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# Suicide Mortality in Nevada's Military Veterans, 2008-2010


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# Suicide in Nevada's Military Veteran Population
# 2008-2010
# A Silent and Tragic Epidemic

## Introduction

Suicide is defined as an act of intentional self-harm resulting in death. It is a pressing public health concern in Nevada. The state of Nevada has consistently ranked in the top 5 for the highest suicide rates in the nation. Nevada's perennially high rates of suicide can result in public complacency, diminishing discussion and community action. The consequence can be a lack of preparedness for preventing these deaths and the secondary harm they cause.

Suicide is an action often taken by individuals who feel isolated and hopeless, with high levels of emotional pain, physical pain, family and personal problems, and financial stress. Nevada's military veterans, particularly younger veterans, are dying from suicide at alarming rates above the state's already high rate. The finding of suicide rates so much higher than expected fits the definition of an epidemic.

A veteran who is recently released from active duty, reserve, or National Guard is often one who has experienced wars of the last decade. Veterans may have endured deployments that disrupt life with family and friends, even considering the unprecedented access to technology that enhances communication with loved ones. Deployments bring exposure to long periods of numbing routine with time to worry about crises occurring at home, interspersed with moments of extreme violence and death.

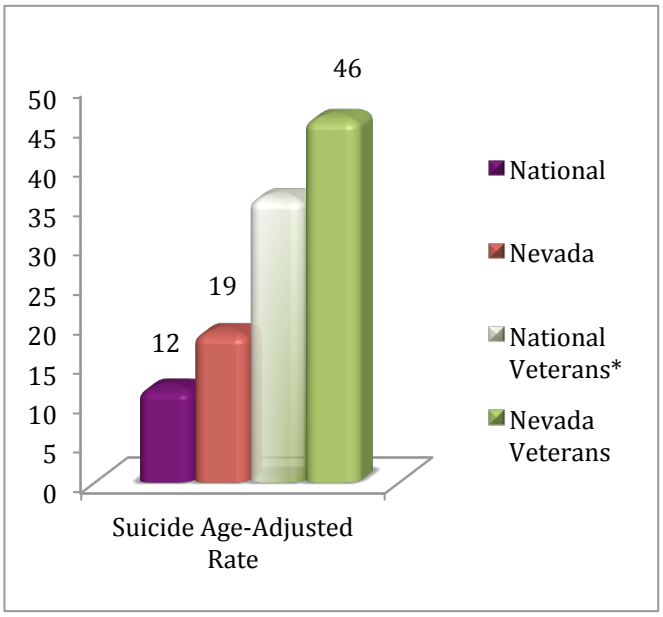
Individuals in uniform yet not deployed into actual war zones may experience continuous training for performing a wartime mission, longer assignments to other hot regions, delayed discharges, emotional turmoil of friends who are injured or killed, and guilt for "not being there to help." The stress of being in military service can include feeling cut off and isolated from "the real world" where birthdays and holidays are observed along with weddings, funerals, and the arrival of new babies. Deployment brings concern for family back home who deal with everyday emergencies such as car or home repairs and school activities.

The paradox of military service during wartime with exposure to trauma and violence and isolation from loved ones can be a tremendous sense of pride, belonging, purpose, and accomplishment. The dynamics of belonging to a unit with support structures and certainty enhances the resilience of the individual. However, discharge or return to reserve status can strip away these supports, plunging an individual into a struggling economy characterized by loss of jobs, homes, and friends. This confluence of circumstance and experience can result in feelings of loss and hopelessness that for some leads to thoughts of suicide.

The data and information contained in this report highlight the need for efforts to control this epidemic. This document is intended to be a brief examination of suicide, not a full discussion or action plan. It is hoped that the information will be used to create policies, programs and actions that will help control Nevada's epidemic of veteran suicides.

**Data Profile of Nevada Military Veteran Suicides**

*Figure 1. Suicide Rates U.S. and Nevada, 2009 and Nevada Veterans Aggregate 2008-2010 (All rates per 100,000 population)*

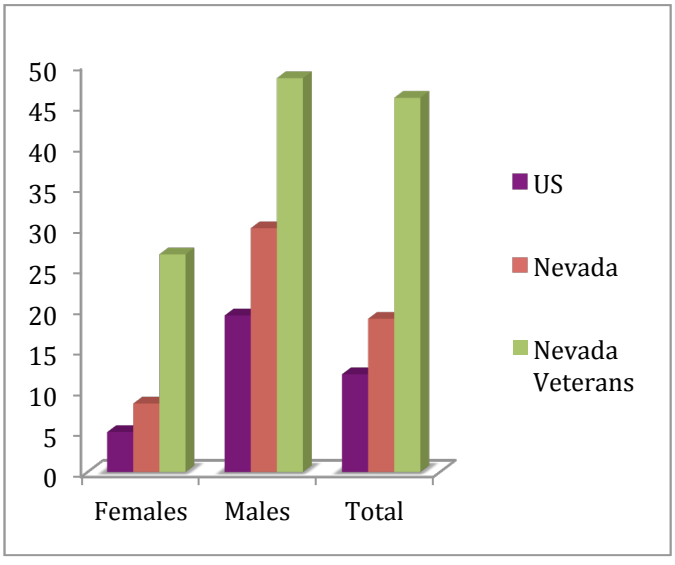



A national rate for suicide in the veteran population is not known. Studies of veteran suicides conclude that the rate is three to four times the rate for the total population. (Sundararaman, Panangala, & Lister, 2008) The rate in figure 1 is calculated conservatively and is presented here for the purposes of discussion. The source for all Nevada data is from death certificates filed with the Office of Vital Records for years 2008-2010 combined.

