2019 National Veteran Suicide Prevention Annual Report

Office of Mental Health and Suicide Prevention

VA | U.S. Department of Veterans Affairs

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Executive Summary

45,390 American adults died from suicide in 2017, including 6,139 U.S. Veterans[1]. Our nation is understandably grieving with each suicide, prompting our collective and tireless pursuit of evidence-based clinical interventions and expansion of community prevention strategies to reach each Veteran. VA offers through this report a renewed and determined call to unrelentingly address suicide in our Veteran population and our society, as suicide has no single cause and the tragedy of suicide affects all Americans. Findings in this report reflect the most current national data (available through 2017) from the Centers for Disease Control and Prevention's National Death Index.

Key results include the following:

- The number of Veteran suicides exceeded 6,000 each year from 2008 to 2017.
- Among U.S. adults, the average number of suicides per day rose from 86.6 in 2005 to 124.4 in 2017. These numbers included 15.9 Veteran suicides per day in 2005 and 16.8 in 2017.
- In 2017, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, after adjusting for population differences in age and sex.
- Firearms were the method of suicide in 70.7% of male Veteran suicide deaths and 43.2% of female Veteran suicide deaths in 2017.
- In addition to the aforementioned Veteran suicides, there were 919 suicides among never federally activated former National Guard and Reserve members in 2017, an average 2.5 suicide deaths per day.

Suicide prevention is a national priority and VA is dedicated to this mission. While the data in this report extends only through 2017, since that time VA has continued to work actively in partnership with the White House, Congress, Veterans Health Administration networks, and federal and community partners to address the issue of Veteran suicide. The most recent and notable manifestation of this comprehensive approach to Veteran suicide prevention is the President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS), mandated by an executive order signed by the President in March 2019. A cabinet-level task force has been launched to develop a national roadmap for suicide prevention, which will include proposals and plans addressing integration and collaboration across sectors, a national research strategy, and a cohesive implementation strategy.

Together, we can all make a difference.

[1] See Page 4 regarding Veteran status.

Suicide as a National Problem

One suicide is heartbreaking, notably affecting an estimated 135 surviving individuals for each death by suicide.[2] Our nation grieves with each suicide, necessarily prompting the collective tireless pursuit of evidence-based clinical interventions and community prevention strategies. In this spirit, VA offers in this report a renewed and determined call to addressing the crisis of suicide in our Veteran population and among all Americans.

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 former service members who most closely meet the official definition of Veteran status that is used by VA and other federal agencies (see endnote regarding Title 38).[3] 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.

We note that a prior report indicated that there were on average 20 suicide deaths per day in 2014 when combining three groups who died from suicide: Veterans, current service members, and former National Guard or Reserve members who were never federally activated.[4]

This report is specific to Veterans as defined above (Title 38). For this reason, results should not be directly compared with information presented in previous reports.

We include information in a separate section on suicide among former National Guard or Reserve members who were never federally activated. Information regarding individuals who died by suicide during U.S. military service is available from the Department of Defense.[5]

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[2] Cerel, J., Brown, M.M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, Cl. (2019) How many people are exposed to suicide? Not six. Suicide and Life Threatening Behavior, 49(2), 529–534.

[3] 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.

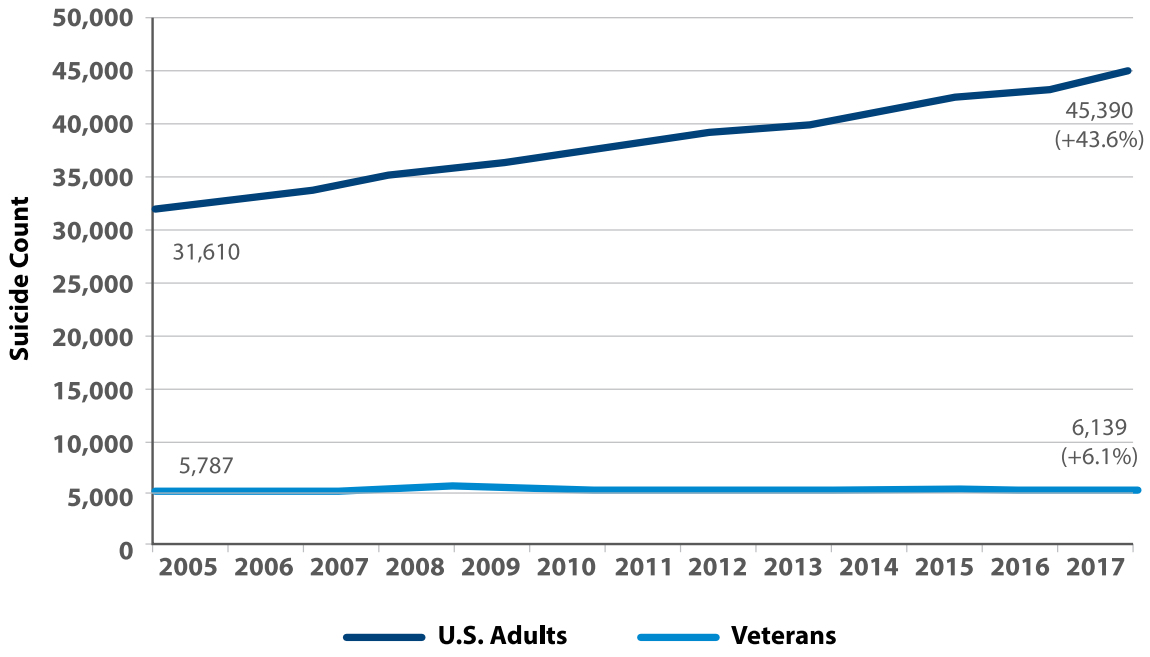
[4] Department of Veterans Affairs, Office of Suicide Prevention. Suicide Among Veterans and Other Americans, 2001–2014. 3 August 2016. ***https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf***

[5] 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***.

Suicide Across the United States

- 45,390 American adults died by suicide in 2017, compared with 31,610 in 2005.[6]
- These deaths included 6,139 Veterans in 2017, compared with 5,787 in 2005.[7]
- In 2017, Veterans accounted for 13.5% of all deaths by suicide among U.S. adults and constituted 7.9% of the U.S. adult population. In 2005, Veterans accounted for 18.3% of all deaths by suicide and represented 11.3% of the U.S. adult population.

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



Across the nation, the number of suicide deaths has been rising since the turn of the millennium. From 2005 to 2017, there was a 43.6% increase in the number of suicide deaths in the general population and a 6.1% increase in the number of suicide deaths in the Veteran population.

- In 2005, an average of 86.6 American adults, who included Veterans, died by suicide each day. In 2017, an average of 124.4 Americans died by suicide each day.
- In 2005, an average of 15.9 Veterans died by suicide each day. In 2017, an average of 16.8 Veterans died by suicide each day.

[6] The U.S. adult population increased from approximately 215 million to 251 million during this period.

[7] The U.S. Veteran population decreased from approximately 24.2 million to 19.8 million during this period.

Understanding the Cultural Context of Suicide in the United States

There is:

- No all-encompassing explanation for suicide
- No single path to suicide[8]
- No single path away from suicide[9]
- No single medical cause, etiology, or treatment or prevention strategy

Instead, suicide involves dynamic and individual interactions between the following domains:

- International (e.g., war, the global economy)
- National (e.g., economic disparities, media portrayals and accounts, policies pertaining to lethal means access, policies pertaining to health care access)
- Community (e.g., health care access, employment rates, level of community services and connectedness, homelessness rates)
- Family and relationship (e.g., level of social support, intensity of relationship problems)
- Individual (e.g., health and well-being)

Demonstrating the interplay of these dynamic domains, U.S. suicide rates have been found to vary by decade, by economic conditions, by region and state, by demographics, and by occupational categories. Suicide rates among Veteran users of Veterans Health Administration (VHA) services have been found to be affected by economic disparities, homelessness, unemployment, level of military service connected disability status, community connection, and personal health and well-being. The following details highlight VHA Veteran experiences across these domains:

- **Economic Disparities:** Veterans enrolled in VHA care were less likely to be employed and had lower income levels than Veterans not receiving VHA care.[10] Some Veterans report difficulty in transitioning to civilian positions. Their highly developed skills obtained in the military may not translate to higher-level positions in the civilian world. In addition, unemployment and poverty are correlated with homelessness among Veterans.
- **Homelessness:** In January 2017, the U.S. Department of Housing and Urban Development Point-in-Time Count estimated that 40,000 Veterans were homeless and just over 15,300 were living on the street or unsheltered on any given night. Homelessness appears to play a role in suicide for VHA patients. VHA patients with indications of homelessness or who received homelessness-related services had higher rates of suicide than other VHA patients.[11]
- **Service Connection:** VHA patients with military service connected disability status may have lower risk of suicide than other VHA patients.[11]

[8] Turecki, G., Brent, D.A. (2016). Suicide and suicidal behavior. Lancet. 387:1227–39.

[9] 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.

[10] 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***

[11] McCarthy JF, Bossarte R, Katz IR, 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.

- **Social Connection:** Isolation has been shown to be a risk factor for suicide.[12] Among VHA patients, suicide rates have been found to be highest among those who were divorced, widowed, or never married and lowest among those who married.[11] Also, among VHA patients, suicide rates were elevated among individuals residing in rural areas.[11] [13]
- **Health and Well-Being:** VHA Veterans who died by suicide were more likely to have sleep disorders, traumatic brain injury, or a pain diagnosis.[11] In addition, 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 were also associated with greater likelihood of suicide.[11]

In summary, the sociocultural context of suicide provides a complex entwining of factors associated with, but not directly predictive of, suicide. Therefore, meaningful improvement of suicide prevention efforts is possible only through a systematic and unified public health approach addressing international, national, and community-level issues and resources paired with individualized support, care, and personal responsibility.

