 2019 estimated total five years prior[3]. Additionally, PIT count results over this most recent five-year period illustrate that the number of sheltered individuals has remained consistent; however, the unsheltered count in Arizona has increased at a higher rate than the sheltered and overall PIT count.

[3] Aggregated 2023 Point in Time (PIT) Count survey results across Arizona's three CoC: Maricopa Regional CoC PIT 2023 results: Tucson/Pima CoC PIT 2023 results: Balance of State CoC PIT 2023 results:

Figure 2: Number of people experiencing homelessness by CoCs during the 2023 PIT count

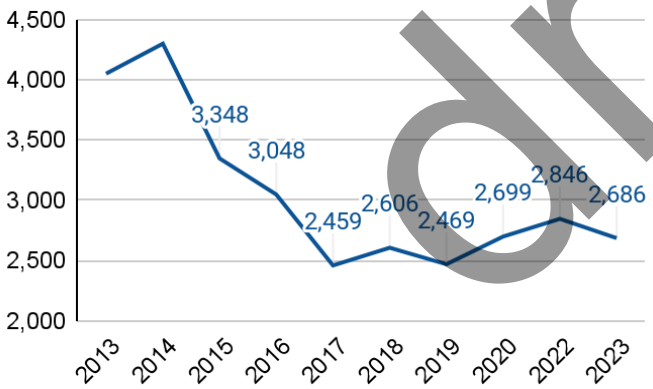


Experiencing Homelessness

Despite rising costs of living and increases in overall homelessness, homelessness among families in Arizona has decreased by over 33 percent, from 4,052 people in families experiencing homelessness in 2013, to 2,686 people in families statewide in 2023[4]. However, regionally, Maricopa County has seen a 14 percent increase in family homelessness over a five-year period from 2017 to 2023.

For the purposes of the PIT count and homelessness services, families are defined as households with at least one adult and one child.

Figure 3: People in Families Experiencing Homelessness in Arizona (2013-2023)



Among the families identified as experiencing homelessness in 2023, most were in either Emergency Shelter (ES) or transitional housing. However, due to tendencies to sleep in vehicles or other hidden areas, this count of family homelessness is an approximation. Many family service providers conducted interview surveys over the phone to better count.

**NOTE: The 2021 unsheltered PIT count was not conducted due to the COVID-19 Pandemic.*

Veteran Homelessness

The 2023 PIT count identified 929 self-reported veterans without homes across Arizona, representing an 8 percent increase statewide since 2022. Despite Maricopa County seeing a 15 percent decrease in veteran homelessness from 2020 to 2022, the number of individuals experiencing homelessness who self-reported as veterans since 2022 increased 20 percent, for a total of 505 in January 2023. However, in the Tucson/Pima region, there was a 5.6 percent decrease in overall veteran homelessness since 2022, including a 41.5 percent decrease in unsheltered veterans in 2023, down to 63 from 96 percent. This decrease in homeless veterans in the Tucson/Pima region may result from

[4] Aggregated reports for Arizona's three CoCs from the Homeless Management Information Systems (HMIS)

the Supportive Services for Veteran Families funding awarded to Arizona service providers, as well as the Veterans Affairs Supportive Housing voucher program administered by several public housing agencies.

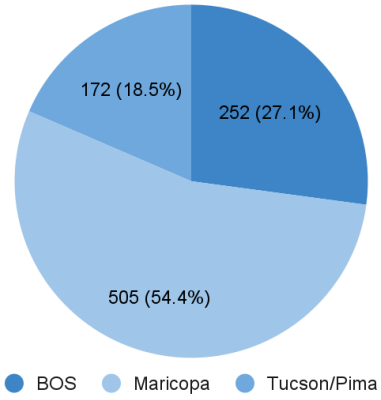


Figure 4: Regional Breakdown of Veterans Experiencing Homelessness in 2023

Chronic Homelessness

Chronic homelessness is defined as individuals or families that have been experiencing homelessness continuously for one year or four or more times in the last three years, where the combined length of time homeless is at least 12 months. The number of households meeting this definition has significantly increased over time, indicating that more support services are needed to assist individuals in obtaining and maintaining housing. Unfortunately, Arizona's rate of chronic homelessness increased 197 percent in ten years from 2013-2023

Figure 5: Chronic Homelessness in Arizona from 2013-2023

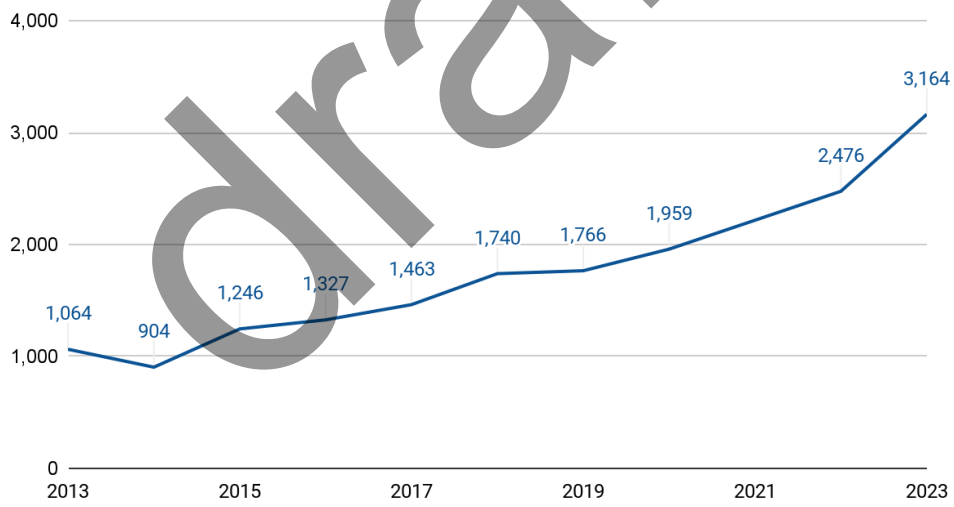
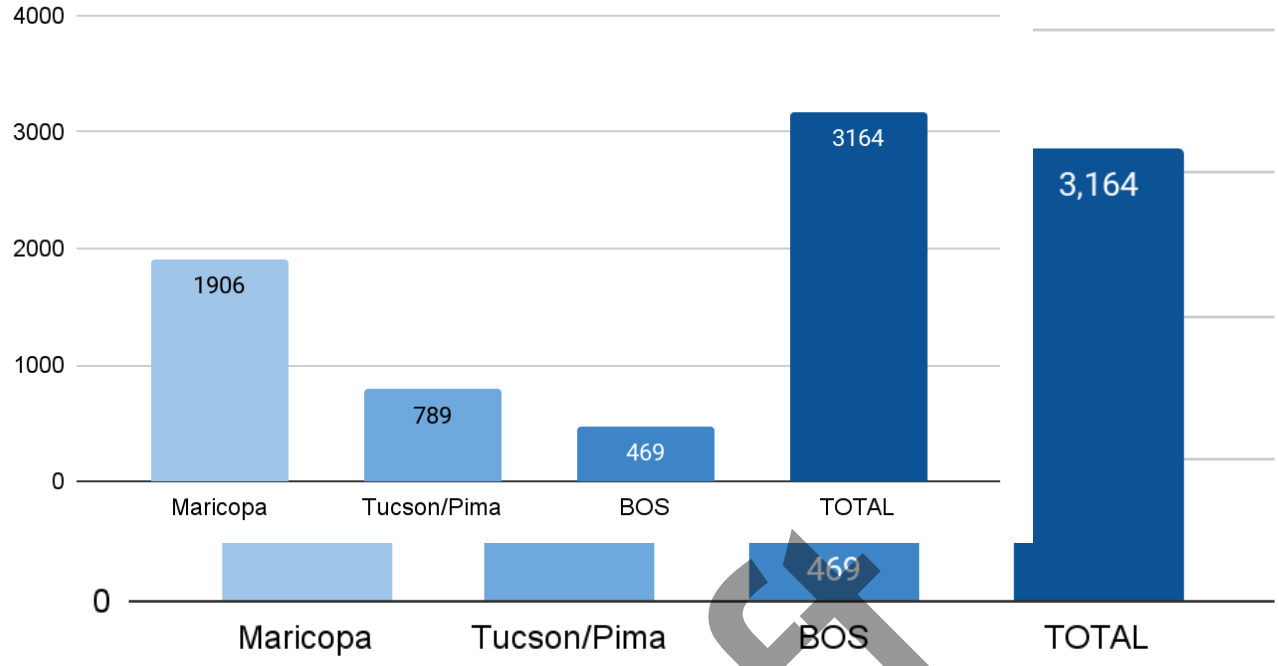


Figure 6: Individuals experiencing chronic homelessness in Arizona in 2023

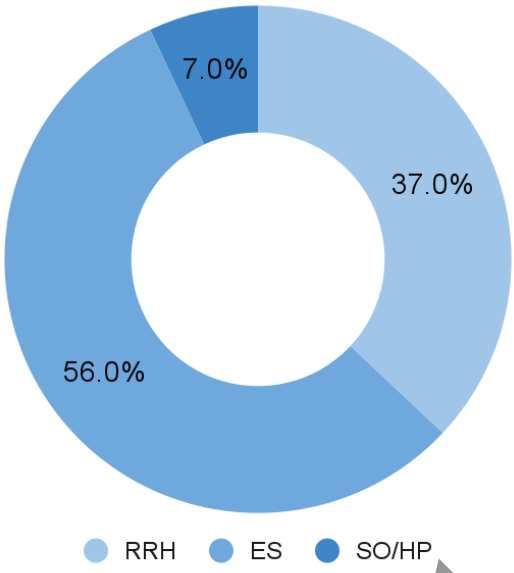


INVESTMENT

The Department's Homeless Services Program is funded by various sources, including federal, state, and other funds. The federal sources comprise the Coronavirus Aid, Relief, and Economic Security Act, Emergency Solutions Grant (ESG), Social Services Block Grant, and Temporary Assistance for Needy Families. The state sources include the Arizona State Lottery and General Fund. Additionally, ADES received $4 million in one-time funding through the American Rescue Plan Act to establish Homeless Youth services.

In SFY 2023, homeless services funds were allocated to homeless service providers across the state, contracted between July 1, 2022, through June 30, 2023. These homeless services funds were allocated using a combination of data sources, including Census data and the reported number of persons experiencing homelessness in all three of Arizona's CoC. This methodology was applied to existing contracts and resulted in a proportional allocation to Maricopa County, the Tucson/Pima region, and the BOS Continuum of Care to serve Arizona's remaining 13 counties. Of these homeless services funds, over 56 percent was directed at Emergency Shelter (ES), 37 percent was committed to RRH Programs, and the remaining 7 percent to Homeless Prevention (HP) and Street Outreach (SO).

Figure 7: Percent of ESG services provided in 2023



COORDINATED ENTRY AND HOUSING FIRST

Federally funded homeless programs are required to utilize a *coordinated entry* process. Coordinated entry is an approach to coordination and management of a crisis response system's resources to efficiently and effectively connect individuals to housing and service interventions that will rapidly end their homelessness. Through coordinated entry, CoCs prioritize housing and intervention services based on an individual's vulnerability.

The coordinated entry process paves the way for more efficient homeless assistance and is a system-wide process developed to ensure that all people experiencing homelessness have fair and equal access to needed and available resources. They are to be quickly identified, assessed, referred, and connected to housing and assistance based on their strengths and needs. All ESG-funded agencies participate in coordinated entry and receive referrals utilizing all of their resources to provide ES, PSH, and RRH to stabilize households and end their homelessness.

Housing First is an evidence-based approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions. Supportive services are also offered to maximize stability and prevent returns to homelessness. Permanent housing, a safe place to lay one's head each night, is the most significant and essential need for all individuals.

Homeless service providers contracted with ADES operate under the Housing First philosophy. Once the individuals or families are safely housed, the provider will work with them and utilize community resources to provide supportive services. At this point, both physical and emotional wellness will be fully pursued. The providers will work with these individuals and families in obtaining stability by addressing and attempting to remove any barriers that have prevented them from living stable, self-sufficient, and fulfilling lives.

INTERVENTIONS AND PLACEMENTS

The Department has helped to prevent and intervene in homelessness through the Emergency Rental Assistance Program (ERAP), ESG, domestic violence services, and other human services and workforce resources that enable households to address immediate needs, create pathways to economic independence, and avoid the significant and compounding downstream costs of trauma and homelessness.

In compliance with coordinated entry and Housing First best practices, ADES-contracted providers serve Arizona's homeless population through four methods: SO, ES, RRH, and HP.

Emergency Rental Assistance

In partnership with other ERAP jurisdictions, ADES maintained access to emergency rental assistance statewide by reallocating $248M and expanding service areas to serve Yuma County, Phoenix, and Mesa. The ADES ERAP provides rent and utility assistance to eligible Arizona renters impacted by the pandemic, allowing eligible households to receive assistance with past-due, current, and future obligations. In SFY 2023, over $200 Million in assistance helped prevent the eviction and disruption of utilities to over 83,000 households across the state.

Street Outreach

SO involves homeless service providers going out into the community to meet with unsheltered homeless individuals where they reside to provide resources and essential services. It pursues and attempts to engage individuals who may be disconnected or alienated from mainstream services and are living on the streets, in their cars, in encampments, and in other places not designed for human habitation. This intervention is critical for individuals who choose to live on the street and lack access to or knowledge of available services.

Emergency Shelter

ES is a temporary intervention that provides sleeping accommodation, meals, supportive wraparound services, and case management designed to assist individuals and families in their immediate need and transition to permanent housing. This may include communal living or hotel/motel vouchers when shelters are not present in the community. As illustrated by Figure 9 below, ES is the intervention that serves the most people. Many individuals are able to stabilize themselves and get rehoused after a short stay in a shelter. All shelters should operate using a low-barrier model to ensure they are serving the most vulnerable in the community.

Rapid Rehousing

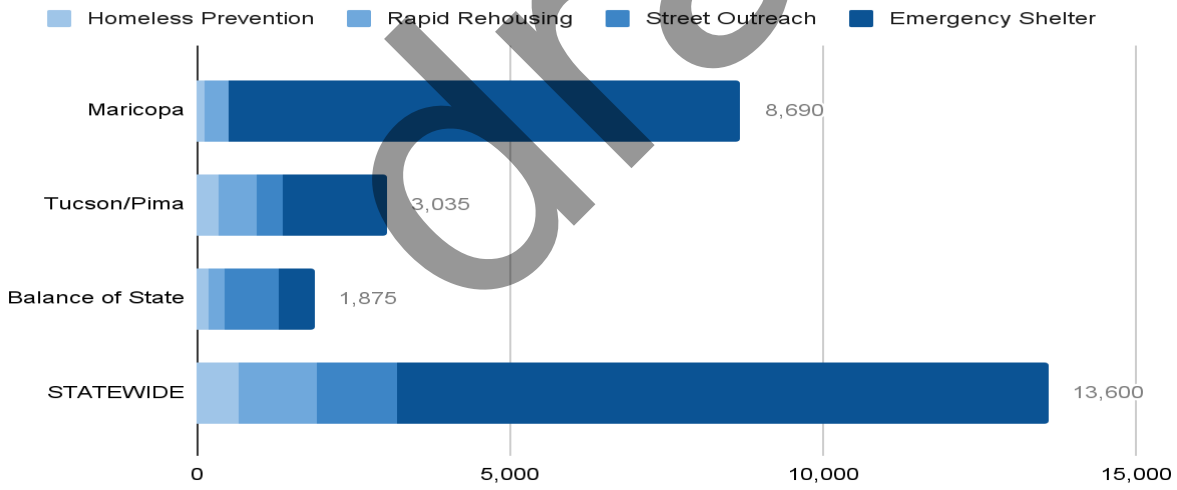
The RRH Program provides case management and financial assistance to households experiencing homelessness. This assistance includes financial relief toward monthly rent obligations, security deposits and fees, and utility assistance. Rental assistance is paid up to 100 percent initially but gradually steps down as the individual is able to pay rent in its entirety. RRH prioritizes moving individuals and their families into permanent housing as quickly as possible. Typically, this is within 90 to 180 days of entering the program. This temporary intervention lasts from three to 24 months, based on that household’s need and situation.

Homeless Prevention

There has been an increase in individuals seeking HP assistance due to rising costs of living, increasing housing expenses, and record-breaking eviction filings – in Maricopa County in particular – where there were over 7,600 evictions in the month of August 2023, surpassing previous evictions records set at the height of the housing market crash in August and September 2005[5]

HP is an expedited intervention that provides rental assistance and case management to prevent individuals from becoming homeless. This can include utility arrearages, security deposits, and mediation programs for landlord-tenant disputes. Once an individual becomes homeless, the challenges and barriers they face to becoming stably housed again increase exponentially. HP alleviates those burdens by keeping them in their current home.

Figure 8: ESG services provided in SFY 2023



Domestic Violence Services

Additionally, interpersonal violence is an issue closely related to homelessness. The ADES Domestic Violence Services Fund provides ES, Transitional Housing, and Housing Intervention. In SFY 2023, 4,246

[5] Macdonald-Evoy, Jerrod, "Surge in Maricopa County evictions continues, with no sign of slowing," Arizona Mirror. Published September 14, 2023: https://www.azmirror.com/2023/09/14/surge-in-maricopa-county-evictions-continues-with-no-sign-of-slowing/

adults and children received ES, 304 adults and children received Transitional Housing, and 95 households received Housing Intervention Services.

CONCLUSION

The increasing homeless population in Arizona continues to impact providers and has forced creative solutions to address the needs of clients. Continued coordination between state agencies, and providers, and the availability of supportive services will be essential to addressing homelessness in Arizona. Building upon the lasting work that has been done, the ADES Homeless Coordination Office, in collaboration with statewide partners, remains committed to and engaged in all community-wide efforts and plans to reduce and alleviate homelessness, including participation in the four workgroups of the Governor's Interagency and Community Council on Homelessness , and coordinating within the Department to build agency connections to a variety of supportive services, including ARIZONA@WORK, food assistance and hunger relief, Low Income Housing Energy Assistance , child care assistance, and more. Through these collaborative efforts, ADES will continue to strengthen individuals, families, and communities for a better quality of life, and a thriving Arizona.