*Estimated national rate of suicide among veterans.

*Figure 2. Suicide Rates per 100,000 Population for U.S. and Nevada, 2009 and Nevada Veterans by Gender, Aggregate 2008-2010*

The data does allow for a comparison of Nevada suicide rates to US rates by gender. (McIntosh, 2012) Available Nevada data allows for a comparison of suicide rates for the total population and the state's veteran population.




In the United States, suicide rates for women tend to be lower than rates for men. This is also true in Nevada. The data finds that females in Nevada have a suicide rate (8.4) higher than the national female rate (4.9), nearly double the national rate.

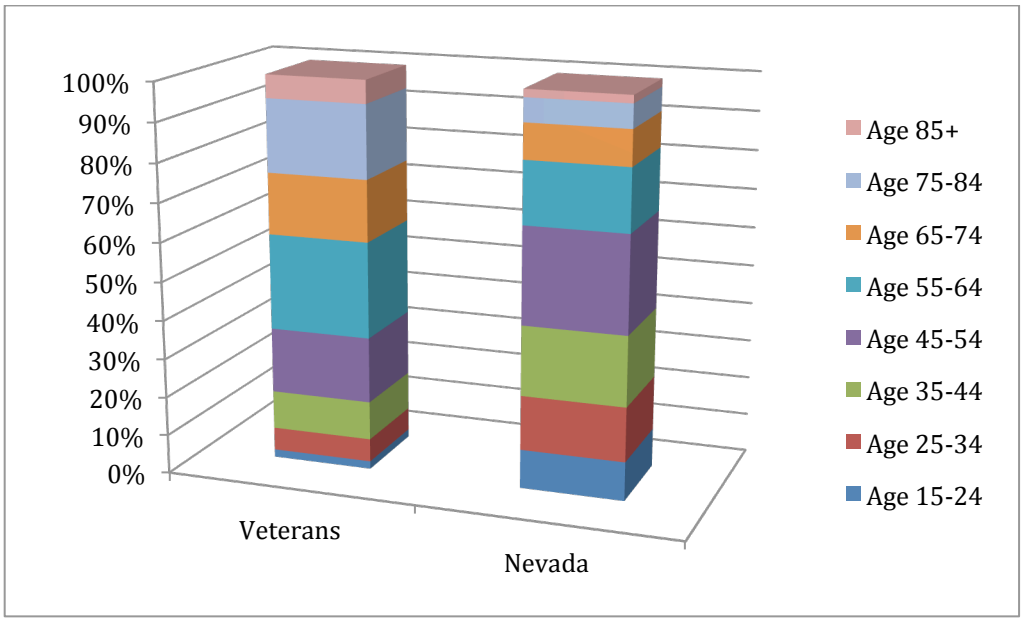
In comparison, the suicide rate for female Nevada veterans at 26.7 is more than three times higher than the Nevada female rate and six times higher than the national rate. The suicide rate for female

Nevada veterans exceeds the national rate for men, the total national rate, and the total Nevada rate. For the years 2008 through 2010, 14 Nevada women veterans lost their lives to suicide.

Suicide rates for men in Nevada are similarly higher than the national rate. The suicide rate among male veterans is elevated high above the rates for all males within Nevada and the nation. The suicide rate for Nevada male veterans is at 48.3 compared to the total male Nevada rate of 29.9 and the national rate of 19.2.

Conventional assessments of the percentage of suicide by age to all suicide deaths confirms impressions that suicide among veterans occurs mostly in middle-age rather than the slightly younger shift in the total population. Figure 3 presents age of occurrence for veterans and Nevada for 2010. (Office of the Actuary, Office of Policy and Planning, 2007)

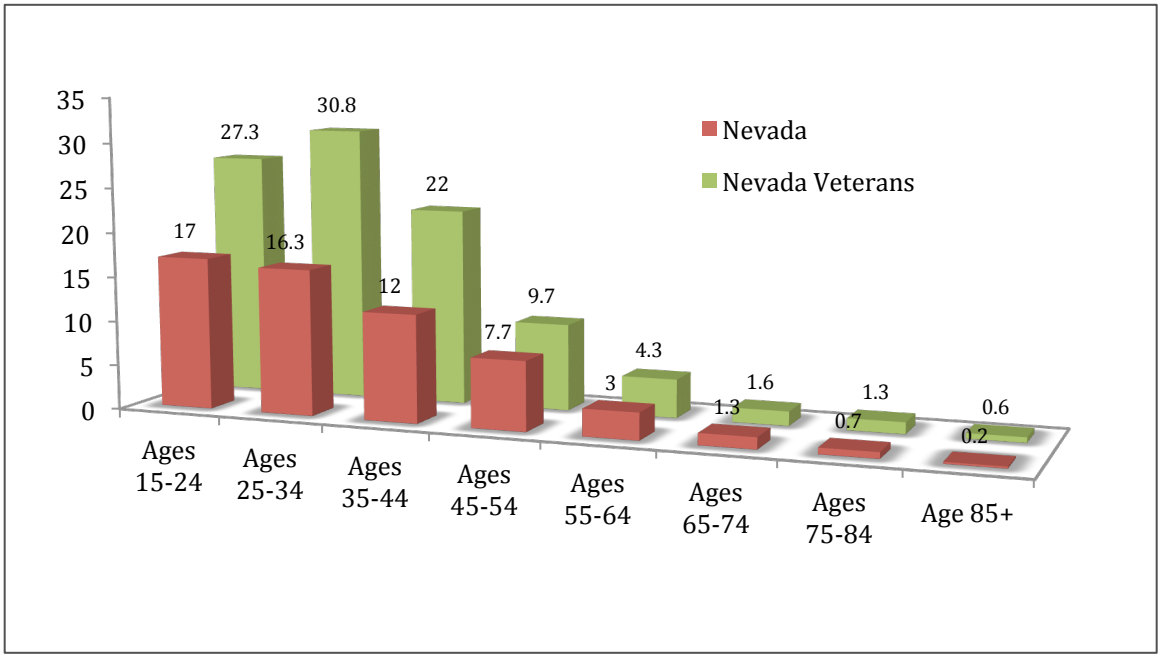
*Figure 3. Nevada Suicide Deaths as a Percentage of All Suicide Deaths by Age Group and Veterans Status, 2010*




