**Twin Cities Suicide Prevention Coalition**

**Military Culture Informational Toolkit**

*for preventing suicide in Service Members, Veterans and their Families*

This toolkit provides a general understanding of Service Members, Veterans and Families and the role that military culture has in facilitating connection and preventing suicide. It outlines steps community members can take in order to demonstrate cultural competency, provide support and help prevent suicide in Service Members, Veterans and their Families.

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**Twin Cities Suicide Prevention Coalition**

The Twin Cities Suicide Prevention Coalition was founded in 2019, as a collaboration between U.S. Department of Veterans Affairs (VA) and community organizations, agencies and individuals working towards the same goal.

**Our Vision:** Eliminate suicide in Service Members, Veterans and Families, within the greater Twin Cities, Minnesota, metropolitan area.

To accomplish this vision, we are focusing on three priority areasof suicide prevention:

* Identify Service Members, Veterans and their Families, and screen for suicide risk
* Promote connectedness and improve care transitions
* Increase lethal means safety and safety planning

The Twin City Suicide Prevention Coalition directs suicide prevention outreach in local communities where Service Members and Veterans work, live and thrive. **Everyone has a vital role to play in preventing suicide.**

**Please join us in this mission.**

**Overview**

Today there are over 20 million Veterans in the U.S.1 Service Members, Veterans and their Families (SMVF) live and work in communities across our nation. They are our co-workers, neighbors, classmates and friends. Nevertheless, fewer than 7% of Americans have ever served in uniform.2 Most civilians are unfamiliar with military culture and they may not feel comfortable effectively engaging and connecting with those in the military community. This toolkit was created to improve experiences of SMVF by educating communities about culture of the military and increasing awareness around suicide prevention. Our hope is to facilitate communication and increase connection of the civilian community with individuals currently or previously serving in the military, and their family members.

Minnesota is home to 331,383 Veterans.3 SMVF are an integral part of our communities and they present unique needs and challenges. Now more than ever, we need to engage a community approach to find, care for and help those in the SMVF community thrive.

This toolkit summarizes principles of the military, military services and military culture. **There are several nuances that contribute to military culture.** It is influenced by individual experiences and can be objective and subjective in nature. However, being familiar with and understanding general military culture will help increase support and connection with Service Members, Veterans and their Families.

**Service Member and Veteran Suicide**

Suicide is a growing public health concern. In the U.S., approximately 17 Veterans are dying by suicide every day. Suicide rates in the general population also continue to rise. In 2018, 46,510 American adults died from suicide, including 6,435 U.S. Veterans.1 Every suicide has the possibility of impacting an estimated 115 people, with one in five identifying a devastating and life-changing disruption.4

Veterans die by suicide at a rate of 1.5 times that of the general population.1 In order to eliminate Veteran and Service Member suicide, VA has adapted the public health model for suicide prevention. This model focuses on clinical intervention and proactive community-based prevention strategies to address suicide in our nation.

There is no single cause of suicide and all Veterans and Service Members do not have the same level of risk for suicide.5 Suicide is often the result of a complex interaction of factors at the individual, interpersonal, community and societal levels. As such, the public health approach to Veteran and Service Member suicide prevention must reach and connect with Veteran and Service Member peers, family members, employers, co-workers, medical and mental healthcare providers, faith-based communities, local government officials and first responders, in addition to several other community partners and organizations.

**Structure of the Military**

The Department of Defense has three military departments – the U.S. Army, U.S. Navy and U.S. Air Force. The Army is organized within its own department. The Navy and Marine Corps are organized under the Department of the Navy, and the Air Force and recently established Space Force are organized within the Department of the Air Force.6 The three components of the military include: Active Duty, National Guard and Reserve. This distinction is important, as not all Service Members enter the military in the same way and each component has their own subculture, within the greater culture of the military.

Not all people who serve in the military are “soldiers.” Each branch of service has their own identity and uses their own language. Service Members and Veterans may appreciate being asked which branch of the military they served in and what they did during their service.

[NEED TO ORDER EMBLEMS: US Army, US Marine Corps, US Navy, US Air Force, US Space Force and US Coast Guard. NEED TO GET SPACE FORCE EMBLEM AND INCLUDE “GUARDIAN” UNDERNEATH EMBLEM]



**Recognition**

Identifying SMVF within your community is important in order to acknowledge their service, skills and the distinct value they offer to our social order and society as a whole. Acknowledgement is the first step in recognizing cultural challenges SMVF may face and connecting them to resources that can empower them and improve their quality of life. SMVF may not disclose service on their own, so it is important to ask the question: **“Have you, or a close family member, ever served in the military?”** Some individuals may feel that this question is insignificant, however SMVF generally appreciate this inquiry when framed with intent to relate to, or understand them, and connect them to resources in which they are entitled.

