

VETERAN WELL-BEING IN ARKANSAS: A COMPREHENSIVE NEEDS ASSESSMENT ON SUICIDE AND ADDICTION

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ABSTRACT

Veterans in Arkansas face elevated risk for suicide, substance use disorders, and co-occurring mental health conditions, challenges that are intensified by rural geography, fragmented systems of care, and limited access to timely, coordinated services. This comprehensive needs assessment synthesizes peer-reviewed literature, federal and state surveillance data, and de-identified crisis response records from a veteran-led community organization to examine the intersecting drivers of suicide risk and substance-related crises among veterans, particularly those not engaged in Veterans Health Administration (VA) care.

Findings indicate that suicide among veterans remains a persistent public health concern, with the majority of deaths occurring outside the VA healthcare system and disproportionately affecting younger, male, and firearm-involved populations. Substance use emerged as a consistent and prominent factor in community-based crisis cases, with approximately two-thirds of documented veteran crises involving substance use. Co-occurring conditions—including PTSD, chronic pain, sleep disturbance, and polysubstance use—were frequently identified as compounding risk factors for suicide and overdose. Evidence further highlights structural barriers to care, including limited rural mental health capacity, inconsistent emergency department practices, inadequate care coordination, and gaps in the identification of veteran status across systems.

This assessment also underscores the importance of system-level influences, such as inpatient psychiatric bed shortages, fragmented public health surveillance, and inconsistent integration of evidence-based suicide prevention practices across VA and non-VA settings. Taken together, the findings demonstrate that veteran suicide risk is shaped by interconnected clinical, behavioral, and structural factors that extend beyond traditional healthcare environments.

The report concludes that effective prevention in Arkansas requires coordinated, multi-sector strategies that integrate substance-aware and trauma-informed care, strengthen rural emergency response systems, expand peer-led and community-based interventions, and improve cross-system data sharing and continuity of care. These approaches are essential to reducing preventable deaths and improving overall well-being among veterans across the state.

Introduction and Purpose of the Needs Assessment

Veterans who have served in the armed forces face unique challenges during the transition to civilian life, many of which place them at elevated risk for mental health disorders, substance use, and suicide. In Arkansas, these risks are compounded by rural geography, limited access to specialty mental health services, and fragmented systems of care. Suicide, addiction, and untreated mental illness among veterans represent a critical public health concern, particularly for individuals who are disconnected from formal Veterans Administration (VA) services.

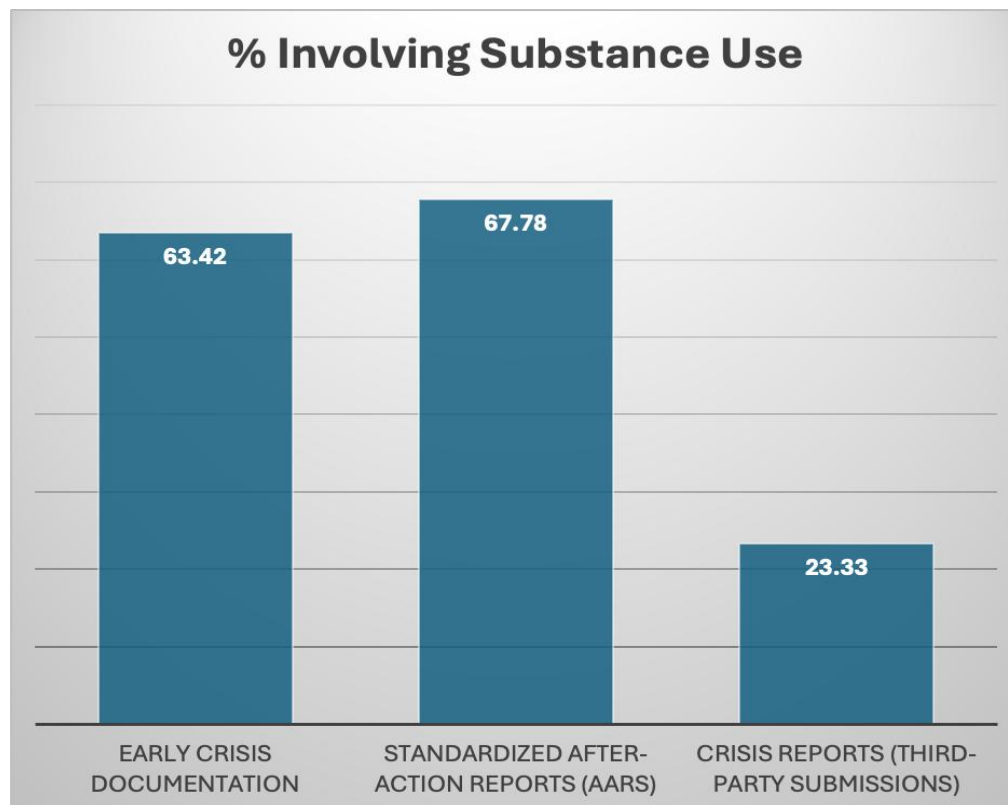
This paper presents a needs assessment examining suicide risk, substance use, and mental health challenges among veterans in Arkansas. Particular attention is given to substance-involved crises, veterans receiving care outside the VA system, and system-level barriers that limit timely intervention. Understanding how these risks intersect at the community and system level is essential for informing prevention strategies that extend beyond clinical settings.

This assessment synthesizes peer-reviewed literature, national and state surveillance data, and de-identified crisis response records collected by We Are The 22, a veteran-led nonprofit organization providing peer-based suicide intervention services across Arkansas. No new primary data were collected. Instead, this assessment relies on secondary analysis of existing datasets and organizational records to identify patterns of suicide risk, service gaps, and unmet needs among Arkansas veterans.