[12] 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***

[13] 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.

Veteran Suicide in the U.S.

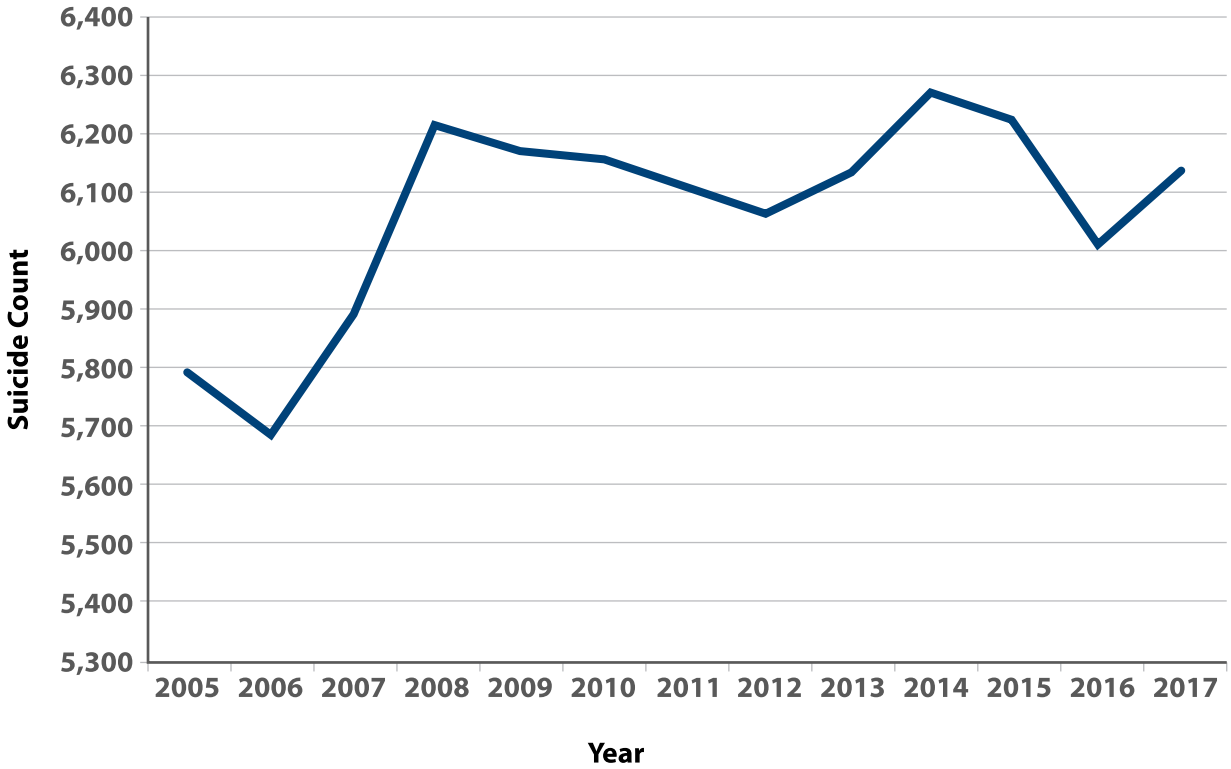
Veterans do not live, work, and serve in isolation from the community, the nation, or the world. The issue of suicide in the U.S. also affects the Veteran population. Below, we convey current Veteran suicide data, looking at both Veterans served by VHA and Veterans not accessing VHA care.

Total Number of Veteran Suicides: 2005–2017[14]

As is true of the United States 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 5,787 in 2005 to 6,139 in 2017.
- The annual number of Veteran suicide deaths has exceeded 6,000 since 2008.
- The annual number of Veteran suicide deaths increased by 129 from 2016 to 2017.
- The number of Veteran suicides per year was lowest in 2006, highest in 2014, and the number in 2017 was lower than in five of the prior years.

Graph 2. Annual Number of Veteran Suicides, 2005–2017



[14] The numbers reported in this section are actual counts of each Veteran who died by suicide. Beyond total count, unadjusted rate calculations can be helpful for understanding mortality within each population. Adjusted rates attempt to account for differences between populations, e.g., in age and sex. For further discussion and presentation of suicide rates, see Page 10.

Average Number of Veteran Suicides per Day: 2005–2017[15]

The average number of Veteran suicides per day increased from 2005 to 2017.

- In 2005, an average of 86.6 American adults, who included Veterans, died by suicide each day. In 2017, an average of 124.4 Americans died by suicide each day.
- In 2005, an average of 15.9 Veterans died by suicide each day. In 2017, an average of 16.8 Veterans died by suicide each day.
- The average number of Veteran suicide deaths per day has equaled or exceeded 16.0 since 2007.
- The average of 16.8 Veteran suicide deaths per day in 2017 was higher than the 16.4 average suicide deaths per day in 2016 and equal to or lower than in 2008–2011 and 2013–2015.
- 16.8 Veteran average deaths per day in 2017 is lower than the annual averages in 7 of the last 13 years.

Table 1. Total and Daily Average Numbers of Suicide Deaths, Title 38 Veterans, 2005–2017

Year	Suicide Deaths	Average per Day
2005	5,787	15.9
2006	5,688	15.6
2007	5,893	16.1
2008	6,216	17.0
2009	6,172	16.9
2010	6,158	16.9
2011	6,116	16.8
2012	6,065	16.6
2013	6,132	16.8
2014	6,272	17.2
2015	6,227	17.1
2016	6,010	16.4
2017	6,139	16.8

[15] Previous VA reporting regarding average suicide deaths per day included suicides among Title 38 Veterans, current service members and former never federally activated Guard and Reserve members. In reporting on suicide deaths through 2016, information was provided regarding Title 38 Veterans and, separately, the number of deaths among former never federally activated Guard and Reserve. In this year's report, we focus on the Title 38 Veterans, and in supplemental reporting, we provide not only counts but also rates for the former never federally activated Guard and Reserve. Information regarding suicide among current service members is available from the Department of Defense Suicide Prevention Office.

Age- and Sex-Adjusted Suicide Rate

The Veteran population decreased by 18% from 2005 to 2017. To allow for comparisons between populations and over time, suicide rates have been adjusted to account for population differences by age and sex.[16]

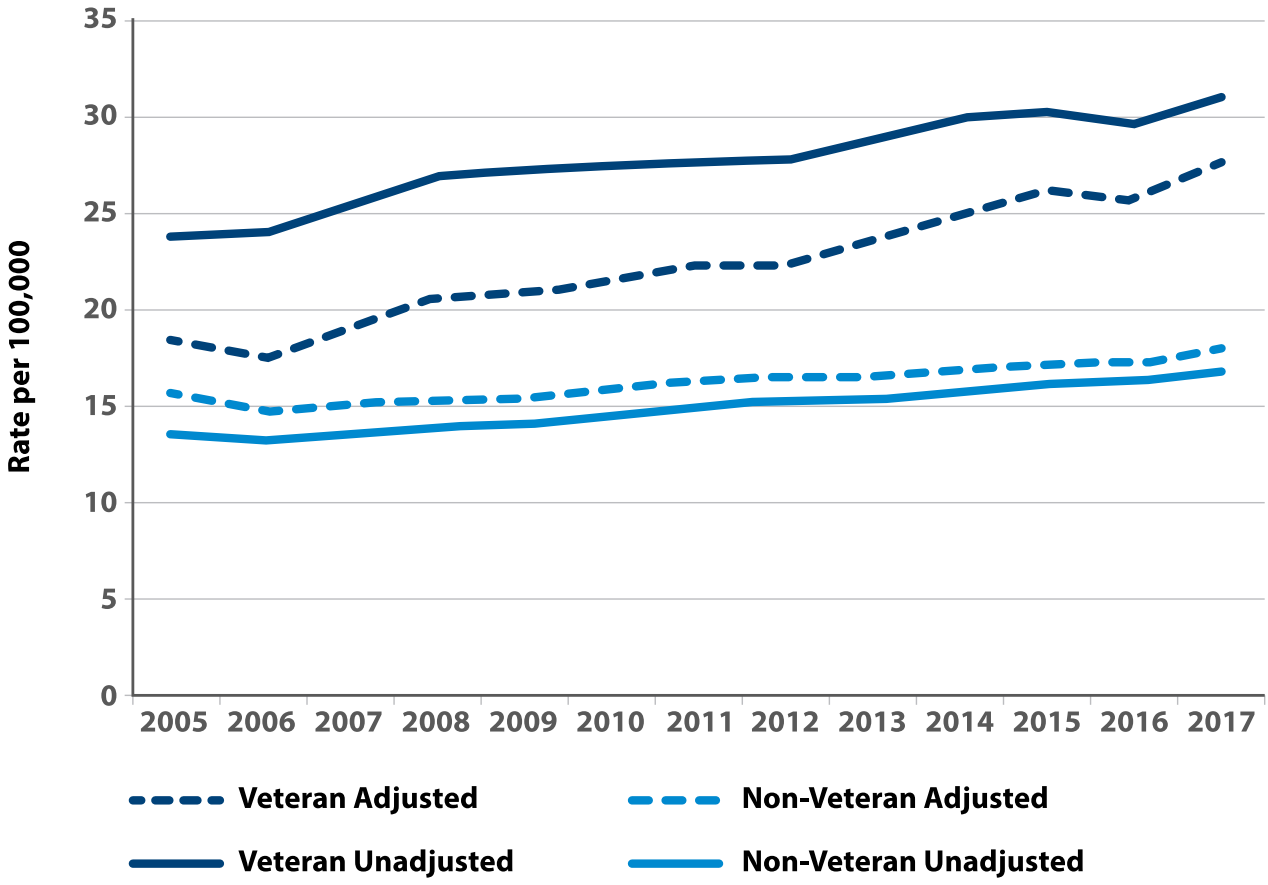
- From 2005 to 2017, the age- and sex-adjusted suicide rate for the overall U.S. population increased from 14.7 suicide deaths per 100,000 to 18.0 per 100,000.
- The suicide rates for both Veterans and non-Veteran adults increased between 2005 and 2017.
- The U.S. population increased by 17.0% from 2005 to 2017.
- The Veteran population decreased by 18.3% from 2005 to 2017.
- The age- and sex-adjusted suicide rate for the Veteran population increased from 18.5 suicide deaths per 100,000 in 2005 to 27.7 per 100,000 in 2017.
- The age- and sex-adjusted rate for the Veteran population increased from 25.7 suicide deaths per 100,000 in 2016 to 27.7 suicide deaths per 100,000 in 2017. The change from 2016 to 2017 is not statistically significant; however, the adjusted suicide rate for Veterans increased significantly from 2005 to 2017.
- In 2017, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, after adjusting for age and sex.

