2025

National Veteran Suicide Prevention
ANNUAL REPORT

Part 2: Report Findings

Office of Suicide Prevention
March 2026

Contents

Introduction

Reducing Veteran suicide is the U.S. Department of Veterans Affairs (VA) top clinical priority. Veteran suicide is a critical issue that affects all Americans. In 2023, suicide claimed the lives of 47,711 American adults, including 6,398 U.S. Veterans. The tragic loss of life through suicide is not only a personal or family tragedy, but a profound public health concern that resonates throughout the broader Veteran community and impacts families and communities across the Nation. This underscores the urgent need for collective action and the deployment of strategies that effectively address the root causes of suicide and strengthen protective factors to help Veterans thrive.

The 2025 National Veteran Suicide Prevention Annual Report offers the most current data on suicide among Veterans and non-Veteran U.S. adults, including trend rates spanning from 2001-23. The Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (P.L. 118-210 § 149 (a)), passed in 2025, requires annual VA suicide reports with specified elements for inclusion. These will be released by July 2026 in an update to the present report.

This report is an essential component of our ongoing efforts to understand and address the critical issue of suicide within the Veteran community. Our commitment is to ensure that every Veteran has access to the support and resources they need to thrive, thereby strengthening the wellbeing of our communities across the Nation.

Key Findings

In addressing the issue of Veteran suicide, emphasizing the critical roles of hope, purpose, community, and comprehensive support systems is essential to counter-balancing the challenges that drive Veteran risk. A strong community offers Veterans a vital network of support, fostering connections that alleviate isolation and invigorate a sense of belonging and purpose. By integrating these key factors–hope, community, and a holistic approach to care–we create a safer, more supportive environment for Veterans. Through coordinated efforts to tailor support to the diverse and individual clinical, social, psychological, and spiritual needs of each Veteran, we honor their service.

In 2023, key areas emerged, including:

Overarching Trends

- In 2023, there were 6,398 Veteran suicide deaths (44 fewer than in 2022).[1]
- There were 47,711 suicides among all U.S. adults in 2023, on average 130.7 per day. These included, on average, 17.5 Veteran suicides per day, of which 6.8 per day were among Veterans who received Veterans Health Administration (VHA) care in 2022 or 2023 (39.0%) and 10.7 were among Other Veterans (61.0%).
- In 2023, suicide was the 12th leading cause of death for Veterans, and was the second-leading cause of death for Veterans under age 45.
- In 2023, the rate of suicide[2] for Veterans was 35.2 per 100,000 (up from 34.7 per 100,000 in 2022).
    - The suicide rate was 13.9 per 100,000 for female Veterans (up from 13.7 per 100,000 in 2022) and 37.8 per 100,000 for male Veterans (up from 37.3 per 100,000 in 2022).

[1] These included 286 suicides among female Veterans (eight more than in 2022) and 6,091 among male Veterans (73 fewer than in 2022). Throughout this report, counts by age and sex may not sum to the overall totals due to missing information on age or sex.

[2] A rate is a measure of how commonly something occurs in a population, with time explicitly included in the denominator. A rate is calculated as the number of events divided by the cumulative person-years at risk for the event in the population. Suicide rates are commonly expressed in units per 100,000. In this report we refer to unadjusted suicide rates as "suicide rates" and rates that are adjusted for population age differences are specified as "age-adjusted suicide rates." For more information, see the Methods Summary appendix.

Mental Health and Substance Use Treatments

- Among Veterans in VHA care who died from suicide in 2023, 60.9% had a VHA mental health or substance use disorder diagnosis[3], 39.1% did not.
- From 2001 to 2023, the suicide rate among Veterans in VHA care with mental health or substance use disorder diagnoses fell 34.7%, from 87.0 per 100,000 to 56.9 per 100,000.
- In 2023, the suicide rate among Veterans in VHA care with indications of nicotine use (55.1 per 100,000) was 81.2% higher than the suicide rate for Veterans in VHA care without indications of nicotine use (30.3 per 100,000).
- The suicide rate in 2023 among Veterans in VHA care with indications of nicotine use was 2.5% lower than in 2022.

Veteran Age and Sex Trends

- In 2023, suicide rates were highest among Veterans between ages 18 34 (47.9 per 100,000), followed by those between ages 35-54 (37.3 per 100,000).
- From 2001-23, for both sexes, age-adjusted rates rose proportionally more for Veterans without recent VHA use.
    - From 2001-23, while age-adjusted suicide rates rose 29.6% for female Veterans with recent VHA use, they rose by 64.6% for female Veterans without recent VHA use.
    - Similarly, while age-adjusted suicide rates rose 23.0% for male Veterans with Recent VHA Use, they rose by 71.1% for male Veterans without Recent VHA Use.
- From 2022-23, age-adjusted suicide rates increased by 2.8% for female Veterans and decreased by 0.8% for female non-Veteran adults, and age-adjusted rates increased by 3.1% for male Veterans and decreased by 2.3% for male non-Veteran adults.

Lethal Means

- In 2023, the largest component of the overall suicide rate for Veterans (35.2 per 100,000) was firearm suicide (25.8 per 100,000), followed by suffocation suicide
- Of note, this report includes information on all Veteran deaths that coroners and medical examiners documented as suicide deaths. These include overdose deaths with suicidal intent.
    - The unadjusted rate of suicide by drug overdose fell from 2.8 per 100,000 in 2010 to 1.8 per 100,000 in 2023.
    - The unadjusted rate of suicide by overdose involving opioids fell from 1.0 per 100,000 in 2010 to 0.6 per 100,000 in 2023.
    - The unadjusted rate of suicide by overdose involving synthetic opioids[4] was 0.2 per 100,000 in both 2010 and 2023.
    - Suicides by drug overdose accounted for 9.7% of all Veteran suicide deaths in 2010 and 5.0% in 2023.
- From 2001-23, while Veteran firearm suicide rates rose 67.0% and suffocation suicide rates rose 53.0%, the poisoning suicide rate fell by 16.3%.
- From 2022-23, while the firearm suicide rate for Veterans rose by 1.3% and the suffocation suicide rose by 9.0%, the poisoning suicide rate fell by 10.3%.
- From 2001-23, the firearm suicide and suffocation suicide mortality rates of male Veterans exceeded those of female Veterans. By contrast, poisoning suicide rates of female Veterans exceeded those of male Veterans.
- Veteran rates of firearm suicide and poisoning suicide mortality exceeded those of non-Veterans for both men and women.
    - Differentials in rates by Veteran status were particularly high among female adults. For example, in 2023, the firearm suicide rate among female Veterans was 168.3% higher than for female non-Veteran adults, and the firearm suicide rate among male Veterans was 70.5% higher than for male non-Veteran adults.

[3] The presence of mental health or substance use disorder diagnoses were assessed in encounters with VHA providers in 2022 to 2023.

[4] Synthetic opioids, excluding methadone. Synthetic opioids include fentanyl.

- Firearms were commonly involved in suicide deaths by U.S. adults. In 2023, firearms were involved in:
    - 73.3% of Veteran suicides and 52.9% of suicides of non-Veteran adults
    - 49.0% of suicides of female Veterans and 35.3% of suicides of non-Veteran women
    - 74.5% of suicides of male Veterans and 58.2% of suicides of non-Veteran men

Receipt of VHA Health Care

- In 2023, suicide was the 15th leading cause of death for Veterans in VHA care and the 11th leading cause of death for Other Veterans.
- As for other leading causes of death, including heart disease, cancer, stroke, and unintentional injury, in 2023 suicide rates were higher among Recent Veteran VHA Users[5] than for Other Veterans.[6]
- From 2001-23, for both sexes, age-adjusted rates rose proportionally more for Veterans without recent VHA use than for Veterans who were recent Veteran VHA users.
    - From 2001-23, while age-adjusted suicide rates rose 29.6% for female Veterans with recent VHA use, they rose by 64.6% for female Veterans without recent VHA use.
    - Similarly, while age-adjusted suicide rates rose 23.0% for male Veterans with Recent VHA Use, they rose by 71.1% for male Veterans without Recent VHA Use.
- In each year, from 2020-23, suicide rates were highest for Veterans who received any Community Care services followed by Veterans who received any VHA direct care, and suicide rates were lowest among Veterans who did not receive either Community Care or VHA direct care.

Military Sexual Trauma

- Military Sexual Trauma (MST) refers to experiences of sexual assault or sexual harassment during military service.
    - Among female Recent Veteran VHA Users in 2023, the suicide rate was 45.3% higher for those with positive screens for MST (18.7 per 100,000) than those with negative screens (12.9 per 100,000), and among male Recent Veteran VHA Users the suicide rate in 2023 was 27.6% higher for those with positive screens (55.9 per 100,000) than for those with negative screens (43.8 per 100,000).
- From 2022-23, suicide rates fell among Veterans in VHA care with positive screens for MST. For female Veterans with MST rates fell 25.1% and for male Veterans with MST rates fell 26.0%.

Female Veterans

- Among female Veterans in VHA care aged 40-64 who received menopausal hormone therapy, suicide rates fell 54.7% from 2004-07 (30.8 per 100,000) to 2020-23 (15.3 per 100,000).
- Adjusting for age differences, the suicide rate in 2023 for female Veterans was 103.1% higher than for female non-Veteran U.S. adults, and the age-adjusted rate[7] for male Veterans was 49.7% higher than for male non-Veteran U.S. adults.

[5] Veterans alive at the start of the year and with a VHA health care encounter in the year or prior calendar year.

[6] Veterans alive at the start of the year and who did not have a VHA health care encounter in the year or calendar prior year.

[7] To compare rates across populations or periods, we use direct age-adjusted rates, stratified by sex. Adjusted rates represent the level of suicide mortality that we would see in the population and time period if the population had the same demographic distribution of a standard population, at least in terms of the adjustment variable(s). Consistent with current practice, in this report adjusted rates use the U.S. adult population in 2000 as the standard population. For more information, see "Suicide Rates" in this report and the "2025 National Veteran Suicide Prevention Annual Report Methods Summary" that accompanies this report.

Veterans Crisis Line

- Among Veterans in VHA care with documented contact with the Veterans Crisis Line in 2022,[8] including calls, chats and texts, the suicide rate in the 30 subsequent days was 718.4 per 100,000, and the rate through 12 months was 254.5 per 100,000.
    - The suicide rate in the 30 days following an initial documented Veterans Crisis Line contact in 2022, for Veterans with VHA care in the prior 24 months, was 2.1% lower than in the 30 days following initial contacts in 2021. The rate was 24.2% lower than was observed for Veterans so identified in 2019 (718.4 per 100,000 versus 947.3 per 100,000). The suicide rate over the 365 days following initial contact in 2022 was 16.1% lower than following initial contact in 2021.

Transitioning Service Members

- Veterans who separated from active military service in 2022 had the lowest 12-month suicide rate (41.2 per 100,000) observed since 2016. The rate for those who separated in 2022 was 19.6% lower than for those who separated in 2019 (51.2 per 100,000).
- For Veterans who separated from active military service in 2022, suicide rates over the following 12 months were highest among those who separated from the Marine Corps (50.9 per 100,000), followed by the Army (43.0 per 100,000), Navy (38.0 per 100,000), and Air Force (29.5 per 100,000).
- For Veterans who separated from active military service in 2022, suicide rates over the following 12 months were higher among those with Defense Health Agency diagnoses of substance use disorders (152.6 per 100,000) and suicidal ideation (130.7 per 100,000) and those with mental health diagnoses (63.2 per 100,000).

Other Veteran Populations

- Across VHA priority groups, suicide rates from 2005 through 2023 were highest for Veterans in priority Group 5[9], which includes income-based eligibility (57.9 per 100,000 in 2023).
    - Among Veterans in Group 5, suicide rates in 2023 were highest for those aged 18-34 (85.4 per 100,000).
- Among Veterans in VHA care, suicide rates in 2023 were highest for American Indian or Alaska Native Veterans and White Veterans, followed by Native Hawaiian or Pacific Islander Veterans and Veterans of multiple races; rates were lowest for Asian and Black or African American Veterans.
- For Veterans in VHA care with suicide attempts documented in 2022, the suicide rate over the subsequent 12 months was 590.7 per 100,000.
- Veterans in VHA care with diagnoses of traumatic brain injury (TBI) had elevated suicide rates. In 2023, the suicide rate for those with TBI diagnoses was 77.6 per 100,000 (94.3% higher than Veterans in VHA care without TBI diagnoses).
- In 2023, the suicide rate among homeless Recent Veteran VHA Users was 146.0% higher than for those without diagnoses of homelessness. In 2023, the suicide rate among Recent Veteran VHA Users with diagnoses of homelessness was 38.8% higher than in 2001 and 14.3% higher than in 2022.
- Suicide rates fell 44.8% among Veterans in VHA care with active behavioral patient record flags, from 296.7 per 100,000 in 2004-05 to 163.9 per 100,000 in 2022-23.
- In 2023, the suicide rate for Veterans in VHA care with cancer diagnoses was 10.3% higher than for those without cancer diagnoses, consistent with patterns observed in each year from 2001 through 2023 except 2022, when the rate for those with cancer diagnoses was 0.4% lower than for Veterans without cancer diagnoses.
- For Recent Veteran VHA Users with active Behavioral Patient Record clinical flags, the suicide rate in 2022 to 2023 was 163.9 per 100,000, which was 302.1% higher than the rate for Veterans in VHA care without active flags in 2022-23 and the prior five years (40.7 per 100,000).

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[8] Veterans in VHA care in 2022 were the most recent cohort for which data was available to evaluate the suicide rate over the entire subsequent 12 months, which included calendar year 2023.

[9] Priority Group 5: Non-service-connected Veterans or Veterans with no service-connected disabilities and with an annual income and net worth below VA's National Income Thresholds. Service-connected Veterans rated 0% disabled and with an annual income below VA's National Income Thresholds.

- From 2001-23, suicide rates for Recent Veteran VHA Users were elevated among those with Veterans Justice Program services compared to those without such contact. In 2023, the suicide rate for Recent Veteran VHA Users who received Veterans Justice Program services (144.6 per 100,000) was 263.7% higher than for Veterans in VHA care who did not receive these services.

Behavioral Health Autopsy Program Findings

- Among Recent Veteran VHA Users whose suicide deaths occurred in 2021-23 and were reported to VHA Suicide Prevention teams, VA Behavioral Health Autopsy Program[10] data indicated that the most frequently identified risk factors were pain (52.3%), sleep problems (51.5%), increased health problems (43.1%), recent declines in physical ability (34.8%), relationship problems (31.9%), hopelessness (30.2%), impulsivity (24.9%), and unsecured firearms in the home (24.4%).

Veteran Groups with Elevated Suicide Rates

Here we highlight 20 Veteran groups with particularly elevated suicide rates:

Measure	Suicide Rate per 100,000
1. Suicide Attempt	590.7
2. Sedative Use Disorder	305.1
3. Other Psychosis	257.3
4. VHA Users with Veterans Crisis Line Contact	254.5
5. Amphetamine Use Disorder	233.6
6. Behavioral Patient Record Flag	163.9
7. Personality Disorder	155.2
8. Recently Separated with Substance Use Disorder	152.6
9. Justice Program Contacts	144.6
10. Recently Separated with Suicidal Ideation	130.7
11. Cannabis Use Disorder	125.8
12. Schizophrenia	124.1
13. Homelessness Diagnosis Without Homeless Program Use	122.8
14. Opioid Use Disorder	121.8
15. Bipolar Disorder	118.8
16. Alcohol Use Disorder	101.7
17. Substance Use Disorder	97.3
18. Cocaine Use Disorder	96.6
19. Priority Group 5, Age 18-35	85.4
20. Traumatic Brain Injury	77.6

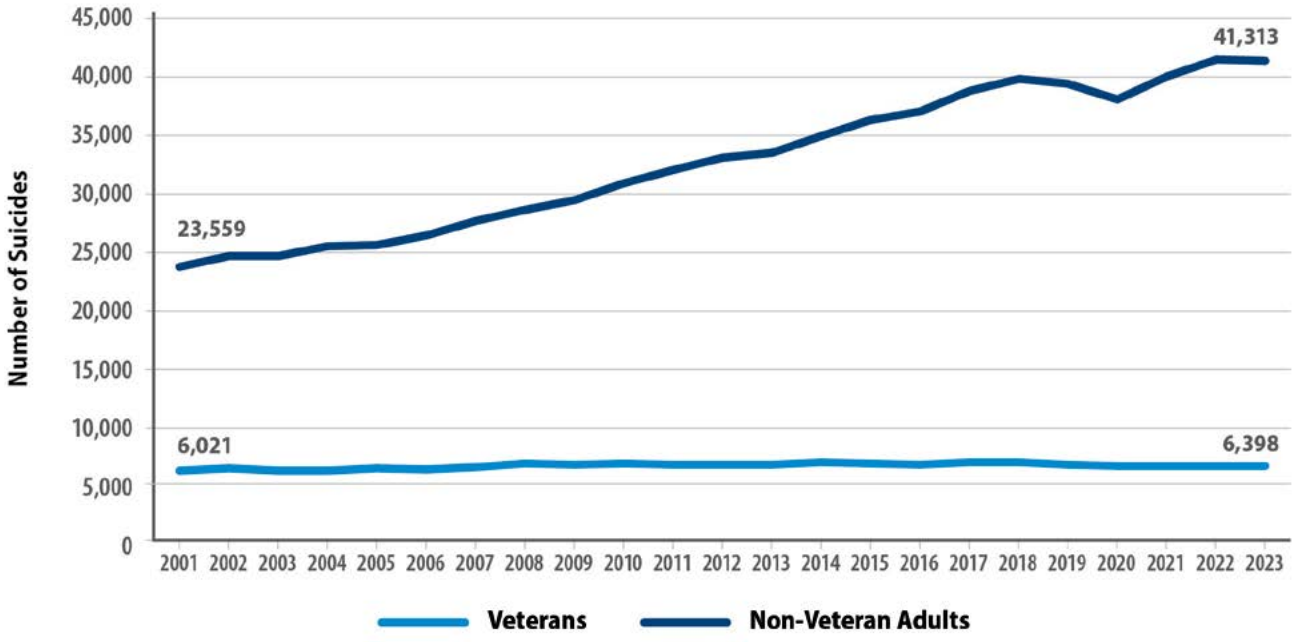
[10] Through this program, suicide prevention teams perform standardized reviews of health records to identify factors relevant to Veteran suicides, considering all available information. See "Behavioral Health Autopsy Program Reviews" in Section B.

Section A: Veteran Suicide, 2001-23

Suicide Deaths

In 2023, there were 47,711 suicides among U.S. adults. These included 6,398 suicides among Veterans[11] (44 fewer than in 2022) and 41,313 among non-Veterans (136 fewer than in 2022). Figure 1, with additional information, is below.

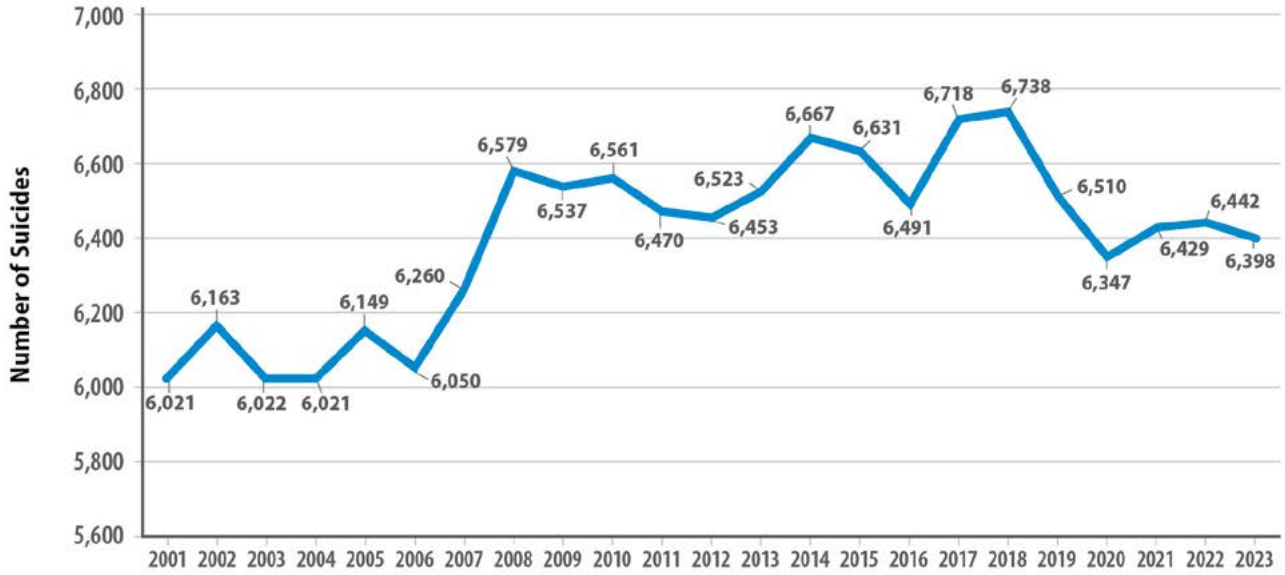
Figure 1: Suicide Deaths Among Veterans and Non-Veteran U.S. Adults, by Year, 2001-23



[11] For 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. For more information, see the Methods Summary appendix

Figure 2, below, details variation in the number of Veteran suicides, by year from 2001-23.