Local Crisis Response Data from Community-Based Veteran Services

Substance-involved crises occurring outside traditional healthcare settings represent a critical gap in existing surveillance and prevention efforts. In addition to national and state-level datasets, this needs assessment incorporates findings from a retrospective review of 800 veteran crisis cases documented by We Are The 22 between 2019 and 2024. These de-identified records include crisis reports, early crisis documentation collected before the implementation of standardized after-action report (AAR) forms, and standardized AARs generated during community-based veteran crisis responses in Arkansas. Findings from this dataset indicate that substance use was involved in approximately two-thirds of crisis cases, with rates ranging from 63% to 68% across early crisis documentation and standardized AARs, indicating a stable and persistent pattern over time rather than a short-term fluctuation. Crisis reports submitted by family members reflected lower documented substance involvement, likely due to limited available information rather than the absence of substance-related factors. Overall, these findings underscore substance use as a consistent and significant contributor to veteran crisis events encountered outside formal clinical settings and highlight the importance of peer-led, substance-aware crisis response models and stronger coordination between veteran-serving, clinical, and community systems of care.

Figure 1; Substance use involvement by crisis record type among veterans served by We Are The 22, 2019–2024.



Note. Figure 1 displays the percentage of veteran crisis cases with documented substance use involvement across early crisis documentation, standardized after-action reports, and third-party crisis reports. Data are based on 800 de-identified crisis cases documented by We Are The 22.

Scope and Magnitude of Veteran Suicide

Suicide remains a leading cause of preventable mortality among veterans in the United States (U.S.) and continues to represent a critical public health concern. According to the U.S. Department of Veterans Affairs' (VA) 2024 National Veteran Suicide Prevention Annual Report, suicide ranked as the 12th-leading cause of death among veterans overall and the second leading cause of death among veterans under the age of 45. In 2022, the VA documented 6,407 veteran suicide deaths, representing an average of 17.6 deaths per day, highlighting the persistence of suicide risk within the veteran population despite ongoing national prevention efforts (U.S. Department of Veterans Affairs, 2024).

VA surveillance data further indicate that the majority of veteran suicide deaths occur among individuals who were not engaged in VA care at the time of death. VA analyses show that approximately 10.5 veteran suicides per day occurred among veterans without recent VA contact, compared to 7.0 deaths per day among those who had recent engagement with VA services. This pattern suggests that nearly 60% of veteran suicide deaths occur outside the VA health-care system, highlighting substantial gaps in access, engagement, outreach, and continuity of care for veterans who are disconnected from formal clinical services (VA, 2024).

Demographic patterns identified in VA surveillance data reveal that suicide risk remains disproportionately high among specific veteran subgroups. According to VA analyses, suicide rates increased from 2021 to 2022, reaching 34.7 deaths per 100,000 veterans (VA, 2024), with the highest rate observed among younger veterans aged 18-34 and among male veterans. Although suicide rates among female veterans declined slightly in 2022, they remain elevated relative to civilian women, reinforcing persistent gender-based disparities in suicide risk among veteran populations.

Method of suicide further differentiates veteran risk profiles. VA surveillance data indicate that firearms were involved in approximately 73.5% of veteran suicide deaths, a substantially higher proportion than that observed among non-veterans (52.2%). This disparity emphasizes the critical role of lethal means access in veteran suicide mortality and highlights the importance of means safety as a core component of suicide prevention strategies targeting veteran populations.

Substance use and mental health conditions are strongly associated with suicide risk among veterans. According to the U.S. Department of Veterans Affairs (VA) 2024 National Veteran Suicide Prevention Annual Report, 60.2% of recent veteran VA users who died by suicide in 2022 had a documented mental health or substance use disorder diagnosis. VA analyses further show particularly elevated suicide rates among veterans with substance use disorder diagnoses, including rates as high as 236 per 100,000 among those with sedative use disorder and 114 per 100,000 among those with opioid use disorder. At the same time, VA records indicate that nearly 40% of VA-engaged veterans who died by suicide had no recorded mental health or substance use diagnosis, suggesting under-identification and risk of unmet diagnostic or treatment needs within clinical settings.

In addition to clinical factors, suicide risk is consistently elevated among veterans experiencing social and structural stressors. VA analyses identify homelessness, justice system involvement, military sexual trauma, and recent declines in physical health as key contributors to increased suicide risk (VA, 2024). VA data further indicate that suicide rates have increased more rapidly among veterans not engaged in VA care than among those receiving VA services. Between 2001 and 2022, suicide rates increased 55.2% among female non-VA users and 67.6% among male non-VA users, compared with smaller increases among veterans engaged in VA care, reinforcing the protective role of sustained healthcare engagement.

Linking federal and state mortality data has improved understanding of veteran suicide patterns, particularly among veterans who are not consistently identified in state-level surveillance systems. Analyses comparing federal VA-DoD mortality records with the Centers for Disease Control and Prevention's National Violent Death Reporting System (NVDRS) demonstrated that veteran status was not uniformly captured across state records, limiting the accuracy of population-based suicide estimates (Hoffmire et al., 2025). In these analyses, veteran status was correctly identified in NVDRS for approximately 84.6% of suicide deaths when compared with VA-DoD mortality data. Identification accuracy was substantially lower among female veterans and younger veterans, indicating that suicide deaths within these subgroups were more likely to be misclassified or unrecognized in state-level systems. This under-identification has important implications for suicide surveillance, as reliance on NVDRS

data alone may underestimate suicide risk among key veteran populations, particularly those not enrolled in VA care.

