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Introduction

This Department of Veterans Affairs (VA) *2022 National Veteran Suicide Prevention Annual Report* documents decreases in Veteran suicide deaths and suicide rates during the two most recent years for which mortality data is available, 2019 and 2020.

The report provides *two decades* of Veteran suicide information, from 2001 through 2020. The report also evaluates Veteran suicide during 2020, in the initial period of the COVID-19 pandemic, comparing patterns of Veteran suicide and Veteran COVID-19 mortality over time and across Veteran subgroups.

Since the announcement of the worldwide COVID-19 pandemic, there have been prominent concerns that the pandemic could increase suicide rates. Mental health and suicide scholars described mechanisms by which pandemic effects could increase risks^{1,2} and “create a perfect storm of increased military Veteran suicide rates.”³ Rapid and accurate information was urgently needed.⁴

In late March 2020, VA initiated near real-time surveillance of Veterans Health Administration (VHA) suicide-related indicators to monitor trends during the pandemic. This work did not identify increases in VHA site-documented suicides, on-campus suicides or VHA emergency department visits for suicide attempts.^{5,6} However, comprehensive evaluation of potential effects on Veteran suicide required 2020 national death certificate data for all Veterans, which is now available. The present report examines Veteran suicide from 2001 through 2020 and evaluates potential pandemic effects on Veteran suicide by comparing patterns of Veteran suicide and COVID-19 mortality.

The report continues a *whole of VA* approach to Veteran suicide prevention that integrates strategic planning, program operations and program evaluation across VA, including VHA, Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA). Further, work has been expanded in collaboration with other Federal agencies supporting a whole of Government approach, highlighted most recently in the White House report *Reducing Military and Veteran Suicide*.⁷ These efforts build upon the strong foundation of VA's 10-year *National Strategy for Preventing Veteran Suicide (2018)*.⁸ This strategy outlines a series of priority goals and executive actions to be pursued in collaboration not only with Federal agencies, but also with other Government programs, public-private partnerships and local communities to implement a full public-health approach unified in collective engagement for Veteran suicide prevention.

¹ Reger, M. A., Stanley, I. H., & Joiner, T. E. (2020). Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm? *JAMA Psychiatry*, 77(11), 1093-1094.

² Banerjee, D., Kosagisharaf, J. R., & Rao, T. S. S. (2021). ‘The dual pandemic’ of suicide and COVID-19: A biopsychosocial narrative of risks and prevention. *Psychiatry Research*, 295. <https://doi.org/10.1016/j.psychres.2020.113577>

³ Levine, J., & Sher, L. (2021). The prevention of suicide among military veterans during the COVID-19 pandemic. *European Archives of Psychiatry and Clinical Neuroscience*, 271:405-406.

⁴ Tandon, R. (2021). COVID-19 and suicide: Just the facts. Key learnings and guidance for action. *Asian Journal of Psychiatry*, 60. <https://doi.org/10.1016/j.ajp.2021.102695>. Tandon further notes that it was important to avoid sensational language regarding potential effects of the pandemic.

⁵ Department of Veterans Affairs. *2020 National Veteran Suicide Prevention Annual Report*. <https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf>

⁶ Department of Veterans Affairs. *2021 National Veteran Suicide Prevention Annual Report*. <https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf>

⁷ White House: *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy*. (2021). Available from: *Military-and-Veteran-Suicide-Prevention-Strategy.pdf* (whitehouse.gov). <https://www.whitehouse.gov/wp-content/uploads/2021/11/Military-and-Veteran-Suicide-Prevention-Strategy.pdf>

⁸ Department of Veterans Affairs. (2018). *National Strategy for Preventing Veteran Suicide*.

The report provides the most current information regarding:

- Suicide among Veterans overall and compared to non-Veteran U.S. adults
- Suicide among Veteran subpopulations, including:
 - Veterans who received VHA health care⁹ in the year or prior year, or in this report “*Recent Veteran VHA Users*,” overall and for subgroups, including:
 - Demographic, diagnostic, rural/urban and priority eligibility groups
 - Veterans who were not Recent VHA Users, or in this report “*Other Veterans*”
- Veterans who died from suicide, including information on their receipt of VA services:
 - VHA health care encounters
 - VHA enrollment
 - VBA services
- Veteran suicide during the COVID-19 pandemic:
 - Suicide as a leading cause of death
 - Suicide relative to COVID mortality trends, overall and for Veteran subgroups

Key findings include:

- In 2020, there were 6,146 Veteran suicide deaths, which was 343 fewer than in 2019. The unadjusted rate of suicide in 2020 among U.S. Veterans was 31.7 per 100,000.
- Over the period from 2001 through 2020, age- and sex-adjusted suicide rates for Veterans peaked in 2018 and then fell in 2019 and 2020. From 2018 to 2020, age- and sex-adjusted suicide rates for Veterans fell by 9.7%.
- Among non-Veteran U.S. adults, age- and sex-adjusted suicide rates also peaked in 2018 and fell in 2019 and 2020. From 2018 to 2020, age- and sex-adjusted suicide rates for non-Veteran adults fell by 5.5%.
- In each year from 2001 through 2020, age- and sex-adjusted suicide rates of Veterans exceeded those of non-Veteran U.S. adults. The differential in adjusted rates was smallest in 2002, when the Veteran rate was 12.1% higher than for non-Veterans, and largest in 2017, when the Veteran rate was 66.2% higher. In 2020, the rate for Veterans was 57.3% higher than that of non-Veteran adults.
- From 2019 to 2020, the age- and sex-adjusted suicide rate for Veterans fell by 4.8%, while for non-Veteran U.S. adults, the adjusted rate fell by 3.6%.
- From 2019 to 2020, among Veteran men, the age-adjusted suicide rate fell by 0.7%, and among Veteran women, the age-adjusted suicide rate fell by 14.1%. By comparison, among non-Veteran U.S. men, the age-adjusted rate fell by 2.1%, and among non-Veteran women, the age-adjusted rate fell by 8.4%.
- In each year from 2001 through 2020, age- and sex-adjusted suicide rates of Recent Veteran VHA Users exceeded those of Other Veterans. The differential in adjusted rates was smallest in 2018, when the rate for Recent Veteran VHA Users was 9.4% higher, and largest in 2002, when the rate was 80.9% higher. In 2020, the age and sex-adjusted suicide rate of Recent Veteran VHA Users was 43.4% higher than for Other Veterans.
- In 2020, suicide was the 13th leading cause of death among Veterans overall, and it was the second leading cause of death among Veterans under age 45.

⁹ VHA health care receipt is here defined as having at least one VHA inpatient or outpatient utilization record.

- The COVID-19 pandemic was announced in early March 2020. By the year's end, COVID-19 was the 3rd leading cause of death in the United States, both overall¹⁰ and for Veterans. Despite the pandemic, the Veteran suicide rate in 2020 continued a decline that began in 2019.
- Comparisons of trends in Veteran suicide and COVID-19 mortality over the course of 2020, and across Veteran demographic and clinical subgroups, did not indicate an impact of the COVID-19 pandemic on Veteran suicide mortality.

Anchors of Hope

Hope serves as a key and necessary anchor to strengthen Veterans amidst numerous life circumstances. In a similar manner, hope must imbue the overall suicide prevention mission. The following hopeful data points from this year's report serve as anchors:

- There were 343 fewer Veterans who died from suicide in 2020 than in 2019, and 2020 had the lowest number of Veteran suicides since 2006.
- From 2001 through 2018, the number of Veteran suicides increased on average by 47 deaths per year. From 2019 to 2020, there were consecutive reductions, of 307 and 343 suicides, respectively, an unprecedented decrease since 2001.
- From 2018 to 2020, adjusted rates for Veterans fell by 9.7%. By comparison, the adjusted rate for non-Veteran U.S. adults fell by 5.5%.
- The age-adjusted suicide rate for women Veterans in 2020 was the lowest since 2013, and the age-adjusted suicide rate for Veteran men was the lowest since 2016.
- From 2019 to 2020, among Veteran men, the age-adjusted suicide rate fell by 0.7%, and among Veteran women, the age-adjusted suicide rate fell by 14.1%. Among non-Veteran U.S. men, the age-adjusted rate fell by 2.1%, and among non-Veteran women, the age-adjusted rate fell by 8.4%.
- Assessment of Veteran suicide rates by race showed decreases from 2019 to 2020 for all groups.
- Despite the 24.6% decrease in the Veteran population from 2001 to 2020, the number of Veterans with VHA health care encounters in the year or prior year rose 55.0%, from 3.8 million to 5.9 million.
- Despite onset of the COVID-19 pandemic in 2020, age and sex-adjusted suicide rates among Veterans fell 4.8% from 2019 to 2020, versus a 3.6% decline among non-Veteran U.S. adults.

The overall downward trends in Veteran suicide in 2019 and 2020 are encouraging. They followed VA's launch of the 2018 *National Strategy for Preventing Veteran Suicide* (National Strategy).¹¹ This was built upon the foundation of the U.S. Surgeon General's and National Action Alliance for Suicide Prevention's 2012 *National Strategy for Suicide Prevention*.¹² The 2018 strategy reflects a comprehensive public health approach to Veteran suicide prevention. This combines community-based suicide prevention strategies and clinically based interventions. The *National Strategy for Preventing Veteran Suicide* provided the vision to begin coordinated implementation of public health approaches across universal, selective and indicated approaches to reach all Veterans, including those without recent VA contact. These efforts were also fueled by the 2019 publication of the VA and Department of Defense (DoD) *Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide*.¹³ This provided the latest analysis of research on suicide prevention in clinical settings. Together,

¹⁰ Murphy, S. L., Kochanek, K. D., Xu, J.Q., & Arias, E. *Mortality in the United States, 2020*. NCHS Data Brief, No. 427. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: <https://dx.doi.org/10.15620/cdc:112079>

¹¹ Department of Veterans Affairs. (2018). *National Strategy for Preventing Veteran Suicide*. https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

¹² U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012. https://www.ncbi.nlm.nih.gov/books/NBK109917/pdf/Bookshelf_NBK109917.pdf

¹³ Department of Veterans Affairs and Department of Defense. (2019). *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*. <https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf>

the *National Strategy for Preventing Veteran Suicide* and the latest CPG provided a roadmap that would be operationalized in the deployments of the Suicide Prevention 2.0 (SP 2.0) and Suicide Prevention Now (SP Now) initiatives.

Approved for full launch in 2019, SP 2.0 is a 6-year strategic plan with national reach focused on the implementation of clinical and community-based prevention, intervention and postvention services that reflect the National Strategy's four pillars. The SP 2.0 Community-Based Interventions for Suicide Prevention (CBI-SP) domain focuses on enacting the four pillars through the Veterans Integrated Service Network-Based Community Coalition and Collaboration Building, Veteran-to-Veteran Coalition Building and State-Based Coalition and Collaboration Building models. Integrating diversity, equity and inclusion (DEI) is a critical aspect of community work. Community Engagement and Partnership Coordinators (CEPC) are trained in DEI considerations and prompt potential DEI questions through each phase of CEPC's work (Engage, Plan, Implement and Sustain) with local communities. This work is critical to design strategic plans for suicide prevention for each unique community. The SP 2.0 clinically based domain follows the vision associated with the National Strategy's treatment, recovery and support services pillar. SP 2.0 outlines a practical strategy for implementing CPG evidence-based treatments—for example through dissemination of telemental health suicide prevention services across all VHA local health care systems, bringing treatments into the homes of Veterans, a critical service particularly since the start of the COVID-19 pandemic.

While VA worked on the longer-term plan of SP 2.0 implementation, in collaboration with community partners, 2020 also saw the launch of the SP Now initiative, a bundled set of interventions, across five key domains, in alignment with the vision of the National Strategy. The SP Now plan aims to develop and deploy actions that available data suggests have the potential to be effectively implemented and to create meaningful results in a short amount of time. It is focused on these five critical areas:

1. Lethal means safety;
2. Suicide prevention in at-risk medical populations;
3. Outreach and understanding of prior and non-VHA users;
4. Suicide prevention program enhancements; and
5. Media campaigns.

Part 1: Suicide Among Veterans and Non-Veteran U.S. Adults, 2001–2020

This section provides an overview of the most recent Veteran suicide data.¹⁴ It is organized by Suicide Deaths, Average Number of Suicides Per Day and Suicide Rates.

Key Findings

- In 2020, there were 6,146 Veteran suicides. This was on average 16.8 per day. In 2020, there were 343 fewer Veteran suicides than in 2019, and the number of Veteran suicides was lower than each prior year since 2006.
- From 2018 to 2020, age- and sex-adjusted suicide rates for Veterans fell by 9.7%. This was a larger percentage decrease than was observed for non-Veteran U.S. adults (5.5%).
- In 2020, adjusting for population age and sex differences, the suicide rate for Veterans was 57.3% greater than for non-Veteran U.S. adults.

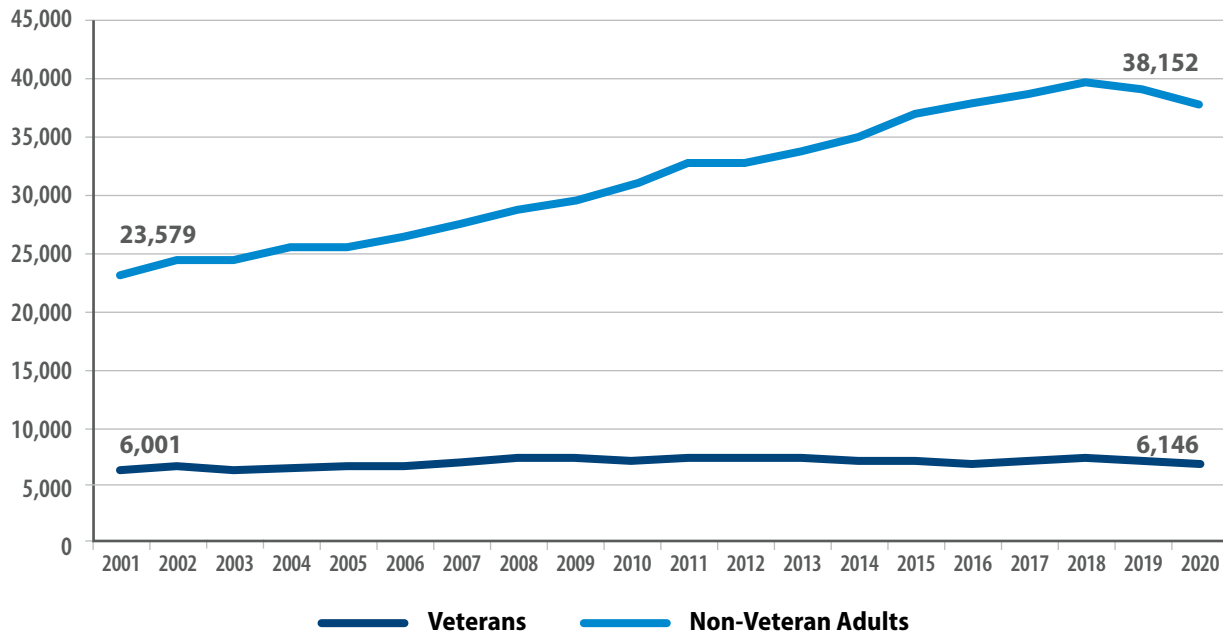
Among U.S. adults who died from suicide in 2020, firearms were more commonly involved among Veterans (71.0%) than non-Veterans (50.3%).

¹⁴ For this report, Veterans are defined as persons who had been activated for Federal military service and were not currently serving at the time of death. For more information, see the accompanying *2022 Veteran Suicide Surveillance Methods Summary*.

Suicide Deaths

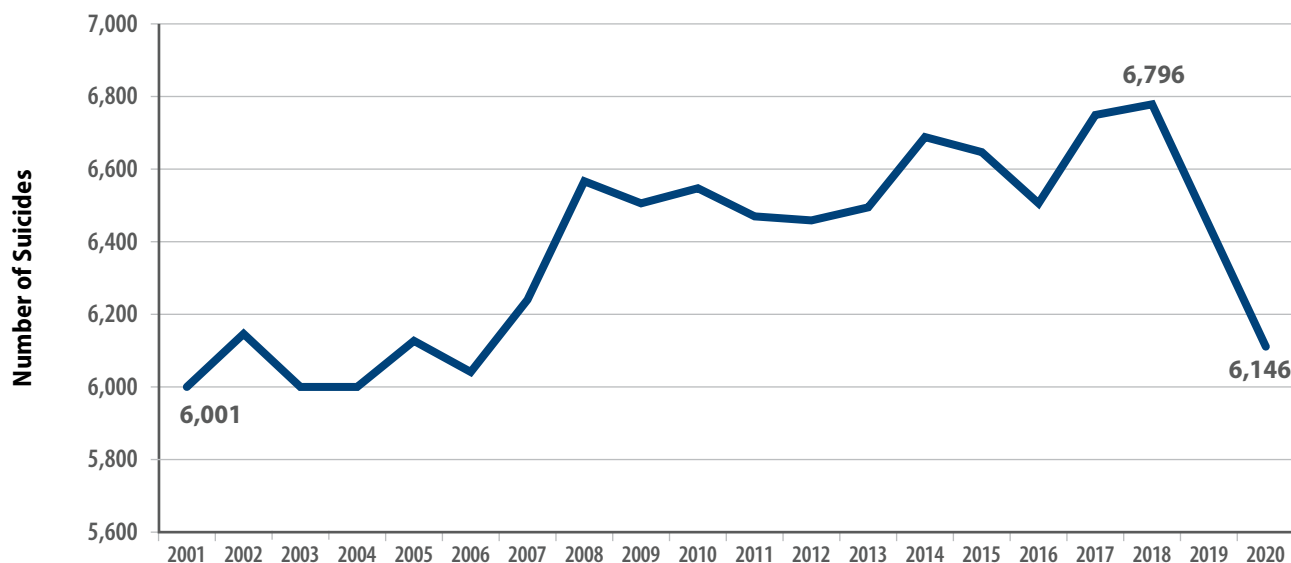
- Among Veterans, non-Veteran adults and U.S. adults overall, the number and rate of suicide deaths fell in 2019 and again in 2020, after increases from 2001 through 2018 (Figures 1 and 3).