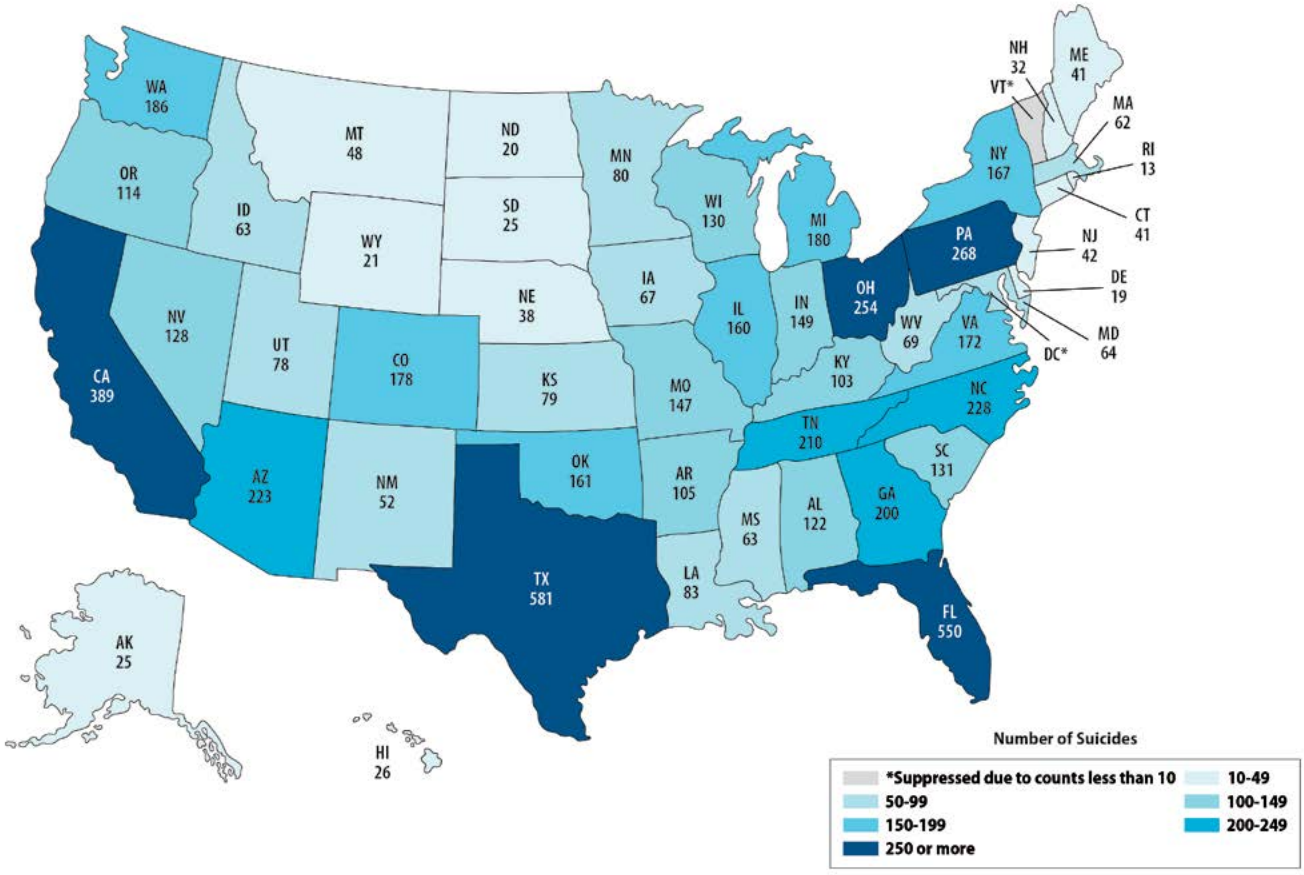
Figure 2: Veteran Suicide Deaths, 2001-23



Veteran Suicide Deaths, by State

Figure 3, below, shows the number of Veteran suicide deaths in 2023, by state.

Figure 3: Number of Veteran Suicide Deaths by State, 2023[12]



[12] Counts for U.S. territories in 2023 are not presented due to counts of fewer than 10 suicide deaths. For more information, please see the accompanying State Data Appendix.

Below, Table 1 lists the 10 states with the highest number of Veteran suicides in 2023. These states accounted for 48.3% (3,089) of the 6,398 Veteran suicides in 2023.

Table 1: Ten States with the Highest Number of Veteran Suicides in 2023

	State	Number of Veteran Suicides	Number of Veterans
1	Texas	581	1,544,000
2	Florida	550	1,424,000
3	California	389	1,481,000
4	Pennsylvania	268	694,000
5	Ohio	254	676,000
6	North Carolina	228	693,000
7	Arizona	223	478,000
8	Tennessee	210	436,000
9	Georgia	200	666,000
10	Washington	186	511,000

Average Number of Suicides Per Day[13]

In 2023, there were, on average, 130.7 documented suicides per day among U.S. adults, including at least 17.5 per day among Veterans and at least 113.2 per day among non-Veteran adults.

- Among all U.S. adults, including Veterans, the average number of suicides per day rose from 81.0 per day in 2001 to 130.7 in 2023. The average number per day among U.S. adults was highest in 2022 (131.2 per day).
- The average number of Veteran suicides per day rose from 16.5 in 2001 to 17.5 in 2023. The average number of suicides per day was highest in 2018 for Veterans (18.5 per day). Of the on average 17.5 Veteran suicides per day in 2023, approximately 39.0% (6.8 per day) were among Recent Veteran VHA Users[14] and 61.0% (10.7 per day) were among Other Veterans.

Suicide Rates

From 2001 to 2023, the Veteran population decreased by 29.8%, from 25.9 million to 18.2 million[15]. During this timeframe, the non-Veteran U.S. adult population increased by 30.9%, from 186.4 million to 243.9 million. In this context, it is important to assess suicide mortality rates, which convey the incidence of suicide relative to the size of the population.

[13] Decreases in the size of the Veteran population and increases in the size of the U.S. population over this period limit interpretation of these statistics. Rates of suicide, stratified by group, are the appropriate measures for understanding changes in Veteran and non-Veteran populations. These are included elsewhere in this report and in the accompanying national data appendix.

[14] Consistent with prior reports, Recent Veteran VHA Users were defined as Veterans who received inpatient or outpatient care (in person or via telehealth) at a VHA facility in the year of interest or the prior year (here, in 2023 or in 2022). Health care received from non-VHA facilities, including such care that was funded by VA (that is, community care) was not included.

[15] Overall Veteran population estimates were derived from the Veteran Population Projection Model 2023 (see Methods Summary appendix).

Rates

Suicide rates represent the number of suicide deaths relative to the population's time at risk of being documented with a suicide death.[16] Rates are reported as suicides per 100,000.[17] Direct adjusted rates are used for comparisons while adjusting for population differences.[18] To report the burden of suicide in a given population and period, we use unadjusted rates. To compare rates across populations or periods, we use direct age-adjusted rates, stratified by sex.[19]

- The suicide rate for Veterans was 23.2 per 100,000 in 2001; 34.7 per 100,000 in 2022; and 35.2 per 100,000 in 2023. For non-Veteran U.S. adults, the suicide rate was 12.6 per 100,000 in 2001; 17.2 per 100,000 in 2022; and 16.9 per 100,000 in 2023.
- In 2023, Veterans between ages 18-34 had a suicide rate of 47.9 per 100,000, and the rate was 37.3 per 100,000 for those between ages 35-54; 31.2 per 100,000 for those between ages 55-74; and 33.5 per 100,000 for those aged 75 and older.
- In 2023, the suicide rate for female Veterans was 13.9 per 100,000 (up from 13.7 per 100,000 in 2022) and it was 37.8 per 100,000 for male Veterans (up from 37.3 per 100,000 in 2022).
- In 2023, the suicide rate of female non-Veteran U.S. adults was 7.20 per 100,000 (similar to 7.23 in 2022) and it was 28.4 per 100,000 for male non-Veteran U.S. adults (down from 28.8 per 100,000 in 2022).

[16] Risk time is measured using mid-year population estimates when individuals' exact risk times were unavailable. It was calculated exactly for analyses of subgroups of Veterans with recent VHA care.

[17] For the Veteran population, risk time was assessed using the mid-year population estimate, as detailed in the see the Methods Summary appendix. When risk time was assessed per individual-level risk-time information, we included "per 100,000 person-years."

[18] Suicide risks may differ across demographic categories. If groups differ in these characteristics, then that variation may account for some of the differences in unadjusted rates. The Veteran and non-Veteran adult populations differ by age and sex. Overall, Veterans are, on average, older and more male. Adjusted rates translate the unadjusted rate for a population into a measure of what the rate would be if the compared populations had the same distributions of the demographic factors that are adjusted for. Per standard practice, adjusted rates are calibrated to the demographic distribution as the U.S. adult population in 2000. However, such direct adjustment has limitations. When the demographic distributions are markedly different from those of the reference population (as the Veteran population's sex distribution is compared to that of the U.S. adult population of 2000), "direct estimates are strongly weighted toward the relative mortality risk of groups least well represented in the reference population." See: Morral AR, Schell TL, Smart R. Comparison of Suicide Rates Among U.S. Veterans and Nonveteran Populations. 2023. JAMA Network Open. 6(7): e2324191. Consequently, in this report, direct adjustment is limited to age-adjustment stratified by sex.

[19] Adjusted rates represent the level of suicide mortality that we would see in the population and time period if the population had the same demographic distribution of a standard population, at least in terms of the adjustment variable(s). Consistent with current practice, in this report, adjusted rates use the U.S. adult population in 2000 as the standard population. Unadjusted rates are presented when adjustment was not possible due to small numbers within strata. Use of the direct method and the standard U.S. population of 2000 for adjustment are consistent with CDC reporting (Garnet MF, Curtin SC. 2023. Suicide Mortality in the United States, 2001-2021. CDC NCHS, Data Brief 464. Klein RJ, Schoenborn CA. Age Adjustment Using the 2000 Projected U.S. Population. Healthy People 2000 Statistical Notes, no. 20. Hyattsville, Maryland: National Center for Health Statistics. January 2001).

Table 2, below, presents suicide rates among Veterans and non-Veteran U.S. adults, overall and by sex, from 2001 through 2023.[20]

- The suicide rate for Veterans in 2023 was 35.2 per 100,000. In 2001, it was 23.2 per 100,000.
- The suicide rate for non-Veteran U.S. adults in 2023 was 16.9 per 100,000. In 2001, it was 12.6 per 100,000.

Table 2: Suicide Rate, Veteran and Non-Veteran U.S. Adults, by Year and Sex, 2001-2023

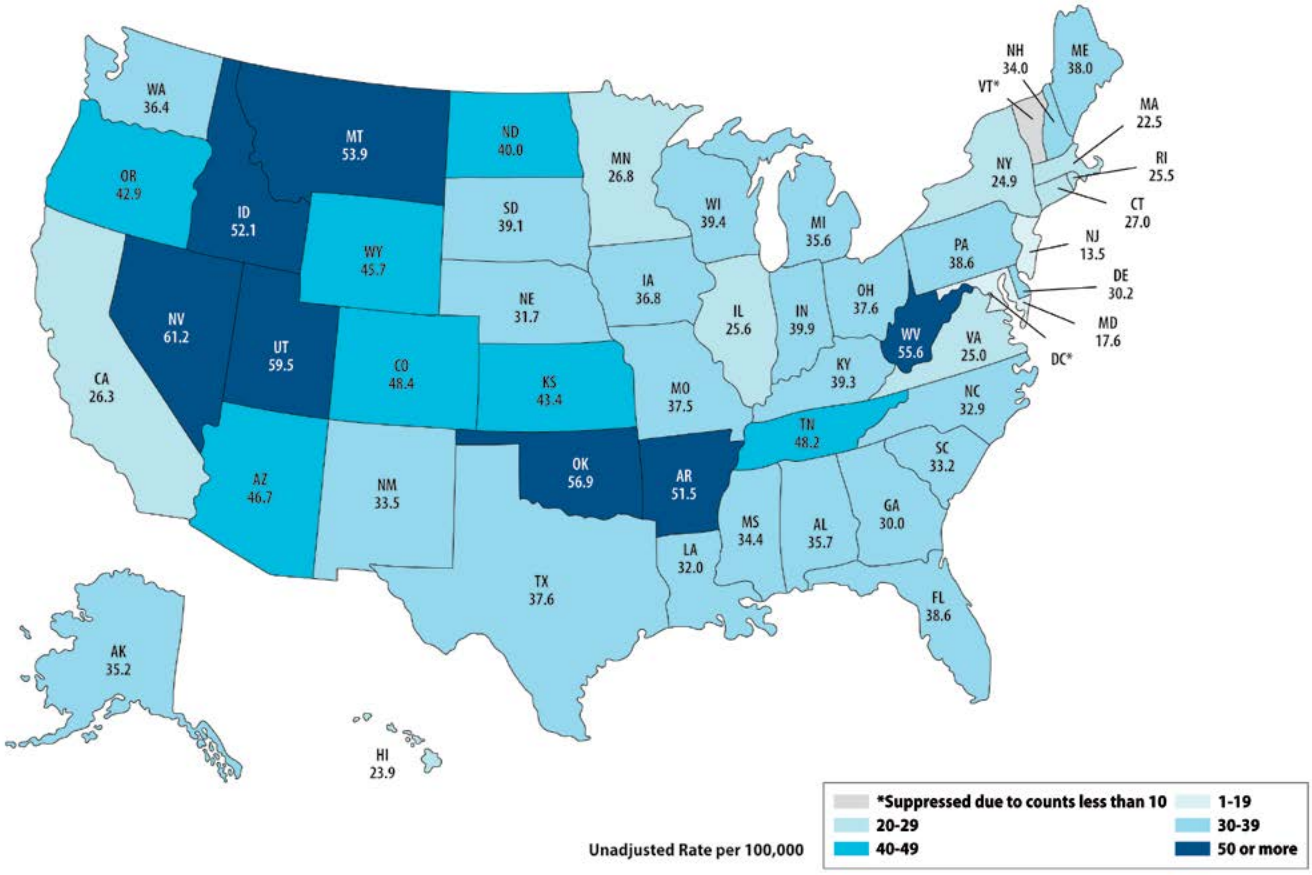
	Suicide Rate per 100,000					
	Veterans			Non-Veteran U.S. Adults		
Year	All	Female	Male	All	Female	Male
2001	23.2	9.4	24.2	12.6	5.2	22.9
2002	24.2	7.9	25.3	13.0	5.4	23.2
2003	23.9	8.9	25.0	12.8	5.4	22.8
2004	24.2	9.5	25.3	13.0	5.8	22.8
2005	24.9	10.3	26.1	12.9	5.6	22.6
2006	24.9	9.5	26.2	13.1	5.8	22.8
2007	26.3	10.2	27.6	13.5	6.0	23.3
2008	28.0	11.7	29.3	13.8	6.1	23.8
2009	28.3	12.6	29.6	14.0	6.2	24.0
2010	28.6	13.0	30.0	14.5	6.4	24.9
2011	28.6	14.2	29.9	14.8	6.6	25.3
2012	28.9	13.0	30.3	15.1	6.8	25.7
2013	29.4	13.4	30.9	15.1	6.9	25.5
2014	30.5	15.4	31.9	15.6	7.2	26.1
2015	30.9	15.9	32.4	16.0	7.6	26.5
2016	30.8	14.4	32.5	16.2	7.5	26.9
2017	32.5	15.6	34.2	16.8	7.5	28.0
2018	33.0	14.7	35.0	17.1	7.6	28.6
2019	32.5	14.7	34.5	16.7	7.3	28.1
2020	32.5	14.1	34.6	16.0	6.7	27.0
2021	33.8	17.5	35.7	16.7	6.9	28.3
2022	34.7	13.7	37.3	17.2	7.2	28.8
2023	35.2	13.9	37.8	16.9	7.2	28.4

[20] These document the number of suicide deaths per year for every 100,000 individuals in the population of interest, based on the estimated mid-year population.

Suicide Rates, by State

Rates of Veteran suicide mortality vary across the United States. Figure 4, below, shows the Veteran suicide rates for U.S. states in 2023.[21]

Figure 4: Suicide Rate per 100,000, Veterans, by State, 2023



[21] Rates for U.S. territories in 2023 are not presented due to counts of fewer than 10 suicide deaths. For more information, please see the "State Data Sheets" and the "State Data Appendix" that accompany this report.

Below, Table 3 presents suicide rates by state, from highest to lowest.

Table 3: Suicide Rate per 100,000, Veterans, by State, From Highest to Lowest Rate, 2023[22]

	State	Veteran Suicide Rate per 100,000	Veteran Suicide Deaths
1	Nevada	61.2	128
2	Utah	59.5	78
3	Oklahoma	56.9	161
4	West Virginia	55.6	69
5	Montana	53.9	48
6	Idaho	52.1	63
7	Arkansas	51.5	105
8	Colorado	48.4	178
9	Tennessee	48.2	210
10	Arizona	46.7	223
11	Wyoming	45.7	21
12	Kansas	43.4	79
13	Oregon	42.9	114
14	North Dakota	40.0	20
15	Indiana	39.9	149
16	Wisconsin	39.4	130
17	Kentucky	39.3	103
18	South Dakota	39.1	25
19	Florida	38.6	550
20	Pennsylvania	38.6	268
21	Maine	38.0	41
22	Ohio	37.6	254
23	Texas	37.6	581
24	Missouri	37.5	147
25	Iowa	36.8	67
26	Washington	36.4	186
27	Alabama	35.7	122
28	Michigan	35.6	180
29	Alaska	35.2	25
30	Mississippi	34.4	63
31	New Hampshire	34.0	32
32	New Mexico	33.5	52
33	South Carolina	33.2	131
34	North Carolina	32.9	228
35	Louisiana	32.0	83
36	Nebraska	31.7	38
37	Delaware	30.2*	19
38	Georgia	30.0	200
39	Connecticut	27.0	41
40	Minnesota	26.8	80
41	California	26.3	389
42	Illinois	25.6	160
43	Rhode Island	25.5*	13
44	Virginia	25.0	172
45	New York	24.9	167
46	Hawaii	23.9	26
47	Massachusetts	22.5	62
48	Maryland	17.6	64
49	New Jersey	13.5	42

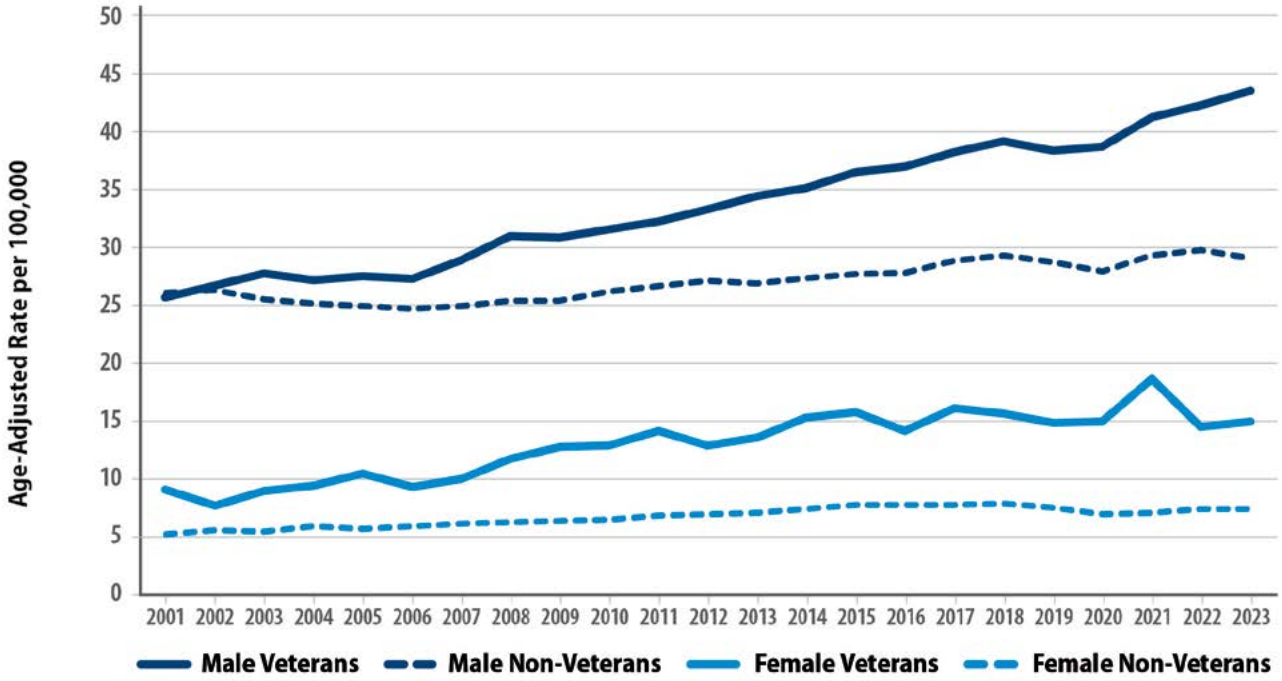
[22] Rates are not presented for Vermont, the District of Columbia, and U.S. territories, as each had fewer than 10 Veteran suicide deaths in 2023.

