VA | U.S. Department of Veterans Affairs

2020

National Veteran Suicide Prevention Annual Report

Office of Mental Health and Suicide Prevention

Table of Contents

Executive Summary

46,510 American adults died from suicide in 2018, including 6,435 U.S. Veterans. Here, we review, analyze, and report Veteran suicide data from 2005 to 2018, overall and across categories, including the number of suicide deaths, the average number of suicides per day, and suicide rates.[1] The report expands upon previous reports by including Veteran suicide rates by race and ethnicity, responding to issues of local, national, and international concern. We evaluate and report this data in the situational context of the coronavirus disease 2019 (COVID-19) pandemic; we therefore also provide VA COVID-19 suicide surveillance data available at the time of publication. With this exception, all data points rely on comprehensive cause of death data from joint VA and Department of Defense searches of the Centers for Disease Control and Prevention's National Death Index, which is available through 2018.

There are several Anchors of Hope initially highlighted in the report, across two significant themes:

1. There was not a significant increase in Veteran suicide rate, average deaths per day, or count from 2017 to 2018.
   - The age- and sex-adjusted rate among Veterans was not significantly different in 2018 (27.5 per 100,000) than in 2017 (27.3 per 100,000).
   - From 2017 to 2018, the average number of Veteran suicides per day rose from 17.5 to 17.6.
   - The annual total number of Veteran suicide deaths increased by 36 from 2017 to 2018, an increase of 0.6% (from 6,399 in 2017[2] to 6,435 in 2018), while the Veteran population fell by 1.5% (from 20.4 million to 20.1 million).
2. Veterans Health Administration (VHA) care matters.
   - Between 2017 and 2018, the age- and sex-adjusted suicide rate among Veterans with recent VHA use decreased by 2.4%, while among Veterans who did not use VHA care the rate increased by 2.5%.[3]
   - For VHA patients diagnosed with depression, the suicide rate decreased from 2005 to 2018, from 72.9 per 100,000 to 66.4 per 100,000. The 2018 suicide rate was an increase from 2017, with 65.1 per 100,000.
   - For VHA patients diagnosed with anxiety, the suicide rate decreased from 2005 to 2018, from 83.1 per 100,000 to 67.0 per 100,000. The 2018 suicide rate was an increase from 2017, with 65.6 per 100,000.
   - In 2018, VHA patients with any mental health or substance use disorder diagnosis had a suicide rate of 57.2 per 100,000, compared with 58.6 per 100,000 in 2005 and 57.9 per 100,000 in 2017.
   - The ratio of suicide rates among VHA-engaged Hispanic[4] male Veterans, compared to those among Hispanic male U.S. adults, was lower in 2018 than in 2017.

[1] Analyses were conducted for the years 2005–2018 to use complete and consistent data sources for the Veteran, Veteran user of Veterans Health Administration care, and non-Veteran populations.

[2] Note: This present report documents 6,399 Veteran suicides in 2017, while the 2019 National Veteran Suicide Prevention Annual Report listed 6,139 Veteran suicides in that year. This change is primarily due to improvements in the assessment of whether former Service members had been federally activated, a criterion for the federal definition of Veteran status. Additional changes were related to enhanced search and matching information. The report also applies the most current available data regarding the Veteran population, VetPop2018.

[3] This difference was not statistically significant.

[4] Information regarding Hispanic ethnicity was obtained from multiple VA patient record sources. Individuals were assumed to be of Hispanic ethnicity if their most common self-identified race was "Hispanic-White" or "Hispanic-Black" or if their most common self-identified ethnicity was "Hispanic." If self-identified information was unavailable, the most common non-self-identified values were used. For reporting purposes, Hispanic ethnicity was mutually exclusive from race categories. As a result, "White" represents White-Non-Hispanic and "Black" represents Black Non-Hispanic.

Key data points include the following:

- Suicide Count
    - Suicide continues to increase in the U.S. adult population. 46,510 American adults died by suicide in 2018, compared with 45,390 in 2017 and 31,610 in 2005.[5] Across the nation, the number of suicide deaths has been rising since the turn of the millennium.
    - From 2005 to 2018, there was a 47.1% increase in the number of suicide deaths in the general population, coinciding with an increase in the U.S. adult population from approximately 215 million to 253 million during this period. From 2017 to 2018, there was a 2.5% increase in the number of suicide deaths in the general population (from 45,390 to 46,510) and a 0.7% increase in the U.S. adult population (from 251 to 253 million).
    - In each year since 2008, the number of Veteran suicides has exceeded 6,300. 6,435 Veterans died by suicide in 2018, compared with 6,056 in 2005, an increase of 6.3%, despite a decrease in the Veteran population during this time period from 24.5 million to 20.1 million.[6] The annual total number of Veteran suicide deaths increased by 36 from 2017 to 2018, an increase of 0.6% (from 6,399 in 2017[7] to 6,435 in 2018), while the Veteran population fell by 1.5% (from 20.4 million to 20.1 million).
    - Within the years 2005–2018, the number of Veteran suicides per year was lowest in 2006 and highest in 2014. The total in 2018 was lower than in six of the years from 2005 to 2017.
    - In 2018, Veterans accounted for a lower proportion of suicide deaths among U.S. adults than in prior years. Veterans accounted for 13.8% of all deaths by suicide in 2018, compared to 19.2% in 2005 and 14.1% in 2017.
- Average Number of Suicide Deaths per Day
    - The average number of suicide deaths per day continues to increase within the general population. The average rose from 86.6 per day in 2005 to 124.4 in 2017 and 127.4 in 2018.
    - The average number of Veteran suicides per day rose from 16.6 in 2005 to 17.6 in 2018. From 2017 to 2018, the average number of Veteran suicides per day rose from 17.5 to 17.6.

[5] The U.S. adult population, including Veterans, increased from 214,524,444 in 2005 to 252,806,449 in 2018, per U.S. Census Bureau, American Community Survey, 2018 American Community Survey 1-Year Estimates, Table B21001; Generated by VA OMHSP, using ***https://data.census.gov/cedsci/*** (25Mar2020).

[6] The U.S. Veteran population decreased from approximately 24.5 million to 20.1 million during this period.

[7] Note: This report documents 6,399 Veteran suicides in 2017, while the 2019 National Veteran Suicide Prevention Annual Report listed 6,139 Veteran suicides in that year. This change is primarily due to improvements in the assessment of whether former Service members had been federally activated, a criterion for the federal definition of Veteran status. Additional changes were related to enhanced search and matching information. The report also applies the most current available data for the Veteran population, VetPop2018.

- Suicide Rates
  - Overall, from 2005 to 2018, the age- and sex-adjusted[8] suicide rates among Veterans were higher and rose faster than those among non-Veteran U.S. adults. The age- and sex-adjusted suicide rate for the Veteran population rose from 18.5 suicide deaths per 100,000 in 2005 to 27.5 suicide deaths per 100,000 in 2018. The rate rose slightly from 2017 (27.3 per 100,000) to 2018 (27.5 per 100,000).[9] Among both Veteran and non-Veteran U.S. adults, changes in age- and sex-adjusted suicide rates from 2017 to 2018 were not statistically significant. For Veterans these rates were 27.3 and 27.5 per 100,000, and for non-Veteran U.S. adults they were 17.9 and 18.2 per 100,000, respectively.
  - The unadjusted suicide rate among Veterans rose from 24.7 per 100,000 in 2005 to 31.3 per 100,000 in 2017 and 32.0 per 100,000 in 2018. Among non-Veteran U.S. adults, the unadjusted rate rose from 13.5 per 100,000 to 16.9 per 100,000 in 2017 and 17.2 per 100,000 in 2018.
  - While in 2005 the Veteran suicide rate was 1.2 times the rate for non-Veteran adults, in each year from 2013 through 2018 the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, after adjusting for differences in age and sex.
  - Suicide rates for those engaged in VHA care decreased from 2017 to 2018.
    - From 2005 to 2018, age- and sex-adjusted suicide rates increased by 25.6% for Veterans with recent VHA use and 57.0% for Veterans without recent VHA use. Between 2017 and 2018, the age- and sex-adjusted suicide rate among Veterans with recent VHA use[10] decreased by 2.4%, while among Veterans who did not use VHA care the rate increased by 2.5%.[11]
    - Among women Veterans in VHA care, suicide counts decreased from 94 in 2017 to 81 in 2018 and age-adjusted rates decreased from 15.7 per 100,000 to 14.0.[12] Both years' counts and rates represent an increase over the count (56) and rate (13.8 per 100,000) in 2005.

[8] Adjusting for population differences, for example in age and sex, ensures that differences in rates are not driven by differences associated with these measures. Adjusted rates can be interpreted as the hypothetical rate that would have occurred if the observed age- or age- and sex-specific rates were present in a population with the age or age and sex distribution of the standard population. Useful for comparisons, they do not measure magnitude of differences. To compare rates in terms of absolute magnitude, we compare crude rates. See ***https://www.cdc.gov/nchs/data/statnt/statnt06rv.pdf***.

[9] The change from 2017 to 2018 was not statistically significant.

[10] Recent Veteran VHA users are defined as Veterans with a VHA encounter in the year of death or the prior year.

[11] This difference in age- and sex-adjusted rates comparing 2017 and 2018 was not statistically significant.

[12] The difference in rates from 2017 to 2018 was not statistically significant.

- Race/Ethnicity
    - Overall suicide rates and trends of increase were lower among Black Veterans than among White Veterans.
    - The ratio of age-adjusted suicide rates for male Hispanic Veterans in VHA care to rates among all male Hispanic U.S. adults was 1.96 in 2005, 2.06 in 2017, and 1.46 in 2018.
    - Further work is needed to understand factors associated with Veteran suicide, including differences by race and ethnicity.
- Lethal Means
    - In 2018, firearms were the method of suicide in 69.4% of male Veteran suicide deaths and 41.9% of female Veteran suicide deaths.
- Never Federally Activated Former Service Members
    - There were 538 suicides among never federally activated former Service members in 2018, an average of 1.5 suicide deaths per day. This is separate from the average of 17.6 suicides per day among Veterans.
    - By comparison, the count of suicide deaths among never federally activated former Service members was 471 (average of 1.3 per day) in 2005 and 554 (average of 1.5 per day) in 2017.
- COVID-19 Pandemic
    - In the context of the COVID-19 pandemic, VA is monitoring trends in suicide-related behaviors. Thus far, findings do not indicate increases in suicide-related behavior among Veterans in VHA care.

While we are heartened by the Anchors of Hope, we are simultaneously burdened by the loss of every Veteran to suicide. We recognize the work yet needing to be done, and we welcome broad partnership and collaboration toward eradicating Veteran suicide.

Suicide as a National Problem

The coronavirus disease 2019 (COVID-19) pandemic has affected our nation at the societal and individual levels. Suicide deaths, rates, and trends during the COVID-19 pandemic cannot accurately be determined at this point in time. This report, which includes the most recent national suicide mortality data, through 2018, will inform continued efforts implementing the national strategy, combining evidence-based clinical interventions and proactive community-based prevention strategies to address the ongoing problem of suicide in our nation — for Veterans and non-Veterans alike.

Anchors of Hope

Findings documented in this report highlight the continuing and increasing problem of suicide among U.S. adults and among Veterans, and the need for ongoing efforts to improve methods of suicide risk mitigation. Yet there are within the report signals of improvement and of hope. We turn first to highlight these areas deliberately as a reminder to all that there is always hope, as we continue to move together in this daily Mission to end Veteran suicide.

Anchor 1: From 2017 to 2018, adjusted suicide rates fell among Veterans with recent VHA care, while rising among other Veterans.

- Between 2017 and 2018, the age- and sex-adjusted suicide rate among Veterans with recent VHA use decreased by 2.4%, while among Veterans who did not use VHA care the rate increased by 2.5%.[13]
- As compared with 2005, age- and sex-adjusted rates among Veterans with recent VHA use in 2018 increased by 25.6%, or 5.8 deaths per 100,000, and among Veterans who did not use VHA care the rate increased by 57.0%, or 9.9 deaths per 100,000.

Anchor 2: Among Veterans in VHA care, rates fell from 2005 to 2018 in those with depression, anxiety, and substance use disorders.

- For VHA patients diagnosed with depression, the suicide rate decreased from 2005 to 2018, from 72.9 per 100,000 to 66.4 per 100,000. The 2018 suicide rate was an increase from 2017's rate, 65.1 per 100,000.
- For VHA patients diagnosed with anxiety, the suicide rate decreased from 2005 to 2018, from 83.1 per 100,000 to 67.0 per 100,000. The 2018 suicide rate was an increase from 2017's rate, 65.6 per 100,000.
- In 2018, VHA patients with any mental health or substance use disorder diagnosis had a suicide rate of 57.2 per 100,000, compared with 58.6 per 100,000 in 2005 and 57.9 per 100,000 in 2017.

Anchor 3: In 2018, suicide rates decreased for specific Veteran populations engaged in VHA care.

VHA is working to understand and address health care disparities for Veterans, including in VHA mental health care.

- Findings document a recent decrease in suicide risk among male Hispanic Veterans engaged in VHA care.

[13] This difference was not statistically significant.

- The ratio of suicide rates among VHA-engaged Hispanic[14] male Veterans to rates among Hispanic male U.S. adults was lower in 2018 than in 2017.
- Further, overall suicide rates and trends of increase were lower among Black Veterans than among White Veterans.
- Among women Veterans with recent VHA care, suicide counts and rates decreased from 2017 to 2018.[15] Among other women Veterans, the number of suicide deaths was unchanged from 2017 to 2018.

Ongoing work is needed to understand factors associated with Veteran suicide, including differences by race and ethnicity, as well as study of treatment intervention outcomes across all populations.

Anchor 4: The Veteran suicide rate did not increase significantly between 2017 and 2018.

- The age- and sex-adjusted rate among Veterans was not significantly different in 2018 (27.5 per 100,000) than in 2017 (27.3 per 100,000). However, the 2018 rate was significantly higher than the rate in 2005 (18.5 per 100,000).

Anchor 5: There is a groundswell of support for coordinated efforts at the local, regional, and national levels to implement a public health approach to end suicide.

VA's 2018 *National Strategy for Preventing Veteran Suicide* (National Strategy)[16] defined a broad vision for implementation of a public health approach to end suicide. In 2020, VA translated the vision offered by the 10-year National Strategy and its four major domains into operational plans of actions through the Suicide Prevention 2.0 initiative (SP 2.0) and the Suicide Prevention Now initiative (Now). SP 2.0 focuses on nationally implementing and operationalizing across a 6-year period new and bundled community-based and clinically based services and programs reflective of the National Strategy. The Now initiative focuses on enhancing, expanding, and reinforcing existent suicide prevention clinical and outreach services, including predictive analytics, safety planning in the emergency department, caring contacts, lethal means safety training and resources, and universal suicide screening.

- In 2020, 20 additional states have been incorporated into the VA/Substance Abuse and Mental Health Services Administration Governor's Challenge, for a total of 27 states currently involved. The program continues to advance toward its goal of expanding to all 50 states and U.S. territories over the next two years.
- In 2020, VA launched the expansion of evidence-based psychotherapies for suicide prevention, as outlined in the ***VA/Department of Defense Clinical Practice Guideline on the Assessment and Management of Patients at Risk for Suicide***, to reach Veterans across all 140 of its health care systems and through all 18 of its telehealth hubs.
- The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) was signed on June 17, 2020, and launched a nationwide charter to raise awareness about mental health, connect Veterans and others at risk of suicide to federal and local resources, and facilitate focused and coordinated research into suicide.

VA is committed to understanding Veteran suicide and applying epidemiological findings to inform Veteran suicide prevention while also proactively implementing outreach, programs, and interventions to end suicide. While we have these Anchors of Hope, we now turn to reviewing the results of the full report, followed by outlining our past and current engagements with all the nation to address this national heartbreaking concern.

[14] Information regarding Hispanic ethnicity was obtained from multiple VA patient record sources. Individuals were assumed to be of Hispanic ethnicity if their most common self-identified race was "Hispanic White" or "Hispanic Black" or if their most common self-identified ethnicity was "Hispanic." If self-identified information was unavailable, the most common non-self-identified values were used. For reporting purposes, Hispanic ethnicity was mutually exclusive from race categories. As a result, "White" represents White-Non-Hispanic and "Black" represents Black-Non-Hispanic.

[15] The difference in rates from 2017 to 2018 was not statistically significant.

[16] Department of Veterans Affairs (2018). National Strategy for Preventing Veteran Suicide. Washington, DC. Available at ***https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.***

Understanding the Cultural Context of Suicide

Suicide has no single causative explanation or pathway;[17] in turn, there is likely no single solution.[18]

The loss of any individual to suicide cannot typically be explained by individual factors alone. The problem of suicide reflects a complex interaction of factors placing strain on individuals at the international level (e.g., wars, global pandemic), national level (e.g., economic disparities, health care policies), community level (e.g., employment rates, access to care), familial and relational level (e.g., level of support, relationship problems), and individual level (e.g., health concerns). U.S. suicide rates have reflected over time these unique complexities of interaction, as rates vary by region and state, by demographics, by occupation, and more.

Beyond the complex interaction of multiple and dynamic risk factors, certain suicide risk factors have been found to meaningfully impact Veterans, as well as in some cases to differentiate risk for Veterans who receive VHA services versus Veterans who do not receive VHA services. Specifically, suicide rates among Veteran users of VHA services are higher overall from 2005 to 2018 in comparison to those among non-VHA Veterans. According to various studies, a multitude of societal factors may affect Veteran suicide rates; these factors and corresponding data points are outlined below.

Societal Factors Related to Suicide	Impact on Veterans as Described in the Literature
Economic Disparities	• Veterans enrolled in VHA care are less likely to be employed and more likely to have lower income levels than Veterans not receiving VHA care.[19] • Some Veterans report difficulty in transitioning to civilian positions and difficulty translating military-related skills to higher-paying civilian jobs. • Unemployment and poverty are correlated with homelessness among Veterans. • More recently, with the nation's experience of the COVID-19 pandemic, there has been an increase in unemployment among Veterans. In April 2020, there were 833,000 more unemployed Veterans than in April 2019. Over this time, the Veteran unemployment rate increased from 2.3% to 11.7%.[20]

[17] Turecki, G., Brent, D.A. (2016) Suicide and suicidal behavior. Lancet. 387:12271,227–39.