Figure 1: Suicide Deaths Among Veterans and Non-Veteran U.S. Adults, by Year, 2001–2020



- Figure 2 on the next page details variation in the number of Veteran suicides, by year from 2001 through 2020. Veteran suicide deaths rose from 6,001 in 2001 to 7,960 in 2018 and then fell to 6,146 in 2020.

Figure 2: Veteran Suicide Deaths, 2001–2020



Average Number of Suicides Per Day¹⁵

- Among all U.S. adults—including Veterans—the average number of suicides per day rose from 81.0 per day in 2001 to 121.0 in 2020. The average number of suicides per day among U.S. adults was highest in 2018 (127.4 per day).
- The average number of Veteran suicides per day rose from 16.4 in 2001 to 16.8 in 2020. It was highest in 2018 (18.6 per day). Of the on average 16.8 Veteran suicides per day in 2020, approximately 39.7% (6.7 per day) were among Recent Veteran VHA Users¹⁶ and 60.3% (10.1 per day) were among Other Veterans.

Suicide Rates

Over the 2 decades from 2001 through 2020, the Veteran population decreased by 24.6%, from 25.7 million to 19.4 million. In the same years, the non-Veteran U.S. adult population increased by 27.2%, from 186.6 million to 237.3 million. In this context, it is important to assess suicide mortality rates, which convey the incidence of suicide relative to the size of the population.

Unadjusted suicide rates represent the number of suicide deaths in a population relative to the population’s time at risk of being observed with a suicide death.¹⁷ Rates are reported as suicides per 100,000.¹⁸ Adjusted rates are used for comparisons while adjusting for population differences, such as age and sex distributions.¹⁹ To describe the burden of

¹⁵ It should be noted that decreases in the size of the Veteran population and simultaneous increases in the size of the U.S. population over this time period limit interpretation of these statistics. Rates of suicide, stratified by group, are more appropriate for understanding changes in Veterans and non-Veteran populations and are provided throughout this report.

¹⁶ With regard to suicide in 2020, Recent Veteran VHA Users were defined as Veterans with VHA health care encounters in 2019 or 2020.

¹⁷ Risk time was measured using mid-year population estimates when individuals’ exact risk times were unavailable, and risk time was calculated exactly for analyses of subgroups of Veterans with recent VHA care.

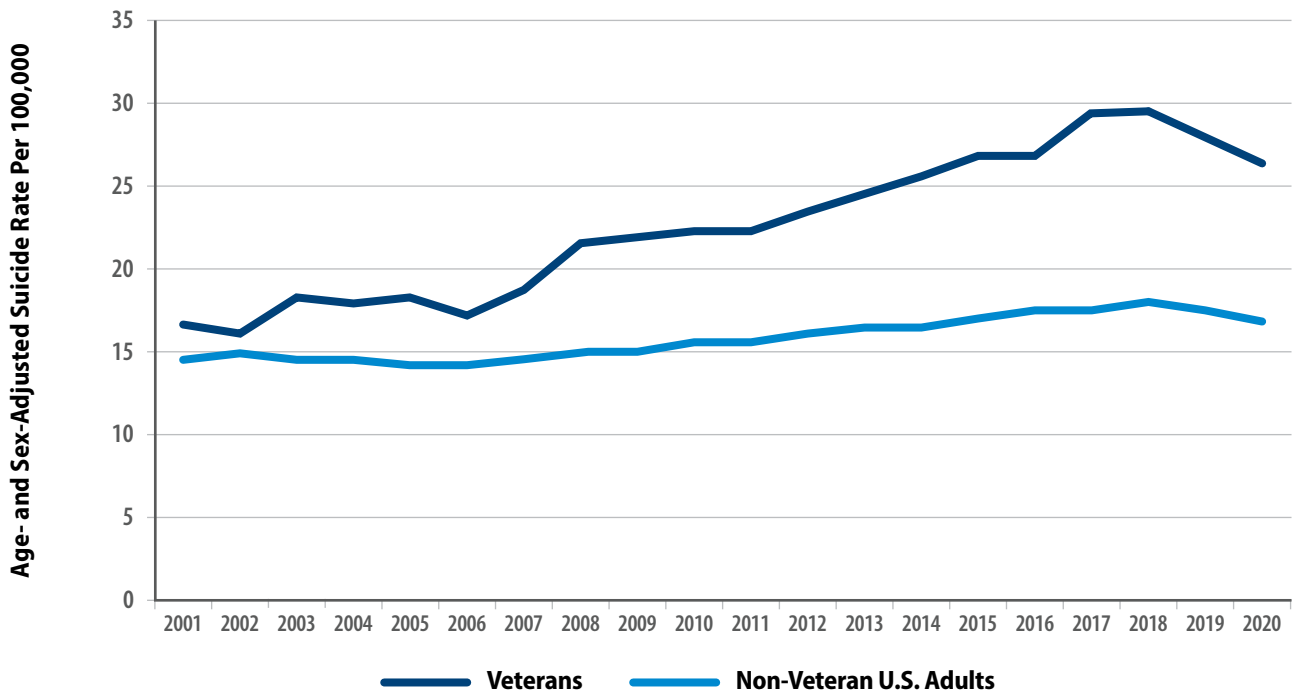
¹⁸ For the Veteran population, risk time was assessed using the mid-year population estimate. When risk time was assessed per individual level risk-time information, we included “per 100,000 person-years.”

¹⁹ Unadjusted rates directly communicate the magnitude of suicide mortality in a given population over a period of time. For example, we know that Veteran and non-Veteran adult populations differ by age and sex. In 2020, 9.4% of Veterans were aged 18-34, compared to 31.3% of non-Veteran adults. Also, 89.7% of all Veterans were men, while men accounted for 45.4% of non-Veteran U.S. adults. Suicide risks differ across age and sex categories, and, consequently, if groups differ in terms of these characteristics, then that may account for some of the differences in unadjusted rates. Technically, adjusted rates translate the unadjusted rate for a population into a measure of what the rate would be if the compared populations had the same distributions of the demographic factors that are adjusted for. Per standard practice, adjusted rates are calibrated to the demographic distribution of the U.S. adult population in 2000. Calculating adjusted rates (e.g., age-adjusted or age- and sex-adjusted rates) enables rate comparisons while adjusting for population demographic differences.

suicide in a given population and time period, we use unadjusted rates. To compare rates across populations or periods, we use adjusted rates.²⁰

- The unadjusted suicide rate for Veterans was 23.3 per 100,000 in 2001 and 31.7 per 100,000 in 2020. For non-Veteran U.S. adults, the suicide rate was 12.6 per 100,000 in 2001 and 16.1 per 100,000 in 2020.
- In 2020, Veterans age 18-34 had an unadjusted suicide rate of 46.1 per 100,000, while the rate was 31.8 per 100,000 for those age 35-54, 27.4 per 100,000 for those age 55-74 and 32.0 per 100,000 for those age 75 and older.
- In 2020, the unadjusted suicide rate of Veteran men was 33.7 per 100,000 (2.3% lower than in 2019), and it was 13.8 per 100,000 for Veteran women (20.3% lower than in 2019).
- Age- and sex-adjusted suicide rates from 2001 through 2020 are presented in Figure 3 below for Veterans and non-Veteran U.S. adults, by year. From 2001 through 2020, adjusted rates rose faster for Veterans than for non-Veteran U.S. adults. The difference in rates was greatest in 2017, when Veteran adjusted rates were 66.2% greater than those of non-Veteran adults. In 2020, this differential fell to 57.3%.
- From 2019 to 2020, the age- and sex-adjusted suicide rate among Veterans fell by 4.8%. By comparison, the adjusted rate for non-Veteran U.S. adults fell by 3.6%.
- From 2018 to 2020, adjusted rates for Veterans fell by 9.7%. By comparison, the adjusted rate for non-Veteran U.S. adults fell by 5.5%.

Figure 3: Age- and Sex-Adjusted Suicide Rates, Veterans and Non-Veteran U.S. Adults, 2001–2020

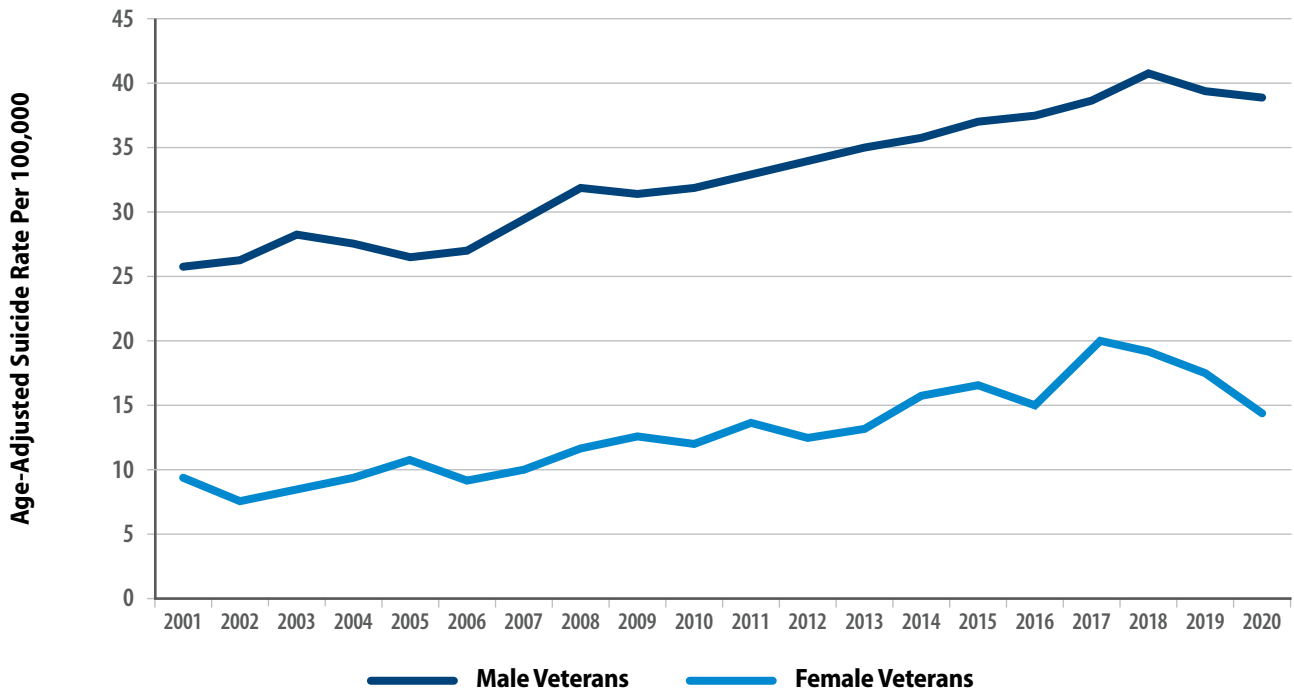


²⁰ The interpretation of adjusted rates is somewhat technical. They represent the level of suicide mortality that we would see in the population and time period if the population had the same demographic distribution of a standard population, at least in terms of the adjustment variable(s). Consistent with current practice, in this report, adjusted rates use the U.S. adult population in 2000 as the standard population. When adjustment was not possible, due to small numbers within adjustment strata, unadjusted rates are presented.

Suicide Rates by Sex

- Figure 4 below presents age-adjusted suicide rates for Veteran men and for Veteran women, by year, 2001-2020. For Veteran men, rates were highest in 2018 and declined through 2020. For Veteran women, rates were highest in 2017 and declined through 2020.

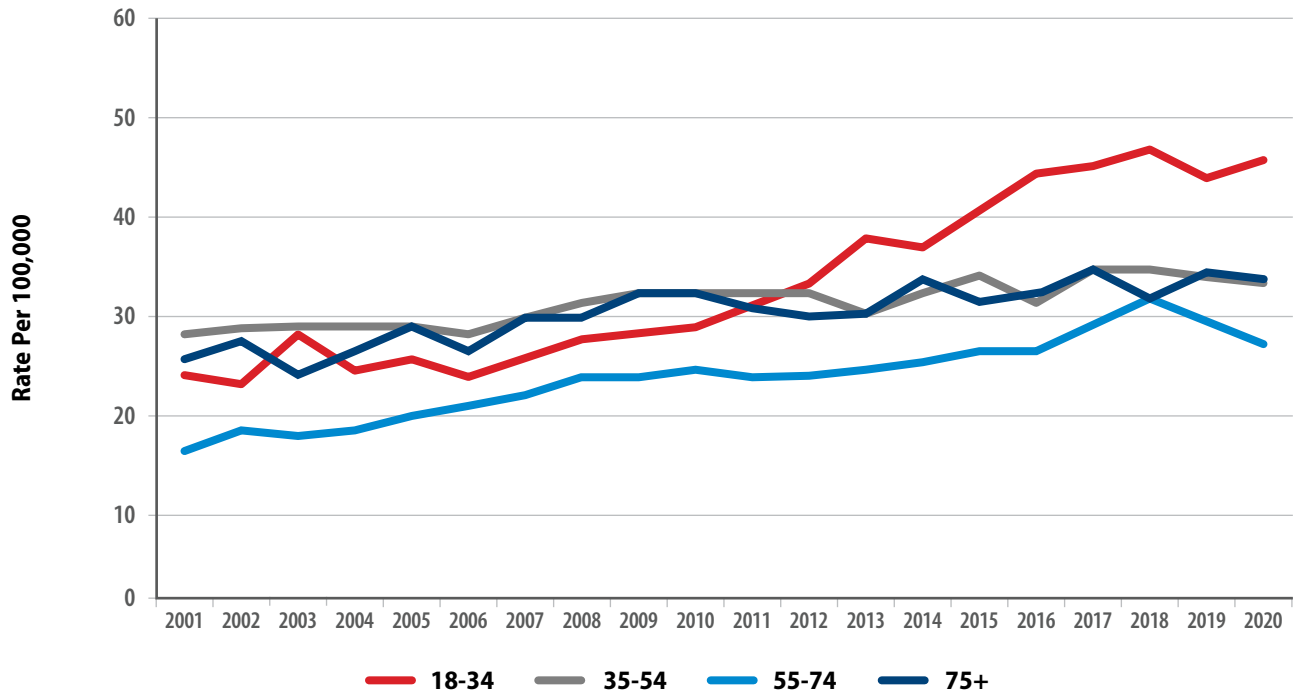
Figure 4: Age-Adjusted Suicide Rate Per 100,000, Male and Female Veterans, 2001–2020



Suicide Rates by Age

Figure 5 below presents unadjusted suicide rates for Veterans, by age categories and year, 2001-2020. From 2001 to 2020, the unadjusted suicide rate among Veterans between the ages of 18 and 34 increased by 95.3%. For those age 35-54, the rate increased by 12.9%; for those age 55-74, the rate increased by 58.2%; and for those age 75 and older, the rate increased by 21.2%. From 2019 to 2020, suicide rates among Veterans between the ages of 18 and 34 increased, while rates for each other age group decreased.

Figure 5: Unadjusted Suicide Rate Per 100,000, Veterans, by Age Group, 2001–2020



Suicide Rates by Sex and Age

We examined unadjusted suicide rates for Veteran men and for Veteran women, by age categories and year, 2001-2020.

- In 2001, Veterans between the ages of 35 and 54 had the highest suicide rates, among both Veteran men and Veteran women. In 2020, suicide rates were highest among Veterans between the ages of 18 and 34 (52.3 per 100,000 among Veteran men age 18-34 and 19.5 per 100,000 among Veteran women age 18-34).
- Suicide rates among both male and female Veterans ages 18-34 increased from 2019 to 2020, while for all other groups, rates decreased.