However, the age profile reflects the percentage of veterans in each age group. A higher percentage of age cohorts are veterans during periods of mandatory military service and as a result, in terms of actual counts, more suicides occur in middle age and older veterans due to the military draft during World War II, the Korean War, and the Vietnam War.

Veteran suicide prevention efforts should not be based solely on occurrence data in today's all volunteer force structure. Figure 4 presents a different understanding of veteran suicide when suicide occurrence is compared among peers of the same age category. Suicide occurred at higher percentages within each age group for younger veterans compared to the population as a whole within each age group in 2010. Suicide among younger veterans is more likely to occur as a manner of death than among their age cohort peers.

*Figure 4. Nevada Suicide Deaths as a Percentage of All Deaths within Age Cohort and Veteran Status, 2010*

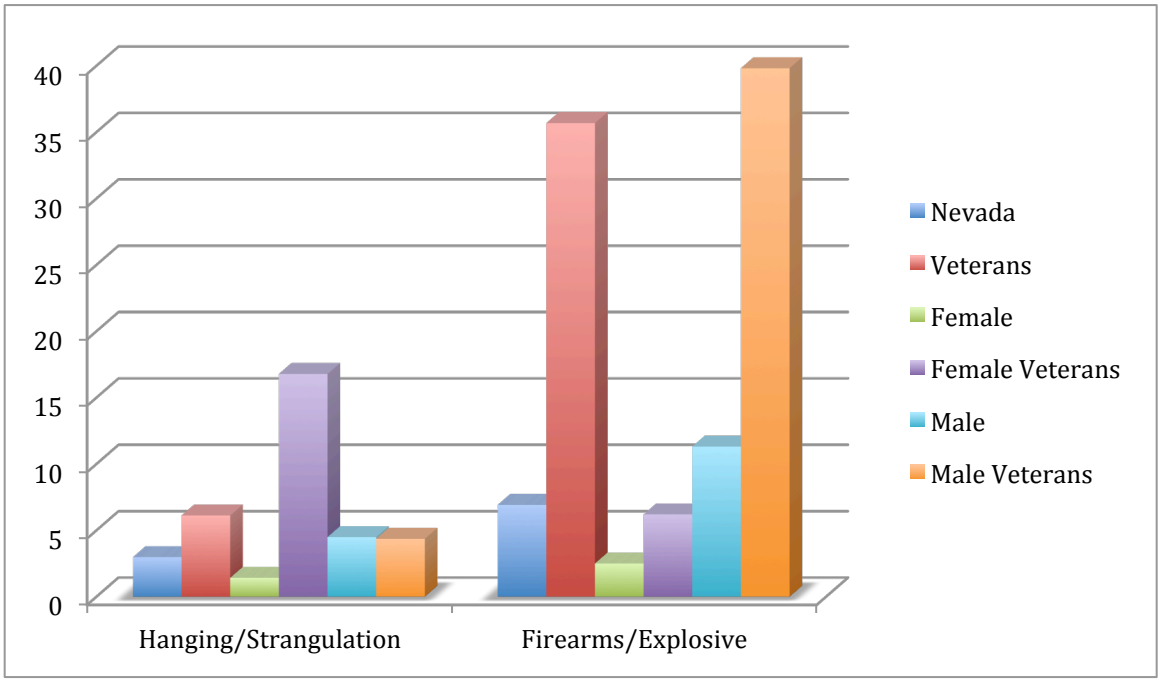



Differences observed in method used for suicide in the veteran and general populations exist in Nevada. Data aggregated for 2008-2010 suggests that veterans are more likely to die from self-inflicted gunshot wounds or by hanging/strangulation/suffocation compared to the general population for these methods. Although more women died from suicide due to poisoning in the general population, this did not hold true for women veterans. More women veterans died from hanging or firearms as a method of suicide than from poisoning.

A discussion of veteran suicide is not complete without a discussion of firearm use. Veterans' use of firearms as a method of suicide amounts to nearly half of all Nevada suicides by firearms (48%, 275 veterans out of 527 deaths) for 2008-2010. Yet veterans were less likely to die in accidents or homicides with the use of a firearm than the general population. It reasons that veterans have a basic competency in the use of firearms, thus preventing death from accidents or becoming the victim of firearm homicide. But when a veteran turns a firearm on himself or herself, the outcome is certain and fatal.

All veteran suicide prevention efforts should address access to firearms and openly discuss safety measures that can be implemented by the veteran or family to reduce easy impulsive access to firearms in the home. Figure 5 presents data related to the two predominant methods used by veterans in completed suicide.