Table 2. Age- and Sex-Adjusted Veteran Suicide Rate per 100,000 Population Members, 2005–2017

Year	Suicide Deaths	Average per Day	Veteran Population	Age-and-Sex-Adjusted Suicide Rate
2005	5,787	15.9	24,240,000	18.5
2006	5,688	15.6	23,731,000	17.6
2007	5,893	16.1	23,291,000	18.8
2008	6,216	17.0	22,996,000	20.6
2009	6,172	16.9	22,603,000	20.8
2010	6,158	16.9	22,411,000	21.4
2011	6,116	16.8	22,061,000	22.3
2012	6,065	16.6	21,765,000	22.4
2013	6,132	16.8	21,415,000	23.6
2014	6,272	17.2	21,029,000	25.0
2015	6,227	17.1	20,560,000	26.3
2016	6,010	16.4	20,170,000	25.7
2017	6,139	16.8	19,803,000	27.7

[16] Unadjusted rates can be helpful for understanding mortality within each population. We note that the Veteran population is older and has a higher a percentage of men in comparison with the non-Veteran population. Thus, we also include age and sex adjusted rates, per the U.S. 2000 Standard Population. Annual rates are per 100,000 population or, for Veterans with recent VHA use, person-years, as risk time could be calculated exactly for the VHA population.

Graph 3. Unadjusted and Age- and Sex-Adjusted Suicide Rates for Veterans and Non-Veteran Adults (2005–2017)

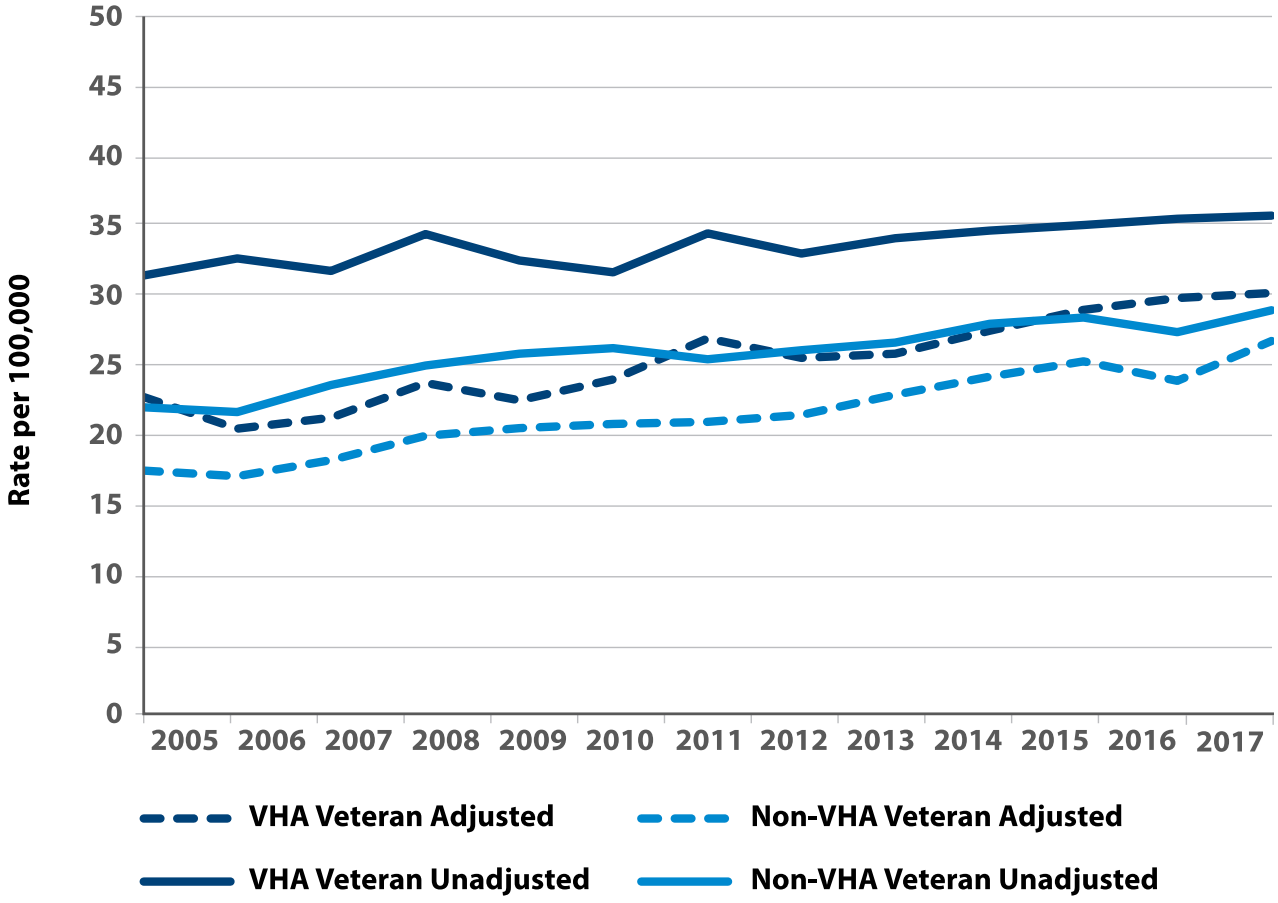


Age- and Sex-Adjusted Suicide Rates for Veterans Who Used VHA Care

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 were defined as Veterans who had a VHA health encounter in the calendar year of interest or in the prior calendar year.

- For each year, from 2005 to 2017, Veterans with recent VHA use had higher suicide rates than other Veterans. However, over these years, suicide rates among Veterans with recent VHA use increased at a slower pace than for other Veterans.
- The age- and sex-adjusted suicide rate among Veterans with recent VHA use increased by 1.3% between 2016 and 2017.
- The age- and sex-adjusted suicide rate among Veterans who did not use VHA care increased by 11.8% between 2016 and 2017.

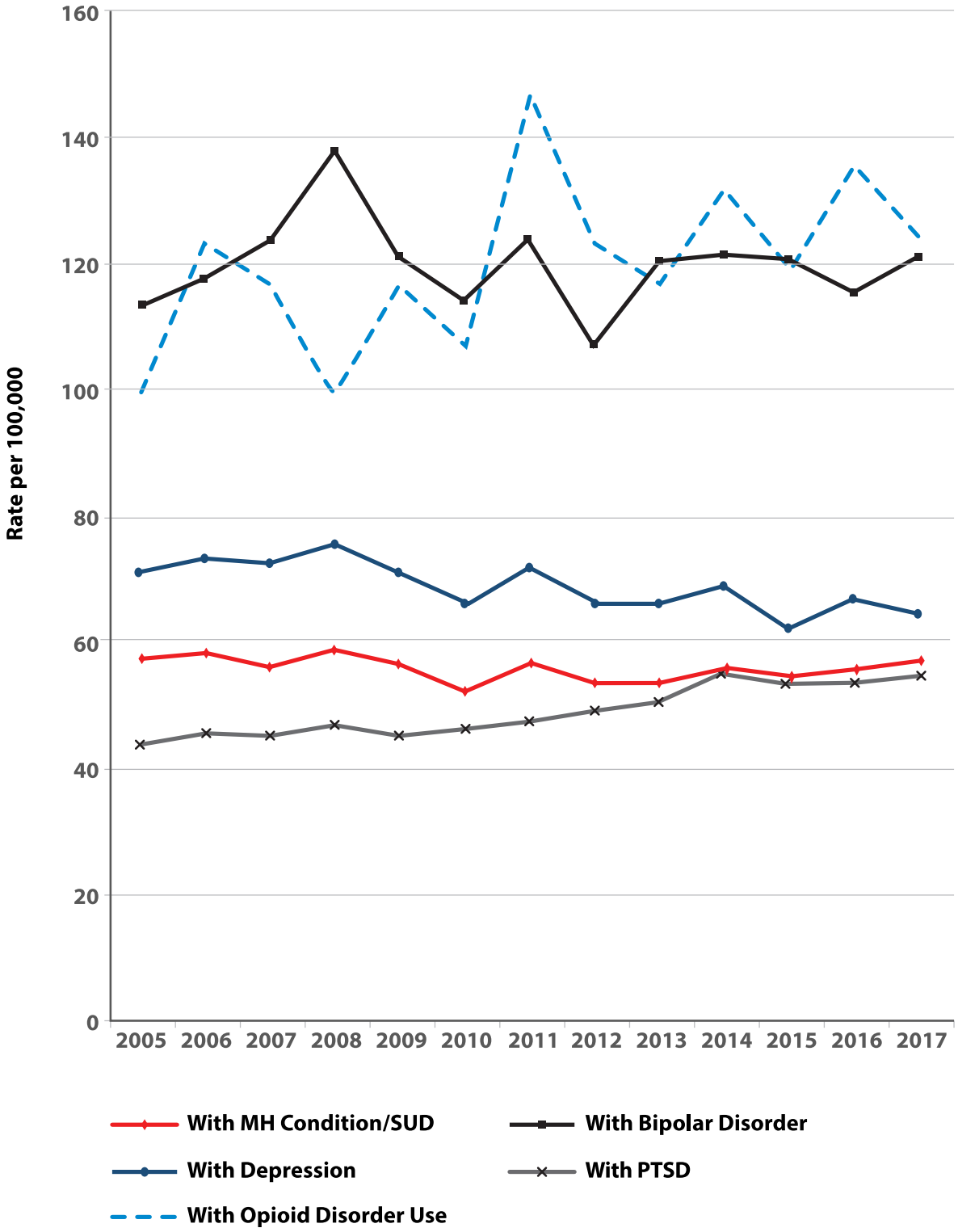
Graph 4: Age- and Sex-Adjusted Suicide Rates, Veterans With and Without Recent VHA Care, 2005–2017