Variability in state reporting practices further contributed to the inconsistent identification of veteran suicide deaths. Incomplete or missing identifying information within death records reduced linkage accuracy and limited the ability to reliably track veteran suicide trends across regions and over time (Hoffmire et al., 2025). Although the expansion of NVDRS to nationwide coverage has strengthened public health surveillance capacity, accurate monitoring of veteran suicide continues to depend on consistent, high-quality data reporting across states (CDC, 2022).

This surveillance data describes the scope and distribution of suicide mortality among U.S. veterans, highlighting persistent demographic disparities, the predominance of firearm-related deaths, and the disproportionate burden borne by veterans who are not engaged in VA care at the time of death. These patterns establish the magnitude of the problem and highlight the need to examine the factors that place certain veterans at elevated risk for suicide beyond simple population counts.

Key Contributing Factors to Veteran Suicide and Crisis Risk

Substance Use Disorders

Beyond documented suicide outcomes, substance use disorders represent a central and intersecting risk factor shaping veteran mental health, morbidity, and suicide vulnerability. Evidence indicates that substance use among veterans frequently co-occurs with psychiatric illness, chronic pain, housing instability, and barriers to care, particularly during the transition from military to civilian life. Rather than functioning as an isolated condition, substance use often reflects broader patterns of coping, trauma exposure, and disengagement from formal systems of care. Understanding substance use within this broader clinical and social context is essential for identifying pathways to risk and informing prevention strategies that address both behavioral health and structural barriers.

Consistent with this broader framing, prior research indicates that veterans are at significantly higher risk for developing substance use disorders than non-veterans. Lloyd et al. (2024) found that co-occurring conditions such as PTSD, chronic pain, housing instability, and limited access to care contribute to heightened vulnerability for both substance use and mental health disorders among veterans. The authors further noted that the COVID-19 pandemic exacerbated existing access barriers by straining healthcare systems, intensifying provider shortages, and further limiting treatment availability for veterans, particularly in rural areas. These overlapping risk factors often compound one another, creating complex clinical and social circumstances that complicate prevention and intervention efforts.

Alcohol misuse is a dominant and highly prevalent component of substance use disorders among veterans. Miller (2025) reports that over 80% of veterans with a substance use disorder engage in alcohol misuse and that veterans are more likely than civilians to develop AUD. Binge drinking and alcohol abuse are particularly common, with male veterans experiencing higher rates of AUD diagnoses than female veterans. Miller also notes that substance use

patterns among veterans include misuse of prescription opioids, especially among those with service-connected injuries, as well as illicit substances such as cannabis, heroin, and cocaine.

The consequences of substance use among veterans extend beyond prevalence to include substantial mortality risk. Suicide rates among veterans remain significantly higher than among civilians, and substance use is a prominent contributing factor. Miller (2025) found that approximately 30% of veterans who died by suicide had a documented history of substance abuse, reinforcing the role of SUDs as a critical pathway linking substance use, mental health conditions, and suicide risk. To illustrate the scale of substance-related morbidity within the veteran population, estimates cited by Miller (2025) indicate that in 2018, approximately 874,000 veterans over the age of 26 were diagnosed with AUD, while an additional 45,000 veterans were diagnosed with heroin use disorder. These findings highlight the substantial burden of substance use disorders among veterans and their relevance for suicide prevention and broader veteran health strategies.

Sleep Disturbance and Alcohol Misuse as a Compounding Risk Pathway

Alcohol misuse is a well-established risk factor for suicidal ideation among veterans, particularly when it co-occurs with other behavioral health conditions. Evidence from Chakravorty et al. (2014) suggests that sleep disturbance represents an additional and underrecognized pathway through which suicide risk may be amplified among veterans who misuse alcohol. In that study, insomnia, defined as difficulty initiating or maintaining sleep or experiencing non-restorative sleep, was independently associated with suicidal ideation among military personnel, even after accounting for psychiatric symptoms as well as alcohol and drug use.

The Chakravorty study further demonstrated that insomnia and hazardous drinking frequently co-occur among veterans, indicating that sleep disturbance and alcohol misuse often intersect, rather than occur independently. The study sample consisted primarily of middle-aged men identifying as either White (47%) or Black (46%), with nearly two-thirds screening positive for at least one psychiatric disorder. Within this group, 30% reported binge drinking in the prior three months, 72% reported use of another substance in the past year, and 38% endorsed suicidal ideation during the previous year (Chakravorty et al., 2014).

Sleep disturbance was highly prevalent in this population. Most participants reported short sleep duration, and those with shorter sleep duration were significantly more likely to endorse suicidal ideation than those reporting longer sleep duration, even after controlling for psychiatric comorbidity and substance or alcohol use (Chakravorty et al., 2014). This pattern of compounding risk becomes particularly relevant when alcohol misuse intersects with prescribed medications such as long-term opioid therapy.

Long-Term Opioid Therapy and Co-Occurring Substance Use

Long-term opioid therapy (LTOT) represents a significant clinical context shaping suicide and crisis vulnerability among veterans. Many veterans receive opioids for chronic pain management, and prolonged exposure increases the likelihood of co-occurring substance use. Analysis of Veterans Health Administration data from 2014-2019 found that approximately one in four veterans prescribed LTOT screened positive for risky alcohol use, tested positive

for another substance on urine drug screening, or had a documented substance use disorder diagnosis (Ngo et al., 2025). Alcohol was the most frequently identified substance, followed by sedatives, cannabis, and stimulants.