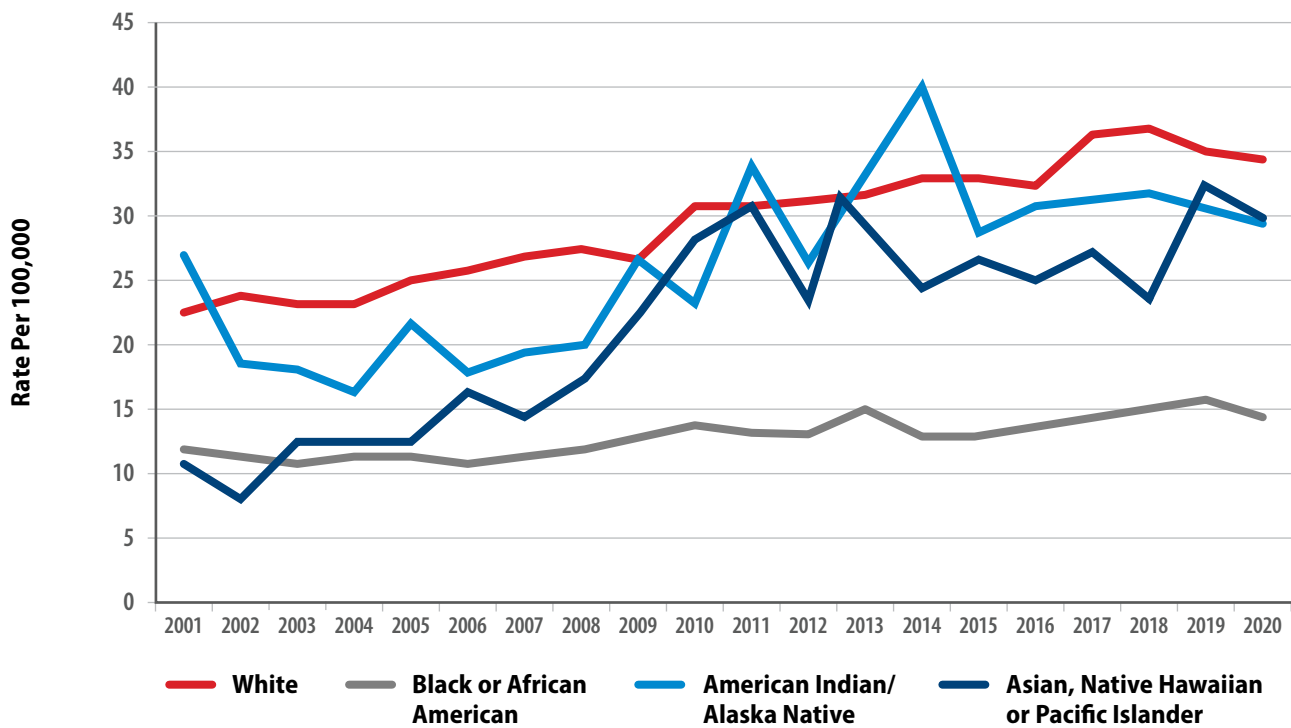
Suicide Rates by Race and Ethnicity

Figure 6 below presents unadjusted Veteran suicide rates, by race.²¹

In 2020, the suicide rate was 34.2 per 100,000 among White Veterans; 30.2 per 100,000 among Asian, Native Hawaiian or Pacific Islander Veterans; 29.8 per 100,000 among American Indians or Alaska Native Veterans; and 14.2 per 100,000 among Black or African American Veterans.

In 2020, the suicide rate among White Veterans was more than twice the rate among Black or African American Veterans. From 2019 to 2020, rates decreased for Veterans in each category.

Figure 6: Unadjusted Suicide Rates, Veterans, by Race,²² 2001–2020



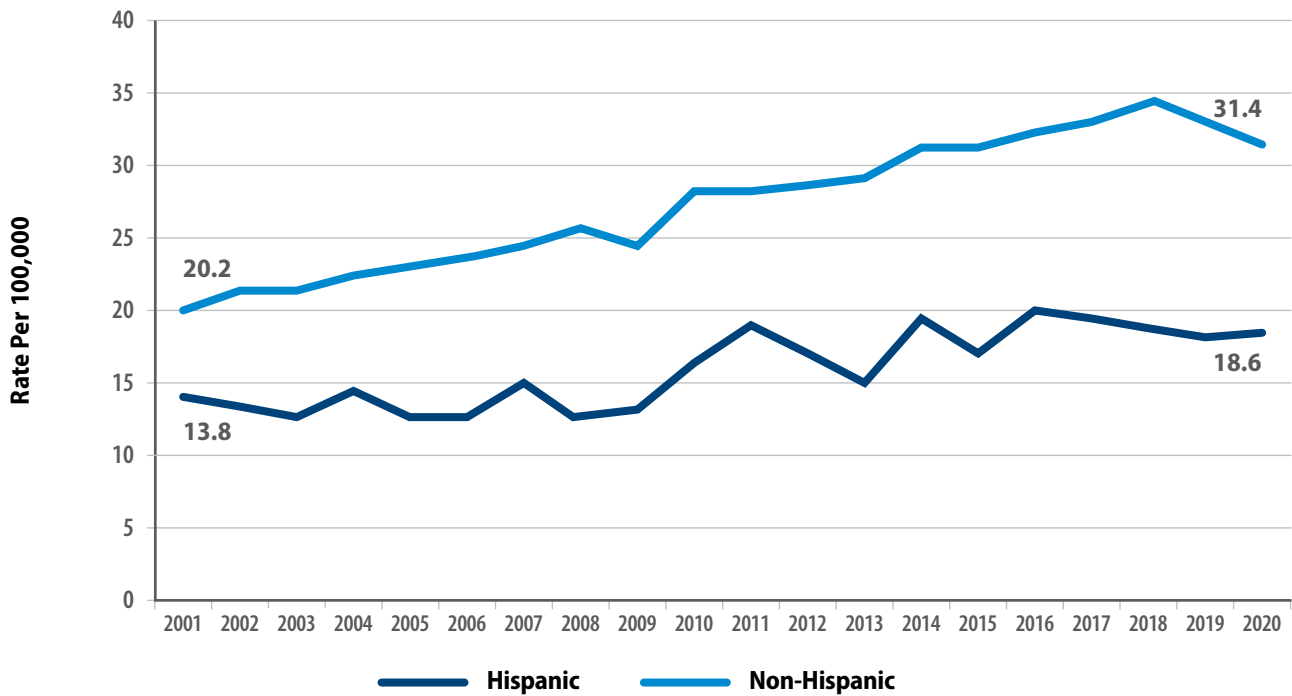
²¹ It was not possible to generate adjusted rates, due to data constraints. Consequently, differences in rates may in part be due to population differences in demographic factors that are independently associated with suicide risk.

²² Categories presented are mutually exclusive. Individuals identified as multiple races are categorized separately, and not presented due to inconsistent data availability over the reporting period. The availability of information regarding race demographics for the overall Veteran population is limited, sometimes combining the Asian, Native Hawaiian and Pacific Islander race categories. To provide the most complete information available, we present information using this combined category.

Figure 7 below presents unadjusted suicide rates for Veterans, by Hispanic ethnicity.²³

- In each year, unadjusted suicide rates were lower among Veterans with Hispanic ethnicity than among non-Hispanic Veterans.
- From 2019 to 2020, rates increased among Veterans with Hispanic ethnicity, while decreasing for other Veterans.

Figure 7: Unadjusted Suicide Rates, Veterans, by Hispanic Ethnicity, 2001–2020



- Among U.S. adults overall, similar patterns were observed. Suicide rates were higher for those who were not Hispanic or Latino (14.7 per 100,000 in 2001 and 18.7 per 100,000 in 2020) than for those who were Hispanic or Latino (7.1 per 100,000 in 2001 and 9.9 per 100,000 in 2020).
- From 2019 to 2020, rates increased among U.S. adults overall with Hispanic ethnicity, while decreasing for other U.S. adults.

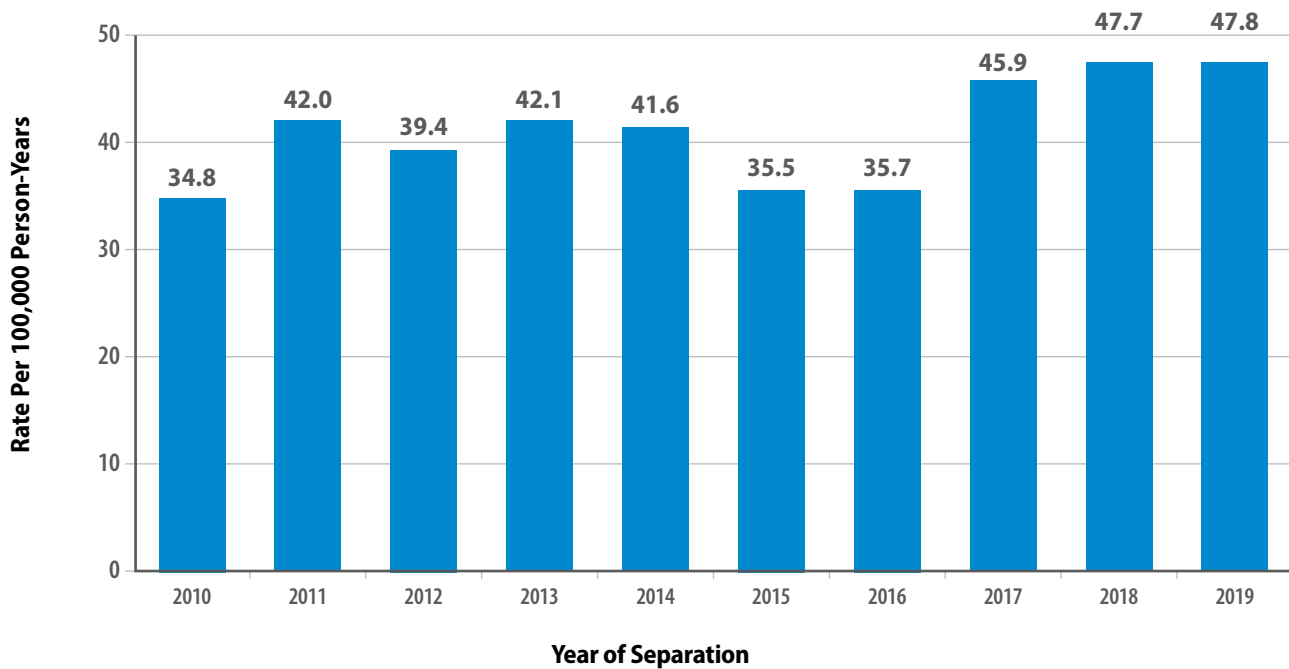
²³ It was not possible to generate adjusted rates, due to data constraints. Consequently, differences in rates may in part be due to population differences in demographic factors that are independently associated with suicide risk.

Suicide Rates in Year Following Military Separation

Figure 8 below presents the unadjusted suicide rate per 100,000 over 12 months following Veterans' separations from active military service, by year of separation, 2010-2019.^{24,25}

- Suicide rates following separation ranged from 34.8 per 100,000, for Veterans who separated in 2010, to 47.8 per 100,000 for Veterans who separated in 2019.

Figure 8: Unadjusted Suicide Mortality Rate, 12 Months Following Separation from Active Military Service, by Year of Separation, 2010–2019



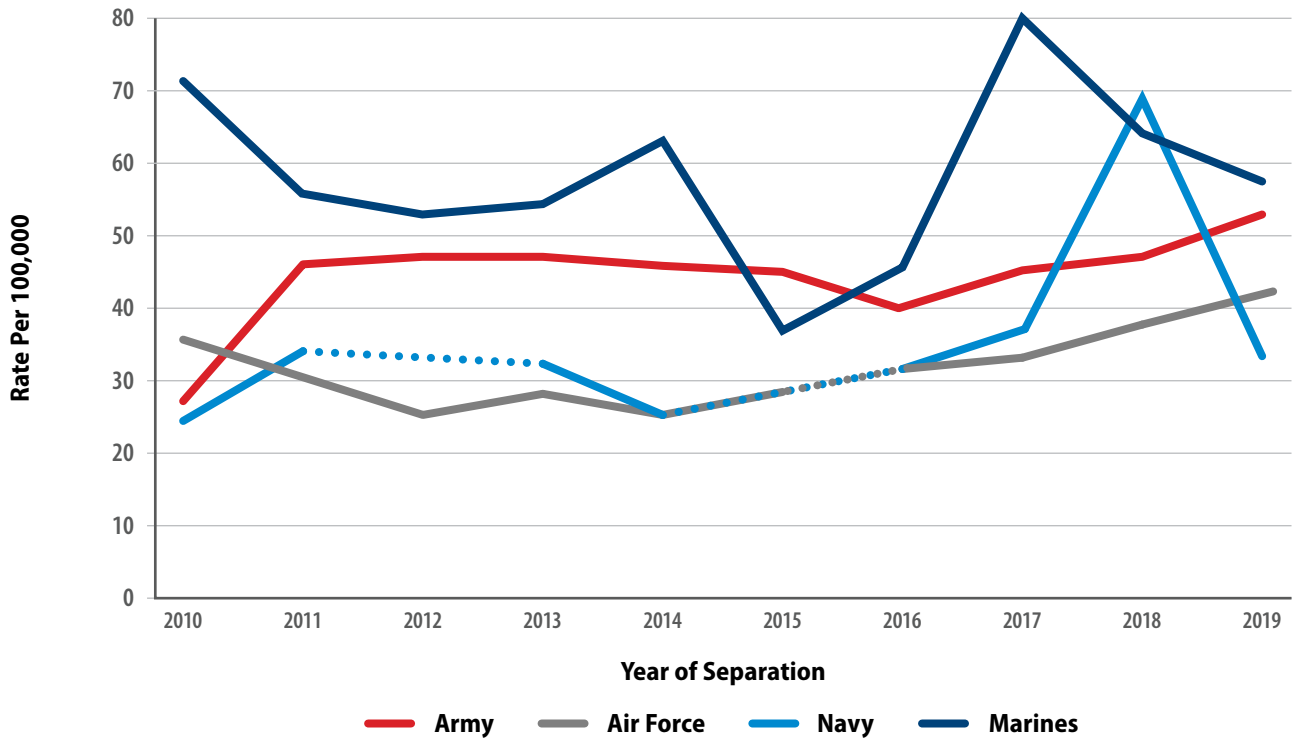
²⁴ Twelve-month suicide mortality rates are reported for cohorts of Veterans who separated from military service in the years 2010 through 2019. Separations were identified using VA/DoD Identity Repository (VADIR) data. Reporting is not included for years prior to 2010, due to data constraints. Given small cell sizes, it was not possible to calculate adjusted rates. Ninety-five percent confidence intervals were overlapping for each year. We note that a 2020 separation cohort is not included here, as 12-month following would require 2021 mortality data, which is not currently available.

²⁵ In 2010, there were 227,084 Veterans with separations from active military service, and there were 209,164 in 2019. For Veterans who separated in 2010, 16.8% were female and the median age at separation was 26. For those who separated in 2019, 17.2% were female and the median age at separation was 27. There were 79 and 100 Veteran suicides within 12 months of military separations in 2010 and 2019, respectively.

Figure 9 below presents unadjusted suicide rates in the 12 months following separations, by year of separation and service branch.

- For the most recent separation cohort, who separated from active military service in 2019, suicide rates over the following 12 months were highest among those who separated from the Marines (58.3 per 100,000), followed by the Army (52.7 per 100,000), Air Force (42.4 per 100,000) and Navy (34.4 per 100,000).

Figure 9: Unadjusted Suicide Mortality Rate, 12 Months Following Separation from Active Military Service, by Year of Separation and Branch of Service, 2010–2019²⁶



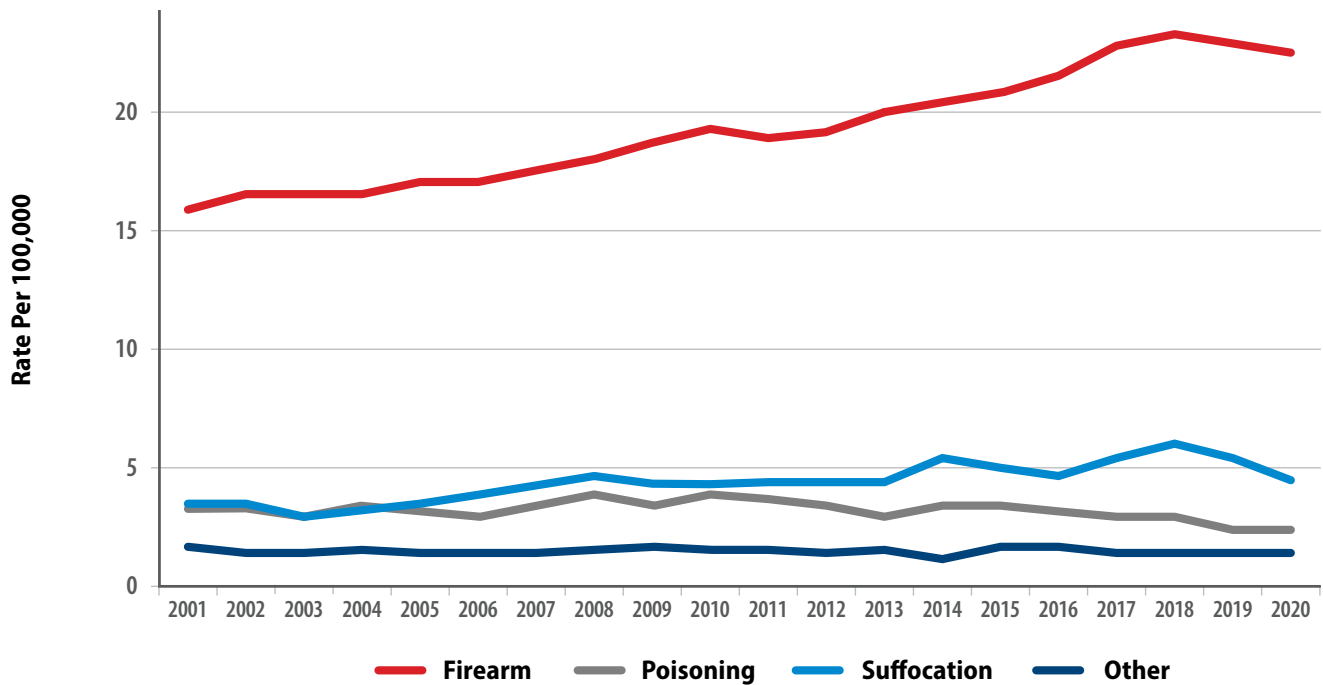
²⁶ Rates are suppressed if there were fewer than 10 suicide deaths, with dotted lines connecting non-suppressed data points. The dotted lines represent suppressed rates and should not be interpreted as estimated rates.

Method-Specific Suicide Rates

Figure 10 below shows method-specific suicide rates among Veterans, by year, 2001-2020.