It is important to note that not all individuals who served in the military recognize or identify themselves as Veterans. This is unique to the individual and could be due to several factors. The manner of their military experiences, what an individual’s job duty was, if they underwent deployment, or simply understanding what defines “Veteran” at state and federal levels, could influence a person identifying themselves as a Veteran. Some individuals may think they do not qualify as a Veteran if they were not deployed or did not experience combat. Others may not acknowledge their service as they themselves, may not have felt recognized or perceived as equal to other Service Members within the military.

**Challenges for Service Members, Veterans and their Families**

The military is not just a job, it is a way of life. Unlike any other profession, the military is immersed in all aspects of a Service Member’s existence. Family, work, health, housing and social structure, among other important characteristics of life, are largely impacted by service. Family members of those in the military serve alongside their loved ones, and often military service affects the entire family unit. The family structure may be damaged due to absence of the Service Member – resulting in relationship difficulties, marital stress, as well as financial strain.

Regardless of military branch, there are inherent dangers associated with combat and non-combat service in the military. Physical injury and death, traumatic experiences and resulting post-traumatic stress or moral injury, (distressing feelings following an experience that contradicts one’s moral beliefs) are some of the risks of service. Some additional hazards Service Members are exposed to include extreme temperature injuries, psychological stress, infectious disease, and chemical and biological weapons.7 SMVF may face a variety of difficulties today because of the risks connected with military service. Common challenges currently facing Service Members and Veterans are unemployment, poor physical and mental health, homelessness and lack of education.8

**Service Members and Veterans may struggle with unemployment**. When Service Members discharge from the military, they commonly need to re-enter the workforce, or possibly enter it for the first time. Transition to civilian life, even for a Service Member who has served 20 years in the military, may include acquiring a new occupation. This transition period can include admission into secondary education settings or beginning a new career field with little to no experience.

Service Members and Veterans may confront unique challenges and barriers to consistent work such as physical and mental health struggles, lack of sustainable housing and lack of education. The ability to find a job can be especially complex for Service Members and Veterans who are disabled.

Differences in communication style may even impact employability of Service Members and Veterans. As a part of military culture, loud, direct and brief communication is a necessity as there is rarely time, especially during difficult deployment situations, to provide lengthy explanations. Service Members and Veterans who have become accustomed to brief and direct communication may be perceived as aggressive, overbearing, or indifferent in the context of some occupational situations. Hypervigilance may also become present in emotionally charged conversations. Increasing volume, intensifying tone, facial expressions, and body language all play a part in how Service Members and Veterans have been conditioned to manage stress and emotions. It is important to note that these communication style differences do not indicate that Service Members and Veterans are rude, hostile, or uncaring. Rather, identifying these discrepancies can help civilians to better understand military culture, identify details of a Service Member or Veteran’s communication style and body language, and facilitate healthy conversations around what could otherwise be interpreted as difficult engagements.

**Service Members and Veterans may experience impaired physical and mental health.** Many Service Members and Veterans sustain debilitating physical injuries that result in disability, inability to retain employment and inhibit them from maintaining a healthy quality of life. Service Members and Veterans experience more severe pain, at a higher prevalence - approximately 40% more often, than non-Veterans. This includes back pain, joint pain, severe headache, migraine and neck pain, among other musculoskeletal conditions.9 Chronic pain is more prevalent, and of greater intensity in the Veteran population, than in the non-Veteran population. Some notable consequences of pain are lost work productivity, increased healthcare costs, mood disorders, substance use disorders, strain on family and social relationships, decreased quality of life and increased risk for suicide, among others.10

Some Service Members and Veterans may struggle with mental health challenges. They may have ‘invisible wounds’ and may not exhibit obvious symptoms or it may not outwardly appear that something is wrong. Invisible wounds could be emotional, behavioral or cognitive conditions associated with experienced trauma that present barriers to mental and physical healthcare of Service Members and Veterans.11 Service Members and Veterans who have experienced post-traumatic stress, traumatic brain injury, moral injury or military sexual trauma may struggle discussing their experiences and related symptoms.

It is imperative to understand that all Service Members and Veterans do not have Post-Traumatic Stress Disorder (PTSD). An estimated 11-20% of Veterans returning from Operations Iraqi Freedom and Enduring Freedom are diagnosed with PTSD. An estimated 30% of Vietnam Veterans will experience PTSD in their lifetime.12 PTSD is a condition that effects more than Service Members and Veterans – at least half of Americans have reported a traumatic event in their lives. Of these, one in ten men and two in ten women will develop PTSD. 13

PTSD is characterized by a set of unique and distressing symptoms that individuals may develop after experiencing or witnessing a life-threatening or traumatic event. During this event, the affected individual may have felt that they had no control over what was occurring or fearful of what was going to happen. Symptoms differ widely among individuals and demonstrate varying degrees of disruption to a person’s daily life. Some symptoms may include trouble sleeping, upsetting memories, or reliving the event, experiencing an increase of negative thoughts and emotions, and feeling on edge, among others.13 To be diagnosed with PTSD, an individual must experience the following for at least a month-long duration: at least one re-experiencing symptom, one avoidance symptom, two reactivity symptoms and two cognition and mood symptoms.14

Instead of conceptualizing post-traumatic stress specifically as a mental illness or pathological response, it may be better characterized for some, as a difficult, albeit typical reaction to distressing events.15 Some Service Members and Veterans may be able to cope with post-traumatic stress symptoms in healthy ways and do not necessarily have to undergo PTSD treatment to do so. Normalizing the experience of post-traumatic stress supports de-stigmatizing individuals who may experience symptoms and informs our communities that post-traumatic stress does not inherently imply that a Service Member or Veteran is disordered, mentally ill, dangerous, or suicidal.