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

- Among Veterans with recent VHA use who died by suicide in 2017, 58.7% had a diagnosed mental health or substance use disorder in 2016 or 2017.
- In 2017, VHA patients with any mental health or substance use disorder diagnosis had a suicide rate of 56.9 per 100,000, compared with 57.1 per 100,000 in 2005.
- Suicide rates were highest among Veteran VHA patients diagnosed with bipolar disorder and those diagnosed with opioid use disorder.
- For VHA patients diagnosed with depression, the suicide rate decreased from 2005 to 2017, from 70.2 per 100,000 to 63.4 per 100,000.

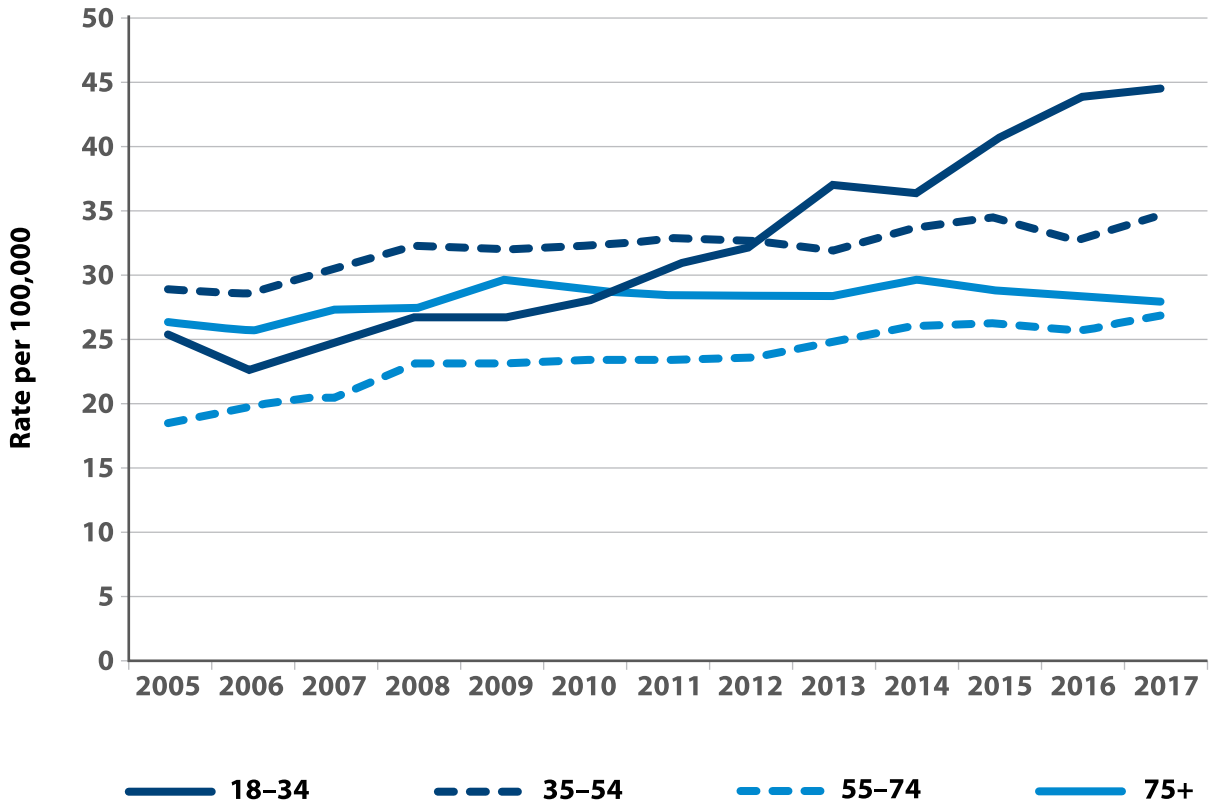
Graph 5. Suicide Rates per 100,000, Among Veteran VHA Patients With Mental Health (MH) or Substance Use Disorder (SUD) Diagnoses, 2005–2017



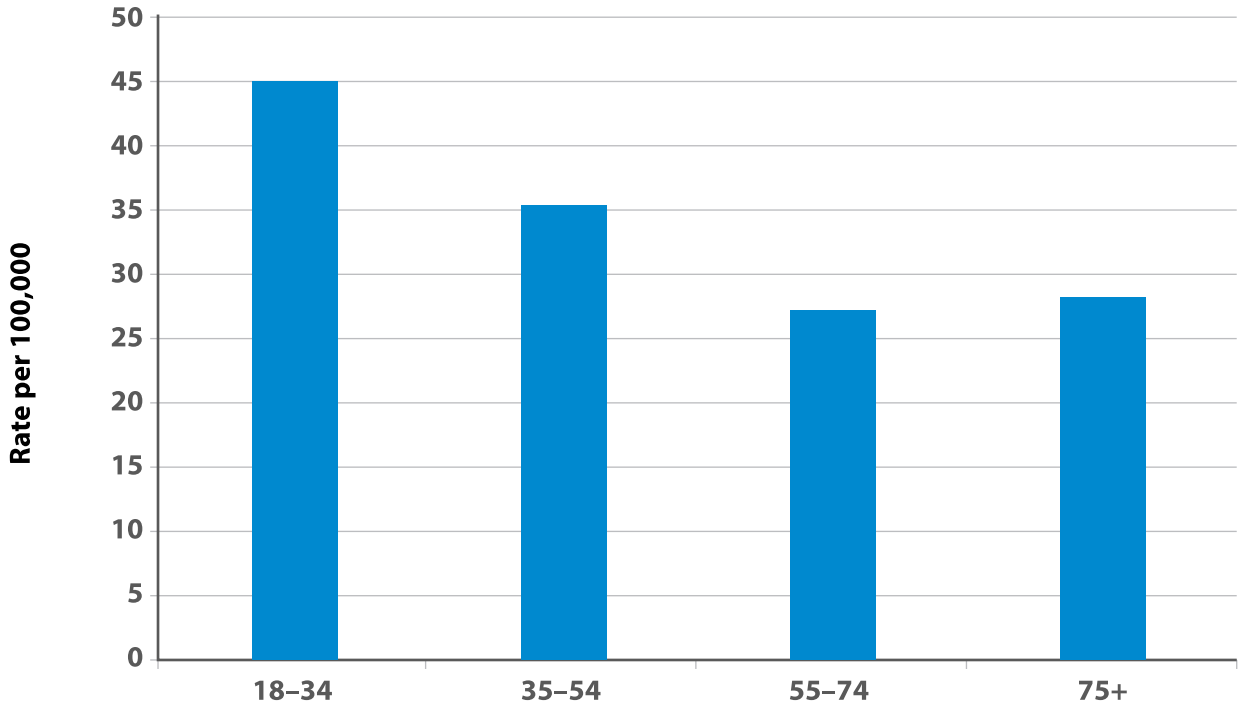
Veteran Suicide Rates by Age Group

- Veterans ages 18–34 had the highest suicide rate in 2017 (44.5 per 100,000).
- The suicide rate for Veterans ages 18–34 increased by 76% from 2005 to 2017.
- Veterans ages 55–74 had the lowest suicide rate per 100,000 in 2017.
- The absolute number of suicides was highest among Veterans 55–74 years old. This group accounted for 38% of all Veteran deaths by suicide in 2017.