Information and data for this report are derived from the following sources:

- Aggregated reports for Arizona's three CoCs from the Homeless Management Information Systems
- United States Census Bureau 2022 ACS: https://www.census.gov/programs-surveys/acs/data.html
- National Low Income Housing Coalition report, *The Gap: A Shortage of Affordable Rental Homes:* https://nlihc.org/housing-needs-by-state/arizona
- Annual PIT surveys, conducted annually the last week of January
    - Maricopa Regional CoC PIT 2023 results: https://azmag.gov/Portals/0/Homelessness/PIT-Count/2023/2023-PIT-Count-Report-Final.pdf?ver=8CRzv7xw28C-V2G0sMdKfw%3d%3d
    - Tucson/Pima CoC PIT 2023 results: https://tpch.net/wp-content/uploads/TPCH-2023-Point-in-Time-Count-Housing-Utilization-Report-5.15.23.pdf
    - BOS CoC PIT 2023 results: https://housing.az.gov/sites/default/files/documents/files/2023-AZBOSCOC-PIT-Count-Submitted-to-HUD_4-2023.pdf
- [1]Macdonald-Evoy, Jerrod, "Surge in Maricopa County evictions continues, with no sign of slowing," *Arizona Mirror.* Published September 14, 2023: https://www.azmirror.com/2023/09/14/surge-in-maricopa-county-evictions-continues-with-no-sign-of-slowing/

National Strategy for Preventing Veteran Suicide

2018–2028

U.S. Department of Veterans Affairs

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Preface From Dr. Carolyn Clancy

Executive in Charge, Office of the Under Secretary for Health

We are pleased to share with you the National Strategy for Preventing Veteran Suicide, which provides a road map for how the U.S. Department of Veterans Affairs (VA) intends to address the tragedy of suicide among Veterans.

Suicide is a national public health issue that impacts people from all walks of life, regardless of whether or not they have served in the military. According to data released by the Centers for Disease Control and Prevention (CDC), suicide was the 10th leading cause of death across all ages in 2016, claiming the lives of nearly 45,000 people.[1] It is estimated that Veteran suicides represent approximately 22 percent of all suicide deaths in the U.S.

In the Department of Veterans Affairs FY 2018–2024 Strategic Plan, we have identified preventing Veteran suicide as our highest clinical priority, one that will require all of government, as well as public-private partnerships, to achieve. We know that suicide is preventable, and we all have a role to play in saving lives. We must act now to save lives and help those who have served our nation live healthy, productive lives.

Suicide is a complex problem, and it requires coordinated, evidence-based solutions that reach beyond the traditional medical model of prevention. Ensuring access to quality mental health services for those in need is one part of a broader solution, but not sufficient on its own.

VA has embraced a comprehensive public health approach to reduce Veteran suicide rates, one that looks beyond the individual to involve peers, family members, and the community. Yet we know we cannot do it alone, as roughly half of all Veterans in the U.S. do not receive services or benefits from VA. This means we must collaborate with partners and communities nationwide to use the best available information and practices to support all Veterans, whether or not they're engaging with VA.

It is our hope that the National Strategy for Preventing Veteran Suicide will serve as a road map to all stakeholders that share our determination to prevent Veteran suicide.

Thank you to all those working with us to achieve our mission.

Carolyn M. Clancy, M.D.
Executive in Charge

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2016). Accessed March 2, 2018, at www.cdc.gov/injury/wisqars.

A Letter From Dr. David Carroll

Executive Director, Office of Mental Health and Suicide Prevention

As the Executive Director of the Office of Mental Health and Suicide Prevention at the U.S. Department of Veterans Affairs (VA), I am honored to present this strategy for preventing suicide among Veterans.

VA is determined to reduce the number of Veteran deaths by suicide, saving lives by using prevention strategies that are based on the best evidence available. This plan offers guidance to VA and its stakeholders — other federal agencies, state and local governments, health care systems, community organizations, and other public and private institutions — so that we can begin making progress toward reducing suicide rates among Veterans in the next several years.

VA has made great strides in Veteran suicide prevention, especially in crisis intervention. But if we are going to end Veteran suicide, then we must continuously work to prevent it before Veterans reach a crisis point. This will require VA to expand our treatment and prevention efforts to address issues that arise well before a suicidal crisis, while also continuing to expand our crisis intervention services. And that is exactly what we aim to achieve with this strategy.

This strategy has been modeled after the 2012 National Strategy for Suicide Prevention, released by the Office of the Surgeon General and the National Action Alliance for Suicide Prevention. VA executive leadership participates in the Action Alliance, a body of professionals across the public and private sectors that collectively work toward zero suicide nationwide. In conjunction with our goal to prevent Veteran suicide, VA supports the national goal of reducing suicide in the U.S. by 20 percent by the year 2025.

In this National Strategy for Preventing Veteran Suicide, the goals and objectives of the 2012 National Strategy have been adapted to address suicide prevention among Veterans. This plan reflects VA's vision for a coordinated national strategy to prevent suicide among *all* Veterans — one that maintains VA's focus on high-risk individuals in health care settings but also incorporates broad public health approaches for prevention, with an emphasis on comprehensive, community-based approaches. We want to underscore two key themes of this strategy:

- **Collaboration:** A coordinated effort at the federal, state, and local levels is key to preventing Veteran suicide.
- **Urgency:** The magnitude of the loss of Veteran life to suicide is not acceptable, and urgent action is needed to prevent these tragic deaths.

Together, we can and will save Veterans' lives, and we will not stop in our efforts to work to end suicide among Veterans.

David Carroll, Ph.D.
Executive Director

Dedication

To Veterans who have lost their lives by suicide,

to Veterans who have thoughts of suicide,

to Veterans who have made an attempt on their lives,

to those caring for a Veteran,

to those left behind after a death by suicide,

to Veterans in recovery, and

to all those who work tirelessly to prevent Veteran suicide and suicide attempts in our nation.

We believe that we can and will make a difference.

Introduction

Background

Suicide is a public health challenge that causes immeasurable pain among individuals, families, and communities across the country. Suicide is also preventable. Veteran suicide is an urgent issue that the U.S. Department of Veterans Affairs (VA), along with its stakeholders, partners, and communities nationwide, must address. VA supports the national goal of reducing the annual suicide rate in the U.S. 20 percent by the year 2025 and is implementing a public health approach to achieve this mission.

Suicide prevention is VA's highest priority, and VA has made great strides in Veteran suicide prevention, especially in crisis intervention. We will not relent in our efforts to connect Veterans who are experiencing an emotional or mental health crisis with lifesaving support. Mental health and crisis support services are critical for people showing signs of suicide risk in their thoughts or behavior, but we must go beyond engaging mental health providers, to involve the broader community and reach Veterans where they live and thrive — before they reach a crisis point.

As a national leader in suicide prevention and the nation's largest integrated health care system, the Veterans Health Administration has unparalleled experience in preventing Veteran suicide. But the agency by itself cannot adequately confront the issue. While VA encourages Veterans to seek and use its services and benefits, the reality is that many Veterans do not engage with VA. To serve all Veterans, VA must build effective networks of support, communication, and care across the communities in which Veterans live and work every day. With resources and services working in a coordinated manner, we as a nation can prevent these tragic deaths by suicide.

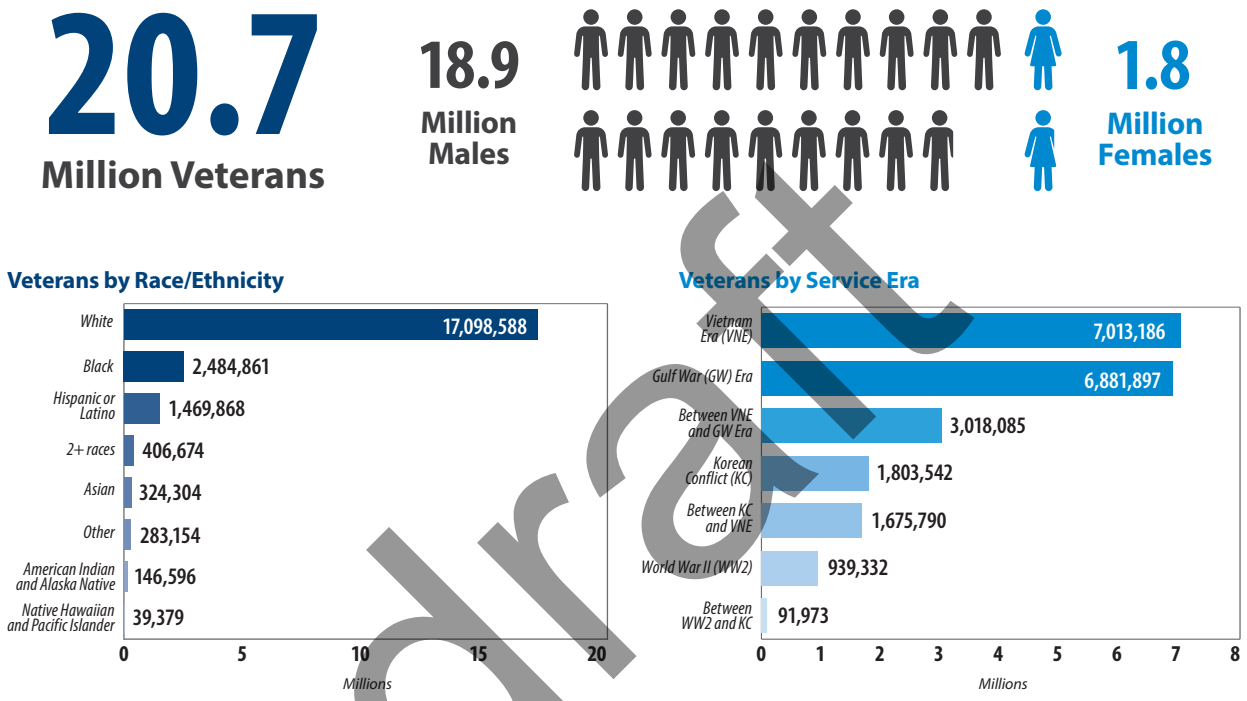
To accomplish this, VA has developed the National Strategy for Preventing Veteran Suicide in alignment with the 2012 National Strategy for Suicide Prevention. The purpose of the National Strategy for Preventing Veteran Suicide is to provide a framework for identifying priorities, organizing efforts, and contributing to a national focus on Veteran suicide prevention over the next several years. Data and figures referred to in this strategy reflect the most current, publicly available data at the time of publication.

Key Facts About Veterans

There are approximately 20 million Veterans in the U.S.[2]

Figure 1 depicts the composition of the Veteran population in the U.S. based on gender, race and ethnicity, and service era.

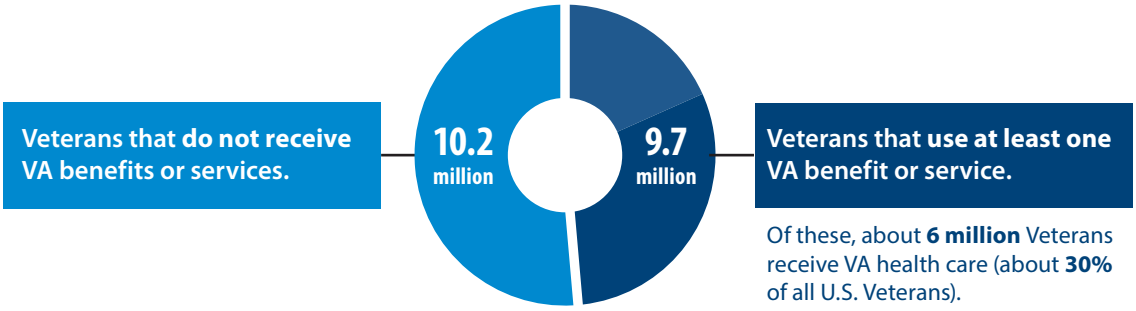
Figure 1: *The U.S. Veteran Population*



Of the approximately 20 million Veterans in the U.S. — who include almost 2 million women — less than 10 million[3] receive one or more benefits or services from VA. Of these, approximately 6 million receive VA health care, as depicted in Figure 2.[4]

2. U.S. Department of Veterans Affairs, *Table 1L: VETPOP2016 Living Veterans by Period of Service, Gender, 2015-2045, 9/30/2015* (n.d.). Accessed March 2, 2018.
3. U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Statistics at a Glance* (Dec. 31, 2017). Accessed March 2, 2018, at www.va.gov/vetdata/docs/Quickfacts/Stats_at_a_glance_2_2_18.PDF.
4. U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *VA Utilization Profile FY 2016* (2017). Accessed March 2, 2018, at www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile.pdf.

Figure 2: *Number of Veterans Who Do and Do Not Receive VA Benefits or Services*



Veterans between the ages of 25 and 34 and over the age of 65 are more likely to use VA benefits compared with Veterans of other ages.[5]

Although only about 30 percent of Veterans receive VA health care and fewer than 50 percent use any VA benefits or services at all, VA believes it is our responsibility to work with partners, communities, and like-minded organizations to prevent suicide among all Veterans — even those who do not use VA health care, services, or benefits.

Key Facts About Veteran Suicide

There is no single cause of suicide. Suicide deaths reflect a complex interaction of risk and protective factors at the individual, community, and societal levels.

Risk factors are characteristics associated with a greater likelihood of suicidal behaviors. Some risk factors for suicide include:

- A prior suicide attempt
- Mental health conditions
- Stressful life events such as divorce, job loss, or the death of a loved one
- Availability of lethal means

Protective factors can help offset risk factors. These are characteristics associated with a lesser likelihood of suicidal behaviors. Some protective factors for suicide include:

- Positive coping skills
- Having reasons for living or a sense of purpose in life
- Feeling connected to other people
- Access to mental health care

In addition to the protective factors described above, Veterans may possess unique protective factors related to their service, such as resilience or a strong sense of belonging to a unit. They may also possess risk factors related to their military service, such as service-related injury or a recent transition from military service to civilian life. Preventing Veteran suicide requires strategies that maximize protective factors while minimizing risk factors at all levels throughout communities nationwide.

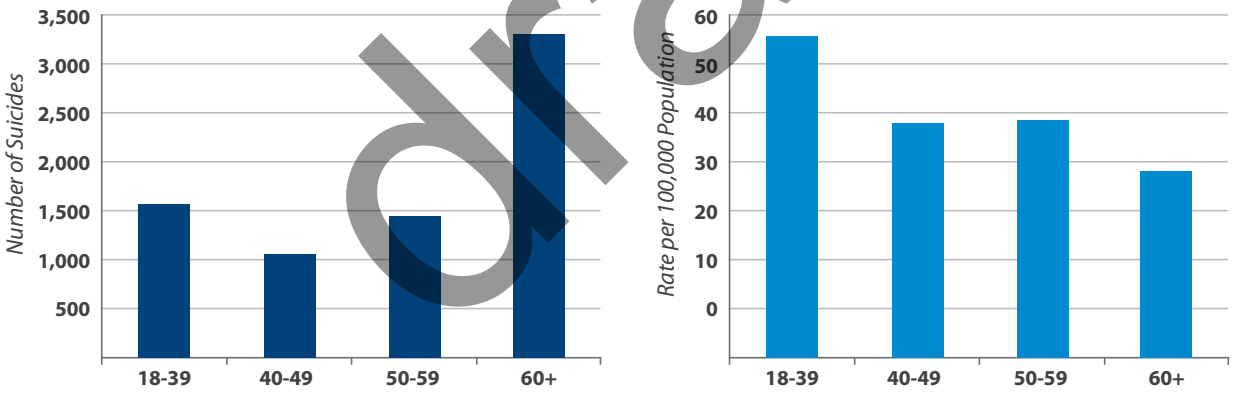
5. U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *VA Utilization Profile FY 2016* (2017). Accessed March 2, 2018, at www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile.pdf.

Veteran suicide rates and numbers of deaths vary across regions and demographics. Recent data suggest that:

- **An average of 20 Veterans die by suicide each day.**[6] About six of the 20 are recent users of Veterans Health Administration services. On average, there are 93 suicides among the general U.S. non-Veteran adult population per day.[7]
- **Overall, the trend among rates of Veteran suicide mirrors those of the general population across geographic regions**, with the highest rates in western states. While rates of suicide are higher in some states with smaller populations, the largest numbers of Veteran suicides are in the heaviest populated areas of the nation.
- **The burden of suicide resulting from firearm injuries is high.** About 67 percent of all Veteran deaths by suicide were the result of firearm injuries.
- **Rates of suicide are highest among younger Veterans** (ages 18–29) and lowest among older Veterans (ages 60 and older).
- **Despite comparatively lower rates, the largest number of deaths by suicide is among middle-age and older adult Veterans.** Approximately 65 percent of all Veterans who died by suicide were age 50 or older.

The distinction between rates and counts of deaths is illustrated in Figure 3 below. While *rates* are lower among the older Veteran population, the bulk of the *count* of suicide deaths occurs in this age group due to the large size of the population. The younger Veteran population, which includes more recently transitioned Veterans, is smaller. This population has a smaller *count* of suicide deaths, but a higher *rate* of suicide.

Figure 3: *Veteran Suicide Deaths: Count vs. Rate*



Older Veteran population accounts for the bulk of suicide deaths. This is because of the population's size.

Younger Veteran population includes more recently transitioned Veterans and has a higher rate of suicide.

VA works to provide the best-quality, most timely data about Veterans and Veteran suicide so that all stakeholders interested in preventing suicide may benefit from the insights.

6. U.S. Department of Veterans Affairs, Office of Suicide Prevention, *Suicide Among Veterans and Other Americans 2001–2014* (2016). Accessed March 2, 2018, at www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf.
7. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2016). Accessed March 2, 2018, at www.cdc.gov/injury/wisqars.