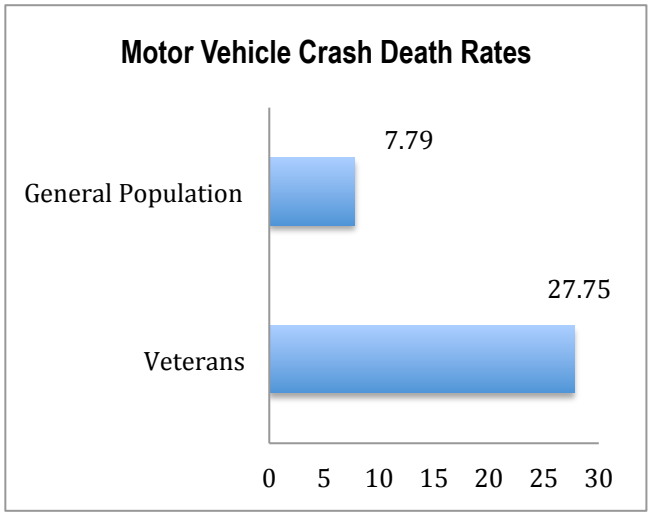
*Figure 5. Suicide Deaths by Select Methods by Gender and Veteran Status, Nevada, Aggregate 2008-2010*



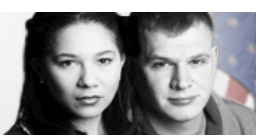

Data tables 1 through 4 at the end of this document provide additional detail for suicide accidents and homicide. Most notable for non-suicide deaths is death in motor vehicle crashes among veterans compared to the general population (figure 6).

*Figure 6. Death Rate due to Motor Vehicle Crash by Veteran Status, Nevada 2008-2010, Age Adjusted.*

The high rate of death due to motor vehicle crashes for veterans is reflective of a pattern of risk taking behaviors found in studies of this population. The number of "hidden suicides" in these numbers is unknown: some veterans seek to relive the "adrenaline rush" of near death military experiences by taking extreme risk in civilian life. Other veterans may feel surviving military experiences confers a level of invincibility. Impact from high levels of substance use is also a factor in accidental deaths. Veteran suicide prevention efforts should not overlook these factors.





## Data Limitations

The populations for this report are from both state and national sources. Since this report uses two different sources for populations, rate comparisons and analysis can become complicated and should be interpreted with caution.

Notations: Data is not final and is subject to changes. Due to small counts the rate may be statistically insignificant. Age rates are per 100,000 age-specific (>15) population. Crude rates are per 100,000 populations. Non-veteran population is based on the Nevada Interim populations, which is based on the 2005 population estimates provided by the Nevada State Demographer. Veteran population based on Department of Veteran Affairs (Office of the Actuary, Office of Policy and Planning, 2007) veteran population projections.

## Risk Factors

Suicide is an act of intentional self-harm resulting in death. Risk factors that increase an individual's likelihood of completing suicide can be classified broadly as individual, community, societal, and peer/family risk factors. Each risk factor contains a cluster of conditions, some of which can be changed and those that cannot be changed. Clusters of risk are identified as follows with examples listed (Office of Suicide Prevention, 2007):

### Individual

- Age
- Sex
- Substance abuse
- Previous attempt
- Mental illness
- Job loss

### Peer/Family

- History of Suicide
- Violence, i.e. domestic violence, assault, combat
- Abuse
- Suicide exposure
- Divorce

### Community

- Stigma
- Isolation
- Barriers to mental health and physical health care
- Barriers to social support services, i.e. housing, transportation

### Societal

- Cultural values, i.e. warrior ethos, military culture
- Attitudes, i.e. to show emotion is a weakness
- Media influence
- Western/rural lifestyles, i.e. access to firearms

## Protective Factors

Protective factors are conditions that help decrease an individual's risk for suicide. Protective factors include support systems and environments that can counter risk and increase an individual's abilities for problem solving, sense of belonging, resiliency, and hopefulness for a positive future. Typical protective factors are presented below. Protective factors, like risk factors, are often unique to different cultures, age groups, gender, and race, or ethnicity.

Typical Protective Factors

- Effective clinical care for mental, physical, and substance use disorders
- Restricted access to lethal means
- Ongoing support through mental and physical health care relationships
- Strong connections to peer, family, and community, e.g., veteran's organizations
- Life skills in problem solving, conflict resolution, and non-violent handling of disputes
- Cultural beliefs that discourage suicide and support self-preservation

**Community Factors**

After homecoming ceremonies and parades are over, many veterans who have left active duty face challenges such as obtaining employment, returning to family life, and paying bills. Some veterans return home with memories of combat that include images of the deaths of fellow unit members, enemy fighters, and non-combatant elderly, children, men, and women. Some veterans return home still reliant on pain medications, alcohol or other substances. A veteran with many or all of these stresses must then navigate a complex system of administration, benefit eligibility, and finding and accessing healthcare.

Figure 7 represents this complex system that relies on the veteran to seek assistance. The implication is that the veteran understands assistance is needed. Information about Nevada's service system was obtained through interviews and document or plan reviews in January and February of 2012. More recent program efforts may not be represented in this document. A veteran can face barriers to accessing healthcare, especially mental health services, even within the Department of Veterans Affairs programs (VA).

There are limited outreach efforts for readjustment and counseling to veterans. Even "best practice" efforts by VA Vet Centers and Mental Health Services only reach a limited number of potentially eligible veterans. A veteran can seek care through the Veteran's Healthcare Administration system of hospitals and clinics. However, enrollment, program capacity limits, and eligibility requirements can result in long waiting times for appointments or block access altogether to veterans who lack service-connected conditions or are otherwise not eligible for care. Even recently discharged veterans must access healthcare benefits within five years of discharge or face service connection eligibility requirements. The current wars have lasted for over a decade resulting in many younger veterans now losing automatic eligibility. Further, some men and women do not realize they are veterans because of long-held stereotypes that veterans are old grandfatherly men or characters who resemble Rambo. Veterans also must overcome military cultural stigma that it is a demonstration of weakness to ask for help or seek mental health services.