- From 2001 to 2020, method-specific rates increased for firearm suicide mortality (+45.0%) and suffocation suicide mortality (+44.8%). Rates decreased 13.8% for poisoning suicide mortality and increased 22.9% for suicide involving other methods. These changes may underlie overall trends in Veteran suicide from 2001 through 2020.
- From 2018 to 2020, method-specific suicide rates decreased for firearm suicide mortality (-2.5%), poisoning suicide mortality (-17.6%) and suffocation suicide mortality (-16.8%), while increasing for suicide involving other methods (+3.4%).
- From 2019 to 2020, rates decreased for firearm suicide mortality (-1.2%), poisoning suicide mortality (-4.8%) and suffocation suicide mortality (-13.7%), while increasing for suicides involving other methods (+3.2%).

Figure 10: Unadjusted Method-Specific Suicide Rates, Veterans, 2001–2020



Further analyses indicate that firearm suicide mortality rates in 2020 were greater among Veteran men (24.3 per 100,000) than Veteran women (6.7 per 100,000).

Lethal Means Involved in Suicide Deaths

Table 1 below provides information on lethal means involved in suicide deaths of non-Veteran U.S. adults and Veterans in 2020, and a measure of change compared to suicides in 2001.

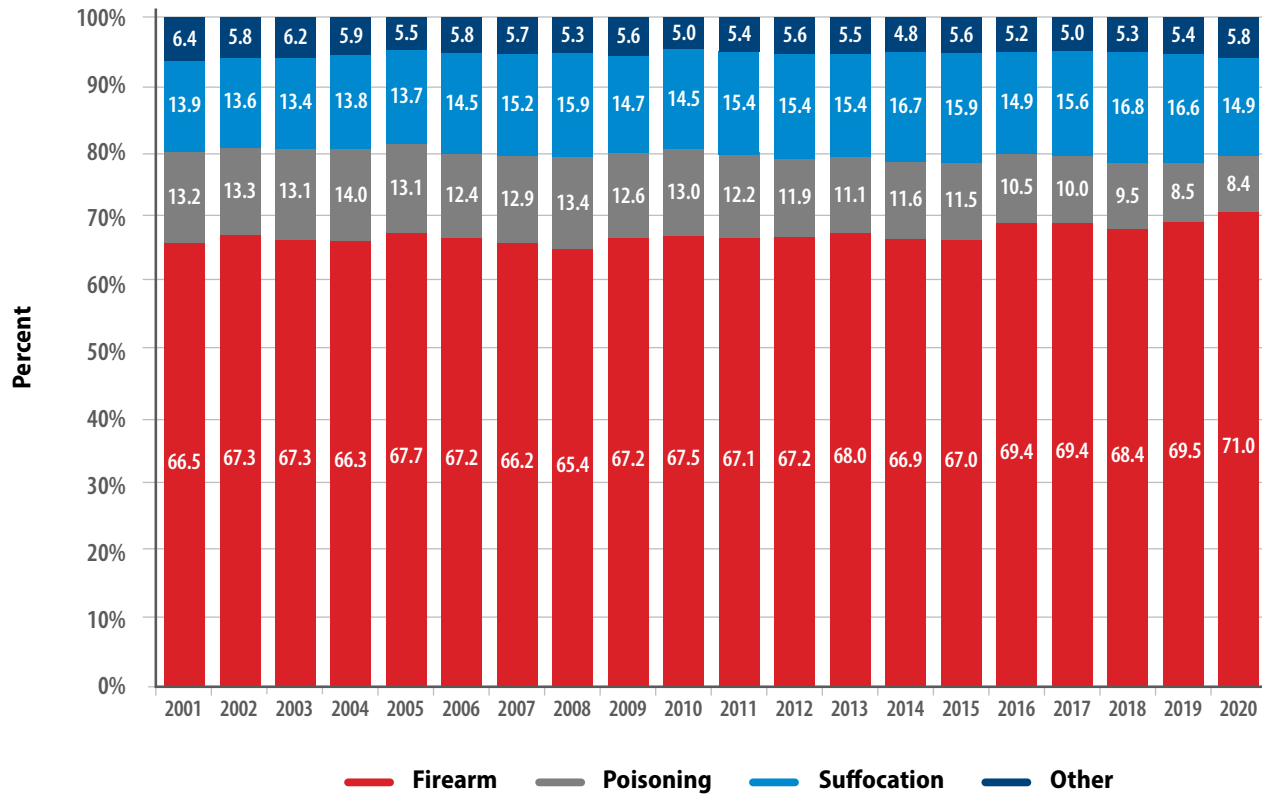
Table 1: Suicide Deaths, Methods Involved, 2020 and Difference From 2001*

	SUICIDE DECEDENTS, METHODS INVOLVED											
	Non-Veteran U.S. Adults		Veterans		Non-Veteran Men		Veteran Men		Non-Veteran Women		Veteran Women	
	2020	Change*	2020	Change*	2020	Change*	2020	Change*	2020	Change*	2020	Change*
Firearms	50.3%	-2.3%	71.0%	+4.5%	55.3%	-2.7%	72.1%	+4.8%	33.3%	-2.1%	48.2%	+11.2%
Poisoning	12.8%	-5.6%	8.4%	-4.8%	8.0%	-4.3%	7.5%	-4.9%	29.3%	-8.7%	26.8%	-16.0%
Suffocation	28.4%	+7.6%	14.9%	+0.9%	28.6%	+6.2%	14.7%	+0.6%	27.7%	+12.0%	19.2%	+8.8%
Other	8.4%	+0.3%	5.8%	-0.6%	8.1%	+0.8%	5.8%	-0.5%	9.6%	-1.1%	5.8%	-3.9%

*Difference compared to suicide deaths in 2001

Figure 11 presents the distribution of methods involved in Veteran suicide deaths, 2001-2020.

Figure 11: Methods Involved, Percentage, Veteran Suicide Deaths, 2001–2020

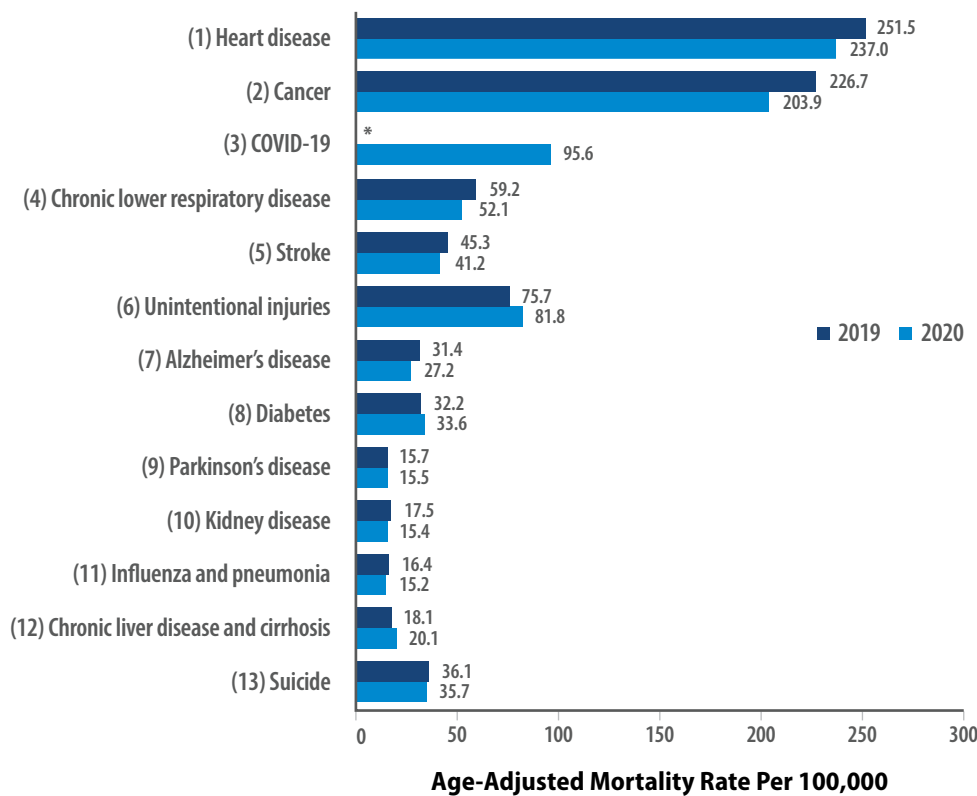


- Among Veteran suicide deaths in 2020, relative to those in 2001, there were increases in the percentage involving firearms (+4.5%) and suffocation (+0.9%) and decreases for those involving poisoning (-4.8%) and other means (-0.6%).
- For suicide deaths of non-Veteran U.S. adults, there were increases from 2001 to 2020 in the percentage involving suffocation (+7.6%) and other means (+0.3%) and decreases in the percentage involving firearms (-2.3%) and poisoning (-5.6%).
- From 2019 to 2020, among Veteran suicide deaths, the involvement of firearms increased from 69.5% to 71.0%, while poisoning and suffocation involvement decreased, from 8.5% to 8.4% and from 16.6% to 14.9%, respectively.
- In 2020, firearms were involved in 72.1% of suicides by male Veterans, up from 70.6% in 2019 and in 48.2% of suicides by female Veterans, down from 48.4% in 2019.
- The distribution of methods involved in suicides by non-Veteran U.S. adults changed from 2019 to 2020: Involvement of firearms increased from 47.7% to 50.3%, while poisoning and suffocation fell, from 13.9% to 12.8% and from 29.7% to 28.4%, respectively.

Leading Causes of Death, Veterans

Among all Veterans in 2020, suicide was the 13th leading cause of death.²⁷ Figure 12 shows age-adjusted, cause-specific mortality rates per 100,000, by leading cause in 2020.²⁸

Figure 12: Top 13 Leading Causes of Death in 2020, Veterans, Age-Adjusted Mortality Rates in 2019 and 2020



*COVID-19 deaths were identified based on underlying cause of death ICD-10 code U07.1. This was added as a cause of death in 2020. There is no comparison rate for 2019.

²⁷ Thirteen leading causes were presented in order to be inclusive of suicide, the 13th leading cause among Veterans, overall. Causes of death are classified based on the underlying cause of death. Leading causes of death are ranked based on the number of deaths, by cause.

²⁸ In the top 7 leading causes of death, deaths from non-COVID-19 causes decreased from 2019 through 2020, with 1 exception: unintentional injuries. This category of death, which includes overdose mortality, increased among Veterans from 2019 through 2020.

The relative rank of suicide as a leading cause of death was higher among younger Veterans (Table 2).

Table 2: First and Second Leading Causes of Death in 2020, Veterans and Suicide Ranking, by Age and Sex

	FIRST LEADING CAUSE OF DEATH	SECOND LEADING CAUSE OF DEATH	RANK OF SUICIDE AS A LEADING CAUSE OF DEATH
All Veterans			
All Ages	Heart disease	Cancer	13th
18 to 34	Accidents (Unintentional Injuries)	<i>Suicide</i>	2nd
35 to 44	Accidents (Unintentional Injuries)	<i>Suicide</i>	2nd
45 to 54	Heart disease	Cancer	4th
55 to 64	Cancer	Heart disease	9th
65 to 74	Cancer	Heart disease	15th
75 to 84	Heart disease	Cancer	16th
85 and older	Heart disease	Cancer	17th
Male Veterans			
All Ages	Heart disease	Cancer	13th
18 to 34	Accidents (Unintentional Injuries)	<i>Suicide</i>	2nd
35 to 44	Accidents (Unintentional Injuries)	<i>Suicide</i>	2nd
45 to 54	Heart disease	Accidents (Unintentional Injuries)	4th
55 to 64	Heart disease	Cancer	9th
65 to 74	Cancer	Heart disease	15th
75 to 84	Heart disease	Cancer	16th
85 and older	Heart disease	Cancer	17th
Female Veterans			
All Ages	Cancer	Heart disease	10th
18 to 34	Accidents (Unintentional Injuries)	<i>Suicide</i>	2nd
35 to 44	Accidents (Unintentional Injuries)	Cancer	3rd
45 to 54	Cancer	Heart disease	5th
55 to 64	Cancer	Heart disease	9th
65 to 74	Cancer	Heart disease	16th
75 to 84	Cancer	Heart disease	--*
85 and older	Heart disease	Alzheimer's disease	--*

*Not reported when based on fewer than 10 deaths

Part 2: Veterans, by Contact with VA Administrations

Here we present information specific to subgroups of Veterans defined by contact with two VA administrations, VHA and VBA. VHA delivers health services for Veterans. VBA supports Veterans in five areas of benefits and entitlements: Compensation and Pension; Education; Home Loan Guaranty; Insurance; and Veteran Readiness and Employment.

Findings include suicide rates for annual cohorts of Veterans who received VHA health care²⁹ in the year or prior year, who in this report are described as “Recent Veteran VHA Users” or as “VHA Veterans,” including by demographic and clinical subgroups, rurality, VHA enrollment and VA eligibility priority groups. For Veterans who died from suicide in 2020, we report on points of VA contact, including receipt of VHA health care, VHA enrollment and VBA services.

Veterans Health Administration (VHA) Health Care

VHA Health Care Engagement, 2001–2020

From 2001 to 2020, the Veteran population decreased by 24.6%. Over these years, VA expanded health care eligibility³⁰ and there were substantial increases in Veterans’ receipt of VHA health care. Despite the overall Veteran population decreases, the number of Veterans with VHA health care encounters in the year or prior year rose 55.0%, from 3.8 million to 5.9 million. By comparison, the number of Other Veterans, who were not recent VHA users, fell 38.6%, from 21.8 million to 13.4 million. In 2020, Recent Veteran VHA Users accounted for 30.6% of all Veterans, up from 14.9% in 2001.

Prior studies report differences between Veterans with versus without VHA health care services utilization. For example, Veterans receiving VHA care are more likely to be unmarried, smokers and from minority populations, with less education, lower annual incomes, poorer self-reported health status, more chronic medical conditions³¹ and self-reported disability due to physical or mental health factors³² and greater reporting of trauma, lifetime psychopathology and current suicidality.³³

To inform Veteran suicide prevention approaches—including clinically and community-focused initiatives—it is important to understand trends in suicide mortality among Recent Veteran VHA Users and among Other Veterans.

²⁹ VHA health care receipt is here defined as having at least one VHA inpatient or outpatient utilization record, per VHA Corporate Data Warehouse records.

³⁰ For example, the National Defense Authorization Act of 2008 extended the period of eligibility for health care for Veterans who had served in a theater of combat operations after 11/11/1998 to 5 years following discharge or release. Qualifying Veterans would be eligible for enrollment in Priority Group 6 unless eligible for enrollment in a higher priority group. <https://www.va.gov/healthbenefits/assets/documents/publications/FS16-4.pdf>

³¹ Dursa, E. K., Barth, S. K., Bossarte, R. M., & Schneiderman, A. I. (2016). Demographic, Military, and Health Characteristics of VA Health Care Users and Nonusers Who Served in or During Operation Enduring Freedom or Operation Iraqi Freedom, 2009-2011. *Public Health Reports*, 131(6), 839-843.

³² Nelson, K. M., Starkebaum, G. A., & Reiber, G. E. (2007). *Veterans Using and Uninsured Veterans Not Using Veterans Affairs (VA) Health Care*. 122:94-100.

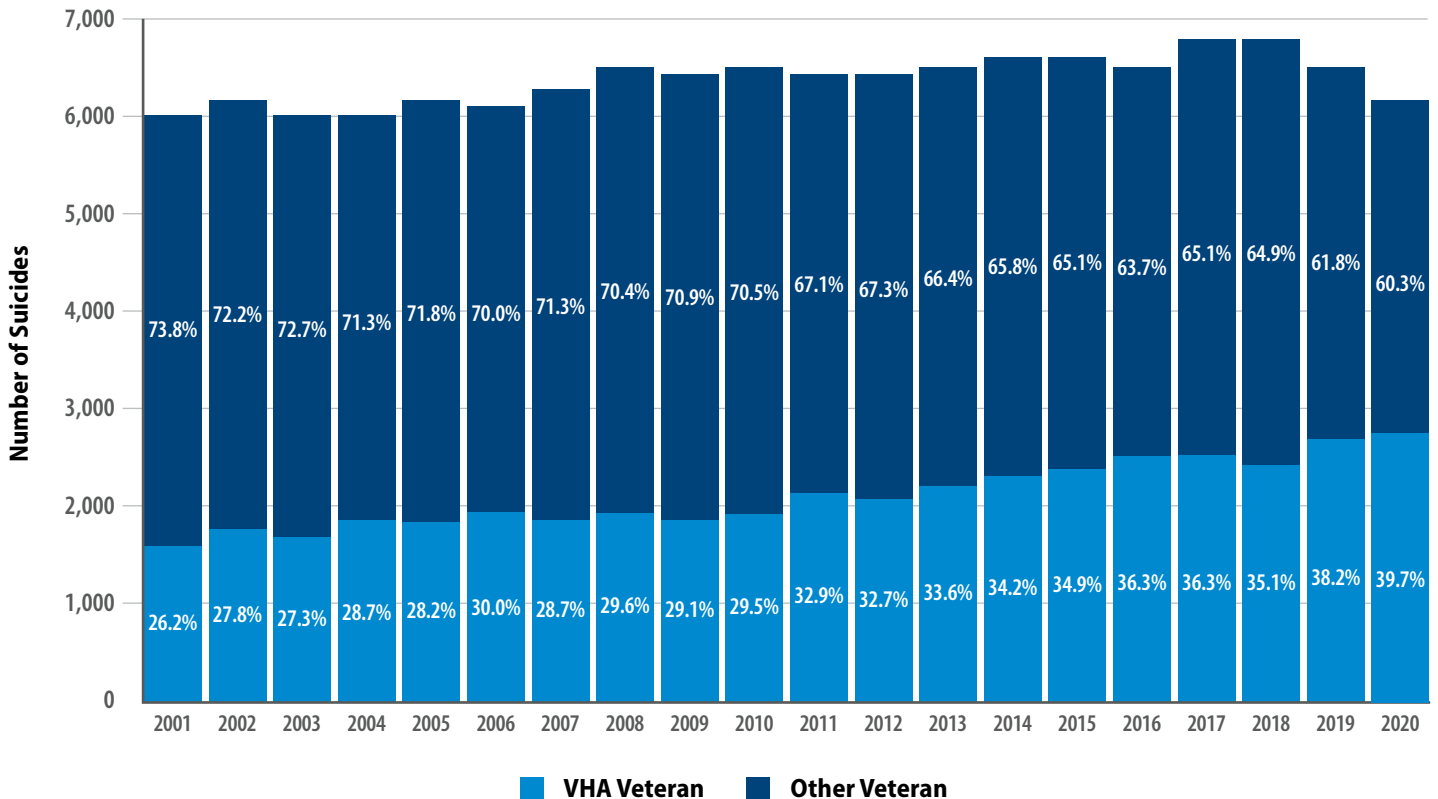
³³ Meffert, B. N., Morabito, D. M., Sawicki, D. A., Hausman, C., Southwick, S. M., Pietrzak, R. H., & Heinz, A. J. (2019). U.S. Veterans Who Do and Do Not Utilize VA Healthcare Services: Demographic, Military, Medical, and Psychosocial Characteristics. *Primary Care Companion CNS Disorders*, 21(1). doi:10.4088/PCC.18m02350

Suicide Deaths

Figure 13 below presents the annual number of Veteran suicide deaths, 2001-2020 and the percentage among Recent Veteran VHA Users (“VHA Veteran”) and Other Veterans.