A Public Health Approach to Preventing Veteran Suicide

VA's Commitment to All Veterans

VA is advancing a public health approach to reduce deaths by suicide among the greatest number of Veterans possible.

Guidance from the CDC offers four key components of the public health approach, which uses science to address multiple risk factors for suicide and prevent suicidal thoughts and behaviors from occurring.[8]

These components are:

- **Population Approach:** Public health uses a population approach to improve health on a large scale. A population approach means focusing on prevention approaches that impact groups or populations of people, as opposed to treatment of individuals.
- **Primary Prevention:** Public health focuses on preventing suicidal behavior before it occurs and addresses a broad range of risk and protective factors.
- **Commitment to Science:** Public health uses science to increase our understanding of suicide prevention so we can develop new and better solutions.
- **Multidisciplinary Strategies:** Public health advocates for multidisciplinary collaboration, bringing together many different perspectives to engineer solutions for diverse communities.

The public health perspective asks questions such as: Where does the problem begin? How could we prevent it from occurring in the first place? To answer these questions, VA follows a systematic approach used by the CDC in preventing suicide[9]:

Step 1: Define the problem. This involves collecting data to determine the "who," "what," "where," "when," and "how" of suicide deaths.

Step 2: Identify risk and protective factors. Scientific research methods are used to explore the factors that increase risk for suicide, as well as the protective factors that serve as buffers against suicide risk.

Step 3: Develop and test prevention strategies. Suicide prevention strategies are developed and tested to see if they succeed in preventing suicide and/or suicidal behaviors.

Step 4: Assure widespread adoption. Strategies shown to be successful in Step 3 are broadly disseminated and implemented by a variety of stakeholders who play a role in preventing Veteran suicide.

8. Centers for Disease Control and Prevention, *Enhanced Evaluation and Actionable Knowledge for Suicide Prevention Series. Suicide Prevention: A Public Health Issue* (n.d.). Accessed March 2, 2018, at www.cdc.gov/violenceprevention/pdf/ASAP_Suicide_Issue2-a.pdf.
9. Centers for Disease Control and Prevention, *The Public Health Approach to Violence Prevention* (n.d.). Accessed March 2, 2018, at www.cdc.gov/violenceprevention/pdf/ph_app_violence-a.pdf.

Adherence to this framework ensures that suicide prevention strategies are developed based on sound data and research, and that effective strategies backed by science are promoted and adopted by practitioners, intermediaries, and other stakeholders who have the ability to save Veteran lives.

To advance the goal of eliminating Veteran suicide, VA and its stakeholders must reduce the burden of suicide among *all* Veterans, whether or not they are receiving benefits or services from VA.

Not all Veterans are connected to VA or other agencies, so VA and its stakeholders must find innovative strategies to serve Veterans who do not — and may never — seek care, benefits, or services within its system. In addition, many risk factors related to suicide are influenced by community and societal factors outside the bounds of VA's influence. This will require VA to reach beyond the health care setting, through which it has traditionally supported Veterans' health, and empower actors to prevent Veteran suicide in other sectors, including:

- Non-VA health care
- Veterans and Military Service Organizations
- Faith communities
- Higher learning
- Law enforcement and criminal justice
- Employment
- Community service
- Nonprofits and nongovernmental organizations
- Media and entertainment
- Private sector industries
- Public-private partnerships
- Federal, state, and local government

No one organization can tackle Veteran suicide prevention alone. To save lives, multiple systems must work in a coordinated way to reach Veterans where they are.

A Framework for Prevention

Not all Veterans have the same risk for suicide, and prevention strategies are most effective when they are matched to a Veteran's or group of Veterans' level of risk.[10]

To better understand the most appropriate mix of prevention efforts needed to reach all Veterans, VA has relied on a prevention framework developed by the National Academy of Medicine (formerly the Institute of Medicine) that sorts prevention strategies into three levels (as depicted in Figure 4):

- ***Universal* strategies aim to reach *all* Veterans in the U.S.** These include public awareness and education campaigns about the availability of suicide prevention resources for Veterans, promoting responsible coverage of suicide by the news media, and creating barriers or limiting access to hot spots for suicide, such as bridges and train tracks.
- ***Selective* strategies are intended for *some* Veterans** who fall into subgroups that may be at increased risk for suicidal behaviors. These include outreach targeted to women Veterans or Veterans with substance use challenges, gatekeeper training for intermediaries who may be able to identify Veterans at high risk, and programs for Veterans who have recently transitioned from military service.
- ***Indicated* strategies are designed for the relatively *few* individual Veterans** identified as being at high risk for suicidal behaviors, including someone who has made a suicide attempt. These include referring Veterans in crisis to the Veterans Crisis Line, putting time and space between a Veteran who has expressed thoughts of suicide and a firearm or prescription medication, and providing a Veteran survivor of a suicide attempt or loss with enhanced support and expedited access to care.

10. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for the Application of Prevention Technologies, *Risk and Protective Factors* (2015). Accessed March 2, 2018, at www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors#universal-prevention-interventions.

Figure 4: *National Academy of Medicine Classifications of Prevention*

Universal *(all)*
Universal prevention strategies are designed to reach the entire Veteran population.

Selective *(some)*
Selective prevention strategies are designed to reach subgroups of the Veteran population that may be at increased risk.

Indicated *(few)*
Indicated prevention strategies are designed to reach individual Veterans identified as having a high risk for suicidal behaviors.

The goals and objectives of the National Strategy for Preventing Veteran Suicide are broad and can be adapted to fit specific settings and meet the distinctive needs of groups of varying levels of risk, including new settings and groups that may be identified in the future.

Research from the CDC asserts that, just as suicides are not caused by a single factor, suicide cannot be prevented by any single strategy or approach. Rather, suicide prevention is best achieved across the individual, relationship, family, community, and societal levels and across the private and public sectors.[11]

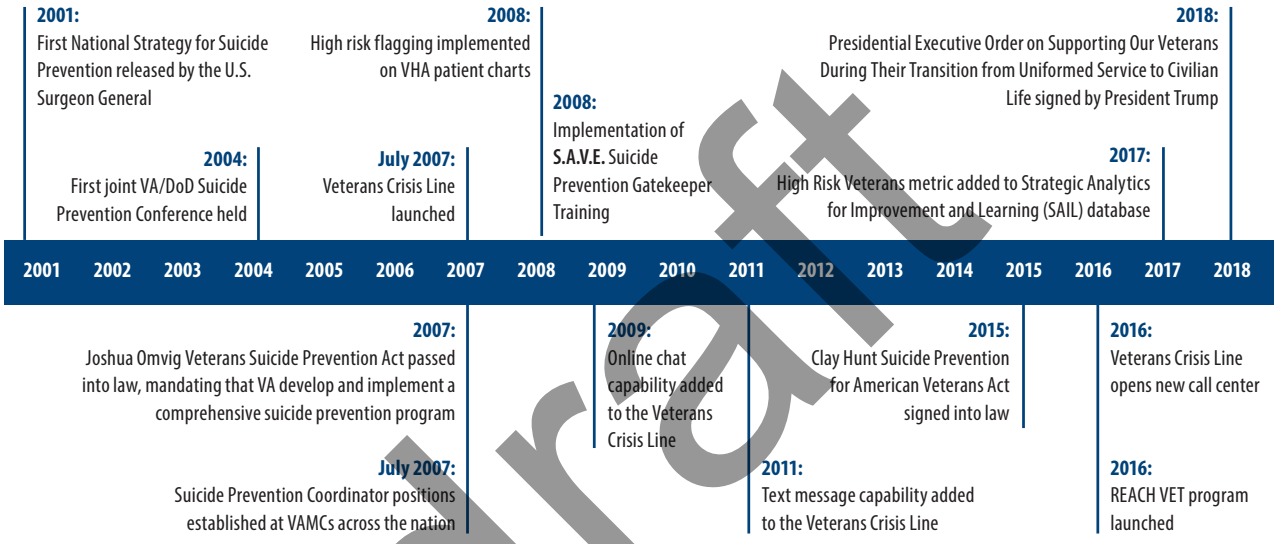
11. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (2017). Accessed March 2, 2018, at www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

VA's Suicide Prevention Program

Since the Suicide Prevention Program launched in 2007, VA has been leading innovative, research-driven suicide prevention efforts.

The Veterans Health Administration is the largest integrated health care system in the country, providing care at more than 1,200 health care facilities, including 170 medical centers and more than 1,000 outpatient clinics, and serving 9 million enrolled Veterans each year. Over the last decade, the administration has implemented numerous programs, policies, and initiatives related to suicide prevention (see Figure 5), VA's top clinical priority.

Figure 5: *VA Suicide Prevention Timeline*



VA works continuously to expand suicide prevention initiatives, including by:

- Bolstering mental health services for women Veterans
- Broadening telehealth services
- Developing free mobile apps to help Veterans and their families
- Improving access to care by providing mental health screening and treatment services through Vet Centers and readjustment counselors
- Using telephone coaching to assist families of Veterans

VA partners with hundreds of organizations at the national and local levels — including the U.S. Department of Defense (DoD) — to raise awareness of VA's suicide prevention resources and to educate people about how they can support Veterans and Service members in their communities. VA also partners with community mental health providers to expand the network of local treatment resources available to Veterans who need them. Veterans Service Organizations (VSOs) are likewise important partners, as they are integral to reaching all Veterans, wherever they are. VSO-run programs make a difference in Veterans' lives every day by helping them find employment, manage claims and benefits, stay socially connected, and more. These factors all protect against suicide risk.

As VA advances a public health approach to preventing Veteran suicides, it is using the best evidence available to promote broad, bundled strategies across many sectors. VA is committed to furthering research, gathering quality data, identifying and sharing best practices, and transforming the delivery of care and support to Veterans, with the ultimate goal of eliminating Veteran suicide. As efforts evolve to better meet Veterans' needs, the previously outlined concepts and frameworks will continue to guide VA's Suicide Prevention Program as it uses best practices and evidence to save Veteran lives.

Using the Strategy for Preventing Veteran Suicide

VA recognizes the need for a comprehensive, coordinated approach to ending Veteran suicide, and we know that our experience, expertise, and leadership make us well-positioned to lead this cause. **However, VA alone cannot end Veteran suicide.** The 14 goals described in this document outline our vision for what the nation must collectively achieve by 2028. To realize these goals, VA is broadening its efforts to best align with this vision. But we need partners and like-minded groups across all sectors — including health care, faith-based, and community organizations — to work with us in reaching all Veterans, wherever they may be.

The National Strategy for Preventing Veteran Suicide is modeled after the 2012 National Strategy for Suicide Prevention and encompasses four interconnected strategic directions:

1. Healthy and Empowered Veterans, Families, and Communities
2. Clinical and Community Preventive Services
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation

The 14 goals and 43 objectives included in the National Strategy for Preventing Veteran Suicide are meant to work together in a synergistic way to promote wellness, increase protection, reduce risk, and promote effective treatment and recovery.

This strategy is intended to serve as a framework for identifying priorities, organizing efforts, and contributing to a national focus on Veteran suicide prevention.

It represents a comprehensive, long-term approach to Veteran suicide prevention. The goal of saving Veteran lives can be achieved only by bundled science-based actions that complement each other. It is designed to be accessible to all stakeholders interested in preventing suicide, including individuals, groups, communities, organizations, institutions, and every level of government. VA's hope is that everyone connected to Veterans will assume collective ownership of the strategy and use it to guide suicide prevention efforts. With a diverse group of stakeholders acting together and using the strategy as a common point of reference, we increase the likelihood of success in preventing suicide among Veterans.

The strategy can assist in identifying priorities for individuals and groups as they develop an organizational strategic plan, an annual work plan, or specific action plans for an organization's efforts in suicide prevention. Developing and adhering to a plan is important, as it allows organizations to chart their progress against the overall goals of the strategy. Coordination with other organizations that are working toward the same or complementary goals, as presented in the strategy, is highly encouraged.

The field of suicidology uses common words that have specific definitions relevant to suicide diagnosis, intervention, and prevention. Such words used in this document are defined in Appendix A.

Strategic Direction 1: Healthy and Empowered Veterans, Families, and Communities

The goals and objectives that constitute this strategic direction seek to create supportive environments that promote the general health of Veterans and reduce the risk for suicidal behaviors, as well as associated risks. Suicide shares risk and protective factors with mental health and substance use disorders, trauma, and other types of violence, such as bullying and domestic violence. As a result, a wide range of partners can contribute to suicide prevention, including organizations and programs that promote the health of children, youths, families, working adults, older adults, and others in the community. All these partners should integrate suicide prevention into their work.

Eliminating stigma associated with suicidal behaviors, mental health and substance use disorders, and exposure to violence is a key area of concern within this strategic direction. In particular, there is a need to raise awareness that prevention and treatments for mental health and substance use disorders are effective and that recovery is possible.

Communication efforts, such as campaigns and social marketing interventions, play an important role in changing knowledge, attitudes, and behaviors to help prevent suicide. Safe and positive messaging addressing mental illness, substance abuse, and suicide can help reduce stigma and promote help-seeking. These types of messages help create a supportive environment in which someone who is experiencing problems feels comfortable seeking help, and where families and communities feel empowered to link a person with care before, during, or after a crisis and assist the person in regaining a meaningful life.

Goal 1. Integrate and coordinate Veteran suicide prevention activities across multiple sectors and settings.

Veterans are an integral part of every community. While some organizations specifically serve Veterans, it is important to recognize that effective outreach to Veterans requires programs that are carried out in diverse settings and systems. Greater coordination of efforts among different stakeholders and settings can increase the reach and impact of suicide prevention activities, while preventing duplication of efforts and promoting greater cost-effectiveness. In particular, it is important to take advantage of existing programs and efforts that address risk and protective factors for suicidal behaviors, including programs that may not yet include suicide prevention as an area of focus. For example, many employee assistance programs seek to promote resilience among employees by building problem-solving skills. These types of strategies can also be useful for suicide prevention.

Objective 1.1: Foster the integration of Veteran suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to play in supporting suicide prevention activities.

Because Veterans are also members of their communities, suicide prevention should be integrated into the activities of all organizations and programs that provide services and support in the community. While all national, state or regional, and local organizations can play a role in preventing Veteran suicide, examples include:

1. Veterans and Military Service Organizations
2. Federal government agencies
3. State and local government entities

4. Workplaces
5. Chambers of commerce
6. Faith-based organizations
7. Health care organizations (e.g., providing physical, mental health, and substance abuse treatment)
8. Lethal means education and suicide prevention organizations
9. Communication and media organizations
10. Technology companies
11. Law enforcement and criminal justice agencies
12. Legal support service providers
13. Community service providers
14. Institutions of higher learning and other educational settings

Helping these community partners understand military and Veteran culture and integrate suicide prevention into their work will promote greater understanding of suicide and help counter the stigma that can prevent Veterans from seeking help. It also will support the delivery of suicide prevention activities that are culturally appropriate for Veterans. Strategies for involving these stakeholders include infusing suicide prevention into key professional meetings, developing public-private partnerships, and establishing suicide prevention coalitions, which can help facilitate and advance suicide prevention efforts in a particular geographic area.

Objective 1.2: Support the establishment of effective, sustainable, and collaborative suicide prevention programming for Veterans at the national, state/territorial, tribal, and local levels.
Services for Veterans are often spread across multiple agencies at the national, state/territorial, tribal, and local levels. This can make it difficult for the agencies and programs involved in suicide prevention to work collaboratively. Increased coordination of suicide prevention activities among these various partners could help improve services and outcomes for Veterans, while making suicide prevention efforts more sustainable in the long term.

Identifying the agencies that participate in Veteran suicide prevention and clarifying each agency's role is an important first step. This clarification can make it easier for different agencies to identify gaps and overlaps in their services and to obtain support for their respective suicide prevention efforts. This collaboration can also aid in sharing information, establishing and standardizing best practices, and developing registries of programs or resources that can benefit the broader community. It may be useful to identify lead agencies at the state and local levels that can help bring together new and different partners with a role to play in suicide prevention.

Objective 1.3: Sustain and strengthen collaborations across federal agencies to advance Veteran suicide prevention.
Because suicide affects many different groups and is related to mental health, substance abuse, trauma, violence, injury, and other issues, many federal agencies have a role to play in suicide prevention. The Federal Working Group on Suicide Prevention is an important mechanism for maintaining collaboration across these agencies. Formed in 2000, the group shares information and coordinates efforts across:

- Department of Veterans Affairs
- Department of Defense
- Department of Health and Human Services
- Department of Homeland Security
- Department of Justice
- Department of Education
- Department of Transportation

The Federal Working Group on Suicide Prevention meets regularly and publishes a Compendium of Federal Activities. As an example of a group outcome, VA works closely with DoD on several joint initiatives, such as distributing firearm locks and organizing the VA/DoD Suicide Prevention Conference, which occurs every other year.

Improved coordination of funding priorities at the federal level could help strengthen the infrastructure for delivering suicide prevention services to Veterans at the state/territorial, tribal, and local levels.

Objective 1.4: Promote the development of sustainable public-private partnerships to advance Veteran suicide prevention.
Suicide is a complex issue that affects Veterans from all backgrounds, and not all Veterans are connected to VA or other agencies. Hence, no single agency, organization, or governmental body can have sole responsibility for suicide prevention.

The National Action Alliance for Suicide Prevention is a public-private partnership to advance and coordinate the implementation of suicide prevention in the United States. A subcommittee of the Action Alliance that focuses on suicide prevention among Veterans could draw the attention needed to unique aspects of this population while also integrating Veterans issues into the broader work of the Action Alliance. In addition, VA encourages creation of public-private partnerships that focus specifically on preventing Veteran suicide at the local, state/territorial, and national levels.

Objective 1.5: Support the integration of Veteran suicide prevention into all relevant policy decisions.
Changes in health care systems and policies provide important opportunities for integrating, enhancing, and transforming suicide prevention efforts. Policy decisions that increase access to care for mental health and substance use disorders can greatly contribute to Veteran suicide prevention. Examples include federal and state parity laws requiring equal health insurance coverage for behavioral health care as for physical health care.