Traumatic brain injury (TBI) or a disruption in normal brain function, can result from a variety of experiences in the military that cause a bump, blow or jolt to the head or penetrating head injury.16 Heavy artillery fire; vehicular or aircraft accidents; contact with improvised explosive devices and other explosives; fragmented or bullet injuries sustained above the shoulders, among other traumatic experiences, are common in military service. A Service Member or Veteran may have diagnosed or undiagnosed TBI and could exhibit lifelong challenges with a variety of executive functioning tasks. They may demonstrate difficulty with cognition, memory impairment, headaches, irritability and depression, among other complications.16 Between 2000-2019, more than 414,000 traumatic brain injuries were reported in Service Members.17

Moral injury may be incurred through a traumatic or unusually stressful event or circumstance, during a Service Member’s time the military. Moral injury could also be thought of as spiritual distress or inappropriate or misplaced guilt and shame. It can be exhibited as psychological and behavioral symptoms that challenge deeply held moral, spiritual or value-related beliefs.18

Military sexual trauma(MST) is sexual assault or harassment, or any unwanted sexual activity against a Service Member’s will, experienced during their military service. Examples include being physically forced to have sex or be involved in sexual activities, being touched in a sexual way, comments about an individual’s body or threatening and unwanted sexual advances.19 Nationally, VA’s screening program asserts that among Veterans seen in VA for care, MST prevalence is about one in three female Veterans and one in 50 male Veterans.19 MST has varying effects on individuals. Some common experiences include difficulty with intense, sudden emotional reactions, feelings of shame and self-blame, numbness or difficulty experiencing emotions, sexual difficulties, trouble sleeping, difficulties with attention, self-doubt and physical health problems, among other symptoms.19 There are a variety of treatment modalities available that can help lessen the pervasive negative effects of MST, help people recover and greatly improve quality of life.

It may be difficult for some Service Members and Veterans to ask for help if they are facing physical or mental health challenges. Military culture may fundamentally imply that seeking help or asking for assistance is a sign of weakness or personal insufficiency. A Service Member or Veteran may struggle to understand help-seeking behaviors differently, even after their time in service has ended. Negative attitudes about seeking help, confidentiality concerns and judgement of others for needing to seek help, are ongoing barriers to care.20

**Homelessness affects more than an estimated 40,056 U.S. Veterans on any given night.**21 According to the U.S. Department of Housing and Urban Development (HUD), being homeless is defined as lacking regular, secure and adequate nighttime residence.22 11% of the U.S. adult homeless population are Veterans and they struggle with several challenges to maintaining stable housing. Some common barriers are obtaining a livable income, a shortage of affordable housing and limited access to healthcare. A number of Veterans may struggle with symptoms of PSTD and substance abuse, and this is further complicated by the burden of insufficient family and social support. As military education and experiences may not generalize to civilian workforce, homeless Veterans also struggle with deficiencies in training that are necessary to succeed in the civilian world.20

**Many Service Members join the armed forces immediately after high school and do not receive a college education prior to their service.**8 Lack of education in the Veteran population can be attributed to several challenges they face upon reintegration into higher education settings, following their time in service. Veterans in college and higher education settings have indicated they commonly struggle with difficulties such as isolation, feeling alienated, complications adjusting to campus culture and trouble relating to faculty, and students who are much younger than them.23 College Veterans have higher rates of psychological symptoms and health-risk behaviors than their non-Veteran peers.24 They tend to be considered non-traditional age, with only 20% being 17-23 years in age. They are more likely to be married, have children or be single parents.25 Juggling multiple roles and responsibilities can lead to high stress levels and burnout. Feeling mentally, emotionally and physically fatigued can result in college Veterans needing to take sabbaticals from schooling, prolong their post-secondary experience or abandon higher education all together. Additionally, many Veterans leave higher education settings because they may become frustrated with the process and inability to obtain financial education benefits from VA, such as the GI Bill.26 The rate at which Veterans earn postsecondary degrees is comparable to non-Veteran students. However, the rate at which they do so is slower and takes longer. Extended completion time creates barriers to using the GI Bill as it is time-limited, and a Veteran may not be able to obtain a degree in a four-year time span.25

**Transition to Civilian Life**

Transition to civilian life can be a difficult time for some Service Members and Veterans as they will re-integrate into social and professional civilian settings at non-traditional age and without the same cultural experiences as civilians. Individuals experiencing periods of transition are at an elevated risk for suicide as they may struggle with feeling misunderstood and adjusting to new and different environments.