- Among Veteran suicide decedents, the percentage with recent VHA encounters increased from 26.2% in 2001 to 39.7% in 2020.

Figure 13: Veteran Suicides, Percentages With and Without Recent³⁴ VHA Health Care Encounters, 2001–2020



³⁴ Dursa, E. K., Barth, S. K., Bossarte, R. M., & Schneiderman, A. I. (2016). Demographic, Military, and Health Characteristics of VA Health Care Users and Nonusers Who Served in or During Operation Enduring Freedom or Operation Iraqi Freedom, 2009-2011. *Public Health Reports*, 131(6), 839-843.

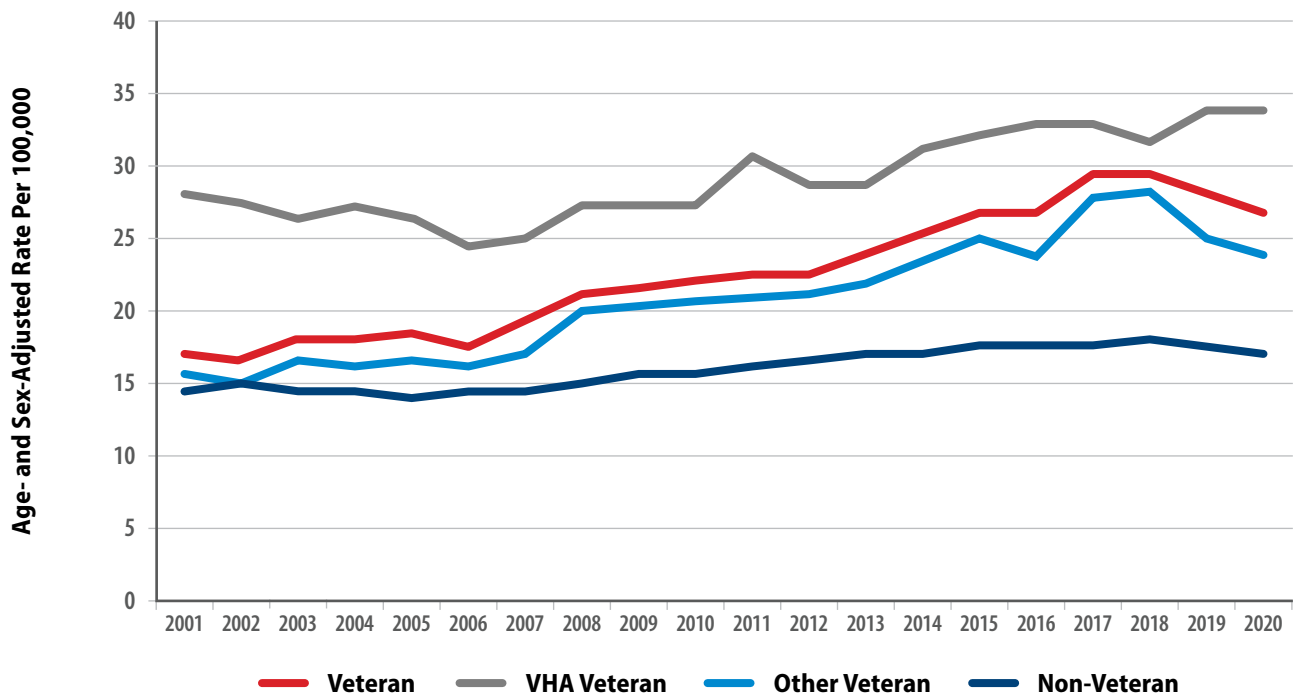
Average Number of Suicides Per Day

- Among annual cohorts of Recent Veteran VHA Users, the average number of suicides per day increased from 4.3 in 2001 to 6.7 in 2020.
- From 2001 through 2020, the average per day was highest in 2019 (6.8 per day).

Suicide Rates

Figure 14 below presents trends in age- and sex-adjusted suicide rates among Veterans overall, Recent Veteran VHA Users (“VHA Veteran”), Other Veterans and non-Veteran U.S. adults, 2001-2020.

Figure 14: Age- and Sex-Adjusted Suicide Rates, Veterans, Overall and by Recent VHA Care and Non-Veteran U.S. Adults, 2001–2020



- Age- and sex-adjusted suicide rates for 2001 and for 2020 were higher among Recent Veteran VHA Users than for Other Veterans.
- As shown in Table 3 on the next page, from 2001 to 2020, adjusted rates increased by 22.6% for Recent Veteran VHA Users and by 54.0% among Other Veterans. From 2001 through 2020, adjusted rates rose more steeply for Other Veterans than for Recent Veteran VHA Users. From 2019 to 2020, adjusted rates among Recent Veteran VHA users fell by 0.5% and rates among Other Veterans fell by 6.3%.
- For Veteran men with recent VHA care, the age-adjusted rate rose by 4.4% from 2019 to 2020, while for Veteran women with recent VHA care, the age-adjusted suicide rate fell by 11.9%.
- From 2001 to 2020, age-adjusted suicide rates rose 20.4% for male Veterans with recent VHA use and 46.4% for male Veterans without recent VHA use. Age-adjusted suicide rates rose 23.2% for female Veterans with recent VHA use and 68.2% for female Veterans without recent VHA use.

Table 3: Veteran Age- and Sex-Adjusted Suicide Rates Per 100,000, 2001, 2019 and 2020

	2001	2020	Change	2019	2020	Change
Recent Veteran VHA Users	27.8	34.1	+22.6%	34.3	34.1	-0.5%
Other Veterans	15.5	23.8	+54.0%	25.4	23.8	-6.3%

Figure 15: Age- and Sex-Adjusted Suicide Rates Per 100,000, with 95% Confidence Intervals, Veterans, by Recent VHA Care, 2001–2020

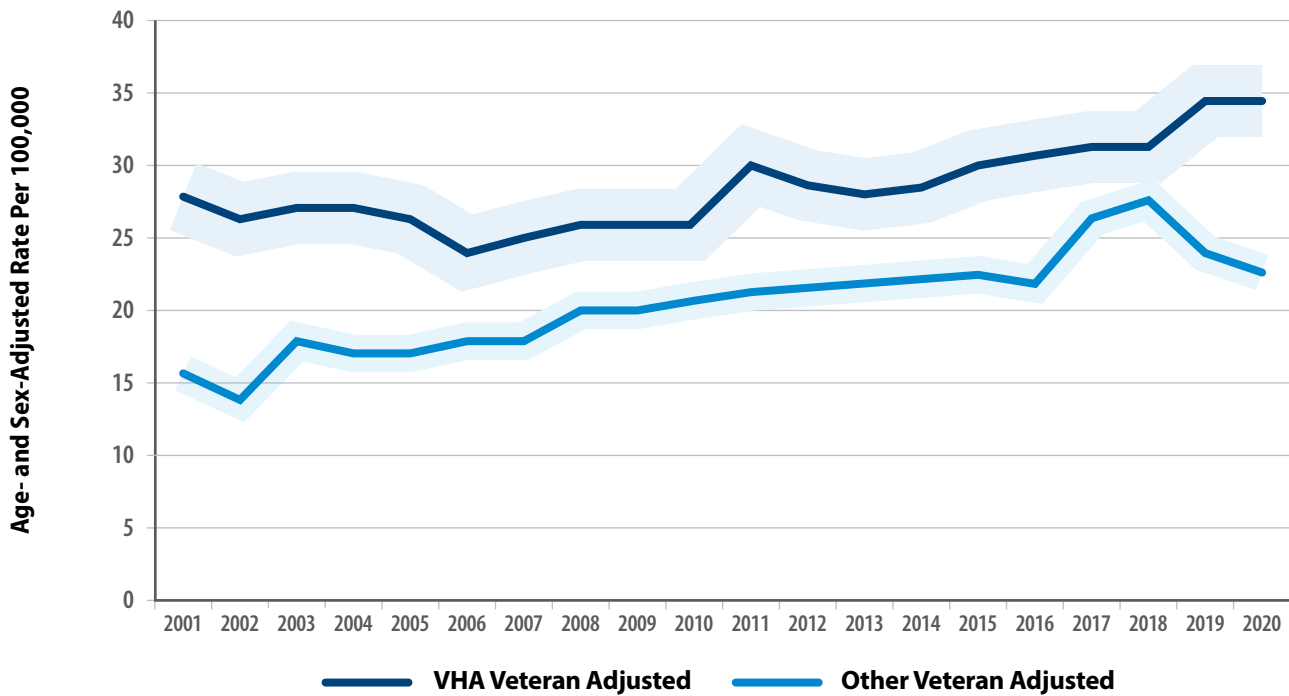


Table 4 on the next page presents focused comparisons, by sex, of age-adjusted suicide rates, for 2020 versus 2001 and for 2020 versus 2019.

- Adjusted rates rose substantially from 2001 through 2020 for Recent Veteran VHA Users and for Other Veterans. From 2019, age-adjusted rates rose only among Veteran men with recent VHA health care, while falling for Veteran women with recent VHA care and for both men and women Veterans who were not recent VHA users.

Table 4: Age-Adjusted Suicide Rates Per 100,000, Veteran VHA Users and Other Veterans, by Sex³⁵

	2001	2020	Change	2019	2020	Change
Recent Veteran VHA Users						
Men	43.4	52.2	+20.4%	50.1	52.2	+4.4%
Women	13.6	16.8	+23.2%	19.1	16.8	-11.9%
Other Veterans						
Men	23.3	34.1	+46.4%	35.1	34.1	-2.7%
Women	8.3	13.9	+68.2%	16.2	13.9	-13.9%

Mental Health and Substance Use Disorder Diagnoses

Ensuring access to mental health and substance use disorder services is a VHA priority and part of VA's *National Strategy for Preventing Veteran Suicide*.³⁶

- From 2001 to 2020, the prevalence of VHA mental health or substance use disorder (SUD) diagnoses among annual cohorts of Recent Veteran VHA Users rose from 27.9% to 41.9%.³⁷
- VHA mental health or SUD diagnoses were documented for 56.1% of Recent Veteran VHA Users who died from suicide in 2001 and for 58.0% of those who died in 2020.
- Among those who died from suicide in 2020, the prevalence of depression diagnoses was 35.2%, anxiety 25.6%, posttraumatic stress disorder (PTSD) 24.4%, alcohol use disorder 19.6%, cannabis use disorder 8.3%, bipolar disorder 7.5%, opioid use disorder 4.9%, personality disorder 4.6% and schizophrenia 4.5%.
- Conversely, 42.0% of Recent Veteran VHA Users who died from suicide in 2020 did not have a documented VHA mental health or substance use disorder diagnosis.
- The suicide rate among cohorts of Recent Veteran VHA Users with mental health or substance use disorder diagnoses fell from 77.7 per 100,000 in 2001 to 55.5 per 100,000 in 2020. By contrast, the rate among Recent Veteran VHA Users who did not have documented mental health or SUD diagnoses rose from 25.6 per 100,000 in 2001 to 29.8 per 100,000 in 2020.
- Trends in rates varied by condition. From 2001 to 2020, suicide rates fell 28.7% for patients with mental health/SUD diagnoses, while rising 16.6% for patients without documented diagnoses.
- From 2001 to 2020, suicide rates fell for Recent Veteran VHA Users with diagnoses of:
 - Mental health or SUD (-28.7%)
 - Depression (-38.6%)
 - Sedative use disorder (-38.5%)³⁸
 - PTSD (-29.2%)
 - Anxiety (-30.3%)

³⁵ Note: Rates in Tables 2 and 3 are not comparable. In Table 2, they are age- and sex-adjusted, while in Table 3, rates are age-adjusted, stratified by sex.

³⁶ https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

³⁷ Diagnoses were assessed in the year or prior calendar year. An individual's likelihood of having a documented diagnosis may vary by the number of VHA health care contacts in the relevant time period. VHA transitioned from International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), to ICD-10-CM diagnosis codes on Oct. 1, 2015. Diagnoses were not mutually exclusive, and analyses do not adjust for demographic differences or comorbidities.

³⁸ In 2001, there were 21 suicides among recent Veteran VHA Users with sedative use disorder. In 2020, there were 33.

- Alcohol use disorder (-15.2%)
- Substance use disorders (-10.5%)
- Bipolar disorder (-8.8%)
- Personality disorder (-3.5%)
- And rates rose for those with:
 - Opioid use disorder (+35.4%)
 - Cocaine use disorder (+34.3%)
 - Schizophrenia (+19.3%)
 - Cannabis use disorder (+16.0%)
 - Stimulant use disorder (+6.7%)

For 2019 and 2020 Recent Veteran VHA User cohorts, Table 5 below presents the number of suicide deaths and unadjusted suicide rates per 100,000.

- Overall, while suicide rates fell from 2019 through 2020 for those with any mental health or SUD diagnosis, suicide rates rose for those with any substance use disorders.

Table 5: Suicide Deaths and Rates Among Recent Veteran VHA Users, by Mental Health and SUD Diagnoses, 2019 and 2020

Diagnoses ⁴⁰	SUICIDE DEATHS		SUICIDE RATES PER 100,000 ³⁹		
	2019	2020	2019	2020	Change ⁴¹
Without MH Condition/SUD	1,005	1,025	28.2	29.8	+1.7
With Any MH Condition/SUD	1,472	1,415	57.1	55.5	-1.7
Anxiety	650	625	68.8	64.8	-4.0
Bipolar disorder	185	184	109.5	111.4	+1.9
Depression	946	859	66.6	60.9	-5.7
Personality disorder	122	112	154.0	147.9	-6.1
Posttraumatic stress disorder	599	595	53.8	52.9	-0.9
Schizophrenia	81	109	87.4	123.5	+36.1
Substance Use Disorder	623	626	87.1	89.9	+2.8
Alcohol use disorder	491	478	89.9	90.1	+0.2
Cannabis use disorder	177	202	93.0	108.8	+10.2
Cocaine use disorder	63	67	64.6	74.8	+15.8
Opioid use disorder	108	119	114.4	133.1	+18.7
Sedative use disorder	38	33	195.1	185.8	-9.3
Stimulant use disorder	85	93	138.9	159.9	+21.0

³⁹ Suicide rates and change in rates are per 100,000 person-years.

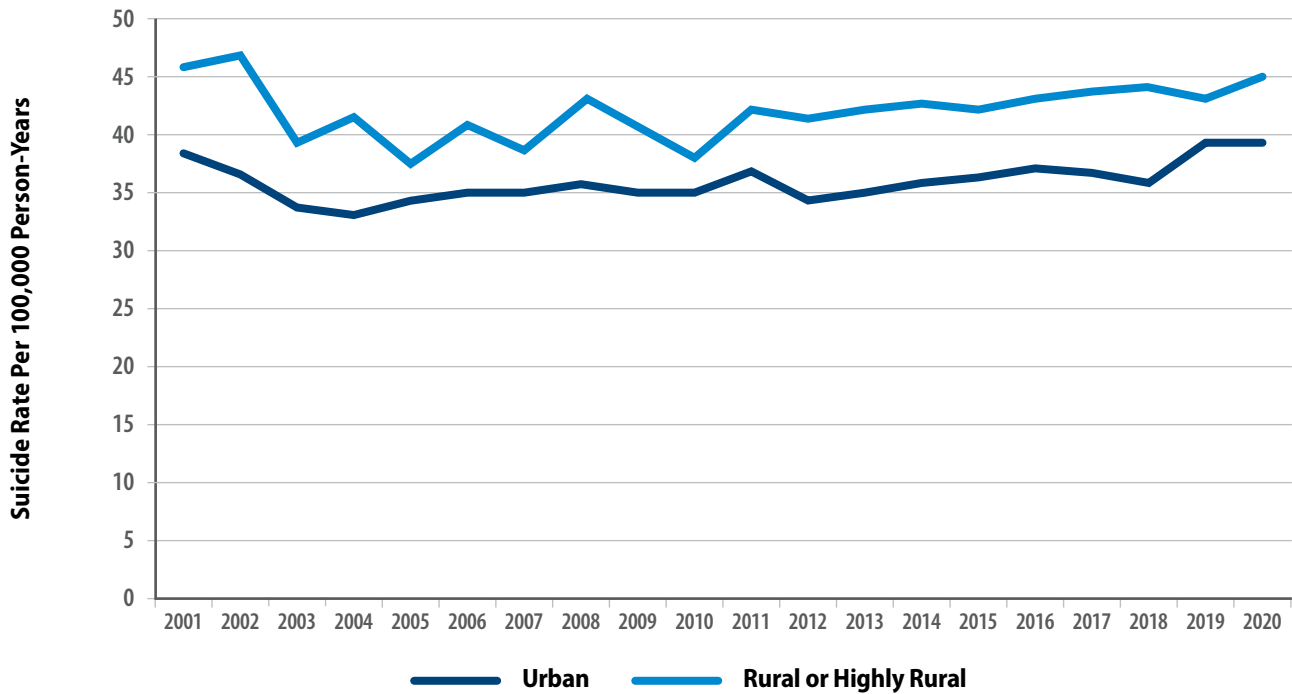
⁴⁰ Diagnosis categories are not mutually exclusive.