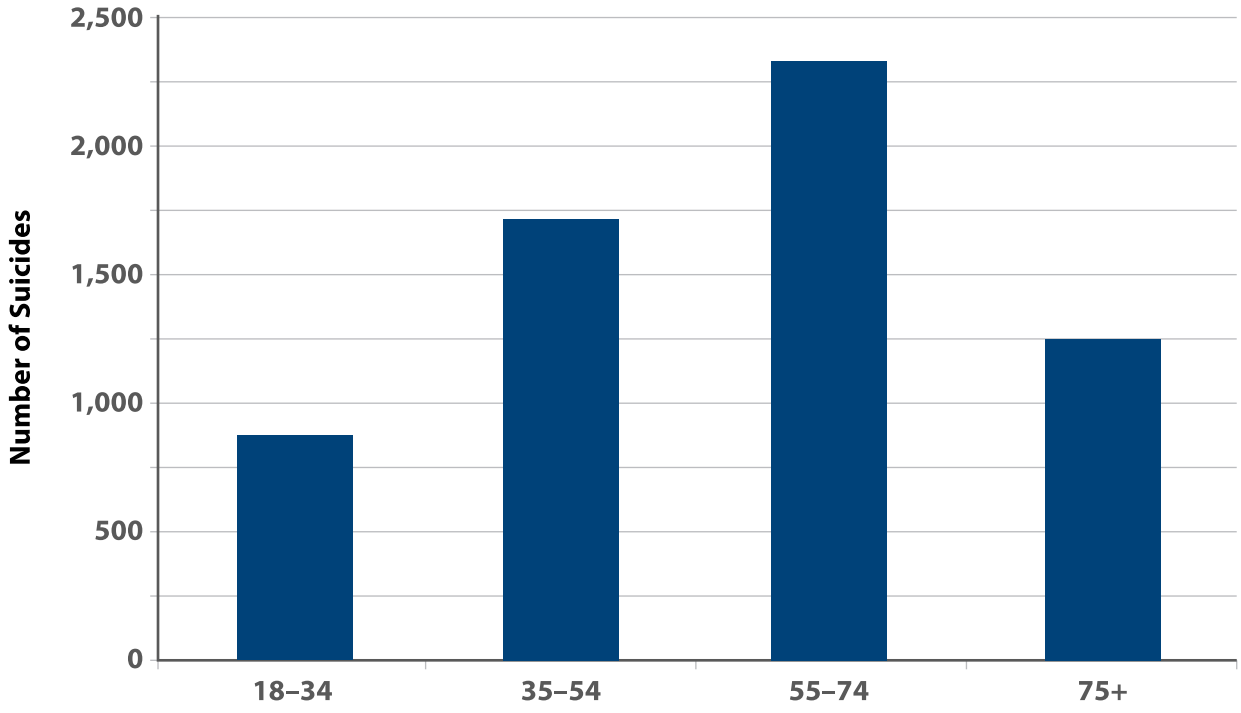
Graph 6. Veteran Suicide Rates per 100,000, by Age Group, 2005–2017



Graph 7. Veteran Suicide Rates per 100,000, by Age Group, 2017



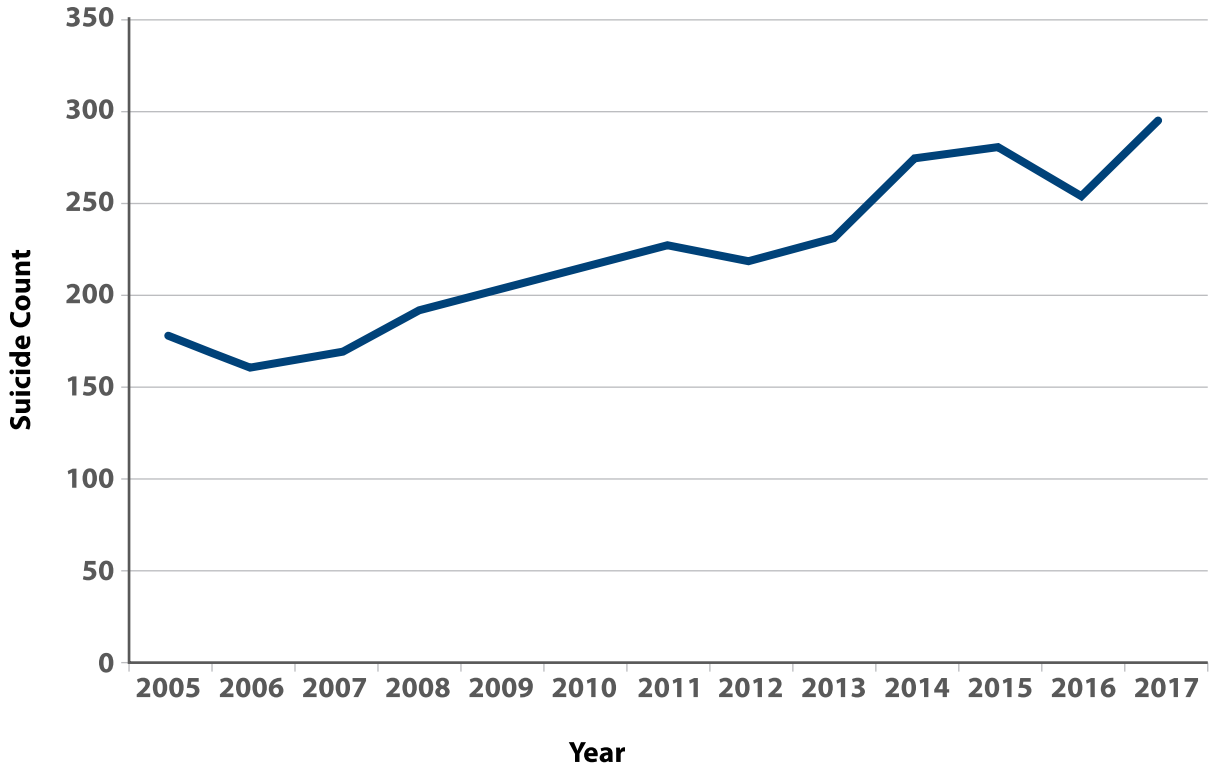
Graph 8. Veteran Suicide Counts by Age Group, 2017



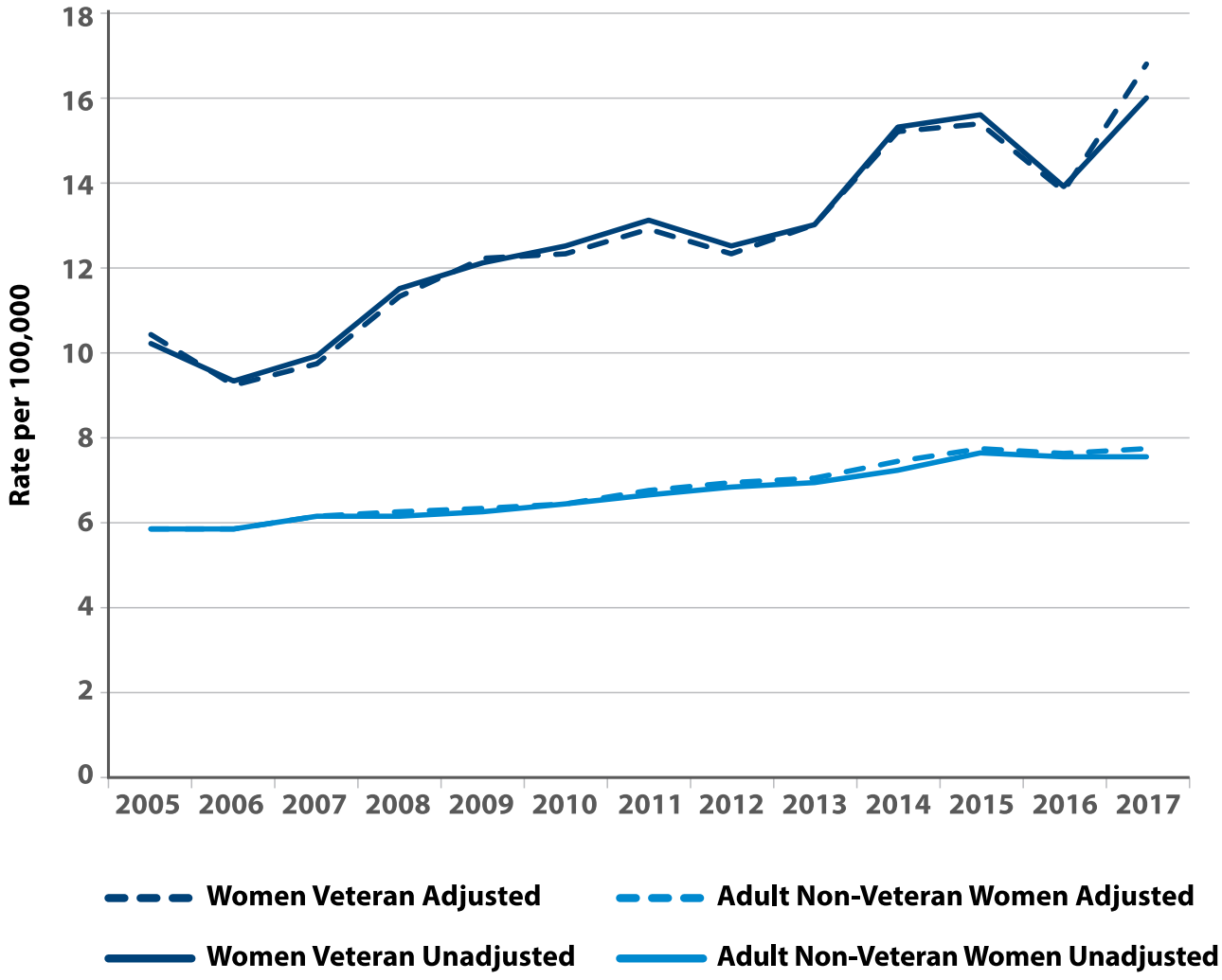
Veteran Suicide Rate by Sex

- Between 2005 and 2017, the women Veteran population increased by 6.5%.
- After adjusting for age, the 2017 rate of suicide among women Veterans was 16.8 per 100,000, compared with 39.1 per 100,000 among male Veterans.
- After adjusting for age, the 2017 rate of suicide among women Veterans was 2.2 times the rate among non-Veteran women.
- After adjusting for age, the 2017 rate of suicide among male Veterans was 1.3 times higher than the rate among non-Veteran males.