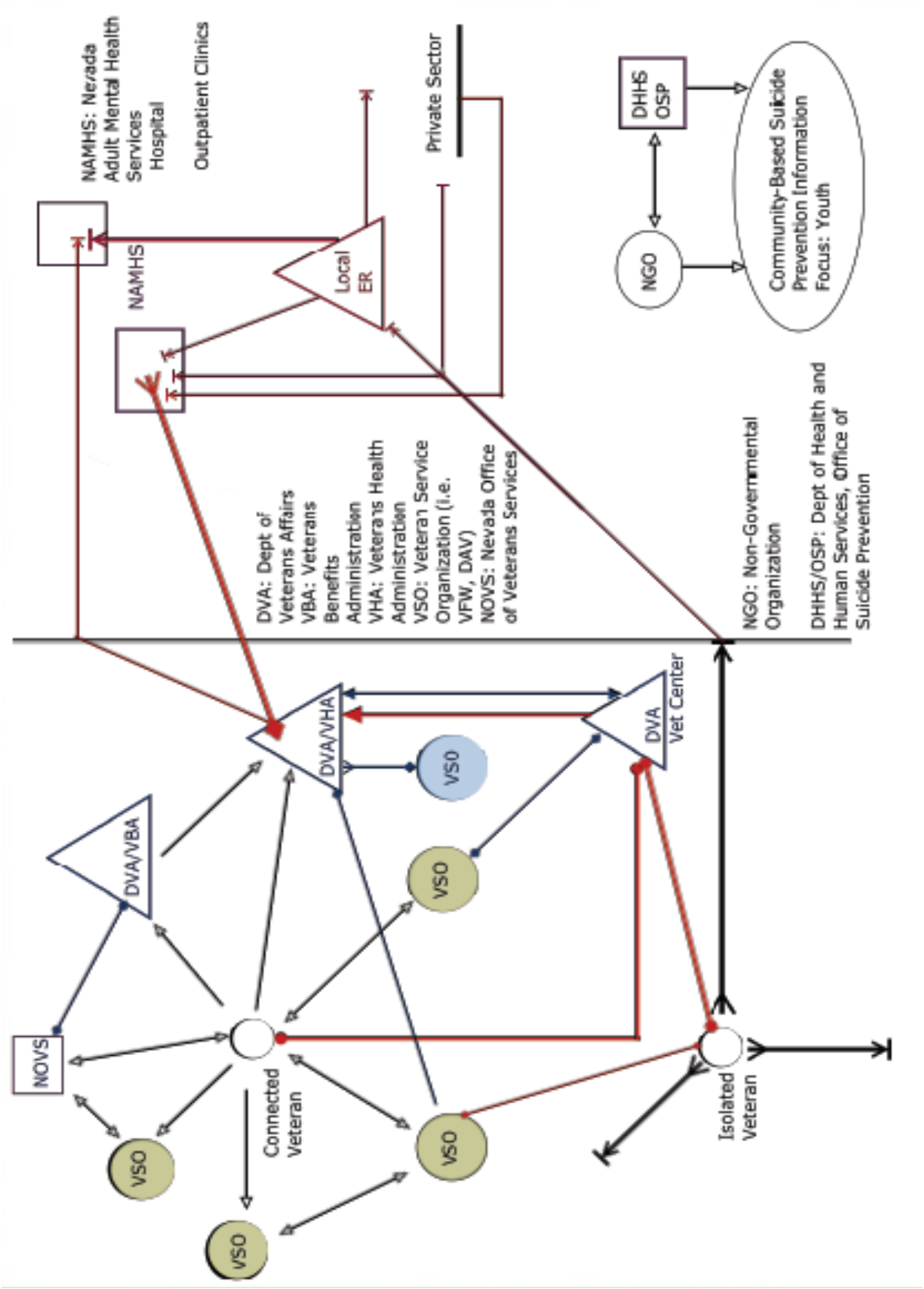
In the broader civilian community, veterans face many misperceptions regarding access to care. Interviews with state and local mental health providers reveal a pervasive belief that veterans "belong to the VA" in spite of the fact that only 25-35% of veterans are provided care through the VA. Those few veterans who somehow manage to seek care from non-VA services are

quickly referred to the VA regardless of eligibility and often with no follow-up. A notable exception is the utilization of the Southern Nevada Adult Mental Health Services Hospital for psychiatric patients in need of secure observation and treatment due to a lack of similarly equipped VA facilities in the region.

State and local suicide prevention programs are even more distant in addressing veteran suicide. As depicted in figure 7, state and community-based suicide prevention planning in recent years has been focused on suicide by youth. In fact, examination of the most recent version of Nevada's State Suicide Prevention Plan contained many false assumptions regarding suicide protective factors for veterans. (Office of Suicide Prevention, 2007)

Taken together, uninformed civilian systems and limited access and outreach from VA systems results in many veterans lost in communities unaware and unprepared for their suffering, risk taking, and isolation.