Co-occurring substance use substantially compounds mortality and overdose risk among veterans receiving LTOT. Compared with veterans prescribed LTOT alone, those with cannabis, sedative, and stimulant involvement were associated with increased fatal overdose risk, with stimulant use demonstrating the largest relative increase in overdose hazard. Sedative involvement was also associated with elevated risk of traumatic death (Ngo et al., 2025). These findings indicate that mortality risk varies by substance type and that co-use intensifies vulnerability among veterans already exposed to long-term opioid therapy.

Despite clinical guidance discouraging long-term opioid therapy among individuals with substance use disorders, additional substance use remains prevalent in practice. Alcohol and sedative involvement are most common, but cannabis and stimulant use also presents meaningful risk. Cannabis involvement was associated with a 16% increase in all-cause mortality among veterans receiving LTOT (Ngo et al., 2025). Stimulant involvement was associated with more than triple the hazard of fatal overdose, highlighting the severity of polysubstance risk in this population.

Although urine drug screening is widely used within the VA as a risk mitigation strategy, implementation varies across facilities, and is not consistently standardized (Ngo et al., 2025). This variability may limit early identification of high-risk substance use patterns and delay intervention. Expanded and more consistent guidance regarding screening, frequency, methods, and follow-up care is necessary to reduce overdose and crisis vulnerability among veterans prescribed LTOT.

System Level and Structural Barriers to Prevention and Care

Mental Health and Substance Use as Structural Barriers

Mental illness and substance use disorders (SUDs) frequently co-occur among U.S. veterans and are closely linked to suicide risk, chronic pain, and healthcare utilization. National veteran health statistics indicate that mental health conditions such as depression, anxiety, and PTSD frequently intersect with substance use, and that many veterans report using alcohol or drugs as a means of coping with trauma exposure, psychological distress, and challenges associated with reintegration into civilian life (Miller, 2025). These patterns indicate the interconnected nature of mental health and substance use among veterans and highlight the complexity of addressing risk through isolated clinical interventions.

Co-occurring mental health conditions are especially common among veterans who served in Afghanistan and Iraq. Among veterans in this group with a diagnosed substance use disorder, between 82% and 93% also had at least one mental health disorder, with approximately 37% to 50% of these veterans diagnosed with conditions such as depression or PTSD (Miller, 2025). PTSD is particularly prevalent, affecting approximately one-quarter of veterans overall, and is strongly associated with substance use. Veterans with both PTSD and a substance use disorder experience greater symptom severity and higher risk for continued substance misuse,

illustrating the compounding nature of co-occurring mental health and substance-related conditions within veteran populations.

Social and structural factors further exacerbate mental health risk and complicate access to care. Housing instability represents a major contributor to suicide risk among veterans and is closely intertwined with mental health challenges, trauma exposure, and substance use. In 2020, veterans comprised nearly 8% of homeless adults nationwide, representing approximately 37,000 individuals (Miller, 2025). Veterans with substance use disorders or co-occurring mental health conditions face heightened vulnerability to homelessness, which in turn increases suicide risk and creates significant barriers to continuity of care and treatment engagement.

Although veterans are generally eligible for a range of healthcare and disability benefits, access to care remains uneven across the population. Not all veterans utilize VA healthcare services despite eligibility, and patterns of engagement vary by age, deployment history, and severity of physical or mental health conditions. Older veterans, who have been deployed or have more severe conditions, particularly PTSD, are more likely to seek care through the VA (Miller, 2025). Nearly half of veterans used VA services in 2016, while many simultaneously relied on other forms of insurance, including Medicare, TRICARE, or Medicaid. These patterns suggest that eligibility alone does not guarantee engagement in care and that structural and system-level barriers may persist even when services are technically available.

Mental Health System Capacity and Access Barriers

While insurance coverage and eligibility influence whether veterans can access care, access alone does not guarantee that appropriate services are available when suicide risk is acute. Even among veterans engaged in VA care, system-level constraints, particularly limitations in inpatient psychiatric capacity, may restrict timely access to lifesaving mental health treatment. Examining how healthcare system strains affect suicide outcomes is therefore essential for understanding gaps in veteran mental health services.

Evidence from VA data indicates that mental health system capacity is a critical factor shaping suicide risk among veterans. In a large retrospective cohort study of 111 VA hospitals, Kaboli et al. (2021) examined the relationship between acute inpatient psychiatric bed occupancy and suicide incidence among veterans enrolled in VA primary care. The authors found that hospitals operating at very high occupancy levels (>95%) experienced a significantly higher suicide incidence compared with hospitals operating below 85% occupancy. Importantly, suicide risk was not associated with the absolute number of psychiatric beds, but rather with capacity strain, highlighting that access barriers arise when systems operate near or beyond functional limits.

During the study period examined by Kaboli et al. (2021), suicide rates among VA-enrolled veterans increased from 39.7 to 41.6 deaths per 100,000 person-years, while psychiatric bed occupancy declined overall, and many facilities reported sustained periods of severe overcrowding. High occupancy was associated with a 10% increase in suicide risk, even after adjusting for patient demographics, community mental health resources, and hospital characteristics. These findings suggest that when inpatient psychiatric units operate at or near

capacity, veterans experiencing acute crises may face delays in admission, premature discharge, or referral to non-VA facilities where continuity of care may be weaker.

Additional patterns identified by Kaboli et al. (2021) further demonstrate the complexity of suicide risk within constrained systems. Suicide incidence varied by age, season, and geographic region, with higher risk observed among veterans aged 45-64, during spring and summer months, and in Mountain and Pacific regions. Notably, community-level factors such as the availability of non-VA psychiatric beds or state mental health spending were not significantly associated with suicide risk, reinforcing the importance of access and capacity within the VA system itself.

Structural limitations within mental health care delivery, particularly inpatient capacity strain, clearly influence suicide risk among veterans. Even when veterans are connected to care, limitations in system capacity may prevent timely intervention during periods of acute need. As a result, many veterans experiencing suicidal crises are treated in non-VA settings, where system constraints, clinical practices, and gaps in veteran-specific care further shape outcomes.

Emergency Department Care for Veterans Outside the VA System

In Arkansas, many veterans experiencing suicidal crises are treated in rural community emergency departments rather than within the VA system, making emergency departments a critical point of intervention for veterans disconnected from VA care. This dynamic is especially pronounced in rural counties with high suicide rates, where limited access to specialty mental health services places additional strain on emergency departments.

Using interviews with clinicians from five rural hospitals, Waliski et al. (2023) examined how emergency departments assess and manage suicidal patients, with specific attention to veterans treated outside the VA system. Clinicians described routine use of suicide screening questions focused on suicidal ideation, intent, and recent self-harm behaviors. When patients were assessed as being at imminent risk, they were typically held for observation and referred for inpatient psychiatric care when beds were available. However, Waliski and colleagues found that clinicians often felt undertrained and uncertain about best practices, particularly when suicide risk overlapped with intoxication or polysubstance use, which complicated assessment and disposition decisions.

A key finding of the study was that veteran status was not systematically incorporated into clinical care. Although military service history was frequently collected during registration for billing purposes, Waliski et al. (2023) reported that this information was rarely used in suicide risk assessment, safety planning, or discharge decision-making. As a result, veteran status did not consistently influence treatment pathways or aftercare planning, despite veterans' elevated suicide risk and the availability of veteran-specific services.

The authors also identified significant gaps in the use of evidence-based suicide prevention practices. None of the participating emergency departments reported routine use of structured suicide safety planning, lethal means counseling, or post-discharge care contacts, which are all interventions recommended by VA/DoD clinical practice guidelines and national suicide prevention organizations (Waliski et al., 2023). Instead, some clinicians described continued reliance on "no-harm contracts," a practice no longer considered best practice. Aftercare was

typically limited to referral lists or discharge instructions, and clinicians noted that recommended follow-up timelines of three to five days were often unrealistic in rural settings, where outpatient behavioral health appointments were more commonly available 10-14 days after discharge.

In describing barriers specific to rural contexts, Waliski et al. (2023) emphasized limited local mental health infrastructure, long travel distances, extended wait times for care, and geographic isolation as major challenges for veterans following emergency department discharge. Clinicians expressed concern that these barriers increased vulnerability during the post-discharge period and reduced the likelihood of successful follow-up.

Based on these findings, Waliski et al. (2023) outlined several system-level opportunities to improve suicide prevention for veterans treated in rural emergency departments. These included making veteran status clinically visible through integration into triage and assessment processes, providing targeted training for emergency department staff on evidence-based suicide prevention and veteran-specific risk factors, replacing outdated “no-harm contracts” with structured safety planning and caring contacts, strengthening referral pathways to VA and community-based services, expanding telehealth to address rural access gaps, and integrating veteran peer and community care support programs to reduce isolation and improve continuity of care. Many of these same-level challenges, particularly fragmented identification, limited care coordination, and gaps in follow-up, also arise in other settings where veterans interact with public systems, including the criminal justice system.

Justice-Involved Veterans and Gaps in Primary Care Engagement

Veterans involved in the criminal justice system experience disproportionately high rates of mental illness, substance use disorders, and homelessness, factors that are independently and collectively associated with elevated suicide risk. Within the VA, the Veterans Justice Program (VJP), which includes Veterans Justice Outreach and Health Care Reentry Veterans, was developed to identify justice-involved veterans and facilitate connection to VA health care and community-based resources (Tsai et al., 2025). To assess how effectively these programs translate identification into sustained engagement in care, Tsai et al. (2025) analyzed VA administrative data from more than 20,000 justice-involved veterans served by the VJP. Although the majority of veterans in this cohort were enrolled in VA healthcare, approximately one in eight veterans (12.4%) were not assigned to a VA primary care team, indicating a gap between program contact and continuity of care.

Patterns of disengagement were particularly concerning among veterans with the highest clinical needs. Tsai et al. (2025) found that justice-involved veterans who were not assigned to a VA primary care team were more likely to have diagnosed mental health or substance use disorders, yet were less connected to VA benefits, including service-connected disability ratings. At the same time, Tsai et al. (2025) identified pathways that may reduce care fragmentation, showing that justice-involved veterans who engaged in outpatient mental health or substance use treatment were significantly more likely to be assigned to VA primary care. This pattern suggests that integrated behavioral health services can function as an effective entry point for broader healthcare engagement among justice-involved veterans.

These findings indicate that while VJP functions as an important bridge between criminal justice settings and the VA, substantial gaps in primary care engagement persist. For justice-involved veterans, incomplete connection to core VA services may limit access to chronic disease management, substance use treatment, and suicide prevention supports, reinforcing the need for integrated, cross-system approaches to care coordination. Together with evidence from emergency departments and VA capacity constraints, these findings demonstrate that veterans at the highest risk for suicide frequently interact with multiple public systems without sustained engagement in coordinated care, highlighting the need for prevention strategies that extend beyond single settings or programs.

Implications for Prevention and Harm Reduction

The system-level barriers identified across both VA and non-VA care settings have direct implications for suicide and overdose prevention among veterans. As demonstrated in rural emergency departments, suicide risk often escalates rapidly, yet veterans may encounter gaps in care at the precise moment intervention is most needed. Prevention efforts, therefore, must extend beyond traditional clinical settings and combine timely access to care with low-barrier, community-based supports capable of reaching veterans both inside and outside the VA system.

Low-intensity engagement strategies have been implemented to address gaps in connection to care among high-risk veterans, particularly those who are not consistently engaged with formal healthcare systems. One such approach is the use of caring letters by the Veterans Crisis Line (VCL), which involves sending brief, supportive messages from a clinician or peer veteran following a crisis interaction to promote continued connection and help-seeking (Reger et al., 2024). National evaluations of this approach found that caring letters were not associated with reductions in suicide attempts or all-cause mortality; however, veterans who received caring letters demonstrated significantly higher utilization of VA services, including outpatient care, outpatient mental health services, inpatient care, and emergency department visits. Within a needs assessment context, these findings suggest that caring letters function as an engagement mechanism, rather than a standalone suicide prevention intervention, highlighting the importance of pairing low-intensity outreach with comprehensive mental health and substance use treatment options.

Given the multifactorial nature of overdose risk among veterans, prevention efforts must incorporate comprehensive harm reduction strategies. Veterans receiving long-term opioid therapy frequently present with co-occurring substance use, which is associated with elevated mortality and overdose risk (Ngo et al., 2025). Expanding access to medications for opioid use disorder (MOUD), naloxone distribution, and coordinated substance use treatment services is therefore critical. Strengthening linkages between VA and community-based providers may also improve continuity of care for veterans who are not consistently engaged with VA services, particularly those experiencing co-occurring substance use and social vulnerability.

Alcohol-Focused Prevention Strategies

Alcohol misuse represents a particularly important target for prevention efforts among veterans. High-risk drinking behaviors are particularly prevalent among younger veterans during the post-deployment period and are strongly associated with PTSD, aggression, sleep

disturbance, suicidal ideation, anxiety, and depression. Prior studies have reported heavy drinking and binge drinking rates ranging from 19% to 43% among veterans, with approximately 12% meeting criteria for AUD, yet nearly 80% of veterans with AUD do not receive treatment. Given these patterns and the stigma and access barriers associated with traditional care, Young et al. (2018) evaluated brief computer-delivered interventions as a promising strategy to reduce alcohol misuse and improve engagement among younger veterans.

One such intervention with demonstrated effectiveness among veterans is Personalized Normative Feedback (PNF). PNF provides individuals with accurate, peer-referenced information about alcohol use patterns, with the goal of correcting misperceptions about normative drinking behavior. The underlying assumption of PNF is that overestimation of peer alcohol use contributes to heavier drinking and that recalibrating these perceptions can result in meaningful reductions in consumption.

Evidence supporting the use of PNF among veterans comes from a study of young adult veterans ages 18-24, a group at elevated risk for alcohol-related harm. In this study, participants reported baseline alcohol consumption averaging approximately 18 drinks per week. Veterans in the intervention group received personalized feedback comparing their drinking levels to actual norms among fellow veterans, while the control group received unrelated normative information. At one-month follow-up, veterans who received PNF reported a reduction in alcohol consumption to an average of 11 drinks per week, representing a substantial short-term decrease in drinking relative to baseline levels (Young et al., 2018). These findings suggest that PNF may serve as a feasible, low-barrier intervention for reducing alcohol misuse among younger veterans, particularly when integrated into broader engagement and harm-reduction strategies.

Large-scale analyses of VA data further demonstrate the importance of addressing substance use as a core component of suicide prevention. In a national cohort study of 4.86 million veterans receiving VA services, Bohnert et al. (2017) found that substance use disorders significantly increased suicide risk for both men and women, even after adjusting for age, medical comorbidity, and co-occurring psychiatric conditions. AUD, opioid use disorder, and sedative use disorder were among the strongest predictors of suicide mortality, highlighting substance use as an independent and critical driver of suicide risk.

While co-occurring substance use elevates overdose risk across veteran populations, these risks are not evenly distributed. Veterans who co-use alcohol and opioids experience particularly elevated fatal overdose risk, and structural inequities in access to treatment and harm reduction services may further compound vulnerability (Ngo et al., 2025). These disparities likely reflect structural inequities in access to substance use treatment, harm reduction services, and culturally responsive care rather than differences in substance use alone. Addressing these inequities is essential for ensuring that prevention strategies reach veterans most at risk and align with broader public health goals of equity and access.

Public Health Approaches to Veteran Suicide Prevention

When system capacity, access barriers, and social determinants converge, prevention efforts must move upstream. Public health approaches provide a framework for addressing veteran

suicide risk across multiple levels, from data surveillance to community engagement and policy-informed intervention. This framework is particularly relevant for veterans because inpatient capacity strain can delay crisis care even for those engaged in VA services, while a substantial proportion of veteran suicide deaths occur among individuals who are not engaged in VA care at the time of death (Kaboli et al., 2021; VA, 2024). Veterans disconnected from VA services may be more likely to encounter emergency departments, community organizations, or informal support networks rather than formal mental health systems, limiting the reach of clinic-based prevention efforts and reinforcing the need for coordinated public health action (Ramchand et al., 2025).

At the national level, the CDC leads a data-driven public health approach to suicide prevention, with specific attention to populations experiencing elevated risk, including veterans (CDC, 2022). A central component of this approach is the NVDRS, which integrates data from death certificates, medical examiner reports, and law enforcement investigations to capture detailed information on suicide circumstances across all U.S. states, Washington, DC, and Puerto Rico (CDC, 2022). By capturing detailed information on mental health history, substance use, recent life stressors, and method of death, NVDRS enables identification of population-level risk patterns that are not visible through healthcare utilization or data alone, particularly for veterans who are not engaged in formal treatment at the time of death (VA, 2024).

