2021

National Veteran Suicide Prevention

ANNUAL REPORT

Office of Mental Health and Suicide Prevention

September 2021

VA | U.S. Department of Veterans Affairs

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[1] The data analyses in this report are conducted by the Department of Veterans Affairs (VA) Suicide Prevention Program's Data and Surveillance team in the Office of Mental Health and Suicide Prevention, which includes VA staff from the Center of Excellence for Suicide Prevention and the Serious Mental Illness Treatment Resource and Evaluation Center. Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC). This document summarizes VA suicide surveillance processes, including conduct of VA/DoD searches of death certificate data from the CDC's National Death Index (NDI), data processing, and determination of decedent Veteran status. A full description of the data sources for this report is available in the supplementary document located at: ***Veteran Suicide Surveillance: Methods Summary (va.gov)***.

Introduction

The U.S. Department of Veterans Affairs' 2021 National Veteran Suicide Prevention Annual Report shows the overall Veteran suicide count and rate decreased in 2019 from 2018 and from 2017.

The data within the report is notable because:

- It provides information from 2001 through 2019, while recent prior reports included data from 2005 forward.
- This update includes the most current data and applies methodologic enhancements, resulting in the most comprehensive assessment to date of Veteran suicide mortality, for the years 2001-2019.[2]

The report represents and communicates a "whole of VA" approach to suicide prevention that integrates strategic planning, program operations, and program evaluation across the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration. The report represents and communicates a "whole of government" approach to suicide prevention that integrates strategic planning across federal agencies to facilitate complementary and collaborative prevention, intervention, and postvention approaches tailored to agency-specific populations. The report represents and communicates the value of "public/private partnerships" to reinforce and magnify collective and unified engagement of suicide prevention.

Given this background, this report includes the following updated information and data:

- There were 399 fewer Veteran suicides in 2019 than in 2018.
- There was a 7.2% overall decrease in the age- and sex-adjusted Veteran suicide mortality rate in 2019, as compared to 2018.
- The unadjusted suicide rate for male Veterans decreased 3.6% in 2019 from 2018 while the unadjusted suicide rate for female Veterans decreased 12.8% in 2019 from 2018.

Decreases in Veteran suicide across multiple fronts and methods of measurement in 2019 were unprecedented across the last 20 years.

[2] Enhancements included improved identification of matches between VA/DoD search records and CDC NDI and assessment of mid-calendar year Veteran population for Veteran suicide rate calculations, rather than end-of-fiscal-year population estimates.

Suicide Among U.S. Adults and Among Veterans, 2001–2019

The number and rate of suicide deaths rose from 2001 to 2018 across the U.S. population. Yet the U.S. population, as well as the Veteran population, experienced a decrease in the suicide count and rate from 2018 to 2019. Furthermore, in retrospect and with updated data, the Veteran suicide count decreased in 2018—one year ahead of the U.S. population suicide decrease, as Figures 1 and 3 illustrate. This section provides an overview of Veteran data within the context of U.S. national data organized by Suicide Deaths by Count/Number, Suicide Average Per Day, and Suicide Rates.

Suicide Deaths by Count/Number

The number (count) of suicides among U.S. adults increased from 29,580 in 2001 to 45,861 in 2019 (see Figure 1). Veterans accounted for 5,989 suicides in 2001, which represented 20.2% of suicides among U.S. adults in 2001; and 6,261 suicides in 2019, which, by comparison, represented 13.7% of suicides among U.S. adults in 2019. Veterans ages 55-74 were the largest population subgroup; they accounted for 38.6% of Veteran suicide deaths in 2019.

Figure 1: Suicide Deaths, by Year, 2001–2019

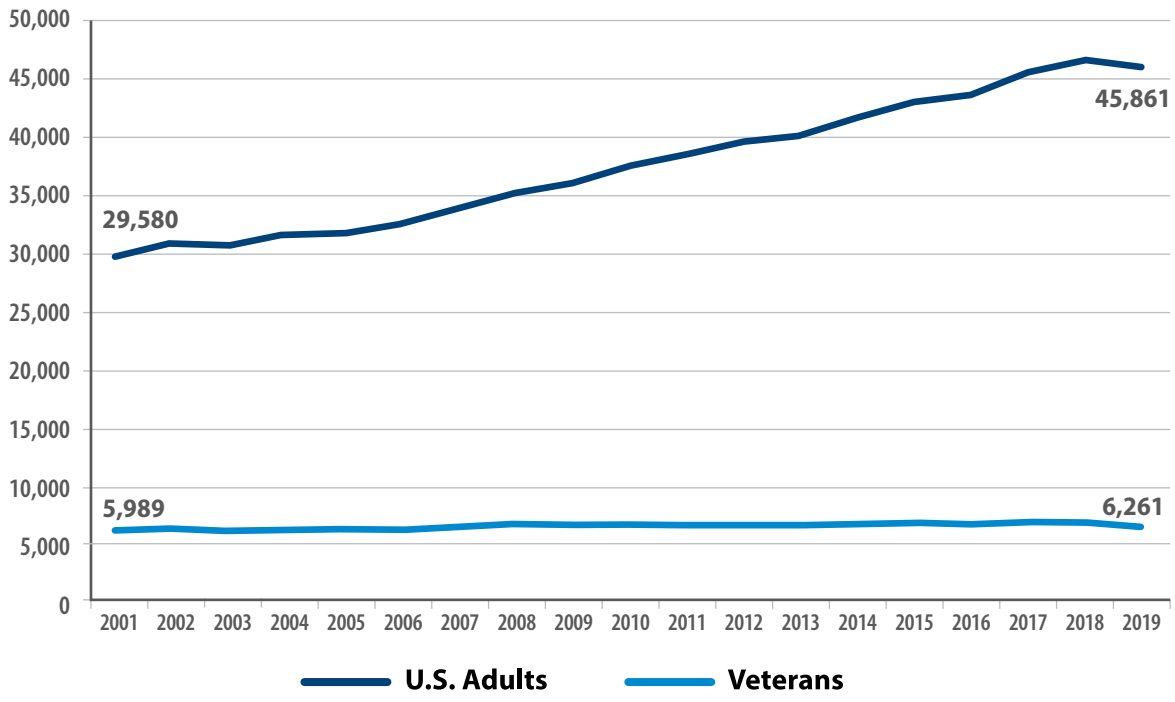
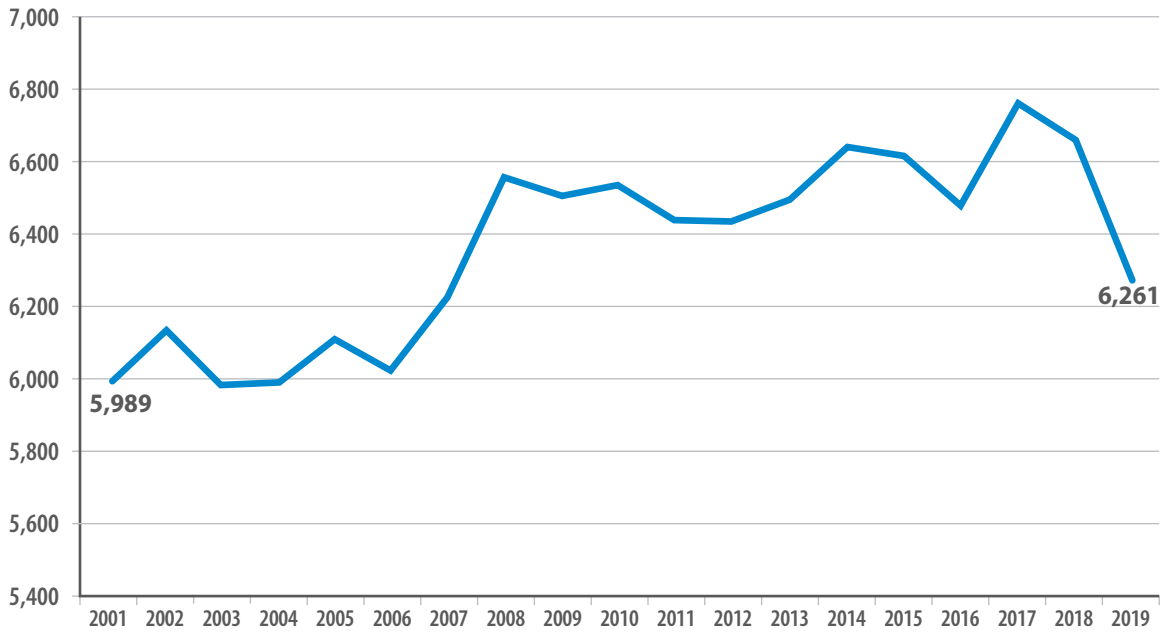


Figure 2, below, provides an overview of the trend line pertaining to Veteran suicide deaths by year from 2001 to 2019.

Figure 2: Veteran Suicide Deaths, 2001–2019



Suicide Average Per Day

The average number of suicides per day among U.S. adults rose 55.0%, from 81.0 in 2001 to 125.6 in 2019. Across the same 18-year period, the average number of Veteran suicides per day rose 4.5%, from 16.4 in 2001 to 17.2 in 2019.

In 2019, among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019.

Suicide Rates

From 2001 to 2019, the U.S. adult population increased 26.2%, from 186.6 million in 2001 to 235.4 million in 2019. From 2001 to 2019, the Veteran population decreased 23.1%, from 25.7 million in 2001 to 19.8 million in 2019. In this context, from 2001 to 2019, the unadjusted suicide rate among non-Veteran U.S. adults rose 33.0%, from 12.6 per 100,000 in 2001 to 16.8 per 100,000 in 2019. In comparison, the rate among Veterans rose 35.9% from 2001 to 2019, from 23.3 per 100,000 in 2001 to 31.6 per 100,000 in 2019.

In 2019, the unadjusted suicide rates were highest among Veterans ages 18-34 (44.4 per 100,000). The unadjusted rate decreased 12.8% for female Veterans in 2019 compared to 2018, and decreased 3.6% for male Veterans in 2019 compared to 2018. To account for a) differences between the non-Veteran U.S. population and the Veteran population in terms of age and sex, and b) differences across time within the Veteran population, age- and sex-adjusted suicide rates were calculated. Figure 3 indicates that the difference in adjusted rates between Veterans and non-Veterans was highest in 2017, when Veteran adjusted rates were 66.3% greater than those for non-Veteran adults; this differential decreased to 52.3% in 2019.

Figure 3: Age- and Sex-Adjusted Suicide Rates, Veterans and Non-Veteran U.S. Adults, 2001–2019

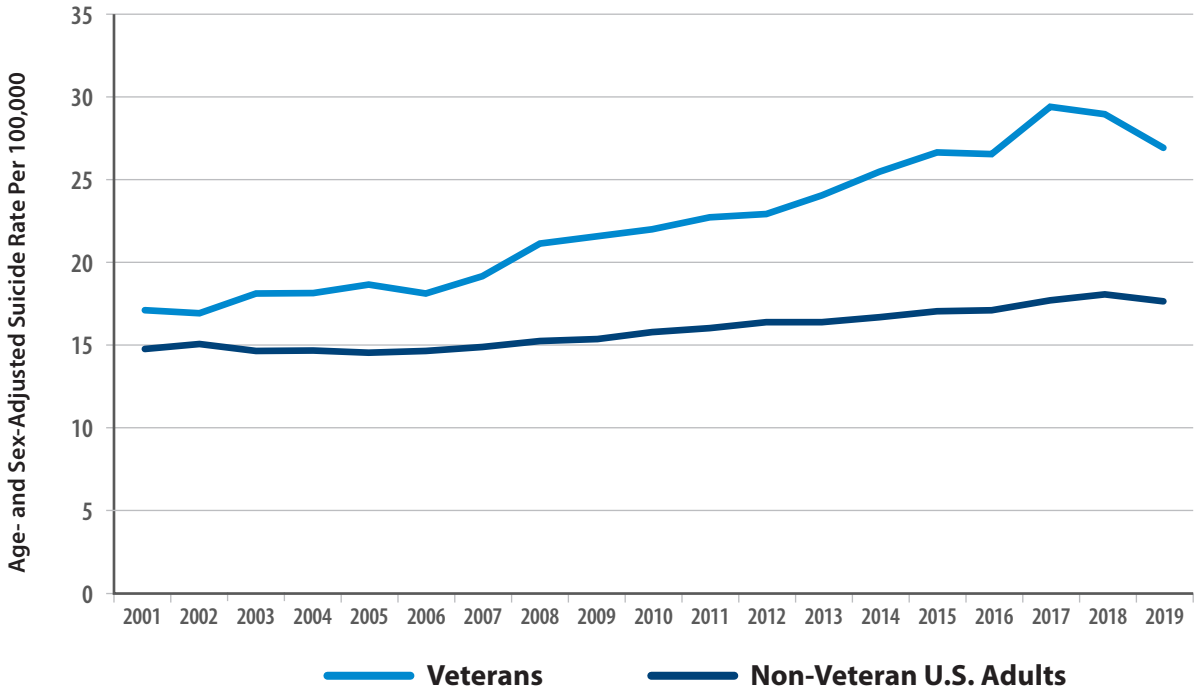


Figure 4 demonstrates the Veteran-specific age- and sex-adjusted suicide trend rate from 2001 to 2019. The age- and sex-adjusted suicide rate decreased 7.2% in 2019 compared to 2018, decreasing from 29.0 Veteran suicides per 100,000 in 2018 to 26.9 Veteran suicides per 100,000 in 2019.

Figure 4: Age- and Sex-Adjusted Suicide Rates, Veterans, 2001–2019

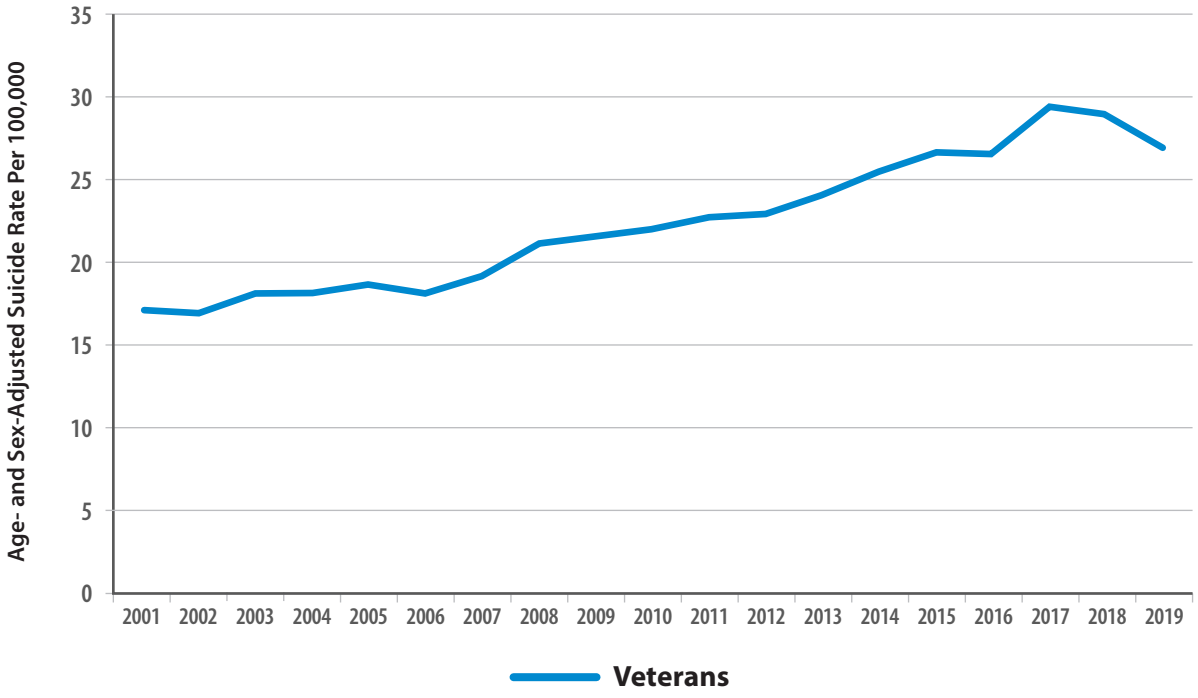
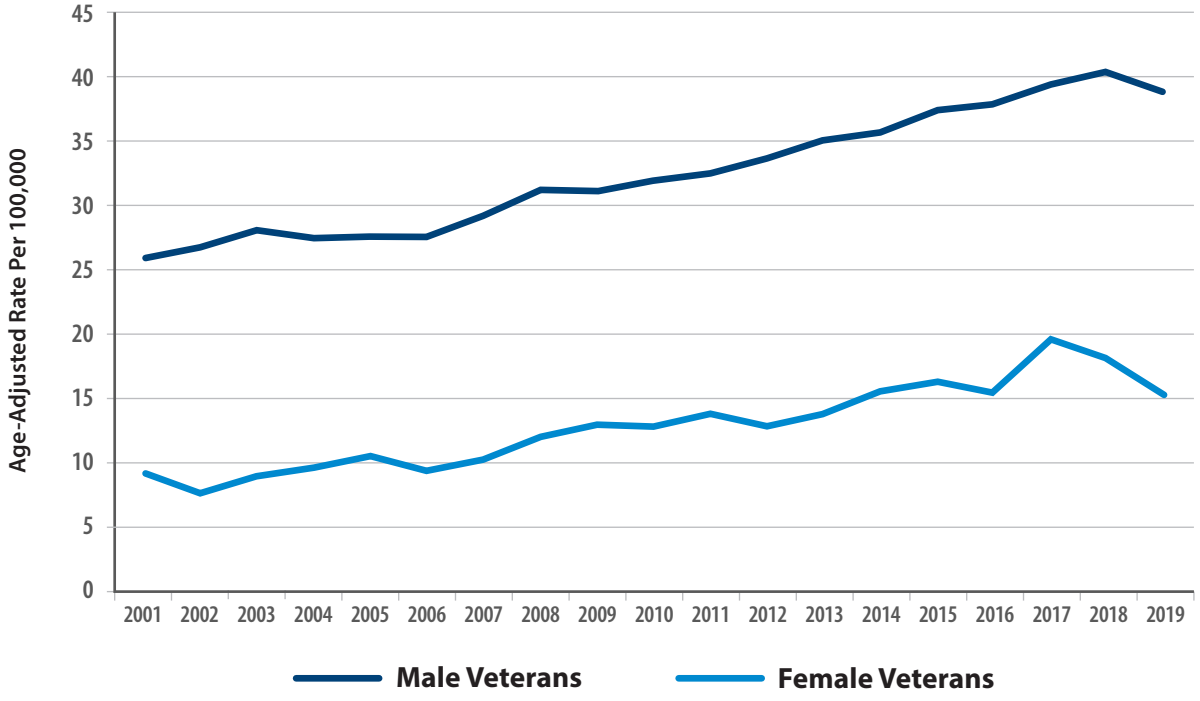


Figure 5 presents age-adjusted suicide rates for Veteran men and women by year, 2001-2019. Rates for Veteran men were highest in 2018 (40.4/100,000) and fell 3.8% in 2019 (38.8/100,000); rates for Veteran women were highest in 2017 (19.9/100,000) and fell in 2018 (18.1/100,000) and again in 2019 (15.4/100,000), which represented a 14.9% decrease relative to 2018.

Figure 5: Age-Adjusted Suicide Rate Per 100,000, Male and Female Veterans, 2001–2019



Figures 6 and 7 reflect the unadjusted suicide rates by race and ethnicity, respectively. White Veterans continue to exhibit the highest unadjusted rates, followed by American Indians/Alaskan Natives; Asians, Native Hawaiians, or Other Pacific Islanders; followed by Black/African American Veterans.

Figure 6. Unadjusted Suicide Rates, Veterans, by Race, 2001–2019

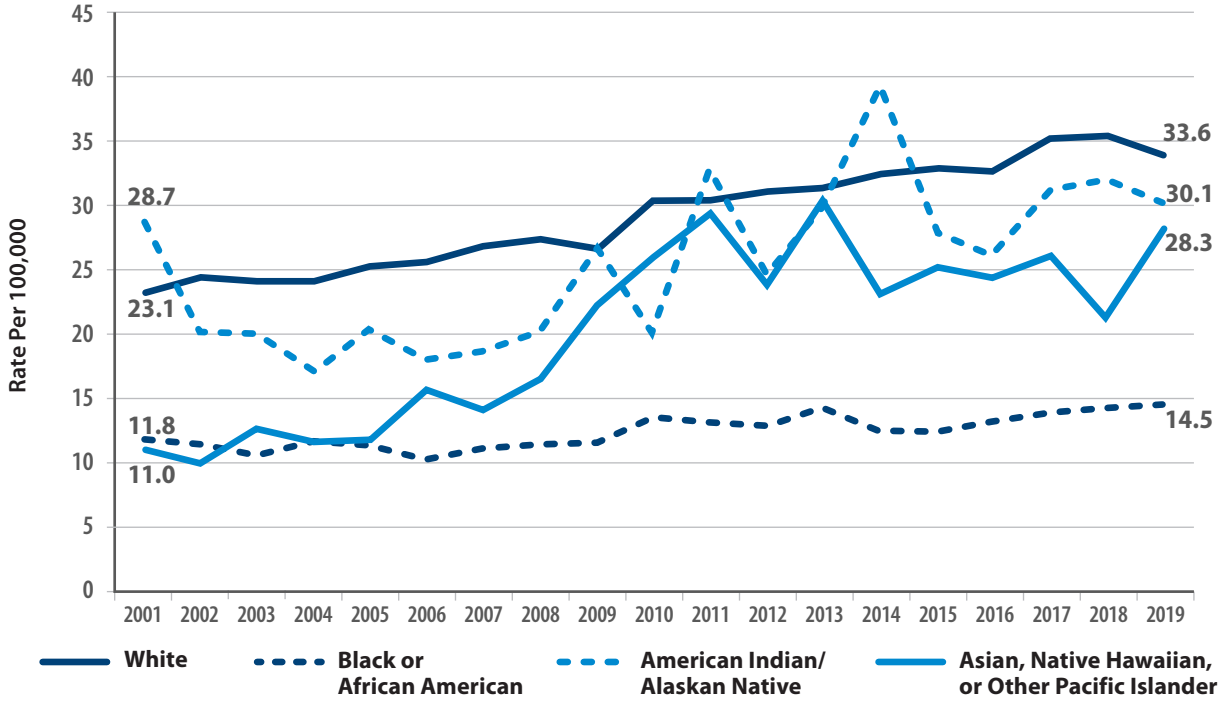
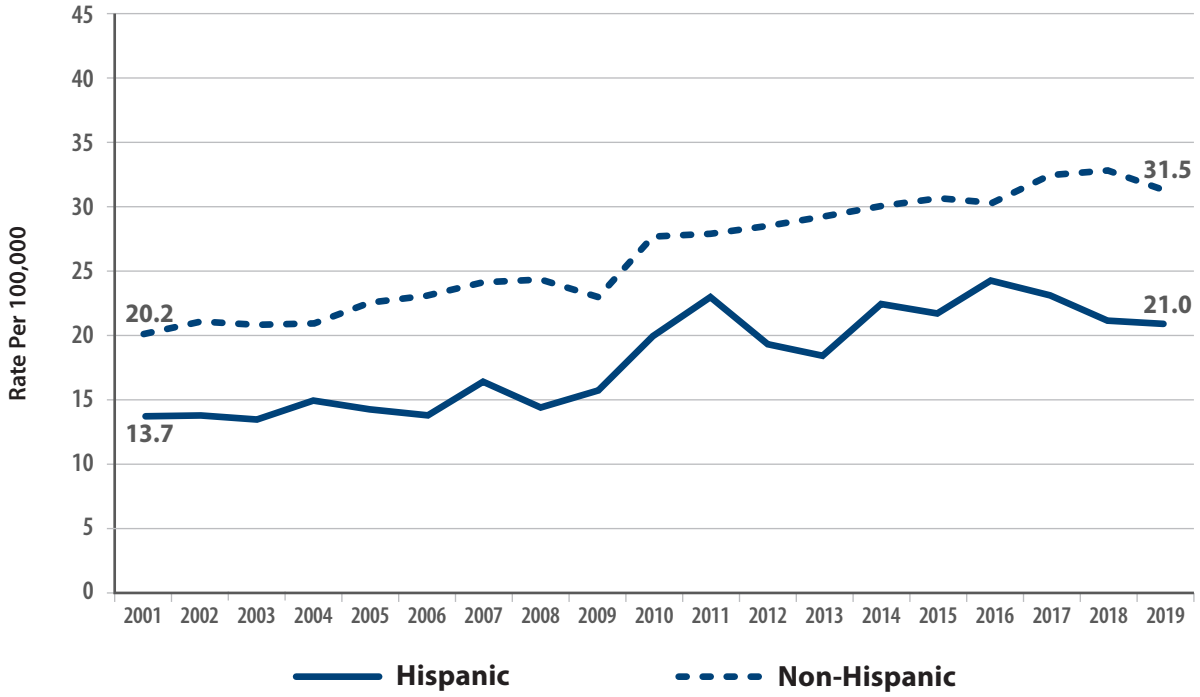


Figure 7. Unadjusted Suicide Rates, Veterans, by Hispanic Ethnicity, 2001–2019



Summary

There were 399 fewer Veteran suicides in 2019 than in 2018. Adjusted rates fell from 2018 to 2019 for Veterans; rates fell 7.2% among Veterans and 1.8% among non-Veterans. Average Veteran suicides per day decreased to 17.2 in 2019. In 2019, the adjusted rate for Veterans was 52.3% greater than for non-Veteran U.S. adults. The rate difference between Veterans and the non-Veteran U.S. population was highest in 2017 at 66.3%.

Lethal Means Involved in Suicide Deaths

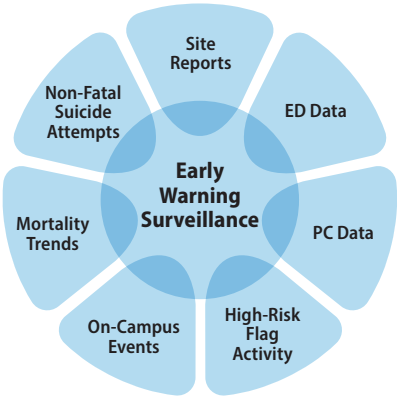
Among non-Veterans overall, there were increases from 2001 to 2019 (Table 1) in the percentage of suicides involving suffocation and "other means" and decreases in the percentage involving firearms and poisoning. Among Veterans, there were increases in the percentage involving firearms and suffocation and decreases for those involving poisoning and other means. Firearms accounted for 70.2% of male Veteran suicides in 2019 (up from 69.6% in 2018) and 49.8% of female Veteran suicides in 2019 (up from 41.1% in 2018). The proportion of firearm-related Veteran suicide deaths increased in 2019 compared to 2001.

Table 1: Suicide Deaths, Methods Involved, 2019 and Change From 2001*

	Non-Veteran U.S. Adults		*Veterans*		*Non-Veteran Men*		*Veteran Men*		*Non-Veteran Women*		*Veteran Women*	
	2019	**Change***	**2019**	**Change***	**2019**	**Change***	**2019**	**Change***	**2019**	**Change***	**2019**	**Change***
Firearms	47.9%	(-4.8%)	69.2%	(+2.7%)	53.0%	(-5.0%)	70.2%	(+2.9%)	31.3%	(-4.2%)	49.8%	(+12.8%)
Poisoning	13.9%	(-4.5%)	8.4%	(-4.8%)	8.5%	(-3.8%)	7.5%	(-4.9%)	31.0%	(-7.1%)	26.3%	(-16.6%)
Suffocation	29.6%	(+8.8%)	16.9%	(+2.9%)	30.2%	(+7.9%)	16.8%	(+2.7%)	27.7%	(+12.0%)	20.5%	(+10.1%)
Other	8.7%	(+0.6%)	5.4%	(-0.9%)	8.3%	(+1.0%)	5.5%	(-0.8%)	10.0%	(-0.7%)	3.4%	(-6.3%)

** Change Versus Among Suicide Decedents in 2001*

COVID-19: Monitoring of VHA Suicide-Related Indicators



The sections above present information about suicide mortality through 2019, the most recent year for which cause of death information is available from the Centers for Disease Control and Prevention (CDC). In 2020, the COVID-19 pandemic began, with tragic consequences for the people of the U.S. and around the world. Currently, there have been over four million deaths worldwide due to COVID-19,[3] including over 600,000 deaths in the U.S.[4]

The Secretary of Health and Human Services declared COVID-19 a national public health emergency on January 27, 2020. Once CDC National Death Index (NDI) data are finalized for 2020, VA will evaluate trends in Veteran suicide related to the pandemic. In the context of this report, to assess trends in association with the COVID-19 pandemic, we present information on suicide-related indicators for Veterans receiving VHA care.

In March 2020, VA began monitoring trends in VHA patient encounters and site-reported indicators of suicide-related behavior. VHA site reports include information regarding Veteran suicide deaths and nonfatal suicide attempts. Information regarding nonfatal suicide attempts is based on VHA facility reports and diagnosis indications. We have highlighted several examples of these in the figures below. Specifically, this work includes tracking, by week, of VHA site-reported Veteran suicides (Figure 8), VHA emergency department visits for suicide attempts (Figure 9), on-campus suicide attempts and deaths (Figure 10), and all-cause mortality among Veteran VHA patients with and without diagnosed mental health conditions (Figure 11, Figure 12).

Key Findings

- VA has not observed increases in documentation of the above suicide-related indicators.
- VA has observed increases in all-cause mortality among Veteran VHA patients, including those with and those without diagnosed mental health conditions. Increased all-cause mortality associated with the pandemic exceeds the number of VA deaths that have been directly attributed to COVID-19.
- Age- and sex-adjusted all-cause mortality is greater among Veterans in VHA care with mental health conditions compared to other Veterans in VHA care.
- The level of *differential* mortality by mental health status has not increased since the pandemic began.

[3] World Health Organization (2021). Weekly epidemiological update on COVID-19 – 20 July 2021. Accessed: ***Weekly epidemiological update on COVID-19 - 20 July 2021 (who.int).***

[4] Centers for Disease Control and Prevention (2021) COVID-19. Accessed: ***https://www.cdc.gov/coronavirus/2019-ncov/index.html***.

Select Figures

Figure 8: VHA Site-Reported Veteran Suicides, by Week

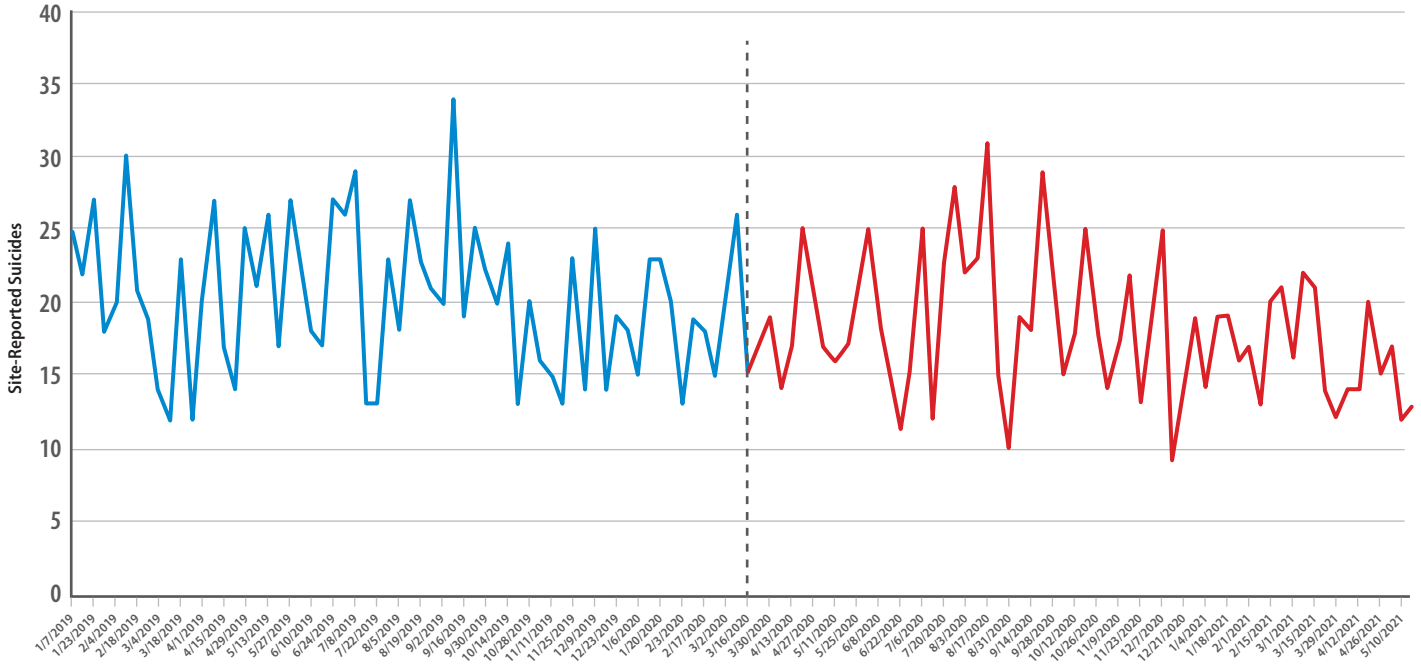


Figure 9: VHA Emergency Department Visits for Suicide Attempts

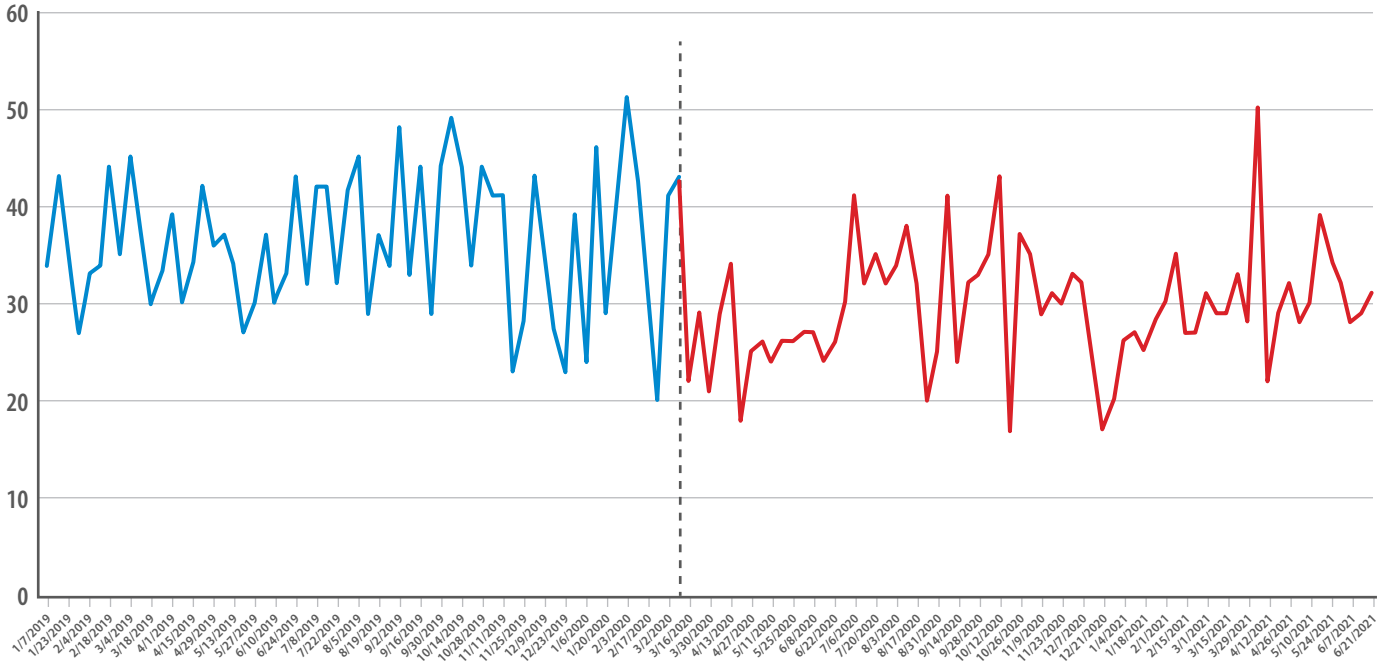


Figure 10: Issue Brief Indications of On-Campus Suicide Attempts and Deaths

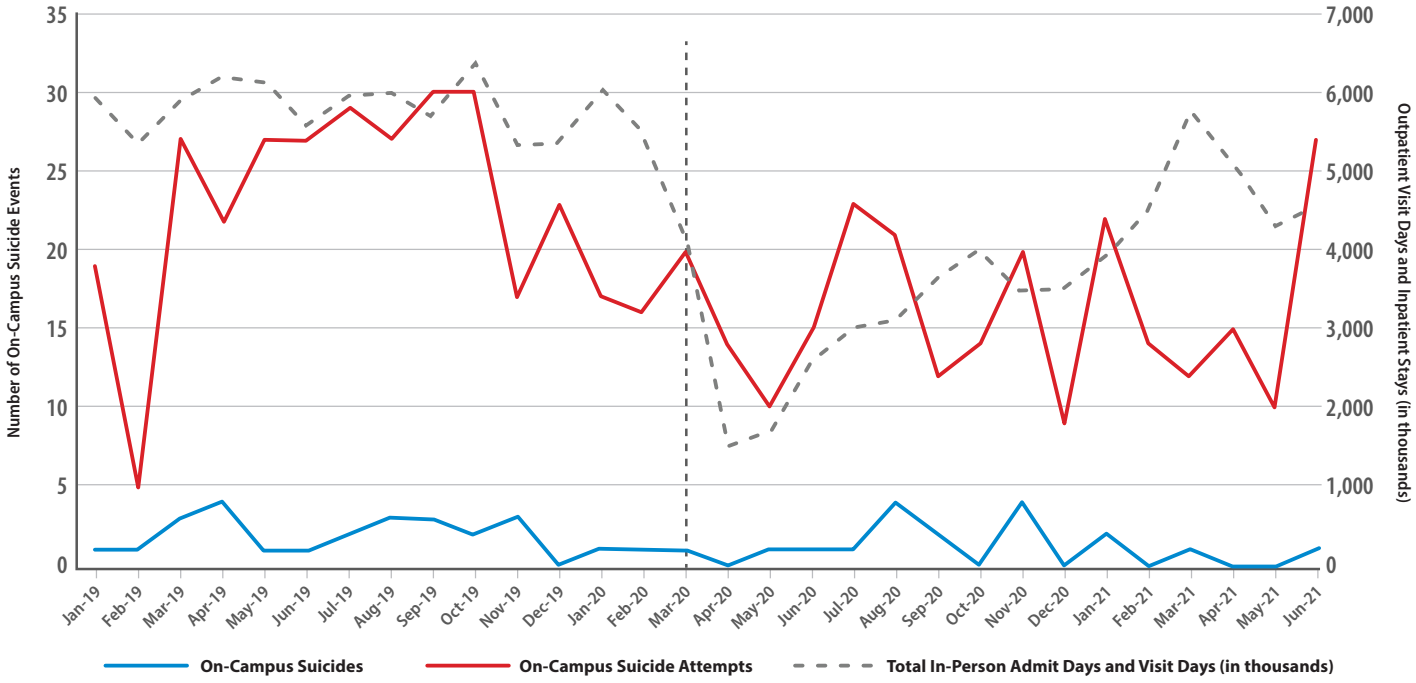


Figure 11: Age- and Sex-Adjusted All-Cause Mortality Per 100,000, Veteran VHA Users, by Week, Overall and by Mental Health Status

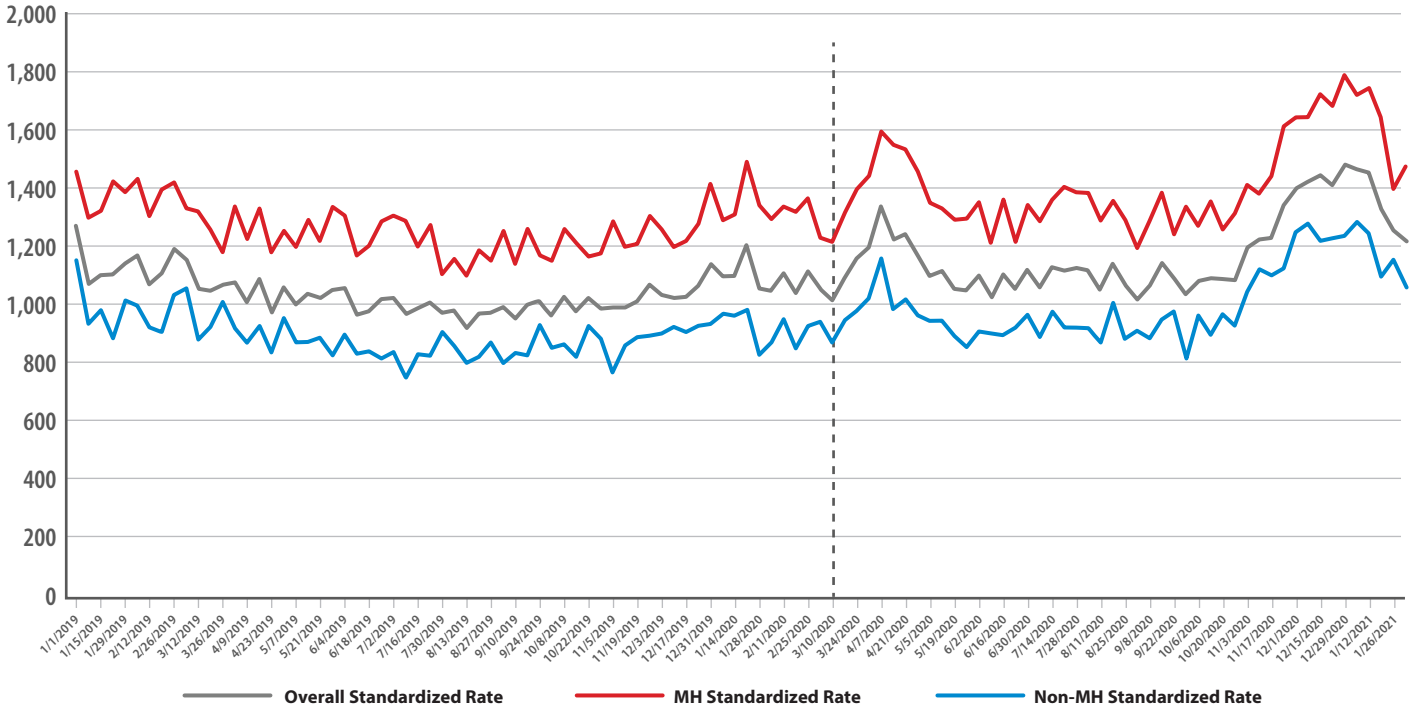
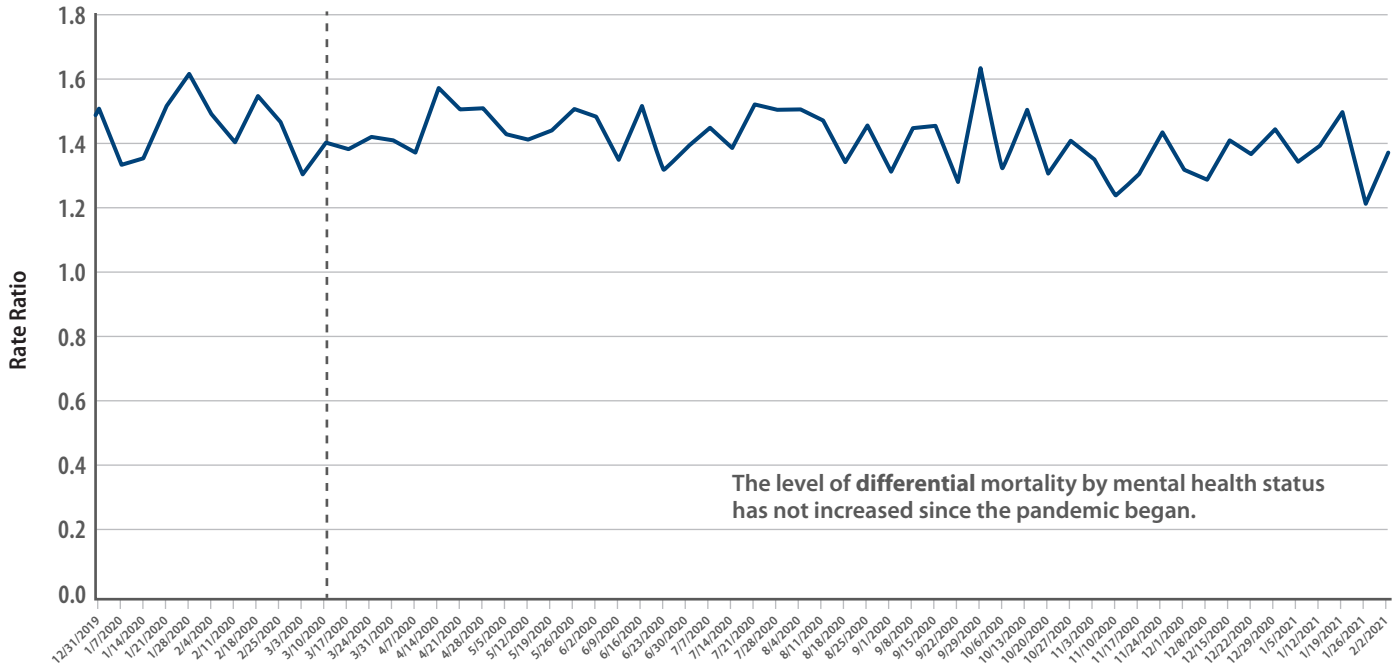


Figure 12: Ratio of Age- and Sex-Adjusted All-Cause Mortality Per 100,000, Mental Health vs. Non-Mental Health Patients, Veteran VHA Users



Anchors of Hope

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

- 399 fewer Veterans died from suicide in 2019 than in 2018, reflecting the lowest raw count of Veteran suicides since 2007.
- From 2005 to 2018, identified Veteran suicides increased on average by 48 deaths each year. A reduction of 399 suicides within one year is unprecedented, dating back to 2001.
- The single-year decrease in the adjusted suicide rate for Veterans from 2018 to 2019 (7%) was larger than any observed for Veterans from 2001 through 2018. Further, the Veteran rate of decrease (7.2%) exceeded by four times the non-Veteran population decrease (1.8%) from 2018 to 2019.
- There was a nearly 13% one-year rate (unadjusted rate) decrease for female Veterans, which represents the largest rate decrease for Women Veterans in 17 years.
- COVID-19-related data continues to emerge and clarify, but data thus far do not indicate an increase in Veteran suicide-related behaviors. Additionally, the level of differential mortality by mental health status has not increased since the pandemic began.

Next Steps

Although VA is heartened that 399 fewer Veterans died by suicide in 2019 compared to 2018, VA is poignantly and painfully mindful that 6,261 Veterans died by suicide in 2019. While the differential in adjusted suicide rates between Veterans and non-Veterans decreased from its high of being 66.3% greater in 2017, the fact remains that Veterans in 2019 reflected a suicide rate 52.3% higher than non-Veterans in the U.S. The Veteran suicide rate decreased four times more in 2019 compared to the U.S. adult population in 2019, and Veterans ages 18-34 continue to die by suicide at a 1.65 times higher rate than other Veteran age groups, overall. Though the female Veteran suicide rate (unadjusted) decreased by nearly 13% in 2019 and the male Veteran suicide rate decreased by nearly 4%, female and male Veterans alike continue to die by firearm-related suicide at notably higher proportions than their non-Veteran peers.

Although current COVID-19-related data does not indicate increased Veteran suicide behaviors, including deaths and attempts, all-cause mortality among VHA Veterans was increased during COVID-19 and exceeds the number of deaths that have been directly associated with COVID-19. It also remains to be seen the impact of COVID-19 beyond the data and surveillance tools and means currently available to VA. Furthermore, the potential for a negative rebound effect in the proximal years following initial impact of wide-scale catastrophic or seismic events witnessed within modern history merits vigilance paired with aggressive prevention and intervention preparation and implementation.

Taken together, much work remains to be done. As long as Veteran suicide numbers are annually in the thousands, there is no sense of mission accomplishment or satisfaction within VA, despite being heartened by unprecedented decreases in Veteran suicide the year prior to full COVID-19 onset. Suicide prevention, therefore, remains a top priority for VA. Beyond mere words, this level of prioritization is currently being enacted through the most significant amount of resources ever appropriated and apportioned to VA suicide prevention. In response, VA continues to implement its 10-year vision, as outlined in the 2018 *National Strategy for Preventing Veteran Suicide* (National Strategy),[5] to end Veteran suicide through implementing a public health approach that combines both community-based and clinically based strategies across prevention, intervention, and postvention areas of focus. This strategic plan has operationalized significant deployment and implementation of the Suicide Prevention 2.0 initiative (SP 2.0); Suicide Prevention Now initiative (Now); the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS); 988 and Veterans Crisis Line (VCL) expansion; new legislation, including the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) (P.L. 116-171) and the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020 (P.L. 116-214); and collaborative efforts with VBA and collaborative interagency efforts with the Domestic Policy Council (DPC).

Suicide Prevention 2.0 (SP 2.0)

SP 2.0 includes both a Community-Based Intervention for Suicide Prevention (CBI-SP) approach and a clinical approach focusing on broad dissemination of evidence-based psychotherapies outlined in the recently updated clinical practice guideline.[6] SP 2.0 CBI-SP reaches Veterans inside and outside of VA's system by embracing cross-agency collaborations and community partnerships. SP 2.0 CBI-SP migrates three initiatives into a comprehensive approach to community-based suicide prevention addressing needs at state and local community levels: State-Based Coalition and Collaboration Building Model (e.g., Governor's Challenge, Veterans Integrated Service Network (VISN)-Based Community Coalition and Collaboration Building Model (e.g., VISN-wide community suicide prevention pilot programs) and Veteran-to-Veteran Coalition Building Model (e.g., Together With Veterans). For state-level prevention, VA, along with the Substance Abuse and Mental Health Service Administration (SAMHSA), is expanding the *Governor's Challenges to Prevent Suicide Among*

[5] 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***.

[6] 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***.

Service Members, Veterans, and their Families. Through these efforts, VA, SAMHSA, and state-level policy makers partner with local leaders to implement a comprehensive suicide prevention plan. Currently, 35 states are actively engaged with a goal to reach all 50 states by the end of 2022. For local community action through interstate efforts, VA is expanding community-based efforts across all VISNs with the *Community Engagement and Partnerships – Suicide Prevention* program focused on community coalition-building combined with targeted outreach and education. VA has expanded to nine VISNs and will engage the remaining nine VISNs by the end of 2022. Finally, VA is expanding community-based efforts through rural Veteran-to-Veteran approaches through the Together With Veterans program, partnering with VA's Office of Rural Health program to focus on building partnerships with rural Veterans and their communities to implement community-based suicide prevention. Five evidence-based strategies support local planning efforts. These strategies are designed for community-wide implementation to increase awareness and knowledge about Veteran suicide and improve community response to the needs of local Veterans. Across all three approaches to CBI-SP, there are three overarching focused priority areas: 1) identifying Service members, Veterans, and their families and screening for suicide risk; 2) promoting connectedness and improving care transitions; and 3) increasing lethal means safety and safety planning.

SP 2.0 clinical efforts are focused on increased access to evidence-based psychotherapies for suicide prevention as outlined by the Clinical Practice Guidelines (CPG): Cognitive Behavioral Therapy for Suicide Prevention, Problem-Solving Therapy, and Dialectical Behavioral Therapy, as well as Advanced Safety Planning Interventions. To that end, VA's Suicide Prevention Program has partnered with VA's national Clinical Resource Hub leadership team to stand up national telehealth capability to provide these treatments outlined in the CPG. VA is currently hiring over 100 clinicians to provide these treatments across all 140 health care systems. In addition to both SP 2.0 community and clinical efforts, the SP 2.0 model is built upon a foundation of mental health and suicide prevention staffing to ensure Veterans have access to the full continuum of mental health services. The minimal outpatient mental health staffing ratio includes 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. Currently, our suicide prevention staffing models are being revised to help best inform staffing needs with expansion of suicide prevention efforts in VA.

Now Initiative

The Now initiative aims to initiate quick deployment of interventions that are deemed to most efficiently impact Veterans at high risk for suicide within one year. The five areas of focus are: 1) lethal means safety; 2) suicide prevention in medical populations; 3) outreach to and understanding of prior VHA users; 4) suicide prevention program enhancements (e.g., Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH-VET) expansion, Safety Planning in the Emergency Department expansion); and 5) paid media. Over the past year, several advancements have been accomplished through Now, including mandatory training requirements of all VHA providers in lethal means safety, expanded partnerships with the National Shooting Sports Foundation and American Foundation for Suicide Prevention for publishing a lethal means safety toolkit, piloting efforts to re-engage prior VHA users, reaching all five REACH-VET performance metrics nationally, increased safety planning in the emergency department from a baseline of 35% to 86%, and significant expansion of paid media campaigns.

PREVENTS

On March 5, 2019, Executive Order 13861 was signed and established a three-year effort known as PREVENTS. The Roadmap developed by the PREVENTS Office, co-chaired by White House DPC Director and the Secretary of Veterans Affairs, has three main areas of focus: National Suicide Prevention Campaign, improving suicide prevention research, and building partnerships. Recently, PREVENTS came under the oversight of VA's Office of Mental Health and Suicide Prevention. PREVENTS efforts have been coordinated and cross-walked nationally to ensure amplification of a unified public health approach in alignment with the National Strategy and its operationalized plans in SP 2.0 and Now initiatives.

988/Veterans Crisis Line (VCL)

VCL provides 24/7 world-class crisis services through phone, chat, and text for all Veterans, Service members, National Guard and Reserve members, and their family members and friends. The recent enactment of the ***National Suicide Hotline Designation Act*** (P.L. 116-172) established 988 as a national three-digit emergency telephone number, replacing the full 1-800-273-8255 National Suicide Prevention Lifeline number. This full transition must occur by July 16, 2022. Forecasting modeling projects that transitioning to a three-digit code will increase VCL call volume significantly, and VCL is implementing plans to meet this increased demand. Presently, VCL has added 460 new positions to its organizational chart and has begun its hiring process to prepare for this increased demand.

Hannon Act of 2019 (P.L. 116-171)

The Hannon Act was signed into law on October 17, 2020, providing VA with a significant opportunity to expand suicide prevention efforts across multiple lanes. Notably, Section 201 established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), which enables VA to provide resources for community-based suicide prevention efforts to meet the needs of Veterans and their families through outreach, suicide prevention services and connecting to VA and community resources. In alignment with VA's National Strategy for Preventing Veteran Suicide (2018), this new grant program will assist in implementing a public health approach that blends community-based prevention with evidence-based clinical strategies. This grant program will be modeled after VA's Supportive Services for Veteran Families (SSVF) grant program, which has been able to leverage partnerships with community-based organizations that use VA grant assistance to provide participants who may not have had any contact with VA with supportive services, including outreach, case management, and financial assistance, as defined and described in the SSVF program rules. Many Veterans who die by suicide did not receive care from VA prior to their deaths. VA recognizes the critical importance communities play in ending suicide. This grant program will strengthen local community capacity to conduct outreach to Veterans and families, provide them with suicide prevention services, and connect them to resources within the community and VA to prevent Veteran suicide. SSG Fox SPGP will be a $174 million, three-year community-based grant program that will provide resources to community organizations serving certain Veterans at risk of suicide and their families across the country. Organizations can apply for grants worth up to $750,000 per fiscal year and may apply to renew awards from year to year throughout the length of the program.

The Veterans COMPACT Act of 2020 (P.L. 116-214)

The COMPACT Act was signed into law by President Trump on December 5, 2020, and enables VA to implement programs, policies, and reports related to transitioning Service members, suicide prevention, and crisis services; mental health education and treatment; and improvement of services for women Veterans. Specific to emergency suicide care, this act will strengthen coordination of care between VCL and the Office of Community Care by furnishing emergent care to an eligible individual at a medical facility of the department, pay for emergent suicide care provided to an eligible individual at a non-department facility, and reimburse an eligible individual for emergent suicide care provided to the eligible individual at a non-department facility.

Veterans Benefit Administration (VBA)

Suicide prevention coordination within VBA is focused upon increased and improved data sharing toward enhanced suicide risk prediction and identification; increased coordination regarding Veterans experiencing financial insecurity or debt liability paired with VHA high-risk identification and clinical engagement; continued coordination between VBA's Solid Start Call Center operations and VCL operations; and implemention of broad and far-reaching suicide prevention gatekeeper training for VBA personnel serving in direct contact with Veterans regarding the full range of benefit and compensation services.

Domestic Policy Council (DPC)

VA serves as a member of DPC's Interagency Policy Council on Suicide Prevention, including subgroups working on 988/crisis response, Lethal Means Safety, real-time surveillance, and efforts for Veteran and military suicide prevention. This interagency group allowed for creating and amplifying suicide prevention efforts across agencies in each of these areas with sharing of resources and data, combined with focused strategic priorities for implementation.

Together, these combined efforts operationalize the vision of the National Strategy, combining our efforts across VA with the community and other federal agencies and our congressional partners in a unified effort to continue to move forward our mission to end Veteran suicide.

Conclusion

From a suicide data and surveillance, as well as research and program evaluation perspective, more remains to be known and understood regarding prevention and intervention factors, dynamics, and associations. Therefore, pairing with and not in replacement of our gold-standard surveillance methods via partnership with CDC and DoD, upon which we rely for the Annual Report, VA is actively seeking meaningful valid, reliable, and scalable methods for improving early warning and rapid suicide surveillance. Additional work remains to be done and is currently being performed to better understand prevention and intervention factors, dynamics, and associations within the Veteran population seen in the VA within the year or the year prior to death, as well as the Veteran with no record of VHA engagement within that same time period. Both populations contain significant and meaningful internal variance and differences, rendering it questionably valid to reliably report upon them as homogenous groups alone. Greater complexity of analysis is needed to further our efforts. A similar truth holds for meaningful Veteran subpopulations known to be at elevated risk, such as female Veterans, Veterans ages 18-34, Native Veterans, Asian American/Pacific Islander (AA/PI) Veterans, lesbian, gay, bisexual, transgender, queer and others (LGBTQ+) Veterans, Veterans with serious medical conditions, and aging Veterans. Additional reporting and research will, therefore, ensue beyond the present annual report.

Firearm safety in the context of suicide prevention remains a highly salient and evidence-based aspect of Veteran suicide prevention, yet we have thus far continued to witness proportions of 50-70% for firearm-related Veteran suicide. Relatively little remains known regarding effective public health campaigns addressing Veteran suicide prevention. The years 2021 and 2022 will, therefore, serve as host and witness to aggressive extensions of the VA suicide prevention strategic plan to include specifically addressing data and surveillance, prevention, intervention, postvention, program evaluation, research, and policy development tailored and applied to Native Veterans, AA/PI Veterans, female Veterans, Veterans ages 18-34, LGBTQ+ Veterans, aging Veterans, Veterans facing serious medical illness, and Veterans facing financial insecurity and economic vulnerability. Simultaneously and equally important, risk and protective factors embedded within macro and micro societal issues of (in)equity, (in)equality, and (in)justice must be confronted across Veteran suicide prevention research, surveillance, policy development and implementation, program implementation, and program development.

The years 2021 and 2022 will also bring to fruition the implementation and delivery of a comprehensive public health campaign addressing firearm safety in the context of Veteran suicide prevention. The campaign will serve as a forerunner for the nation and for the field of suicide prevention regarding public health suicide prevention campaign design, implementation, and measurement. The fact that it will be focused upon Lethal Means Safety and firearm safety therein will allow VA to be responsible stewards of our leadership role and resources to make meaningful contributions of knowledge, data, and actions not only for application to Veteran suicide prevention but for our public and private sector colleagues and teammates deeply invested and engaged in suicide prevention for the benefit of all.

399 fewer, 6,261 to go. We hold this belief to be true: Suicide is preventable on the individual and on the community level. We have a plan: We believe in and are implementing a data-founded public health approach across prevention, intervention, and postvention domains within clinical and community settings alike and with tailored applications across population segments and needs. We have the heart and the will, but we know that suicide prevention will require all of us collectively and uniquely engaged within a unifying and overriding goal of saving lives from suicide. We, therefore, continue to seek everyone's support, partnership, and engagement.