Graph 9. Total Count of Suicides Among Women Veterans, 2005–2017



Graph 10. Suicide Rates Among Women Veterans and Non-Veteran Women, 2005–2017



Veteran Suicide Methods

- In 2017, 69.4% of Veteran suicide deaths were due to a self-inflicted firearm injury, while 48.1% of non-Veteran adult suicides resulted from a firearm injury.
- In 2017, 70.7% of male Veteran suicide deaths and 43.2% of female Veteran suicide deaths resulted from a firearm injury.

Table 3. Method of Suicide Among Veteran and Non-Veteran Adults Who Died from Suicide, 2017

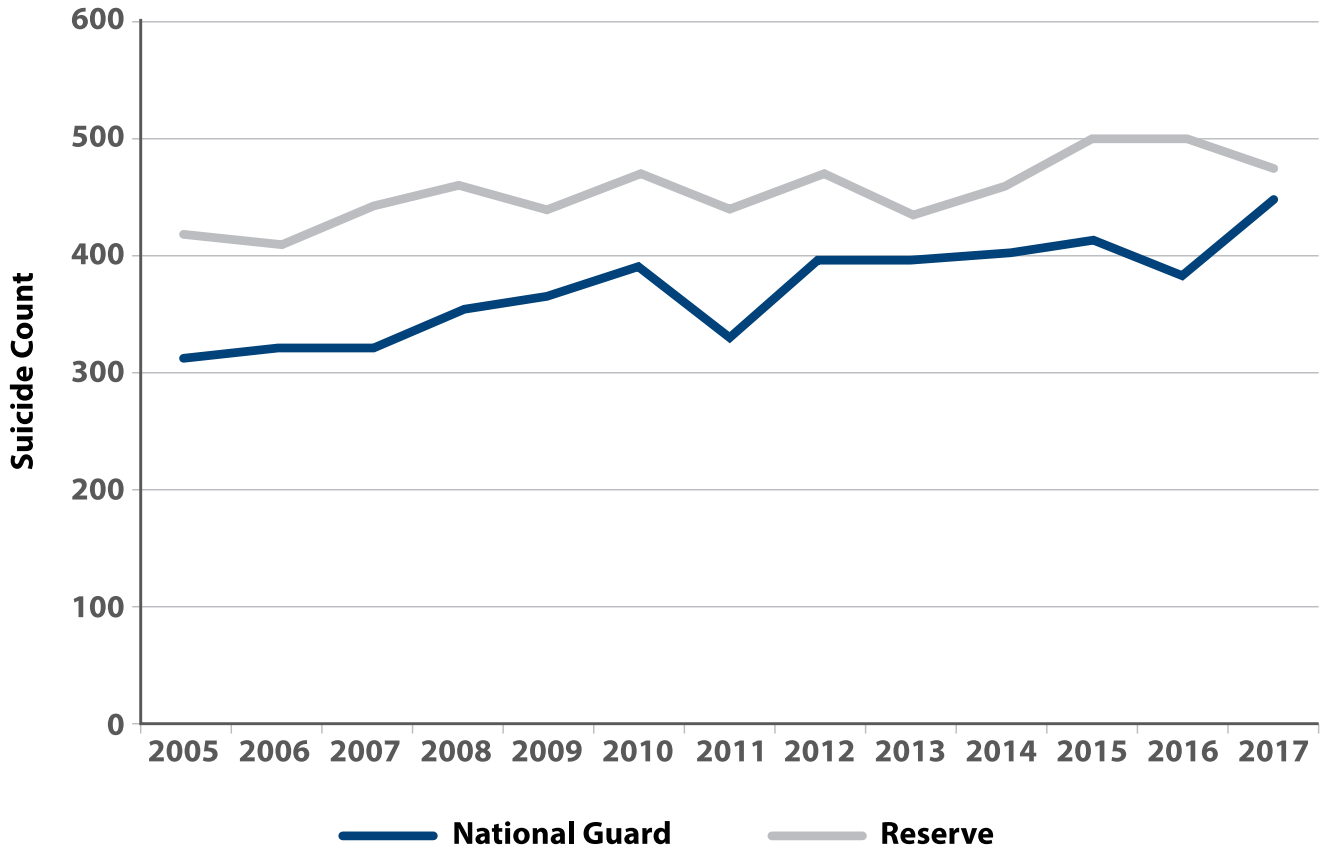
Method	Percentage of Non-Veteran Adult Suicide Deaths	Percentage of Veteran Suicide Deaths	Percentage of Male Non-Veteran Adult Suicide Deaths	Percentage of Male Veteran Suicide Deaths	Percentage of Female Non-Veteran Adult Suicide Deaths	Percentage of Female Veteran Suicide Deaths
Firearm	**48.1%**	**69.4%**	**53.5%**	**70.7%**	**31.3%**	**43.2%**
Poisoning	**14.9%**	**9.9%**	**9.2%**	**8.9%**	**32.3%**	**28.7%**
Suffocation	**28.7%**	**15.8%**	**29.3%**	**15.6%**	**26.6%**	**19.9%**
Other	**8.4%**	**5.0%**	**7.9%**	**4.8%**	**9.8%**	**8.1%**

Never Federally Activated Former Guard and Reserve Members

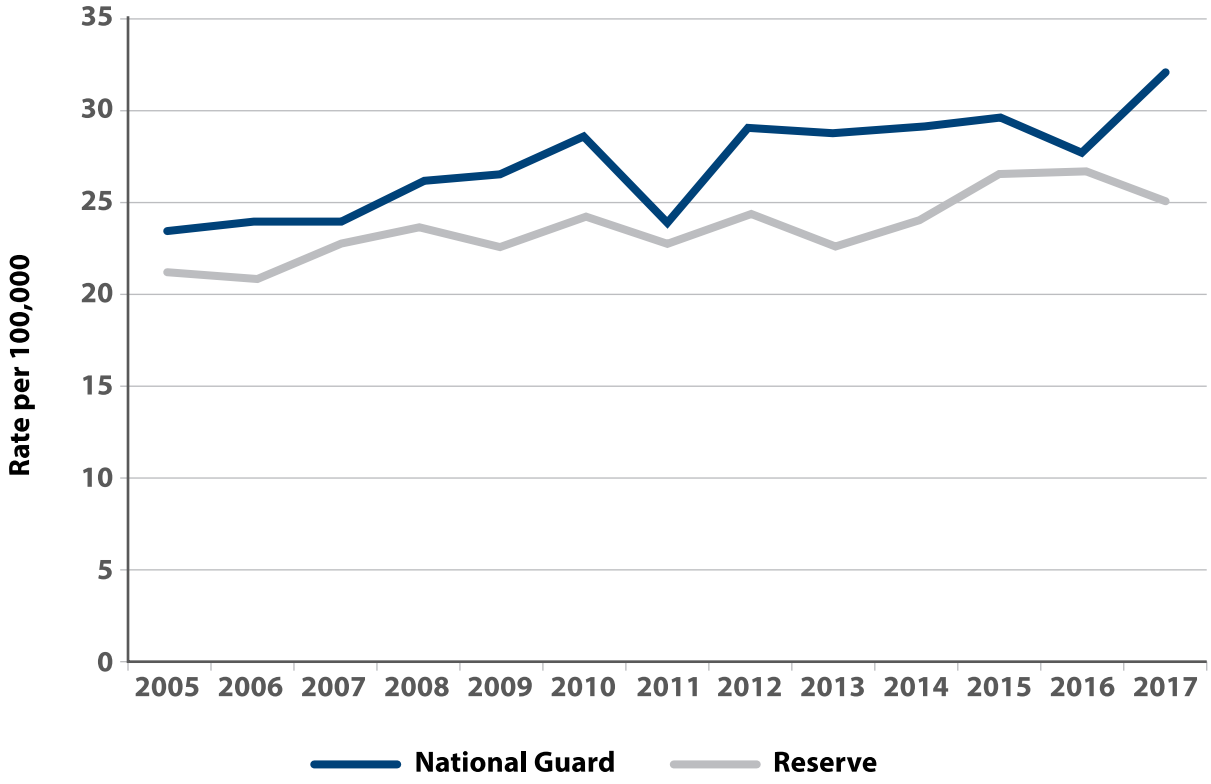
Former National Guard and Reserve members are former service members who may not have Veteran federal legal status due to their type of service. This typically limits their access to VA benefits and services under current laws and regulations. In 2017, there were 919 suicides among never federally activated former National Guard and Reserve members, constituting about 12.4% of the total number of suicides among current and former service members (Graph 11).

- Between 2016 and 2017, the suicide rate among never federally activated former National Guard members increased from 27.7 per 100,000 to 32.2 per 100,000.
- Between 2016 and 2017, the suicide rate among never federally activated former Reserve members decreased from 26.6 per 100,000 to 25.3 per 100,000.
- In 2017, there were 919 suicides among never federally activated former National Guard and Reserve members, an average of 2.5 suicide deaths per day.