Age-Adjusted Rates, by Sex and Veteran Status

Below, Figure 5 presents age-adjusted suicide rates among Veteran and non-Veteran U.S. adults, by sex, 2001-23. For female Veterans, rates were highest in 2021, and for female non-Veterans, rates were highest in 2018. For male Veterans rates were highest in 2023, and for male non-Veterans, rates were highest in 2022.

- Adjusting for age differences, the suicide rate in 2023 among female Veterans was 103.1% higher than for female non-Veteran U.S. adults, and the age-adjusted rate for male Veterans was 49.7% higher than for male non-Veteran U.S. adults.[23]
- From 2022-23, the age-adjusted suicide rate increased 2.8% among female Veterans and 3.1% among male Veterans. By comparison, from 2022-23, the age-adjusted suicide rate decreased 0.8% among female non-Veterans and 2.3% among male non-Veterans.
- From 2001-23, the age-adjusted suicide rate increased 64.1% for female Veterans, 41.0% for female non-Veterans, 69.3% for male Veterans, and 11.7% for male non-Veteran U.S. adults.

Figure 5: Age-Adjusted Suicide Rate, Veteran and Non-Veteran U.S. Adults, by Sex, 2001-23



Indirect Adjustment, Suicide Mortality, by Veteran Status

In this report, we present age-adjusted suicide rates, by sex, calculated using direct adjustment.[24] A second approach for comparisons uses indirect adjustment, which calculates the ratio of the number of actual Veteran suicides to the number that would occur if the Veteran population had the same age- and sex-specific suicide rates as the non-Veteran population. For 2023, this standardized mortality ratio (SMR) was 1.177.

This means that the number of Veteran suicides was 17.7% higher (about 962 more[25]) than what would be estimated if the Veteran population experienced the same suicide rates as non-Veteran adults. Applying this for each year, 2001-23,

[23] For female U.S. adults, differentials in adjusted rates by Veteran status were highest in 2021, and for male U.S. adults, differentials were highest in 2023.

[24] That is, age-specific suicide rates of the compared populations are applied to the age distribution of the overall U.S. population in 2000. See: Klein RJ, Schoenborn CA. 2001. Age Adjustment Using the 2000 Projected U.S. Population. Healthy People 2000 Statistical Notes, no. 20. Hyattsville, Maryland: National Center for Health Statistics. January 2001.

[25] There were 962.4 "excess" Veteran suicide deaths in 2023 relative to what would be expected if the Veteran population had the same age- and sex-stratified suicide rates as the non-Veteran U.S. adult population.

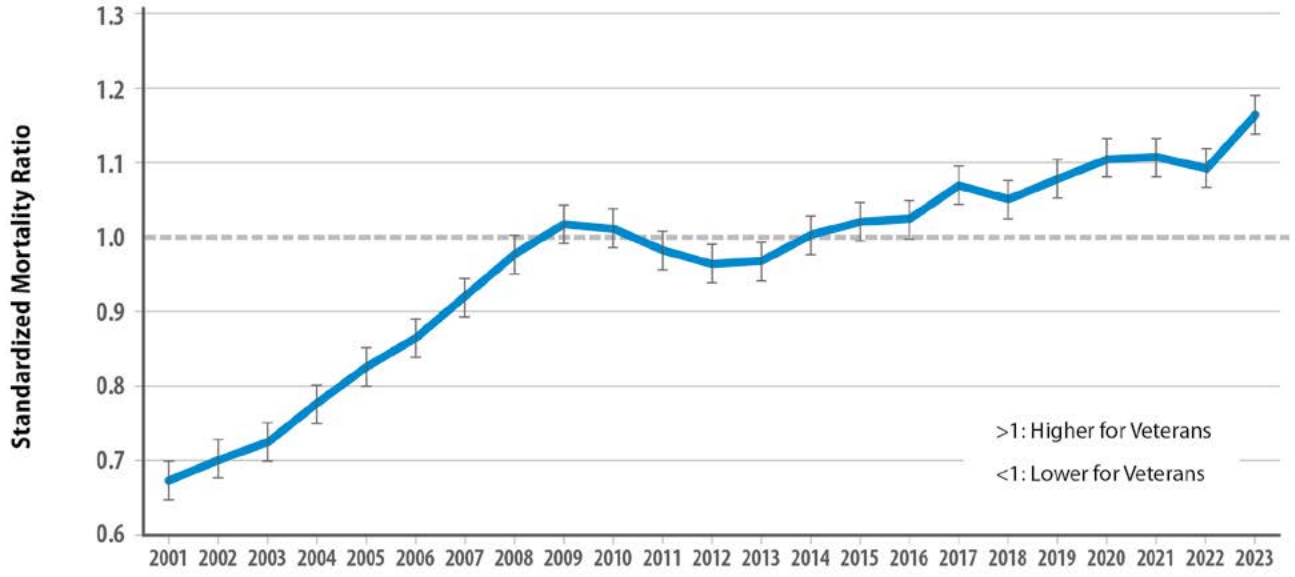
the SMRs indicate that Veterans had decreased suicide mortality (relative to non-Veterans) from 2001-07, and Veterans had relatively greater (or "excess") suicide mortality from 2009-10 and 2014-23. From 2001-23, SMRs ranged from 0.777 in 2001 to 1.177 in 2023.

For the years 2001-23, there were 1,041 fewer Veteran suicides than if the Veteran population had the suicide rates of non-Veterans.[26] This reflects lower suicide mortality among male Veterans from 2001-07, despite greater suicide mortality from 2016-23 and greater suicide mortality among female Veterans in all years.

Increases in Veteran suicide rates relative to those of non-Veteran adults are reflected in the increased excess Veteran suicide mortality over the years of this report.

To consider variation in SMRs over time,[27] Figure 6, below, presents standardized mortality ratios standardized for each year to the demographic distribution of the 2023 Veteran population.[28]

Figure 6: Suicide Age- and Sex- Standardized Mortality Ratio, for Veterans Relative to Non-Veteran U.S. Adults, 2001-23



[26] "Excess suicide deaths" refers to the difference between the observed number of Veteran suicides and the number that would be observed ("expected") if the age- and sex-specific suicide rates in the non-Veteran U.S. adult population were applied to the Veteran population. Negative values indicate there were fewer Veteran suicides than would be observed if Veterans had the rates of non-Veterans. Cumulative difference between observed and "expected" suicide deaths ("excess suicide deaths"), by sex:

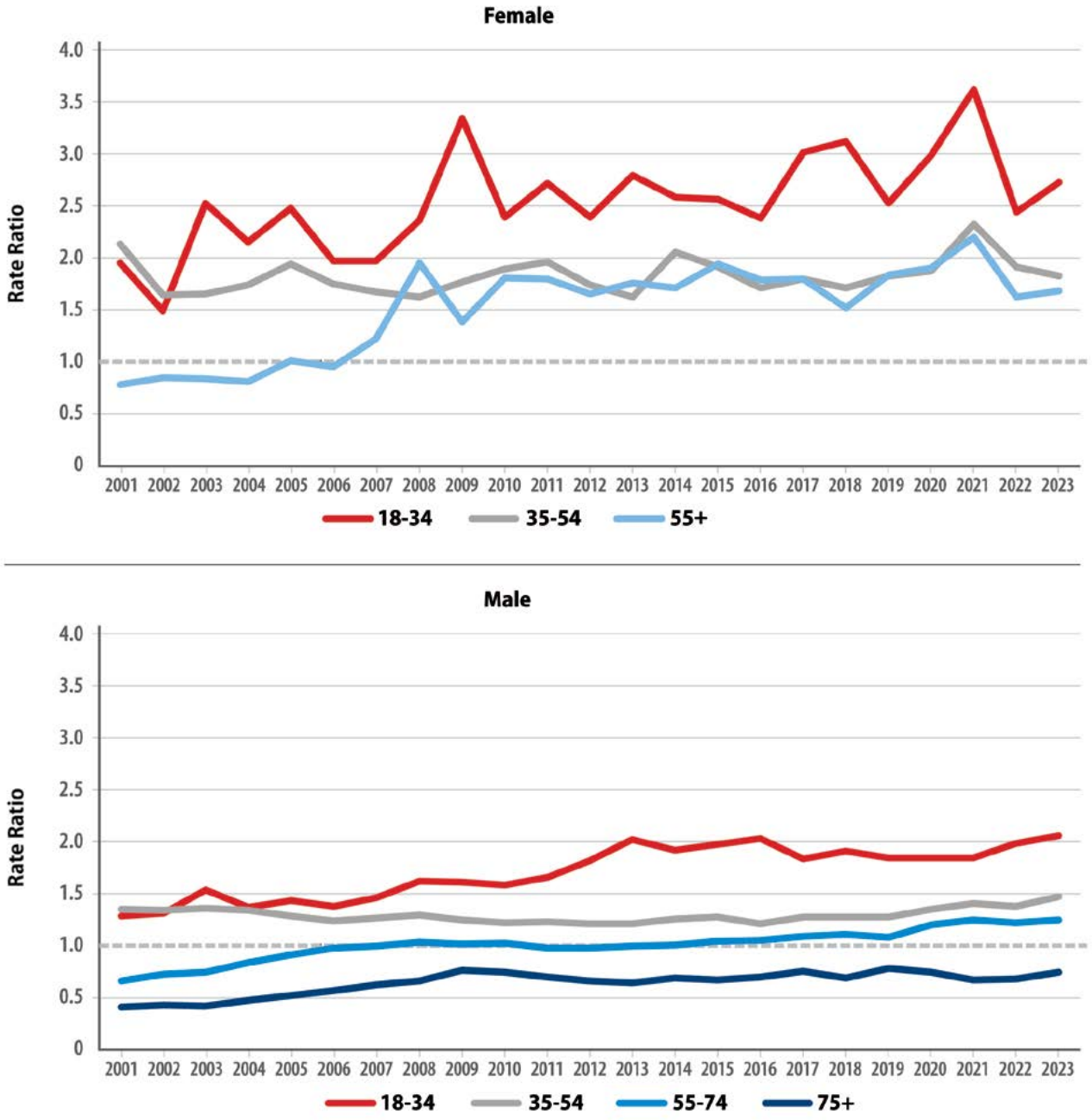
	Female Veterans	Male Veterans	All Veterans
2001-11	+890.7	(-7,548.0)	(-6,631.4)
2012-23	+1,690.7	+3,863.7	+5,590.4
2001-23	+2,581.4	(-3,684.4)	(-1,041.0)

[27] As SMRs are not comparable if the index population changes over time, the 2023 Veteran population is the index for each year.

[28] This was calculated as: (Suicides that would have occurred if Veteran age- and sex-strata-specific rates in the year occurred in a population with the distribution of the Veteran population in 2023) / (Suicides that would have occurred if non-Veteran U.S. adult population's age- and sex-strata-specific rates occurred in a population with the distribution of the Veteran population in 2023).

The most informative approach for comparisons is to compare unadjusted suicide rates for subgroups[29], presented here as the ratios of rates for Veterans relative to non-Veteran U.S. adults.[30] These show differentials in suicide risks by Veteran status, and how these vary by sex and age, as seen below in Figure 7.[31]

Figure 7: Ratios of Age-Group-Specific Suicide Rates, Veterans: Non-Veteran U.S. Adults, by Sex, 2001-23[32]



[29] These are available in the "National Data Appendix" that accompanies this report.

[30] Findings using direct and indirect adjustment may be variable due to heterogeneity in the populations and strata-specific suicide risks. It is important, therefore, to examine the ratios of strata-specific unadjusted suicide rates for Veterans relative to non-Veteran U.S. adults. See: Anderson RN, Rosenberg HM. 1998. Age Standardization of Death Rates: Implementation of the Year 2000 Standard. CDC National Vital Statistics Reports. 47(3):1-17.

[31] These present the ratio of the unadjusted suicide rate of Veterans to that of non-Veterans, for each year. Values greater than 1.0 indicate increased risk among Veterans in the age and sex group, and values less than 1.0 indicate decreased suicide risk among Veterans in the age and sex group, relative to non-Veteran adults in that particular age and sex group.

[32] Due to the small number of deaths among older age groups of female Veterans, the 55-74 and 75-and-older age groups are combined, for reporting purposes.

In all years from 2001-23, Veterans had greater suicide rates than non-Veterans among female and male individuals under age 55 (rate ratio greater than 1.0). In all years, male Veterans aged 75 and older had lower suicide rates than male non-Veterans in the same age group (rate ratio less than 1.0). For female and male individuals, from 2003-23, the highest rate ratios were among those aged 18-34, indicating that for those aged 18-34, increased rates for Veterans were most pronounced relative to those of non-Veterans.

In summary, patterns of suicide among Veteran and non-Veteran U.S. adults differ across demographic subgroups and over time.

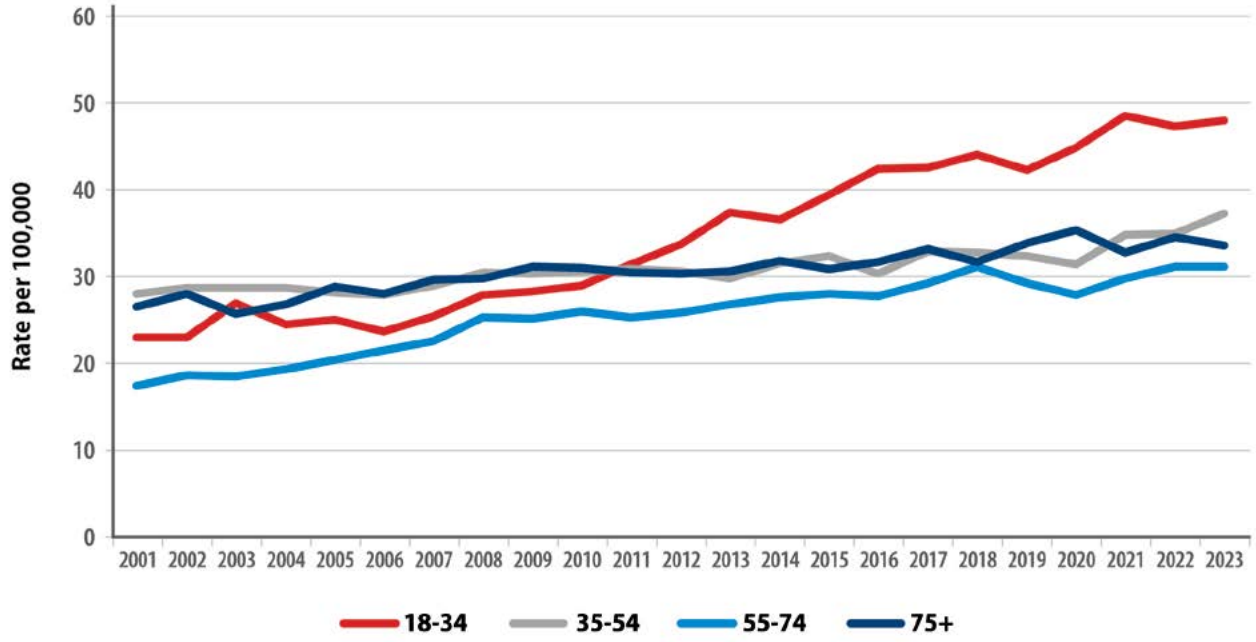
Suicide in Veteran Subpopulations

Age

Figure 8, below, presents suicide rates for Veterans, by age categories and year, 2001-2023.

- From 2022-23, the suicide rate among Veterans aged 18-34 increased by 1.5%; the rate for Veterans aged 35-54 increased by 6.6%; the rate for Veterans aged 55-74 increased by 0.3%; and for Veterans aged 75 and older, the suicide rate decreased by 2.8%.

Figure 8: Suicide Rate, Veterans, by Age Group, 2001-23



Sex and Age

Figures 9 and 10 present suicide rates[33] for female and male Veterans, by age categories and year, 2001-23.

- In 2023, suicide rates were highest among Veterans between ages 18-34 (18.1 per 100,000 among female Veterans aged 18-34 and 54.8 per 100,000 among male Veterans aged 18-34).
- Suicide rates among all female Veterans 35-54 and male Veterans aged 75 and older decreased from 2022-23, while rates for all other female and male Veterans increased.

Figure 9: Suicide Rate, Female Veterans, by Age Group,[34] 2001-23

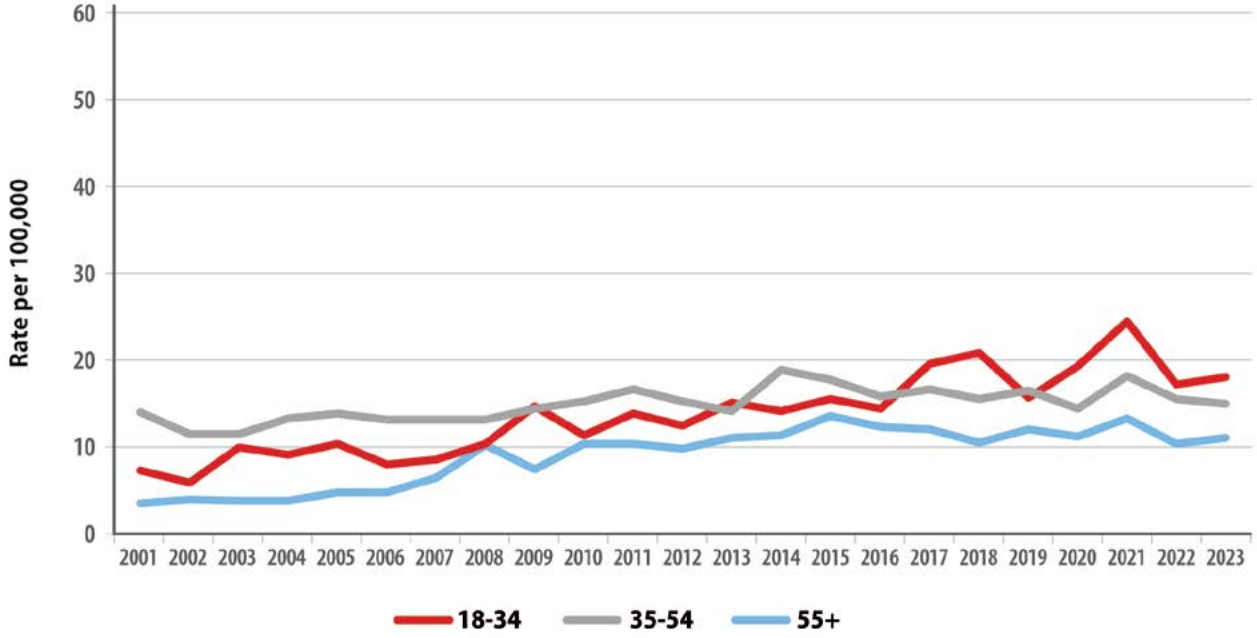
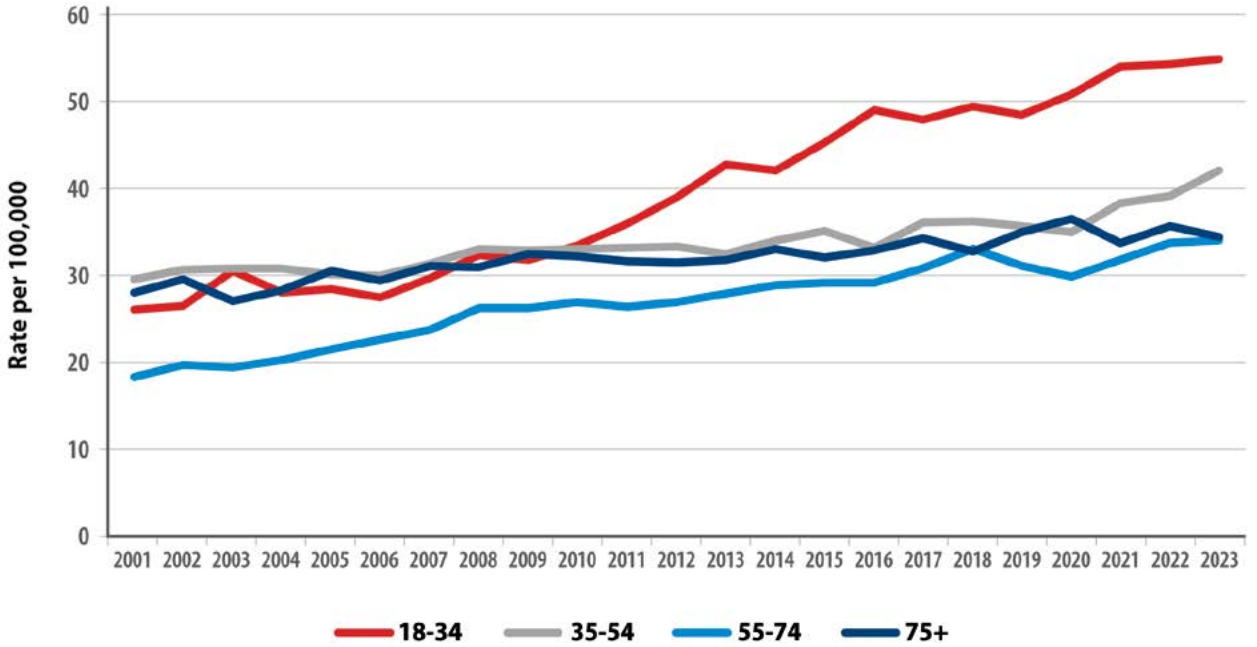


Figure 10: Suicide Rate, Male Veterans, by Age Group, 2001-23



[33] As rates are specific to age and sex subgroups, adjustment was not applicable.

[34] Due to the small number of deaths among older age groups of female Veterans, the 55-74 and 75-and-older age groups are combined, for reporting purposes.

In Year Following Military Separation

Figure 11, below, presents the suicide rate per 100,000 over 12 months following Veterans' separation from active military service, by year of separation, 2010-22[35,36]

- Veterans who separated from active military service in 2022 had the lowest 12-month suicide rate (41.2 per 100,000) observed since 2016. The rate was 19.6% lower than for those who separated in 2019 (51.2 per 100,000).

Figure 11: Suicide Rate, 12 Months Following Separation from Active Military Service, by Year of Separation, 2010-22[37]

- For Veterans who separated from active military service in 2022,[38] suicide rates over the following 12 months were highest among those who separated from the Marine Corps (50.9 per 100,000), followed by the Army (43.0 per 100,000), Navy (38.0 per 100,000), and Air Force (29.5 per 100,000).

[35] Twelve-month suicide mortality rates are reported for cohorts of Veterans who separated from military service in the years 2010 through 2022. Separations were identified using VA/Department of Defense Identity Repository (VADIR) data. Reporting is not included for years prior to 2010 due to data constraints. Given small cell sizes, it was not possible to calculate adjusted rates. The 12-month observation period for the most recent cohort presented (separations in 2022) extended into 2023, using the most current available mortality data. Ninety-five percent confidence intervals (not shown) were overlapping for each year, indicating no statistical differences in rates.

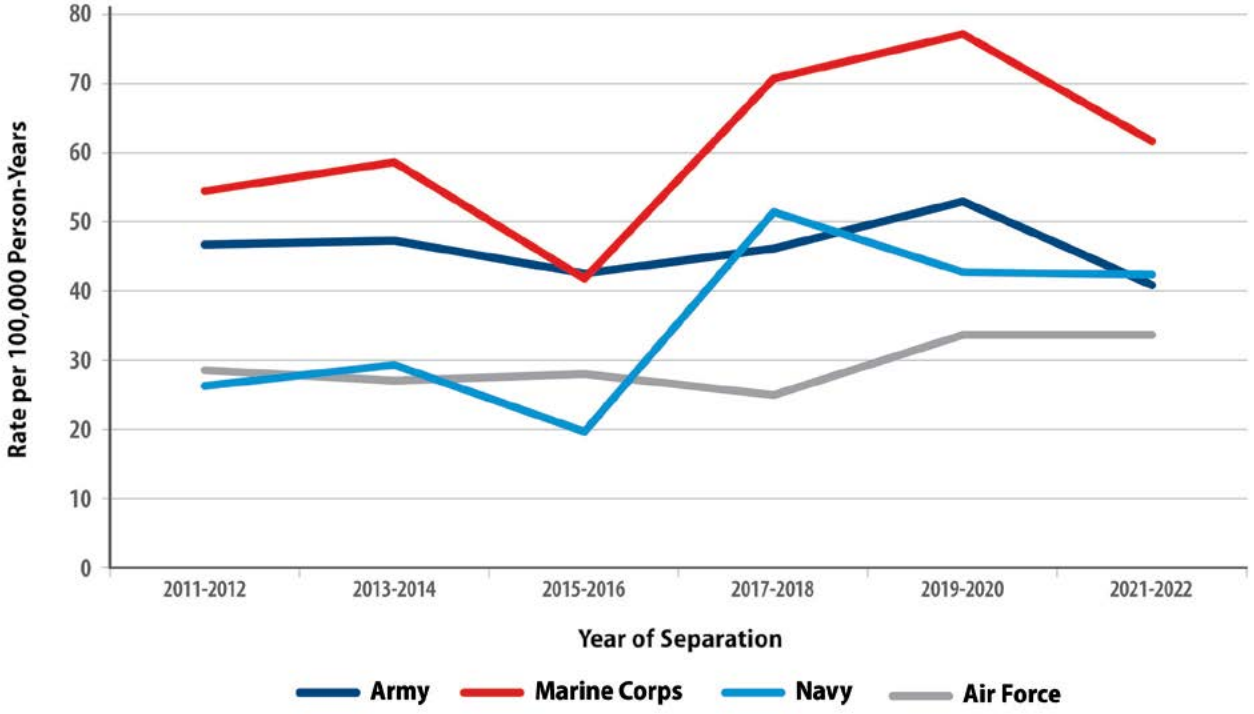
[36] In 2010, there were 227,008 Veterans with most recent separations; there were 238,058 in 2022. For Veterans who separated in 2010, 16.8% were female and median age was 26. For those who separated in 2022, 18.0% were female and median age was 27. There were 79 and 98 Veteran suicides within 12 months of separations in 2010 and 2022, respectively.

[37] Data is reported for the final separation in the period 2010 to 2022. Suicide was assessed in the 12 months following separation.

[38] This information is specific to Veterans who separated in 2022. See the figure below for information on rates that combine information for two-year period (for example, for those separated in 2021-22).

Figure 12, below, presents this information in two-year groups to enable reporting for branch/single-year periods with fewer than 10 suicide deaths.

Figure 12: Suicide Rate, 12 Months Following Separation from Active Military Service, by Branch of Service and Year of Separation, 2011-22[39]

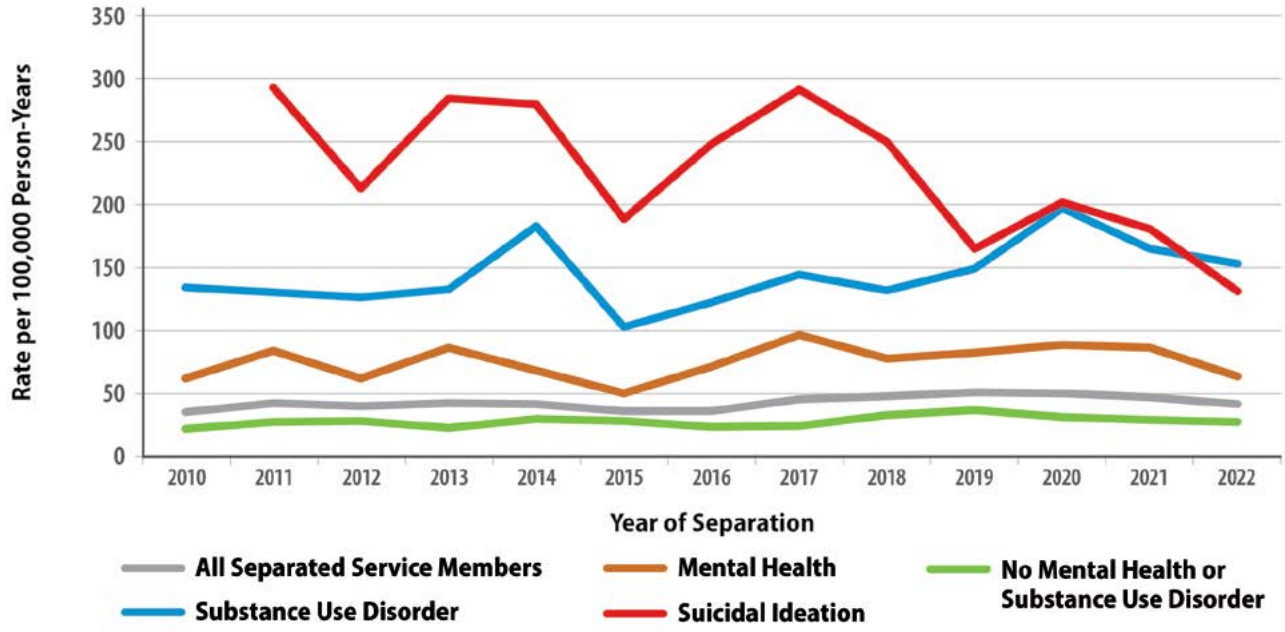


[39] Data is reported for the final separation from active military service in the period 2010 to 2022. Suicide mortality is assessed in the 12 months following separation. Combines information for pairs of separation cohorts to prevent suppression due to small counts.

Below, Figure 13 presents suicide rates in the 12 months following separation, by year of separation, overall and for those with Defense Health Agency diagnoses of suicidal ideation, substance abuse disorders (SUDs), and mental health conditions.

- For Veterans who separated from active military service in 2022, suicide rates over the following 12 months were higher among those with Defense Health Agency diagnoses of SUDs (152.6 per 100,000) and suicidal ideation (130.7 per 100,000) and those with mental health diagnoses (63.2 per 100,000).

Figure 13: Suicide Rate, 12 Months Following Separation from Active Military Service, Overall and By Defense Health Agency Diagnoses in 12 Months Prior to Separation, Separation Cohorts, 2010-22[40]



[40] Data is reported for the final separation from active military service in the period 2010 to 2022. Suicide mortality is assessed in the 12 months following separation. There were fewer than 10 suicide deaths for the 2010 cohort members with suicidal ideation; rate not presented.

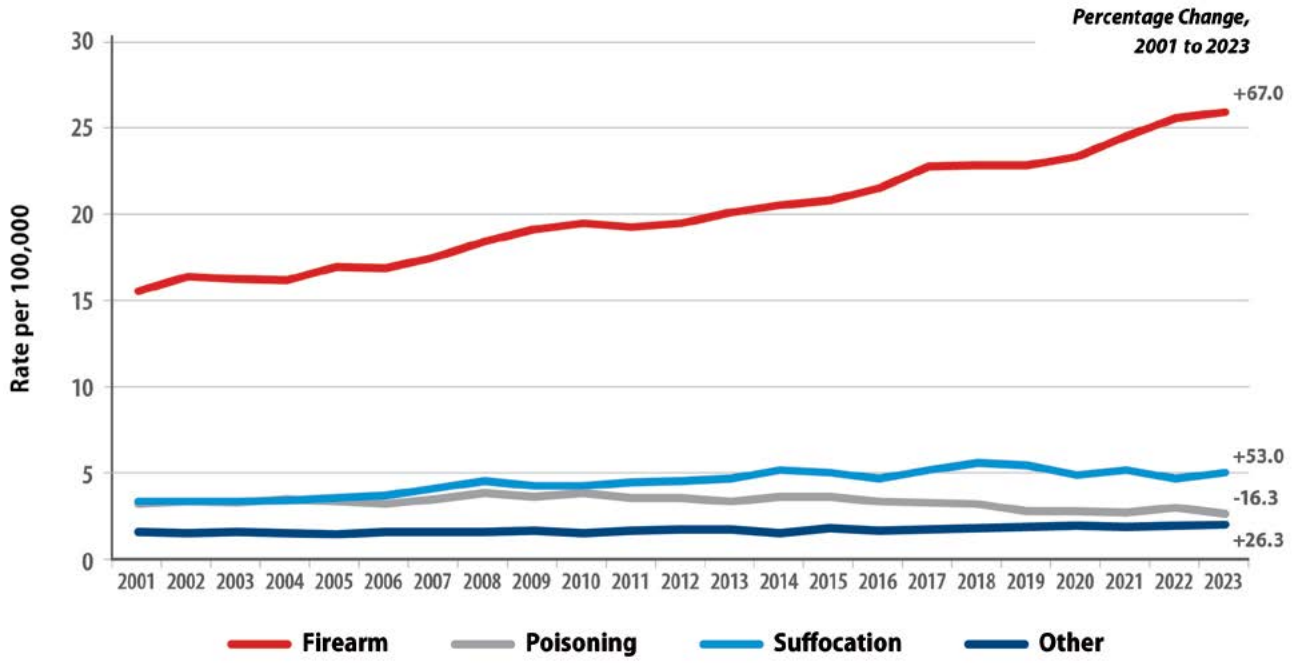
Method-Specific Suicide Rates

Figure 14 presents method-specific[41] suicide rates among Veterans, by year, 2001-23, and the percentage change in rates from 2001-23.

- In each year, Veteran firearm suicide rates exceeded those of all other categories.
- Changes in Veteran method-specific suicide rates are listed below:

	2001-23	2022-23
Firearm Suicide Rate:	+67.0%	+1.3%
Poisoning Suicide Rate:	(-16.3%)	(-10.3%)
Suffocation Suicide Rate:	+53.0%	+9.0%
Other Methods Suicide Rate:	+26.3%	+4.0%

Figure 14: Method-Specific Suicide Rate, Veterans, 2001-23, and Change from 2001-23



Similar to patterns for Veterans, among non-Veteran U.S. adults, firearm suicide mortality rates exceeded all other method-specific suicide rates in each year.[42] For non-Veteran U.S. adults, there was also a decrease from 2001 to 2023 in poisoning suicide mortality rates (-5.9%) and increases in rates of firearm suicide mortality (+34.6%), suffocation suicide mortality (+63.9%), and suicide involving other methods (+43.8%).[43]

[41] Methods were assessed from death certificate data per International Classification of Diseases, Tenth Revision (ICD-10) codes X72-X74 for firearm, X60-X69 for poisoning (including intentional drug overdose) and X70 for suffocation (including strangulation). "Other Means" (U03, X71, X75-X84, Y87.0) included cutting/piercing, drowning, falls, fire/flame, other land transport, being struck by/against, and other specified or unspecified injury.

[42] Results not shown.

[43] Firearms accounted for a larger portion of the overall Veteran suicide rate in 2001 and 2023 (66.5% and 73.3%, respectively) than for non-Veterans (52.7% and 52.9%, respectively).

Figures 15 and 16 show method-specific suicide rates for female and male Veterans.

Figure 15: Method-Specific Suicide Rate, Female Veterans, 2001-23, and Change from 2001 to 2023[44]

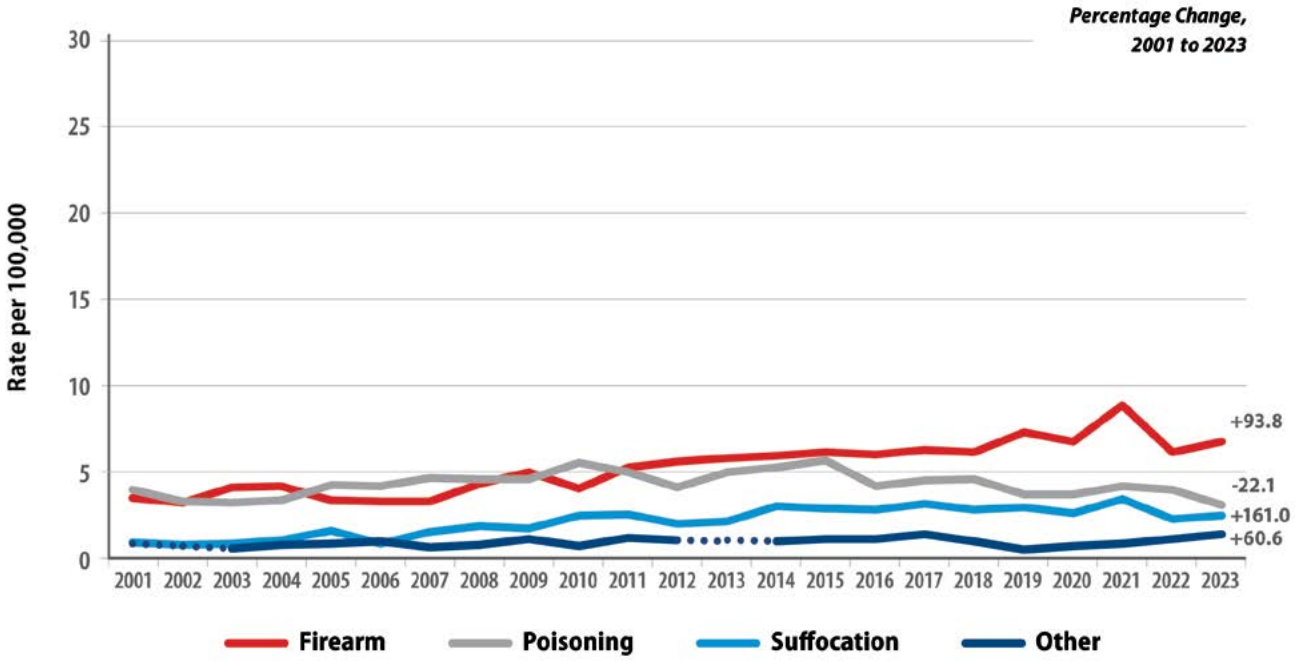
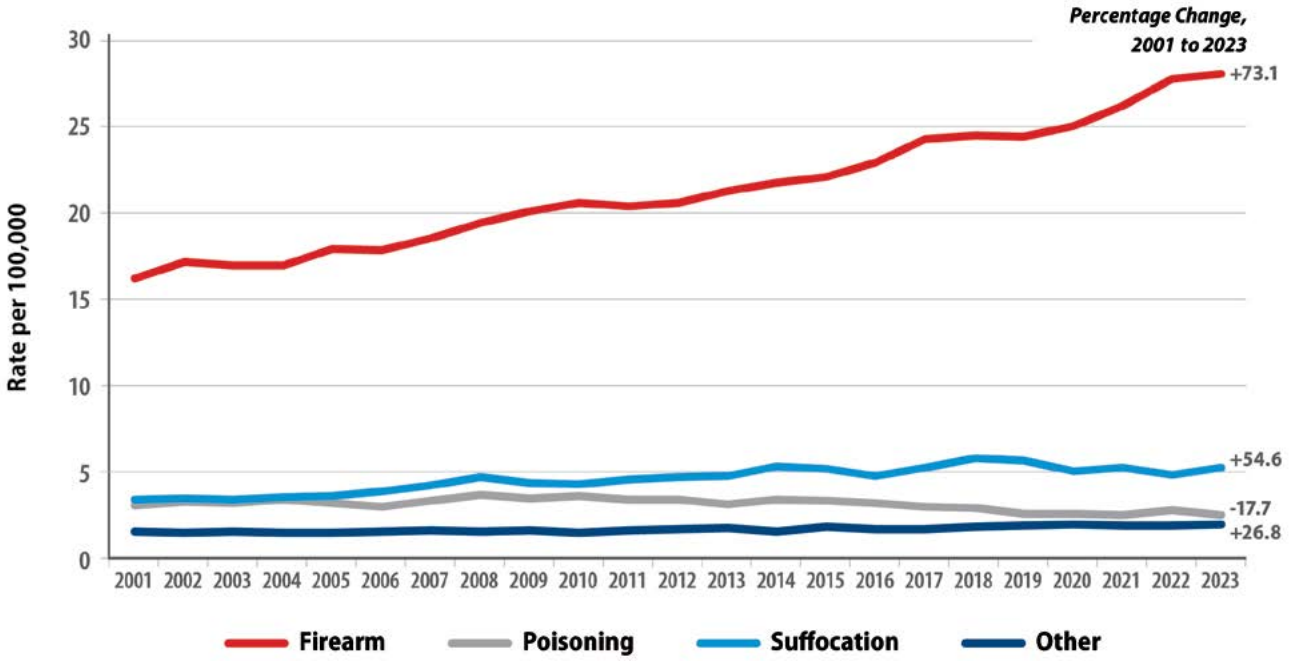


Figure 16: Method-Specific Suicide Rate, Male Veterans, 2001-23, and Change from 2001 to 2023



[44] Rates are suppressed for female Veterans, Other, for 2001, 2002, and 2013. Dotted lines are for presentation purposes and do not represent estimated rates.

Method-Specific Suicide Rates, by Veteran Status and Sex

Here we compare method-specific rates of female Veterans and male Veterans, and we compare rates of female non-Veterans and male non-Veterans. As indicated below, method-specific suicide rates varied by sex for Veterans and non-Veterans. The magnitude of this variation differed by Veteran status.

- In each year, firearm suicide and suffocation suicide mortality rates were lower for female Veterans than for male Veterans, while poisoning suicide mortality rates were higher for female Veterans than for male Veterans.
- In 2023:
    - Firearm suicide rate: 312.0% higher for male Veterans than for female Veterans.
    - Suffocation suicide rate: 106.7% higher for male Veterans than for female Veterans.
    - Poisoning suicide rate: 20.7% lower for male Veterans than for female Veterans.
- From 2001-22, all method-specific suicide rates were greater for male non-Veteran adults than for female non-Veteran adults. This pattern was also observed in 2023, except for the poisoning suicide mortality rate: The rate for female non-Veteran adults (2.195 per 100,000) was higher than for male non-Veteran adults (2.190 per 100,000).
- In 2023:
    - Firearm suicide rate: 548.4% higher for male non-Veteran adults than for female non-Veteran adults.
    - Suffocation suicide rate: 313.5% higher for male non-Veteran adults than for female non-Veteran adults.
    - Poisoning suicide rate: 0.2% lower for male non-Veteran adults than for female non-Veteran adults.

Method-Specific Suicide Rates, by Sex and Veteran Status

Here we compare method-specific rates of female Veterans to those of female non-Veterans, and we compare method-specific rates of male Veterans to those of male non-Veterans.[45] As indicated below, method-specific suicide rates varied by Veteran status, for both female and male adults. The magnitude of this variation differed by sex.

- In each year, from 2001-23, firearm suicide mortality and poisoning suicide mortality rates were higher for female Veterans than for female non-Veterans.
- In 2023:
    - Firearm suicide rate: 168.3% higher for female Veterans than for female non-Veterans.
    - Suffocation suicide rate: 43.7% higher for female Veterans than for female non-Veteran adults.
    - Poisoning suicide rate: 42.2% higher for female Veterans than for female non-Veterans.
- In each year, from 2001-23, firearm suicide mortality and poisoning suicide mortality rates were higher for male Veterans than for male non-Veteran adults, and suffocation mortality rates were lower for male Veterans than for male non-Veteran adults.
- In 2023:
    - Firearm suicide rate: 70.5% higher for male Veterans than for male non-Veteran adults.
    - Suffocation suicide rate: 28.1% lower for male Veterans than for male non-Veteran adults.
    - Poisoning suicide rate: 13.0% higher for male Veterans than for male non-Veteran adults.

[45] Compared to non-Veteran adults, Veterans are more likely to own firearms. Estimates derived from 2015 National Firearm Survey reports and VetPop data suggest that in 2015 firearm ownership was approximately 107% higher for female Veterans than for female non-Veteran adults, and it was approximately 62% higher for male Veterans than for male non-Veteran adults.

Lethal Means Involved in Suicide Deaths

Table 4, below, provides information on Lethal Means, or methods, involved in suicide deaths of Veterans and non-Veteran U.S. adults in 2023 and a measure of change compared to suicides in 2001.

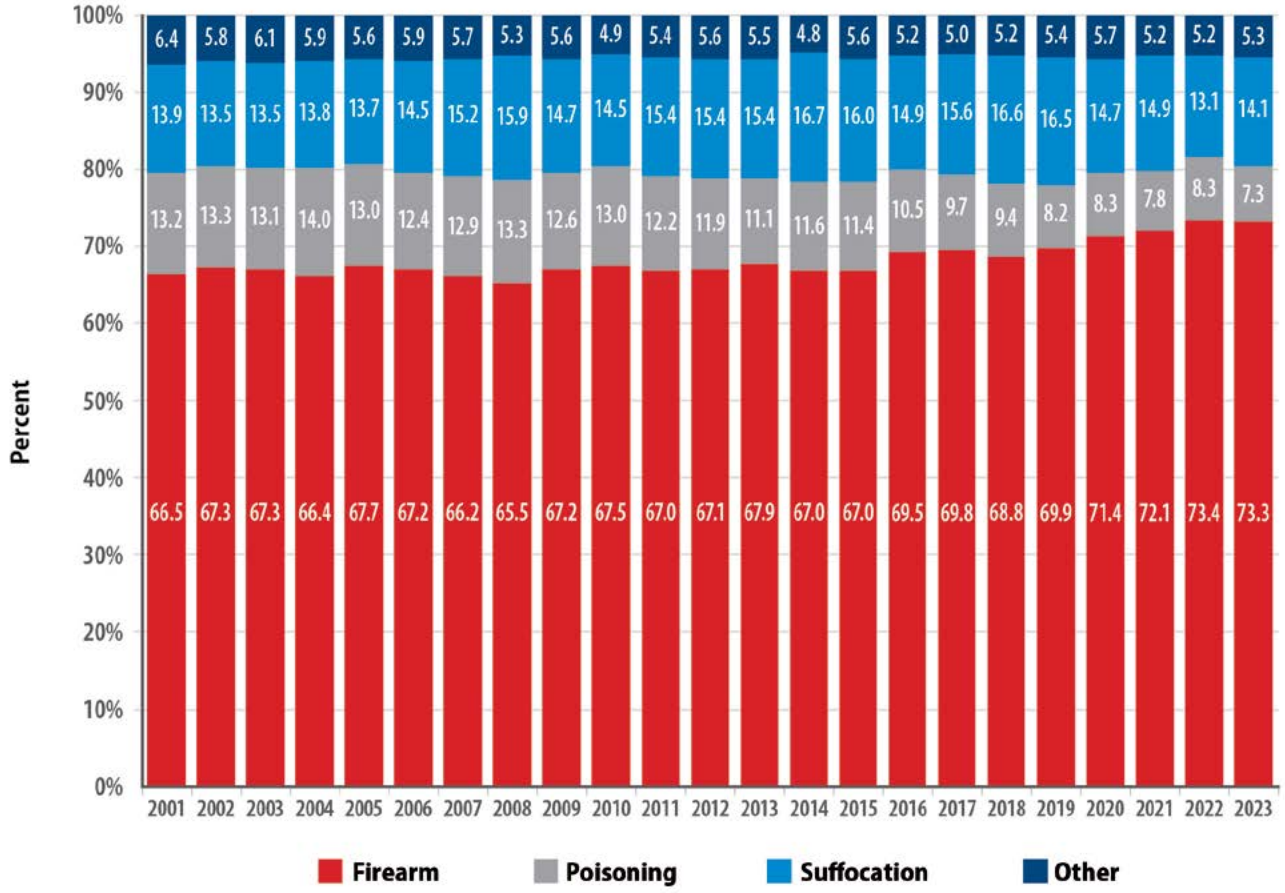
Table 4: Suicide Deaths, Methods Involved, 2023 and Difference From 2001, U.S. Adults, by Veteran Status, Sex, and Age Groups[46]

	Veterans		Non-Veteran Adults		Female Veterans		Female Non-Veterans		Male Veterans		Male Non-Veterans	
	2023	Change	2023	Change	2023	Change	2023	Change	2023	Change	2023	Change
All Ages												
Firearms	73.3%	+6.8%	52.9%	+0.2%	49.0%	+11.5%	35.3%	-0.1%	74.5%	+7.2%	58.2%	+0.1%
Poisoning	7.3%	-5.9%	12.9%	-5.5%	22.4%	-20.2%	30.5%	-7.6%	6.6%	-5.9%	7.7%	-4.6%
Suffocation	14.1%	+0.1%	25.4%	+4.6%	18.2%	+7.9%	24.5%	+8.8%	13.9%	-0.2%	25.7%	+3.3%
Other	5.3%	-1.1%	8.7%	+0.6%	10.5%	+0.8%	9.6%	-1.1%	5.1%	-1.2%	8.4%	+1.1%
Ages 18-34												
Firearms	68.5%	+7.8%	51.3%	-0.2%	50.0%	+13.3%	34.3%	-1.5%	70.1%	+8.2%	55.6%	+1.0%
Poisoning	4.8%	-6.5%	9.8	-2.9%	--	--	22.1%	-8.3%	4.4%	-5.6%	6.7%	-2.6%
Suffocation	19.9%	-2.4%	29.7%	+1.3%	28.3%	+15.0%	33.3%	+9.2%	19.0%	-3.7%	28.8%	-0.5%
Other	6.8%	+1.2%	9.2%	+1.9%	--	--	10.3%	+0.6%	6.5%	+1.2%	8.9%	+2.1%
Ages 35-54												
Firearms	63.2%	+8.7%	46.9%	+0.3%	46.3%	+6.5%	34.7%	+2.1%	64.4%	+9.3%	50.7%	-1.2%
Poisoning	8.9%	-10.2%	13.2%	-11.6%	25.2%	-20.2%	29.6%	-14.5%	7.5%	-10.3%	8.1%	-9.4%
Suffocation	22.5%	+3.1%	31.2%	+11.3%	20.3%	+12.0%	27.2%	+14.2%	22.7%	+2.9%	32.4%	+9.9%
Other	5.5%	-1.7%	8.8%	+0.0%	8.1%	+1.6%	8.5%	-1.7%	5.3%	-1.9%	8.8%	+0.7%
Ages 55-74												
Firearms	73.4%	-2.6%	57.1%	-5.9%	54.7%	+36.5%	36.7%	-5.2%	74.2%	-2.2%	64.1%	-7.1%
Poisoning	8.4%	-1.5%	15.9%	-0.9%	25.6%	-29.0%	36.7%	+1.3%	7.7%	-2.0%	8.8%	-0.7%
Suffocation	12.1%	+3.7%	18.1%	+6.0%	--	--	16.4%	+4.9%	12.2%	+3.9%	18.7%	+6.4
Other	6.1%	+0.4%	8.9%	+0.7%	11.6%	-6.6%	10.2%	-1.0%	5.9%	+0.3%	8.4%	+1.4%
Ages 75 and older												
Firearms	86.3%	+4.9%	71.5%	+2.8%	--	--	37.0%	+1.0%	86.9%	+5.3%	80.7%	+2.2%
Poisoning	5.5%	-1.0%	13.3%	+3.1%	--	--	39.5%	+12.2%	5.2%	-1.4%	6.4%	+1.2%
Suffocation	4.7%	-1.3%	9.3%	-3.8%	--	--	12.9%	-7.6%	4.6%	-1.3%	8.4%	-2.6%
Other	3.5%	-2.6%	5.9%	-2.0%	--	--	10.6%	-5.7%	3.4%	-2.6%	4.6%	-0.8%

[46] "Change" is the absolute difference comparing the percentage of suicide deaths in 2023 to the percentage of suicide deaths in 2001. Percentages and differences are not presented when based on fewer than 10 deaths, indicated by "--."

Below, Figure 17 presents the distribution of methods involved in Veteran suicide deaths, 2001-23.

Figure 17: Methods Involved, Percentage, Veteran Suicide Deaths, 2001-23



From 2022-23, among Veteran suicide deaths, the involvement of firearms and poisoning decreased from 73.4% to 73.3% and 8.3% to 7.3%, respectively, while the involvement of suffocation increased from 13.1% to 14.1%.

- In 2023, firearms were involved in 49.0% of suicides by female Veterans, up from 45.3% in 2022, and in 74.5% of suicides by male Veterans, down from 74.7% in 2022.
- Among suicide deaths by non-Veteran U.S. adults, from 2022-23, the involvement of poisoning decreased from 13.2% to 12.9%, and suffocation decreased from 25.9% to 25.4%.

The unadjusted rate of suicide by drug overdose fell from 2.8 per 100,000 in 2010 to 1.8 per 100,000 in 2023. The unadjusted rate of suicide by overdose involving opioids fell from 1.0 per 100,000 in 2010 to 0.6 per 100,000 in 2023. The unadjusted rate of suicide by overdose involving synthetic opioids[47] was 0.2 per 100,000 in both 2010 and 2023. Suicides by drug overdose accounted for 9.7% of all Veteran suicide deaths in 2010 and 5.0% in 2023.

[47] Synthetic opioids, excluding methadone. Synthetic opioids include fentanyl.

Section B: Veterans with VHA Contact

Findings include suicide rates for annual cohorts of Veterans who received VHA health care[48] in the year or prior year, who in this report are described as Recent Veteran VHA Users or as VHA Veterans, including by demographic and clinical subgroups, rurality, VHA enrollment, and VA eligibility priority groups.

VHA Health Care Engagement, 2001-23

From 2001-23, the Veteran population decreased by 29.8%. Over these years, VA continued to expand health care eligibility,[49] and there were substantial increases in Veteran receipt of VHA health care. Despite decreases in the overall Veteran population, the number of Veterans with VHA health care encounters in the year or prior year (Recent Veteran VHA Users) rose 59.4%, from 3.8 million in 2001 to 6.1 million in 2023. In 2023, Recent Veteran VHA Users accounted for 33.7% of all Veterans, up from 14.8% in 2001.

As noted previously, prior studies document population differences between Veterans with versus without VHA health care services utilization, consistent with a greater concentration of potential suicide risk factors among Veterans who are served by VHA health care providers. As a population, these Veterans have been found to be more likely to be unmarried and to use tobacco and to have received less formal education, lower incomes, poorer self-reported health status,[50] more chronic medical conditions[51] and self-reported disability due to physical or mental health factors,[52] greater depression and anxiety,[53] and greater reporting of trauma, lifetime psychopathology, and current suicidality.[54] To inform Veteran suicide prevention approaches—including clinical- and community-focused initiatives—we continue to work to understand trends in suicide mortality among Recent Veteran VHA Users and among Other Veterans.

[48] VHA health care receipt is here defined as having at least one VHA inpatient or outpatient utilization record, per VHA Corporate Data Warehouse records. VHA health care is regarded "as good as or better than non-VA care in terms of clinical quality and safety." See: Apaydin EA, Paige NM, Begashaw MM, Larkin J, Miake-Lye IM, Shekelle PG. 2023. Veterans Health Administration (VA) vs. non-VA Healthcare Quality: A Systematic Review. J Gen Intern Med. doi: 10.1007/s11606-023-08207-2. O'Hanlon C, Huang C, Sloss E, et al. 2016. Comparing VA and Non-VA Quality of Care: A Systematic Review. 32(1):105-121.

[49] For example, the National Defense Authorization Act of 2008 expanded the period within which certain combat Veterans could enroll in VHA health care following the date of their discharge or release.

[50] Agha Z, Lofgren RP, VanRuiswyk JV, Layde PM. 2000. Are Patients at Veterans Affairs Medical Centers Sicker? A Comparative Analysis of Health Status and Medical Resource Use. Arch Intern Med. 160:3252-3257.

[51] Dursa EK, Barth SK, Bossarte RM, Schneiderman AI. 2016. Demographic, Military, and Health Characteristics of VA Health Care Users and Nonusers Who Served in or During Operation Enduring Freedom or Operation Iraqi Freedom, 2009-2011. Public Health Reports. 131(6):839-843.

[52] Nelson KM, Starkebaum GA, Reiber GE. 2007. Veterans Using and Uninsured Veterans Not Using Veterans Affairs (VA) Health Care. Public Health Rep. 122:934-100.

[53] Fink DS, Stohl M, Mannes ZL, Shmulewitz D, Wall M, Gutkind S, Olfson M, Gradus J, Keyhani S, Maynard C, Keyes KM, Sherman S, Martins S, Saxon AJ, Hasin DS. 2022. Comparing Mental and Physical Health of U.S. Veterans by VA Healthcare Use: Implications for Generalizability of Research in the VA Electronic Health Records. BMC Health Services Research. 22:1500 https://doi.org/10.1186/s12913-022-08899-y. (Accessed 1/15/2026).

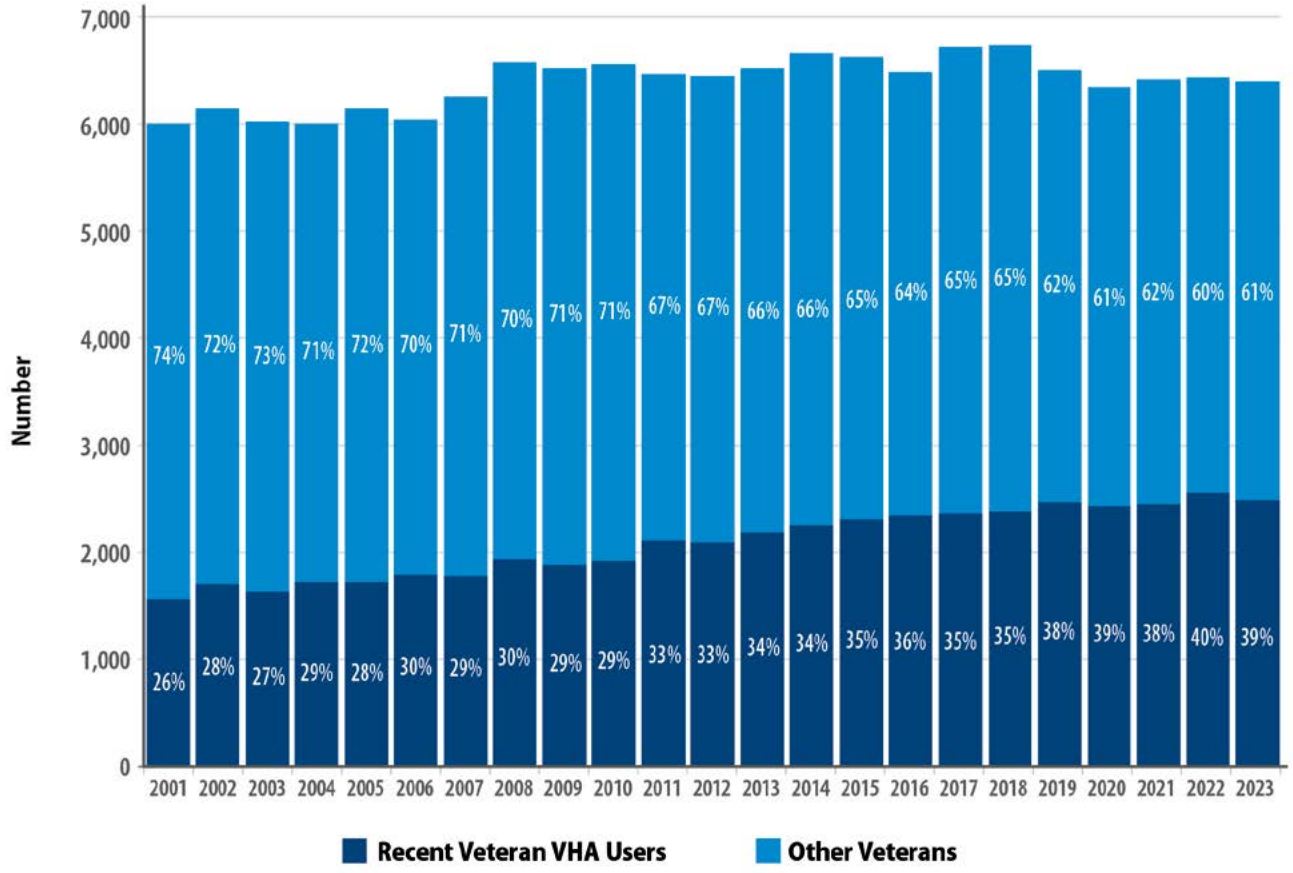
[54] Meffert BN, Morabito DM, Sawicki DA, Hausman C, Southwick SM, Pietrzak RH, Heinz AJ. 2019. U.S. Veterans Who Do and Do Not Utilize VA Health Care Services: Demographic, Military, Medical, and Psychosocial Characteristics. Primary Care Companion CNS Disorders. 21(1):doi:10.4088/PCC.18m02350.

Suicide Deaths

Figure 18, below, presents the annual number of Veteran suicide deaths, 2001-23, and the percentage among Recent Veteran VHA Users ("VHA Veterans") and Other Veterans.

- Among Veteran suicide decedents, the percentage with recent VHA encounters increased from 26.2% in 2001 to 39.0% in 2023.

Figure 18: Veteran Suicide Decedents, Number and Percentage With and Without Recent VHA Health Care Encounters,[55] 2001-23



[55] With a VHA inpatient or outpatient health care encounter in the year of interest or the prior year.

Suicide Rates Among Veterans in VHA Care[56]

Age and Sex

Table 5, below, presents changes in suicide rates from 2001-23 and from 2022-23 for age- and sex-subgroups of Recent Veteran VHA Users and Other Veterans.

Table 5: Suicide Rate per 100,000, Change from 2001 to 2023 and from 2022 to 2023, Veteran VHA Users and Other Veterans, by Sex and Age[57]

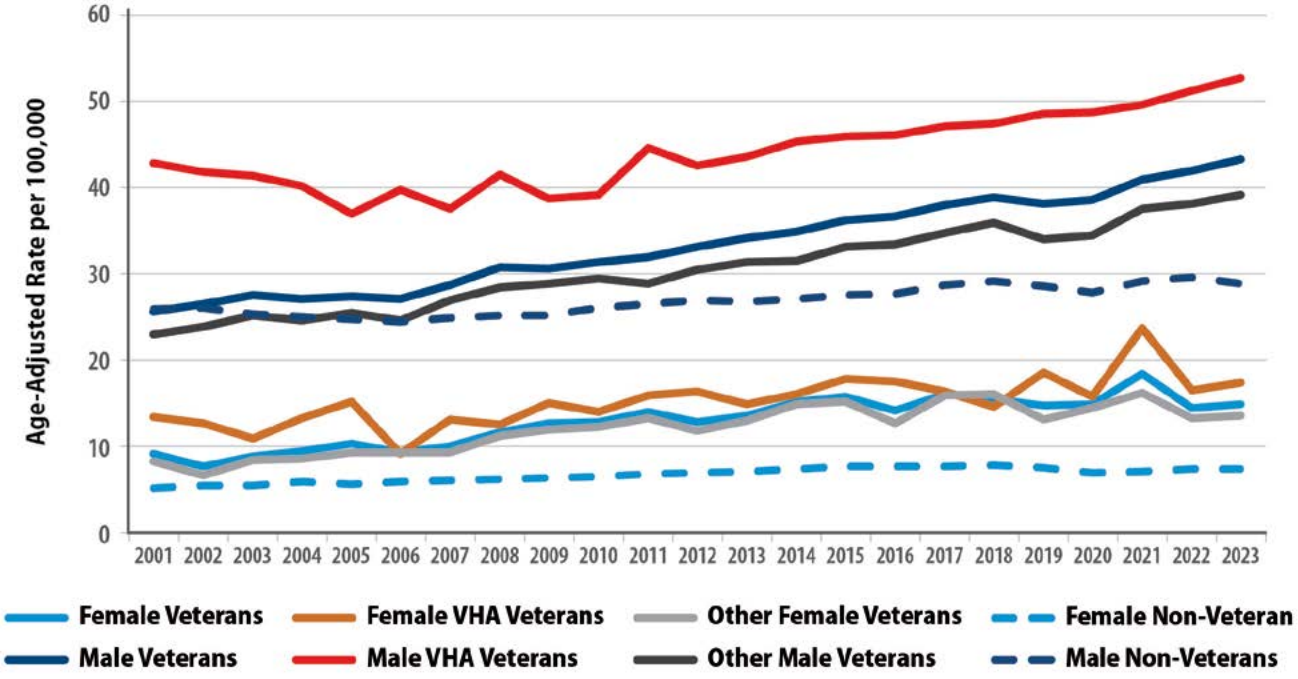
	2001	2023	Change	2022	2023	Change
Recent Veteran VHA Users						
Female						
Aged 18-34	--	24.2	--	17.3	24.2	+39.5%
Aged 35-54	17.2	16.6	-3.6%	19.1	16.6	-13.3%
Aged 55-74	--	10.7	--	14.3	10.7	-24.8%
Aged 75+	--	--	--	--	--	--
Male						
Aged 18-34	35.6	67.1	+88.6%	68.3	67.1	-1.7%
Aged 35-54	52.2	53.4	+2.2%	47.1	53.4	+13.4%
Aged 55-74	36.5	34.8	-4.9%	34.7	34.8	+0.1%
Aged 75+	43.9	43.9	-0.2%	51.4	43.9	-14.7%
Other Veterans						
Female						
Aged 18-34	7.1	14.9	+110.5%	17.4	14.9	-14.3%
Aged 35-54	13.4	14.2	+5.9%	13.7	14.2	+3.3%
Aged 55-74	--	11.7	--	9.8	11.7	+18.6%
Aged 75+	--	10.1	--	4.8	10.1	--
Male						
Aged 18-34	25.0	50.0	+100.3%	48.8	50.0	+2.6%
Aged 35-54	25.9	36.6	+41.1%	35.5	36.6	+3.2%
Aged 55-74	14.2	33.1	+132.6%	32.7	33.1	+1.2%
Aged 75+	23.9	29.0	+21.2%	27.4	29.0	+6.0%

[56] This section presents information on suicide among annual cohorts of Recent Veteran VHA Users, who are defined as Veterans alive at the start of the year and with direct VHA care (inpatient or outpatient encounters) in the year or prior year.

[57] Rates are suppressed if there were fewer than 10 suicide deaths, and rates are more variable for smaller Veteran subpopulations.

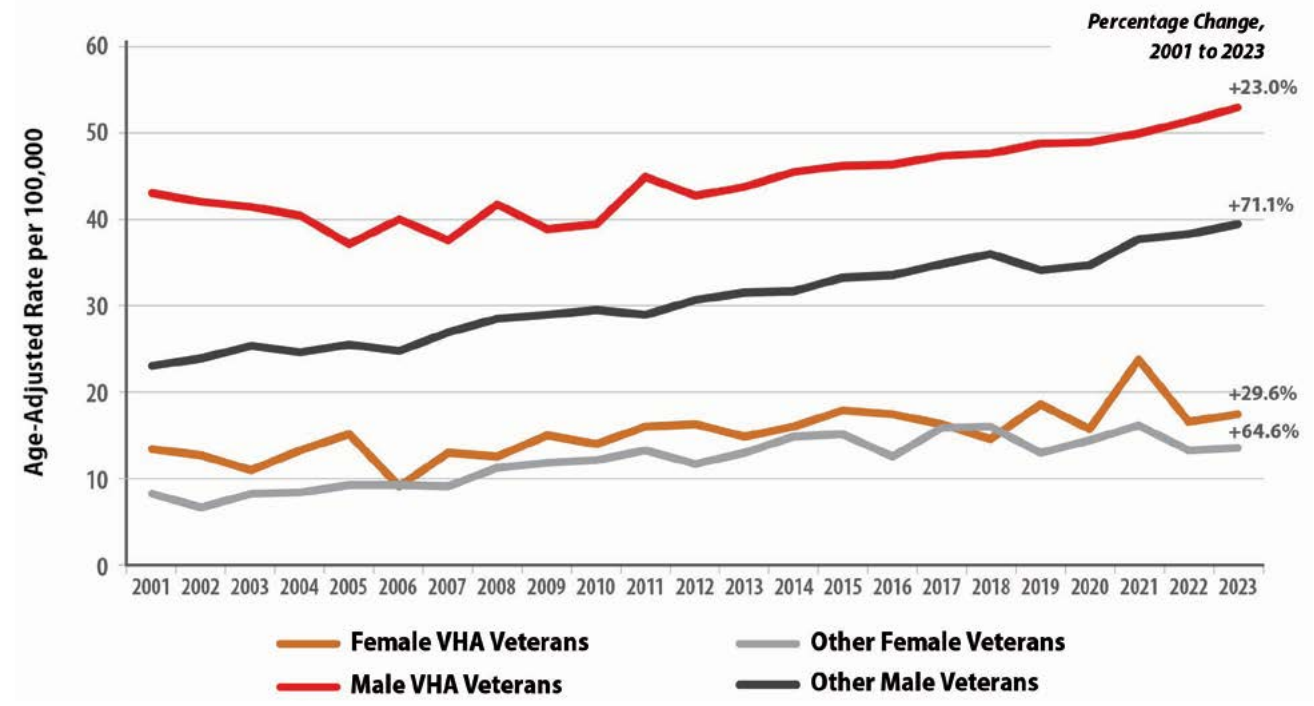
Figure 19, below, presents age-adjusted suicide rates for Veterans, by sex, and by recent VHA care, and for non-Veteran U.S. adults, 2001-23.

Figure 19: Age-Adjusted Suicide Rate, Veterans, by Sex, and by Recent VHA Care, and Non-Veteran U.S. Adults, by Sex, 2001-23



Below, Figure 20 presents age-adjusted suicide rates for Recent Veteran VHA Users and for Other Veterans, 2001-23, and the percentage increase in rates, from 2001-23.

Figure 20: Age-Adjusted Suicide Rate,[58] Veterans, by Sex and Recent VHA Care, 2001-23, and Change from 2001 to 2023



[58] Adjusted using the direct method, and the 2000 U.S. population as the standard.

Table 6, below, presents comparisons, by sex, of age-adjusted suicide rates.

- From 2022-23, age-adjusted rates increased for female Veterans in VHA care (+5.1%) and for female Veterans who were not Recent Veteran VHA Users (+1.6%). Concurrently, rates rose for both male Recent Veteran VHA Users (+3.0%) and male Veterans who were not Recent Veteran VHA users (+2.7%).
- From 2001-23, age-adjusted suicide rates rose for all groups.

Table 6: Age-Adjusted Suicide Rate per 100,000, Change from 2001-23 and from 2022-23, Veteran VHA Users and Other Veterans, by Sex

	2001	2023	Change	2022	2023	Change
Recent Veteran VHA Users						
Female	13.4	17.4	+29.6%	16.6	17.4	+5.1%
Male	43.1	53.0	+23.0%	51.5	53.0	+3.0%
Other Veterans						
Female	8.2	13.6	+64.6%	13.3	13.6	+1.6%
Male	23.0	39.4	+71.1%	38.4	39.4	+2.7%

Behavioral Patient Record Flag

Veterans in VHA care may receive Behavioral Patient Record Flags related to behavior that is intimidating, threatening or dangerous, or could put at risk the health and safety of health care workers, other patients, or other individuals.[59] VA is not authorized to refuse to deliver care, [60] and over many years, VA has developed strategies to provide care options that minimize risk while ensuring services delivery for the vulnerable population of Veterans with disruptive and assaultive behavior.[61] Over time, VA has enhanced systems for gathering and monitoring reports regarding disruptive behavior.[62]

[59] Semeah L, Cowper-Ripley D, Freytes M, Jia H, Uphold C, Hart D, Campbell C. 2019. Occupational Hazard: Disruptive Behavior in Patients. Federal Practitioner. 3 6(4):158-163.

[60] Hodgson MJ, Mohr DC, Drummond DJ, Bell M, Van Male L. Managing Disruptive Patients in Health Care: Necessary Solutions to a Difficult Problem. 2012. American Journal of Industrial Medicine. 55:1009-1017.

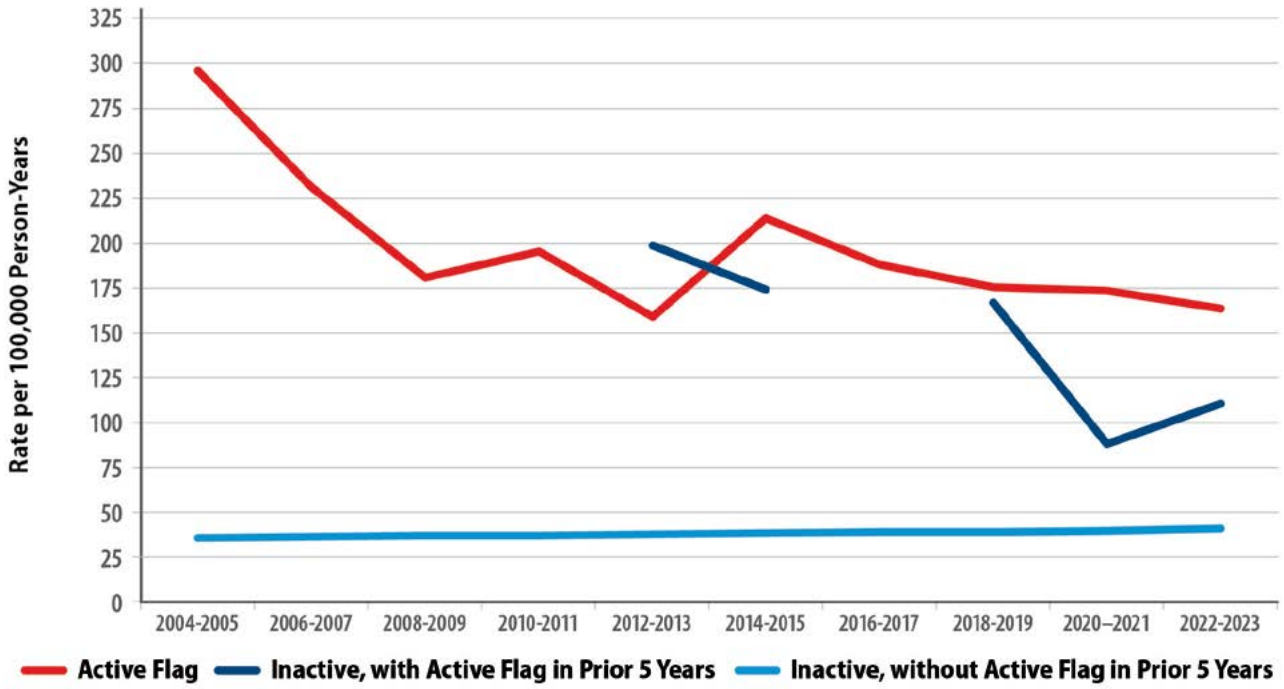
[61] Blow FC, Lawton Barry K, Copeland LA, McCormick RA, Lehmann LS, Ullman E. Repeated Assaults by Patients in VA Hospital and Clinic Settings. 1999. Psychiatric Services. 50:390-394.

[62] Hutton S, Vance K, Loftus SM, Roth G, Van Male LM. 2023. National Development and Implementation of a Democratized Disruptive Behavior Reporting System in Health Care. J Medical Systems. 47:104. https://doi.org/10.1007/s10916-023-01999-0. (Accessed 1/15/2025.)

Figure 21, below, presents suicide rates among Recent Veteran VHA Users with Behavioral Patient Record Flag related indicators.[63]

- In the years 2022-23, the suicide rate for Veterans with active Behavioral Patient Record Flags was 163.9 per 100,000; the rate was 110.5 per 100,000 for those with inactive flags who had an active flag in the prior five years; and the rate was 40.7 for those without active flags in 2022-23 or in the prior five years.
- The differential in suicide rates between those Veterans in VHA care who had active Behavioral Patient Record Flags and those without flags in the period or the prior five years fell from +729.8% in 2004-05 to +302.1% in 2022-23.

Figure 21: Suicide Rate, Recent Veteran VHA Users, by Behavioral Patient Record Flag Status, for Two-Year Periods, 2004-23



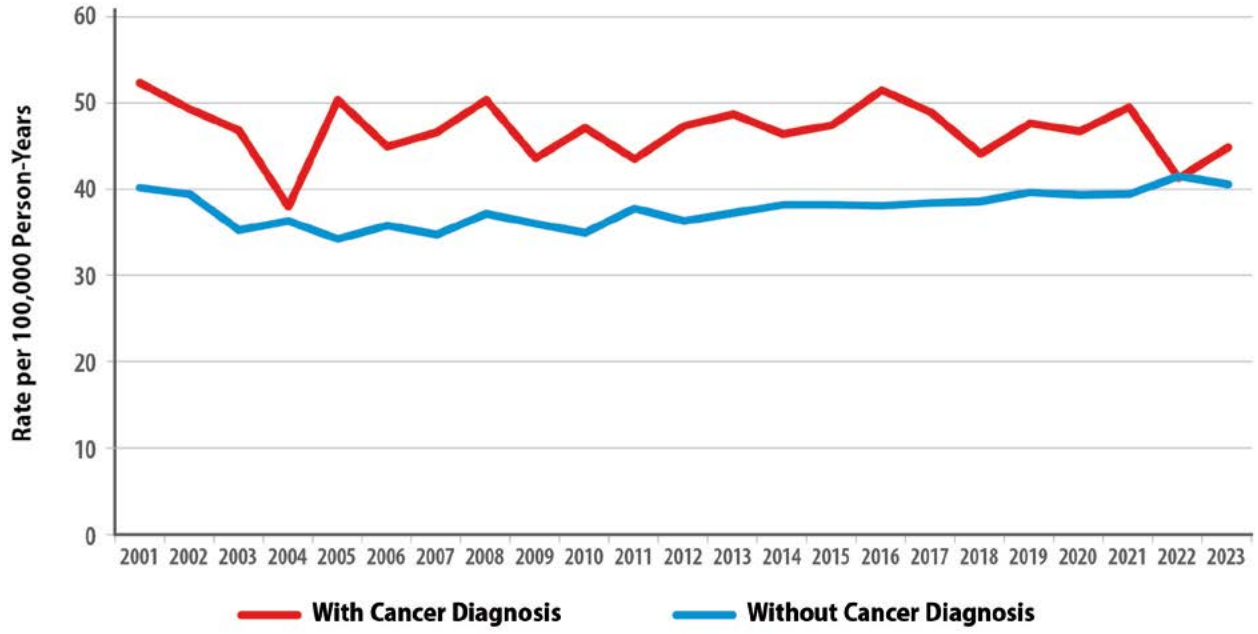
[63] There were 25,146 Veterans who had an active behavioral patient record flag in the period 2022-23.

Cancer

Cancer diagnoses are associated with increased suicide risks.[64,65] Figure 22, below, presents suicide rates for Recent Veteran VHA Users with cancer diagnoses.

- In 2023, the suicide rate for Recent Veteran VHA Users with cancer diagnoses was 10.3% higher than for those without cancer diagnoses (44.8 per 100,000 vs. 40.6 per 100,000). This is consistent with findings for 2001-21, when suicide rates were also greater for those with cancer diagnoses. Of note, in 2022, the suicide rate for Veterans with cancer diagnoses was 0.4% lower than for Veterans without cancer diagnoses.
- From 2022-23, the suicide rate for Recent Veteran VHA Users with cancer diagnoses rose 8.5%, from 41.3 per 100,000 to 44.8 per 100,000.

Figure 22: Suicide Rate, Veteran VHA Users, by Cancer Diagnosis Status, 2001-2023[66]



[64] Amiri S, Behnezhad S. 2019. Cancer Diagnosis and Suicide Mortality: A Systematic Review and Meta-Analysis. Archives of Suicide Research. 0:1-19.

[65] Dent KR, Szymanski BR, Kelley MJ, Katz IR, McCarthy JF. 2023. Suicide Risk Following a New Cancer Diagnosis Among Veterans in Veterans Health Administration Care. Cancer Medicine.12(3):3520-3531.

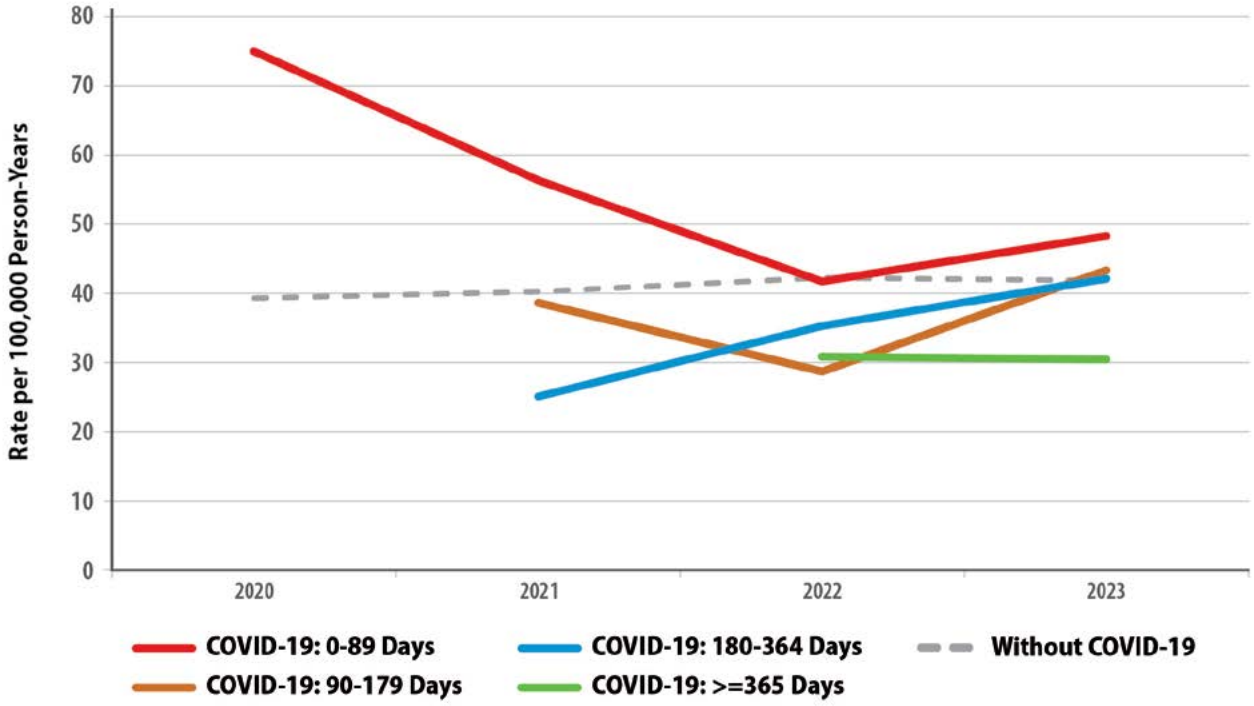
[66] Cancer diagnoses are defined as any ICD-10 cancer diagnosis present in the year or year prior. Cancer diagnoses include all reportable subtypes as specified by the National Cancer Institute's Surveillance Epidemiology End Results (SEER) Program: https://seer.cancer.gov/tools/conversion/ (Accessed 1/15/2025.)

COVID-19

Research indicates that in the first year of the COVID-19 pandemic, Veterans in VHA care were at increased risk for suicide attempts and other self-directed violence, particularly in the first month of infection.[67] Figure 23, below, presents suicide rates for Recent Veteran VHA Users, by COVID-19 infection status, 2020-23.

- In 2020 and 2021, suicide rates in the three months following indications of a COVID-19 infection were 91.0% and 40.4% higher than for patients without indications of COVID-19, respectively. The rate for this measure was not elevated in 2022 and was 15.5% higher following infections in 2023 compared to patients without infection.

Figure 23: Suicide Rate, Recent Veteran VHA Users, by COVID-19 Status and Days Since Infection, 2020-23

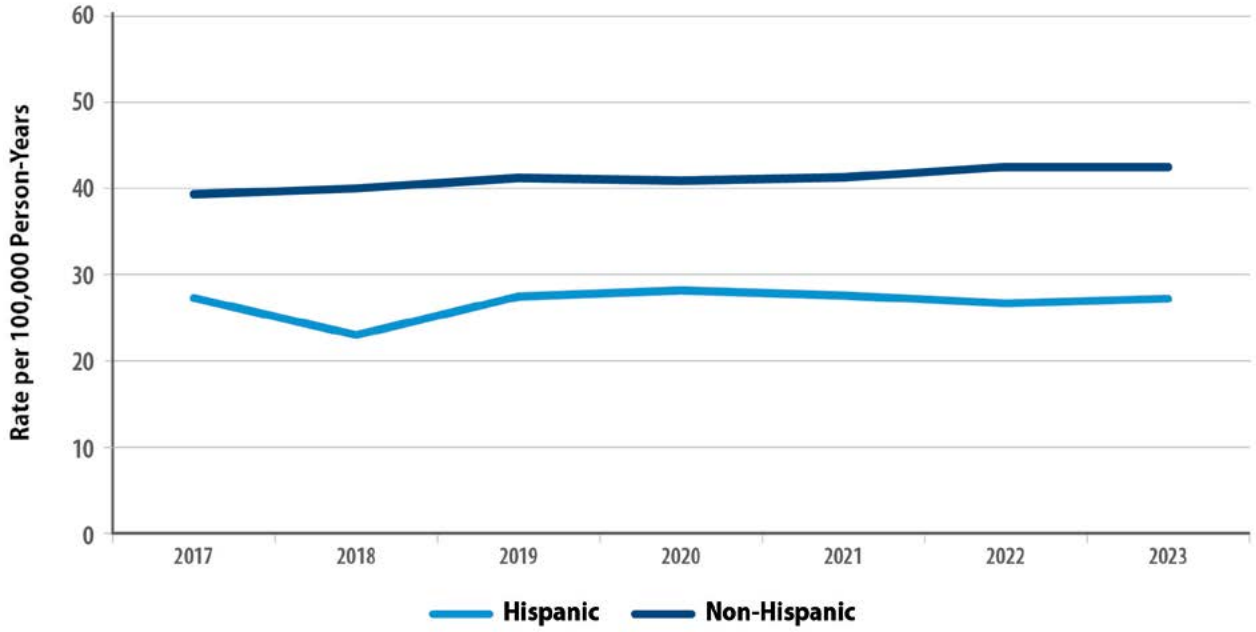


[67] Hynes DM, Niederhausen M, Chen JI, Shahoumian TA, Rowneki M, Hickok A, Shepherd-Banigan M, Hawkins EJ, Naylor J, Teo A, Govier DJ, Berry K, McCready H, Osborne TF, Wong E, Herbert PL, Smith VA, Barrett Bowling C, Boyko EJ, Ioannou GN, Iwashyna TJ, Maciejewski ML, O'Hare AM, Viglianti EM, Bohnert ASB. 2024. Risk of Suicide-Related Outcomes After SARS-COV-2 Infection: Results from a Nationwide Observational Matched Cohort of US Veterans. J Gen Intern Med. 39(4):626-635.

Ethnicity

Below, Figure 24 presents suicide rates among Recent Veteran VHA Users by ethnicity, 2017-23. In each year, suicide rates were lower for Veterans with Hispanic ethnicity, compared to non-Hispanic Veterans.

Figure 24: Suicide Rate, Recent Veteran VHA Users, by Hispanic Ethnicity, 2017-23

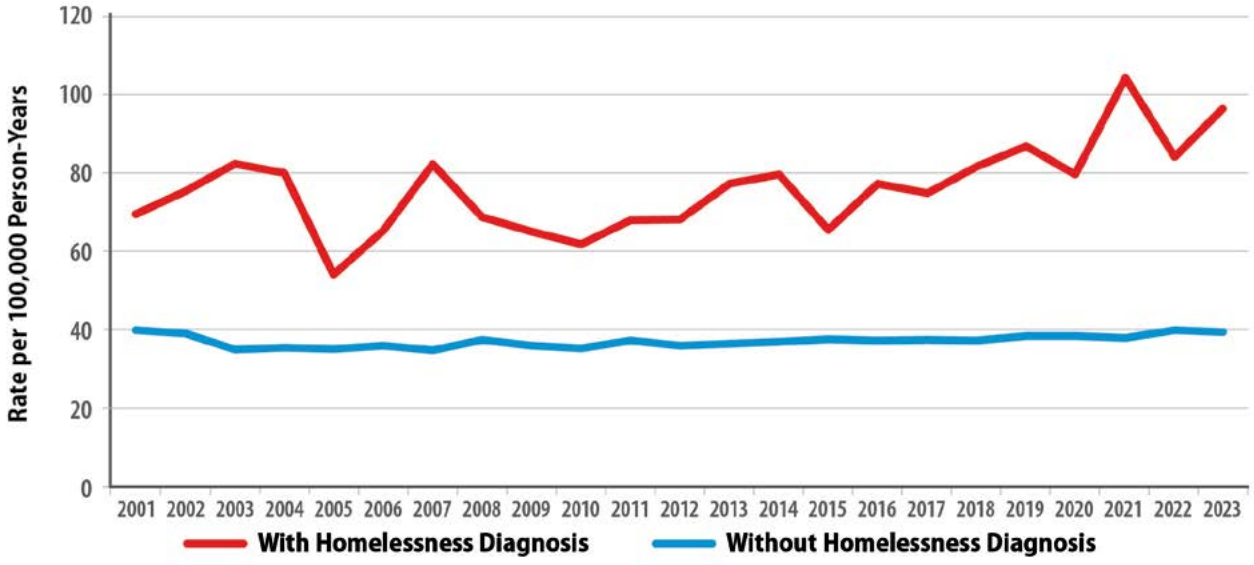


Homelessness

Figure 25 presents suicide rates among annual cohorts of Recent Veteran VHA Users, by homelessness status,[68] 2001-23.

- In each year, the suicide rate of Recent Veteran VHA Users with diagnoses of homelessness was elevated compared to those without diagnoses of homelessness.
  - In 2001, the suicide rate for Recent Veteran VHA Users with diagnoses of homelessness was 72.5% higher than for those without diagnoses of homelessness.
  - In 2023, the suicide rate for homeless Recent Veteran VHA Users was 146.0% higher than for those without diagnoses of homelessness.
- In 2023, the suicide rate among Recent Veteran VHA Users with diagnoses of homelessness was 38.8% higher than in 2001 and 14.3% higher than in 2022.

Figure 25: Suicide Rate, Recent Veteran VHA Users, by Homelessness Diagnosis Status, 2001-23

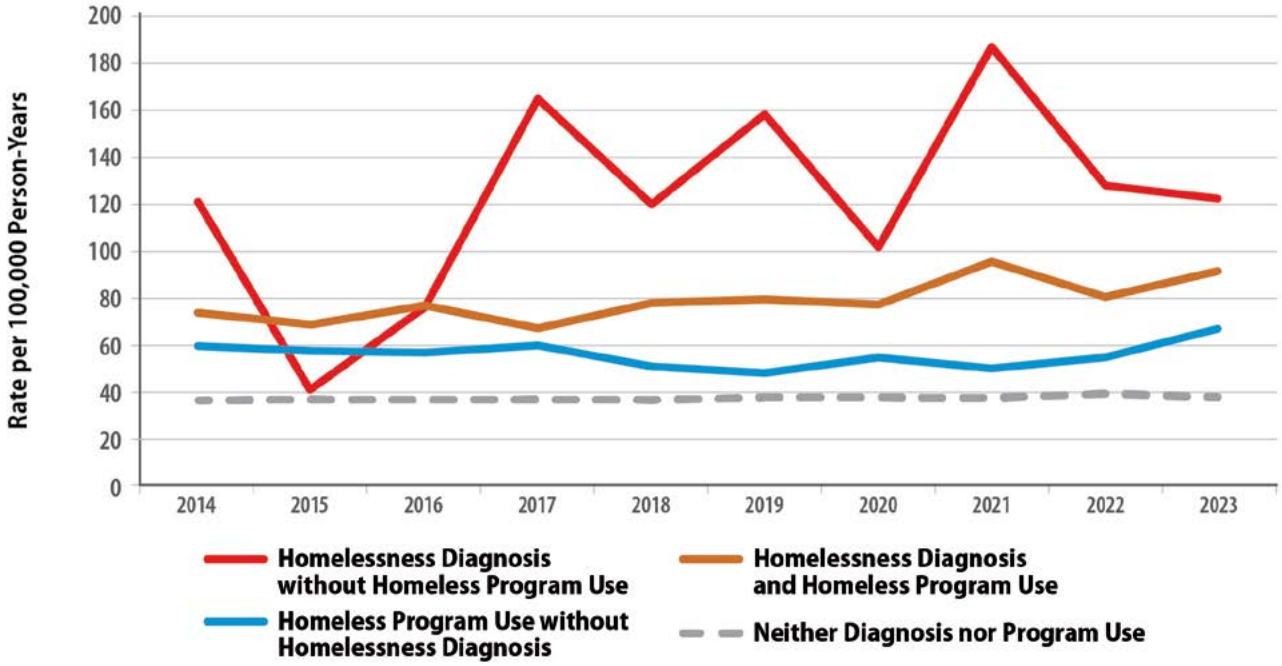


[68] Homelessness is identified using International Classification of Diseases, Ninth Revision (ICD-9) Code V60.0 and ICD-10 Code Z59.0 recorded during encounters at VA hospitals. We considered individuals as having an indication of homelessness if they had an ICD code in an encounter in the year or year prior.

Figure 26, below, presents suicide rates among Recent Veteran VHA Users, by receipt of diagnoses of homelessness or of VA homeless program services.

- In 2023, for Veterans with homelessness diagnosis, the suicide rate was 33.7% lower for those who also received VA homeless program services (91.8 per 100,000) than for those who did not receive these services (122.8 per 100,000).
- The suicide rate was 67.3 per 100,000 for those who received homeless program services and who did not have a diagnosis of homelessness, and for those with neither a homelessness diagnosis nor homeless program services, the suicide rate was 38.4 per 100,000.

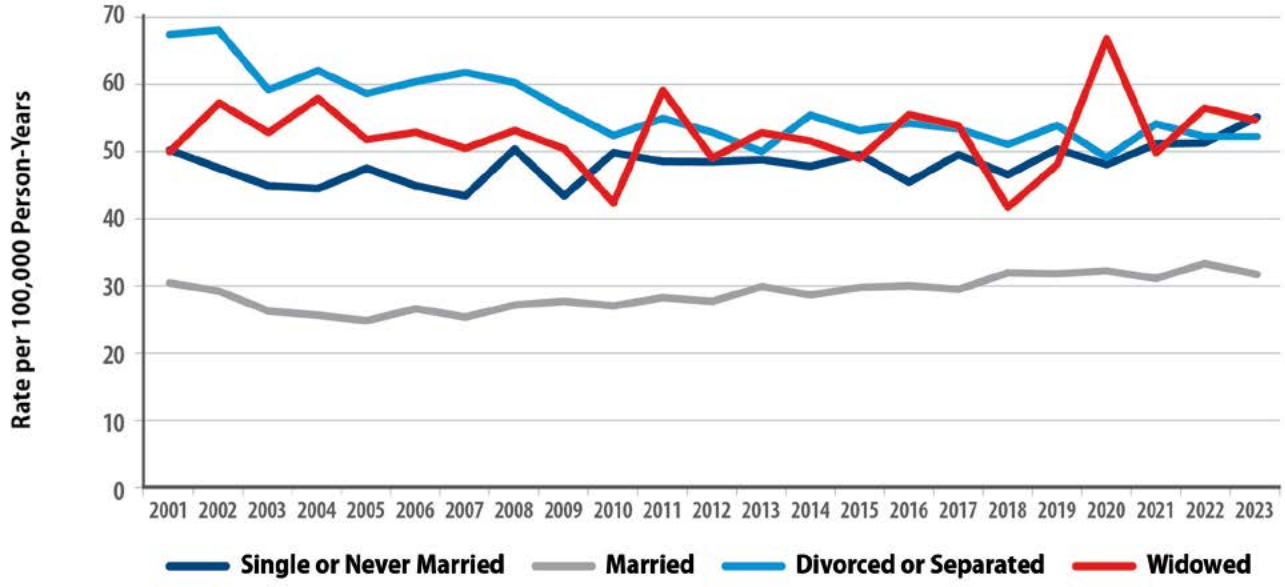
Figure 26: Suicide Rate, Recent Veteran VHA Users, by Homelessness Diagnosis and Homeless Program Use Status, 2014-23



Marital Status

Figure 27, below, presents suicide rates among Recent Veteran VHA Users by marital status.[69] In each year, suicide rates were lowest among Recent Veteran VHA Users who were married, compared to those with other categories of marital status.

Figure 27: Suicide Rate, Recent Veteran VHA Users, by Marital Status, 2001-23



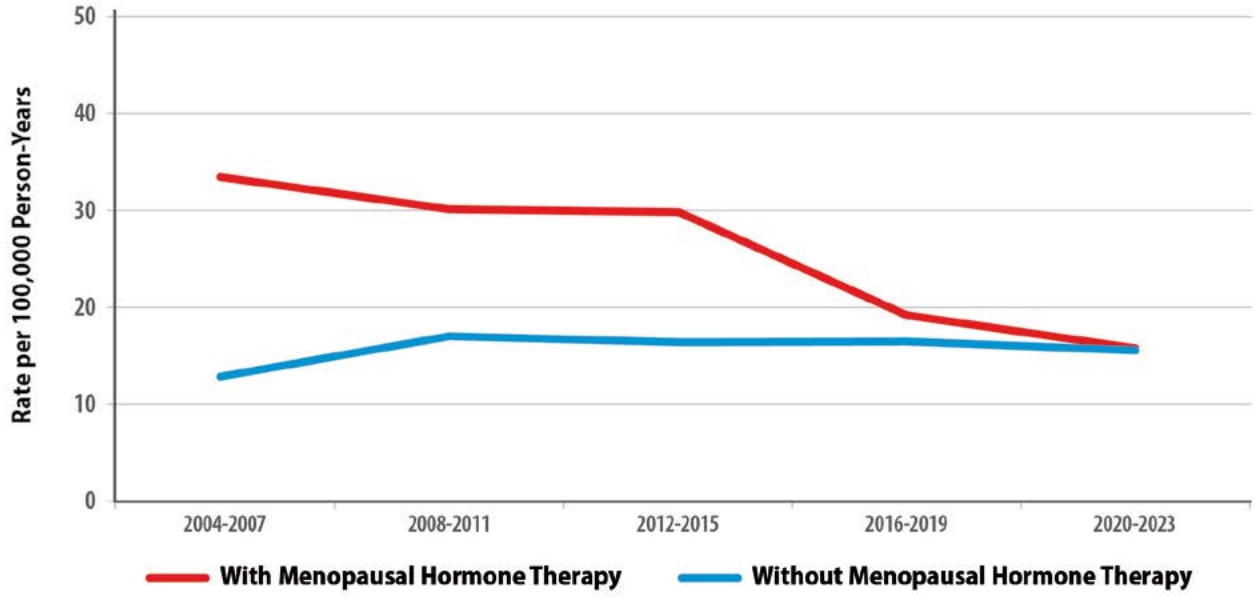
[69] Per VHA visit records, using the most recent status in the year or prior year. Excludes those with unknown marital status.

Menopausal Hormone Therapy Receipt

Figure 28, below, presents suicide rates for female Recent Veteran VHA Users between the ages of 40-64, by receipt of VHA menopausal hormone therapy.[70]

- Among female Veterans in VHA care aged 40-64 who received menopausal hormone therapy, the suicide rate fell 54.7% from 2004-07 (30.8 per 100,000) to 2020-23 (15.3 per 100,000). Conversely, for those who did not receive menopausal hormone therapy, the suicide rate rose 18.0% from 2004-07 (13.0 per 100,000) to 2020-23 (15.3 per 100,000).

Figure 28: Suicide Rate, Female Recent Veteran VHA Users Age 40-64,[71] by Menopausal Hormone Therapy Receipt, for Four-Year Periods, 2004-23



Mental Health and Substance Use Disorder Diagnoses

Ensuring access to mental health and SUD services is a VHA priority and part of VA's National Strategy for Preventing Veteran Suicide.[72]

- The prevalence of VHA mental health or SUD diagnoses among annual cohorts of Recent Veteran VHA Users was 27.7% in 2001, 43.4% in 2022, and 46.3% in 2023.[73]
- Among annual cohorts of Recent Veteran VHA Users who died from suicide, VHA mental health or SUD diagnoses were documented in the year or prior calendar year for 55.9% of those who died in 2001, 60.5% of suicide decedents in 2022, and 60.9% of suicide decedents in 2023.
- Among those who died from suicide in 2023, the prevalence of diagnoses of depression in the year or prior calendar year was 38.1%, anxiety 27.5%, posttraumatic stress disorder (PTSD) 26.7%, alcohol use disorder 20.3%, cannabis use disorder 8.9%, bipolar disorder 10.7%, personality disorder 4.2%, opioid use disorder 3.7%, other psychotic disorders[74] 4.1%, attention deficit hyperactivity disorder (ADHD) 3.8%, and schizophrenia 3.8%.

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[70] Menopausal hormone therapy was indicated per receipt of estrogen hormone therapy per VHA medication classes HS300 and GU500. Information from annual assessments is reported for four-year periods 2004-23.

[71] Excludes Veterans with diagnoses of gender identity disorder given potential receipt of hormone therapy for gender-affirming purposes rather than treatment of menopause symptoms. See: Gibson CJ, Li Y, Jasuja GK, Self KJ, Seal KH, Byers AL. 2021. Menopausal Hormone Therapy and Suicide in a National Sample of Midlife and Older Women Veterans. Medical Care. 59:S70-S76.

[72] https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf. (Accessed 8/26/2025).

[73] Diagnoses were assessed in the year or prior calendar year. An individual's likelihood of having a documented diagnosis may vary by the number of VHA health care contacts in the relevant period. VHA transitioned from International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), to ICD-10-CM diagnosis codes on October 1, 2015. Diagnoses were not mutually exclusive, and analyses do not adjust for demographic differences or comorbidities.

[74] Non-schizophrenia and non-bipolar disorder conditions that involved psychoses. McCarthy JF, Blow FC. 2004. Older Patient with Serious Mental Illness: Sensitivity to Distance Barriers for Outpatient Care. Medical Care. 42(11):1073-1080.

- Conversely, 39.1% of Recent Veteran VHA Users who died from suicide in 2023 did not have a documented VHA mental health or SUD diagnosis in 2022 or 2023.
- The suicide rate among Recent Veteran VHA Users with mental health or SUD diagnoses fell 34.7% from 2001 (87.0 per 100,000) to 2023 (56.9 per 100,000).
- The suicide rate among Recent Veteran VHA Users who did not have VHA mental health or SUD diagnoses rose 15.5% from 2001 (24.6 per 100,000) to 2023 (28.4 per 100,000).
- Trends in suicide rates from 2001-23 for Recent Veteran VHA Users varied by condition.

	% Change
Depression	↓ 43.9%
Anxiety	↓ 40.4%
PTSD	↓ 34.9%
Sedative Use Disorder	↓ 19.2%
Alcohol Use	↓ 16.3%
Substance Use Disorders (SUD)	↓ 15.0%
Bipolar Disorder	↓ 12.1%
Personality Disorder	↓ 11.2%

	% Change
Other Psychotic Disorders	↑ 79.7%
Cocaine Use Disorder	↑ 57.0%
Other SUDs	↑ 54.2%[75]
Amphetamine Use Disorder[76]	↑ 28.7%
Schizophrenia	↑ 11.6%
Cannabis Use Disorder	↑ 10.8%
Opioid Use Disorder	↑ 8.7%

[75] "Other SUDs" diagnoses include inhalant use disorder and hallucinogen use disorder, as well as diagnoses for unknown substances or SUDs that were not identified as alcohol use disorder, amphetamine use disorder, cannabis use disorder, cocaine use disorder, opioid use disorder, or sedative use disorder.