To address persistent gaps in identifying suicide risk among veterans, CDC collaborates with the Department of Defense (DoD) and the VA to link mortality and service records across federal systems (CDC, 2022). Analyses comparing VA-DoD mortality data with NVDRS have demonstrated that veteran status is not consistently captured in state-level death records, leading to under-identification of veteran suicide deaths in public health surveillance, particularly among women veterans and younger veterans (Hoffmire et al., 2025). In addition to improving fatality surveillance, CDC supports near real-time monitoring of nonfatal suicidal behaviors through emergency department surveillance in select states, enabling earlier detection of suicide attempts and emerging clusters among populations that may not be connected to ongoing mental health care (CDC, 2022). These surveillance efforts strengthen the ability of public health systems to identify risk outside traditional clinical settings and inform timely, population-level prevention responses.

Surveillance systems are most effective when paired with prevention infrastructure capable of translating data into coordinated action. Through the Comprehensive Suicide Prevention (CSP) program, CDC funds state health departments and academic partners to implement and evaluate multi-sector suicide prevention strategies that address upstream risk factors, such as substance use, housing instability, social isolation, and access to lethal means (CDC, 2022). These initiatives emphasize collaboration with healthcare systems, veteran-serving organizations, and community partners to expand prevention efforts beyond clinical environments and reach individuals who are not engaged in VA care (CDC, 2022). By prioritizing data-informed interventions and cross-sector partnerships, CSP reflects a public health model that aligns closely with the gaps in access, engagement, and continuity of care identified throughout this needs assessment.

While federal public health initiatives provide a critical foundation for suicide prevention, the broader landscape of veteran-focused prevention efforts remains fragmented across

government agencies, nonprofit organizations, and private-sector actors. This expansion has increased innovation reach, but has also contributed to fragmentation, making it difficult to assess coverage, identify gaps, and coordinate strategies across systems (Ramchand et al., 2025). For veterans who move between healthcare, community, and informal support settings, or who are not consistently engaged with any single system, this fragmentation can limit the effectiveness of prevention efforts and obscure where investments are needed most.

In response to the complexity and fragmentation of veteran suicide prevention efforts, national partners have sought structured frameworks to better organize, evaluate, and coordinate activities across sectors. In 2023, the Face the Fight coalition, an alliance of corporations, foundations, nonprofits, and veteran-serving organizations, commissioned the RAND Corporation to examine current and emerging approaches to veteran suicide prevention and to situate them within a coherent public health framework grounded in prevention (Ramchand et al., 2025). This effort was designed to move beyond isolated program descriptions and instead assess how prevention activities collectively address risk across different populations, settings, and stages of suicide prevention.

As part of this initiative, RAND conducted a comprehensive review of 307 suicide prevention programs, including 156 active programs and 226 proposed initiatives, with some overlap between categories (Ramchand et al., 2025). Programs were identified through online searches, submissions from the VA's Mission Daybreak competition, and grants funded by Face the Fight. Each program was categorized into one or more of 26 distinct suicide prevention activity types, ranging from pharmacotherapy and counseling to peer support, wellness retreats, arts therapy, spiritual programs, and social support initiatives (Ramchand et al., 2025). This broad scope reflects the diverse ways suicide prevention is currently conceptualized and implemented across veteran-serving systems.

To organize this diverse landscape, RAND developed the Suicide Prevention Activity Matrix, a conceptual framework that classifies prevention activities according to both who they target and what prevention goals they aim to achieve. Drawing on the socio-ecological model, activities were grouped across individual, interpersonal, and community or social levels, capturing interventions directed at veterans themselves, their families and support networks, and the broader environments influencing veteran well-being (Ramchand et al., 2025). This structure allows for clearer assessment of how programs complement one another and where prevention efforts may be concentrated or lacking.

In addition to the target population, the matrix organizes activities by prevention using a disease prevention framework, including primordial prevention, well-being promotion, mental health treatment, mental health supports, and crisis response (Ramchand et al., 2025). This approach highlights whether programs aim to address upstream social and environmental conditions, prevent the onset of suicidal thoughts, manage existing mental health symptoms, support treatment engagement, or intervene during acute crises. By mapping activities across both dimensions, the matrix clarifies how prevention strategies align, or fail to align, with population-level needs identified through surveillance and needs assessment data.

Analysis of active programs revealed that most veteran suicide prevention efforts focused on building social connection, providing case management, and offering non-crisis psychological counseling, often through multi-component interventions (Ramchand et al., 2025). Veterans

were the primary target population, though many programs also included support for family members and peers. Nonprofit organizations operated the majority of programs and nearly half utilized virtual or hybrid delivery models, reflecting growing reliance on technology-enabled care to improve reach and accessibility (Ramchand et al., 2025). Fewer programs targeted broader community or societal-level factors, suggesting potential gaps in upstream prevention.

Review of proposed programs indicated a shift towards technology-driven solutions, including mobile health applications, suicide risk assessment tools, and real-time monitoring platforms, often integrated into multifunctional systems. While these approaches may enhance scalability and access, RAND emphasized that innovation alone is insufficient without alignment to evidence-based practices and clear integration into existing care pathways (Ramchand et al., 2025). These findings reinforce the importance of evaluating not only individual interventions but also how prevention strategies collectively address risk across settings and stages of need.

Recommendations for Prevention and System Improvement

Findings from this needs assessment indicate that suicide prevention efforts for veterans in Arkansas must extend beyond traditional clinical settings and address the intersecting roles of substance use, mental health, and system-level barriers to care. Given that a substantial proportion of veteran suicide risk emerges outside VA services, prevention strategies should prioritize coordination across VA and non-VA systems, community-based prevention supports, and public health infrastructure.

First, suicide prevention efforts should incorporate substance-aware and trauma-informed approaches across emergency departments, community organizations, and peer-led crisis response programs. Community-based crisis data demonstrate that substance use is frequently involved in veteran crises, highlighting the need for assessment protocols that address intoxication, polysubstance use, withdrawal risk, and co-occurring overdose risk alongside suicidal ideation. Integrating harm-reduction strategies, including naloxone distribution and linkage to medications for opioid use disorder, can reduce mortality risk while supporting engagement in care.

Second, sleep disturbance should be incorporated into suicide risk assessment, particularly for veterans presenting with alcohol misuse or other substance-related concerns. Evidence indicates that insomnia and short sleep duration are independently associated with suicidal ideation among veterans who misuse alcohol. Routine screening for sleep disturbance in both clinical and community settings may help identify veterans at elevated risk who might otherwise be missed by standard psychiatric screening alone.

Third, care coordination across systems should be strengthened, particularly in rural and non-VA settings where veterans often present during crises. Emergency departments should make veteran status clinically visible and implement evidence-based suicide prevention practices, including structured safety planning, lethal means counseling, and proactive follow-up after discharge. Formal referral pathways between emergency departments, VA services, community mental health providers, and veteran-serving organizations can improve continuity of care during high-risk transition periods.

Fourth, addressing system capacity constraints is essential for timely intervention. Monitoring psychiatric bed occupancy and developing regional surge strategies, such as telepsychiatry, crisis stabilization units, and cross-facility placement agreements, may reduce delays in care during periods of high demand. These strategies are particularly important in rural regions where specialty mental health resources are limited.

Finally, prevention efforts should include targeted strategies for high-risk and underserved veteran subpopulations, including women veterans, LGBTQ veterans, justice-involved veterans, and veterans living in rural areas. Tailored outreach, culturally responsive care, and peer-led engagement models can reduce stigma, address access barriers, and improve trust among veterans who are less likely to engage with traditional systems of care. Strengthening partnerships with community-based organizations and local leaders can further extend the reach of these efforts and ensure services are delivered in familiar, trusted settings. Additionally, investing in data-driven approaches to identify emerging needs and monitor outcomes can help refine interventions and ensure resources are directed where they are most effective.

LIMITATIONS

This needs assessment has several limitations that should be considered when interpreting its findings. The assessment relies exclusively on secondary data sources, including published literature, national and state surveillance data, and de-identified organizational crisis response records. As a result, the findings describe associations and patterns, rather than causal relationships.

Community-based crisis response data from We Are The 22 reflect veterans reached through peer-led intervention services and may not represent all veterans in Arkansas, particularly those who are socially isolated or not connected to community organizations. Documentation practices also varied over time, and earlier crisis records may lack the level of detail found in standardized after-action reports, potentially leading to under-documentation of substance use or co-occurring conditions.

Limitations in surveillance systems further affect population-level estimates. Suicide mortality data are subject to reporting delays, and veteran status is not consistently captured across state-level records, particularly for women and younger veterans. These factors may result in underestimation of suicide deaths within certain subpopulations and limit near-real-time monitoring.

Finally, much of the available research focuses on veterans engaged in VA care, which may limit generalizability to veterans who receive care exclusively through non-VA systems or who are not engaged in healthcare services at all. Despite these limitations, convergence across multiple data sources strengthens confidence in the identified gaps and supports the relevance of the recommendations.

CONCLUSION

Veterans in Arkansas face complex and intersecting risks related to suicide, substance use, and mental health challenges, many of which are exacerbated by rural geography, system

fragmentation, and gaps in access to care. Response to these challenges requires a comprehensive, community-based approach. This needs assessment demonstrates that suicide risk frequently emerges outside traditional VA settings and is often intertwined with substance use, sleep disturbance, and limited continuity of care during crisis periods. The data presented in this needs assessment illustrates critical gaps in access to care, particularly among those not engaged with the VA, and underscores the urgent need for tailored interventions that reach veterans where they live, work, and socialize.

Findings from community-based crisis response data highlight the prevalence of substance-involved crises and reinforce the need for prevention strategies that are flexible, substance-aware, and capable of reaching veterans in non-clinical environments. Addressing these challenges will require coordinated, multi-sector approaches that integrate public health surveillance, healthcare systems, community organizations, and peer-led supports.

By strengthening cross-system coordination, expanding evidence-based and harm-reduction-oriented interventions, and tailoring prevention efforts to the needs of high-risk veteran subpopulations, stakeholders can reduce preventable deaths and improve overall well-being among veterans in Arkansas. The findings of this needs assessment provide a foundation for targeted, evidence-informed action to better support veterans and their families across the state.

With the growing prevalence of co-occurring disorders such as PTSD and substance use, it is vital to prioritize trauma-informed care models and accessible services that address not only mental health and substance use but also housing instability and unemployment. By adopting innovative, low-barrier approaches such as telehealth, peer support programs, and integrated care strategies, we can improve outreach and engagement, especially for younger and female veterans. It is essential for policymakers, healthcare providers, and communities to collaborate in bridging these gaps and ensuring that Arkansas veterans receive the care and support they deserve. Only through these combined efforts can we hope to reduce the tragic rates of suicide and improve the overall health and well-being of those who have served our country.

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