*Figure 7. Veteran and Community-Based Access to Care Map.*




Outreach: Red lines with circle at each end Care referral: Red or Maroon Lines with blocked arrow
Possible Dead End Referral: Ending in blocked lines or arrows Information Flow: Clear arrow tips

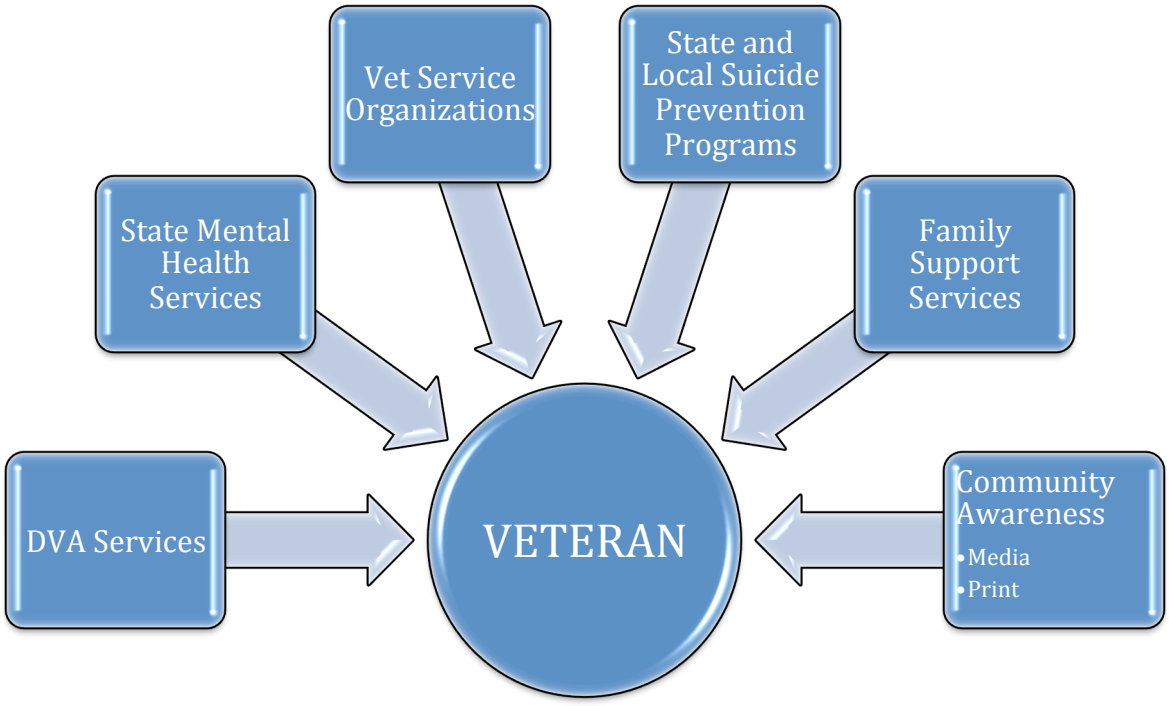
Below, figure 8 represents a veteran-focused suicide prevention system in which the community is aware of veteran suicide risk, and every contact point is an opportunity for outreach, risk assessment/screening, intervention, and education.

In a veteran-focused system, there is community level communication and collaboration. Every organization takes responsibility for seeing that veterans are provided effective services in a timely manner with emergent and urgent care options for veterans in crisis. There is no "Wrong Door." Veteran-focused systems have formal processes for tracking veterans with identified suicide risk to assure they are not lost in the system without follow-up.

Tracking systems include shared outreach, awareness, prevention, and education campaign materials developed by the Department of Veterans Affairs. Also included are and partner organizations that target veterans with public service announcements, print factsheets, and flyers. Likewise, local and state suicide prevention programs collaborate with VA suicide prevention coordinators for access to campaign materials and dedicated veteran suicide prevention activities.

Veteran-focused communities embrace efforts to dispel myths and stereotypes about veterans needing help with readjustment issues or seeking care for mental illness and depression. Such communities provide support and encouragement to veterans seeking help and their friends and family.

*Figure 8. Veteran Focused Suicide Prevention System.*



**Conclusion**

In today's all volunteer military, young women and men join for a variety of reasons, most of which come from a desire to better themselves through education and skills training. Young adults are enlisting in the armed services frequently as a financial necessity to provide for their own needs and often those of their children. In many neighborhoods, enlisting in the military is one of the few sure ways to escape poverty, violence, and abuse. Others serve in the reserve and National Guard as part-time military professionals, keeping their training up-to-date for when their community or their country needs them to protect the core of our national values and interests.

Military personnel receive benefits, trade skills, personal security, and fulfill their desire to serve. In return, they accept risks to their bodies and minds to accomplish the mission given to them. This sacrifice is most demanding in times of war and conflict. Not a single soldier returns home from military service the same as when they left. Some become stronger with self-discipline, goal orientation, and confidence. Some are left with the confusion and aftermath of experiencing personal violence and abuse at the hands of their fellow unit members. Others return home with wounded bodies and minds that impact the rest of their lives.

As a society, we must fulfill our responsibility to those who have carried our freedom and interests into battle. If we fail to acknowledge their pain and allow death to occur at their own hand in the very communities they fought to protect, is to render their service and sacrifices meaningless. Further, current veteran suicide rates in Nevada compromise the health and wellbeing of our entire society

This report stands as a "Call to Action" for every community, healthcare provider, university, college, job-training program, employer, supervisor, co-worker, family, friends, and individual to notice, helping these veterans survive and thrive, after the parade, after the homecoming.