[18] Zalsman G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., … Zohar, J. (2016) Suicide prevention strategies revisited: 10-year systematic review. Lancet. 3:646–59.

[19] Eibner, C., Krull, H., Brown, K., Cefalu, A., Mulcahy, A. W., Pollard, M., … Farmer, C. M. (2016). Current and projected characteristics and unique health care needs of the patient population served by the Department of Veterans Affairs. RAND Health Quarterly, 5(4), 13. Accessed at ***https://www.rand.org/pubs/periodicals/health-quarterly/issues/v5/n4/13.html.***

[20] U.S. Bureau of Labor Statistics. ***https://www.bls.gov/news.release/empsit.t05.htm*** (accessed 5/27/2020).

Societal Factors Related to Suicide	Impact on Veterans as Described in the Literature
Race, Ethnicity, and LGBT Disparities	• Suicide rates vary by race and ethnicity. In the U.S., suicide rates are highest among American Indian and Alaska Native populations, followed by White populations.[21] • Racial and ethnic groups differ in experiences of discrimination and historical trauma and in access to culturally appropriate mental health treatment, which may be related to suicide risk.[22] • During the COVID-19 pandemic, the rate of suicidal ideation reported in the last 30 days was noted to be significantly higher for certain populations, including racial and ethnic minority populations (e.g., Hispanic, non-Hispanic Black). • Veterans with LGBT or related identities may be at elevated risk for suicide.[23] • Lesbian, gay, and bisexual Veterans are more likely to report suicidal ideation and to screen positive for posttraumatic stress disorder, depression, and alcohol problems than heterosexual Veterans.[24,25]
Homelessness	• It is estimated that 37,085 Veterans were homeless and 14,345 were living on the street or unsheltered on any given night in 2019.[26] • VHA patients with indications of homelessness or who received homelessness-related services had higher rates of suicide than other VHA patients.[27]
Service Connection	• VHA patients with military service-connected disability status may have lower risk of suicide than other VHA patients.[28]

[21] Curtin SC, Hedegaard H. Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017. NCHS Health E-Stat. 2019.

[22] Joe, S., Silvia, S. C., & Romer, C. (2008). Advancing prevention research on the role of culture in suicide prevention. Suicide and Life-Threatening Behavior, 38(3), 354–362.

[23] Matarazzo, B.B., Barnes, S.M., Pease, J.L., Russell, L.M., Hanson, J.E., Soberay, K.A., & Gutierrez, P.M. (2014). Suicide Risk among Lesbian, Gay, Bisexual, and Transgender Military Personnel and Veterans: What Does the Literature Tell Us? Suicide and Life-Threatening Behavior, 44(2), 200–217.

[24] Blosnich, J.R., Bossarte, R.M., Silenzio, V.M.B. (2012). Suicidal Ideation Among Sexual Minority Veterans: Results from the 2005–2010 Massachusetts Behavioral Risk Factor Surveillance Survey. American Journal of Public Health, 102(S1), S44–S47.

[25] Cochran, B.N., Balsam, K., Flentje, A., Malte, C.A., & Simpson, T. (2013). Mental Health Characteristics of Sexual Minority Veterans. Journal of Homosexuality, 60(2–3), 419–435.

[26] Department of Housing and Urban Development. HUD 2019 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations. September 20, 2019. ***https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2019.pdf***

[27] McCarthy, J.F., Bossarte, R., Katz, I.R., Thompson, C., Kemp, J., Hannemann, C., Nielson, C., Schoenbaum, M. (2015) Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. American Journal of Public Health. 105(9):1935–42.

[28] McCarthy, J.F., Bossarte, R., Katz, I.R., Thompson, C., Kemp, J., Hannemann, C., Nielson, C., Schoenbaum, M. (2015) Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. American Journal of Public Health. 105(9):1935–42.

Societal Factors Related to Suicide	Impact on Veterans as Described in the Literature
Social Connection and Isolation	• Isolation is a risk factor for suicide,[29] which is a significant concern given social distancing practices to reduce the spread of COVID-19. • Among VHA patients, suicide rates are highest among those who are divorced, widowed, or never married, and rates are lowest among those who are married.[30] • Suicide rates are elevated among individuals residing in rural areas.[31]
Health and Well-Being	• VHA patients who died by suicide are more likely to have sleep disorders, traumatic brain injury, or a pain diagnosis than other VHA patients.[32] • Mental health diagnoses (including bipolar disorder, personality disorder, substance use disorder, schizophrenia, depression, and anxiety disorders), inpatient mental health care, prior suicide attempts, prior calls to the Veterans Crisis Line, and prior mental health treatment are associated with greater likelihood of suicide.[33]

The sociocultural context of suicide leads to the conclusion that a national plan to end suicide is needed through a systematic, public health approach combining both community-based prevention strategies and clinically based interventions. In the time since VA's previous suicide report,[34] issues of local, national, and international concern have focused attention on suicide risk associated with Veteran race/ethnicity and the ongoing international COVID-19 pandemic. The current report includes new information regarding differences in Veteran suicide rates by race and summarizes ongoing suicide surveillance related to the COVID-19 pandemic.

Annual VA Suicide Report Update

The Department of Veterans Affairs conducts ongoing suicide surveillance to inform Veteran suicide prevention. For the overall Veteran population, this work began in 2016, when VA completed the largest analysis of Veteran suicide to date.[35] This work has continued each year since, with ongoing data enhancements. This year's report examines mortality records from all 50 states and Washington, D.C., for the period 2005 to 2018. The report provides information regarding Veteran suicide counts, averages per day, rates, and differences in rates of suicide by receipt of VHA services. It also provides data

[29] Steele, I. H., Thrower, N., Noroian, P., & Saleh, F. M, (2017). Understanding suicide across the lifespan: A United States perspective of suicide risk factors, assessment and management. Journal of Forensic Sciences, 63 (1), 162–171. Doi: 10.1111/1556-4029.13519. Accessed at ***https://onlinelibrary.wiley.com/doi/full/10.1111/1556-4029.13519.***

[30] McCarthy, J.F., Bossarte, R., Katz, I.R., Thompson, C., Kemp, J., Hannemann, C., Nielson, C., Schoenbaum, M. (2015) Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. American Journal of Public Health. 105(9):1935–42.

[31] McCarthy JF, Blow FC, Ignacio RV, Ilgen MA, Austin KL, 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.

[32] McCarthy, J.F., Bossarte, R., Katz, I.R., Thompson, C., Kemp, J., Hannemann, C., Nielson, C., Schoenbaum, M. (2015) Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. American Journal of Public Health. 105(9):1935–42.

[33] McCarthy, J.F., Bossarte, R., Katz, I.R., Thompson, C., Kemp, J., Hannemann, C., Nielson, C., Schoenbaum, M. (2015) Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. American Journal of Public Health. 105(9):1935–42.

[34] ***https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf***

[35] Department of Veterans Affairs, Veterans Health Administration, Office of Suicide Prevention. Suicide among Veterans and other Americans 2001–2014. August 2016.

regarding suicide rates among specific Veteran subpopulations. The report uses the most comprehensive information regarding Veteran status, the Veteran population, and suicide mortality. For this reason, results should not be compared with information in previous reports: This report provides the most current information for all years.

Veteran Status

It is important to consider Veteran suicide in the context of suicide mortality among all U.S. adults. Also, in reporting on Veteran suicide, we focus on those former Service members who, from the available data, most closely meet the official definition of Veteran status used by VA and other federal agencies.[36] For this report, a Veteran is defined as someone who had been activated for federal military service and was not currently serving at the time of death.

This year's report focuses on Veterans as defined above.[37] We include information in a separate section on suicide among former Service members who were never federally activated.[38] Information regarding individuals who died by suicide during U.S. military service is available from the Department of Defense.[39]

Rates: Crude and Adjusted

The current report presents information on crude and adjusted suicide rates. Crude rates are helpful for understanding the burden of suicide in a given population at a given time. They do not account for age, sex, or other differences between populations. Adjusted rates are helpful for comparing across populations or periods — for example, comparing Veterans who use VHA care to those who do not.[40]

[36] Section 101(2) of Title 38, United States Code defines "Veteran" for purposes of the title to mean "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." ***https://www.ssa.gov/OP_Home/comp2/D-USC-38.html***. For purpose of this report, Veterans were defined as persons who had been activated for federal military service and were not currently serving at the time of death.

[37] Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. 2019 National Veteran Suicide Prevention Annual Report. October 2019. ***https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf***; Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. VA National Suicide Prevention Data Report: 2005–2016. September 2018. ***https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf***

[38] Improved methodologies by the Department of Defense (DoD) Defense Manpower Data Center in querying historical DoD service record data enabled more complete assessment of whether former Service members had been federally activated. This enhanced identification of Veteran suicide decedents, however available data does not distinguish between those who served in the National Guard or Reserve.

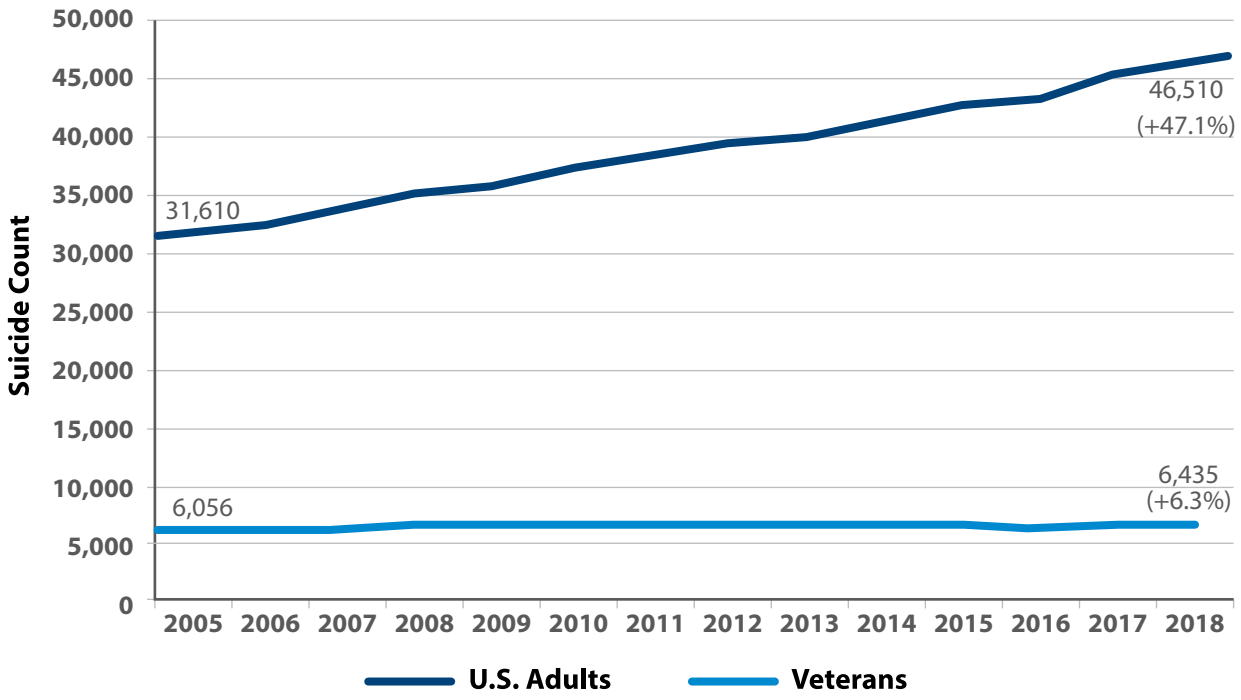
[39] For information on suicide among current Service members, official suicide counts are published in the Department of Defense (DoD) Quarterly Suicide Report, available at ***www.dspo.mil/Prevention/Data-Surveillance/Quarterly-Reports***.

[40] Adjusting for population differences, for example in age and sex, ensures that differences in adjusted rates are not driven by differences in these measures. Adjusted rates can be interpreted as the hypothetical rate that would have occurred if the observed age-specific rates were present in a population with the age distribution of the standard population. Useful for comparisons, they do not measure magnitude of differences. To compare rates in terms of absolute magnitude, we compare crude rates. See: ***https://www.cdc.gov/nchs/data/statnt/statnt06rv.pdf***.

Suicide Data Throughout the United States

- 46,510 American adults died by suicide in 2018, compared with 45,390 in 2017 and 31,610 in 2005.[41]
- These deaths included 6,435 Veterans in 2018, compared with 6,399 in 2017[42] and 6,056 in 2005.[43]
- From 2005 through 2018, the proportion of suicide deaths in the U.S. attributable to the Veteran population decreased steadily. In 2005, Veterans accounted for 19.2% of all deaths by suicide while representing 11.4% of the U.S. adult population; in 2017, Veterans accounted for 14.1% of all deaths by suicide among U.S. adults while constituting 8.1% of the U.S. adult population; and in 2018, Veterans accounted for 13.8% of all deaths by suicide among U.S. adults and constituted 8.0% of the U.S. adult population.

Graph 1. Number of Suicides, U.S. Adult and Veteran Populations, 2005–2018



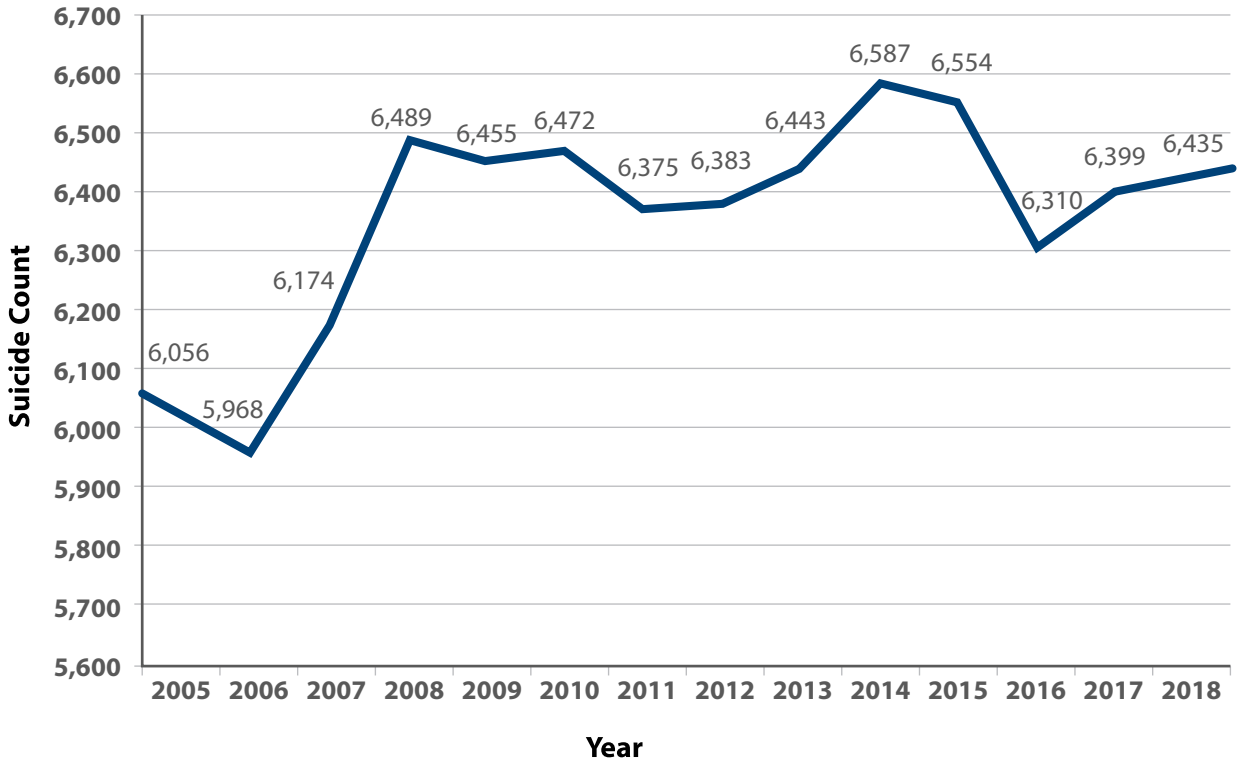
- Across the nation, the number of suicide deaths has been rising. From 2005 to 2018, there was a 47.1% increase in the number of suicide deaths in the U.S. adult population, including a 6.3% increase in the number of suicide deaths in the Veteran population. From 2017 to 2018, increases were 2.5% among U.S. adults and 0.6% among Veterans, respectively.

[41] The U.S. adult population increased from approximately 215 million to 253 million during this period.

[42] Note: this present report documents 6,399 Veteran suicides in 2017, while the 2019 National Veteran Suicide Prevention Annual Report listed 6,139 Veteran suicides in that year. This change is primarily due to improvements in the assessment of whether former Service members had been federally activated, a criterion for the federal definition of Veteran status. Additional changes were related to enhanced search and matching information. The report also applies the most current available data regarding the Veteran population, VetPop2018.

[43] The U.S. Veteran population decreased from approximately 24.5 million to 20.1 million during this period.

Graph 2. Number of Veteran Suicides, 2005–2018



- In 2005, an average of 86.6 American adults, including Veterans and non-Veterans, died by suicide each day. An average of 124.4 and 127.4 American adults died by suicide each day in 2017 and 2018, respectively.
- Since 2008, the average number of Veteran suicide deaths per day has remained between 17 and 18 annually. In 2018, an average of 17.6 Veterans died by suicide each day.

Veteran Suicide in the U.S.

Veterans do not live, work, and serve in isolation from their communities, the nation, or the world. The issue of suicide in the U.S. also affects the Veteran population. Below, we provide the most current Veteran suicide data, looking at both Veterans served by VHA and Veterans not accessing VHA care.