VA is working to increase access to VA services for transitioning Service members by facilitating registration and enrollment for health care. VA encourages all health systems and providers to consider how access to care and suicide prevention efforts for Veterans can be improved.

Goal 2. Implement research-informed communication efforts designed to prevent Veteran suicide by changing knowledge, attitudes, and behaviors.

Communication efforts targeting Veterans need to be culturally appropriate and recognize that while Veterans may share some common experiences, they are a diverse and unique group. Communication efforts addressing Veteran suicide prevention should be research-based and reflect safe messaging recommendations specific to Veteran suicide.

Effective communication with Veterans about suicide prevention requires a wide range of efforts, such as communication campaigns and social marketing interventions. These efforts can help shift knowledge, attitudes, and behaviors among Veterans, their loved ones, and intermediaries such as service providers, including by dispelling misconceptions about mental health treatment, raising awareness of available resources, and encouraging help-seeking and healthy behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach Veterans.
The field of communications and social marketing has developed research-informed principles for effective communication. Communication campaigns addressing Veteran suicide prevention should incorporate the principles for effectiveness identified in the literature. These principles include:

1. Conducting formative research
2. Using behavior theory
3. Segmenting the audience
4. Identifying and using effective channels and messages
5. Conducting process evaluation to ensure high message exposure
6. Using an appropriate design for outcome evaluation

Communication efforts should target defined audiences — for example, Veterans with a particular set of risk factors, or the friends and families of Veterans at high risk. Demographic factors, such as age, income, and gender, may be used to identify different audience segments, along with factors related to the call to action being promoted. Efforts promoting behavior change should convey a clear call to action and provide specific information for executing the action. All communication efforts should be evaluated to measure their reach and determine their effectiveness in achieving the intended audience behavior.

Objective 2.2: Connect policymakers with resources for communicating about Veteran suicide prevention.
An important step in educating policymakers is proactively reaching out to them to increase their understanding of Veteran suicide, its impact on their constituents and stakeholders, and effective solutions. These outcomes can counter narratives about distressed Veterans that perpetuate stereotypes and stigma, and can motivate leaders to take action by promoting initiatives, policies, and programs to prevent Veteran suicide. Describing effective Veteran suicide prevention programs of federal, state/territorial, tribal, and nonprofit agencies and local coalitions will help build support for these efforts. It also may be useful to share evaluation data that show communities that have been successful in reducing risk and increasing protective factors for suicide.

Communication efforts designed to educate policymakers are especially important because policy and systemic changes are effective and long-lasting ways to advance suicide prevention. These policymakers may include federal, state, and local officials; tribal council members; and institutional and organizational leaders and their research and policy staff. To be most effective, messages should link to specific actionable requests and reflect an understanding of broader issues of concern to the policymaker. Communication efforts should be framed in ways that will speak to diverse policymakers at the national, state, tribal, and local levels and build broad support for suicide prevention.

Objective 2.3: Increase multiplatform communication efforts that promote positive messages and support safe crisis intervention strategies.
With changes in technology and social media, Veterans are increasingly using interactive and dynamic technology such as social networking websites, email, blogs, web applications, video chat, mobile apps, and text messages. These technologies provide new opportunities for Veteran suicide prevention. For example, VA is using telehealth (telehealth.va.gov) to provide services to Veterans in rural areas. Another example is the chat line (VeteransCrisisLine.net/Chat) and text messaging service (text to 838255) operated by VA's Veterans Crisis Line call center (1-800-273-8255 and Press 1).

Efforts to prevent Veteran suicide must consider the best ways to use existing and emerging communication tools to encourage help-seeking and provide support to individuals with varying levels of suicide risk, as well as their friends, families, and intermediaries. The CDC recommends carefully planning how new communications channels fit into an overall communications effort, understanding the level of effort needed to maintain these channels, and using these tools strategically by making choices based on audience. While more research is needed on how to best use emerging communication tools in suicide prevention, some guidance is available on best practices for using social media in health promotion:

1. Action Alliance Framework for Successful Messaging: suicidepreventionmessaging.org
2. Recommendations for Reporting on Suicide: reportingonsuicide.org
3. Recommendations for Blogging on Suicide: www.bloggingonsuicide.org
4. Social Media Guidelines for Mental Health Promotion and Suicide Prevention: www.eiconline.org/teamup/wp-content/files/teamup-mental-health-social-media-guidelines.pdf
5. CDC Social Media Tools, Guidelines, and Best Practices: www.cdc.gov/socialmedia/tools/guidelines

Suicide prevention programs that incorporate emerging technologies have a responsibility to ensure the safety of users. They should consider in advance how to monitor these channels regularly and respond to disclosures of suicidal thoughts or behaviors. These programs should include links to online crisis resources, such as the Veterans Crisis Line. In addition, because many of these media include user-generated content, it is important to think about how to moderate online conversations to ensure that public-facing messages are positive and that they promote hope, connectedness, social support, resiliency, and help-seeking.

Objective 2.4: Develop and promote educational materials about the warning signs for Veteran suicide and how to connect individuals in crisis with assistance and care.

Family members, friends, co-workers, and others can play an important role in recognizing when a Veteran is in crisis and connecting the Veteran with sources of help. However, many of these people may not know the warning signs of suicidal behavior or where a distressed person can go for help. It is crucial to widely disseminate information on warning signs, guidance on how to interact with Veterans in crisis, and available resources. In doing so, it is important to use communication strategies that are research-based, thoughtfully planned, and designed to meet the needs of specific groups. Incorporating stories of individuals who received and benefited from help may motivate others to take action.

In particular, there is a need to increase awareness of the role of crisis lines, such as the Veterans Crisis Line, in providing services and support to Veterans in crisis. Providing follow-up calls and services after an acute crisis can also enhance safety and connect Veterans with appropriate care and services.

Goal 3. Increase knowledge of the factors that offer Veterans protection from suicidal behaviors and that promote their wellness and recovery.

Many Veterans pride themselves on being able to take care of themselves and serving as protectors to their loved ones and communities; for some, seeking support from others can be a challenge. While effective treatment for mental health and substance use disorders has increased over the years, stigma associated with these disorders and suicidal behaviors, as well as misconceptions about the nature of treatment, continues to prevent some Veterans from seeking help.

There is a need to eliminate cultural biases toward help-seeking behavior and to increase awareness of the factors that can serve as a buffer against suicide risk. Connectedness to others — including family members, co-workers, community organizations, and social institutions — has been identified as an important protective factor. These positive relationships can help increase a Veteran's sense of belonging, foster a sense of personal worth, and provide access to sources of support.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk for Veterans.
While the focus of Veteran suicide prevention is predominantly on counteracting risk factors, strengthening protective factors can help prevent suicide by promoting physical, mental, emotional, and spiritual wellness. For example, building the problem-solving skills and social support of Service members transitioning from the military can help them better cope with future challenges as Veterans. A focus on strengthening protective factors should be the norm rather than the exception.

Many groups and organizations in the community, including faith-based organizations and aging services networks, can contribute to Veteran suicide prevention by enhancing connectedness, especially among Veterans who may be isolated or marginalized. These organizations can help ensure that social support is more widely available from peers and others. Specific training addressing Veteran suicide prevention could enhance these providers' ability to deliver support to individuals at risk and make appropriate referrals. The DoD BeThere Peer Support Call and Outreach Center (BeTherePeerSupport.org) is an example of a resource designed to promote connectedness among both Service members and Veterans.

Objective 3.2: Work to reduce stigma associated with suicidal behaviors and mental health and substance use disorders among Veterans.
Military culture emphasizes strength, resilience, and unit cohesion. Some of these aspects can serve as protective factors by strengthening a sense of connectedness; however, they can also reinforce stigma toward mental health challenges that affect Veterans after they have transitioned from the military. In addition, Service members may have concerns about the impact that seeking help for mental health issues could have on their careers.[12] These factors may discourage many Veterans from seeking help, or even from talking about the psychological distress that could lead to suicidal behaviors. Strategies for addressing cultural beliefs related to Veteran suicidal behaviors will be most effective when they are grounded in a full understanding of and respect for the cultural context of these beliefs.

Veterans would benefit from broad communication, public education, and public policy efforts to promote mental health, increase understanding of mental health and substance use disorders, and eliminate barriers to help-seeking. A cultural shift is needed for more Veterans to view seeking treatment as a natural and acceptable behavior and not a sign of weakness.

Objective 3.3: Promote the understanding that recovery from mental health and substance use disorders is real and possible for all Veterans.
Social attitudes, bias, and discrimination often present barriers to treatment and undermine the recovery of Veterans with mental health or substance use disorders. A better understanding of crisis,

12. Tanielian, et al., "Barriers to Engaging Service Members Within the U.S. Military Health System." *Psychiatric Services 67*, No. 7 (2016). Accessed March 2, 2018, at https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500237?code=ps-site.

trauma, and recovery can help the community promote resilience and wellness among Veterans. It is important to increase awareness that, in most cases, Veterans with a mental health or substance use disorder can recover and regain meaningful lives. Family members, peers, mentors, individuals who have attempted suicide, individuals who have experienced a suicide loss, and members of the faith community can be important sources of support. These individuals can impart hope and motivation for achieving recovery; provide support for addressing specific stressors, such as the loss of a job; and help foster a sense of meaning and purpose.

Goal 4. Promote responsible media reporting of Veteran suicide, accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry, and the safety of online content related to Veteran suicide.

Media and the internet play a significant role in shaping the public perception of Veterans, mental illness, and suicide. Entertainment and technology can contribute to suicide prevention by combating prejudice, providing opportunities for peer-to-peer support, and linking Veterans in crisis with sources of help. In contrast, when not used responsibly, media can have a negative effect, resulting in cluster suicides, suicide contagion, and a negative perception of Veterans. It is important to encourage media influencers to present accurate and responsible portrayals of Veteran suicide and related issues (e.g., mental health and substance use disorders, violence).

Portrayals of Veteran suicide in the news and entertainment media too often perpetuate the misconception that a Veteran's suffering from mental trauma is always the result of combat exposure and that suicide cannot be prevented. There is a need to shift the focus of these portrayals to stories of Veterans who have faced a mental health challenge, sought help and appropriate treatment, and recovered. Stories addressing Veteran mental illness, substance abuse, and suicidal behaviors should promote hope, resiliency, and recovery. This approach can motivate family, friends, and others to provide support and protection to Veterans who may be at risk for suicide and make it easier for a Veteran in crisis to seek help and regain a meaningful life.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of Veteran suicide and other related behaviors.

Responsible, culturally competent coverage of Veteran suicide and other related behaviors can play an important role in preventing suicide contagion. Recommendations for media reporting of suicide were issued in April 2011 and are posted online (www.reportingonsuicide.org). In addition, the Associated Press has recently added entries covering mental health and suicide to its stylebook. Disseminating these guidelines to all media outlets that report on the issue of Veteran suicide can improve the quality of these reports.

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of Veteran suicide and other related behaviors.

Depictions of Veteran mental health issues and suicide are common in the entertainment media. In 2009, the Entertainment Industries Council created a guide for the entertainment industry titled "Picture This: Depression and Suicide Prevention" (available at www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf). The guide can help creators of entertainment content provide responsible portrayals of Veteran suicidal behaviors, mood disorders, and related issues.

Recognition programs and other incentives can help promote greater awareness and adoption of these recommendations. There are a few such awards programs for the general population, such as the Voice Awards, which honor those who give voice to stories of recovery, and the PRISM Awards, which recognize accurate depictions of mental health and substance use issues, treatment, and recovery. It may be helpful to highlight Veteran-specific awards in these programs or develop awards and recognition dedicated to accurate and responsible portrayals of Veteran suicide.

Strategic Direction 2: Clinical and Community Preventive Services

The factors that contribute to suicide deaths are multiple and complex. Preventing these deaths requires that support systems, services, and resources work together to promote wellness and help Veterans successfully navigate these challenges.

Clinical and community-based programs and services play a key role in promoting wellness, building resilience, and preventing suicidal behaviors among Veterans. Screening for depression and alcohol misuse has been endorsed by the U.S. Preventive Services Task Force, and suicide assessment and preventive screening, along with other clinical preventive services, are provided by VA and community health care providers. For Veterans who are not eligible for VA care, these screenings are now covered as preventive services under Medicare. The Columbia-Suicide Severity Rating Scale (C-SSRS) is an example of an evidence-based suicide risk assessment tool used by VA and non-VA health care systems, as well as in other community and clinical settings.

A wide range of community partners also have an important role to play in delivering prevention programs and services to Veterans at the local level. These community-based professionals and organizations should be competent in serving Veterans in a way that is culturally appropriate and uses their preferred language. Greater coordination among community and clinical preventive service providers and VA health care providers can have a synergistic effect in preventing Veteran suicide and related behaviors.

Goal 5. Develop, implement, and monitor effective programs that promote wellness and prevent Veteran suicide and related behaviors.

Preventing Veteran suicide requires that appropriate community-based and preventive clinical supports be available at the state/territorial, tribal, and local levels to assist those with suicide risk. These programs should support the active participation of a diverse range of community members in Veteran suicide prevention programs, including care providers. Clinical and community-based services for Veterans should seek to promote wellness, eliminate risk factors, increase resilience and protective factors, link Veterans in crisis with appropriate services and support, and address the environmental and social conditions that can contribute to suicidal behaviors.

In developing, implementing, and monitoring programs, it is critical to use suicide prevention strategies that have been shown to be effective among Veterans. Two important resources for identifying evidence-based programs and best practices are the National Registry of Evidence-based Practices and Programs Learning Center and the Suicide Prevention Resource Center website. As these registries currently have only a few evidence-based programs for Veterans, it is important to continue evaluating programs and adding high-quality programs to the registries.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local Veteran suicide prevention programming.

The goal of saving lives can only be achieved with a combination of efforts at multiple levels. In addition to VA and other federal agencies, states, territories, tribes, and communities can play an important role in implementing Veteran suicide prevention programs that meet the diverse needs of Veterans. In doing so, it is important to involve multiple partners, including agencies and organizations involved in public health, behavioral health, injury prevention, and related areas.

Suicide prevention efforts should engage multiple partners and sectors and provide services that are culturally and geographically appropriate for Veterans across the country. It is also important to make certain that Veteran suicide prevention efforts reach a diverse mix of Veterans and their families at the community level. In addition, these efforts should be evaluated and modified accordingly to ensure effectiveness.

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent Veteran suicide and related behaviors.

As Veterans are integrated members of their communities, many institutions, agencies, and organizations play a role in promoting health, reducing risk factors, increasing protective factors, training personnel who are in contact with Veterans at risk for suicide, and providing support to Veterans in crisis. Some of these organizations are health care systems, faith-based organizations, justice system institutions, law enforcement institutions, organizations serving older adults, Veterans Service Organizations, workplaces, and educational institutions. Engaging these and other community groups can greatly expand the reach of Veteran suicide prevention efforts, making it possible to provide assistance and support to Veterans who may be most vulnerable, underserved, or difficult to reach.

Objective 5.3: Deliver interventions to reduce suicidal thoughts and behaviors among Veterans with suicide risk.

Suicide risk and protective factors for Veterans can vary across communities and change over time. Different interventions are needed to meet the diverse needs of Veterans. State and local suicide prevention programs must continuously identify at-risk Veterans and develop and implement programs tailored to their unique needs. Each program should also include a thorough evaluation that rigorously assesses outcomes and impact. C-SSRS is a suicide risk assessment tool used by VA and non-VA health care systems, as well as other organizations, to identify risk and determine the appropriate level of care. This tool can be used across diverse settings and does not require special training.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental health and substance use disorders for all Veterans.

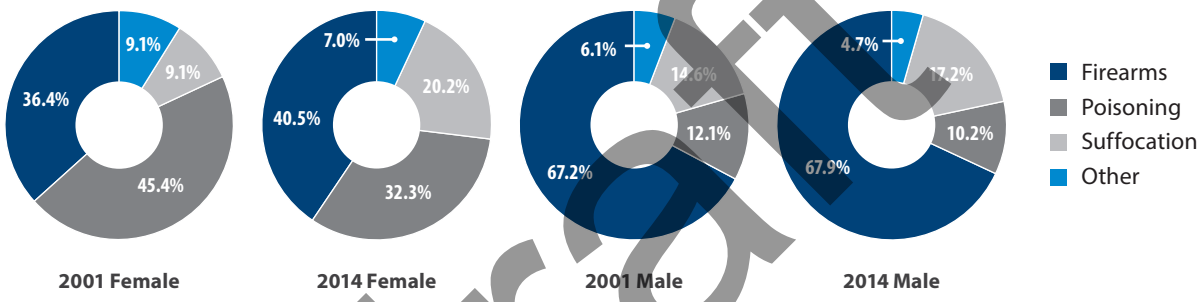
Having a serious mental health disorder such as major depression or bipolar disorder is a recognized risk factor for suicidal behaviors. This is particularly true if the person also has a substance use disorder. Yet many Veterans with these disorders lack access to behavioral health care. Health care systems should recognize and respond to mental health and substance use problems in the same way they respond to physical health problems. Greater coordination among the different programs that provide services addressing Veterans' mental health, substance use, and physical health can increase access to care. This coordination can range from sharing information between service providers to delivering different services in the same setting. These linkages will help provide Veterans with multiple access points to behavioral health care, thereby helping ensure that Veterans who may be at risk for suicidal behaviors are connected to appropriate sources of care.

Goal 6. Promote efforts to reduce access to lethal means of suicide among Veterans with identified suicide risk.

