

Frequently Asked Questions

Why does VA generate an annual report on Veteran suicide?

The annual report of Veteran suicide mortality is a critical part of our public health approach to inform next steps in suicide prevention across the nation. This work surged forward in 2006, when VA initiated comprehensive assessments of national death certificate data for all Veterans Health Administration (VHA) patients.¹ In 2016, VA generated the first annual report on suicide including the entire Veteran population, based on analyses of national death certificate data for all Veterans. Over time, VA reporting has added new years of data and expanded assessments. For example, this report provides, for the first time, information on suicide rates among Veterans who received Veterans Benefits Administration (VBA) services (see pages 69-70 in the report).

Information from the reports, as well as from year-round VA suicide analytics and research, is used to inform and enhance Veteran suicide prevention initiatives. The reports tell us about patterns of Veteran suicide overall and, more specifically, for Veteran subpopulations. The reports also provide information about ongoing Veteran suicide prevention initiatives. By producing the reports, VA contributes to public efforts to understand Veteran suicide and support suicide prevention.

Is the VA report on Veteran suicide comprehensive and complete?

The report is comprehensive and complete, utilizing the most accurate and current data available and established definitions for Veteran status and suicide mortality. See the [National Veteran Suicide Prevention Annual Report Methods Summary](#) for details regarding VA suicide surveillance processes, including conduct of joint VA/Department of Defense (DoD) searches of death certificate data from the Centers for Disease Control and Prevention (CDC) National Death Index (NDI), data processing, identification of decedent Veteran status, identification of suicide deaths, and mortality rate calculations. The NDI is considered the gold standard of U.S. mortality databases. This report uses established criteria to identify suicide deaths from the death certificate records² and relies on the official reports of coroners and medical examiners regarding cause of death. The report includes the most current information available regarding Veteran suicide for all years examined. For this reason, its findings update information included in previous reports.

Does the VA report on Veteran suicide include drug overdose deaths?

This report includes information on all Veteran deaths that coroners and medical examiners document as suicide deaths. These include overdose deaths with suicidal intent. In 2021, of the 6,392 Veteran suicide deaths, 335 (5.2%) were indicated on death certificate records as drug overdoses with suicidal intent. VA criteria for identifying suicide deaths are the same as those used by other federal agencies, including the National Center for Health Statistics.

1 McCarthy JF, Valenstein M, Kim HM, Ilgen M, Zivin K, Blow FC. 2009. Suicide Mortality Among Patients Receiving Care in the Veterans Health Administration Health System. *American Journal of Epidemiology*. 169(8):1033-1038.

2 National Center for Health Statistics. 2009. Instruction Manual. Part 9. ICD-10 Cause-of-Death Lists for Tabulating Mortality Statistics. Available: <https://www.cdc.gov/nchs/data/dvs/part9instructionmanual2009.pdf>