⁴¹ Calculated using non-rounded numbers.

Rurality

Among Veteran VHA Users, suicide rates were elevated for residents of rural areas, as compared to urban areas (Figure 16 below). For example, for individuals in rural or highly rural areas, the rate was 44.9 per 100,000 and it was 38.8 per 100,000 for those in urban areas. These differences may be partly attributed to demographic differences among Veteran VHA Users, by rurality status.⁴²

Figure 16: Unadjusted Suicide Rate Per 100,000 Person-Years, Recent Veteran VHA Users, by Urban, Rural or Highly Rural Status, 2001–2020



⁴² Previously documented differentials in suicide risk among VHA patients by rurality (McCarthy, J. F., Blow, F. C., Ignacio, R. V., Ilgen, M. A., Austin, K. L., & Valenstein, M. (2012). Suicide Among Patients in the Veterans Affairs Health System: Rural-Urban Differences in Rates, Risks and Methods. *American Journal of Public Health*, 102:S111-117.) may be substantially explained by demographic differences (Peltzman, T., Gottlieb, D. J., Levis, M., & Shiner, B. (2022). The Role of Race in Rural-Urban Suicide Disparities. *Journal of Rural Health*, 38(2), 346-354.). This interpretation was supported by supplemental analyses, not presented here, of trends in rates for combined annual VHA patient cohorts, 2016-2020, by race and Hispanic ethnicity status, stratified by rural/urban status. These document that between 2016 and 2020, the suicide rate in rural versus urban areas was 14.6% lower for American Indian or Alaska Native Veterans, 16.5% lower for Black Veterans, 2.7% higher for White Veterans, 3.8% higher for Native Hawaiian or Pacific Islander Veterans, 26.2% higher for Hispanic Veterans and 8.8% higher for Veterans with multiple race categories. Differentials for Asian and for Native Hawaiian or Pacific Islander Veterans are not reported here, due to small numbers of suicide decedents.

Gender Identity

VA is working to enhance data resources to inform suicide prevention for Veteran subgroups by gender identity. Self-identified gender identity is the best approach for ascertaining gender identity, including transgender identity. However, current systems are not yet sufficiently developed for comprehensive reporting. Transgender Veterans—whose gender identity differs from the identity assumed by their assigned sex at birth—in VHA care are at increased risk for suicidal ideation⁴³ and non-fatal suicide attempts.⁴⁴ For this report, as a first step, we assessed a measure of transgender identity using diagnosis indicators⁴⁵ linked to transgender identity that are most often used in the context of gender-affirming therapy.⁴⁶

To enhance sensitivity of ascertainment, we generated annualized suicide rates, 2011-2019, for suicide in the year of interest through the end of the *subsequent* year, for recent Veteran VHA Users with a VHA diagnosis related to gender identity occurring in the year or the prior 3 years.

- The number of Veteran VHA patients with diagnoses related to gender identity increased from 2,515 in 2011 to 8,316 in 2019, and the unadjusted annualized suicide rate fell from 267.8 per 100,000 person-years in 2011 to 98.5 per 100,000 person-years in 2019 (Table 6 below).

Table 6: Suicide Rates Per 100,000 Person-Years, in the Year and Following Year, Veteran VHA Users with Diagnoses Related to Gender Identity in the Year or Prior 3 Years, 2011–2019*

Year	Veteran VHA Patients with Diagnoses Related to Gender Identity in Year or Prior 3 Years	Percentage of Veteran VHA Users	Suicide Deaths in Year or Subsequent Year	Unadjusted Suicide Rate Per 100,000 Person-Years
2011	2,515	0.04%	13	267.8
2012	2,845	0.05%	--	--
2013	3,313	0.05%	--	--
2014	3,831	0.06%	10	134.6
2015	4,624	0.07%	12	133.1
2016	5,553	0.09%	11	101.7
2017	6,429	0.10%	17	136.2
2018	7,420	0.11%	17	118.0
2019	8,316	0.13%	16	98.5

* Suppressed if number of suicides was less than 10

⁴³ https://www.va.gov/HEALTHEQUITY/docs/LGBT_Veterans_Disparities_Fact_Sheet.pdf

⁴⁴ Blossnich, J. R., Boyer, T. L., Brown, G. R., Kauth, M. R., & Shipherd, J. C. (2021). *Differences in Methods of Suicide Death Among Transgender and Nontransgender Patients in the Veterans Health Administration, 1999-2016*. 59:S31-S35.

⁴⁵ Diagnoses related to gender identity include ICD-9-CM codes 302.5, 302.6 and 302.85 and ICD-10-CM codes F64 and Z87.890.

⁴⁶ This approach likely undercounts the number of transgender Veterans in VHA care.

VHA Priority Eligibility Groups

Veterans who apply for VHA care are assigned to one of eight priority eligibility groups. Table 7 below presents unadjusted suicide rates per 100,000 person-years for annual cohorts of Veteran VHA Users, 2014-2020.⁴⁷ In 2020, the suicide rate was highest for Veterans in priority eligibility group 5, which includes income-based eligibility.

Table 7: Unadjusted Suicide Rates, Enrolled Recent Veteran VHA Users, by VHA Priority Eligibility Group, 2014–2020

	SUICIDE RATE PER 100,000 PERSON-YEARS							PRIORITY ELIGIBILITY GROUP CRITERIA
	2014	2015	2016	2017	2018	2019	2020	
Group 1	39.4	41.8	38.8	38.8	39.7	40.2	39.9	Service-connected disability rated as 50% or more disabling, or have service-connected disability that makes one unable to work, or received the Medal of Honor.
Group 2	32.3	27.7	30.1	29.1	33.7	29.4	33.5	Service-connected disability rated as 30% or 40% disabling.
Group 3	29.7	31.8	31.8	32.9	32.9	34.6	28.8	Former prisoner of war, or received the Purple Heart medal, or were discharged for a disability that was caused by—or got worse because of—one’s active-duty service, or service-connected disability rated as 10% or 20% disabling, or awarded special eligibility classification under Title 38, U.S.C. §1151, “benefits for individuals disabled by treatment or vocational rehabilitation.”
Group 4	43.0	45.3	48.6	37.8	38.9	42.1	44.8	Are receiving VA aid and attendance or housebound benefits, or received a VA determination of being catastrophically disabled.
Group 5	51.2	49.4	51.1	52.4	48.9	51.5	52.0	Do not have a service-connected disability, or have a non-compensable service-connected disability rated as 0% disabling, and have an annual income level below our adjusted income limits (based on resident ZIP code), or receiving VA pension benefits, or eligible for Medicaid programs.
Group 6	22.9	25.1	21.1	25.7	32.3	28.8	33.6	Have a compensable service-connected disability rated as 0% disabling, or exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, or participated in Project 112/SHAD, or served in the Republic of Vietnam between 1/9/1962 and 5/7/1975, or served in Persian Gulf War between 9/2/1990 and 11/11/1998, or served on active duty at Camp Lejeune 30+ days between 8/1/1953 and 12/31/1987. VA may also assign a Veteran to priority group 6 if they meet all of the requirements listed below. Veterans are: Currently or newly enrolled in VA health care, and served in a theater of combat operations after 11/11/1998, or were discharged from active duty on or after 1/28/2003, and were discharged less than five years ago. ⁴⁸
Group 7	35.7	39.9	44.8	35.7	36.0	44.7	33.5	Gross household income is below the geographically adjusted income limits (GMT) for where one lives and agrees to pay copays.
Group 8	37.8	37.8	39.3	38.9	36.4	41.1	46.1	Gross household income is above VA income limits and geographically adjusted income limits for where one lives, and agree to pay copays. Eligibility for VA health care benefits will depend on subpriority group.

⁴⁷ <https://www.va.gov/health-care/eligibility/priority-groups/> Group 8 refers to subgroups A-D. Group 8EG (non-enrolled) is not reported, due to small numbers for most years. In 2020, Veteran VHA Users in group 8EG had 23 suicides and a suicide rate of 60.8 per 100,000 person-years. Reporting does not include Veterans whose eligibility was categorized as No Priority, per the VA Enrollment System Administrative Data Repository.

⁴⁸ Returning combat Veterans are eligible for these enhanced benefits for five years after discharge. At the end of this enhanced enrollment period, VA assigns Veterans to the highest priority group they qualify for at that time.

Lethal Means Involved, by Recent VHA Use

Table 8 below presents information on method of suicide among men and women Veterans, by recent VHA utilization status.

Table 8: Method of Suicide, Percentage, Veteran Suicide Decedents, by VHA Use and Sex⁴⁹

	2001	2020	Change	2019	2020	Change
Recent Veteran VHA Users⁵⁰						
Men						
Firearm	66.6	73.6	+7.0	72.1	73.6	+1.5
Suffocation	10.9	12.0	+1.1	14.3	12.0	-2.3
Poisoning	14.2	7.9	-6.3	7.7	7.9	+0.2
Other	8.3	6.4	-1.9	5.9	6.4	+0.5
Women						
Firearm	27.0	50.0	+23.0	46.6	50.0	+3.4
Suffocation	---	14.6	---	22.0	14.6	-7.4
Poisoning	40.5	28.1	-12.4	27.1	28.1	+1.0
Other	---	---	---	---	---	---
Other Veterans						
Men						
Firearm	67.5	71.1	+3.6	69.7	71.1	+1.4
Suffocation	15.1	16.4	+1.3	17.8	16.4	-1.4
Poisoning	11.8	7.2	-4.6	7.2	7.2	0.0
Other	5.6	5.3	-0.3	5.2	5.3	+0.1
Women						
Firearm	40.2	47.2	+7.0	49.3	47.2	-2.1
Suffocation	8.5	21.7	+13.2	19.4	21.7	+2.3
Poisoning	43.6	26.1	-17.5	27.8	26.1	-1.7
Other	---	---	---	---	---	---

⁴⁹ Information is not presented when based on fewer than 10 deaths, indicated by “---.”

⁵⁰ With VHA health care encounters in the year or prior year.

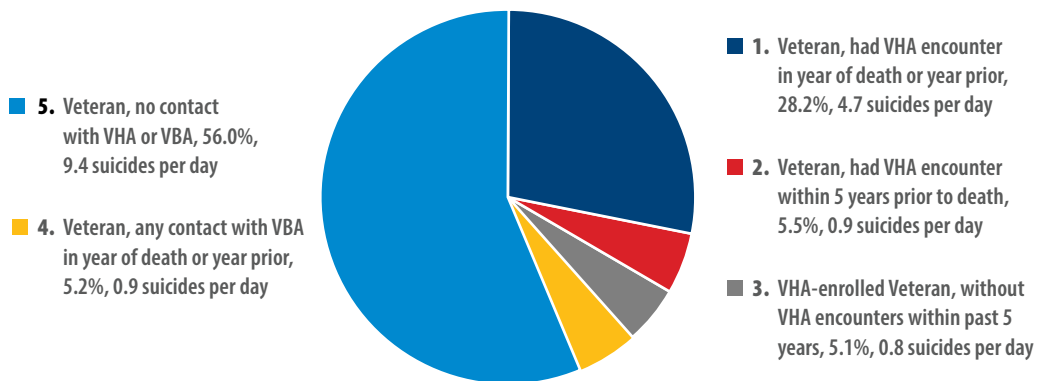
Suicide Decedents in 2005 and 2020: Contacts with VHA and VBA

This section presents new analyses regarding points of VA contact by Veteran decedents, including VHA health care encounters, VHA enrollment and VBA contacts. We present findings for the 6,123 Veterans who died from suicide in 2005 and the 6,146 Veterans who died from suicide in 2020.⁵¹

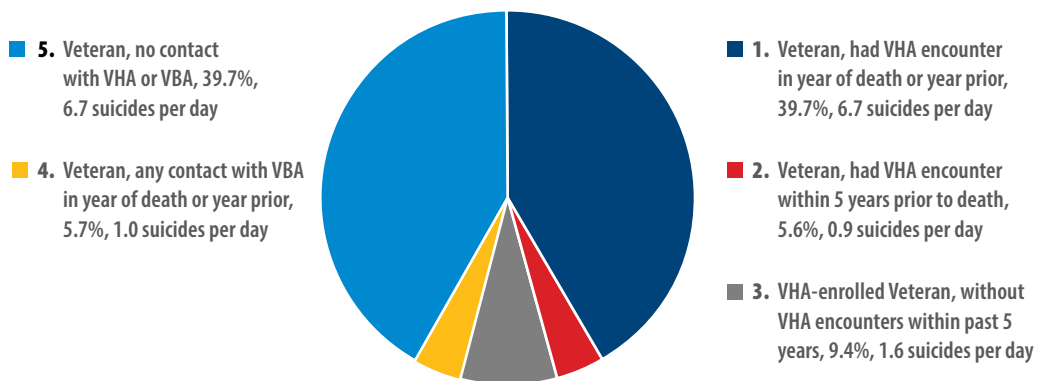
As indicated in Figure 17 below, while most Veteran suicide decedents in 2005 (56.0%) did not have VHA health encounters in the prior 5 years, VHA enrollment or VBA contacts in the year of death or prior year, for Veterans who died by suicide in 2020, only 39.7% did not have any of these indications of VA contact. Veteran suicide decedents in 2020 were more likely than those in 2005 to have received VHA health care encounters and to have VHA enrollment.

Figure 17: Veteran Suicide Decedents in 2005 and 2020, Sequential Mutually Exclusive Categories of VA Points of Contact, Percentage and Average Suicides Per Day⁵²

16.8 Veteran Suicide Decedents Per Day in 2005



16.8 Veteran Suicide Decedents Per Day in 2020



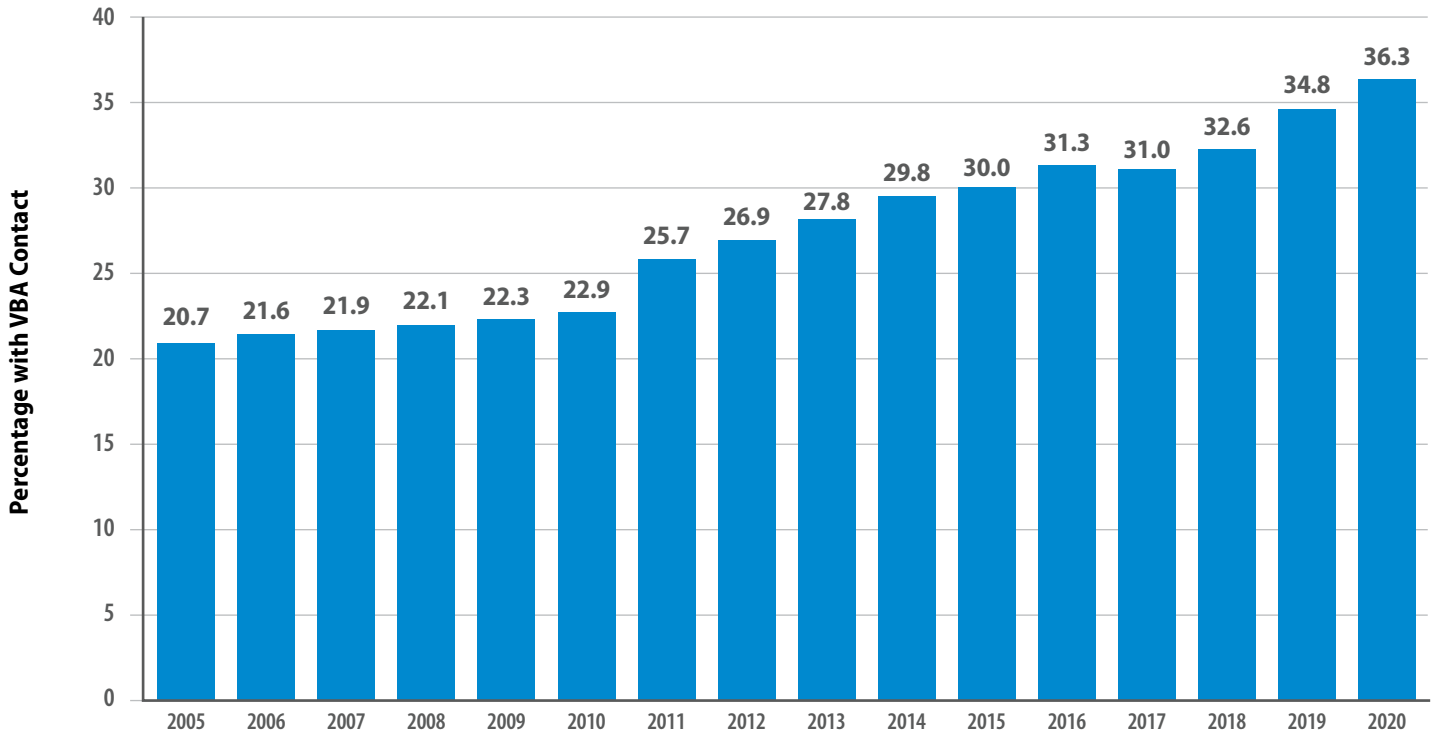
⁵¹ As background, this report shows that for Veterans who died from suicide in 2005, 28.2% had received VHA health care encounters in the year or prior year and 71.8% had not. For Veterans who died from suicide in 2020, 39.7% had recent VHA health care encounters and 60.3% had not. However, recent health care encounters represent only one measure of contact with the Department of Veterans Affairs. To consider VA points of contact more broadly, this section describes the distribution of Veteran suicide decedents across sequential, mutually exclusive categories of VA contact. These categories were, in order, recent VHA health care encounters, then contacts in the prior five years, then VHA enrollment, and, finally, contacts with VBA in the year of death or prior year. In each year, there were on average approximately 17 Veteran suicides per day. The figures below describe the distribution of Veteran suicide decedents across categories in terms of a percentage and in terms of average suicide deaths per day.