Reducing access to suicide methods that are highly lethal and commonly used is a proven strategy for decreasing suicide rates. While some suicidal crises last a long time, most last minutes to hours. Limiting access to lethal means during periods of crisis can make it more likely that the person will delay or survive a suicide attempt. Furthermore, the overwhelming majority (about 90 percent) of those who survive a suicide attempt do not go on to die by suicide.[13] Of those who do die by suicide, the rates differ by gender and by mechanism:

- Among male Veterans who die by suicide, about **68 percent** die from firearm injury, about **17 percent** die by suffocation, about **10 percent** die by poisonings, which includes intentional drug overdoses, and about **5 percent** die by other methods of intentional self-harm.
- Among female Veterans who die by suicide, about **41 percent** die from firearm injury, about **20 percent** die by suffocation, about **32 percent** die by poisonings, and **7 percent** die by other methods of intentional self-harm.

Figure 6: *Veteran Suicide Deaths by Mechanism and Gender in 2001 and 2014*



For Veterans whose recent history includes a suicidal crisis, or for Veterans who are experiencing suicidal ideation or significant distress, suicide risk is reduced by safely storing potential means for suicide, including firearms and other weapons, medications, illicit drugs, household chemicals, poisons, and materials used for hanging or suffocation. Installing bridge barriers or otherwise restricting access to popular jump sites may also prevent Veteran suicides, depending on specific local conditions.

Objective 6.1: Encourage providers who interact with Veterans at risk for suicide to routinely assess for access to lethal means. Professionals who provide health care and other services to Veterans at risk for suicide as well as their families and other caregivers are in a unique position to ask about the availability of lethal means and work with these Veterans and their support networks to reduce access. These professionals include health care providers, social workers, members of the clergy, first responders, professionals working in the criminal justice system, and others who may interact with Veterans in crisis. These providers can educate Veterans with suicide risk — and their loved ones — about safe firearm storage and access, as well as the appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons. Outreach efforts can also educate Veterans and other care providers about reducing the stock of medicine in the medicine cabinet to a nonlethal quantity and locking up medications that are commonly abused (e.g., prescription painkillers and benzodiazepines, which are used to induce sleep, relieve anxiety and muscle spasms, and prevent seizures). A useful resource to support this goal is the Suicide Prevention Resource Center's Counseling on Access to Lethal Means (CALM), a free online course designed for providers who counsel people at risk for suicide, including mental health and medical providers (available at www.sprc.org/resources-programs/calm-counseling-access-lethal-means).

13. Harvard School of Public Health https://www.hsph.harvard.edu/means-matter/means-matter/survival/

Objective 6.2: Partner with firearm dealers and firearm owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Most Veterans own firearms and are familiar with their use. Among Veterans who attempt suicide, those who use firearms are more likely to die than those who use other means. Reaching out to firearm owners, firearm dealers, shooting clubs, hunting organizations, and others to promote firearm safety and increase their involvement in suicide prevention is an important strategy for reducing Veteran suicide risk. Brochures and websites promoting firearm safety to firearm owners could be tailored to Veterans and include a statement regarding the importance of being alert to signs of suicide risk in a loved one and keeping firearms out of the person's reach.

When a Veteran is at risk for suicide, it is recommended that all firearms in the household be temporarily stored with a friend or relative or in a storage facility. At a minimum, all firearms should be securely locked away from the vulnerable person's access until he or she has recovered. Partnering with firearm owner groups and Veterans to distribute firearm locks and educate people about safe storage will help ensure that firearm safety education is culturally relevant and technically accurate, that it comes from a trusted source, and that it does not have an anti-firearm bias. As an example, VA partners with DoD to distribute free firearm locks to Veterans during Suicide Prevention Month.

Goal 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

All community-based and clinical suicide prevention professionals whose work brings them into contact with Veterans at risk for suicide should be trained on military culture, how to address suicidal thoughts and behaviors, and how to respond to those who have been affected by suicide. These professionals include:

1. Adult and child protective service professionals
2. Bank, mortgage, and financial service providers
3. Crisis line staff and volunteers
4. Divorce, family law, criminal defense, and other attorneys (and those in criminal/civil justice system)
5. Employee assistance programs and other human resource professionals in the workplace
6. Faith-based professionals
7. First responders, including law enforcement, fire department, and emergency medical services
8. Funeral home directors and staff
9. Health care providers, including behavioral health care professionals
10. Professionals who serve the military and Veterans
11. Providers of aging services
12. Social service and human service providers

Training programs should be tailored to the specific needs and roles of the providers and regularly updated to reflect new knowledge in the field.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of Veteran suicide and related behaviors.

Thousands of first responders, crisis line volunteers, law enforcement professionals, members of clergy, individuals working in the justice system and law enforcement, and others who are on the front lines of preventing Veteran suicide should be trained on military culture and suicide prevention. Publicly available toolkits and trainings address the needs of these various groups:

1. **Military Culture School:** Online training on military and Veteran culture offered by PsychArmor Institute, an accredited nonprofit that provides free education and support to help all Americans engage with the military community. The online Military Culture School is available at https://psycharmor.org/military-culture-school.
2. **S.A.V.E. Training:** Training designed to help anyone who interacts with Veterans learn to identify the **Signs** of suicide, **Ask** questions, **Validate** the Veteran's experience, and **Escort** the Veteran to care and **Expedite** treatment. S.A.V.E. training is provided through VA suicide prevention resources across the country, which can be found using VA's resource locator at www.VeteransCrisisLine.net/ResourceLocator.

These trainings should continue to be implemented, evaluated, and updated. Additional gatekeeper training should be developed to ensure that every gatekeeper understands their unique role when it comes to preventing suicide. In addition, there is a need to make educational programs available to family members and others who are in close relationships with Veterans at risk for suicide or who have been affected by suicidal behaviors.

Objective 7.2: Provide training to mental health and substance use providers on the recognition, assessment, and management of at-risk behavior among Veterans, and the delivery of effective clinical care for Veterans with suicide risk.

Mental health and substance use providers should have the foundational attitudes, knowledge, and clinical prevention skills to reduce Veterans' suicide risk and increase their protective factors. Caring for Veterans with suicide risk requires being able to work collaboratively with the Veteran. Skill development and practice by providers and a culture of shared responsibility can help build comfort, confidence, and competence in engaging and caring for Veterans. Training programs for mental health and substance use providers should seek to:

1. Increase feelings of confidence and empowerment in working with Veterans at risk for suicide.
2. Address the emotional and legal issues associated with adverse patient outcomes, including death by suicide.
3. Equip practitioners with attitudes, knowledge, and skills for coping with sentinel events (unexpected events in a health care setting, not connected with a patient's illness, that result in the patient's death or serious physical or psychological injury), along with knowledge of the VA/DoD clinical practice guidelines for suicide prevention.
4. Educate practitioners about how to exchange confidential patient information appropriately to promote collaborative care while safeguarding patient rights.
5. Address the value of a team-based approach to managing suicide risk.
6. Provide practitioners with clinical preventive skills to engage in shared services for Veterans with suicide risk, including by addressing the value of shared responsibility and collaborative care and increasing knowledge and skills for communicating collaboratively with Veterans, families, significant others, and other providers to ensure continuity of care.
7. Include cultural competence training components focused on Veterans and high-risk Veteran groups.
8. Address the provision of effective support services for those who have experienced a suicide loss.

VA's Community Provider Toolkit can provide helpful guidance to providers who are working with Veterans, including information about screening for military experience, understanding military culture, and referring Veterans to VA care, as well as tools for addressing a variety of behavioral health concerns. The Community Provider Toolkit is available at www.mentalhealth.va.gov/communityproviders.

Objective 7.3: Promote the adoption of core education and training guidelines on the prevention of Veteran suicide and related behaviors by all health professions, including graduate and continuing education.

All education and training programs for health professionals, including graduate and continuing education programs for these professions, should adopt core education and training guidelines addressing the prevention of Veteran suicide and related behaviors. All degree-granting undergraduate and graduate programs in relevant professions should include these guidelines as part of their curricula. Programs should also ensure that graduates have an understanding of military culture and Veteran suicide prevention as appropriate for their respective disciplines.

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of Veteran suicide and related behaviors by credentialing and accreditation bodies.

The inclusion of core education training in recertification or licensing programs can help ensure that professionals who have completed training have knowledge of military culture and addressing Veteran suicidal behaviors and that they remain competent over time. Within the Veterans Health Administration and in most states and territories, physicians, psychologists, social workers, nurses, and other health professionals must complete licensing examinations or recertification programs in order to maintain active licenses or professional certifications. Accrediting and credentialing organizations should promote evidence- and best practices-based suicide prevention training and military culture training for the organizations and practitioners they accredit or credential. In addition, because suicide shares risk and protective factors with mental health and substance use disorders, as well as with trauma and interpersonal violence, suicide-related curricula should be linked with training on these topics. State governments and professional organizations can help support the incorporation of suicide prevention and military culture topics into the training of professionals in various disciplines.

Objective 7.5: Develop and disseminate protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing Veteran suicide risk.

Communication and collaboration across multiple levels of care are key to successfully managing suicide risk among Veterans. Clinical preventive and communication protocols for clinicians and clinical supervisors, emergency workers, crisis staff, professionals providing adult and child protective services, and others providing support to Veterans at risk for suicide can help improve communication and collaborative management of suicide risk. The VA/DoD clinical practice guidelines for suicide prevention offer guidance on implementing effective strategies for improving communication and collaboratively managing suicide risk. The guidelines are available at www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf.

Strategic Direction 3: Treatment and Support Services

Veterans at high risk for suicide require clinical evaluation and care to identify and treat behavioral and medical conditions and to specifically address suicide risk. The VA/DoD clinical practice guidelines describe the critical decision points in managing suicidal risk behavior for self-directed violent behavior and provide clear and comprehensive evidence-based recommendations for practitioners throughout VA. The guidelines can serve as recommendations for other health care systems and are intended to improve patient outcomes and local management of patients with suicidal risk behavior.

Goal 8. Promote suicide prevention as a core component of health care services.

The use of comprehensive, systems-level strategies that make suicide prevention a core goal has been shown to improve outcomes for patients with suicide risk. VA, for example, has adopted a comprehensive approach in which suicide prevention is a core component of mental health and substance use services. As part of this approach, a Suicide Prevention Coordinator is placed at every VA medical center in the country. Preliminary data suggest that these programs have been associated with a reduction in suicide rates among those in certain high-risk subgroups who are receiving health care through VA, including middle-age men. This strategy could be useful for other health care systems that make suicide prevention a core goal.

Objective 8.1: Promote the adoption of "zero suicides" as an aspirational goal by VA medical centers and community support systems that provide services and support to defined Veteran populations.

Managing the VA system of care, as well as non-VA systems, to achieve the goal of zero suicides requires that medical centers and facilities evaluate performance rigorously and use adverse events as opportunities to improve their capacity to save lives. It also requires putting into place mechanisms to support clinicians in the aftermath of a patient's death by suicide. Part of the zero-suicides strategy requires health systems to conduct a root cause analysis (a structured process used to determine causes) of suicide attempts and deaths, and to use findings to improve service quality by focusing on systemic issues rather than individual blame.

Objective 8.2: Promote timely access to assessment, intervention, and effective care for Veterans with a heightened risk for suicide.

Timely access to care is critically important to Veterans in crisis. Crisis hotlines, online crisis chat and intervention services, self-help tools, crisis outreach teams, and other services play an important role in providing needed care to Veterans with high suicide risk. Virtual or remote care — such as telephone calls to crisis hotlines and counseling by telephone, text message, or online chat — allows individuals in crisis to access help 24 hours a day, 7 days a week. An example is VA's Veterans Crisis Line, which provides free, 24/7 confidential support to Veterans, Service members, and their loved ones by phone (1-800-273-8255 and Press 1), online chat (VeteransCrisisLine.net/Chat), or text message (text to 838255).

This type of care is typically available at little to no cost to Veterans in crisis and provides more immediate access and greater convenience and anonymity than face-to-face therapy. Providing detailed instructions about how to access round-the-clock care is a critical part of safety planning for providers working with high-risk Veterans. Providing Veterans with information about how and when to access care through an emergency department is necessary but not sufficient. Access to virtual or remote care is critical for augmenting the care provided at clinics and private practices, which usually have limited hours of operation, and can be useful for reaching Veterans in rural and underserved areas.

Objective 8.3: Promote continuity of care to support the safety and well-being of all Veterans treated for suicide risk in emergency departments and inpatient units.

Patients leaving an emergency department or hospital inpatient unit after a suicide attempt, or otherwise at high risk for suicide, require immediate, proactive follow-up. Having survived a suicide attempt is one of the most significant risk factors for later death by suicide. The risk is particularly high in the weeks and months following the attempt, including the period after discharge from acute care settings such as emergency departments and inpatient psychiatric units. Among patients with high suicide risk, particularly those who have attempted suicide, continuity of care is crucial for promoting positive outcomes. The VA/DoD clinical practice guidelines provide recommendations for following up with Veterans in the aftermath of a suicide attempt. Peer support and caring outreach should be included in all aftercare plans.

Objective 8.4: Encourage collaboration between providers of mental health and substance use services and community-based programs, including peer support programs.

To be effective in suicide prevention, providers of mental health and substance use services must coordinate services with each other and with other service providers in the community. Timely and effective cooperation, collaboration, and communication between mental health and substance use providers and sources of support in the community are critical to promoting Veteran safety and recovery. VA-based providers, as well as others who work frequently with Veterans, should develop connections to community-based supports, such as community agencies for substance abuse prevention and treatment, suicide prevention and mental health advocacy organizations, aging services organizations, Veterans Service Organizations, and programs providing peer support services. These programs can help foster a sense of connection and belonging and provide critically needed services, including employment and vocational help, housing assistance, social interactions that are not focused on illness, and peer support.

Goal 9. Promote and implement effective clinical and professional practices for assessing and treating Veterans identified as being at risk for suicidal behaviors.

Effective clinical and professional practices in assessing and treating Veterans with high suicide risk can help prevent these individuals from harming themselves. These practices should be grounded in evidence-based care or in best practices, in cases where promising approaches have been identified but where more research is needed.

Objective 9.1: Support the development and implementation of guidelines for delivering services to Veterans with suicide risk in the most collaborative and responsive settings.

The proper documentation of assessment and treatment can improve the care of Veterans with high suicide risk and, at the same time, protect providers from allegations of malpractice. The VA/DoD clinical practice guidelines for suicide prevention are intended to reduce current discrepancies between practices, provide facilities with a structured framework for improving patient outcomes, provide evidence-based recommendations, and identify outcome measures to support the development of practice-based evidence that can be used to improve clinical guidelines. These guidelines should be implemented across health care settings, including all VA facilities, and updated on a regular basis to reflect the latest evidence in suicide prevention.

All Veterans who are admitted to an inpatient mental health unit require follow-up mental health services after discharge, as well as connections to community-based support. Health care systems should seek to dramatically shorten the time between inpatient discharge and follow-up outpatient treatment. Continuity of care following a suicide attempt should represent a collaborative approach between the Veteran and provider that gives the Veteran a feeling of connectedness. Strategies may include appointment telephone reminders, providing a "crisis card" with emergency phone numbers and safety measures, and sending a letter of support.

Objective 9.2: Support the development and implementation of guidelines to effectively engage families and other concerned individuals, when appropriate, throughout entire episodes of care for Veterans with suicide risk.

Family members, significant others, and close friends can play an important role in enhancing the safety of Veterans with suicide risk. These individuals should be trained to understand, monitor, and intervene with loved ones who are at risk for suicide. Because the exact timing of suicidal behaviors is very difficult to predict, it is important that key members of the family unit and social support network be knowledgeable about risk factors and about how to help protect a Veteran from suicide. They should know when to contact treatment providers or emergency services and how to take reasonable precautions and reduce access to lethal means. Family members must feel able to ask directly about suicidal thoughts but should not be placed in the position of providing around-the-clock "suicide watches." Involving the patient's family members or close friends is an important way to help ensure that Veterans leaving the emergency department after a suicide attempt or those being discharged after inpatient care keep their follow-up appointments. These individuals also can help support patient adherence to important treatment decisions.

Contact and collaboration between providers and the patient's family members or friends usually requires consent from the Veteran. The VA/DoD clinical practice guidelines provide recommendations on involving family members and loved ones in caring for a Veteran.

Goal 10. Provide care and support to individuals affected by suicide deaths and suicide attempts to promote healing, and implement community strategies to help prevent further suicides.

Veterans who have made a suicide attempt may receive insufficient care in the community. Similarly, those who have experienced a suicide loss may receive little or no guidance or support related to the traumatic impact of this occurrence. While most who have been bereaved by suicide recover from the trauma, many people may suffer alone and experience harmful effects that can be devastating and sometimes long-lasting. For these reasons, it is crucial to pay attention to the needs of these vulnerable and underserved groups.

Objective 10.1: Support the development of guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the national, state/territorial, tribal, and community levels.

Veterans may experience bereavement due to the suicide of a loved one or a fellow Veteran. In addition, a community experiences grief when a Veteran dies by suicide. Guidelines for providing care and support to those who have experienced a suicide loss are needed. Communities vary tremendously in the extent to which they provide these types of support services. People bereaved by suicide often have difficulty finding the services they need when they are ready to access them.

Developing comprehensive national guidelines for effective support will provide a road map for the kinds of services communities can provide to those affected by suicide. This support can include, but is not limited to:

- Trained outreach teams to support those who are bereaved by suicide
- Face-to-face and online support groups
- Memorial services
- Interactions among survivors of suicide loss

VA is part of the Action Alliance's Survivors of Suicide Loss Task Force, which is developing consensus guidelines for creating and implementing effective, comprehensive support programs for individuals affected by a suicide loss. VA has also partnered with the Tragedy Assistance Program for Survivors, a nonprofit organization dedicated to meeting the needs of bereaved survivors who have lost a Service member or Veteran loved one.

Objective 10.2: Provide appropriate clinical care to Veterans affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Exposure to a suicide attempt or death, particularly of someone close, can have harmful effects on Veterans, including putting them at increased risk for suicide. The reactions can be intense, complex, and long-lasting and may be accompanied by powerful emotions such as denial, anger, guilt, and shame. Each person will experience this grief in a unique way. Because of the stigma attached to suicide, family members and friends may not know how to help a Veteran who has been affected by a suicide loss or attempt. Shame and embarrassment may prevent the Veteran from reaching out for help. While support groups can be very helpful, Veterans affected by suicide must also have access to knowledgeable professional services and support.