The loss of structure and containment the military provides can present a variety of challenges for Service Members following their time in service. With so many new avenues to pursue, a Service Member or Veteran may feel overwhelmed with how to begin their transition into a higher education setting, the workforce, or various social situations. Some Service Members and Veterans may struggle with defining a new self-identity, as they have come to associate a large part of their lives within military service. If they are no longer immersed in this way of life, they may struggle to find a new purpose or ‘mission.’

At home, a Service Member or Veteran may have difficulty with re-entry into family roles – such as reassuming parental duties and changed responsibilities of being a spouse or significant other since they were last present in the family system. This period of transition can feel isolating as the Service Member or Veteran may have experienced traumatic events and may not be comfortable discussing these occurrences, or other difficult feelings, related to their service. Family, friends, co-workers and community members play valuable roles in helping a Service Member or Veteran successfully transition into civilian life. A strong support system is key to a Service Member or Veteran’s mental wellness and achieving a healthy quality of life.

**Screen Service Members, Veterans and Families for Suicide Risk**

SMVF in crisis will present differently, depending on their unique situations. They may not be forthcoming about struggles with mental health or thoughts of suicide. Having a conversation about mental health issues and suicide includes monitoring for risk factors. SMVF at increased risk for suicide include, but are not limited to, the following populations: younger age groups (18-34); women; individuals who identify themselves as American Indian; those in a period of transition; those with access to lethal means and individuals with previous exposure to suicide.1

Suicide risk factors are characteristics that are associated with increased likelihood of suicidal behaviors.

**Common suicide risk factors:**

* Prior suicide attempt
* Mental health issues
* Abuse of substances, such as drugs and alcohol
* Recent loss
* Inadequate access to physical and mental healthcare
* Legal or financial challenges
* Relationship difficulties
* Unemployment
* Homelessness
* Access to lethal means

 **Common suicide risk factors specifically indicated in Service Members and Veterans:**

* Frequent deployments
* Deployments to hostile environment
* Exposure to extreme stress and death
* Physical and/or sexual assault while in the service
* Service-related pain or injury
* Invisible wounds (traumatic brain injury, post-traumatic stress, etc.)
* Difficulty with readjustment
* Absence of social support
* Lack of positive coping skills
* Negative stigma around mental health

Protective factors are characteristics that are associated with decreased likelihood of suicidal behaviors and can help offset risk factors.

**Common protective factors against suicide:**

* Sense of spirituality
* Perception of social and emotional well-being
* Meaningful sense of connectedness
* Positive problem-solving skills
* Adequate access to physical and mental healthcare
* Identified mission or purpose
* Employment

**Common warning signs for suicide:**

* Expressing feeling trapped or being in unbearable pain
* Verbalizing thoughts of being a burden to others
* Appearing anxious or agitated
* Behaving recklessly
* Withdrawing from others
* Indicating feeling lonely and isolated
* Exhibiting rage or expressing desire to seek revenge
* Displaying extreme mood swings
* Increasing use of substances, such as drugs and alcohol

 **Common signs of immediate risk for suicide:**

* Talking about wanting to die or to kill oneself
* Looking for a way to kill oneself, such as searching online, obtaining lethal means such as a gun or rope, or stockpiling medication
* Expressing hopelessness or having no reason to live

**Inquiring about suicide is important.** Asking SMVF about suicide does not lead to thoughts of suicide. In fact, as a result of discussing suicidality with individuals who have had these feelings and/or suicidal behaviors, there has been a paradigm shift in suicidology. Individuals who have contemplated suicide or have taken steps to act, assert that someone inquiring about suicide provided a sense of permission to talk about their thoughts in a safe space and in some cases, served as a deterrent.

**Special training is not required to safely discuss the subject of suicide.** Conversations with SMVF to check-in about difficult emotions and negative feelings they may be experiencing is a natural way to inquire about mental health and well-being.Demonstrating concern and genuinely expressing interest can make a significant difference for SMVF during a challenging time.Letting SMVF know they are cared for increases feelings of connectedness, an important protective factor against suicide. Willingness to talk about difficult emotions and thoughts of suicide reduces stigma around mental health and increases help-seeking behavior in SMVF.