⁵² Sequential mutually exclusive categories of VA points of contact are ordered from 1 to 5.

Suicide Decedents, VBA Contact

Figure 18 below shows the prevalence of VBA contact among annual cohorts of Veteran suicide decedents, 2005-2020. This rose from 20.7% in 2005 to 36.3% in 2020.

Figure 18: VBA Contact in the Year or Year Prior Among Veteran Suicide Decedents, 2005–2020

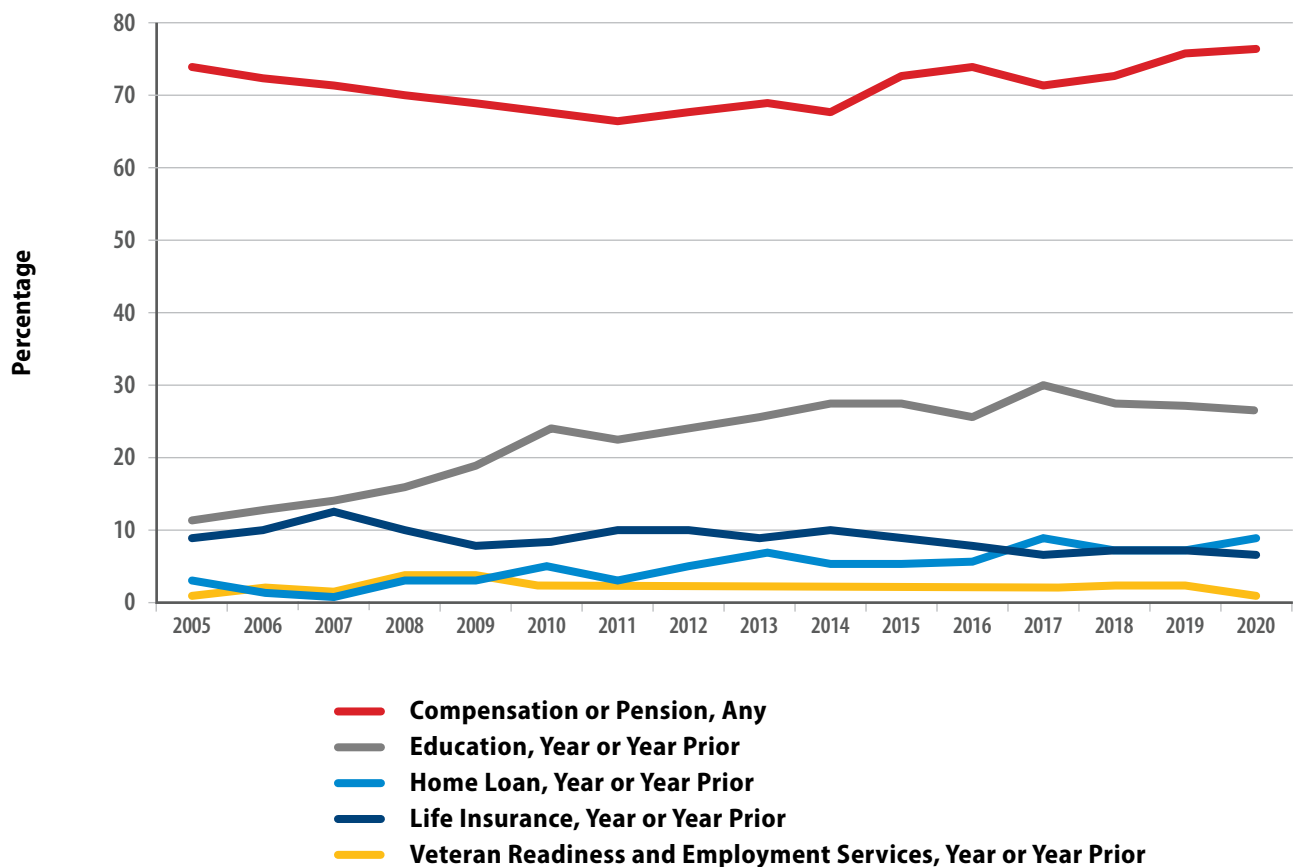


Suicide Decedents with Recent VBA Contact, VBA Services Received

Figure 19 below shows the prevalence of receipt of five non-mutually exclusive categories of VBA services by Veteran suicide decedents who had some VBA contact in the year of death or prior year. Of note, among Veteran suicide decedents with VBA contact, the percentage who received:

- Education-related benefits increased from 12.4% in 2005 to 28.2% in 2020
- Home loans increased from 2.6% in 2005 to 7.8% in 2020
- Life insurance decreased from 9.1% in 2005 to 6.3% in 2020

Figure 19: VBA Services Receipt Prior to Death Among Veteran Suicide Decedents with VBA Contact in the Year or Year Prior to Death, 2005–2020



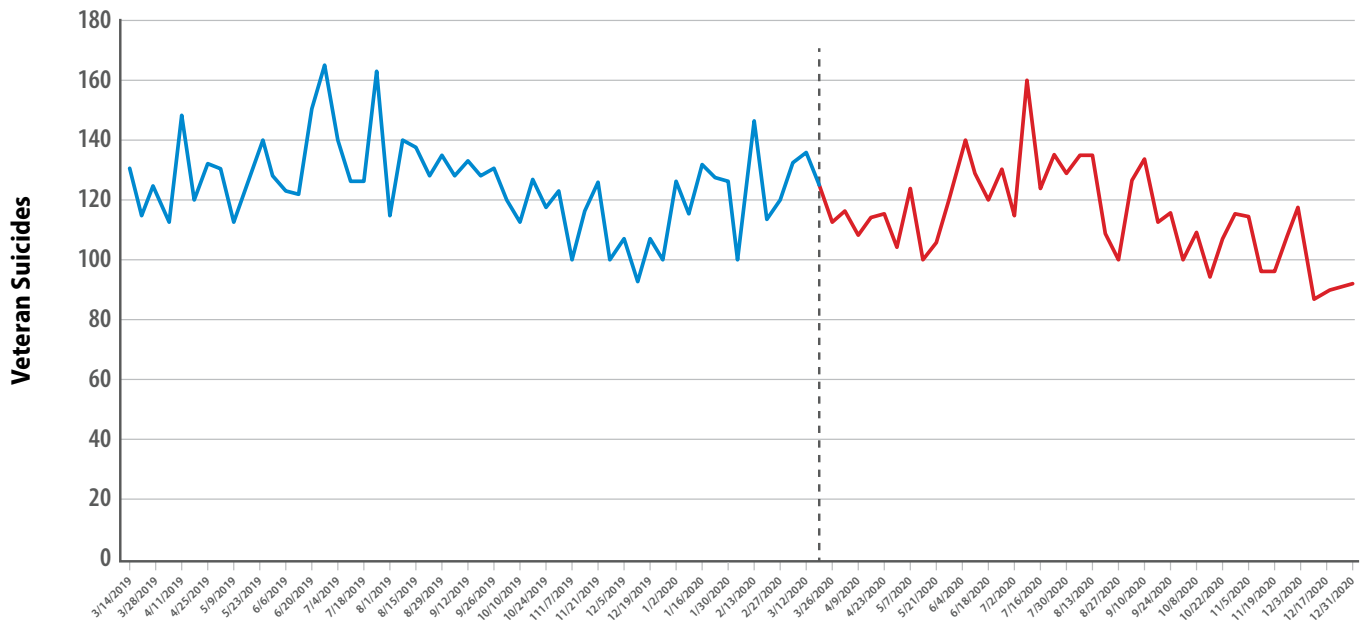
Part 3: COVID-19 Pandemic: Suicide Surveillance

VA has tracked VHA indicators of suicide-related behaviors prior to and following the start of the COVID-19 pandemic.⁵³ In the present report, using 2020 national death certificate data, we report on suicide mortality for the entire Veteran population.

Suicide Deaths, Pre- and Post-Pandemic Declaration

Figure 20 below shows the number of Veteran suicide deaths, by week, from 12 months prior to the declaration of the COVID-19 pandemic through 2020.

Figure 20: Veteran Suicide Deaths, by Week, 12 Months Prior to Onset of the COVID-19 Pandemic, Through 2020



- Trend analyses did not identify associations between onset of the pandemic and Veteran suicide mortality.⁵⁴
- Decreased Veteran suicide in 2020 continued a trend that began in 2019. This pattern was not associated with the COVID-19 pandemic in 2020.

Among Recent Veteran VHA Users, suicide rates were elevated among those with mental health or substance use disorder diagnoses. By contrast, COVID-19 mortality rates were more elevated among patients with chronic medical conditions.

In summary, our assessment of trends in Veteran suicide mortality and comparisons to patterns of Veteran COVID-19 mortality, both over the course of 2020 and across demographic and clinical subgroups, did not identify signals of an impact of the COVID-19 pandemic on Veteran suicide mortality.

⁵³ U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. (September 2021). *2021 National Veteran Suicide Prevention Annual Report*. <https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf>. U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. (November 2020). *2020 National Veteran Suicide Prevention Annual Report*. <https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf>

⁵⁴ Trend analyses using Joinpoint did not identify changes in suicide mortality for Veterans or for non-Veteran U.S. adults, or, among Veterans, for Recent Veteran VHA Users or for Other Veterans.

Part 4: Next Steps in VA's Implementation of a Full Public Health Approach

Core Tenets and Guiding Vision

VA's three core tenets for suicide prevention continue to remain the foundation of our efforts to implement the National Strategy (2018), VA/DoD *CPG for the Assessment and Management of Patients at Risk for Suicide* (2019), and the White House strategy for *Reducing Military and Veteran Suicide* (2021):

- Suicide is preventable.
- Suicide prevention requires a public health approach combining clinical and community-based approaches.
- Everyone has a role to play in suicide prevention.

Our work involves a whole of Government and whole of Nation approach as Veteran suicide is a complex problem that cannot be addressed through a singular solution, nor can it only be addressed by VA or clinical intervention alone. Our data this year again confirms the need for including community prevention, alongside clinical interventions, in our public health approach. The vast majority of Veterans who died by suicide in 2020 were not recent VHA users (60.3%) and community approaches must be utilized to reach all Veterans, not just those within the VA system. Further, mental health solutions alone will not address Veteran suicide, particularly with 42.0% of Recent Veteran VHA Users who died from suicide in 2020 not having a documented VHA mental health or substance use disorder diagnosis. Unemployment, chronic pain, insomnia, relationship strain, homelessness and grief are examples of factors outside of mental health that may play a role in suicide. We must also move beyond the individual factors in suicide and look to address broader international, national, community and relational factors that play a role (e.g., inadequate access to care, global health concerns, war, economic crises, homelessness).⁵⁵

The White House strategy for *Reducing Military and Veteran Suicide* (2021) builds upon prior foundational efforts at the national level, including prior executive orders and the 2012 *National Strategy for Suicide Prevention*, along with its adaptation to military populations in 2015 and Veteran populations in 2018. This strategy's five major priority goals include:

1. Improve lethal means safety;
2. Enhance crisis care and facilitate care transitions;
3. Increase access to and delivery of effective care;
4. Address upstream risk and protective factors; and
5. Increase interagency research management, data sharing and evaluation efforts.

The priority goals here have been cross walked with VA's National Strategy to ensure alignment and operationalization of these goals along with the four directions of the National Strategy, including:

1. Healthy and Empowered Veterans, Families and Communities
2. Clinical and Community Prevention Services
3. Treatment, Recovery and Support Services
4. Surveillance, Research and Evaluation

⁵⁵ Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behavior. *Lancet*, 387(10024), 1227-39.

VA has worked with its Federal partners to reinvigorate the Interagency Task Force on Military and Veterans Mental Health with the purpose of operationalizing the new strategy on military and Veteran suicide prevention. The 2012 Executive Order 13625, Improving Access to Mental Health Services for Veterans, Service Members and Military Families, established the Interagency Task Force on Military and Veterans Mental Health. The interagency task force (ITF) is focused on facilitating interagency collaboration, expanding staffing capacity at the Veteran Crisis Line and joint development of a national suicide prevention campaign focused on connecting Veterans and Service members to resources and support. In 2022, this ITF updated its charter to incorporate both targeted partnerships and overarching priority goals from the *Reducing Military and Veteran Suicide* strategy (White House, 2021). In conjunction with this ITF, VA continues to operationalize the National Strategy, White House Strategy and the 2019 CPG through the combined work of community and clinical strategies through SP 2.0 and SP Now initiatives along with demonstration projects, new innovations and implementation of recently enacted laws.

Community Prevention Highlighted Efforts

SP 2.0 Community Efforts

The SP 2.0 Community-Based Interventions for Suicide Prevention (CBI-SP) model reaches Veterans through facilitating community coalitions focused on ending Veteran suicide, thereby extending VA's reach to Veterans not being touched by VHA or VBA services. The program incorporates:

- State Governor's Challenge initiatives;
- Together With Veterans rural peer-to-peer model; and
- VHA Community Engagement and Partnerships Coordinators.

This evidence-informed model focuses on three key priority areas, which reflect both the National Strategy (2018) and recent White House Strategy (2021):

1. Identify Service Members, Veterans and Their Families and Screen for Suicide Risk;
2. Promote Connectedness and Improved Care Transitions; and
3. Increase Lethal Means Safety and Safety Planning.

As of July 2022, 48 states and 5 territories are participating in the Governor's Challenge. By the end of fiscal year (FY) 2022, all 18 VHA Veterans Integrated Service Networks (VISN) will have CEPCs working with communities, and all states will be engaged in a comprehensive effort working to end Veteran suicide. Together with Veterans⁵⁶ is now established in 27 rural communities and has reached over 200,000 Veterans. As of August 2022, there are now more than 600 community coalitions actively working under the unifying community-based suicide prevention model with over 100 CEPCs already working in the field, expanding the critical efforts of our suicide prevention coordinators within the VHA system.

Through April 2022, the Don't wait. Reach out. campaign had a donated media value of \$5.1 million, showing a 132% return on investment, and over 475 million impressions. Likewise, the Keep It Secure campaign has generated over one billion impressions this fiscal year, and ongoing lethal means safety messaging focused on firearm safety will launch in FY 2023. The VCL campaign from February 2020-March 2022 reached over 1.8 billion impressions and launched 988 external messaging after the launch of Dial 988 then Press 1 on July 16, 2022.

Communication Campaigns

VA has emphasized three paid media campaigns as part of its efforts to reach all Veterans: 1) Don't wait. Reach out.; 2) Keep It Secure; and 3) the Veterans Crisis Line (VCL). To develop the Don't wait. Reach out. campaign, VA entered into an

⁵⁶ Together With Veterans (TWW) - MIRECC / CoE (va.gov)

agreement with the Ad Council, a national non-profit organization that uses donated communication industry resources to elevate messaging. The campaign strategy was informed by extensive research with Veterans and portrays real Veterans in all videos. The Keep It Secure campaign is a national public health campaign addressing the need for secure storage of firearms as part of suicide prevention. Finally, the VCL campaign works to reach Veterans and those who love them with 24/7 support during times of crisis. All three campaigns have exceeded performance expectations in FY 2022.

Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program

The 2020 Commander John Scott Hannon Veterans Mental Health Care Improvement Act (Hannon Act) also expands access to critical mental health care resources. Section 201 of the Hannon Act established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, allowing VA to provide grants to eligible entities to expand suicide prevention services to eligible individuals and their families to reduce the risk of suicide. Community organizations can apply for grants worth up to \$750,000 and may apply to renew awards from year-to-year throughout the length of the program. The first applications were due in June 2022 and the first awards will be issued in September 2022. A robust evaluation program has simultaneously been developed to assess lessons learned for future applications.

Community Collaborations

VA collaborates closely with Veterans Service Organizations (VSO) and other entities that support suicide prevention efforts by facilitating opportunities, such as sharing and promoting content and materials or coordinating guest speakers at stakeholder events. VA works with organizations to promote social connectedness and provide resources through online platforms and mobile apps. These resources are ready for use now and are no cost to Service members, Veterans, their caregivers or families. VA also collaborates with state and local governments through the programs within CBI-SP, including the Governor's Challenge initiative. The coalitions and teams that are supported by CBI-SP include various nongovernmental organizations, such as VSOs, nonprofit organizations, faith-based community groups, academic affiliates, public safety agencies, businesses and state and local hospital systems.

One example of collaboration is VA's work with the PsychArmor Institute to launch a free, online suicide prevention training designed to help equip anyone who interacts with Veterans to demonstrate care, support and compassion when talking with a Veteran who could be at risk for suicide. VA is also working with the National Shooting Sports Foundation (NSSF) to produce videos focused on firearm safety, increase gunlock distribution and expand lethal means safety (LMS) training to community providers. Further, VA released a toolkit, *Suicide Prevention is Everyone's Business: A Toolkit for Safe Firearm Storage in Your Community*, developed in collaboration with the American Foundation for Suicide Prevention and NSSF to raise awareness about safe storage practices for local communities.

Clinical Intervention Highlighted Efforts

SP 2.0 Clinical Telehealth

In addition to community-based efforts, advancing the dissemination of evidence-based clinical practices for suicide prevention across the VHA system is critical. SP 2.0 Clinical Telehealth offers evidence-based psychotherapies, as outlined in the VA/DoD 2019 CPG, to Veterans with recent suicidal self-directed harm. This program ensures access to the following therapy interventions with the greatest evidence for impacting suicide: Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP); Problem-Solving Therapy for Suicide Prevention (PST-SP); Dialectical Behavior Therapy; and the Safety Planning Intervention. Because the program uses a virtual care platform (video telehealth), it allows Veterans the opportunity to access treatment without leaving their homes, which is particularly helpful in a pandemic. As of April 2022, VA has hired 97 therapists and received over 3,000 consults for services.

SP NOW Initiative–Clinical Interventions

As noted above, SP Now is working to strengthen clinical suicide prevention initiatives in VHA. Suicide Prevention in the Emergency Department (SPED) has significantly improved implementation of this program, with 92% of Veterans who present to the emergency department (May 2022) engaged to develop a post-discharge safety plan compared with 60% in January 2020. This practice, through the new White House Strategy (2021), is being adapted to community hospital settings as part of a new integrated project team (IPT). Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) is exceeding benchmarks for all five performance metrics, with ongoing work to further strengthen the algorithm and expand the reach of impact. Enhanced implementation of universal suicide risk screening for Veterans, as outlined in the VA/DoD CPG,⁵⁷ is another critical effort in the SP Now initiative. SP Now clinical enhancements have also been made to further strengthen interventions for Veterans with a High Risk for Suicide Patient Record Flag (HRS-PRF), including: enhancing standard operating processes for flag management for consistency across the VHA enterprise; developing an e-consult to further standardize processes to refer Veterans at high risk for suicide for consideration of HRS-PRF placement; creating a standard progress note template to enhance completion of HRS-PRF referrals; and documenting all flag actions, including improved utilization of flag inactivation criteria.

SP Now implemented a systemic effort at the start of the pandemic to provide outreach and support to Veterans at high risk for suicide who have screened or tested positive for COVID-19. The Suicide Prevention Population Risk Identification and Tracking for Exigencies dashboard was utilized to identify and assist providers to identify and track this vulnerable group of Veterans. In May 2022, outreach was attempted to 93% of identified Veterans, with 83% of those Veterans receiving successful outreach.

Innovation Efforts, Research and Ongoing Statutory Implementation

Innovation Efforts

In FY 2022, VA's Suicide Prevention Program launched several demonstration projects to expand its public health approach through innovations. These projects were strategically aligned with priorities of both the VA *National Strategy for Preventing Veteran Suicide* (2018) and White House strategy on *Reducing Military and Veteran Suicide* (2021). Projects focus upon addressing individuals at risk for suicide across universal, selective and indicated categories and emphasize: 1) activation and engagement; 2) collaborations with key stakeholders—both within and outside the Federal Government; 3) amplifying dissemination of evidence-based strategies; 4) targeted and tailored approaches for reaching subpopulations (e.g., Native Veterans, Asian American/Pacific Islander Veterans, geriatric populations, homeless Veterans); and 5) continuous quality improvement with an emphasis on the efficacy of intervention, prevention and education efforts.

FY 2022 Suicide Prevention Demonstration Projects

- Acceptance and Commitment Training for Health Care Providers
- Assessing Social and Community Environments with National Data for Veteran Suicide Prevention
- CAT 2.0: Implementing Computerized Adaptive Testing (CAT) for Mental Health in Primary Care Mental Health Integration
- Clinical Practice Guidelines for Suicide Prevention
- Community-Based Early Intervention for Veterans at Risk of Unemployment and Suicide: A Demonstration Project for Supported Employment: Engage and Keep
- Conducting a national program evaluation of new suicide prevention methods within Coaching into Care

⁵⁷ Department of Veterans Affairs and Department of Defense. (2019). *VA/DoD clinical practice guideline for the assessment and management of patients at risk for suicide*. <https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf>

- Developing Artificial Intelligence Methods to Identify Firearm and Substance Use Risk Factors
- Enhancing Risk ID and SPED Among Homeless Veterans Accessing VHA Emergency Services (“Homeless SPED”)
- Improving Safe Firearm Storage in Veterans Through Involving a Concerned Significant Other: A Feasibility and Acceptability Pilot
- Suicide Among Older Veterans: Addressing Firearm Safety
- Examination of the Implementation of High-Risk Flags for Suicide Prevention
- Internet-Delivered Cognitive Behavioral Therapy to Prevent Suicide in Veterans
- Optimizing the Use and Dissemination of Brief Cognitive Behavioral Therapy for Insomnia for the Purpose of Suicide Prevention
- Prevention, Recovery and Emergency Preparedness: Empowering Veterans to Promote Community Resilience (Empowering Veterans)
- Examining the Effectiveness of an Adaptive Implementation Intervention to Improve Uptake of the VA Suicide Risk Identification Strategy
- Centralizing Caring Communications Pilot—REACH VET
- Veterans Caring Buddies: Empowering Veterans to have conversations with Veteran buddies about lethal means safety as a community approach to suicide prevention
- Measuring Feasibility and Effectiveness of a Lethal Means Safety Suicide Prevention Module in Concealed Carry & Firearm Safety Classes in Louisiana
- Understanding Suicide Risk and Enhancing Suicide Prevention Among Asian American and Pacific Islander Veterans
- Veteran Outreach into the Community to Expand Social Support
- Understanding the impact of mental health clinic capacity and efficiency fluctuations on suicide-related events
- Optimizing a Low-Cost, Low-Burden Self-Help Crisis Intervention to Improve Mental Health and Reduce Suicidality Among At-Risk Primary Care Patients During Crisis
- Native Veteran Suicide Prevention: Tribal VHA partnerships for suicide prevention
- The Use of Peers to Extend Treatment Beyond the VA Walls, Promote Treatment Engagement and Reduce the Risk for Suicide
- The Community Context of Suicidal Behavior—Geospatial Mapping and Community-Based Interventions

Special Projects

- National Center for Veteran Financial Empowerment
- Implementation of Primary Care—Mental Health Integrated Collaborative Care Management and Behavioral Health Interdisciplinary Program Mental Health Care Coordination
- Integration of Mental Health into Pain Clinics: A prevention, early intervention and education pilot
- Integration of Mental Health in Oncology Clinics: A prevention, early intervention and education pilot
- Short-term evidence-based PTSD treatments in residential care settings

Mission Daybreak

In addition to these demonstration projects, VA launched “Mission Daybreak,” a Suicide Prevention Grand Challenge that provides an opportunity to support outside entities, such as academia, industry experts, nonprofits, health innovators, technologists and community partners, to engage innovative solutions for Veteran suicide prevention. Through this \$20 million prize competition, submissions were encouraged in potential areas of focus, such as:

- Utilizing digital life data and early warning systems for suicide prevention;
- Creating improved access to and efficiency of VCL services through technological innovations; and
- Preventing firearm suicide and enhancing lethal means safety for suicide prevention.

Initial submissions were due July 8, 2022, as part of Phase I, with finalists being announced to move into Phase II in the early fall and final winners announced in late 2022.

Research and Program Evaluation

Research and program evaluation are critical for VA’s advancement of new innovations in suicide prevention, as well as continuing implementation of current initiatives through ongoing assessment for needed improvements and new directions. VA’s Suicide Prevention Program works closely with VA’s Rocky Mountain Mental Illness Research Education and Clinical Center, VISN 2 Center of Excellence for Suicide Prevention and VA’s Office of Research and Development. This includes a regular assessment of VA’s suicide prevention research portfolio to review alignment with the National Strategy and assessing the need for new research priorities; for example, expansion in a focus on lethal means safety and community-based suicide prevention efforts. VA’s Suicide Prevention Program also regularly coordinates with its research center partners to translate new research findings into practice. Recent examples of these collaborations include the work with REACH VET and SPED, with ongoing shared efforts to support the field through technical assistance, consultation, and ongoing monitoring and feedback during national rollouts.

Ongoing development and implementation of robust program evaluation is critical for successful rollout of VA’s suicide prevention initiatives. For example, VA has created a robust program evaluation for SP 2.0 involving an interrupted time series and a modified stepped wedge design, which VA can use to assess short-term and intermediate outcomes of programs and surveillance data to evaluate population impact. These outcomes will not only inform implementation of a public health approach for suicide prevention in VA, but also the broader national work in suicide prevention. Likewise, VA’s Suicide Prevention Program has worked with national experts in program evaluation to develop and now implement an in-depth evaluation of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program efforts to further inform our work in community-based initiatives. VA also incorporates program evaluation into our demonstration projects to inform opportunities for potential rollout nationally. Recently, VA’s Suicide Prevention Program early demonstration pilot work showed the success of telehealth delivery of CBT-SP, supporting the decision to later implement this nationally through SP 2.0.

Ongoing Statutory Implementation

VA’s suicide prevention efforts are also further advanced through ongoing implementation of new statutory authority. The National Suicide Hotline Designation Act of 2020 (P. L. 116-172) established a national 3-digit emergency number to simplify access to crisis services, replacing the full 1-800-273-8255 National Suicide Prevention Hotline number (press 1 to reach the VCL) with 988 (press 1 to reach the VCL). Full implementation of 988 by all telephone carriers was required by July 16, 2022, and provided a way to increase access to crisis services with an easy number to remember, similar to 911. The VCL increased responder staff by 56% to prepare for 988 implementation and ongoing hiring is underway. Additionally, to prepare fully for 988 increased demand, several VCL initiatives were implemented to improve access across IT modernization, complex caller interventions and air traffic control efficiency. These improvements have resulted in decreased outage time for technology issues, a reduction in abandoned calls (-22.58%), rollover rate reduction (-29.45%)

and reduction in answer time (-7.30%), translating into improved access for Veterans working to reach the VCL during times of crisis. Further, the VCL expanded beyond call support over the past 2 years, including implementation of Caring Letters and establishment of a new Peer Support Outreach Center (PSOC), providing extended reach of VCL interventions. Through Caring Letters, Veterans receive nine letters over the course of a year after their call to the VCL. This is an evidence-based practice recommended as part of the VA/DoD CPG. Since its launch in June 2020, the VCL has mailed over 900,000 Caring Letters to over 140,000 Veterans; approximately 95,600 of those letters were mailed to Veterans for Veterans Day (data through February 2022). The VCL also launched PSOC in May 2021, with the mission to provide support, hope and recovery-oriented services to Veterans who are identified at increased risk for suicide. PSOC provides compassionate outreach via phone services with several calls to identified Veterans over several months after their call to the VCL. PSOC is staffed by VHA peer specialists who are Veterans in recovery from a substance use or mental health disorder and who provide support, hope and recovery-oriented support to Veteran populations.

The Veterans Comprehensive Prevention, Access to Care and Treatment Act of 2020 (COMPACT Act of 2020, P. L. 116-214) includes provisions related to transitioning Service members, suicide prevention and crisis services, mental health education and treatment and improvement of services for women Veterans. Section 201 of the COMPACT Act requires VA to furnish emergent suicide care at either VA or community facilities, including through reimbursement, to eligible individuals. VA estimates that an additional nine million Veterans could qualify for benefits under this authority, roughly doubling the amount of existing and available services.

Next Steps Together

Enterprise-Wide Efforts: VHA, VBA, NCA

Critical to suicide prevention efforts is reaching across all VA administrations to expand our ability to engage Veterans across the system. VA suicide prevention efforts are coordinated across the enterprise, including required VA S.A.V.E.⁵⁸ training for every VA employee. Additionally, VA is addressing the risk factors of unemployment or underemployment, financial insecurity, disabilities (including physical and mental health), lack of access to care and recent transition from military service to civilian life with work within VBA and in coordination with VHA. VBA's provision of benefits and services can address or reduce some of these risk factors by enhancing vocational and financial well-being as well as providing support during higher risk times of transition from the military through programs like Transition Assistance Program and Solid Start. Likewise, VA's disability compensation and pension benefits, which provide financial support for Veterans, and Loan Guaranty Service, which assists Veterans and Service members in obtaining, retaining and adapting homes, are components of suicide prevention. Further, efforts through the Education/GI Bill, Veteran Readiness and Employment, and Personalized Career Planning and Guidance programs assist Veterans in establishing and achieving education and employment goals that serve as further protective factors. VBA has strongly partnered with the expansion of data surveillance allowing increasing reporting on data, as shown in this annual report, which assists with providing further direction to suicide prevention efforts nationwide.

Additional initiatives have also been launched to further address the economic concerns that factor into suicide risk. In 2018, VHA launched Financial Hardship Assistance Program for High-Risk Veterans, a suicide prevention pilot project targeting VA-debt issues among high-risk Veterans. Facilities were encouraged to design intake/screening assessments to incorporate a standardized question about VA indebtedness for Veterans who were identified as high-risk. Suicide Prevention Coordinators (SPCs) then connected Veterans with facility revenue staff who work personally with Veterans to apply for a VA financial hardship program. The program remains active in encouraging site SPCs and revenue staff to collaborate on Veteran identification and support.

As part of VA's response to the COVID-19 pandemic, debt collection for Veterans was temporarily put on hold. To ensure Veterans would have appropriate access to necessary risk mitigation strategies, VA created a toolkit for the field to use to support Veterans who would be receiving these letters and provide them with a variety of debt resolution resources.

⁵⁸ VA S.A.V.E. training consists of: 1) Signs of suicidal thinking; 2) Ask the question; 3) Validate the Veteran's experience; and 4) Encourage treatment and Expedite getting help.

Additionally, education was provided regarding the debt collection process, debt resolution resources and the toolkit to all facility SPCs and the VCL. Further, in 2020 and 2021, VA's Office of Mental Health and Suicide Prevention funded a pilot project, to support Veterans at risk for financial distress, by developing a resource guide and financial literacy programming. This work has informed and led to the development of the National Center for Veteran Financial Empowerment. This center will provide Veterans with support and resources for their unique financial needs. VA is currently hiring a director to lead this center and a full launch for the program is underway. In addition to these advances, the last 2 years have seen closer collaboration with suicide prevention efforts in NCA. Gun lock distribution will launch later this year across all NCA cemeteries. NCA is also expanding suicide prevention training materials for all their sites accessible to individuals who visit NCA cemeteries. Enterprise-wide efforts are critical to ongoing implementation of the full National Strategy.

A Fully Engaged Nation in Veteran Suicide Prevention

Perhaps what is most encouraging at present is the large outpouring of support and desire to act in Veteran suicide prevention across Federal agencies and broadly into communities. This is palpably seen in the work of the U.S. Domestic Policy Council and its interagency efforts in suicide prevention and leadership in launching the White House *Reducing Military and Veteran Suicide* strategy this past fall (2021). Federal agencies are working in a unified manner to share best practices and move forward focused priorities across the Nation. We also see this specifically in the work of the renewed IPT charged with implementing the full strategy.

Additionally, great progress has been made with engaging 48 states and over 500 local suicide prevention coalitions in the work of Veteran suicide prevention. Collaborations continue to expand with new support from broader communities like the firearm industry and technology innovators. Suicide cannot be addressed solely by mental health clinicians, and VA is encouraged to see the wider community embracing this awareness that suicide is not simply a mental health problem. A recent analysis of 365 research studies across 50 years found that mental health indicators were only weakly correlated with suicide or suicide attempts.⁵⁹ While mental health concerns contribute to the risk for suicide, broader societal issues must be addressed.⁶⁰ Identifying those solutions focused on the individual alone will not solve the broader problem of suicide. Societal interventions can address broader risk beyond the individual level (e.g., LMS efforts, communication campaigns). VA, along with other health care systems, must engage new models of care, involve those outside the walls of a clinic and address broader systemic issues through community-based efforts, public health campaigns, education, focused strategic community coalition development and other collaborations.

Further, we must continue to expeditiously and strategically advance implementation of evidence-based clinical interventions focused specifically on suicide prevention^{61,62} while continuing to innovate and study new interventions in clinical settings. Access to evidence-based interventions inside and outside the VA system for Veterans at risk for suicide requires significant expansion, and part of our work together with the White House strategy for *Reducing Military and Veteran Suicide* is considering new models of access to care. In collaboration with the National Academies of Sciences, Engineering and Medicine and experts in access across the Nation, we will need to work to study new models of access that we can test across our system to ensure Veterans can take advantage of these evidence-based treatments. Finally, we need everyone at the table, leveraging work within and outside of clinical health care delivery systems to decrease both individual and societal risk factors for suicide. The public health approach reminds us that what we do can and does make a difference.

To refer to this report, please use the following citation:

U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. 2022 National Veteran Suicide Prevention Annual Report. 2022. Retrieved {insert date} from https://www.mentalhealth.va.gov/suicide_prevention/data.asp.

⁵⁹ Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., & Huang, X., et al. (2017). Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research. *Psychol. Bull.*, 143(2), 187-232.

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