Objective 10.3: Increase efforts to engage Veteran suicide attempt survivors in suicide prevention planning, including peer-to-peer support services, treatment, community suicide prevention education, and the development of guidelines and protocols for survivor support groups.

A history of prior suicide attempts is a risk factor for later death by suicide. Promoting the positive engagement of Veterans in their own care among those who have attempted suicide is crucial in successfully reducing risk for suicide. In addition, these Veterans can be powerful agents for challenging stigma and inspiring hope in others. Peer support is an underused intervention in suicide prevention. Appropriate peer support plays an important role in treating mental health and substance use disorders and helping those at risk for suicide. Guidelines and protocols are needed to support the development of such services for Veterans who have attempted suicide, as is technical assistance for disseminating and implementing these tools.

Objective 10.4: Provide health care providers, first responders, and others with care and support when a Veteran under their care dies by suicide.

Clinicians, first responders, emergency personnel, and other medical professionals who lose a Veteran to suicide should be provided with support to deal with the emotional aftermath of this traumatic event. Such support should address trauma and grief reactions and potential suicide risk among caregivers. Mechanisms for review of such deaths should avoid blaming the caregiver. Instead, the goal should be to respond to the caregiver's need for support and help the provider respond to Veterans who may be at risk for suicide in the future.

Strategic Direction 4: Surveillance, Research, and Evaluation

Public health surveillance refers to the ongoing, systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality. In contrast, research and evaluation are activities that assess the effectiveness of particular interventions, thereby adding to the knowledge base in Veteran suicide prevention.

The collection and integration of surveillance data on Veterans' suicidal behavior should be expanded and improved. In addition, although some evidence is available regarding the effectiveness of particular interventions and approaches, there is a need to assess the effectiveness of practices that specifically address Veterans.

Goal 11. Increase the timeliness and usefulness of national surveillance systems relevant to preventing Veteran suicide and improve the ability to collect, analyze, and use this information for action.

The regular collection and rapid dissemination of Veteran suicide-related data are needed to guide appropriate public health action. The time between when an event takes place and when the data are ready for dissemination must be shortened. This is no simple task, as it involves collecting information on several behaviors (e.g., suicidal thoughts, attempts, deaths) that may be available at different levels (e.g., local, state, national). The information may come from several different sources, including vital statistics, emergency departments, inpatient hospital records, urgent care centers, and death reviews, and may not be connected.

It is important to strengthen systems and improve the quality of the Veteran suicide data collected for surveillance purposes. It is equally necessary to enhance the ability of jurisdictions to use available information for strategic planning to prevent suicidal behaviors.

One public data source that contains information on suicidal behaviors among Veterans is "Suicide Among Veterans and Other Americans (2001–2014)," a VA report on the most comprehensive analysis of Veteran suicide in our nation's history. It examines more than 55 million records from 1979 to 2014 from all 50 states, Puerto Rico, and Washington, D.C.

Examples of existing nationally representative data sources containing information regarding suicidal behaviors include:

1. **CDC's National Vital Statistics System:** Annual data on all suicide deaths occurring in the U.S., available from WISQARS (www.cdc.gov/injury/wisqars)
2. **CDC's National Violent Death Reporting System:** Annual data on suicide deaths from 18 states, available from WISQARS (www.cdc.gov/injury/wisqars/nvdrs.html)
1. **CDC's Youth Risk Behavior Surveillance System:** Data released every two years on suicide ideation and attempts among high school students (www.cdc.gov/healthyyouth/yrbs/index.htm)
2. **SAMHSA's National Survey on Drug Use and Health:** Annual survey that, since 2008, has included questions on suicidal thoughts and behaviors among adults (www.oas.samhsa.gov/nsduh.htm)

Objective 11.1: Continue to make advances in the precision and quality of Veteran suicide-related data.

Consistent suicide-related data can help public health practitioners better understand the scope of the problem, identify high-risk groups, and monitor the effects of suicide prevention programs. However, existing data regarding Veteran suicide and suicidal behavior continue to have many limitations. Deaths from suicide may be misclassified as homicides, accidents, or even deaths from natural causes. Information available from death certificates is limited and provides an incomplete picture of the risk factors for suicide. Death scene investigations can reveal

important information about the circumstances of a suicide and its method. This information can be used to improve understanding of suicide and enhance prevention efforts. Emergency medical technicians, police, medical examiners, and coroners may all contribute to the collection of these data. There is a need to improve the quality and accuracy of death scene investigations by providing training to these responders.

Efforts to link and analyze information coming from separate data sources — such as law enforcement, emergency medical services, and hospitals — are also needed. Linked data can provide much more comprehensive information about an event, its circumstances, the occurrence and severity of injury, the type and cost of treatment received, and the outcome in terms of both morbidity and mortality.

Objective 11.2: Support state/territorial, tribal, and local public health efforts to routinely collect, analyze, report, and use Veteran suicide-related data to implement prevention efforts and inform policy decisions.
Staff members in states/territories, tribes, and local governments require training on how to analyze and interpret Veteran suicide data for policy and prevention purposes. Although national data provide an overall view of the problem, local data are key to effective prevention efforts. State/territorial, tribal, and local suicide rates vary considerably from national rates. There is a need to promote the development of local reports on Veteran suicide and suicide attempts, and to integrate data from multiple data management systems. These reports should describe the magnitude of the Veteran suicide problem and how suicide affects particular groups of Veterans. The reports should also address the use of mental health and substance use services. These publications are useful in tracking trends in Veteran suicide rates over time, identifying changes in groups at risk and methods used, and evaluating suicide prevention efforts. At the local level, they could serve as a resource for developing timely and targeted interventions to prevent Veteran suicidal behaviors. State epidemiologists and Suicide Prevention Coordinators could play an important role in supporting and providing assistance for these local efforts.

Goal 12. Promote and support research on Veteran suicide prevention.

Research on Veteran suicide prevention has increased considerably during the past 20 years. Findings have contributed to the development of assessment tools, resiliency-building interventions, and treatment and symptom-monitoring techniques. Continued advancements will lead to the development of better assessment tools, treatments, and preventive interventions.

Objective 12.1: Develop a national Veteran suicide prevention research agenda with comprehensive input from multiple stakeholders.
The Veteran suicide research agenda builds on existing knowledge of suicide prevention and surveillance findings to identify priority research areas. Topics could include Veterans with increased suicide risk, gender and ethnic differences, social and economic factors, genetic contributions, protective factors, promising interventions for suicide prevention and treatment, and interventions for Veterans who have been affected by suicide.

Objective 12.2: Promote the timely dissemination of suicide prevention research findings.
Emerging suicide prevention research findings that are relevant to Veterans must be translated into recommendations and suggestions for practical application in multiple settings. Researchers should be encouraged to publish their findings so that practitioners can incorporate them into the development of new interventions targeting particular groups of Veterans. There is also a need to disseminate these findings more widely while targeting specific groups, such as health care providers, public health officials, and providers of aging services.

Goal 13. Evaluate the impact and effectiveness of Veteran suicide prevention interventions and systems, and synthesize and disseminate findings to inform future efforts.

Program evaluation is a driving force in planning effective suicide prevention strategies, improving existing programs, informing and supporting policy, and demonstrating the results of resource investments. Interventions to prevent Veteran suicide should be guided by specific testable hypotheses and implemented among groups of sufficient size to yield reliable results. Given the state of the field, program evaluations should emphasize measurable behavioral outcomes in addition to other outcomes (e.g., changes in knowledge or attitudes) and process measures (e.g., number of people attending program sessions).

Programs for disorders that share risk factors with Veteran suicide should be encouraged to incorporate suicide prevention components and related measures in their program design and evaluation plans. For example, suicide shares risk and protective factors with substance abuse. The evaluation of Veteran substance abuse interventions should incorporate suicide-related outcome measures as a way of assessing the potential effect of such programs on preventing Veteran suicidal behaviors.

Objective 13.1: Evaluate the effectiveness of Veteran suicide prevention interventions.
A broad range of interventions can be used for Veteran suicide prevention. Examples include education and awareness programs, life skills development, media reporting guidelines for suicide, community programs, clinical provider training, screening for individuals at high risk, crisis lines, medications, psychotherapy, and follow-up care for suicide attempts. Program evaluations and other studies must evaluate the effectiveness of these interventions and their impact on the prevention of Veteran suicide attempts and deaths. In particular, there is a need to implement and evaluate the effectiveness of interventions for Veterans who have experienced a suicide loss, as few studies have focused specifically on this population.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of Veteran suicide prevention interventions.
Although the number of evaluated Veteran suicide prevention strategies has increased over the years, findings from individual studies must be assessed and synthesized in order to understand the strength of the evidence in support of particular interventions. Systematic reviews are important in the assessment and synthesis of research findings. These reviews can help identify effective interventions and provide recommendations for future programs and research.

More research is needed to better understand the strength of the evidence in support of Veteran suicide prevention interventions. After findings are synthesized, they should be disseminated to promote the broader implementation of the specific types of interventions that have been found to be effective in preventing Veteran suicide.

Objective 13.3: Evaluate the impact and effectiveness of the National Strategy for Preventing Veteran Suicide in reducing Veteran suicide morbidity and mortality.
The National Strategy for Preventing Veteran Suicide represents a comprehensive, long-term approach to Veteran suicide prevention. It is a road map that, when followed, will bring us closer to a nation free of Veteran suicide. Different stakeholder groups (e.g., associations, government agencies, health systems) related to Veteran suicide may find it useful to review the goals and objectives in the strategy and identify their own priority areas for action.

Goal 14. Refine and expand the use of predictive analytics for at-risk Veterans and for known upstream risks such as opioid use.

New uses of analytics, such as in social media and other public data sets, are beginning to be explored but will need careful consideration and evaluation to balance risk and benefit. One potential important use is leveraging social media and digital data to improve surveillance and implement targeted, bundled interventions to subpopulations at risk.

Objective 14.1: Explore the use of predictive analytics to produce insights supporting upstream prevention efforts.
Predictive analytics has the potential to provide insights for any system that has access to large sets of data. Within VA, current use of predictive analytics for suicide risk, such as VA's REACH VET program, shows significant potential but needs continued refinement and evaluation to improve efficiency and impact. This risk-based approach is also limited in use to individual-level impacts for relatively small numbers of Veterans and cannot significantly reduce the overall Veteran suicide rate.

Additional predictive risk approaches, such as VA's Stratification Tool for Opioid Risk Management (STORM), have the potential to identify key upstream risks for suicide and can be combined with REACH VET and other clinically relevant data to inform clinical decision-making. This approach has been launched through the CAPRI, REACH VET, Risk Indicators, and STORM Tool for Analytic Look-up (CRISTAL) dashboard for Veterans Crisis Line responders and is beginning to be used by VA clinicians. However, predictive analytics as a support tool for clinical decision-making in mental health is still in its infancy.

Closing

Suicide is a serious public health issue that impacts not just the Veteran population — approximately 20 million people — but entire communities. A complex challenge like Veteran suicide will only be solved with a comprehensive, coordinated approach that reaches across many sectors. The 14 goals discussed in this strategy represent the best evidence-based approach to solving this problem.

But VA cannot do it alone. We *all* have a role to play in preventing Veteran suicide. As we put this strategy into practice, we ask everyone to join us in this commitment to support the Veterans in *your* community. In turn, we make a commitment to you — to provide best-in-class, evidence-based resources, tools, and education to help you do it.

We *can* end Veteran suicide, and by working together, we *will*.

Appendix A: Key Terms

Affected by suicide. All those who may feel the effect of suicidal behaviors, including those bereaved by suicide, community members, and others.

Behavioral health. A state of mental and emotional being, along with choices and actions, that affects wellness. Behavioral health problems include mental health and substance use disorders and suicide.

Bereaved by suicide. Family members, friends, and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).

Means. The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

Methods. Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Suicidal behaviors. Behaviors related to suicide, including preparatory acts, suicide attempts, and deaths.

Suicidal ideation. Thoughts of engaging in suicide-related behavior.

Suicide. Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide attempt. A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

These definitions reflect how the terms are used in this Strategy for Preventing Veteran Suicide.

Appendix B: Resources

Resources for Veterans and Their Loved Ones

Coaching Into Care

Coaching Into Care is a national telephone service from VA that aims to educate, support, and empower family members and friends who are seeking care or services for a Veteran.

Make the Connection

MakeTheConnection.net is an online VA resource designed to connect Veterans, their family members and friends, and other supporters with information, resources, and solutions to issues affecting their lives.

VA Telehealth Services | Page 16

VA Telehealth Services uses health informatics, disease management, and telehealth technologies to target care and case management — improving access to care and Veterans' health.

Veterans Crisis Line | Pages 9, 16–17, and 26

The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline, online chat service, and text messaging service.

Veterans Crisis Line Resource Locator | Page 24
A locator tool for VA, National Resource Directory, and SAMHSA Behavioral Health Treatment Services resources, hosted by the Veterans Crisis Line.

Community Engagement

Community Provider Toolkit | Page 25
The Community Provider Toolkit links community providers with information and resources that are relevant to Veterans' health and well-being.

Veterans Outreach Toolkit
The Veterans Outreach Toolkit links community members with information and resources that help them send the message that they value Veterans and their service.

#BeThere for Veterans
The #BeThere campaign emphasizes that everyday connections can make a big difference to someone going through a difficult time and that individuals don't need special training to safely talk about suicide risk or show concern for someone in crisis. #BeThere provides resources, ideas, and support for Veterans and Service members as well as their families and friends.

Department of Defense #BeThere Peer Support and Outreach Center | Page 18
The #BeThere peer assistance line is the only dedicated DoD peer support call and outreach center available to all Service members across the Department (including the National Guard and Reserve) and their families. The program is staffed by peer coaches who are Veterans, Service members, and spouses of Veterans and Service members, and is available 24/7 through chat, email, phone, and text.

Department of Defense Transition Assistance Program (TAP)
The Transition Assistance Program was established to meet the needs of separating Service members during their period of transition into civilian life by offering job search assistance and related services.

Military OneSource
Military OneSource offers Service members, military families, and the entire global military community a wide range of individualized consultation, coaching, and counseling services for many aspects of military life.

Military Crisis Line
The Military Crisis Line connects Service members in crisis and their families and friends with qualified, caring VA responders, through a confidential, toll-free hotline, online chat service, and text messaging service.

Resources for Survivors of Suicide Loss

American Foundation for Suicide Prevention – Resources for Loss Survivors
Established in 1987, the American Foundation for Suicide Prevention is a voluntary health organization that gives those affected by suicide a nationwide community empowered by research, education, and advocacy to take action in preventing suicide.

Task Force for Survivors of Suicide Loss (Action Alliance for Suicide Prevention) | Page 29

The goal of the Task Force for Survivors of Suicide Loss is to develop consensus guidelines for creating and implementing effective, comprehensive support programs for those who have lost someone by suicide.

Tragedy Assistance Program for Survivors (TAPS) | Page 29

The Tragedy Assistance Program for Survivors offers compassionate care to all those grieving the loss of a Veteran or Service member loved one.

Public Health Approach to Suicide Prevention

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action | Pages 2, 4, and 12

The National Strategy for Suicide Prevention provides the framework for suicide prevention in the United States. First published in 2001 and then updated in 2012, the national strategy represents the combined work of advocates, clinicians, researchers, survivors, and others. It lays a framework for action to prevent suicide and guides the development of an array of services and programs.

Department of Defense Strategy for Suicide Prevention

The Defense Strategy for Suicide Prevention uses the framework laid out in the 13 goals and 60 objectives of the 2012 National Strategy for Suicide Prevention. The strategy guides the DoD's efforts as it strives to reach the aspirational goal of zero suicides.

CDC Technical Package for Implementing a Public Health Approach to Suicide Prevention

The technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide.

CDC Public Health Approach to Violence Prevention

The Public Health Approach to Violence Prevention offers a framework for asking and answering the right questions. To address these questions, the public health approach uses a systematic, scientific methodology for understanding and preventing violence.

SAMHSA Center for the Application of Prevention Technologies: Practicing Effective Prevention

The Center for the Application of Prevention Technologies: Practicing Effective Prevention resource allows visitors to find information on how to plan, implement, and evaluate evidence-based interventions and learn how prevention relates to behavioral health.

Suicide Prevention Best Practices and Clinical Guidance

VA/DoD Clinical Practice Guideline | Pages 24–28

The clinical practice guidelines on suicide prevention recommend a framework for the assessment of a person thought to be at risk for suicide — and for the immediate and long-term management that should follow once risk has been determined.

Mental Illness Research, Education and Clinical Centers (MIRECCs)

The MIRECCs were established by Congress with the goal of researching the causes and treatments of mental health disorders and using education to put new knowledge into routine clinical practice at VA.

National Registry of Evidence-based Programs and Practices (NREPP) Learning Center | Page 20
The NREPP Learning Center offers dozens of new resources to support the selection, implementation, evaluation, and sustainment of evidence-based programs and practices, along with case studies, stories, and videos.

Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) | Page 33
In 2017, VA launched an innovative program called REACH VET. Using a new predictive model, REACH VET analyzes existing data from Veterans' health records to provide pre-emptive care and support — in some cases before a Veteran has suicidal thoughts.

Stratification Tool for Opioid Risk Management (STORM) | Page 33
STORM is a tool developed within the Veterans Health Administration that prioritizes patients for review and intervention according to their modeled risk for overdose/suicide-related events and displays risk factors and risk mitigation interventions obtained from VHA medical records.

Columbia-Suicide Severity Rating Scale (C-SSRS) | Page 20
The C-SSRS — the most evidence-supported tool of its kind — is a simple series of questions that anyone can use anywhere in the world to prevent suicide.

Training, Counseling, and Educational Resources

Action Alliance Framework for Successful Messaging | Page 17
The Framework for Successful Messaging is a resource to help people communicating about suicide to develop messages that are strategic, safe, and positive, and that make use of relevant guidelines and best practices.

Counseling on Access to Lethal Means (CALM) | Page 22
The CALM course explains why means restriction is an important part of a comprehensive approach to suicide prevention.

Operation S.A.V.E: VA Suicide Prevention Gatekeeper Training | Page 24
Operation S.A.V.E. is a one- to two-hour gatekeeper training session provided by VA Suicide Prevention Coordinators to Veterans and to those who serve Veterans.

Picture This: Depression and Suicide Prevention (Entertainment Industries Council guide) | Page 19
Picture This is a guide for content creators in the entertainment industry that addresses issues related to depression and suicide prevention, which include those as identified by mental health experts, advocates, policymakers, and others working to improve public awareness about and reduce instances of depression and suicide.

CDC's Social Media Tools, Guidelines, and Best Practices | Page 17
To assist in planning, developing, and implementing social media activities, the CDC developed guidelines to provide critical information on lessons learned, best practices, clearance information, and security requirements.

Social Media Guidelines for Mental Health Promotion and Suicide Prevention | Page 17
As part of its TEAM Up initiative, the Entertainment Industries Council developed guidelines to provide tips for organizations and individuals communicating about mental health and suicide on social media to reduce stigma, increase help-seeking behavior, and help prevent suicide.

Recommendations for Reporting on Suicide | Page 17
This website presents research-based recommendations for reporting on suicide, including suggestions for online media, message boards, bloggers, and "citizen journalists."

PsychArmor Institute Military Culture School | Page 24
PsychArmor is a nonprofit that provides free education and support for all Americans to engage effectively with the military community.

Federal Partners

Centers for Disease Control and Prevention | Pages 8, 10, and 17
The CDC works 24/7 to protect America from domestic and foreign threats to health, safety, and security by fighting disease and supporting communities and citizens in doing the same.

U.S. Department of Defense (DoD) | Pages 11 and 14
The DoD provides a lethal joint force to defend the security of the United States and to sustain American influence abroad.

The Federal Working Group on Suicide Prevention | Pages 14–15
The Federal Working Group on Suicide Prevention includes staff members from agencies and operating divisions within the departments of Defense, Health and Human Services, Homeland Security, Justice, Education, Transportation, and Veterans Affairs.

Substance Abuse and Mental Health Services Administration (SAMHSA)
SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

United States Preventive Services Task Force | Page 20
The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The task force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services.

National Action Alliance for Suicide Prevention | Pages 2 and 15
The National Action Alliance for Suicide Prevention is the public-private partnership advancing the National Strategy for Suicide Prevention. The Action Alliance envisions a nation free from the tragic experience of suicide.

Data Resources

CDC National Vital Statistics System | Page 30
The National Vital Statistics System is the oldest and most successful example of intergovernmental data sharing in public health.

CDC National Violent Death Reporting System | Page 30
The National Violent Death Reporting System provides states and communities with a clearer understanding of violent deaths to guide local decisions about efforts to prevent violence and track progress over time.

CDC Youth Risk Behavior Surveillance System | Page 30
The Youth Risk Behavior Surveillance System monitors six types of health risk behaviors that contribute to the leading causes of death and disability among youth and adults.

CDC National Center for Health Statistics (NCHS)
NCHS compiles statistical information to guide actions and policies to improve the health of Americans.

National Death Index (NDI)
The NDI is a centralized database of death record information on file in state vital statistics offices.

SAMHSA's National Survey on Drug Use and Health | Page 30
The National Survey on Drug Use and Health provides up-to-date information on tobacco, alcohol, and drug use, mental health, and other health-related issues in the United States.

VA National Center for Veteran Analysis and Statistics (NCVAS)
NCVAS develops statistical analyses and reports on a broad range of topics, disseminates Veteran data and statistics, and develop estimates and projections on Veteran populations.

Veteran Population (VetPop)
VetPop2016 provides the latest official Veteran population projection from VA.

Economic News Release

CES CPS

Table A-5. Employment status of the civilian population 18 years and over by veteran status, period of service, and sex, not seasonally adjusted

HOUSEHOLD DATA

Table A-5. Employment status of the civilian population 18 years and over by veteran status, period of service, and sex, not seasonally adjusted

[Numbers in thousands]

Employment status, veteran status, and period of service	Total		Men		Women	
	Feb. 2024	Feb. 2025	Feb. 2024	Feb. 2025	Feb. 2024	Feb. 2025
VETERANS, 18 years and over						
Civilian noninstitutional population	17,680	17,375	15,635	15,302	2,045	2,073
Civilian labor force	8,615	8,412	7,419	7,151	1,196	1,261
Participation rate	48.7	48.4	47.5	46.7	58.5	60.8
Employed	8,369	8,069	7,199	6,865	1,170	1,204
Employment-population ratio	47.3	46.4	46.0	44.9	57.2	58.1
Unemployed	247	343	220	286	26	57
Unemployment rate	2.9	4.1	3.0	4.0	2.2	4.5
Not in labor force	9,065	8,963	8,216	8,151	849	812
Gulf War-era II veterans						
Civilian noninstitutional population	5,266	5,594	4,309	4,599	957	995
Civilian labor force	4,195	4,448	3,484	3,681	711	767
Participation rate	79.7	79.5	80.9	80.0	74.3	77.1
Employed	4,090	4,256	3,395	3,530	695	726
Employment-population ratio	77.7	76.1	78.8	76.8	72.7	73.0
Unemployed	105	192	89	151	16	42
Unemployment rate	2.5	4.3	2.6	4.1	2.2	5.4
Not in labor force	1,071	1,146	825	918	246	228
Gulf War-era I veterans						
Civilian noninstitutional population	2,820	3,231	2,389	2,733	431	498
Civilian labor force	2,022	2,146	1,737	1,829	286	317
Participation rate	71.7	66.4	72.7	66.9	66.3	63.7
Employed	1,967	2,048	1,681	1,736	286	313
Employment-population ratio	69.8	63.4	70.4	63.5	66.3	62.8
Unemployed	55	98	55	94	0	5
Unemployment rate	2.7	4.6	3.2	5.1	0.0	1.4
Not in labor force	797	1,085	652	904	145	181
Vietnam-era and earlier wartime veterans						
Civilian noninstitutional population	5,756	4,988	5,513	4,799	243	189
Civilian labor force	695	589	672	570	23	19
Participation rate	12.1	11.8	12.2	11.9	9.6	10.2
Employed	660	569	637	550	23	19
Employment-population ratio	11.5	11.4	11.6	11.5	9.6	10.2
Unemployed	35	20	35	20	0	0
Unemployment rate	5.0	3.5	5.2	3.6	-	-

NOTE: Veterans served on active duty in the U.S. Armed Forces and were not on active duty at the time of the survey. Nonveterans never served on active duty in the U.S. Armed Forces. Veterans could have served anywhere in the world during these periods of service: Gulf War era II (September 2001-present), Gulf War era I (August 1990-August 2001), Vietnam era (August 1964-April 1975), Korean War (July 1950-January 1955), World War II (December 1941-December 1946), and other service periods (all other time periods). Veterans who served in more than one wartime period are classified only in the most recent one. Veterans who served during one of the selected wartime periods and another period are classified only in the wartime period. Dash indicates no data or data that do not meet publication criteria (values not shown where base is less than 75,000).

Employment status, veteran status, and period of service	Total		Men		Women	
	Feb. 2024	Feb. 2025	Feb. 2024	Feb. 2025	Feb. 2024	Feb. 2025
Not in labor force	5,061	4,399	4,841	4,229	220	170
Veterans of other service periods						
Civilian noninstitutional population	3,838	3,562	3,424	3,171	414	391
Civilian labor force	1,703	1,229	1,527	1,071	176	157
Participation rate	44.4	34.5	44.6	33.8	42.5	40.2
Employed	1,651	1,197	1,486	1,050	165	147
Employment-population ratio	43.0	33.6	43.4	33.1	39.9	37.5
Unemployed	52	32	41	22	11	10
Unemployment rate	3.0	2.6	2.7	2.0	6.0	6.6
Not in labor force	2,135	2,333	1,897	2,100	238	234
NONVETERANS, 18 years and over						
Civilian noninstitutional population	240,832	245,953	110,303	112,950	130,529	133,003
Civilian labor force	156,583	159,573	79,939	81,581	76,644	77,992
Participation rate	65.0	64.9	72.5	72.2	58.7	58.6
Employed	150,113	152,685	76,364	77,793	73,749	74,892
Employment-population ratio	62.3	62.1	69.2	68.9	56.5	56.3
Unemployed	6,470	6,888	3,574	3,788	2,896	3,100
Unemployment rate	4.1	4.3	4.5	4.6	3.8	4.0
Not in labor force	84,249	86,380	30,364	31,369	53,884	55,011

NOTE: Veterans served on active duty in the U.S. Armed Forces and were not on active duty at the time of the survey. Nonveterans never served on active duty in the U.S. Armed Forces. Veterans could have served anywhere in the world during these periods of service: Gulf War era II (September 2001-present), Gulf War era I (August 1990-August 2001), Vietnam era (August 1964-April 1975), Korean War (July 1950-January 1955), World War II (December 1941-December 1946), and other service periods (all other time periods). Veterans who served in more than one wartime period are classified only in the most recent one. Veterans who served during one of the selected wartime periods and another period are classified only in the wartime period. Dash indicates no data or data that do not meet publication criteria (values not shown where base is less than 75,000).

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Suicides Involving Veterans

Arizona Violent Death Reporting System

January 1, 2015 – December 31, 2022

July 2023

Center for Violence Prevention and Community Safety
Arizona State University

AZVDRS Violent Death Reporting System

Suicides Involving Veterans, 2015–2022

July 2023

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Suicides Involving Veterans

Arizona Violent Death Reporting System

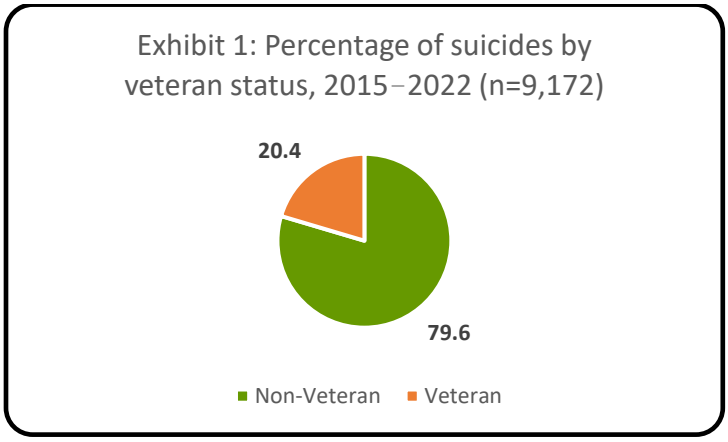
January 1, 2015 – December 31, 2022

The Arizona Violent Death Reporting System (AZ-VDRS) collects violent death data from multiple sources: death certificates issued by the Arizona Department of Health Services (ADHS), police reports obtained from investigating agencies, and death investigation and autopsy reports from medical examiner offices. The purpose of this project is to assist stakeholders with strategic planning and prevention efforts aimed toward reducing the number of violent deaths that occur each year in Arizona. The data used for this report – *Suicides Involving Veterans* – were drawn from the compilation and analysis of eight years of AZ-VDRS data, from January 1, 2015, through December 31, 2022.

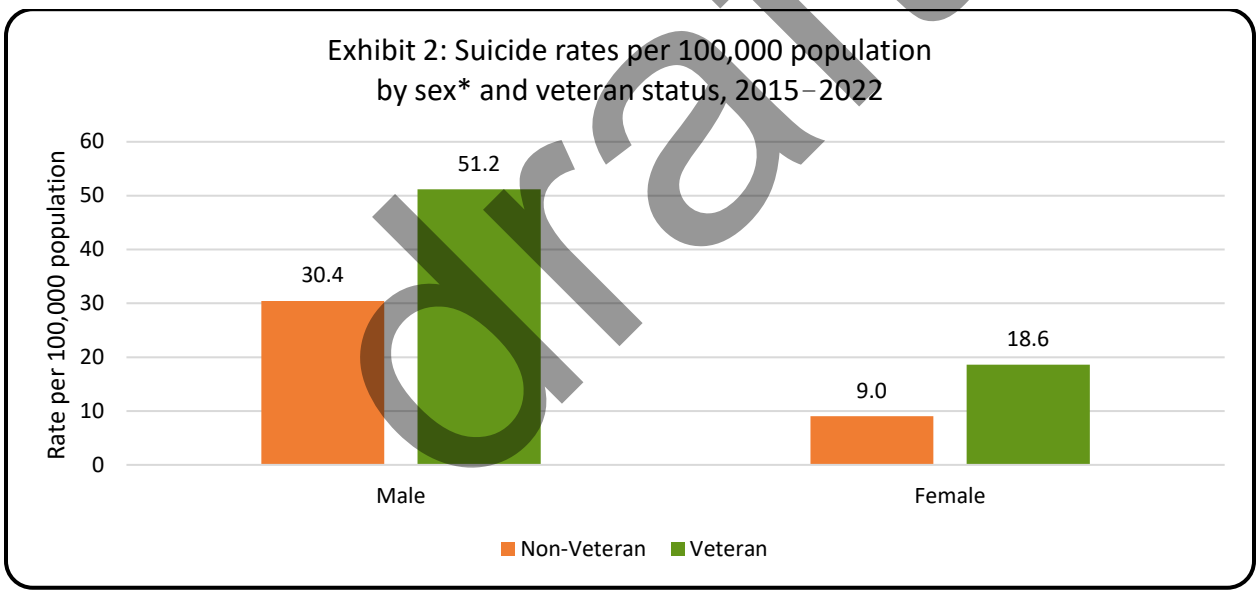
AZ-VDRS recorded a total of 16,602 violent deaths for this period; circumstance data were available for 14,146 (85.2%) of the decedents. From these, we excluded 2,926 (20.7%) homicides, 1,125 (8.0%) violent deaths of undetermined manner, and another 452 (3.2%) deaths involving unintentional firearm deaths and legal interventions, leaving 9,643 (68.2%) suicides for analysis. We further excluded 169 (1.8%) cases for which the decedents' veteran status was unknown, after which our sample consisted of 9,474 suicides for which circumstance and veteran status data were available. Finally, we restricted our analyses to adult (age 18 and older) suicide victims, excluding 302 (3.2%) youth victims and leaving 9,172 suicide victims for this report.

We determined veteran status using the indicator for military veteran on the official death certificate; we did not seek external validation, and our data may thus overcount non-veterans as veterans. Use of this definition is consistent with NVDRS standards and with prior research.[1] Note that the term *veteran* may be defined differently elsewhere; for example, individuals who are ineligible for benefits based on discharge status may be excluded in other contexts. AZ-VDRS data analyses and rate calculations may also differ from those of other sources such as the ADHS when our respective analytic processes differ; for example, AZ-VDRS counts *occurrent* deaths (those occurring within the state, regardless of legal residency) rather than *resident* deaths (those of Arizona residents, regardless of the location where death occurs). AZ-VDRS analyses include all decedents for whom we have sufficient data from the sources noted above, including but not limited to official death certificates. As a result, AZ-VDRS and ADHS reports overlap; at the same time, these organizations can each offer unique insights reflecting their respective analytic strategies. For this report, there are no known systematic errors in the AZ-VDRS veteran status counts.

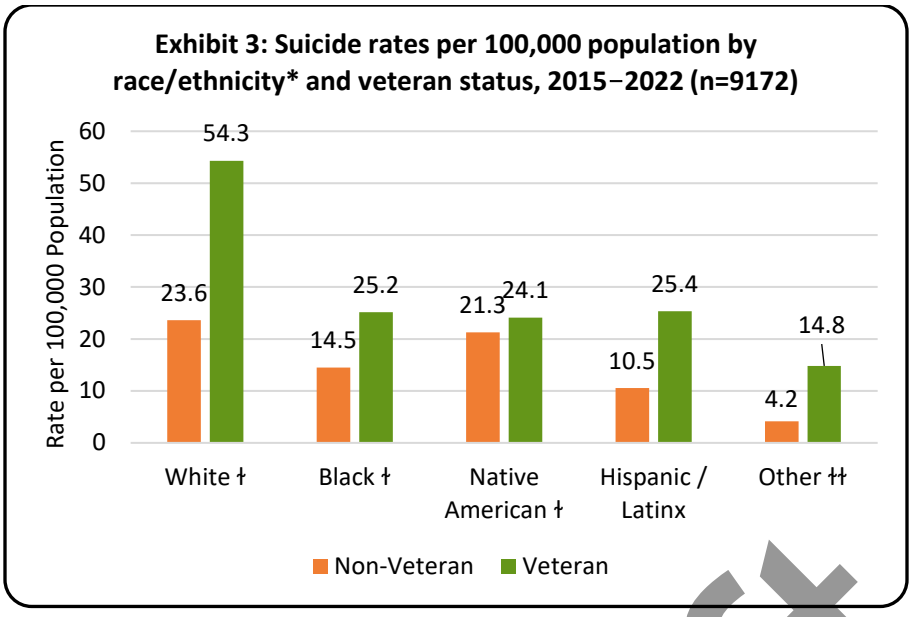
For population estimates, we relied on the American Community Survey (US Census) five-year and one-year estimates for 2015 through 2022 available at the writing of this report. Note that in all the exhibits below, the data and analyses represented are for the state of Arizona, 2015–2022, unless otherwise indicated.



- During the period of 2015–2022, in Arizona, veterans comprised more than one in five (20.4%) suicide victims.