Graph 11: Number of Suicides Among Never Federally Activated Former National Guard and Reserve Members (2005–2017)



Graph 12. Suicide Rates Among Never Federally Activated Former National Guard and Reserve Members (2005–2017)



VA in 2017 and 2019: Putting 2017 Data Into Context

Data in this report is derived from 2017 and earlier. It is therefore challenging to directly and immediately evaluate the impact of initiatives and actions in the present. Since 2017, VA has been actively coordinating across VHA Veterans Integrated Service Networks (VISNs), the Veterans Benefits Administration, and the National Cemetery Administration to address Veteran suicide. VA also has worked in partnership with the White House, Congress, the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, and communities nationwide. Notable developments since 2017 include the following:

Key Initiatives Reaching All Veterans Since 2017

Initiative	Purpose	Key Outcomes
Veterans Crisis Line	Provide 24/7 crisis services for all Veterans by phone, text messaging, or online chat.	• The Veterans Crisis Line is the world's largest provider of crisis call, text, and chat services. • The crisis line improved from answering 70% of incoming calls in 2017 to answering at an average of eight seconds or less 99.96% of calls without rollover in 2019. • The crisis line expanded text and chat access. • The crisis line serves over 650,000 calls per year.
Research and Innovation	Expand awareness and study of innovations that address suicide prevention and mental health concerns in Veteran populations.	• VA has made progress in clinical research developing and testing evidence-based psychotherapy advances; medications; and behavioral, complementary, and alternative approaches to treating PTSD and other mental health conditions affecting Veterans.

Initiative	Purpose	Key Outcomes
Community Partnerships	Expand partnerships with the community to reduce suicide among all Veterans, not just those receiving VHA services.	• VA has expanded its partnerships, with current partners representing hundreds of organizations and corporations at the national and local levels — including Veterans Service Organizations (VSOs), professional sports teams, and major employers. Partners are raising awareness of VA's suicide prevention resources and educating people about how they can support Veterans and service members in their communities. • In March 2018, VA and the Substance Abuse and Mental Health Services Administration launched the Mayor's Challenge partnership to provide cities across the nation with tools and technical assistance for addressing Veteran suicide at the local and community level. The Mayor's Challenge has currently equipped 24 cities with information, resources, and support for creating localized Veteran suicide prevention plans. • The Mayor's Challenge served as a model for the Governor's Challenge, which launched in February 2019 in seven states.
Clinical Partnerships	Expand health care services for Veterans waiting for services or in remote locations with less access to VA locations.	• VA is partnering with community-based mental health providers to expand the network of local treatment resources available to Veterans in need.
Outreach	Expand awareness of and engagement in suicide prevention initiatives within and outside VA.	• More than 400 VA Suicide Prevention Coordinators (SPCs) and their teams, located at every VA Medical Center, connect Veterans with care and educate the community about suicide prevention programs and resources.

Key Initiatives Reaching VHA Veterans Since 2017

Initiative	Purpose	Key Outcomes
Mental Health SAIL Expansion	Provide standardized method for assessing quality of mental health services in VA's SAIL system to provide senior VA leaders with a summary measure regarding VA mental health programs.	• A mental health domain was added to the VHA Strategic Analytics for Improvement and Learning (SAIL) dashboard. • Mental health SAIL includes three composites (population coverage, continuity of care, and experience of care) to "screen" facilities for problems in access or quality, to trigger action planning, and to identify top-performing facilities and best practices. • Facilities with lower than average levels of access and quality in the fourth quarter of FY 2016, as indicated by the SAIL mental health domain, had generally improved by the third quarter of FY 2017, while facilities with excellent access and quality have generally maintained performance over the year. • Of the 48 facilities at more than one-half of a standard deviation (SD) below the mean in FY 2016 Q4, 40 (83%) improved by FY 2017 Q3. Eleven (23%) had large improvement. • Of the 42 facilities at more than one-half of an SD above the mean in FY 2016 Q4, 41 (97%) maintained above-average performance, and 37 (88%) remained more than one-half of an SD above average in FY 2017 Q3.
Primary Care-Mental Health Integration (PCMHI)	Expand primary prevention and early engagement into care by embedding mental health providers in primary care settings and through collaborative care management.	• Expansion of PCMHI focused upon during the MyVA Access Initiative launched in 2016 to improve same day access to service. • Since tracking began in FY 2008, VA has provided over 10 million PCMHI encounters, serving over 2 million patients. In FY 2018 alone, VA provided over 1.2 million clinical encounters for over 400,000 patients. • VA provided more than 1.2 million mental health visits in primary care settings in FY 2017, an increase of 4% from FY 2016 and up 20% from FY 2014. PCMHI same-day access services were only occurring for new Veterans to PCMHI 36.2% of the time (FY 2016 Q4), compared with 53.2% presently (FY 2019 Q3). • The reach of PCMHI services (the percentage of patients in primary care who receive PCMHI services) increased from 7.7% in FY 2016 to 9.0% in FY 2019 (through June 30, 2019).

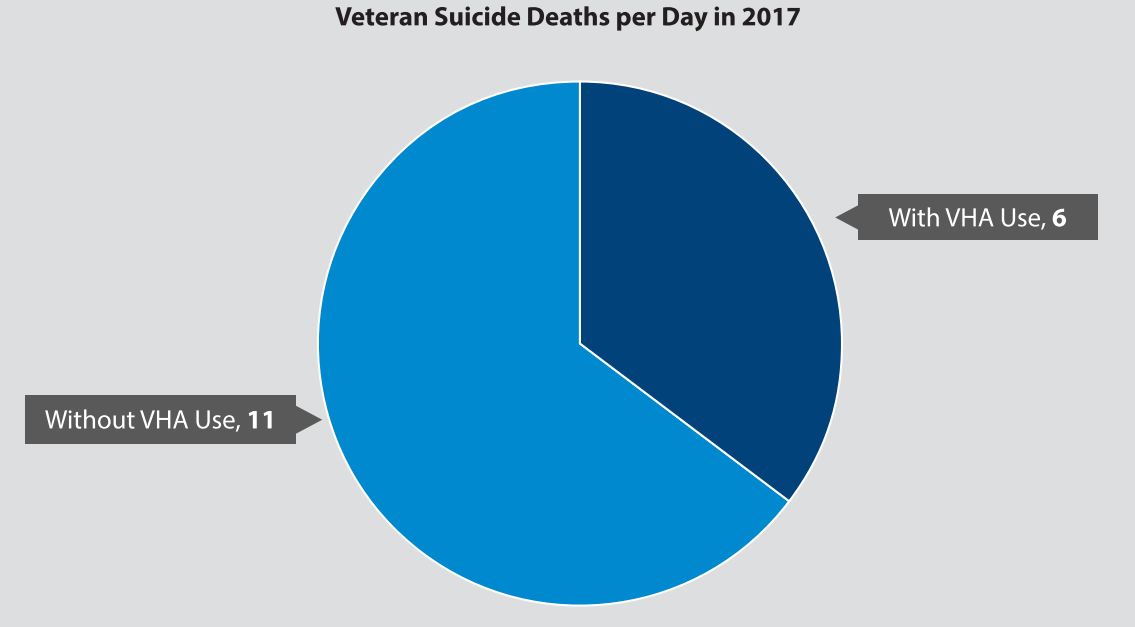
Initiative	Purpose	Key Outcomes
Universal Screening	Provide standardized method for identifying Veterans at high risk for suicide.	• In 2018, VA implemented the largest standardized suicide risk assessment initiative in U.S. health care. • More than 2.8 million Veterans have received standardized risk screening since October 1, 2018, with approximately 3% reporting suicidal ideation.
Expansion of the MyVA Access Initiative	Launched in 2016 with a specific mental health goal of implementation of same day access to services.	• Mental health same-day access service was established across VA in 2017. • In mental health care clinics, the number of same-day scheduled appointments increased from 796,242 in FY 2017 to 824,276 in FY 2018 (an increase from 11.13% to 11.18%). The percentage of new patients with same-day appointments increased from 29.5% (FY 2017) to 33.2% (FY 2018). • In PCMHI, the number of same-day appointments increased from 132,799 in FY 2017 to 179,453 in FY 2018 (representing an increase from 19.1% of all PCMHI appointments to 24.3%).
Mental Health Treatment Coordinator (MHTC)	Assigns an MHTC for each Veteran receiving ongoing VA specialty mental health care to ensure continuity of care and provides the Veteran with a consistent and reliable point of contact, especially during times of care transitions.	• The MHTC serves as a clinical resource for the Veteran and their providers, generally as part of the Veteran's assigned mental health care team. • As of January 30, 2018, 1,347,189 Veterans had an assigned MHTC.
Evidence-Based Treatment Expansion	Expand access to evidence-based treatments for mental health conditions.	• More than 12,700 VA mental health clinicians have been trained in evidence-based treatments, including over 8,500 VA mental health staff members trained in prolonged exposure (PE) and/or cognitive processing therapy, two of the most effective therapies for PTSD. • VA also offers evidence-based medication treatments that may be indicated for a variety of conditions.

Initiative	Purpose	Key Outcomes
Care Related to Military Sexual Trauma	Provide all military sexual trauma-related care free of charge. Veterans may be able to receive this care even if they are not eligible for other VA care. Receipt of free military sexual trauma-related services is separate from the VA disability compensation process; documentation of military sexual trauma (MST) and a service-connected disability are not required for those seeking services.	• In FY 2017, every VHA health care system provided MST-related outpatient care to both women and men. More than 1,325,000 MST-related outpatient mental health visits were provided to Veterans who screened positive for MST — a 9% increase from FY 2016.
Women's Mental Health	Expand access to and quality of mental health services for women Veterans.	• A national network of Women's Mental Health Champions, representing nearly every VA health care system, is now in place to disseminate information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care. • VA has developed numerous clinical training resources for VA providers who treat women Veterans, including a monthly teleconference series, a special teleconference series for prescribers, and web-based advanced clinical training courses that include live demonstrations and role-playing exercises.