*Table 1. Counts and Rates by Method of Suicide by Race/Ethnicity, and Veteran Status, Nevada Residents, Aggregated 2008-2010**

| Method of Suicide | Race | Veteran Status | | | | | |
|---|---|---|---|---|---|---|---|
| | | Veteran | Non-Veteran | Veteran | Non-Veteran | Veteran | Non-Veteran |
| | | Count | | Crude Rate | | Age-Adjusted Rate | |
| Poisoning by Solid, Liquid or Gaseous Substances | White | 40 | 228 | 6.62 | 5.39 | 4.27 | 4.10 |
| | Black | 1 | 9 | 1.85 | 2.13 | 0.56 | 1.57 |
| | Native | 0 | 1 | 0.00 | 1.17 | 0.00 | 0.97 |
| | Asian | 0 | 11 | 0.00 | 2.67 | 0.00 | 1.97 |
| | Hispanic | 1 | 12 | 2.13 | 0.91 | 0.82 | 0.93 |
| | Total | 42 | 261 | 5.72 | 4.04 | 3.43 | 3.17 |
| Hanging/ Strangulation/ Suffocation | White | 40 | 185 | 6.62 | 4.38 | 4.57 | 3.59 |
| | Black | 2 | 6 | 3.69 | 1.42 | 3.07 | 1.00 |
| | Native | 0 | 4 | 0.00 | 4.69 | 0.00 | 3.32 |
| | Asian | 1 | 15 | 4.65 | 3.65 | 2.20 | 3.84 |
| | Hispanic | 3 | 36 | 6.39 | 2.74 | 19.05 | 1.69 |
| | Total | 46 | 246 | 6.26 | 3.81 | 6.12 | 2.98 |
| Drowning/ Submersion | White | 0 | 4 | 0.00 | 0.09 | 0.00 | 0.08 |
| | Black | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Native | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Asian | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Hispanic | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Total | 0 | 4 | 0.00 | 0.06 | 0.00 | 0.05 |
| Firearms/ Explosives | White | 264 | 482 | 43.72 | 11.47 | 39.88 | 8.76 |
| | Black | 6 | 19 | 11.07 | 4.49 | 30.44 | 3.41 |
| | Native | 1 | 4 | 12.49 | 4.69 | 7.90 | 4.49 |
| | Asian | 1 | 18 | 4.65 | 4.40 | 4.38 | 3.50 |
| | Hispanic | 3 | 46 | 6.39 | 3.51 | 18.03 | 3.32 |
| | Total | 275 | 572 | 37.44 | 8.85 | 35.68 | 6.92 |
| Cutting/ Stabbing | White | 4 | 14 | 0.66 | 0.33 | 0.28 | 0.24 |
| | Black | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Native | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Asian | 0 | 2 | 0.00 | 0.49 | 0.00 | 0.35 |
| | Hispanic | 0 | 5 | 0.00 | 0.38 | 0.00 | 0.37 |
| | Total | 4 | 21 | 0.54 | 0.33 | 0.24 | 0.25 |

*Table 1 Continued. Counts and Rates by Method of Suicide by Race/Ethnicity, and Veteran Status, Nevada Residents, Aggregated 2008-2010**

| Method of Suicide | Race | Veteran Status | | | | | |
|---|---|---|---|---|---|---|---|
| | | Veteran | Non-Veteran | Veteran | Non-Veteran | Veteran | Non-Veteran |
| | | Count | | Crude Rate | | Age-Adjusted Rate | |
| Jumped from Height | White | 1 | 19 | 0.17 | 0.45 | 0.13 | 0.36 |
| | Black | 1 | 1 | 3.69 | 0.24 | 1.11 | 0.17 |
| | Native | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Asian | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Hispanic | 0 | 2 | 0.00 | 0.15 | 0.00 | 0.12 |
| | Total | 3 | 22 | 0.41 | 0.34 | 0.20 | 0.27 |
| Other | White | 3 | 18 | 0.50 | 0.43 | 0.35 | 0.33 |
| | Black | 0 | 1 | 0.00 | 0.24 | 0.00 | 0.19 |
| | Native | 0 | 0 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Asian | 0 | 1 | 0.00 | 0.24 | 0.00 | 0.18 |
| | Hispanic | 0 | 7 | 0.00 | 0.53 | 0.00 | 0.28 |
| | Total | 3 | 27 | 0.41 | 0.42 | 0.28 | 0.32 |
| Total | White | 352 | 950 | 58.45 | 22.53 | 49.54 | 17.45 |
| | Black | 10 | 36 | 18.50 | 8.52 | 34.64 | 6.35 |
| | Native | 1 | 9 | 12.49 | 10.56 | 7.90 | 8.80 |
| | Asian | 2 | 47 | 9.29 | 11.46 | 6.58 | 9.85 |
| | Hispanic | 7 | 108 | 14.94 | 8.24 | 37.92 | 6.71 |
| | Total | 373 | 1,153 | 50.78 | 17.85 | 45.95 | 13.95 |

**Notations:**
*Data is not final and is subject to changes.

Due to small counts some rates may be statistically insignificant.

Age rates are per 100,000 age-specific (15+) population. Crude rates are per 100,000 population. Non-veteran population is based on the Nevada Interim populations. Nevada population is interim and based on 2005 population estimates provided by the Nevada State Demographer. Veteran population based on Department of Veteran Affairs (www.va.gov) veteran population distributions.

Due to the use of different populations, rates may not match or be comparable and should be interpreted with caution.

*Table 2. Counts and Rates by Method of Suicide and Veteran Status, Nevada Residents, Aggregated 2008-2010**

| Method of Suicide | Veteran Status | | | | | |
|---|---|---|---|---|---|---|
| | Veteran | Non-Veteran | Veteran | Non-Veteran | Veteran | Non-Veteran |
| | Count | | Crude Rate | | Age-Adjusted Rate | |
| Poisoning by Solid, Liquid or Gaseous Substances | 42 | 261 | 5.72 | 4.04 | 3.43 | 3.17 |
| Hanging/ Strangulation / Suffocation | 46 | 246 | 6.26 | 3.81 | 6.12 | 2.98 |
| Drowning/ Submersion | 0 | 4 | 0.00 | 0.06 | 0.00 | 0.05 |
| Firearms/ Explosives | 275 | 572 | 37.44 | 8.85 | 35.68 | 6.92 |
| Cutting/ Stabbing | 4 | 21 | 0.54 | 0.33 | 0.24 | 0.25 |
| Jumped from Height | 3 | 22 | 0.41 | 0.34 | 0.20 | 0.27 |
| Others | 3 | 27 | 0.41 | 0.42 | 0.28 | 0.32 |
| Total | 373 | 1,153 | 50.78 | 17.85 | 45.95 | 13.95 |

**Notations:**

*Data is not final and is subject to changes.

Due to small counts some rates may be statistically insignificant.

Age rates are per 100,000 age-specific (15+) population. Crude rates are per 100,000 population. Non-veteran population is based on the Nevada Interim populations. Nevada population is interim and based on 2005 population estimates provided by the Nevada State Demographer. Veteran population based on Department of Veteran Affairs (www.va.gov) veteran population distributions.

Due to the use of different populations, rates may not match or be comparable and should be interpreted with caution.

*Table 3. Counts and Rates by Type of Accidents and Veteran Status, Nevada Residents, Aggregated 2008-2010**

| Type of Accident | Veteran Status | | | | | |
|---|---|---|---|---|---|---|
| | Veteran | Non-Veteran | Veteran | Non-Veteran | Veteran | Non-Veteran |
| | Count | | Crude Rate | | Age-Adjusted Rate | |
| Motor Vehicle Accidents | 123 | 640 | 16.75 | 9.91 | 27.75 | 7.79 |
| Other Land Transport Accidents | 5 | 21 | 0.68 | 0.33 | 0.43 | 0.26 |
| Water, Air and Space, and Other Transport Accidents | 13 | 27 | 1.77 | 0.42 | 3.10 | 0.32 |
| Falls | 99 | 332 | 13.48 | 5.14 | 7.05 | 5.21 |
| Firearms | 2 | 9 | 0.27 | 0.14 | 0.09 | 0.11 |
| Drowning and Submersion | 3 | 52 | 0.41 | 0.80 | 0.19 | 0.63 |
| Smoke, Fire and Flames | 11 | 41 | 1.50 | 0.63 | 0.57 | 0.52 |
| Poisoning | 128 | 1,220 | 17.43 | 18.88 | 22.78 | 14.69 |
| Other Non-transport Accidents | 53 | 165 | 7.22 | 2.55 | 3.13 | 2.24 |
| Total | 437 | 2,507 | 59.49 | 38.80 | 65.09 | 31.76 |

**Notations:**
*Data is not final and is subject to changes.

Due to small counts some rates may be statistically insignificant.

Age rates are per 100,000 age-specific (15+) population. Crude rates are per 100,000 population. Non-veteran population is based on the Nevada Interim populations.
Nevada population is interim and based on 2005 population estimates provided by the Nevada State Demographer. Veteran population based on Department of Veteran Affairs (www.va.gov) veteran population distributions.

Due to the use of different populations, rates may not match or be comparable and should be interpreted with caution.

*Table 4. Homicide Counts and Rates by Race/Ethnicity and Veteran Status, Nevada Residents, Aggregated 2008-2010**

| Method of Homicide | Veteran Status | | | | | |
|---|---|---|---|---|---|---|
| | Veteran | Non-Veteran | Veteran | Non-Veteran | Veteran | Non-Veteran |
| | Count | | Crude Rate | | Age-Adjusted Rate | |
| Drugs | 0 | 2 | 0.00 | 0.0 | 0.00 | 0.0 |
| Strangulation | 0 | 20 | 0.00 | 0.3 | 0.00 | 0.2 |
| Firearms | 15 | 262 | 2.04 | 4.1 | 1.75 | 3.2 |
| Smoke, Fire, and Flames | 0 | 2 | 0.00 | 0.0 | 0.00 | 0.0 |
| Stabbing/Blunt Object | 5 | 54 | 0.68 | 0.8 | 0.58 | 0.6 |
| Motor Vehicle | 0 | 1 | 0.00 | 0.0 | 0.00 | 0.0 |
| Bodily Force or Maltreatment | 0 | 1 | 0.00 | 0.0 | 0.00 | 0.0 |
| Other | 8 | 59 | 1.09 | 0.9 | 0.62 | 0.7 |
| Legal Intervention: Firearms | 0 | 15 | 0.00 | 0.23 | 0.00 | 0.18 |
| Legal Intervention: Manhandling | 1 | 1 | 0.14 | 0.02 | 0.19 | 0.01 |
| Total | 29 | 417 | 3.95 | 6.45 | 3.14 | 5.02 |

**Notations:**
*Data is not final and is subject to changes.

Due to small counts some rates may be statistically insignificant.

Age rates are per 100,000 age-specific (15+) population. Crude rates are per 100,000 population. Non-veteran population is based on the Nevada Interim populations.
Nevada population is interim and based on 2005 population estimates provided by the Nevada State Demographer. Veteran population based on Department of Veteran Affairs (www.va.gov) veteran population distributions.

Due to the use of different populations, rates may not match or be comparable and should be interpreted with caution.

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