**Careless comments or jokes about suicide should always be taken seriously.** Identifying risk factors or warning signs for suicide in SMVF can initiate an important conversation regarding suicidal ideation. Talking about suicide can be uncomfortable, but if it is indicated in any way, an individual should follow-up by asking the SMVF directly, if they are thinking about suicide or ending their life. **Ask the question directly:** **“Are you thinking about killing yourself?” or “Are you thinking about suicide?”**

**Lethal Means Safety**

Intentional efforts that reduce access to lethal means among individuals with identified suicide risk is an evidence-based suicide prevention strategy called lethal means safety (LMS). Lethal means are objects or instruments (e.g., medications, bridges, rope, firearms, plastic bags, sharp instruments) that individuals use to cause or inflict self-directed violence.27 In 2018, 68.2% of all Veteran suicides resulted from firearms.1 Asking SMVF about lethal means, specifically firearms, and how they are stored, is especially important when discussing risk for suicide. Approximately 90% of firearm-related suicide attempts are fatal, compared to the 5% of attempts by all other mechanisms combined.1 This underscores the importance of lethal means safety, specifically encouraging safe and locked storage of firearms, with SMVF population.

For SMVF who are at elevated risk of suicide, LMS until the crisis period passes, is a critical element of suicide prevention because the time between when a person decides to die by suicide, and the impulse to act on that decision is often very short. A 2005 study found that 71% of individuals who had attempted suicide estimated that the process took less than an hour. It was also found that people rarely substitute one lethal means for another. 48% of attempters estimated that the time between decision to action was less than 20 minutes and 24% of individuals estimated less than five minutes between their decision to attempt and action.28 Secure storage of firearms and other lethal means, can build in more time and space between SMVF and the lethal object during an acute phase of suicidal crisis. This time and space may save a life.1

Poisoning and suffocation are the second most common lethal means that Veterans use to die by suicide.5 Having a conversation with SMVF regarding the availability and safe storage of other lethal means, such as medication, household cleaner and chemicals can also reduce accessibility and increase time and space during a period of crisis.

**Promote Positive Military Culture**

In our communities, efforts can be made to support military members and families and help address common challenges they may be experiencing. Understanding the expression and influence of military culture, in addition to acknowledging common challenges faced by SMVF, are strategies that can help prevent suicide in this population. These efforts can be implemented at national, state, organizational and individual levels and greatly impact how we value the service and contributions of our SMVF.

Educating our communities about military culture and suicide awarenessis an easy way to support Service Members, Veterans and Families.

* Acknowledge skills and achievements that a SMVF presents as unique strengths that provide value in our civilian communities.
* Promote the understanding of military culture in order to create a culturally competent environment and facilitate connection with SMVF.
* Cultivate cultural awareness of mental health to facilitate comprehensive suicide prevention strategies directed towards SMVF.
* Recognize risk and protective factors for SMVF suicide – minimize risk factors and boost protective factors.
* Facilitate conversations about mental health and suicide prevention.
* Establish SMVF contact with Veteran resources and service organizations in order to provide additional settings in which the SMVF can get connected, thereby lowering their risk of suicide.
* Create a Veteran Employee Resource Group (VERG) or inclusive Employee Resource Group at your workplace that can offer support and on-going training in the workplace to increase cultural awareness and sensitivity.

VA #BeThere campaign started in September 2018, in order to raise awareness around Service Member and Veteran mental health and suicide prevention. The campaign highlighted ways that SMVF can be supported in our communities, without any specific training or qualifications. If you are involved in a community in any capacity, you are in a position to connect with a SMVF. Starting a conversation around distressing issues is an important step that can help a SMVF feel cared-for and valued, as well as help them recognize that assistance and resources are available.

**Ways you can #BeThere for Service Members and Veterans:**

* Be a workout buddy
* Bring a meal
* Call and check-in
* Get outside for an activity
* Send an email
* Learn the warning signs of crisis
* Listen
* Offer to babysit
* Mail a care package
* Send a text
* Share a local resource
* Volunteer with a Veteran organization

**Community Call to Action**

The Twin Cities Suicide Prevention Coalition and the Minneapolis VAMC can provide your organization the following (at no charge):

* Suicide prevention training (S.A.V.E. training): This training helps teach communities how to help SMVF at risk for suicide. It empowers individuals to act with confidence, compassion and empathy if they encounter SMVF (or any individual) who is in suicidal crisis. The steps of S.A.V.E. are:
	+ **S**igns of suicidal thinking should be recognized
	+ **A**sk the most important question of all
	+ **V**alidate the Veteran’s experience
	+ **E**ncourage treatment and **E**xpedite getting help
* Military Culture training: This training describes the important of recognizing and being competent about the values, beliefs and unique perceptions specific to SMVF.
* Lethal means safety information and safety tools such as gun locks.
* Pamphlets and printed resources on suicide prevention and Veterans Crisis Line.

**To join the Twin Cities Suicide Prevention Coalition, request training or for more information, email us: \*\*\***coalition email

**Learn More about Military Culture**

Educating yourself and others on military culture can be done through free courses that provide in-depth information about military culture and suicide prevention training.

**[Psych Armor](https://psycharmor.org/military-culture-school/)**

* Provides military culture and Veteran employer training modules, including S.A.V.E. gatekeeper suicide prevention training.

<https://psycharmor.org/>

[**Relias Academy**](https://reliasacademy.com/rls/store/browse?Ntt=military&search=submit)

* Delivers continuing education courses on the military and common mental health issues, suicide prevention, interventions and family impact.

<https://reliasacademy.com/>

**[VA Community Provider Toolkit](https://www.mentalhealth.va.gov/communityproviders/military_resources.asp)**

* Offers military culture training, primarily focused on healthcare settings. https://www.mentalhealth.va.gov/communityproviders/index.asp

**Lethal Means and Firearm Safety**

* Rocky Mountain MIRECC for Suicide Prevention created an easy to read, printable document on firearm safety. For Firearm Safety in Times of Community Stress, go to: <https://www.mirecc.va.gov/visn19/docs/Firearm_Safety_Times_Comm_Stress_v_9_3_20.pdf>
* National Sportsman Shooting Foundation (NSSF) partnered with VA and American Foundation of Suicide Prevention (AFSP) to create a community firearm safety toolkit designed to help prevent suicide among U.S. Service Members and Veterans. For A Toolkit for Safe Firearm Storage in Your Community, go to: <https://www.mentalhealth.va.gov/suicide_prevention/docs/Toolkit_Safe_Firearm_Storage_CLEARED_508_2-24-20.pdf>

**Resources for Service Members, Veterans and Families**

**SMVF-specific Mental Health**

* C.O.R.E. (Casework, Outreach, Referral, Education) Program: <https://mn.gov/mdva/assets/2018-10-10-core-brochure_tcm1066-355412.pdf>
	+ Brings essential, community-based services directly to SMVF across MN, at no cost to them. Services include individual and family counseling, financial counseling, debt management, addiction counseling, disability services and in-home counseling.
* Give an Hour: <http://www.giveanhour.org/>
	+ Provides free and confidential mental healthcare to SMVF.
* National Center for PTSD: <https://www.ptsd.va.gov/>
	+ Seeks to advance the clinical care and social welfare of SMVF and others who have experienced trauma, or who suffer from PTSD.
* Veterans Crisis Line (VCL): **Call** 1-800-273-8255, press 1. **Text** to 838255. **Online** at: <http://www.veteranscrisisline.net/>
	+ Delivers confidential help for SMVF who may be suicidal or experiencing crisis.
* VCL Be There website: <http://www.bethereforveterans.com/>
	+ Campaign to raise community awareness around Service Member and Veteran mental health issues and suicide prevention.
* Veterans Resilience Project: <http://www.resiliencemn.org/>
	+ MN-based organization that trains and refers to a statewide network of accredited therapists who provide confidential therapy to all Service Members and Veterans.

* Wounded Warrior Project: <https://www.woundedwarriorproject.org/>
	+ Provides SMVF injured or wounded on or after September 11, 2001, free support services and programs.

**National Guard and Active Duty-specific Mental Health**

* Military One Source: 1-800-342-9647 or <https://www.militaryonesource.mil/>
	+ Department of Defense resource website for Active Duty, National Guard and Reserve military members and their families, offering free 24/7 support and counseling on needs directly related to coping with deployments, frequent moves, and military lifestyle in general. Support is provided for taxes, moving, benefits, finances and more.
* MN Army National Guard Resilience, Risk Reduction and Suicide Prevention Program (R3SP): <https://www.facebook.com/MN-National-Guard-Resilience-Risk-Reduction-Suicide-Prevention-R3SP-1577637605887506/>
	+ MN Army National Guard (ARNG)-established task force to coordinate ARNG health promotion and risk reduction efforts.
* MN National Guard Behavioral Health Officers: (651) 282-4282 or <https://minnesotanationalguard.ng.mil/covid-19-resources/>
	+ Behavioral health specialists assist with management and treatment of inpatient and outpatient mental health of MN National Guard Members.

**Community Mental Health**

* American Foundation for Suicide Prevention: <http://www.afsp.org/>
* Canvas Health: [https://www.canvashealth.org/](https://www.canvashealth.org/%22%20%5Ct%20%22_blank)
* Lutheran Social Services: (612) 871-0221 or <https://www.lssmn.org/services/military-and-veterans>
* Mental Health Solutions: (612) 356-2756
* National Alliance on Mental Illness (NAMI): <http://www.nami.org/>
* Nystrom and Associates: 1-844-374-8893
* Youth Service Bureau: (651) 735-9534 or [https://ysb.net](https://ysb.net/)

**MN Veteran Centers**

* Community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans, active duty Service Members, including National Guard and Reserve components, and their families.
* Anoka (previously Brooklyn Park): (763) 503-2220
	+ Duluth: (218) 722-8654
	+ St. Paul: (651) 644-4022
* MNci fors
	+ Directly assist Veterans and their families affected by homelessness, or those in danger of becoming homeless, by meeting their housing and supportive service needs.
* MN [Veterans Resources | CareerForce (careerforcemn.com)](https://www.careerforcemn.com/veterans-resources)
	+ Resource for MN job seekers and employers.