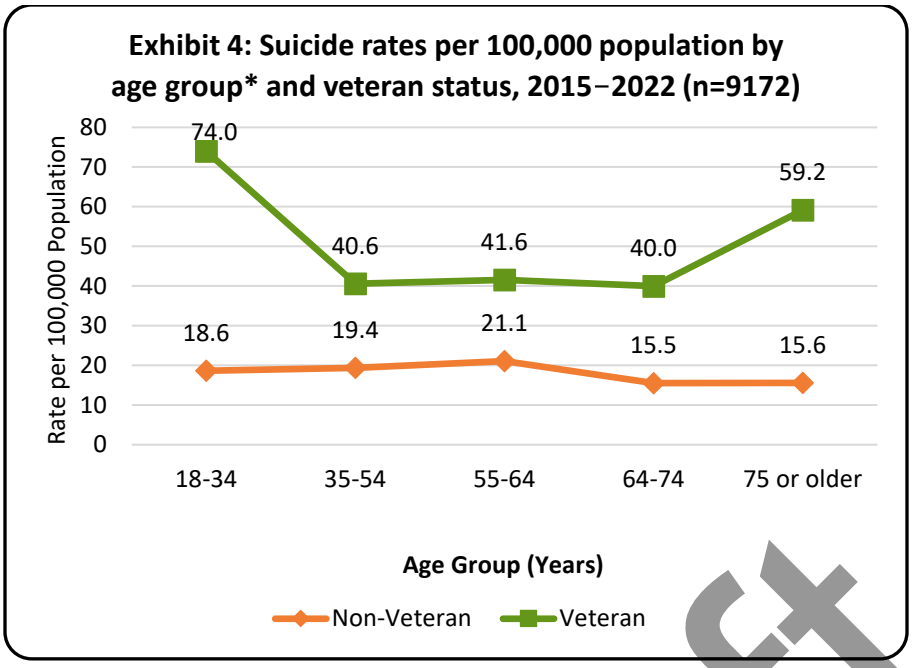
- Overall suicide rates per 100,000 population were significantly higher for male victims, 33.9, than for female victims, 9.2 (*not shown*).[2]
- Males who were veterans were at significantly greater risk of dying by suicide than males who were not veterans; during this period, the suicide rate for veterans was 68.4% greater than the rate for their non-veteran counterparts (51.2, 30.4).
- Female veterans were more than twice as likely to die by suicide as females who were not veterans (18.6, 9.0).



ǂ Non-Hispanic/Latinx; ǂǂ Includes Asian, Native Hawaiian, Pacific Islander, Other, and Unspecified

* Statistically significant at $p \leq .05$

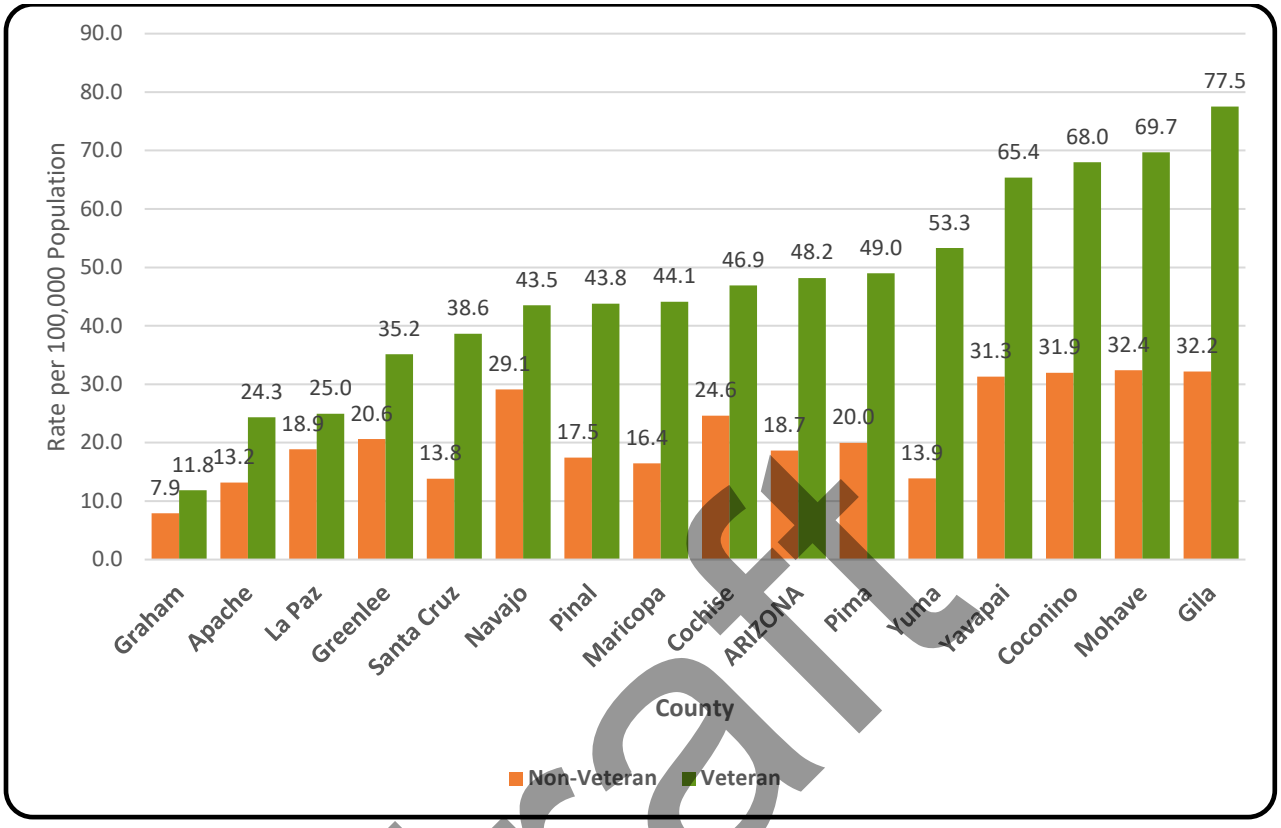
- Across racial/ethnic groups, relative suicide rates for veterans and non-veterans differed significantly.
- The suicide risk was highest for White non-Hispanic/Latinx veterans, with a rate of 54.3 per 100,000 population.
- Within all racial/ethnic groups, veterans were at greater risk of suicide than non-veterans.



* Statistically significant at $p \leq .05$

- Across all age groups, veterans ages 18–34 had the highest suicide rate (74.0); this rate was lower for those ages 35–54 (40.6), remaining relatively flat through ages 55–64 (41.6) and ages 64-74 (40.0) and then increased sharply for ages 75 or older (59.2).
- Across all age groups, non-veteran suicide rates remained relatively level, ranging from 15.5 for those aged 65–74 75 to a high of 19.4 for those ages 35–54; regardless of age group, the rate for non-veterans was never higher than that for veterans.

Exhibit 5. Suicide rates per 100,000 population by county and veteran status, 2015–2022 (n=9,172)



* Statistically significant at $p \leq .05$

- In Arizona, during the period of 2015–2022, the statewide suicide rate among veterans was more than twice that of non-veterans (48.2 and 18.7 per 100,000 population, respectively).
- Suicide rates for veterans were substantially and significantly higher than rates for non-veterans in every Arizona county.
- In La Paz, the suicide rates for veterans and non-veterans were most similar, at 25.0 and 18.9, respectively.
- Gila County (77.5) had the highest veteran suicide rate, followed closely by Mohave County (69.7), Coconino County (68.0), and Yavapai County (65.4); Graham and Apache had the lowest rates (11.8 and 24.3, respectively).
- Yuma Counties had approximately a three-to-one ratio of veteran to non-veteran suicide rates, and Coconino, Gila, Maricopa, Pima, Pinal, and Santa Cruz all had a two-to-one or more ratio of veteran to non-veteran suicide rates.

Exhibit 6. Completed education, marital status, and birthplace among suicide victims ages 18 and older by veteran status, 2015-2022 (n=9,172)

	Non-Veteran		Veteran		Total	
	n	%	n	%	n	%
Completed Education*						
<= 8th grade	216	3.0	26	1.4	242	2.6
9th – 12th grade	839	11.5	66	3.5	905	9.9
High school or GED grad	2596	35.6	633	33.8	3229	35.2
Some college credit	1594	21.8	471	25.2	2065	22.5
Associate or bachelor's Degree	1436	19.7	452	24.1	1888	20.6
Advanced degree	458	6.3	166	8.9	624	6.8
Unknown	161	2.2	58	3.1	219	2.4
Marital Status*						
Never Married	3013	41.3	295	15.8	3308	36.1
Married	1881	25.8	692	37.0	2573	28.1
Married, but separated	295	4.0	72	3.8	367	4.0
Divorced	1636	22.4	541	28.9	2177	23.7
Widowed	381	5.2	255	13.6	636	6.9
Single, unspecified	12	0.2	1	0.1	13	0.1
Unknown	82	1.1	16	0.9	98	1.1
Birthplace*						
Arizona	2196	30.1	239	12.8	2435	26.5
Other US state or territory	4355	59.7	1547	82.6	5902	64.3
Foreign country	608	8.3	53	2.8	661	7.2
Unknown	141	1.9	33	1.8	174	1.9

* Statistically significant at $p \leq .05$

- Veteran suicide victims differed significantly from non-veteran victims with respect to education completed, marital status, and birthplace.
- Veteran suicide victims were substantially more likely to have earned some college credit or a degree, compared to non-veterans (58.2%, 47.8%).
- Veteran suicide victims were also significantly more likely than non-veteran victims to have been married (including married but separated; 40.8%, 29.8%) or divorced (28.9%, 22.4%).
- Non-veteran suicide victims were more than twice as likely as veteran victims to have never married (41.3%, 15.8%).
- Veteran suicide victims were significantly more likely than non-veteran victims to have been born in a US state other than Arizona (82.6%, 59.7%).

Exhibit 7. Locations of suicide by veteran status, 2015–2022 (n=9,172)

	Non-Veteran		Veteran		Total	
Location*	n	%	n	%	n	%
House or apartment	5188	71.1	1454	77.7	6642	72.4
Street/road, sidewalk, alley	275	3.8	56	3.0	331	3.6
Motor vehicle (excluding school bus and public transportation)	465	6.4	107	5.7	572	6.2
Commercial establishment (bar, store, service station, etc.)	52	0.7	5	0.3	57	0.6
Parking lot/public parking garage	126	1.7	35	1.9	161	1.8
Jail, prison, group home, shelter, other supervised residential facility	159	2.2	17	0.9	176	1.9
Park, playground, public use area	88	1.2	21	1.1	109	1.2
Natural area (e.g., field, river, beach, woods)	336	4.6	70	3.7	406	4.4
Hotel/motel	211	2.9	44	2.4	255	2.8
Other	371	5.1	59	3.2	430	4.7
Unknown	29	0.4	4	0.2	33	0.4
Total	7300	100.0	1872	100.0	9172	100.0

* Statistically significant at $p \leq .05$

- Among both veteran and non-veteran suicide victims, about three in four suicides occurred in private residences.
- Although locations where suicides occurred varied significantly among veteran and non-veteran victims, for any single location type, there were few substantive differences between the two groups.
- Notably, less than 0.9% (n=17 of 1,872 veterans) died by suicide while in jail, prison, a shelter, or another supervised facility, compared to 2.2% (n=159) of non-veteran suicide victims.

Exhibit 8. Methods of death by veteran status, 2015–2022 (n=9,172)

	Non-Veteran		Veteran		Total	
Method*	n	%	n	%	n	%
Firearm	4016	55.0	1487	79.4	5503	60.0
Sharp Instrument	125	1.7	26	1.4	151	1.6
Fall	138	1.9	11	0.6	149	1.6
Hanging, strangulation, suffocation	1811	24.8	199	10.6	2010	21.9
Poisoning	1022	14.0	133	7.1	1155	12.6
Drowning	38	0.5	5	0.3	43	0.5
Vehicular	104	1.4	8	0.4	112	1.2
Other †	46	0.6	3	0.2	49	0.5
Total	7300	100.0	1872	100.0	9172	100.0

† Including but not limited to fire/burns, blunt force trauma, other, and unknown.

* Statistically significant at $p \leq .05$

- There were significant differences in the methods or causes of death between veteran and non-veteran suicide victims.
- Notably, about four in five veteran suicide victims used a firearm, compared to about half of non-veteran victims (79.4%, 55.0%).
- Veteran suicide victims also used hanging, strangulation, or suffocation (10.6%) and poisoning (7.1%) far less frequently than non-veteran suicide victims (24.8% and 14.0%, respectively).

Exhibit 9. Circumstances of suicide victims by veteran status, 2015–2022 (n=9,172)

	Non-Veteran (n=7300)		Veteran (n=1872)		Total	
Mental Health	**n**	**%**	**n**	**%**	**n**	**%**
Current Mental Health Problem*	3547	48.6	805	43.0	4352	47.4
Current Depressed Mood*	2471	33.8	565	30.2	3036	51.7
Ever Treated for Mental Illness or Substance Misuse*	2406	33.0	418	22.3	2824	48.1
Current Treatment for Mental Illness or Substance Misuse*	1712	23.5	321	17.1	2033	34.6
Any Mental Health Problem*	4753	65.1	1096	58.5	5849	99.6
Substance Abuse / Addiction						
Alcohol Problem*	1471	20.2	298	15.9	1769	19.3
Other Substance Problem*	1567	21.5	170	9.1	1737	18.9
Other Addiction (gambling, sexual, etc.)	51	0.7	10	0.5	61	0.7
Any Addiction Problem*	2569	35.2	411	22.0	2980	32.5
Interpersonal						
Family Relationship Problem*	605	8.3	86	4.6	691	7.5
Intimate Partner Problem*	2029	27.8	379	20.2	2408	26.3
Other Relationship Problem*	145	2.0	27	1.4	172	1.9
Perpetrator of Interpersonal Violence in Past Month	179	2.5	48	2.6	227	2.5
Victim of Interpersonal Violence in Past Month	34	0.5	1	0.1	35	0.4
Suicide of Friend/Family in Past 5 Years	144	2.0	30	1.6	174	1.9
Other Death of Friend/Family	483	6.6	138	7.4	621	6.8
Any Interpersonal Problem*	3005	41.2	610	32.6	3615	39.4
Life Stressor						
Physical Health Problem*	1420	19.5	201	10.7	1621	17.7
Job Problem*	716	9.8	103	5.5	819	8.9
Recent Criminal-Related Legal Problem*	524	7.2	97	5.2	621	6.8
Other Legal Problems	233	3.2	51	2.7	284	3.1
Financial Problem*	692	9.5	116	6.2	808	8.8
School Problem*	47	0.6	4	0.2	51	0.6
Eviction or Loss of Home	269	3.7	57	3.0	326	3.6
Any Life Stressor*	3054	41.8	975	52.1	4029	43.9
Suicide Event						
History of Suicide Attempts*	1779	24.4	296	15.8	2075	22.6
Disclosed Intent to Complete Suicide	2071	28.4	524	28.0	2595	28.3
History of Suicidal Thoughts*	3709	50.8	883	47.2	4592	50.1
Any Indication of Suicide*	4403	60.3	1010	54.0	5413	59.0

* Statistically significant at $p < .05$

Note: Circumstance characteristics are not mutually exclusive, and any particular victim may have any number of circumstances present.

- Veteran suicide victims were **less** likely than non-veteran victims to have mental health and/or substance misuse issues reported; for example, one or more mental health-related circumstances were reported for 58.5% of veteran victims, compared to 65.1% of non-veteran victims.
- Substance misuse problems, not including alcohol, were reported more than twice as often for non-veteran suicide victims as for veteran victims (9.1%, 21.5%).
- Interpersonal problems appeared to be a less significant factor for veteran suicide victims than for non-veteran victims; some form of interpersonal problem was reported for about one in three veteran victims and about two in five non-veteran victims (32.6%, 41.2%)
- Conversely, life stressors were more likely among veteran suicide victims than for non-veteran victims (52.1%, 41.8%).
- Suicide victims who were veterans were significantly **less** likely than victims who were not to be reported as having a history of attempting suicide (15.8%, 24.4%); in fact, veteran victims were **less** likely to have any prior indicators of suicide risk reported (54.0%, 60.3%, respectively).

Implications

Suicide among military veterans is a critical and emerging issue nationally, and this is of paramount concern in the state of Arizona, where AZ-VDRS findings show a significant and substantial influence of veteran status on individual suicide risk. The proportion of veterans in the state population is higher than the national average. Given the geographic size and rural nature of much of the state, dispersion of resources becomes a critical component of responding to veteran suicides.

Our analyses showed that suicide victims who were veterans were less often reported to have experienced substance abuse and interpersonal problems or conflicts than non-veteran victims. Veteran and non-veteran victims were similar in their associations with life stressors in general, but veteran victims were more likely to have had life stressors contribute to their suicide overall.

Most veteran suicide victims in our analyses were male. It may be a lingering cultural influence that men generally and veterans specifically are disinclined to reach out for help when experiencing mental and emotional distress; this suggests that early screening and treatment for both male and female veterans with risk factors for depression are particularly important for suicide prevention. More than 30% of all veteran suicide victims (not only males) in this report had reportedly been suffering from a depressed mood or dysthymia prior to taking their own lives, yet only 17.1% were currently receiving any mental health treatment (although this may be conflated, as the measure includes substance abuse treatment as well as standard behavioral health treatment). Further, nearly half (47.2%) were known to have had suicidal thoughts, and more than a quarter had disclosed their intent to die by suicide shortly before doing so (28.0%). If we as a state and a nation are serious about preventing suicide among our veterans, increased support for mental health screening and treatment after diagnosis is needed urgently. Critically, we owe veteran men and women the highest standard of care and a rapid, effective response when they have disclosed suicidal thoughts and intentions or have survived actual attempts. The goal should be nothing less than the restoration of their potential for a high quality of life.

[1] Huguet, N., Kaplan, M. S., & McFarland, B. H. (2014). The effects of misclassification biases on veteran suicide rate estimates. American Journal of Public Health, 104(1), 151–155. https://doi.org/ 10.2105/AJPH.2013.301450

[2] AZ-VDRS estimates of suicide rates, particularly those of Native American males, may differ from rates reported by other death surveillance systems due to important variations in data sources and coding protocols. For this reason, comparative analyses outside the NVDRS and AZ-VDRS should be approached with caution.