Total Number of Veteran Suicides, 2005–2018[44]

As is true of the U.S. population broadly, the Veteran population has experienced an increase in the number of deaths by suicide.

- The number of Veteran suicide deaths per year increased from 6,056 in 2005 to 6,399 in 2017[45] and 6,435 in 2018.
- The annual number of Veteran suicide deaths has exceeded 6,300 since 2008.
- The annual number of Veteran suicide deaths increased by 36 from 2017 to 2018, and by 379 from 2005 to 2018.
- The number of Veteran suicides per year was lowest in 2006 and highest in 2014, and the number in 2018 was lower than in six of the prior 13 years.

Average Number of Veteran Suicides per Day, 2005–2018[46]

The average number of Veteran suicides per day increased from 2005 to 2018.

- From 2005 through 2018, the average number of U.S. adults who died by suicide each day rose steadily. In 2005, an average of 86.6 American adults, including Veterans, died by suicide each day. There were an average of 124.4 deaths each day in 2017 and an average of 127.4 in 2018.
- Since 2005, the average number of Veteran suicide deaths per day has remained between 17 and 18, despite observed decreases in the size of the Veteran population. In 2018, an average of 17.6 Veterans died by suicide each day.
- The average of 17.6 Veteran suicide deaths per day in 2018 was higher than the 17.5 average suicide deaths per day in 2017. In 2018, the average of 17.6 Veteran suicides per day comprised 6.5 Veterans with recent VHA use and 11.1 Veterans without recent VHA use.

[44] The numbers reported in this section are actual counts of Veterans who died by suicide. Beyond the total count, unadjusted rate calculations can be helpful for understanding the burden of mortality within each population in a given time period. Adjusted rates are used to account for differences between populations, e.g., in age and sex. For further discussion and a presentation of suicide rates, see Page 12.

[45] Note: This report documents 6,399 Veteran suicides in 2017, while the 2019 National Veteran Suicide Prevention Annual Report listed 6,139 Veteran suicides for that year. This change is primarily due to improvements in the assessment of whether former Service members had been federally activated, a criterion for the federal definition of Veteran status. Additional changes were related to enhanced search and matching information. The report also applies the most current available data regarding the Veteran population, VetPop2018.

[46] Initial VA reporting regarding average suicide deaths per day included suicides among Veterans, current Service members, and never federally activated former Guard and Reserve members. In reporting on suicide deaths through 2016, information was provided regarding Veterans and, separately, the number of deaths among never federally activated former Guard and Reserve members. In this year's report, we focus on Veterans, and, in supplemental reporting, we provide counts for never federally activated former Service members. Information regarding suicide among current Service members is available from the Department of Defense Suicide Prevention Office. The average number of deaths per day is calculated as the number of deaths in the year divided by the number of days in that year.

Table 1. Total and Daily Average Number of Veteran Suicide Deaths, 2005–2018

Year	Suicide Deaths	Average per Day
2005	6,056	16.6
2006	5,968	16.4
2007	6,174	16.9
2008	6,489	17.7
2009	6,455	17.7
2010	6,472	17.7
2011	6,375	17.5
2012	6,383	17.4
2013	6,443	17.7
2014	6,587	18.0
2015	6,554	18.0
2016	6,310	17.2
2017	6,399	17.5
2018	6,435	17.6

Age- and Sex-Adjusted Suicide Rate, 2005–2018

The Veteran population decreased by 18% from 2005 to 2018 and by 1.5% from 2017 to 2018. To allow for comparisons between populations and over time, suicide rates have been adjusted to account for population differences by age and sex.[47]

- From 2005 to 2018, the age- and sex-adjusted suicide rate for the overall U.S. adult population increased from 14.7 suicide deaths per 100,000 to 18.0 per 100,000 in 2017 and 18.3 per 100,000 in 2018.
- The suicide rates for both Veterans and non-Veteran adults increased between 2005 and 2018. Among both Veteran and non-Veteran U.S. adults, changes in age- and sex-adjusted suicide rates from 2017 to 2018 were not statistically significant. For Veterans these rates were 27.3 and 27.5 per 100,000, and for non-Veteran U.S. adults they were 17.9 and 18.2 per 100,000, respectively.

[47] As noted on Page 12, crude or unadjusted rates are helpful for understanding the magnitude of mortality in a population at a given time. The Veteran population is older and has a higher percentage of men than the non-Veteran U.S. adult population. Therefore, we also include age- and sex-adjusted rates, per the U.S. 2000 Standard Population. For Veterans overall, Veterans without recent VHA use, the total U.S. adult population, and the non-Veteran adult population, annual rates are calculated per 100,000 population members. Risk time can be calculated exactly for Veterans with recent VHA use, and rates were calculated per 100,000 person-years for VHA Veteran-focused analyses. Comparisons including Veteran VHA users and other populations employed rates per 100,000 population members for both groups.

- The U.S. adult population, including Veterans and non-Veteran adults, increased by 17.8% from 2005 to 2018, including a 0.7% increase from 2017 to 2018.
- The Veteran population decreased by 18.0% from 2005 to 2018, including a 1.5% decrease from 2017 to 2018.
- The age- and sex-adjusted suicide rate for the Veteran population increased from 18.5 suicide deaths per 100,000 in 2005 to 27.5 per 100,000 in 2018.
- The age- and sex-adjusted suicide rate for the Veteran population increased from 27.3 suicide deaths per 100,000 in 2017 to 27.5 suicide deaths per 100,000 in 2018.[48]
- In 2018, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, after adjusting for age and sex; this is unchanged from 2017 but greater than 2005's differential of 1.2.
- Over the period 2005–2018, age- and sex-adjusted suicide rates rose faster among Veterans than among non-Veteran U.S. adults.[49]

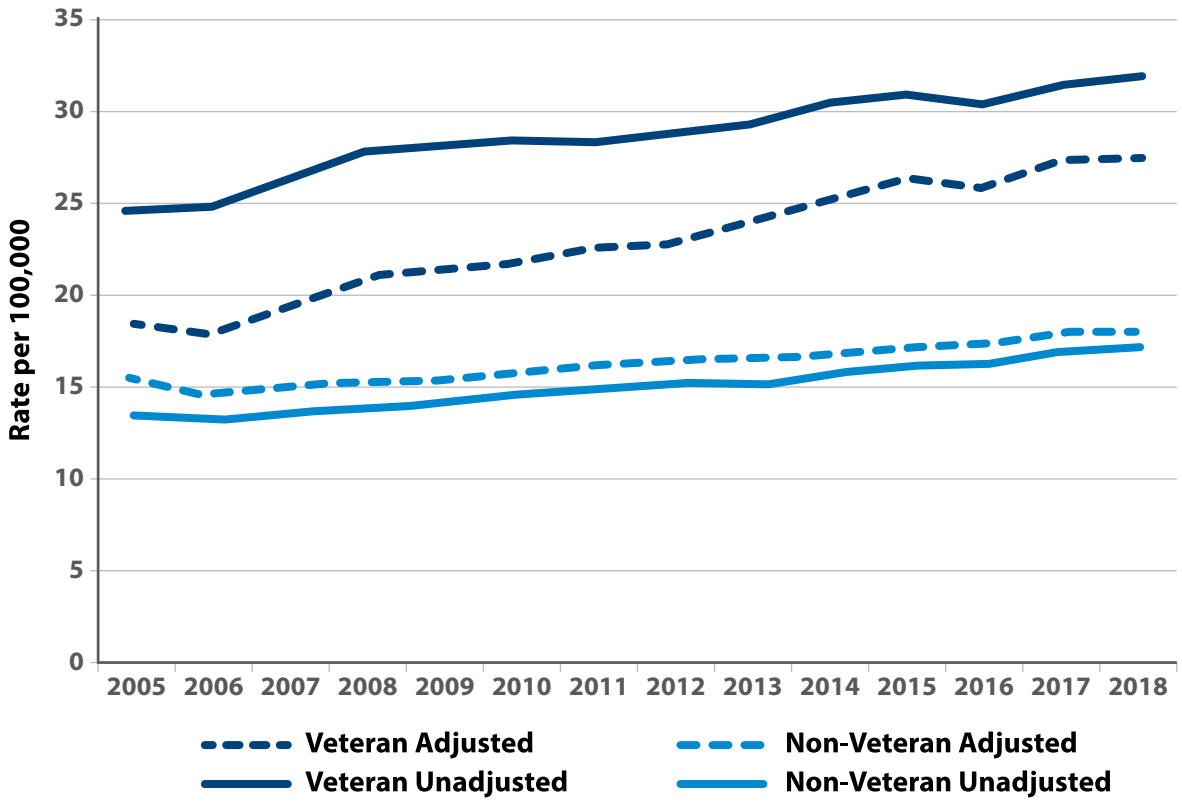
Table 2. Age- and Sex-Adjusted Veteran Suicide Rate per 100,000 Population, 2005–2018

Year	Suicide Deaths	Average per Day	Veteran Population	Age- and Sex- Adjusted Suicide Rate
2005	6,056	16.6	24,546,000	18.5
2006	5,968	16.4	24,020,000	17.8
2007	6,174	16.9	23,597,000	19.1
2008	6,489	17.7	23,295,000	20.9
2009	6,455	17.7	22,914,000	21.4
2010	6,472	17.7	22,739,000	21.8
2011	6,375	17.5	22,472,000	22.6
2012	6,383	17.4	22,143,000	22.8
2013	6,443	17.7	21,977,000	24.0
2014	6,587	18.0	21,601,000	25.2
2015	6,554	18.0	21,175,000	26.3
2016	6,310	17.2	20,813,000	25.8
2017	6,399	17.5	20,423,000	27.3
2018	6,435	17.6	20,126,000	27.5

[48] This change, from 2017 to 2018, was not statistically significant.

[49] In order to assess whether trends over time differed for Veterans versus non-Veteran U.S. adults, we conducted regression analyses for the period 2005–2018, including rate data by year for each group. Findings indicated a greater average increase per year among Veterans (0.76 per 100,000) than was observed among non-Veteran U.S. adults (0.25 per 100,000). This difference was statistically significant ($p<0.001$), which confirms that rates rose faster among Veterans than non-Veterans. Additional analyses over this time period considered subgroups of Veteran and of non-Veteran U.S. adults by age and sex. These indicated that the highest increases in suicide rates were among Veteran and non-Veteran men aged 18–34. Among these men, rates also increased significantly faster among Veterans ($p<0.001$).

Graph 3. Unadjusted and Age- and Sex-Adjusted Suicide Rates for Veterans and Non-Veteran Adults, 2005–2018



Age- and Sex-Adjusted Suicide Rates[50] for Veterans Who Used VHA Health Care, 2005–2018

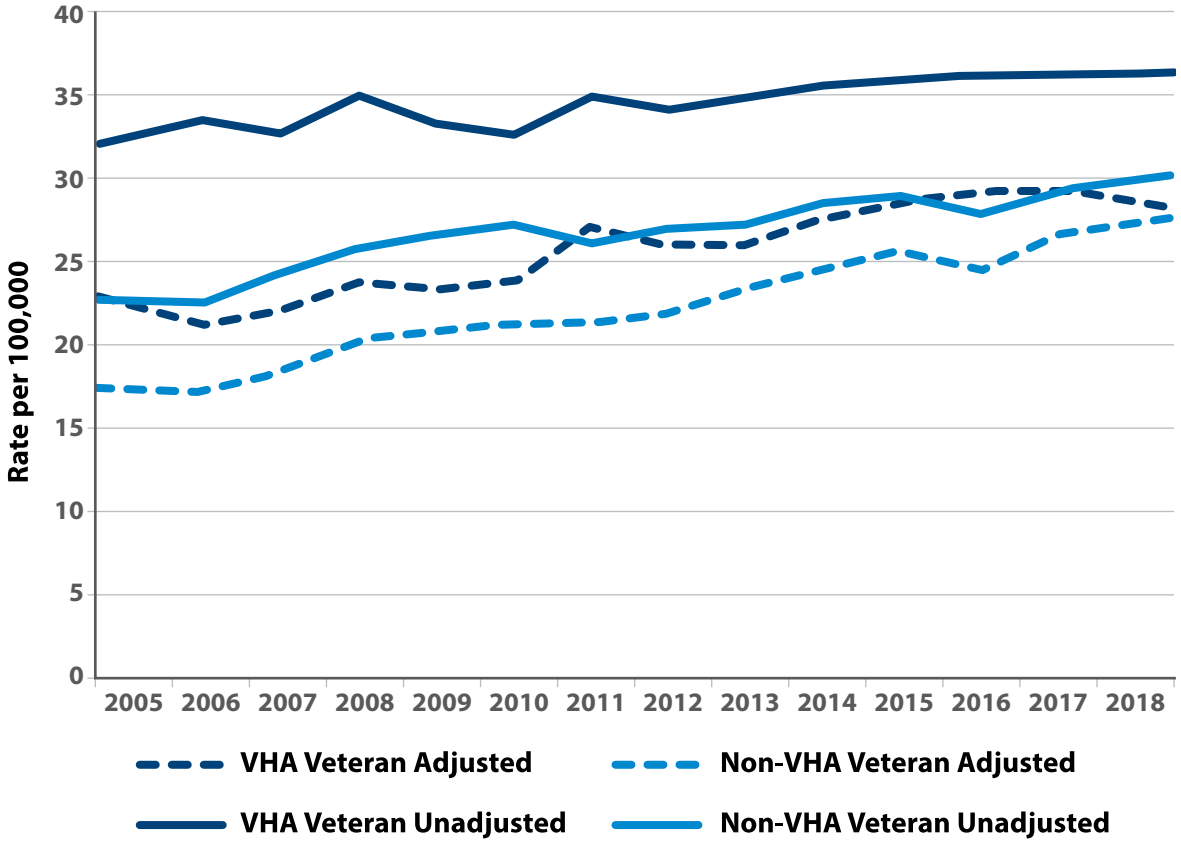
This section presents information on suicide deaths and rates among Veterans with recent use of VHA care and those without recent VHA use. Veterans who had recently used VHA care are defined as Veterans who had a VHA health encounter in the calendar year of interest or in the prior calendar year.

- Between 2017 and 2018, the age- and sex-adjusted suicide rate among Veterans with recent VHA use decreased by 2.4% (from 29.3 to 28.6 per 100,000), while the rate increased by 2.5% among Veterans who did not use VHA care (from 26.6 to 27.3 per 100,000).[51]

[50] As noted earlier, use of adjusted rates is necessary when comparing populations or time periods to ensure comparability in case there are underlying differences in factors that may relate to suicide risk. Suicide rates differ substantially by age and sex in the United States, and consequently adjusted rates account for age and sex.

[51] This difference was not statistically significant.

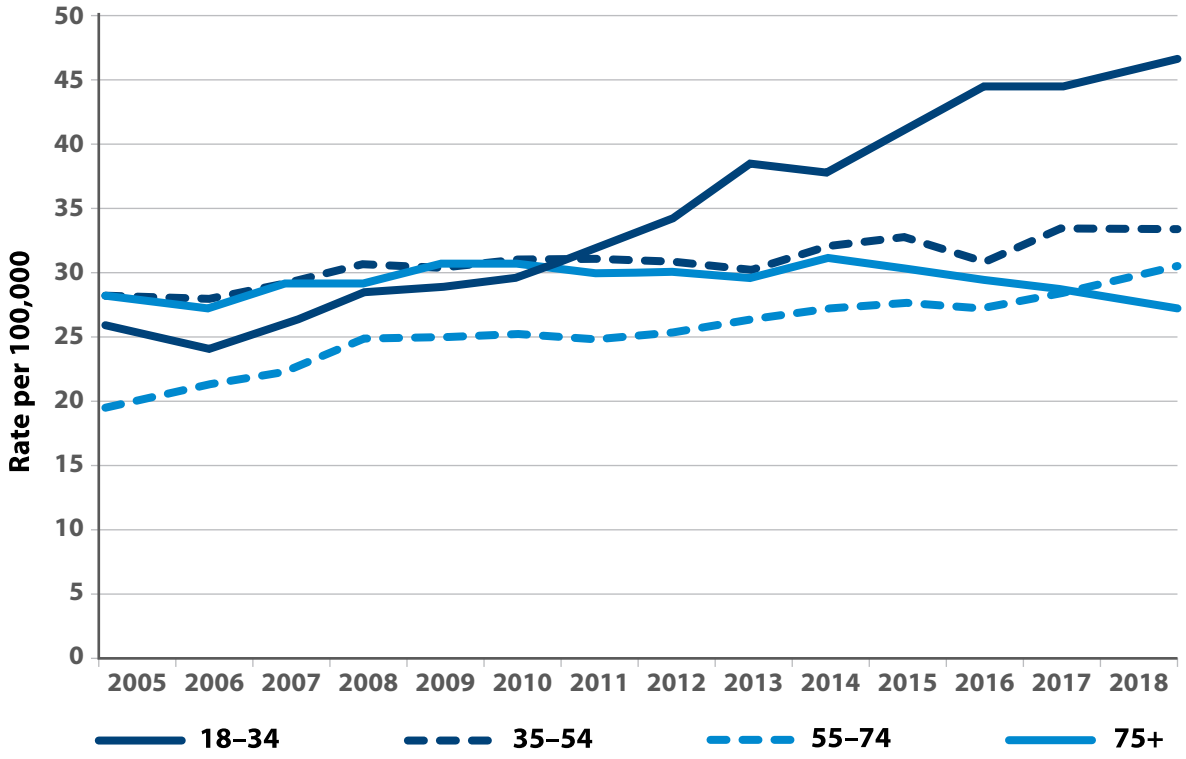
Graph 4. Unadjusted and Age- and Sex-Adjusted Suicide Rates, Veterans, by Recent VHA Care, 2005–2018