Reaching Veterans Not in VHA Care

The majority of Veterans do not use VHA services, and the majority of Veteran suicides occur among Veterans who have not recently received VHA services. VHA has an unparalleled system of recovery-oriented integrated mental health care services, ranging from early preventive services in primary care to intensive residential and inpatient services. One recent study compared over 800,000 Veterans receiving medication treatment for mental health disorders in VHA with over 500,000 comparable individuals in the private sector. The authors found that VHA's performance was superior by greater than 30%.[17] Over 12,700 VHA mental health care providers have received training and supervision in evidence-based psychotherapies.[18] In a comparison of 132 VA hospitals with 402 non-VA hospitals, researchers found that VA performed comparably to or better than non-VA facilities across most nationally recognized quality measures for care, including depression treatment.[19]

As part of the Clay Hunt Suicide Prevention for American Veterans Act (Public Law 114-2), VA mental health and suicide prevention programs were reviewed by independent third-party evaluators.[20] Based on their analyses of the Veterans Outcome Assessment (VOA), these evaluators concluded that engagement in VHA mental services was associated with decreased rates of suicidal ideation and suicide attempts. Twenty-seven percent of Veterans who completed VOA surveys reported that they wished they were dead, 15% reported thoughts of killing themselves, and 8% reported suicidal thoughts or intent in the three months prior to engaging in mental health services. Three months later, Veterans reported decreased suicidal ideation and behaviors. Yet we still are not reaching every Veteran who might benefit from these services.



Note: In 2017, among Veterans who died by suicide, 38% had a VHA encounter in 2016 or 2017 (6.3 suicide deaths per day), while 62% had not (10.5 per day). The chart presents this information as 6 vs. 11 per day to communicate the loss of each Veteran's life.[21]

[17] Watkins, K.E., Smith, B., Akincigil, A., Sorbero, M. E., Paddock, S., Woodroffe, A., … Pincus, H.A. (2016). The quality of medication treatment for mental disorders in the Department of Veterans Affairs and in private sector plans. Psychiatric Services, 67, 391–396.

[18] Veterans Health Administration (2018). VA Office of Mental Health and Suicide Prevention Guidebook. Washington, DC.

[19] Price, R.A., Sloss, E. M., Cefalu, M., Farmer, C. M., & Hussey, P. S. (2018). Comparing quality of care in Veterans Affairs and non-Veterans Affairs settings. Journal of General Internal Medicine, 33 (10), 1631–1638.

[20] 2018 Annual Report: VA Mental Health Programs and Suicide Prevention Services Independent Evaluation (October 2018). First annual report to Congress written by staff at ERPi, Booz Allen Hamilton and Altarum.

[21] This data includes Title 38 Veterans only. Title 38 Veterans exclude those individuals who were currently in active service at time of death or were former never federally activated Guard or Reserve (see p. 19 for information on this group previously covered in prior reports). It should be noted that this adjustment should be considered when citing these numbers in comparison to previous reports, which were not specific to Title 38 Veterans. These numbers are not comparable.

Call to Continued and Further Action

Much More to Urgently Do for the All-Some-Few

Following the National Academy of Medicine's framework, VA suicide prevention strategies may be understood in terms of three levels of strategic focus. First, *universal* strategies aim to reach *all* Veterans. These include public awareness and education campaigns regarding the availability of suicide prevention resources for Veterans and the promotion of responsible media coverage. Second, *selective* strategies are designed for *some* Veteran subgroups that may be at increased risk for suicidal behaviors. Examples include targeted outreach to women Veterans, to Veterans with substance use challenges, and to Veterans with recent separation from military service. And third, *indicated* strategies are designed for the relatively *few* individual Veterans who are identified as having high risk for suicide. Indicated strategies include referral to the Veterans Crisis Line and clinical review and outreach for those Veterans in the highest tier of predicted statistical risk, as VA has implemented in the REACH VET (Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment) program. Each approach equally and urgently matters.

Current VA Public Health Approaches to Suicide Prevention in Partnership With the Community

VA is actively working to reach not only Veterans receiving VHA health services but also other Veterans in the community. In fiscal year 2019, a key goal for VA was the expansion of the public health approach to save lives by reaching Veterans, their loved ones, their communities, and the greater population. Activities range from reaching all Veterans as a primary prevention strategy before they are at high risk for suicide to immediately addressing the needs of those at highest risk for suicide. The table below outlines these high-priority activities across the continuum of care. We actively welcome partnerships with states, organizations, and individual community members in these approaches as well as new innovations to address these needs across the population of all Veterans.

Table 4. Summary of VA Population Health Approaches

	Universal (All)	Selected (Some)	Indicated (Few)
Individual	1. ASCEND survey 2. RISK ID strategy – PHQ2 + I9 3. Whole health 4. EO 13822 5. Paid media campaign – crisis 6. Separated service member dashboard	1. REACH VET 2. Gun locks 3. Clinical practice guidelines 4. RISK ID strategy – C-SSRS 5. SPED 6. SDVCS nomenclature 7. CPG for SP 8. SPP guide 9. CRISTAL/SPPRITE 10. Independence Fund retreats 11. CBT-Insomnia 12. CBT-Pain 13. $AFE money management 14. Paid media campaign – risk groups 15. IBM – GRIT 16. Objective Zero partnership 17. SPP directive	1. High risk flagging 2. CBT-s telehealth 3. Postvention 4. Suicide data report 5. BHAP/FIT-C 6. Enhanced care delivery – high-risk Veterans 7. Risk ID Strategy – CSRE 8. High-risk flag dashboard 9. Revenue Operations 10. ICD-10/SBOR suicidal behaviors 11. State data sheets 12. Issue brief tracking
Relationship	1. S.A.V.E. training 2. Together We Can literature review series.	1. Caring Letters – SPC 2. Safety planning – SPED 3. Conjoint couples therapy 4. Cohen Veterans Network partnership 5. Warrior Care Network/ Wounded Warrior Project partnership	1. Safety planning – high risk 2. Suicide Risk Management Consultation Program 3. Caregiver toolkit 4. CaringBridge partnership

	Universal (All)	Selected (Some)	Indicated (Few)
Community	1. Veterans Crisis Line 2. Mayor's and Governor's Challenges 3. VISN 23 pilot 4. SP 2.0 initiative 5. SP – public health education 6. SPP guide – outreach 7. Suicide Prevention Coordinators – outreach 8. SP VA Pulse page 9. Zero suicide (Clay Hunt) 10. Together With Veterans 11. PsychArmor S.A.V.E. training 12. CVEBs (VEO)	1. Firearm safety toolkit pilot 2. SP 2.0 initiative 3. SPC hiring initiative 4. From Science to Practice literature review series 5. LGBT health education pilot 6. SP 2.0 dashboard	1. SP CoP VA Pulse page 2. Guidance for action following a suicide on VA campus 3. Rural health survey
Societal	1. National Strategy for Preventing Veteran Suicide, 2018–2028 2. Safe firearm storage campaign	1. Entertainment industry messaging campaign	1. Safe messaging campaign

Join Us in Action

Suicide is a national issue, with rising rates of suicide in the general population. In addition, suicide rates are higher, and are rising faster, among Veterans than among non-Veteran adults. Every death by suicide is a tragedy that affects individuals and communities. Unfortunately, no one strategy in isolation has been shown to be effective in ending suicide. We must come together to address systematically the larger societal issues fueling the increased rates of suicide in our nation, keeping at the forefront of our minds that we prevent suicide through meaningful connection, one person at a time.

The most recent and notable manifestation of this cross-cutting and aggressive approach to Veteran suicide prevention is the recently launched President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS) created by the Executive Order signed by the President in March 2019. A cabinet-level task force has been launched to develop this national roadmap for suicide prevention, which will include proposals and plans addressing cross-sector integration and collaboration, a national research strategy, and a cohesive implementation strategy. The PREVENTS taskforce is being led by an Executive Director with experience in the development and implementation of public health efforts and dedication to eradicating suicide. Efforts supporting the development of a national roadmap are already well underway and on target for delivery in March of 2020.

Acronym Listing

Acronym	Description
BHAP	Behavioral Health Autopsy Program
CBT	Cognitive Behavioral Therapy
CBT-s	Cognitive Behavioral Therapy for suicidality
CPG for SP	Clinical Practice Guidelines for Suicide Prevention
CRISTAL	Capri, REACH VET, Risk Indicators, STORM Tool for Analytic Look-up
CVEB	Community Veteran Engagement Board
EO 13822	Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life
FIT-C	Family Interview (Template) Contact Form
FY	Fiscal year
IBM-GRIT	Not an acronym; a mobile solution for Veteran well-being
MH	Mental Health
MHTC	Mental Health Treatment Coordinator
PCMHI	Primary Care Mental Health Integration
PE	Prolonged Exposure
PTSD	Posttraumatic Stress Disorder
Q	Quarter
REACH VET	Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment
SAIL	Strategic Analytics for Improvement and Learning
S.A.V.E.	Signs, Ask, Validate, and Encourage and Expedite
SBOR	Suicide Behavior and Overdose Report
SD	Standard Deviation

Acronym	Description
SDVCS nomenclature	Self-Directed Violence Classification System
SP	Suicide Prevention
SP CoP	Suicide Prevention Community of Practice
SPC	Suicide Prevention Coordinator
SPED	Safety Planning in the ED
SPP	Suicide Prevention Program
SPPRITE	Suicide Prevention Population Risk Identification and Tracking for Exigencies
VA	Department of Veterans Affairs
VEO	Veteran Experience Office
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization