

**U.S. Department of Veterans Affairs
Office of Mental Health and Suicide Prevention
Frequently Asked Questions – “VA National Suicide Data Report”
UPDATED: June 22, 2018**

Part I: 2015 Data Release

What is the U.S. Department of Veterans Affairs (VA) “VA National Suicide Data Report 2005–2015” data report?

This updated data report represents the largest analysis of Veteran suicide in our nation’s history. It builds on prior Veterans Health Administration (VHA) analyses, and introduces new analyses, to offer the most precise information about suicide rates and risk in both the Veteran and non-Veteran population. It represents a comprehensive examination of more than 55 million death certificates, from 1979 to 2015 to assess the differences in the rates of suicide among Veterans who use and do not use VHA services, calculate suicide rates among populations with established and emerging risk factors, and compare Veterans with other Americans.

What is the purpose of the report?

Ongoing collection, analysis, and dissemination of suicide-related data are crucial for understanding Veteran suicide and informing suicide prevention initiatives. VA and our partners will use these data to design the best possible tailored prevention strategies and efforts.

Which populations are examined in the report?

The data report examines suicide rates for three groups:

- Non-Veteran adults (ages 18 and older)
- Veterans
- Veterans who use VHA health care

In reporting suicide deaths per day, VA has assumed an inclusive definition of “Veteran” to refer to anyone who has or is serving in the military, including members of the National Guard and Reserve who have been separated and discharged.

For further context, there are approximately 20 million Veterans in the U.S. — around 18 million men and 2 million women. Of these 20 million, fewer than half receive VA benefits or services. Approximately 6 million Veterans (around 30 percent) receive VA health care.

How do Veteran suicide rates compare to the general population?

According to the most recent CDC data, released in June 2018, suicide rates are on the rise nationally, across the entire U.S. population. Generally speaking, Veteran data tends to reflect the broader U.S. population — and rates are rising for both Veterans and non-Veterans. But for some subgroups of the Veteran population, suicide rates are rising more quickly. Specifically, for those Veterans who do *not* use VHA health care, suicide rates are rising faster than among the VHA-served Veterans.



This all underscores the fact that suicide is a serious public health issue that impacts communities everywhere, across the country. This is why VA is leveraging a public health approach to suicide prevention. Our objective is to prevent suicide among *all* Veterans — not just those in our health care system.

How is VA using the data?

VA is analyzing and reporting on suicide data to gain insight into high-risk populations. VA uses — and will continue to use — these data to improve its strategies, programs, and resources. Additionally, we will share data with community-based health care providers and partners to help them support Veterans in their communities.

Where do the data come from?

This report incorporates the most recent mortality data from the joint VA/Department of Defense (DoD) Suicide Data Repository and includes information for deaths from suicide among all known Veterans of U.S. military service. Data for the joint VA/DoD Suicide Data Repository were obtained from the National Center for Health Statistics' National Death Index (NDI) through collaboration with the DoD. Data available from the NDI include reports of mortality submitted from vital statistics systems in all 50 U.S. states, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands.

What has changed from last year's data report?

This report builds upon prior analysis of Veteran suicide and provides additional and updated information on all known suicides among Veterans living in the United States from 2005 to 2015. In addition to expanding to include 2015 data, it includes updated 2014 data. This report also includes new analyses of suicide rate by service branch and service era, as well as suicide rate analyses by race and ethnicity.

Active-duty service members, and non-activated Guardsmen and Reservists were included in the reported 20 suicide deaths per day in the 2014 data release. This point is more clearly stated in the 2015 report.

What has stayed the same?

Similar to the findings in the 2014 report, the 2015 report found that the average daily number of Veteran suicide deaths has remained stable at 20. Additionally, the percentage of suicides resulting from a firearm injury remained high — in 2015, 67 percent of suicide deaths involved firearms (this was unchanged from 2014).

Why did VA update the 2014 data in addition to adding 2015 data?

As new information becomes available, it's sometimes necessary to update data that's previously been published to ensure that VA is tracking the most precise measures and has the most accurate longitudinal view of trends.



What are the different measures VA uses?

When directing suicide prevention efforts, it's important to consider the distribution of suicides as well as differences in rates among key population subgroups. To track suicide and draw meaningful conclusions from the data, VA uses measures such as:

- **Suicide count:** A suicide count indicates a total number of suicides. Usually, the count alone has little meaning unless the size of the population is known.
- **Suicide rate:** A suicide rate divides the number of suicide deaths by the relevant population size for a period of time.
- **Percent of decedents:** Percent of decedents refers to the share of all deaths that were suicide deaths in a given population over a period of time.
- **Percent change in suicide rates:** Used to compare changes in rates between years.

For example, male Veterans ages 55–74 have the highest *count* of suicides because the population size is largest. But male Veterans ages 18–34 experience the highest *rate* of suicide.

Why are Veterans at risk for suicide?

Certain suicide risk factors and protective factors pertain equally to Veterans and non-Veteran adults. However, Veterans may have unique characteristics and experiences related to their military service that can increase or decrease their risk for suicide.

Suicide risk factors that Veterans and non-Veterans may have include physical and mental illness, substance use, chronic pain, life transitions, and bereavement. Shared protective factors include social connectedness, positive coping skills, access to mental health care, and having a sense of purpose.

Veteran-specific risk factors include transition-related challenges, posttraumatic stress disorder, traumatic brain injury, and experience with firearms. Veterans' protective factors include resilience and having a sense of belonging.

Why did VA include former service members without potential Title 38 status in the analyzed Veteran population for the 2015 data release? How does this impact the data?

This report incorporates data obtained from the Department of Defense that were unavailable for previous reports. These additional mortality data distinguish Veterans with likely Title 38 status (full potential eligibility for VA care) from those who were active duty service members or were never federally activated National Guard Soldiers or Reservists at the time of their death.

All these mentioned populations are considered Veterans in our count of suicide deaths per day, as they have served in the military. These additional data are included for the years 2005-15 in this report's calculations of the number of Veterans who died by suicide each day. All other findings in the report refer specifically to Veterans who had been activated for federal service and were not currently serving on active duty at the time of their death.



The report shows that 3.8 active duty service members or non-activated Guard and Reserve died by suicide each day in 2015. This figure seems different than DoD's counts of suicide per day?

As part of the 2015 National Suicide Data Report, VA reported that 3.8 of the 20.6 Veteran suicides per day were active duty (0.9 suicide deaths per day) and never federally activated Guard and Reserve (2.9 suicide deaths per day). In our report, VA did not differentiate deaths between active duty, current never federally activated Guard and Reserve, and discharged never federally activated Guard and Reserve. This difference in the report may have caused some confusion and led to the misperception that approximately 1,000 more current service members died by suicide than DoD reported in 2015.

In the interest of providing consistent data for anyone who monitors Veteran and military suicide, VA and DoD are working together to better align their reporting processes. In the next report, we will provide enhanced clarity on these distinctions. It will also include data from 2016 and be available in Fall 2018.

What is the role that access to VHA care plays in Veteran suicide rates?

The rate of suicide among Veterans who have *not* recently received VHA services is increasing faster than the rate of suicide among Veterans who have recently received VHA services. Even though the rate of suicide among Veterans using VHA services is higher than the rate among Veterans not using VHA services, the lower rate of increase suggests that our world-class health care and engagement are making a difference.

The VHA is committed to giving Veterans the highest-quality care, including care that may be unavailable to them in the private sector. More Veterans are receiving VA benefits and health services than ever before. In fact, from 2005 to 2015, the number of male and female Veterans who had recently used VHA services increased by nearly 20 percent and 55 percent, respectively.

Suicide is a complex issue, and no single factor — including access to VHA care — accounts for the rate of Veteran suicide. However, the health and well-being of our nation's Veterans remains VA's highest priority, and VA is committed to ensuring that all Veterans receive the support they need. VA works diligently to improve its services every day. Mental health providers, counselors, suicide prevention coordinators and researchers are dedicated to preventing Veteran suicide and providing every Veteran with personalized support.

What do these data mean for VA's suicide prevention efforts?

Data is at the core of VA's public health approach to suicide prevention, which seeks to reach all Veterans and not just those in the VHA's care. This comprehensive approach considers the many factors beyond mental health that contribute to risk for suicide. Using the public health approach, the VA Suicide Prevention Program can deliver resources and support to Veterans earlier — before they reach a crisis point — and through more channels. **VA is using data to tailor the best possible targeted prevention strategies to reach all Veterans**, not just those identified as being at risk. These strategies comprise the following:



- **Universal** strategies, which are intended for all U.S. Veterans
- **Selective** strategies, which are intended for Veterans in subgroups that may be at increased risk for suicide.
- **Indicated** strategies, which are intended for individual Veterans identified as having a high risk for suicide.

What are some of the actions VA has taken since 2015 to prevent Veteran suicide?

VA has made suicide prevention its number one priority, and we continue to develop and build interventions using all available data. Notable activities include:

- Expanding the Veterans Crisis Line: a third call center opened in Topeka, KS in May 2018
- Increasing access to mental health care for Veterans in VA health care
- Building partnerships across many different sectors:
 - Launching the Mayor’s Challenge to Prevent Suicide, in coordination with the Substance Abuse and Mental Health Services Administration (SAMHSA)
 - Convening a Partnership Roundtable with DoD to engage key partners and stakeholders across several stakeholders.
 - Implementing programs with private health care, DoD and other agencies, Veteran Service Organizations (VSOs), community groups, research and policy organizations, and more.
- Leveraging predictive analytics through the REACH VET program
- Continually expanding suicide prevention and mental health awareness campaigns: #BeThere, Make the Connection, Johnson & Johnson ‘No Veteran Left Behind’ PSA
- Offering free suicide prevention training for anyone through the online SAVE video, produced in partnership with PsychArmor Institute.
- Implementing the Joint Action Plan for Supporting Veterans During their Transition from Military to Civilian Life (as part of the **Executive Order Supporting Mental Health Care for Transitioning Service Members**)
- Developing the forthcoming National Strategy for Preventing Veteran Suicide, a framework to identify priorities, organize efforts, and contribute to a national focus on Veteran suicide prevention.

Part II: State Data Sheets

Does the updated report include state-level data?

Separately from this report, VA also provides data sheets on state-level findings, including number of suicide deaths among Veterans, suicide rates by age group, and suicide deaths by method compared to regional and national data. The updated 2015 state data sheets will be available in late June 2018 at mentalhealth.va.gov.



What about local-level data from counties, cities, towns, or other jurisdictions?

Protecting the privacy of Veteran patients is of paramount importance to VA and releasing information about the number of Veterans who died by suicide in specific localities could jeopardize patient privacy, so VA will not release local-level data.

Why are there no state data sheets for U.S. territories other than Puerto Rico?

At this time, data for four of the five permanently inhabited U.S. territories — U.S. Virgin Islands, Guam, American Samoa, and Northern Mariana Islands — are not provided in individual data sheets. This is due to the small number of individuals who died by suicide in these territories, as well as inconsistent reporting to the National Center for Health Statistics National Death Index. Reporting on such a small population would risk identifying individual Veterans. VA continues to investigate methods for providing data from all territories while preserving the privacy of Veteran patients.

What conclusions can be drawn from comparing the suicide rates of one state to another?

Disparities in suicide rates exist between states and, in some cases, regions. Numerous factors that contribute to suicide risk and incidence must be considered when examining a state's suicide data. The varying characteristics of a state's Veteran population, like demographics or unemployment rate, can make it difficult to compare Veteran suicide rates between states. Some states have relatively large Veteran populations or populations in general, which can affect suicide rates. While there is no single reason why one state has higher suicide rates than others, these factors like access to health care, the setting (rural, urban, etc.), and local firearm regulations are relevant considerations when examining differences in rates.