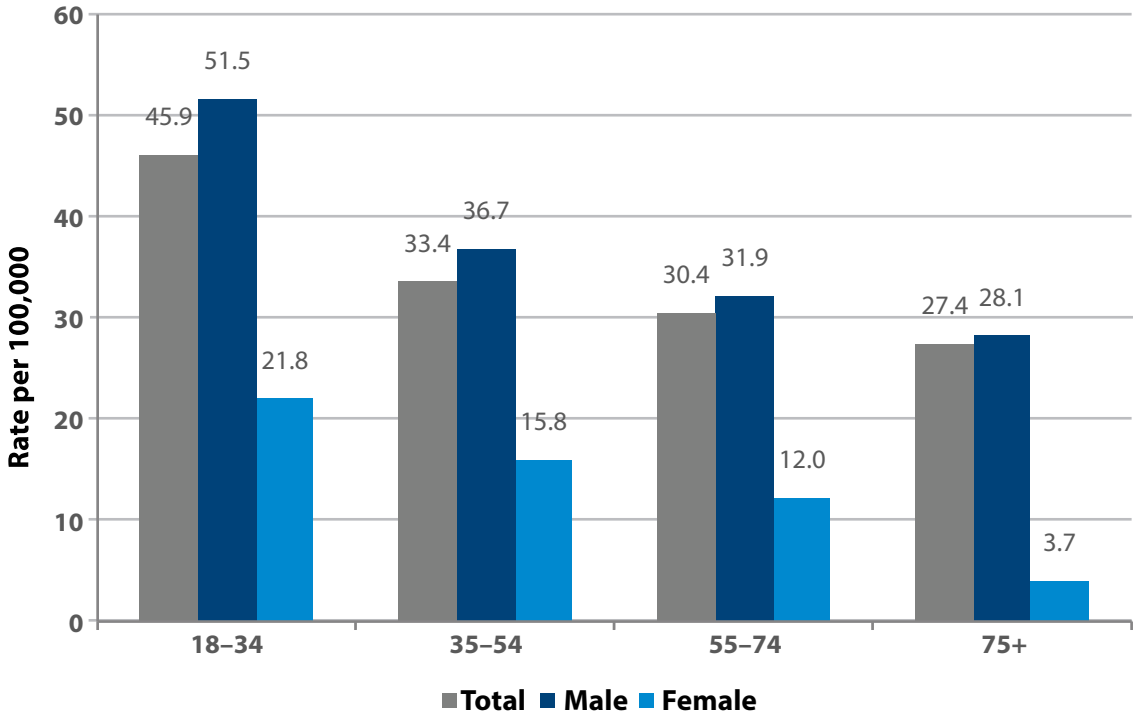
Veteran Suicide Rates by Age Group, 2005–2018

- Veterans ages 18–34 had the highest suicide rate in 2018 (45.9 per 100,000).
- Veterans age 75 and older had the lowest suicide rate in 2018 (27.4 per 100,000).
- The absolute number of suicides was highest among Veterans 55–74 years old (see Graph 7). This group accounted for 40% of all Veteran deaths by suicide in 2018.

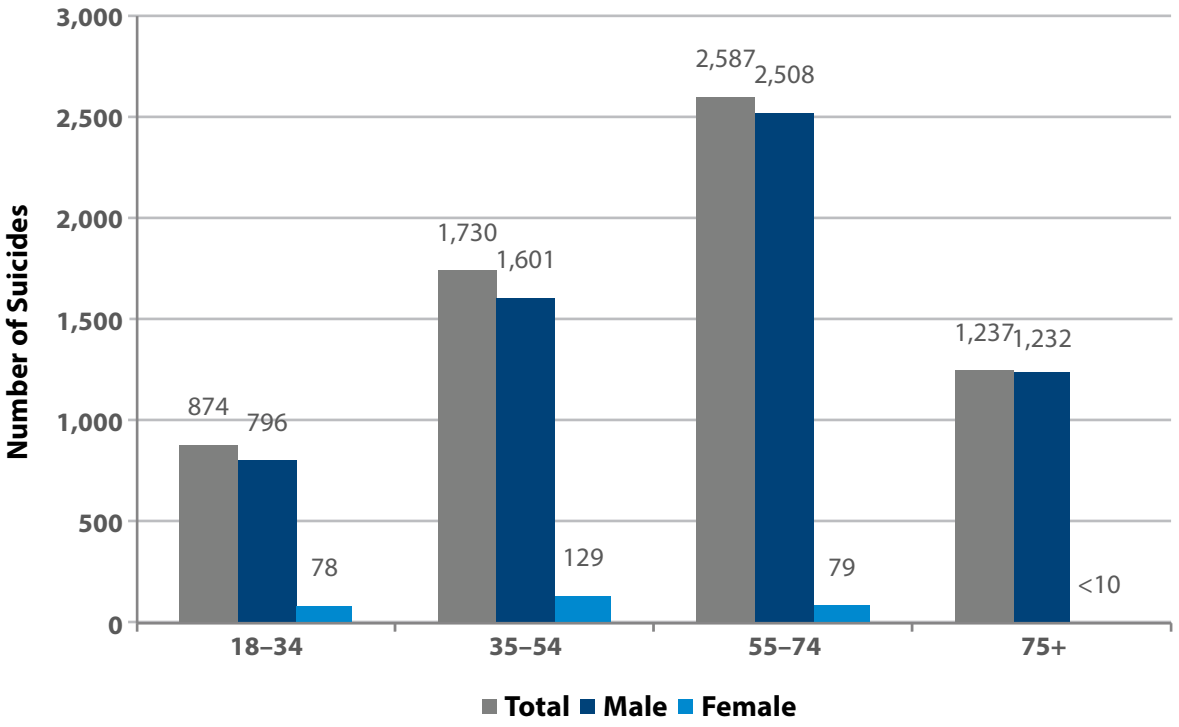
Graph 5. Veteran Suicide Rates, by Age Group and Year, 2005–2018



Graph 6. Veteran Suicide Rate by Age Group and Sex, 2018



Graph 7. Veteran Suicide Death Count, by Age Group and Sex, 2018

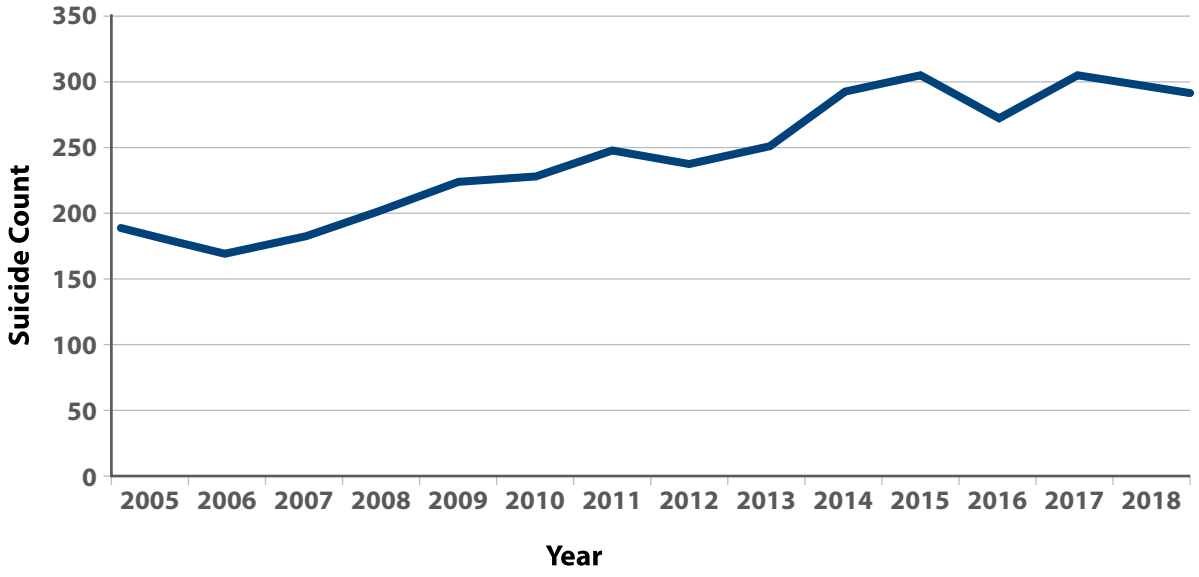


Veteran Suicide Rate by Sex, 2005–2018

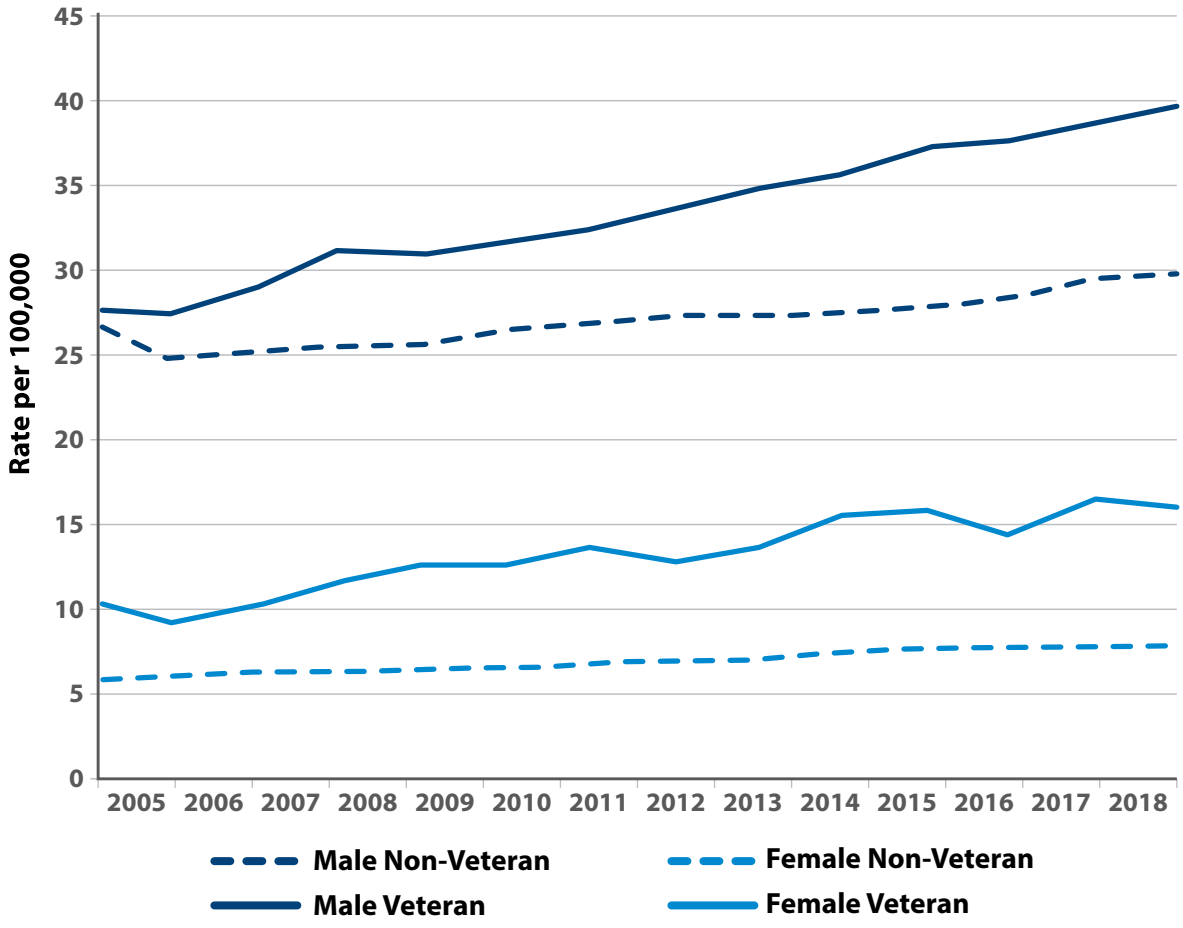
- Between 2005 and 2018, the women Veteran population increased by 6.5%, including a 1.5% increase from 2017–2018.
- In 2018, among women Veterans, the age-adjusted suicide rate was 15.9 per 100,000. Among male Veterans, it was 39.6 per 100,000.
- Overall, the number of suicides among women Veterans fell from 304 in 2017 to 291 in 2018. There were 186 suicides among women Veterans in 2005.
- In both 2017 and 2018, the age-adjusted suicide rate among women Veterans was 2.1 times that of non-Veteran women. In 2005, the age-adjusted suicide rate among women Veterans was 1.8 times that of non-Veteran women.
- Among women Veterans in VHA care from 2017 to 2018, suicide counts decreased from 94 to 81 and age-adjusted rates decreased from 15.7 per 100,000 to 14.0. Also, from 2017 to 2018, among women Veterans not in VHA care, the number of suicide deaths was unchanged at 210 and the age-adjusted rate increased from 16.9 to 17.0 per 100,000.[52] In 2005, among Veteran women in VHA care, there were 56 suicide deaths and an age-adjusted suicide rate of 13.8 per 100,000; among women not in VHA care, there were 130 deaths and an age-adjusted rate of 9.4 per 100,000.
- In 2018, the age-adjusted suicide rate among male Veterans was 1.3 times that of non-Veteran males.
- From 2005 to 2018, suicide rates rose significantly faster among men than among women, both for Veteran and non-Veteran populations.

[52] For both groups, the difference in rates from 2017 to 2018 was not statistically significant.

Graph 8. Suicide Deaths, Women Veterans, 2005–2018



Graph 9. Age-Adjusted Suicide Rates, by Sex and Veteran Status, 2005–2018



Veteran Suicide Rate by Race/Ethnicity, 2005–2018[53]

- Among the Veteran population overall, from 2005–2018, the distribution of Veterans by group changed, with proportional increases among Veterans identified as Black or African American (from 10.2% in 2005 to 12.3% in 2018), American Indian and Alaskan Natives (from 0.7% in 2005 to 0.8% in 2018), and Asian, Hawaiian, and Pacific Islander (from 1.4% in 2005 to 2.0% in 2018). There were decreases among Veterans identified as White (from 84.8% in 2005 to 81.2% in 2018).[54]
- From 2015 to 2018, suicide rates were highest among White Veterans and lowest among Black or African American Veterans.
- Among Veteran VHA users, suicide rates were highest among individuals with race categorized as White or as either American Indian, Alaska Native, Asian, or Pacific Islander.
- In 2018, Black, Hispanic, and White male Veterans in VHA care had similar ratios of age-adjusted suicide rates relative to those of U.S. adult men in the same demographic group.[55]
- The ratio of suicide rates among VHA-engaged Hispanic[56] male Veterans to rates among all Hispanic male U.S. adults was lower in 2018 than in 2017.

[53] Sources of information regarding race/ethnicity differ for the overall Veteran population and for Veterans in VHA care. Consequently, reporting definitions differ by group.

[54] Comprehensive data to identify Hispanic Veteran suicide decedents was unavailable at the time of this report. As currently prepared, ethnicity estimates for Veterans in VHA care are inconsistent with available denominator estimates for the overall Veteran population, due to race and ethnicity being combined into a single indicator, thereby losing granularity and complete ethnicity assessment for Veterans of all races. For this reason, all Veteran estimates by ethnicity are currently unavailable.

[55] We did not include comparisons for American Indian/Alaska Native/Asian Hawaiian/Pacific Islander male VHA patients because it was not possible to generate standardized rates for these groups given low counts in some of the age strata.

[56] Information regarding Hispanic ethnicity was obtained from multiple VA patient record sources. Individuals were assumed to be of Hispanic ethnicity if their most common self-identified race was "Hispanic White" or "Hispanic Black" or if their most common self-identified ethnicity was "Hispanic." If self-identified information was unavailable, the most common non-self-identified values were used. For reporting purposes, Hispanic ethnicity was mutually exclusive from race categories. As a result, "White" represents White-Non-Hispanic and "Black" represents Black-Non-Hispanic.

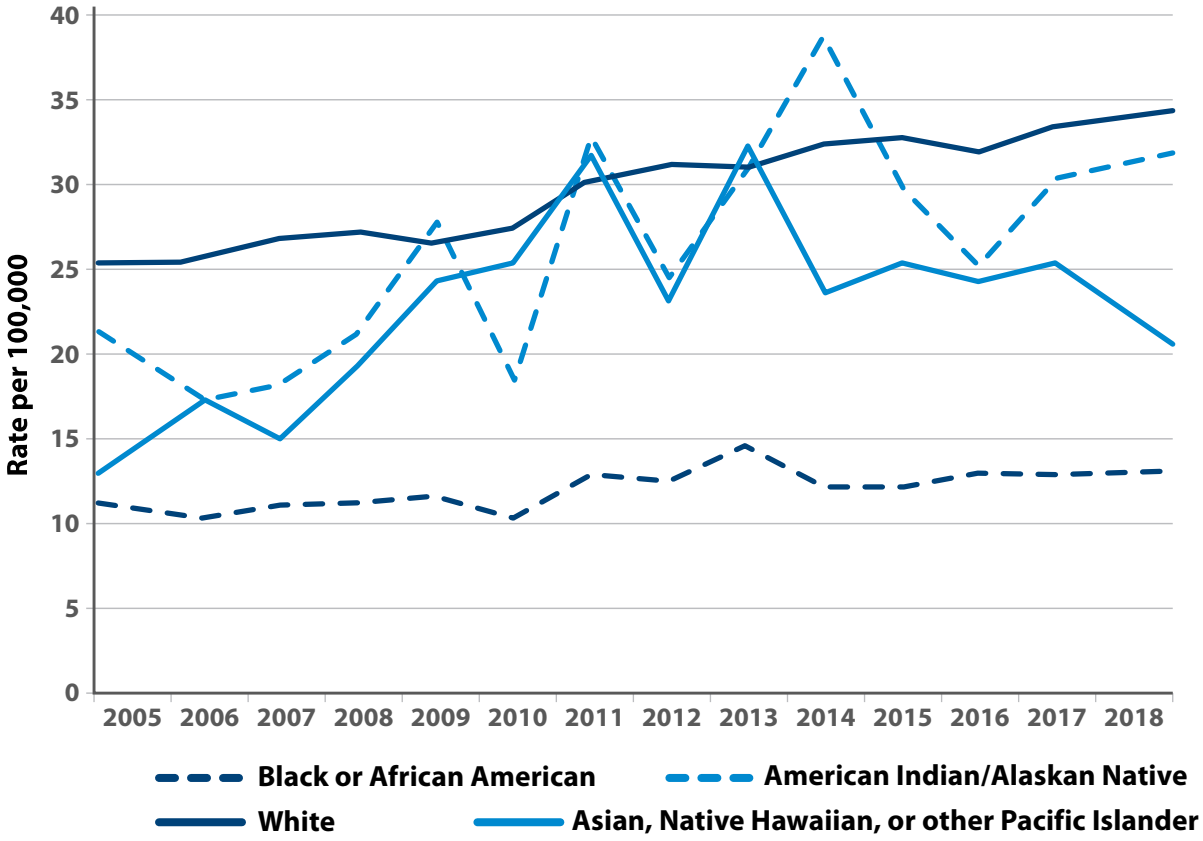
Table 3. Veterans and Veteran Suicide Decedents by Race, 2005 and 2018[57]

Race	2005 Veteran Population	2005 Percentage of Veteran Population	2005 Veteran Suicide Decedents	2005 Percentage of Veteran Suicide Decedents
White	20,820,000	84.8%	5,246	86.6%
Black/African American	2,512,000	10.2%	282	4.7%
Multiple Race	295,000	1.2%	16	0.3%
Asian/Native Hawaiian/ Pacific Islander	342,000	1.4%	45	0.7%
American Indian/ Alaskan Native	178,000	0.7%	38	0.6%

Race	2018 Veteran Population	2018 Percentage of Veteran Population	2018 Veteran Suicide Decedents	2018 Percentage of Veteran Suicide Decedents
White	16,384,000	81.2%	5,618	87.3%
Black/African American	2,479,000	12.3%	323	5.0%
Multiple Race	452,000	2.2%	178	2.8%
Asian/Native Hawaiian/ Pacific Islander	398,000	2.0%	83	1.3%
American Indian/ Alaskan Native	165,000	0.8%	52	0.8%

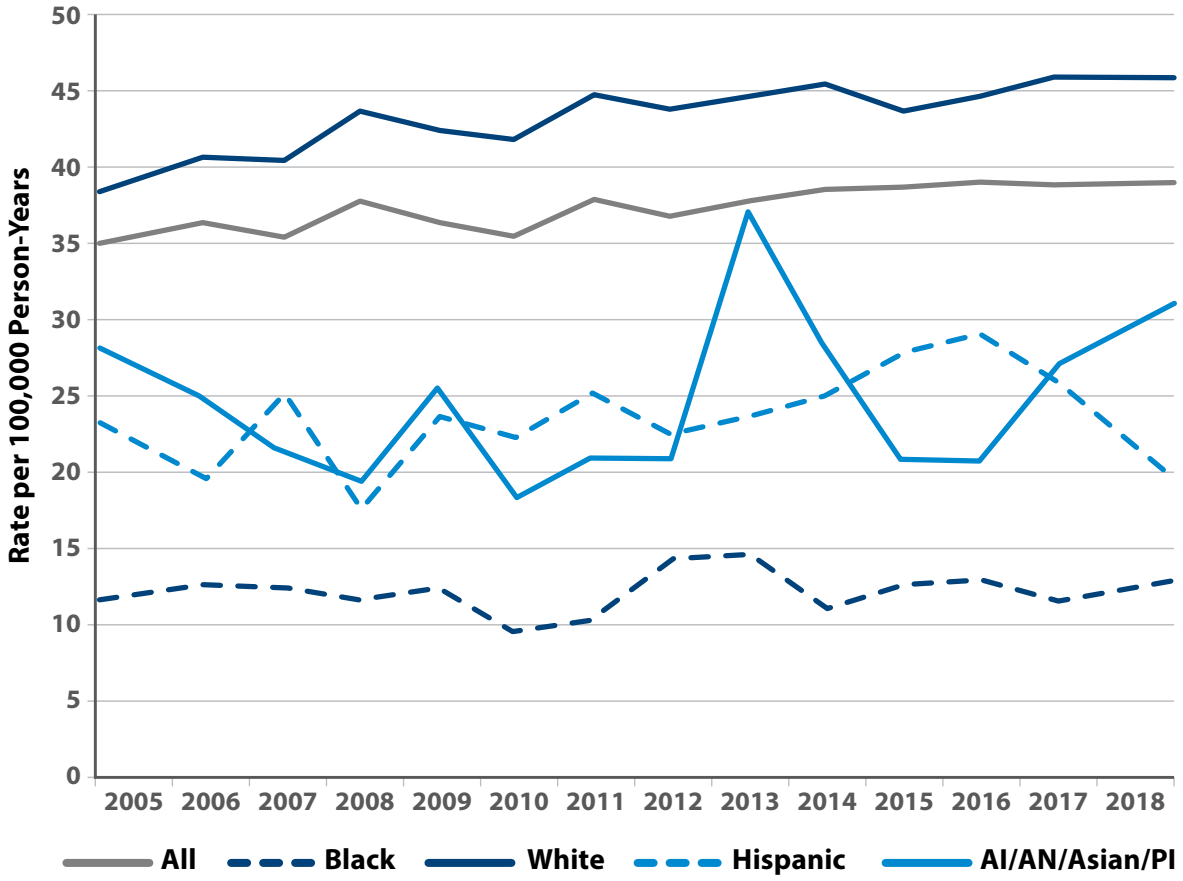
[57] For the Veteran population, estimates utilized data from the VA Office of Enterprise Integration VetPop2018 Model, which reports on race and ethnicity as defined by Office of Management and Budget Guide: ***https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf***. Identification of race for Veteran suicide decedents used VHA administrative data and the USVETS database. Veterans' self-reported information was utilized when available. Percentages do not add to 100%. The Veteran population estimate includes 1.4% "Other" race; race information was unavailable for 7.1% and 2.8% of Veteran suicide decedents in 2005 and 2018, respectively.

Graph 10. Unadjusted Suicide Rates, Veterans, by Race, 2005–2018[58]



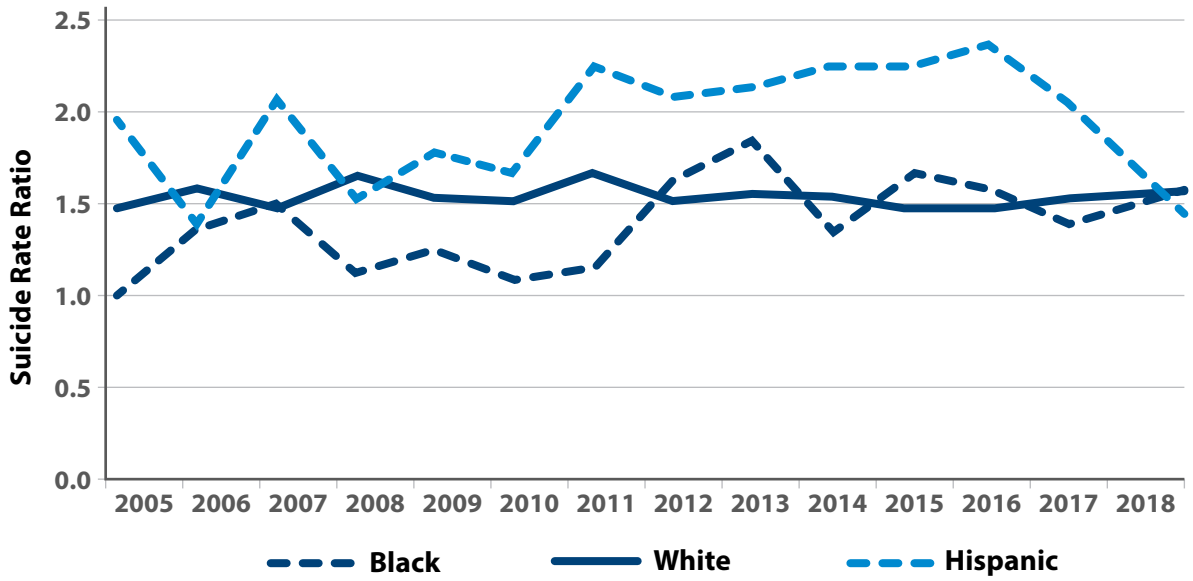
[58] Population counts by race and ethnicity for the total Veteran population were unavailable by age group. Consequently, age adjustment was not conducted. Excludes decedents for whom race information was unavailable (2.2%–13.5%, annually) or indicated as "multiple race" (0.3%–3.1%, annually).

Graph 11. Unadjusted Suicide Rates, Veteran VHA Users, by Race/Ethnicity, 2005–2018[59]



[59] Due to small numbers, information for American Indian, Alaska Native, Asian, and Pacific Islander (AI/AN/Asian/PI) Veterans in VHA care was combined. Analyses do not include individuals with race/ethnicity indicated as unknown or with multiple race categories, due to changes over time in race/ethnicity ascertainment.

Graph 12: Age-Adjusted Suicide Rate Ratios, Male VHA Veterans vs. U.S. Adult Men, 2005–2018[60]

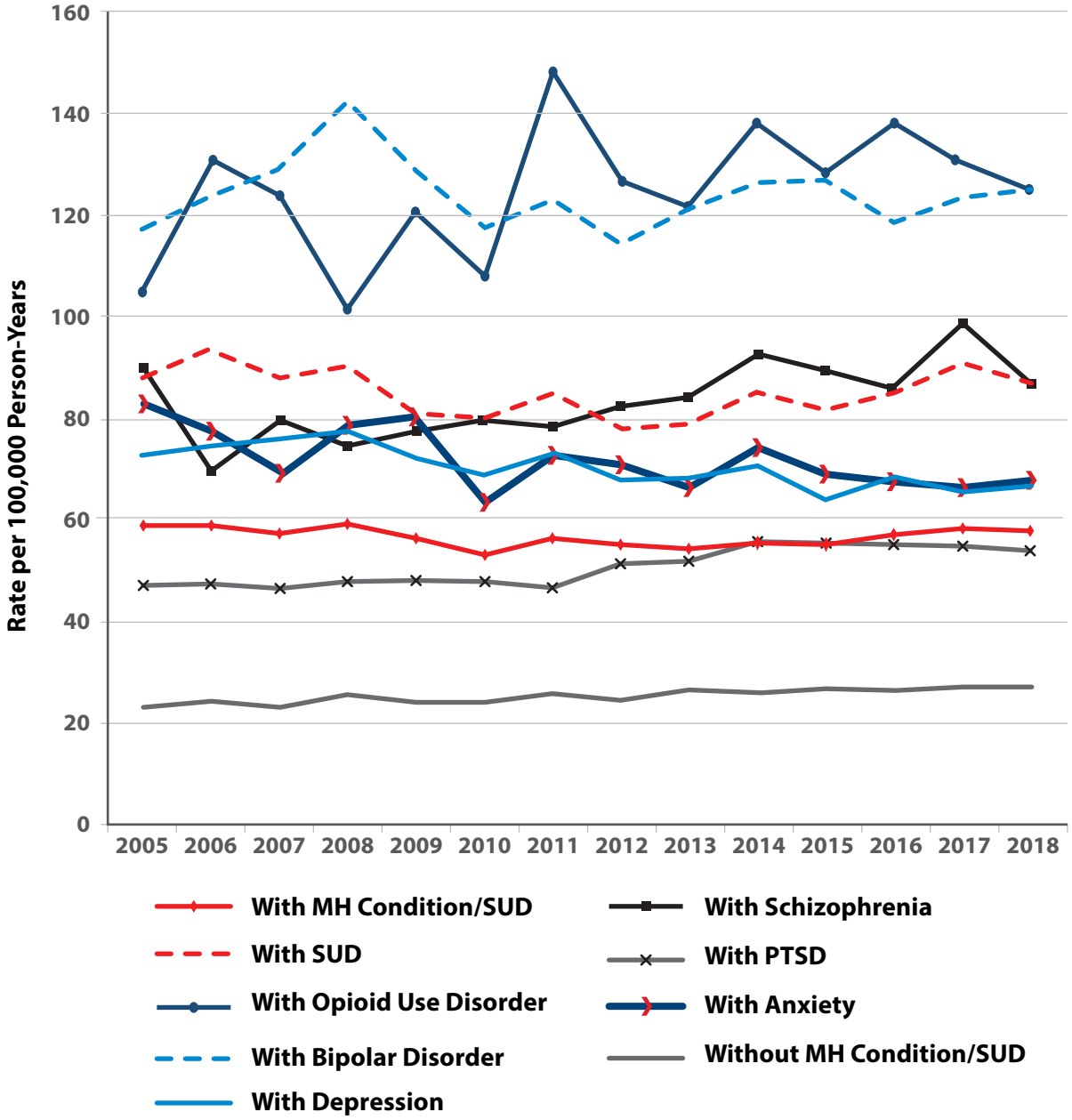


Veteran VHA Patients With Mental Health or Substance Use Disorders, Unadjusted Suicide Rates

- Among Veterans with recent VHA use who died by suicide in 2018, 59.6% had a mental health or substance use disorder diagnosis in 2017 or 2018.
- In 2018, VHA patients with any mental health or substance use disorder diagnosis had a suicide rate of 57.2 per 100,000, compared with 58.6 per 100,000 in 2005 and 57.9 per 100,000 in 2017.
- The suicide rate for VHA patients diagnosed with depression decreased from 2005 to 2018, from 72.9 per 100,000 to 66.4 per 100,000. The 2018 suicide rate represented an increase from 2017's rate, 65.1 per 100,000.
- The suicide rate for VHA patients diagnosed with anxiety decreased from 2005 to 2018, from 83.1 per 100,000 to 67.0 per 100,000. The 2018 suicide rate was an increase from 2017's rate, 65.6 per 100,000.
- Veteran VHA patients diagnosed with bipolar disorder and those diagnosed with opioid use disorder had elevated risk for suicide.

[60] Due to small cell sizes, it was not possible to assess by race/ethnicity for women. Standardized Rate Ratios provide the ratio of age-standardized rates. They compare rates of suicide between Veteran VHA users and members of the general U.S. population with the same characteristics (race/ethnicity, sex). Direct age standardization is a statistical method that uses weighting to reduce the influence of a population's age composition on the reported rate. This allows two populations with different age compositions to be compared without bias. In this case, the rates of the male VHA Veteran population and the U.S. male population were both weighted to reflect the U.S. Census Bureau 2000 population projection. Reporting includes the categories White, Black, and Hispanic, per the CDC WONDER resource. Comparable data was unavailable for Veterans identified as part of the categories Other and Unknown.

Graph 13. Suicide Rates per 100,000, Among Veteran VHA Users With Mental Health (MH) or Substance Use Disorder (SUD) Diagnoses, 2005–2018[61]



[61] Diagnoses based on ICD-9 (International Classification of Diseases, Ninth Revision) codes prior to 10/1/2015, and ICD-10 codes thereafter.

Veteran Suicide Methods

- In 2018, 68.2% of Veteran suicide deaths were due to a self-inflicted firearm injury, while 48.2% of non-Veteran adult suicides resulted from a firearm injury.
- In 2018, 69.4% of male Veteran suicide deaths and 41.9% of female Veteran suicide deaths resulted from a firearm injury.

Table 4. Method of Suicide Among Veteran and Non-Veteran Adults Who Died from Suicide, 2018

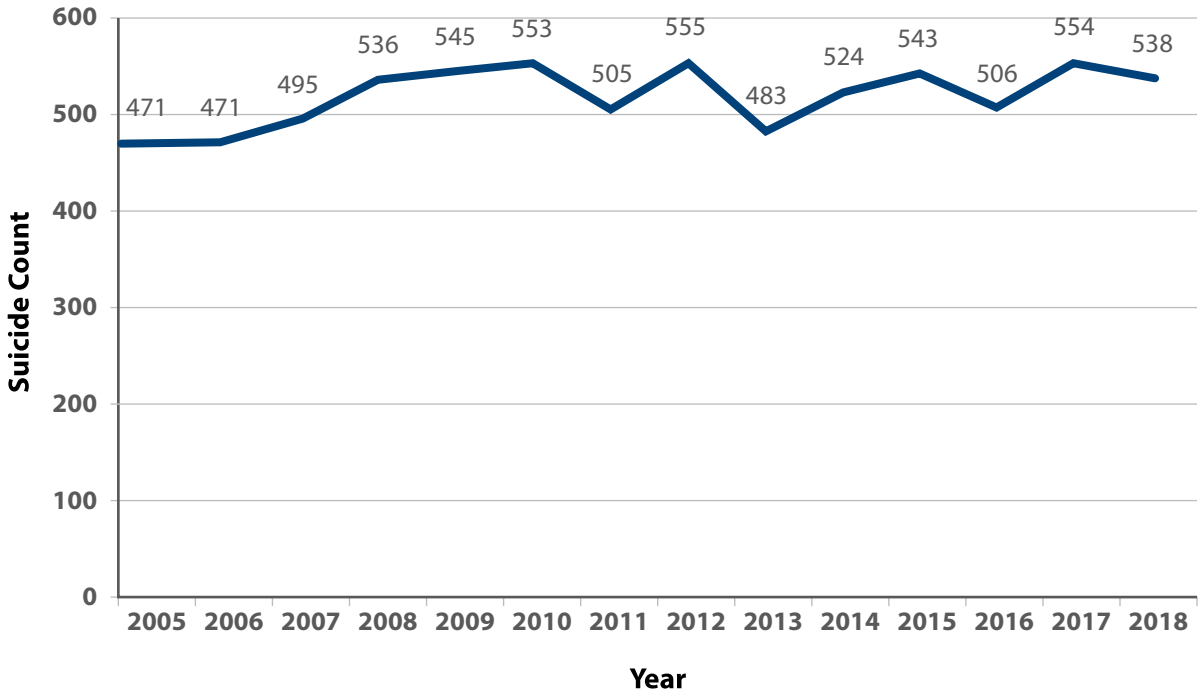
Method	Percentage of Non-Veteran Adult Suicide Deaths	Percentage of Veteran Suicide Deaths	Percentage of Male Non-Veteran Adult Suicide Deaths	Percentage of Male Veteran Suicide Deaths	Percentage of Female Non-Veteran Adult Suicide Deaths	Percentage of Female Veteran Suicide Deaths
Firearm	**48.2%**	**68.2%**	**53.5%**	**69.4%**	**31.7%**	**41.9%**
Poisoning	**13.8%**	**9.5%**	**8.5%**	**8.5%**	**30.3%**	**31.6%**
Suffocation	**29.5%**	**17.1%**	**29.8%**	**16.9%**	**28.4%**	**20.3%**
Other	**8.5%**	**5.2%**	**8.2%**	**5.2%**	**9.6%**	**6.2%**

Never Federally Activated Former Service Members[62]

Former Service members who may not have Veteran federal legal status due to their type of service. This typically limits their access to VA benefits and services under current laws and regulations. In 2018, there were 538 suicides among never federally activated Service members (Graph 14).

- In 2018, there were 538 suicides among never federally activated former Service members, an average of 1.5 suicide deaths per day.

Graph 14. Number of Suicides Among Former Service Members With No Indication of Federal Active Duty, 2005–2018



[62] The Department of Defense Manpower Data Center provided the most comprehensive available data to allow VA to assess whether former Service members had been federally activated. Provided indicators did not enable ascertainment of National Guard versus Reserve status.

VA in 2018 and 2020: Putting the Data in Context

2018: Where We Were

Suicide prevention has evolved in meaningful and significant ways within a relatively brief period. In 2012, the Office of the U.S. Surgeon General collaborated with the National Action Alliance for Suicide Prevention to create the 2012 National Strategy for Suicide Prevention. The plan offered a seminal perspective regarding a comprehensive public health approach to suicide prevention. In 2018, VA developed the *National Strategy for Preventing Veteran Suicide* (National Strategy),[63] which laid the foundation of concepts core to VA's public health approach to suicide. Specifically, the National Strategy integrated community-based and clinically based settings and services to address the following four domains of suicide prevention, intervention, and postvention:

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

While the development of the National Strategy was groundbreaking in defining the vision of reaching and serving Veterans both within and outside VHA clinical care, a tangible operational plan enacting collective alignment and engagement of suicide prevention, intervention, and postvention goals and activities across clinical and community settings was needed. In this context, the VHA Suicide Prevention 2.0 (SP 2.0) Strategic Plan emerged to unify specific clinical services and advancements within VA across the national, regional, and local levels with community-based suicide prevention policy, plans, and services at the national, state, and local levels. Thus, the initial development of Suicide Prevention 2.0 occurred in 2018 with the goal of converting the National Strategy vision across the four primary domains of focus to boots-on-the-ground applications and implementation, the specifics of which are outlined within the present report, organized according to clinically based and community-based domains.

Also in 2018, significant progress was made toward a revised Clinical Practice Guideline (CPG) focused on the assessment and management of patients at risk for suicide.[64] The intent of the CPG was to ensure the identification of the best suicide prevention care practices from the literature to inform VA and the community in expansion of clinical services. The CPG, published in 2019, contains recommendations on screening and risk evaluation as well as clinical risk management and treatment. This publication became the defining document to outline the strategies to be rolled out in SP 2.0 clinically based interventions, further taking the National Strategy from an outlined vision to a practical plan, based in the best clinical evidence, ready for implementation across the nation.

[63] Department of Veterans Affairs (2018). National Strategy for Preventing Veteran Suicide. Washington, DC. Available at ***https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf***.

[64] 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. Accessed: ***https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf***.

2020: Where We Are Now

Public Health Approach: Combining Clinical and Community Interventions

In 2020, VA translated the vision of the 10-year National Strategy and its four major domains into operationalized plans of actions: SP 2.0, started in 2018, combined with the Suicide Prevention Now initiative. SP 2.0 is a six-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 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 described below. The SP 2.0 clinically based domain follows the vision associated with the National Strategy's treatment, recovery, and support services pillar and outlines a practical strategy for implementing CPG evidence-based treatments through the dissemination of TeleMental Health suicide prevention services across all 140 VHA health care systems.

While VA worked on the longer-term plan of SP 2.0 implementation in collaboration with community partners, 2020 also saw the launching 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 initiative, which also includes suicide prevention strategies specific to the COVID-19 pandemic, is a critical effort to rapidly identify and address key priority areas focused on advancing and enhancing Veteran suicide prevention efforts more immediately in 2020–2021. SP Now represents a set of goals that can be achieved in a short period of time and have a meaningful impact in preventing Veteran suicide. The plan includes key mental health and suicide prevention strategies to support Veterans, VHA providers, and the community during the COVID-19 pandemic and in the months that follow. Led by staff within SPP and key VA partners, the focus of SP Now is goals that can be achieved within one year, including activities that will have a meaningful impact in preventing Veteran suicide and are current areas of opportunity for suicide prevention program enhancement.

The following graphic shows the operationalization of the National Strategy in these two plans and is followed by a lengthier description of SP 2.0 and Now.

The National Strategy for Preventing Veteran Suicide

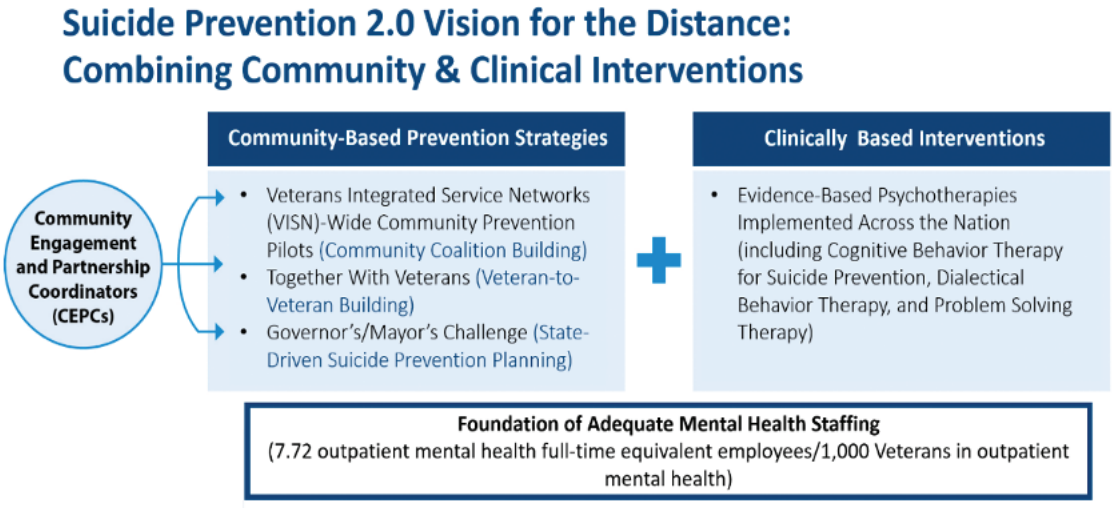
Tactical Implementation Through Now and Suicide Prevention 2.0 Initiatives

	Now	2.0
Healthy and Empowered Veterans, Families, and Communities	• Lethal Means Safety (LMS): dissemination of LMS kits, updated LMS trainings for VHA and MISSION Act providers, and integration of LMS materials and goals into community-based coalition work • Increased outreach and suicide prevention support to homeless Veterans • Develop targeted paid media plan	• Comprehensive Community-Based Intervention for Suicide Prevention (CBI-SP)*: enhances identification of those who have served and refines screening for suicide risk across communities • Veterans with recent suicide attempts will have opportunities to engage in state-of-the-art, evidence-based psychotherapies with the National Suicide Prevention Telehealth Clinical Resource Hubs
Clinical and Community Prevention Services	• Promote LMS storage strategies • Enhance suicide risk screening, assessment, and follow-up in at-risk medical populations; and increase distribution of Naloxone to Veterans with an opioid use disorder • Increase outreach to and understanding of prior VHA users • Suicide Prevention Program enhancements: highrisk for suicide patient record flags, outreach during COVID-19, safety planning, REACH VET, SPED, sameday screening, VCL coordination, and Caring Letters Program • Develop targeted paid media plan	• CBI-SP advances evidence-based treatment for suicide prevention in communities and enhances knowledge and understanding of available VA services • National Suicide Prevention Telehealth Clinical Resource Hubs are adding capacity by funding and training over 100 mental health care providers to offer state-of-the art, evidence-based psychotherapies for Veterans at risk of suicide
Treatment, Recovery, and Support Services	• Enhance suicide risk screening, assessment, and follow-up in at-risk medical populations • Focus on Suicide Prevention Program enhancements, such as SPED and same-day mental health screenings • Increase outreach and suicide prevention support to homeless Veterans	• CBI-SP creates opportunities to engage more Veterans in VA services, as community coalitions join to promote suicide prevention, connectedness, and improving care transitions • National Suicide Prevention Telehealth Clinical Resource Hubs ensure access to psychotherapies supported by the VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (this enhanced care will benefit approximately 13,000 Veterans a year who have survived a recent suicide attempt)
Surveillance, Research, and Evaluation	• Enhance implementation of REACH VET through increased technical assistance and implementation support across all 140 health care systems • Apply data and surveillance methodology to identify and begin outreach to prior VHA users at high risk for suicide • Improve and increase syndrome surveillance at the state level to create an Early Warning Surveillance System	• CBI-SP implements evidence-informed, communitybased interventions for suicide prevention based in community coalition building • The foundation of all Now and 2.0 strategies is based upon research and includes promoting and supporting the latest suicide prevention research • National Suicide Prevention Telehealth Clinical Resource Hubs will facilitate research and evaluation of cognitive behavioral therapy for suicide prevention (CBT-SP), problem-solving therapy for suicide prevention (PST-SP), dialectical behavior therapy (DBT), and safety planning interventions provided in the novel telehealth modality

*CBI-SP program integrates Governor/Mayoral Challenge, VISN-wide Community Prevention Pilots, and Together With Veterans (TWV)

Suicide Prevention 2.0

The SP 2.0 model builds upon the Office of Mental Health and Suicide Prevention's current efforts and reaches Veterans by strengthening VA's focus on high-risk individuals in health care settings and embracing cross-agency collaborations and community partnerships. SP 2.0 advances VA to the next level of implementation of the National Strategy's four pillars by outlining a rigorous structure addressing clinical and community-based domains for action at the national, regional, and local levels. SP 2.0 was approved by the Executive in Charge in 2020 for full execution across VHA with a phased implementation. This multiyear rollout is critical, as it allows for an implementation design (interrupted time series and modified stepped wedge design) that enables VA to assess short and intermediate outcomes of SP 2.0, including program evaluation and surveillance data to assess population impacts. Lessons learned can help inform VA and the broader community on both what works and should be implemented even more broadly, as well as what should be modified or eliminated, with future strategic plans following from the National Strategy. The following is a visual graphic of the overarching SP 2.0 plan, followed by a more detailed description of the initiative.[65]



SP 2.0 Community-Based Interventions (CBI)

The SP 2.0 Community-Based Interventions for Suicide Prevention (CBI-SP) model builds upon the four pillars of the National Strategy by reaching Veterans through multiple touch points, strengthening VA's focus on high-risk individuals in health care settings, and embracing cross-agency collaborations and community partnerships to meet Veterans both within and outside the VA system. SP 2.0 CBI-SP focuses upon enacting the four pillars outlined above through the following three structures (described in detail below):

1. Veterans Integrated Service Network-Based Community Coalition and Collaboration Building Model (e.g., VISN-wide community suicide prevention pilot programs)
2. Veteran-to-Veteran Coalition Building Model (e.g., Together With Veterans)
3. State-Based Coalition and Collaboration Building Model (e.g., Governor's Challenge)

[65] Three particular psychotherapies were selected for implementation in SP 2.0, as they were identified in the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide as having the strongest evidence for suicide prevention: cognitive behavioral therapy for suicide prevention (CBT-SP, strong for evidence), dialectical behavior therapy (DBT, weak for evidence), and problem-solving therapy (PST, weak for evidence). CBT-SP is focused on identifying beliefs activated prior to self-directed violence and generates strategies (cognitive and behavioral) to address these beliefs. It is recommended for those with a recent suicide attempt. This typically also includes the development of a relapse prevention plan. DBT is recommended for individuals with borderline personality disorder (BPD) and recent self-directed violence (SDV) and includes a combination of cognitive behavioral therapy, skills training, and mindfulness techniques used to develop skills in emotion regulation, interpersonal effectiveness, and distress tolerance. PST is recommended for those with a history of more than one incident of SDV, to prevent repeat incidences, and for those with recent SDV, to reduce suicide-related behavior. This involves a cognitive behavioral approach aimed at improving one's ability to cope with stressful life experiences through active problem-solving.

SP 2.0 CBI-SP combines these three initiatives into a comprehensive approach to community-based suicide prevention addressing needs at state and local community levels. For state-level suicide prevention, the Office of Mental Health and Suicide Prevention (OMHSP) is supporting expanding the Governor's *Challenge To Prevent Suicide Among Service Members, Veterans, and Their Families*, in which state policymakers partner with local leaders to implement a comprehensive suicide prevention plan, with a goal to reach all 50 states by the end of fiscal year 2022. For local community action, OMHSP is supporting expansion across all VISNs of a *Community Engagement and Partnerships – Suicide Prevention* program focused on community coalition-building coupled with targeted outreach and education, as well as the ***Together With Veterans (TWV)*** program, a VA Office of Rural Health program focused on empowering and supporting Veteran leadership for suicide prevention. CBI-SP promotes these goals in alignment with the National Strategy:

1. Increased identification of Veterans and family members within the community and increased screening for suicide risk.
2. Increased connectedness within the community and across improved care transitions.
3. Increased lethal means safety and safety planning, community-wide.

In the fourth quarter of fiscal year 2020, SPP added three additional VISNs (4, 9, 12) to the Community Engagement and Partnership for Suicide Prevention pilot program, expanding initial work in VISN 23 in 2018. In this same period, SPP issued a call for all VISNs to submit a Letter of Intent that will add six additional VISNs to SP 2.0 community-based prevention early in fiscal year 2021 and add the remaining VISNs in fiscal year 2022.

VISN-wide community prevention pilot. Within VISNs, the Community Engagement and Partnerships – Suicide Prevention program focuses on community coalition-building coupled with targeted outreach and education. Community-based interventions expand the capacity of VISNs to engage in community-based suicide prevention efforts in their region, thereby reducing suicide rates among Veterans. This includes a comprehensive strategy to hire and train qualified Community Engagement and Partnerships Coordinators, who will collaborate at the community, regional, and state levels to implement evidence-informed, community-based suicide prevention interventions.

Together With Veterans. TWV is a community-based suicide prevention program focused on empowering and supporting Veteran leadership to enhance local suicide prevention networks in rural and frontier communities. TWV engages, trains, and supports local Veteran leadership through five phases of effective community-based prevention programs: (1) building a team, (2) conducting a needs assessment, (3) learning about best practices, (4) developing an action plan, and (5) implementing and evaluating. TWV enhances the capacity of rural and frontier communities' suicide prevention networks through application of four principles: Veteran-led, collaborative, evidence-informed, and community-centered. TWV is a VA Office of Rural Health Enterprise-Wide Initiative in partnership with the OMHSP, currently expanding to 22–34 new sites nationwide in fiscal years 2019–2022.

Governor's Challenge. Since 2018, VA and the Substance Abuse and Mental Health Services Administration have partnered to support cities, counties, and states through the Governor's and Mayor's Challenges To Prevent Suicide Among Service Members, Veterans, and Their Families. This collaborative technical assistance process works to support and enhance the vital suicide prevention efforts at the state and local levels to create plans that will implement the ***National Strategy for Preventing Veteran Suicide***, which provides a framework for identifying priorities, organizing efforts, and contributing to a national focus on Veteran suicide prevention. In 2019, seven states and 24 cities were involved in the Governor's and Mayor's Challenges. As state-level engagement was needed to broaden the effort nationally, the focus changed in fiscal year 2020 to the expansion of the Governor's Challenge. Twenty additional states were added in fiscal year 2020, for a total of 27 states, with the goal of achieving all 50 states by the end of fiscal year 2022.

SP 2.0 Clinically Based Interventions

As a result of 2019 updates to the VA and Department of Defense (DoD) Evidence-Based Practice Work Group Suicide Risk Clinical Practice Guideline (CPG), VA determined that it is clinically imperative to align suicide prevention efforts

with CPG recommendations and make evidence-based psychotherapies for suicide prevention widely available. To that end, VA's Suicide Prevention Program partnered with the national Clinical Resource Hub leadership team to introduce a national telehealth capability to provide the treatments outlined in the CPG. In the fourth quarter of fiscal year 2020, VA's Suicide Prevention Program, in collaboration with the Office of Primary Care, launched the implementation of this national model to deliver evidenced-based psychotherapy interventions for suicide prevention via telehealth across all VISN Clinical Resource Hubs. Initial pilot work has focused on Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) with planning underway to move to other therapies and interventions such as Problem Solving Therapy for Suicide Prevention (PST-SP), Dialectical Behavior Therapy, and Advanced Safety Planning Intervention (ASPI) for Veterans with suicidal ideation and/or a history of suicide attempts, as highlighted in the updated VA/DoD Clinical Practice Guideline (CPG) on the Assessment and Management of Patients at Risk for Suicide, as treatment interventions with the strongest evidence from the literature and not yet rolled out across VA.

SP2.0 relies upon a foundational level of staffing to ensure success. This includes a minimum outpatient mental health staffing ratio aim of 7.72 outpatient mental health full-time employee equivalent (FTEE) staff per 1,000 Veterans in outpatient mental health and a national minimum benchmark for suicide prevention staffing at 0.1 suicide prevention coordinators/case manager FTEE per 1,000 Veterans enrolled at a facility. Every day, more than 450 Suicide Prevention Coordinators and their teams, located at every VA Medical Center, connect Veterans with care and educate the community about suicide prevention programs and resources.

Suicide Prevention Now Initiative

The SP Now initiative focuses specifically on implementation of the National Strategy through a focus on goals achievable in a short time frame that are anticipated to have a meaningful impact in Veteran suicide prevention. The Now initiative has several overarching goals, which include:

- Improving actions to ensure all Veterans are aware of and have access to mental health services.
- Rapid deployment of focused strategies with input from key stakeholders to improve suicide prevention efforts.
- Focusing on areas of high risk and enhancement of existing suicide prevention programs.
- Increasing awareness and engagement of mental health services among all Veterans, while decreasing stigma associated with risk factors for suicide.

The Now initiative focuses on five overarching strategies and 20 supporting goals, all aimed at saving lives in 2020–2021. These strategies and goals were specifically selected after intensive study of 2017 Veteran suicide data, review of the literature and the CPG, and prior study of pandemic-related mental health and suicide prevention concerns. These strategies are currently being implemented across VA in collaboration with interdisciplinary teams across a multitude of settings.

PLANK 1: LETHAL MEANS SAFETY	
STRATEGY 1	Disseminate Lethal Means Safe Storage Information to Primary Care, Women's Health Services, Vet Centers, and Mental Health Clinics During the COVID-19 Pandemic
STRATEGY 2	Implement a One-Time Mandatory Lethal Means Safety Training for all VHA Providers, Including Those in Mental Health, Pain, Emergency Departments, Primary Care, Women's Health Services, and Vet Centers
STRATEGY 3	Train MISSION Act Providers in Lethal Means Safety
STRATEGY 4	Increase Integration of Lethal Means Safety Materials and Goals Into Community-Based Coalition Work
PLANK 2: SUICIDE PREVENTION IN AT-RISK MEDICAL POPULATIONS	
STRATEGY 1	Enhance Suicide Risk Screening, Assessment, and Follow-Up in At-Risk Medical Settings
STRATEGY 2	Provide Suicide Prevention Educational Materials to Medical Providers
STRATEGY 3	Enhance Mental Health Dashboards To Include Additional Medical Risk Factors
STRATEGY 4	Increase Distribution of Naloxone to Patients Diagnosed With Opioid Use Disorder
PLANK 3: OUTREACH AND UNDERSTANDING PRIOR VHA USERS	
STRATEGY 1	Reach Prior VHA Users
PLANK 4: SUICIDE PREVENTION PROGRAM ENHANCEMENTS	
STRATEGY 1	Improve Implementation of High-Risk Flag Processes for Individuals at Highest Risk for Suicide in VHA
STRATEGY 2	Create High-Risk Flag Histories in the Electronic Medical Record To Improve Care and Treatment Coordination for Individuals at High Risk for Suicide
STRATEGY 3	Develop a High-Risk Flag Consult/Referral for Suicide Prevention Coordinators To Assist in Decision-Making and Implementation for Improved Treatment for Those at Highest Risk for Suicide
STRATEGY 4	Improve Suicide Prevention Safety Planning Implementation
STRATEGY 5	Enhance REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment) Implementation
STRATEGY 6	Enhance Safety Planning in the Emergency Department (SPED) Implementation
STRATEGY 7	Improve Veterans Crisis Line (VCL) Consult Hand-Off and Disseminate Caring Contact Letters During the COVID-19 Pandemic
STRATEGY 8	Improve Same Day Five-Point Screening for New Patients
STRATEGY 9	Enhance Outreach to Veterans With Suicide Risk Who Screen/Test Positive for COVID-19
STRATEGY 10	Increase Suicide Prevention Resources and Support for Homeless Veterans Affected by Recent Economic Stressors
PLANK 5: PAID MEDIA	
STRATEGY 1	Implement Paid Media Targeted Plan, Including COVID-19 Specific Messaging

Additional Clinical Strategies

In addition to clinical strategies in SP 2.0 and Suicide Prevention Now, VA continues implementation of a continuum of clinical interventions targeting suicide prevention, based on the National Strategy and CPG foundations. Between October 1, 2018, and September 3, 2020, over 4.8 million Veterans were screened for suicide in VA. VA also has expanded its REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment) program, built upon predictive analytics to identify Veterans at the highest statistical risk of suicide and provide outreach to ensure that they are receiving care. Annually, 30,000 Veterans receive care review and outreach to ensure they are well-engaged in care and that their needs are being met. In 2019, 30,948 Veterans were identified, and 19,743 (63.8%) were successfully reached.

Implementation of Safety Planning in Emergency Departments (SPED), an initiative found to reduce suicidal behaviors by 45%,[66] has been expanded in the past two years. Between October 1, 2019 and May 31, 2020, 3,064 Veterans and 3,425 visits were eligible for SPED. Fifty-nine percent of visits eligible for SPED had a safety plan attempted in the 24 hours prior to or after the emergency department visit.

Further, in response to the potential mental health impacts of COVID-19, VA rapidly adapted a patient-level dashboard that unifies critical information on patients identified as having a high risk for suicide through clinical determination and predictive models (Suicide Prevention Population Risk Identification and Risk Tracking for Exigencies – SPPRITE) to include a Veteran's COVID-19 information. Specifically, providers could now see if a Veteran had screened positive for COVID-19 and if the Veteran had been tested for COVID-19 – as well as the outcome of that test. Since this guidance went to the field in April 2020, outreach was attempted with 78% of those Veterans (1,045 of 1,334) and 66% (877 of 1,334 identified) of those Veterans were successfully contacted regarding their mental health needs.

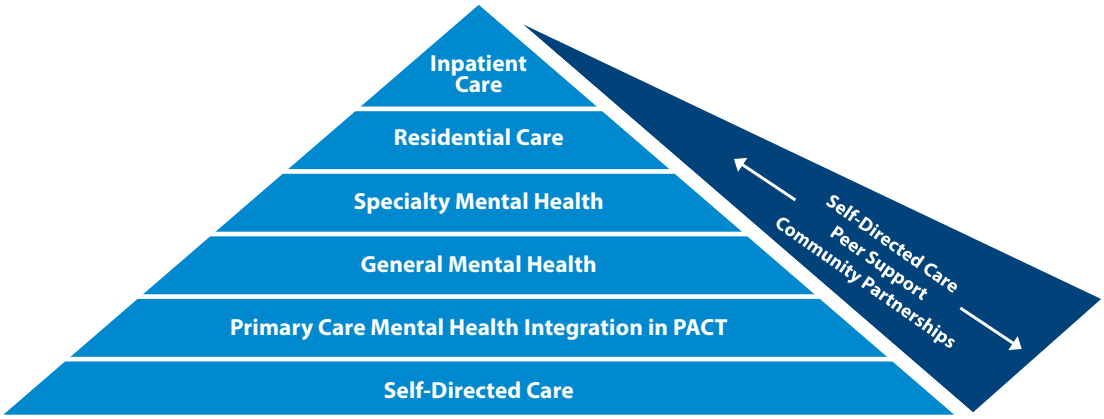
The Veterans Crisis Line provides immediate, 24/7 access to mental health crisis intervention and support for Veterans, Service members, and their families. In 2020, VCL maintained its performance targets, answering 95.86% of calls in 20 seconds or less with an average speed of 10.75 seconds, maintained an abandonment rate of 3.7%, and had a rollover rate of 0.152. In June 2020, VCL launched Caring Letters, an evidence-based intervention for suicide prevention found to reduce the rate of suicide death, attempts, and ideation. Caring Letters entails repeatedly sending brief, nondemanding messages that express caring concern to patients following treatment. These messages have been found to exert a preventive effect by promoting a feeling of caring connection and by facilitating a means to reconnect with treatment options. Veterans will receive nine letters over the course of a year after their initial documented call to VCL, a time of increased risk for suicide.[67] Caring letters will reach over 90,000 Veterans annually and nine thousand Veterans were enrolled within three weeks of this program's launch.

Finally, VA Mental Health care consists of a broad comprehensive system of treatments and services to meet the needs of Veterans, including supporting Veteran resilience, identifying and treating mental health conditions at their onset, addressing mental health crises, and delivering recovery-oriented treatment. VA provides a continuum of forward-looking outpatient, residential, and inpatient mental health services across the country.

[66] Stanley, B., Brown, G.K., Brenner, L.A., Galfaly, H.C., Currier, G.W., Knox, K.L., Chaudhury, S.R., Bush, A.L., Green, K.L. (2018) Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. JAMA Psychiatry. 2018 Sep 1;75(9):894–900. doi: 10.1001/jamapsychiatry.2018.1776.

[67] Hannemann, C.M., Katz, I.R., Hughes, G.J., McCarthy, M.E., McKeon, R., McCarthy, J.F. (in press). Suicide Mortality and Related Behavior Following Calls to the Veterans Crisis Line by Veterans Health Administration Patients. Suicide and Life-Threatening Behavior.

Figure 1. VA Mental Health Continuum of Care



Additional Community Strategies

Communication and Paid Media Campaigns. In 2020, VA launched the development of a Strategic Communications Plan based on new data, innovative and creative communications strategies, emerging technologies, and proven public health best practices. In line with Suicide Prevention 2.0 and the Suicide Prevention Now initiative, the Strategic Communications Plan emphasizes and supports a public health, community approach to ending Veteran suicide. Through validating and refreshing messaging and channels, VA is bringing awareness around suicide prevention to Veterans and their supporters, such as family and friends. By thinking forward and keeping to fundamental communications practices, we are specifically addressing the importance of safely storing lethal means, such as firearms and medication. Furthermore, VA is implementing proven public health campaign standards to provide lifesaving resources. This ensures that every Veteran who needs assistance with a crisis is aware of and educated about VA's programs and resources.

VA develops and implements a variety of communications products and tools, strategies, and distribution processes related to suicide prevention. This entails expanding communications, partnerships, and other efforts to extend prevention beyond the health care setting to all Veterans. Part of VA's efforts include paid media, which, in conjunction with other communications tactics, enhances the ability to target and reach Veteran audiences. Through August 2020, the suicide prevention portion of the VA mental health website has had over 1.2 million website visits, over 138 million completed video views, over 218,000 resource engagements, and over 450,000 cumulative impressions.

Executive Order 13822. Under Executive Order (EO) 13822, Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life, VA partnered with DoD and the Department of Homeland Security to provide increased support services to transitioning Service members. Included among the many accomplishments of EO 13822 was launching a new VA Mental Health Services ***website*** for transitioning Service members and launching a ***Solid Start*** program that contacts all newly separated Service members at least three times during their first year of transition from the military to facilitate access to transition resources, such as peer support; mental health care after separation; understanding eligibility for health care and VA benefits; and a point of contact for any immediate needs. From December 2019 through May 2020, the VA Solid Start Program made 61,000 successful connections with Veterans throughout their first year following military separation. Additionally, the DoD's inTransition program partnered with VA in support of EO 13822 to provide increased support services to transitioning Service members. The inTransition program pairs a licensed, experienced master's-level mental health clinician who provides specialized coaching and assistance via telephone or email, with any Service member or Veteran who requests assistance finding a mental health care provider, at any time, particularly during transitional periods. In 2019, over 17,000 inTransition contacts engaged in treatment.

Executive Order 13861 (EO 13861): President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). PREVENTS is focused on a holistic, public health approach to suicide prevention and published its National Roadmap on June 17, 2020. This visionary roadmap outlines how to change the culture surrounding mental health and suicide prevention through enhanced community integration, prioritized research activities, and implementation strategies to effectively lower the rate of suicide, and analyze opportunities for collaboration within federal, state, local, tribal, and nongovernment entities. PREVENTS has also launched a national public awareness campaign, REACH, stressing that everyone has a role to play in the well-being of family members, friends, and coworkers and creating awareness about risk and protective factors to encourage people to reach out to those who may be struggling. PREVENTS efforts have been coordinated nationally to ensure amplification of a unified public health approach in alignment with the National Strategy and its operationalized plans in the SP 2.0 and Now initiatives.

COVID-19 Pandemic and Initial VHA Suicide Surveillance

COVID-19 Suicide Surveillance

As of October 28, 2020, there have been more than 73,900 documented VA coronavirus disease 2019 (COVID-19) cases and over 3,915 known deaths.[68] Many facets of life during the COVID-19 pandemic may result in increased feelings of loneliness, sadness, fear, and anxiety: constant references to mortality; social distancing from friends and loved ones; economic recession and job loss; disruption of daily routines; concerns about shortages of food and medical supplies; and a general sense of powerlessness. To support Veterans' well-being while we are physically distancing, VA expanded the capacity to provide video and phone TeleMental Health care. VA provides current information on the pandemic[69] and information on maintaining mental health and well-being during the COVID-19 outbreak[70] and has released COVID Coach, a free mobile app for both Apple and Android phones that is designed to help build resilience, manage stress, and increase well-being during this crisis.

Since March 2020, VA has conducted ongoing assessment of trends in VHA site-reported suicide-related behavior and information from VHA patient encounters, in the context of the COVID-19 pandemic. VHA site reports include information regarding Veteran suicide deaths and nonfatal attempts. Information regarding nonfatal suicide attempts is based on VHA facility reports and diagnosis indications. Similar information was unavailable for Veterans who were not engaged with VHA care. These trends offer timely although incomplete information.[71] Select surveillance findings are presented below.

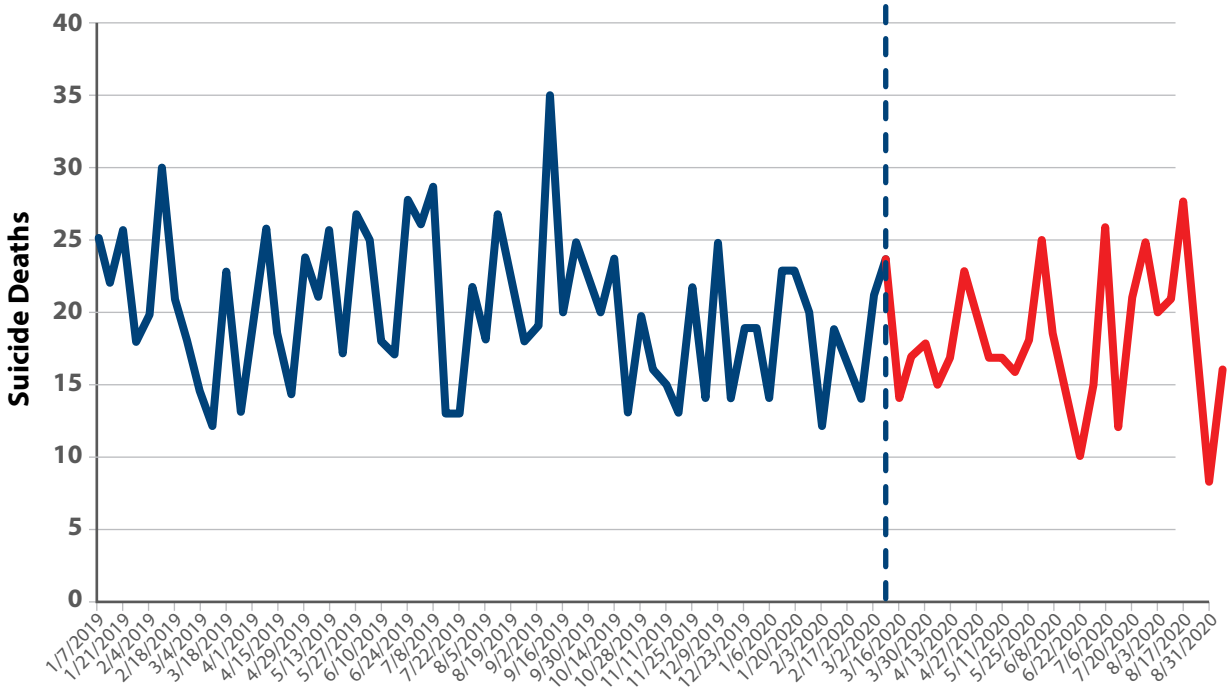
[68] Department of Veterans Affairs. COVID-19 National Summary. ***https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary***. Accessed 10/28/2020.

[69] Veterans Affairs, Public Health. Novel Coronavirus (COVID-19). ***https://www.publichealth.va.gov/n-coronavirus/?utm_source=Homepage&utm_campaign=Coronavirus.*** Accessed 9/14/2020.

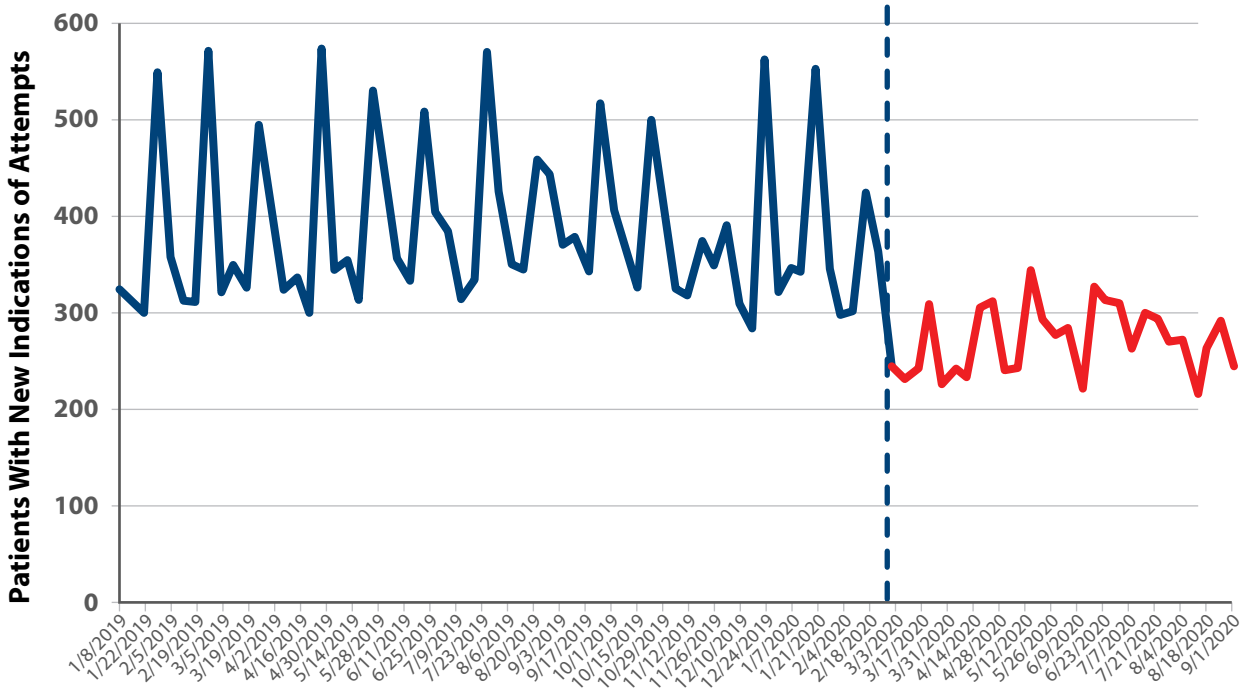
[70] Veterans Affairs, Mental Health. Coronavirus. ***https://www.mentalhealth.va.gov/coronavirus/index.asp***. Accessed 9/14/2020.

[71] Palframan, K.M., Hannemann, C.M., McCarthy, J.F. VHA Suicide Prevention Coordinator Identification of Suicides. Biannual Department of Defense / Department of Veterans Affairs Suicide Prevention Conference. Nashville, Tennessee. August 2019. Findings indicate that site reports documented approximately 33% of all death certificate-indicated suicide deaths in 2013–2016 among recent Veteran VHA users.

Graph 15. VHA Site-Reported Suicide Deaths, by Week, 1/7/2019 – 9/7/2020[72]



Graph 16. VHA Patients With New Indications of Nonfatal Suicide Attempts, by Week, 1/8/19 – 9/15/20 [73]

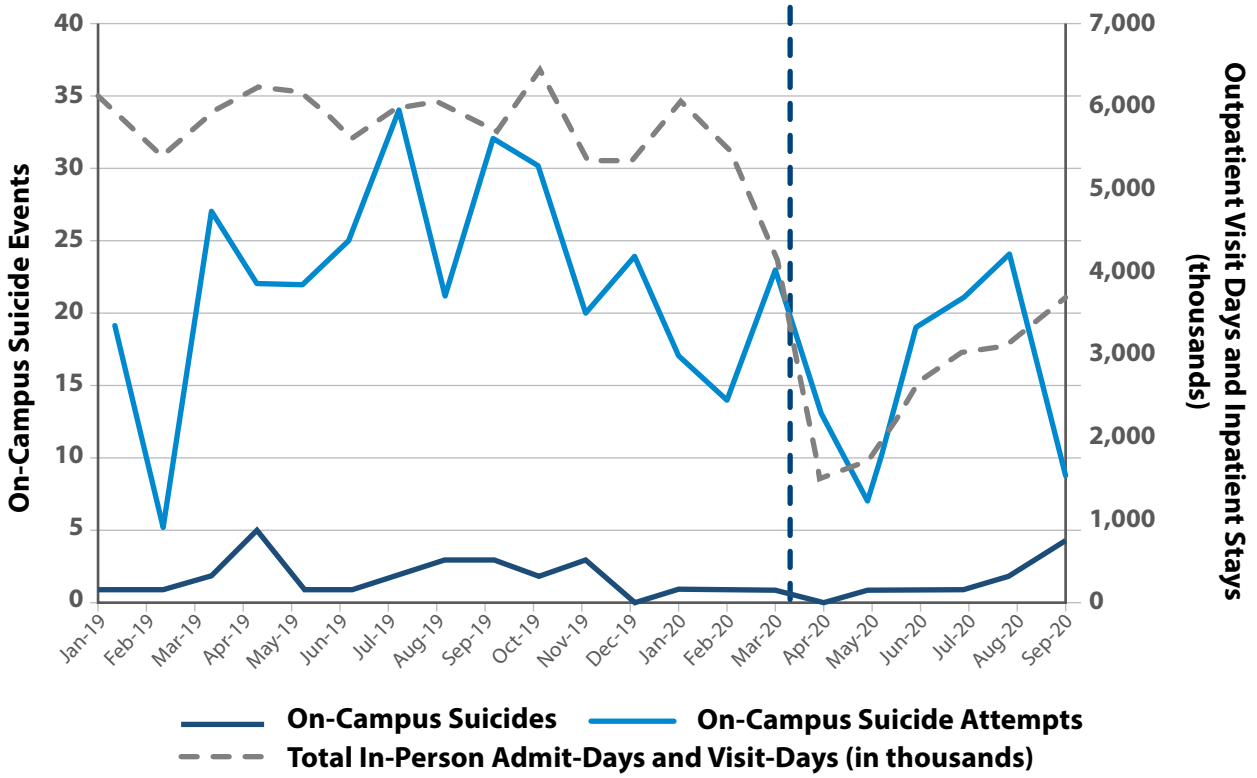


[72] Based on VHA site reporting of Veteran suicide deaths, through the Suicide Behavior and Overdose Reporting (SBOR) and Suicide Prevention Applications Network (SPAN) systems.

[73] Source: VHA SBOR, SPAN and diagnosis records. Provides weekly count of patients with nonfatal attempt indications after a 12-month period without these indications.

The number of documented VHA on-campus suicide attempts and deaths was lower in April and May than in earlier months.

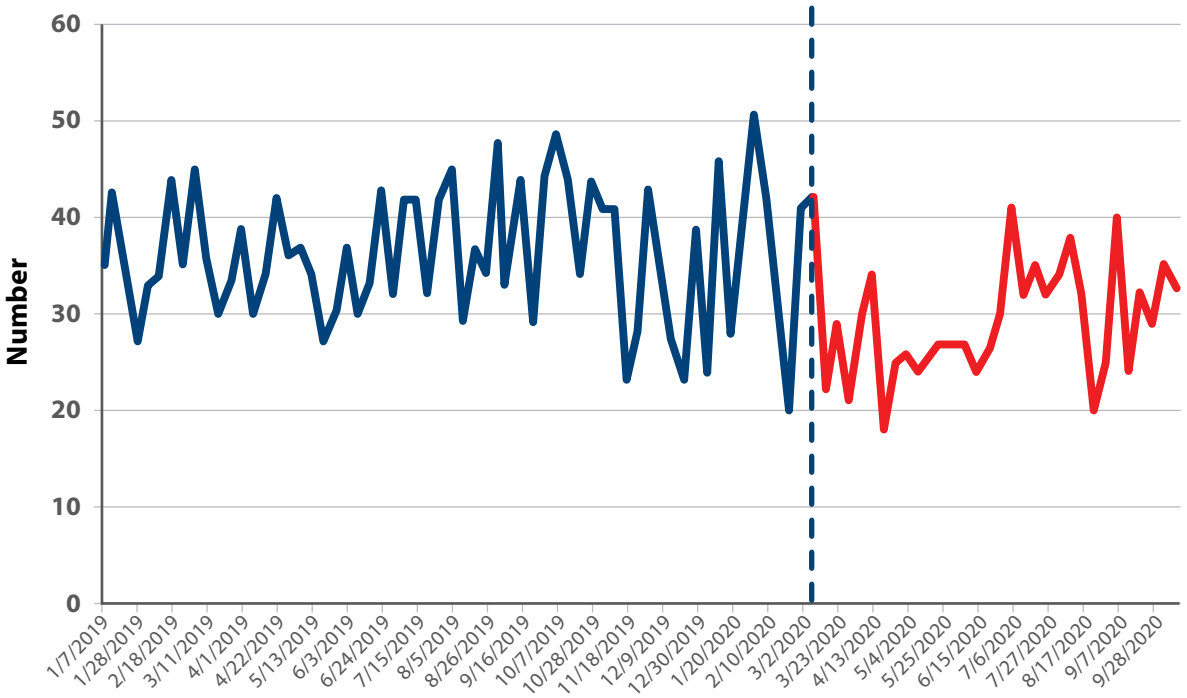
Graph 17. VHA On-Campus Suicide Attempts and Deaths, by Month, January 2019 – September 2020[74]



We observed decreases since mid-March 2020 in VHA emergency department visits for suicide attempts, with an uptick in early July 2020 (see Graph 18 below).

[74] Per VA Office of Mental Health and Suicide Prevention monitoring of VHA site reports and VHA administrative data.

Graph 18. VHA Emergency Department Visits for Suicide Attempts, by Week, 1/7/2019 – 10/12/2020



In summary, findings to date do not indicate pandemic-era increases in site-reported Veteran suicides, nonfatal suicide attempts, on-campus attempts or deaths, or volume of emergency department visits related to suicide attempts. At this time, it is uncertain how changes in VHA utilization and the shift to primarily remote care delivery may affect site documentation of suicide-related behaviors. Monitoring is ongoing.

COVID-19 Mental Health and Suicide Prevention Response

The VHA Mental Health and Suicide Prevention COVID Response Plan was initiated in response to the COVID-19 pandemic and is a public health approach across three domains: universal, selective, and indicated. Universal Strategies encompass engagement of all Veterans. Selective Strategies target engagement of Veterans who may be at increased risk of suicide or who have mental health concerns in response to COVID-19-related stressors. Indicated Strategies target Veterans at elevated risk of suicide or who display escalation in mental health concerns associated with COVID-related stressors. Below is a summary of several highlighted strategies from the plan.

Universal	
Expanded national communication outreach efforts	• Sent Veterans Experience Office's (VEO) Weekly #VetResources newsletter to 11.2M Veterans with relevant information on access to mental health services, including suicide prevention and mental health resources. • Used VetText capability to send a text message to 7.8M Veterans enrolled in VA text services that highlighted info on COVID-19 and access to services. • Developed key websites for Veterans, which provide mental health information related to COVID-19 (VA's main website on COVID-19, Veteran-facing FAQ page for COVID-19, VA's mental health website for COVID-19, National Center for PTSD site on COVID-19). • Launched paid media campaigns for ***Be There***, Lethal Means Safety and Veterans Crisis Line, resulting in 2 million website visits, more than 138 million completed video views, more than 218,000 resource engagements, and more than 450,000 cumulative impressions through August 2020.
Enhanced Lethal Means Safety efforts	• Distributed Lethal Means Safety materials to all Vet Centers and Mental Health, Primary Care, and Women's Clinics. • Updated Lethal Means Safety Training for VA and community providers.
Expanded resources for clinical provider support to assist in COVID-19-related mental health care	• Provided clinical guidance, fact sheets, tips, and consultation to providers through memos, webinars, calls, and one-on-one modalities including topics such as transitioning to telemental health modalities, ensuring access to residential and inpatient settings, using peers and other sources for support, addressing evolving demands and needs, etc.

Selective	
Developed and launched COVID Coach Mobile App	• The app was downloaded more than 135,000 times as of 9/20/2020
Shifted predominantly to virtual care modalities	• Between October and the end of September FY20, VA provided telemental health services to nearly 500,000 Veterans during more than 2 million visits. • In the 5 months prior to the pandemic, VHA Mental Health providers averaged approximately 26,000 VA Video Connect (VVC; telemental health into Veterans' homes) visits a month. For FY20, to date nearly 5,704,500 telephone visits have been completed between mental health providers and Veterans. • In the 5 months prior to the pandemic, VHA mental health providers averaged approximately 146 VVC group psychotherapy visits a month. In September, more than 84,500 VVC group encounters were completed.
Developed enhanced care management activities for Veterans at higher risk	• Modified dashboards to identify Veterans who may be at increased risk due to COVID-19-related isolation. • Facilities can quickly identify Veterans with and without recent care who present with any one of 20 potential risk factors.

Selective	
Launched targeted Suicide Prevention Month paid media efforts	• As of 9/27/2020, the campaign has garnered more than 97.9 million completed video views for SPM; garnered roughly 251,200 site visits; and, drove a total of 28,200 resource engagements associated to paid media.

Indicated	
Expanded Implementation of REACH VET (Recovery Engagement And Coordination for Health - Veterans Enhanced Treatment) program	• Uses predictive (statistical) modeling to identify Veterans at risk for suicide and other adverse outcomes. • The percentage of individuals who were identified by REACH VET as being at the greatest risk who had their care reviewed by a VHA provider rose from 91% in March 2020 to 97% in August 2020. • Outreach provided to those Veterans to collaboratively review their care rose from 89% in January 2020 to 97% in August 2020.
Expanded Implementation of Safety Planning in the Emergency Department (SPED)	• Support for Veterans who go home following a visit to the emergency department during which they are found to be at intermediate or high-chronic or acute risk for suicide.
Developed and implemented the COVID-19 Outreach for Suicide Program to Veterans	• Outreach is provided to Veterans who screen positive, test positive, or are diagnosed with COVID-19 and who are at high risk for suicide. • 1,215 (70.1%) of the 1,733 have been successfully provided outreach.

Expanded Veterans Crisis Line efforts	• Veterans Crisis Line moved operations to telework capacity in April 2020, moving more than 700+ employees to telework in response to COVID-19 without Veterans Crisis Line operational disruption, continuing to meet performance targets answering 95% of calls within 20 seconds with an average speed of 9 seconds.
	• In FY20, the Veterans Crisis Line engaged approximately 1,756 calls per day, and saw an additional 294 contacts through chat and text programs. VCL responders dispatched emergency services to callers at immediate risk approximately 79 times per day.
	• Launched Caring Letters, an evidence-based intervention for suicide prevention found to reduce the rate of suicide death, attempts, and ideation.
	  • Will reach more than 90,000 Veterans annually with nine letters over the course of a year after their call to VCL.
	  • Launched in June 2020, 9,000 Veterans were enrolled within three weeks.

Call to Continued and Further Action

Hope versus despair often typifies an individual's experience of suicide behaviors. Likewise, the dichotomy of hope versus despair is a relevant dynamic within our collective experience and engagement of suicide prevention, intervention, and postvention. Whether the setting is an individual's heart and mind or that of our broader community, it is imperative that hope prevails over despair.

First, this report offers data points that suicide is indeed preventable through clinically based and community-based prevention efforts and interventions, as well as through research and surveillance within and beyond the VA. Yet this report also elucidates that while suicide is preventable, suicide and suicide prevention are extremely complex. Simplistic explanations and blame must be avoided, lest despair become entrenched. This is true at the individual level, as suicide survivors and loved ones will readily convey, as well as at the population level wherein the effects of divisive and fractious finger-pointing leave little gained and a sense of despair in the wake. Second, this report offers conceptual and quantitative data that a public health approach to suicide is a source of hope. Data demonstrates decreasing suicide rates for Veterans engaged in VHA care, however, the data also conveys a message that the mission and the work must include, but extend beyond the clinical domains of diagnoses, etiologies, and treatments into the community setting. Issues pertaining to personal finances, relationships, and vocation meld with community economics, resources, and growth opportunities and wherein state and national policies create the theater of operations within which individuals and communities live. Third, this report offers demonstration of the fact that everyone has a role to play in suicide prevention; it is a source of hope, therefore, that suicide is our collective battle to engage and to win. While the report offers encouraging data that VHA care matters, the data is not in the least obtuse about the fact that Veteran suicide prevention, intervention, and postvention must include but must extend beyond the VA, in partnership with local communities, regions, and states; other federal, state, and county agencies; private industry, service organizations, nonprofits, and faith-based institutions and organizations.

This report likely finds many individuals and communities at a seeming fork-in-the-road between hope and despair with regard to suicide prevention. We are not above or beyond such a dynamic, yet we assertively and hopefully push forward, heartened by Anchors of Hope, while simultaneously deeply burdened by the loss of every Veteran to suicide. In this context, we are entrenched in these foundational truths:

- Suicide is preventable, but should not be an issue of counterproductive blame or shame.
- Suicide prevention will require a public health approach unifying clinical, community, and academic domains.
- Suicide prevention will require all of us to be collectively engaged around the four central pillars of the National Strategy, with each agency, community, organization, and individual offering a necessary component of prevention, or intervention, or postvention in the spirit of mission unification and collaboration.

In the context of our anchored hope, we acknowledge the truism that hope is not in and of itself a plan. Therefore, we have attempted in this report to carefully outline the linkages between the National Strategy with our SP 2.0 and SP Now operational and strategic plans; as well as to highlight the specific actions, programs, and interventions associated with SP 2.0 and SP Now, highlighting the manner in which they are an outflow of the National Strategy. In light of this and in recognition of work needing yet to be done, we invite and welcome broad partnership and collaboration toward eradicating Veteran suicide.

Acronym	Description
ASPI	Advanced Safety Planning Intervention
CBI-SP	Community-Based Interventions Suicide Prevention
CBT	Cognitive Behavioral Therapy
CBT-SP	Cognitive Behavioral Therapy for Suicide Prevention
CPG for SP	Clinical Practice Guidelines for Suicide Prevention
EO 13822	Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life
EO 13861	See "PREVENTS"
FY	Fiscal Year
MH	Mental Health
MSO	Military Service Organization
OMHSP	Office of Mental Health and Suicide Prevention
PREVENTS	President's Roadmap to Empower Veterans And End a National Tragedy of Suicide
PST-SP	Problem-Solving Therapy for Suicide Prevention
Q	Quarter
REACH VET	Recovery Engagement And Coordination for Health — Veterans Enhanced Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SBOR	Suicide Behavior and Overdose Report
SP	Suicide Prevention
SPAN	Suicide Prevention Applications Network
SPED	Safety Planning in the ED
SPP	Suicide Prevention Program
SPPRITE	Suicide Prevention Population Risk Identification and Tracking for Exigencies
SUD	Substance Use Disorder
TWV	Together With Veterans: Rural Veteran Suicide Prevention Program

Acronym	Description
VA	Department of Veterans Affairs
VCL	Veterans Crisis Line
VEO	Veteran Experience Office
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization

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

U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. 2020 National Veteran Suicide Prevention Annual Report. 2020. Retrieved {date} from ***https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf***.