* and Veteran ME
	+ Rallying point for all things related to creating healthier military and prior service communities.
* VA Community Resource and Referral Center (CRRC): 1201 Harmon Place, Mpls. Phone: (612) 313-3240
	+ Provides Veterans who are homeless and at risk of homelessness with access to community-based services that promote permanent housing, health and mental healthcare, career development and access to VA and non-VA benefits.

**Recreation**

* Building Health Military Communities (BHMC): <https://www.facebook.com/BuildingHealthyMilitaryCommunities/>
* MN Department of Natural Resources (DNR): <https://www.dnr.state.mn.us/state_parks/index.html>
* MN Parks: <https://www.nps.gov/state/mn/index.htm>
* National Park Service: <https://www.nps.gov/>
* National Shooting Sports Foundation: (203) 426-1320 or [https://www.nssf.org/](https://www.nssf.org/%22%20%5Ct%20%22_blank)
* ss
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* is ahealthcare

**County Veterans Service Offices (CVSO)**

* [www.macvso.org](http://www.macvso.org)
* County Veteran Service Offices assist Veterans, care givers and beneficiaries in gaining access to government sponsored benefits and community support services.
	+ Anoka County: (763) 324-4500
	+ Carver County: (952) 442-2323
	+ Chisago County: (651) 213-5680
	+ Dakota County: (651) 554-5601
	+ Hennepin County: (612) 348-3300
	+ McLeod County: (320) 864-1268
	+ Ramsey County: (651) 266-2545
	+ Scott County: (952) 496-8176
	+ Washington County: (651) 420-6895

**Veterans Affairs and Veterans Benefits**

* Coaching into Care: 1-888-823-7458 or <https://www.mirecc.va.gov/coaching/>
	+ VA national telephone service that educates, supports and empowers family members and friends who are seeking care or services for a Veteran.
* Disabled American Veterans (DAV) of MN: (651) 291-1212 or <https://davmn.org/>
	+ Provides free support for Veterans of all generations and their families to gain access to full range of benefits available to them.
* MN Department of Veterans Affairs (MDVA): <https://mn.gov/mdva/>
	+ Serving MN Veterans, their dependents and survivors by connecting them with the federal and state care and benefits they have earned.
* MDVA Veterans Linkage Line: 1-888-LINKVET (546-5838) or  <https://linkvet.org/>
	+ Connects SMVF to their earned benefits.
* Veterans Benefits Administration (VBA): 1-800-827-1000 or <http://www.benefits.va.gov/benefits/>
	+ Provides financial and other assistance to SMVF including, but not limited to, home financing, burials, employment, pension and more.

**Toolkit Footnote References**

1. U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. (n.d.) 2020 National Veteran Suicide Prevention Annual Report. (n.p.) Retrieved February 26, 2021 from <https://www.mentalhealth.va.gov/mentalhealth/suicide_prevention/data.asp>

2. Vespa, J. (June 02, 2020) Census Bureau Releases New Report on Veterans. (n.p.) United States Census Bureau. Retrieved March 9, 2021 from <https://www.census.gov/newsroom/press-releases/2020/veterans-report.html>

3. U.S. Department of Veterans Affairs. (September 2020) Research on Pain Management factsheet. (n.p.) Retrieved March 12, 2021 from <https://www.research.va.gov/pubs/docs/va_factsheets/Pain.pdf>

4. Sandler, E. (September 10, 2018) The Ripple Effect of Suicide. (n.p.) National Alliance on Mental Illness Blog. Retrieved March 8, 2021 from <https://nami.org/Blogs/NAMI-Blog/September-2018/The-Ripple-Effect-of-Suicide#:~:text=According%20to%20a%202016%20study,%20it%20is%20estimated,to%20Decrease%20Stigma%20Stigma%20only%20leads%20to%20silence>.

5. U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. (n.d.) National Strategy for Preventing Veteran Suicide 2018-2028. (n.p.) Retrieved February 24, 2021 from <https://sprc.org/sites/default/files/resource-program/VA_National-Strategy-for-Preventing-Veterans-Suicide2018.pdf>

6. Maslowski, P. (April 10, 2007) Understanding the Creation of the U.S. Armed Forces. Philadelphia, PA: Foreign Policy Research Institute. Retrieved February 19, 2021 from <https://www.fpri.org/article/2007/04/understanding-the-creation-of-the-u-s-armed-forces/>

7. Institute of Medicine (US) Medical Follow-Up Agency; Joellenbeck, LM., Russell, PK., & Guze, SB., editors. (n.d.) Strategies to Protect the Health of Deployed U.S. Forces: Medical Surveillance, Record Keeping, and Risk Reduction. Washington DC: National Academies Press (US); 1999. 2, Risks to Deployed Forces. Retrieved March 19, 2021 from <https://www.ncbi.nlm.nih.gov/books/NBK225082/>

8. Weakley, L. (October 14, 2015) Military Spot.com. The Top 5 Challenges Veterans Face Today. (n.p.) Retrieved March 19, 2021 from <http://www.militaryspot.com/career/top-5-challenges-veterans-face-today>

9. National Center for Complementary and Integrative Health. (December 13, 2016) Press release: Veterans Endure Higher Pain Severity than Nonveterans. (n.p.) Retrieved March 26, 2021 from <https://www.nccih.nih.gov/news/press-releases/veterans-endure-higher-pain-severity-than-nonveterans>

10. U.S. Department of Veterans Affairs. (September 2020) VA research on Pain Management factsheet. Washington DC: (n.p.) Retrieved March 26, 2021 from <https://www.research.va.gov/pubs/docs/va_factsheets/Pain.pdf>

11. Air Force Wounded Warrior Program. (n.d.) Invisible Wounds Initiative. (n.p.) Retrieved March 17, 2021 from <https://www.woundedwarrior.af.mil/Airmen-Veterans/Invisible-Wounds-Initiative/#:~:text=WHAT%20IS%20AN%20INVISIBLE%20WOUND,trauma%20experienced%20by%20the%20individual>

12. U.S. Department of Veterans Affairs. (September 24, 2018) PTSD: National Center for PTSD. How Common is PTSD in Veterans? Washington DC: (n.p.) Retrieved March 26, 2021 from <https://www.ptsd.va.gov/understand/common/common_veterans.asp>

13. U.S. Department of Veterans Affairs. (May 2019) PTSD: National Center for PTSD. Understanding PTSD and PTSD Treatment booklet. Washington DC: (n.p.) Retrieved March 26, 2021 from <https://www.ptsd.va.gov/publications/print/understandingptsd_booklet.pdf>

14. U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (May 2019) Post-Traumatic Stress Disorder. Bethesda, MD: (n.p.) Retrieved April 23, 2021 from https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

15. Zimbardo, P. et.al., (2012) The Time Cure: Overcoming PTSD with the New Psychology of Time Perspective Therapy. San Francisco, CA: Jossey-Bass.

16. Center for Disease Control and Prevention. (n.d.) Traumatic Brain Injury & Concussion. (n.p.) Retrieved March 19, 2021 from <https://www.cdc.gov/traumaticbraininjury/index.html>

17. U.S. Department of Veterans Affairs, Office of Research & Development. (n.d.) Traumatic Brain Injury (TBI). Washington DC: (n.p.) Retrieved March 19, 2021 from <https://www.research.va.gov/topics/tbi.cfm>

18. U.S. Department of Veterans Affairs. (n.d.) PTSD: National Center for PTSD. Moral Injury. Washington DC: (n.p.) Retrieved March 19, 2021 from <https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp>

19. U.S. Department of Veterans Affairs. (November 2020) Military Sexual Trauma factsheet. Washington DC: (n.p.) Retrieved March 26, 2021 from <https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf>

20. Kulesza, M. et al., (June 26, 2015) Help-Seeking Stigma and Mental Health Treatment Seeking Among Young Adult Veterans. (n.p.) *Military behavioral health*, *3*(4), 230–239. Retrieved March 19, 2021 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4672863/>

21. National Coalition for Homeless Veterans (n.d.) Background and Statistics FAQ About Homeless Veterans. (n.p.) Retrieved March 19, 2021 from <http://nchv.org/index.php/news/media/background_and_statistics>

22. U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (January, 2021) The 2020 Annual Homeless Assessment Report (AHAR) to Congress. Washington DC: (n.p.) March 19, 2021 from <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>

23. St. Louis Post-Dispatch Military.com (n.d.) Veterans Returning to College Face Unique Challenges. (n.p.) Retrieved March 26, 2021 from <https://www.military.com/veteran-jobs/career-advice/military-transition/veterans-in-college-face-challenges.html>

24. Richman, M. (October 26, 2017) Navigating the college experience. (n.p.) US Department of Veterans Affairs, Office of Research & Development. Retrieved March 26, 2021 from <https://www.research.va.gov/currents/1017-Veterans-face-challenges-in-higher-education.cfm>

25. Borsari, B. et al., (2017) Student service members/veterans on campus: Challenges for reintegration. (n.p.) American journal of orthopsychiatry. 87(2): 166-175. Retrieved March 26, 2021 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5319708/>

26. U.S. Department of Veterans Affairs. (June 11, 2020) VA College Toolkit. Washington DC: (n.p.) Retrieved March 26, 2021 from <https://www.mentalhealth.va.gov/student-veteran/index.asp>

27. The National Action Alliance for Suicide Prevention. (n.d.) Lethal Means. (n.p.) Education Development Center. Retrieved March 3, 2021 from <https://theactionalliance.org/our-strategy/lethal-means>

28. Kresnow, MJ. et al., (2001) Characteristics of impulsive suicide attempts and attempters. (n.p.) Suicide & Life-Threatening Behavior. 32: 49-59. Retrieved March 26, 2021 from <https://pubmed.ncbi.nlm.nih.gov/11924695/>