[76] Amphetamine use disorder includes multiple non-cocaine stimulants, including caffeine or unknown stimulants.

For 2022 and 2023 Recent Veteran VHA User cohorts, Table 7, below, presents the number of suicide deaths and suicide rates per 100,000.

Table 7: Suicide Deaths and Suicide Rates, Recent Veteran VHA Users, by Mental Health (MH) and Substance Use Disorder (SUD) Diagnoses,76[77] 2022 and 2023

Diagnoses	Suicide Deaths		Suicide Rates per 100,000 Person-Years		
	2022	2023	2022	2023	Rate Change
Without MH/SUD Condition	**1018**	**976**	**27.8**	**28.3**	**+0.6**
With Any MH/SUD Condition	**1556**	**1522**	**61.1**	**56.9**	**-4.3**
Depression	991	952	72.3	65.4	-7.0
Anxiety	668	686	69.3	64.9	-4.5
Post-Traumatic Stress Disorder	640	667	55.8	54.5	-1.3
Bipolar Disorder	259	267	116.3	118.8	+2.5
Personality Disorder	115	105	170.2	155.2	-15.0
Other Psychoses	100	103	246.6	257.3	+10.7
Schizophrenia	77	95	98.2	124.1	+26.0
Attention-Deficit Hyperactivity Disorder	83	94	72.6	70.7	-1.8
Substance Use Disorder	**646**	**643**	**101.6**	**97.2**	**-4.3**
Alcohol Use Disorder	503	508	105.1	101.7	-3.4
Cannabis Use Disorder	227	223	135.0	125.8	-9.3
Amphetamine Use Disorder	87	118	180.3	233.6	+53.3
Opioid Use Disorder	99	92	129.8	121.8	-8.0
Cocaine Use Disorder	62	69	87.4	96.6	+9.3
Sedative Use Disorder	37	38	281.3	305.1	+23.8

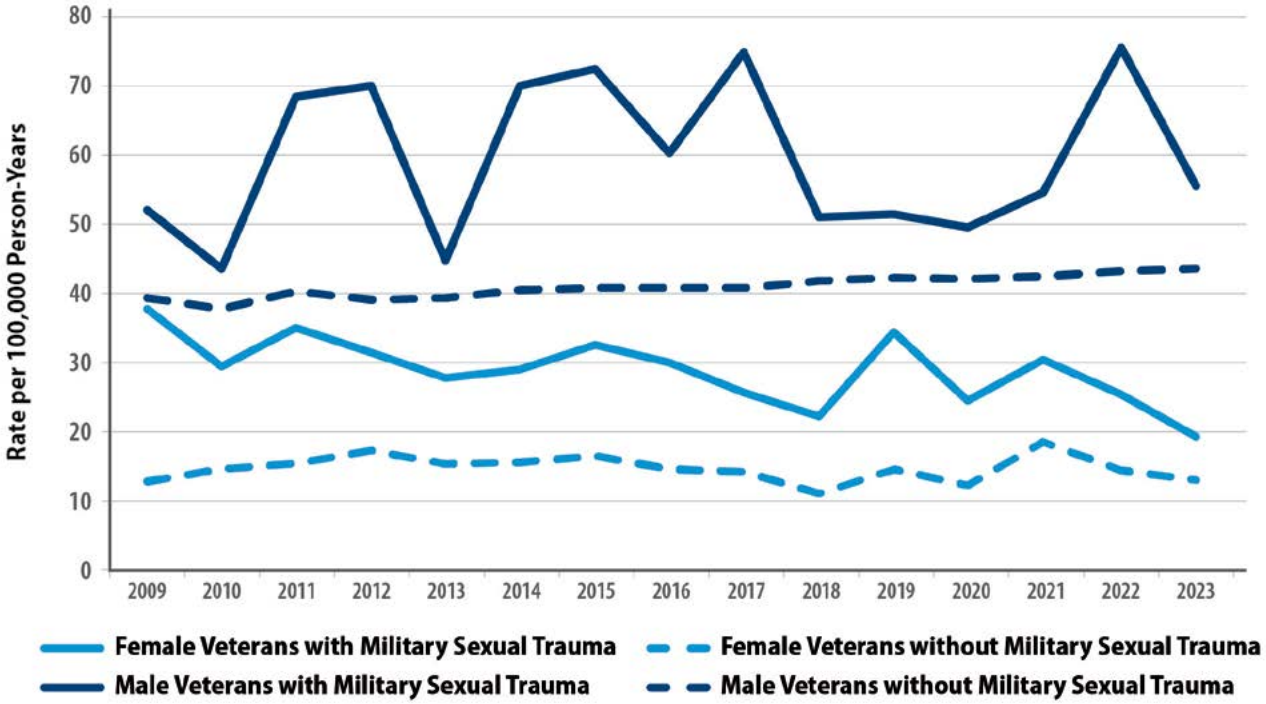
[77] Diagnosis categories are not mutually exclusive.

Military Sexual Trauma (MST)

Suicide risks are elevated among Veterans in VHA care who report experiences of sexual assault or sexual harassment during military service, known as MST.[78,79] Figure 29, below, presents suicide rates for Recent Veteran VHA Users, by sex and MST screening responses, 2009-23.

- In each year from 2009-23, the suicide rate among female and male Recent Veteran VHA Users was greater for those who reported having experienced MST than among those who indicated that they had not experienced MST. For example, among female Recent Veteran VHA Users in 2023, the suicide rate was 45.3% higher for those with positive screens for MST (18.7 per 100,000 for those with positive MST screens and 12.9 per 100,000 for those with negative screens) and the rate was 27.6% higher for male Recent Veteran VHA Users with positive screens for MST (55.9 per 100,000 for those with positive screens and 43.8 per 100,000 for those with negative screens.)
- The suicide rate for female Veterans with positive MST screens fell 25.1% from 2022 to 2023, and for male Veterans with positive MST screens, the suicide rate fell by 26.0%.

Figure 29: Suicide Rate, Recent Veteran VHA Users, by Sex and Military Sexual Trauma Status,[80] 2009-23



[78] Kimerling R, Makin-Byrd K, Louzon S, Ignacio RV, McCarthy JF. 2016. Military Sexual Trauma and Suicide Mortality. Am J Prev Med. 50(6):684-691.

[79] Galovski TE, Street AE, Creech S, Lehavot K, Kelly UA, Yano EM. 2022. State of the Knowledge of VA Military Sexual Trauma Research. J Gen Intern Med. 37(Suppl 3):S825-S830.

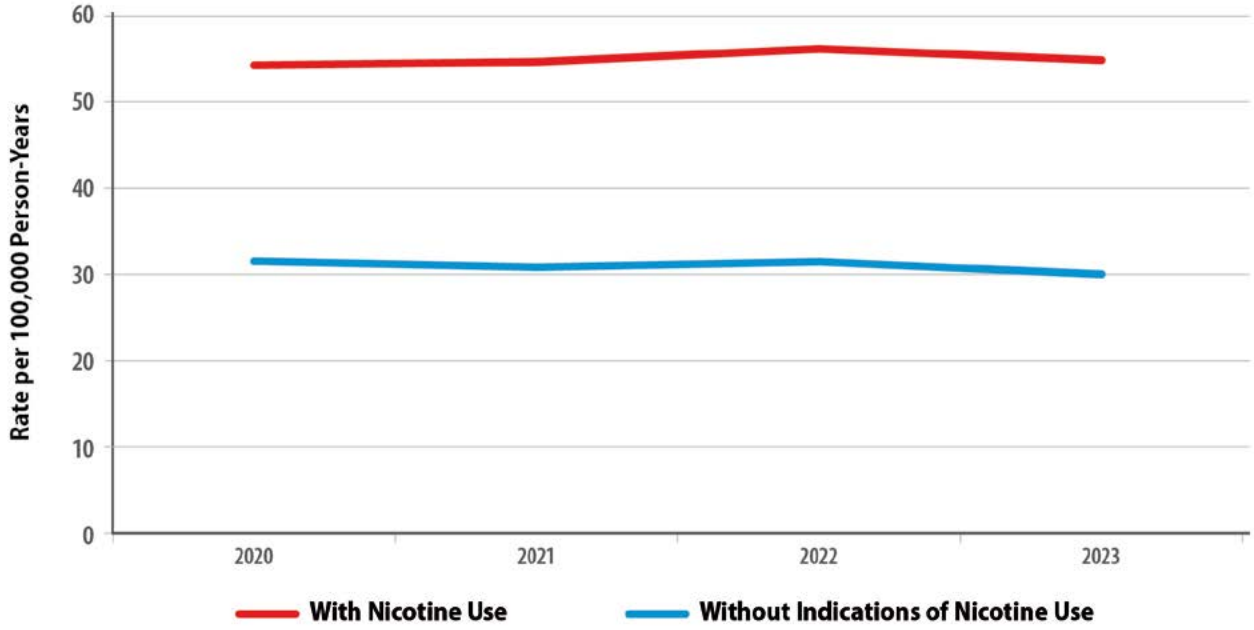
[80] The figure is specific to MST screen responses of "Yes" (positive) or "No" (negative). Results for "Declined" are not presented given annual counts of less than 10. Results for responses of "Unknown" are available upon request (for example, the suicide rate in 2023 for female Veterans with screen results of "Unknown" was 17.9 per 100,000, and for male Veterans it was 44.7 per 100,000).

Nicotine Use

Figure 30, below, presents information on suicide rates among Recent Veteran VHA Users who completed a VHA screen regarding nicotine use during a health care encounter in the year of interest or the prior year. Rates are stratified by nicotine use as identified by a positive screen or a recent diagnosis of tobacco use disorder.

- In 2023, the suicide rate among Veterans in VHA care with indications of nicotine use (55.1 per 100,000) was 81.2% higher than the suicide rate for Veterans in VHA care without indications of nicotine use (30.3 per 100,000).
- The suicide rate in 2023 among Veterans in VHA care with indications of nicotine use was 2.5% lower than in 2022.

Figure 30: Suicide Rate, Recent Veteran VHA Users with a VHA Screen for Nicotine Use, by Nicotine Use,[81] 2020-23



Priority Groups

Veterans who apply for VHA care are assigned to one of eight eligibility priority groups, which affect care costs. Group status is based on military service history, disability rating, income, Medicaid qualification, and other factors. Below, Table 8 presents suicide rates for enrolled Recent Veteran VHA Users, by priority group, 2013-23.[82]

- Each year from 2005-23, suicide rates were highest for Veterans in priority Group 5, which includes income-based eligibility.
- In 2023, the suicide rate was 57.9 per 100,000 for Group 5, followed by groups 8 (43.3 per 100,000), 4 (42.6 per 100,000), 7 (42.1 per 100,000), 1 (37.5 per 100,000), 3 (36.9 per 100,000), 2 (35.1 per 100,000), and 6 (29.5 per 100,000).
- From 2022-23, suicide rates increased for groups 2 (+9.6%), 3 (+2.8%), 5 (+1.8%), and 7 (+1.2%), and rates fell for groups 1 (-2.2%), 4 (-3.0%), 6 (-12.7%), and 8 (-6.9%).
- For Groups 2 and 5, the suicide rates in 2023 were higher than in any of the prior 21 years.

[81] This analysis was specific to Recent Veteran VHA Users who completed a tobacco use screen (including cigarettes, cigars, pipe smoking, snuff, dip, or chewing tobacco). Nicotine use was indicated by positive screens or diagnoses of tobacco use disorder.

[82] https://www.va.gov/health-care/eligibility/priority-groups/ (Accessed 1/15/2026) Group 8 refers to subgroups A-D. Group 8EG (non-enrolled) is not reported, due to small numbers for most years. In 2023, Veteran VHA Users in Group 8EG had 26 suicides and a suicide rate of 61.4 per 100,000 person-years. Reporting does not include Veterans whose eligibility was categorized as No Priority. Per the VA Enrollment System Administrative Data Repository.

Table 8: Suicide Rate, Enrolled Recent Veteran VHA Users, by VHA Priority Group, 2013-23

Suicide Rate per 100,000 Person-Years											
Group[83]	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Group 1	38.5	39.6	41.9	38.8	38.9	39.7	40.4	39.4	39.4	38.3	37.5
Group 2	28.7	32.4	27.8	30.2	29.1	33.8	29.5	32.8	31.9	32.0	35.1
Group 3	29.7	29.8	31.9	31.9	32.9	32.9	34.6	28.2	30.5	35.9	36.9
Group 4	25.0	43.0	45.4	48.8	37.9	39.1	42.3	44.7	38.5	43.9	42.6
Group 5	49.8	51.3	49.5	51.2	52.6	48.9	51.7	51.1	55.4	56.9	57.9
Group 6	17.5	23.0	25.1	21.1	25.8	32.4	28.9	32.5	34.3	33.8	29.5
Group 7	37.4	35.8	40.0	44.9	35.8	36.1	44.7	33.5	45.6	41.6	42.1
Group 8	41.3	37.9	37.9	39.5	38.9	36.5	41.2	45.5	41.5	46.4	43.3

[83] Eligibility priority group criteria:

Group 1: Veterans with a singular or combined rating of 50% or greater based on one or more service-connected disabilities or unemployability; and Veterans awarded the Medal of Honor.

Group 2: Veterans with a singular or combined rating of 30% or 40% based on one or more service-connected disabilities.

Group 3: Veterans who are former prisoners of war; Veterans awarded the Purple Heart; Veterans with a singular or combined rating of 10% or 20% based on one or more service-connected disabilities; Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty; Veterans who receive disability compensation under 38 U.S.C.§ 1151; Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. § 1151, but only to the extent that such Veterans' continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. § 1151; Veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay; and Veterans receiving compensation at the 10% rating level based on multiple non-compensable service-connected disabilities that clearly interfere with normal employability.

Group 4: Veterans who receive increased pension based on their need for regular aid and attendance or by reason of being permanently housebound and other Veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined.

Group 5: Veterans not in Priority Groups 1, 2, 3, or 4 who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. § 1722(a) based on having an annual income level below adjusted income limits (based on resident ZIP code), or receiving VA pension benefits, or eligible for Medicaid programs.

Group 6: Veterans of World War II; Veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War (the period between August 2, 1990, and November 11, 1998), or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. § 1710(e); Camp Lejeune Veterans pursuant to § 17.400; and Veterans with 0% service-connected disabilities who are nevertheless compensated, including Veterans receiving compensation for inactive tuberculosis. Returning combat Veterans are eligible for these enhanced benefits for ten years after discharge. At the end of this enhanced enrollment period, VA assigns Veterans to the highest priority group they qualify for at that time.

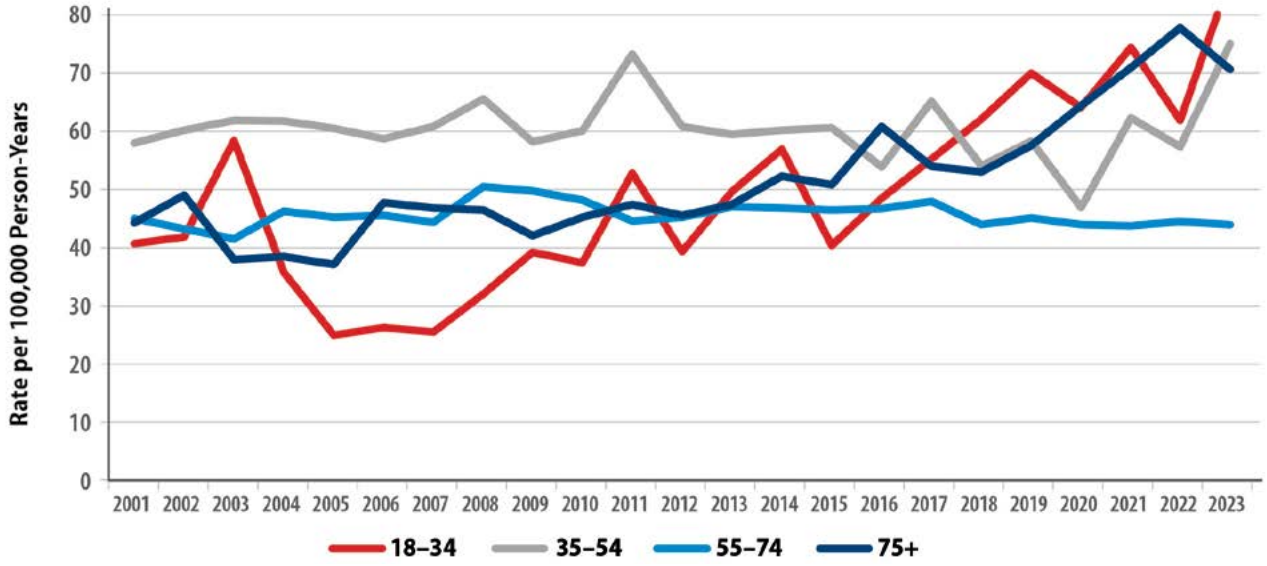
Group 7: Veterans whose gross household income is below the geographically adjusted income limits (GMT) for where the Veteran lives and the Veteran agrees to pay copays.

Group 8: Veterans not included in priority groups 4 or 7, who are eligible for care only if they agree to pay the applicable copayment due to gross household income being above VA income limits and GMT for where the Veteran lives. Eligibility for VA health care benefits will depend on further sub-prioritization within this group.

Figure 31, below, provides rates by age group for Recent Veteran VHA Users in priority group 5, 2001-23.[84]

- In priority group 5, Veterans aged 18-34 had the highest suicide rate in 2023 (85.4 per 100,000).
- From 2022-23, the suicide rate increased 37.9% for those aged 18-34, increased 29.9% for those aged 35-54; decreased 1.5% for those aged 55-74; and decreased 8.9% for those aged 75 and older.

Figure 31: Suicide Rate, Enrolled Recent Veteran VHA Users in Priority Group 5, by Age Group, 2001-23

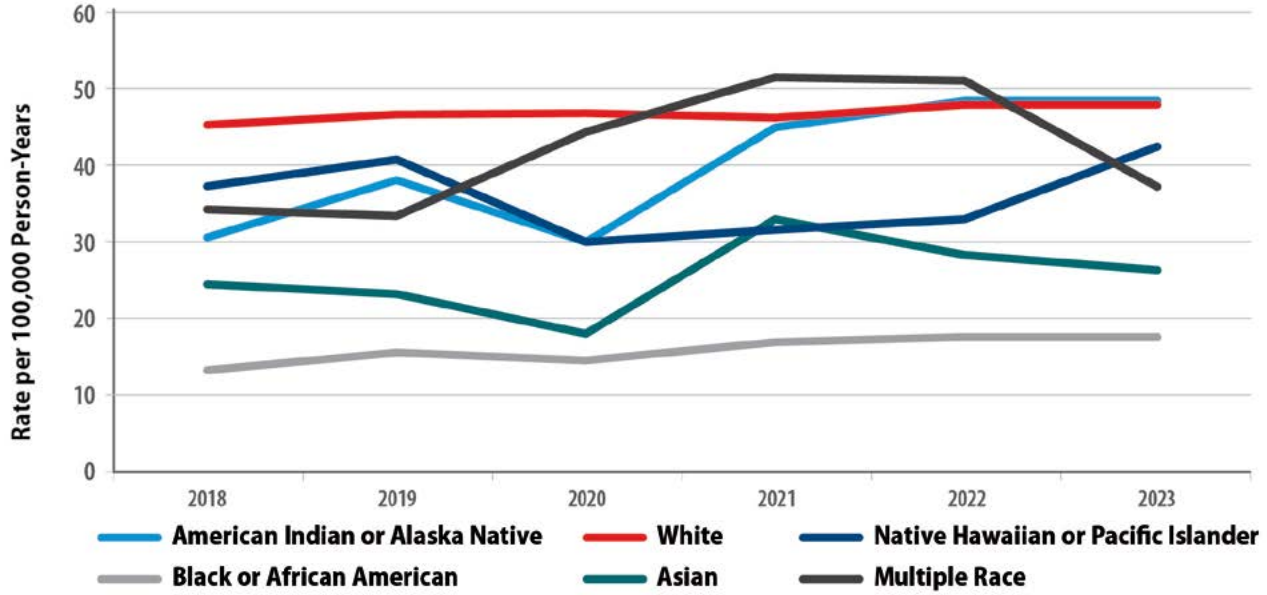


Race

Figure 32 presents suicide rates among Recent Veteran VHA Users by race, 2018-23.[85]

Among Veterans in VHA care, suicide rates in 2023 were highest for American Indian or Alaska Native Veterans and White Veterans, followed by Native Hawaiian or Pacific Islander Veterans and Veterans of multiple races; rates were lowest for Asian and Black or African American Veterans.

Figure 32: Suicide Rate, Recent Veteran VHA Users, by Race, 2018-23



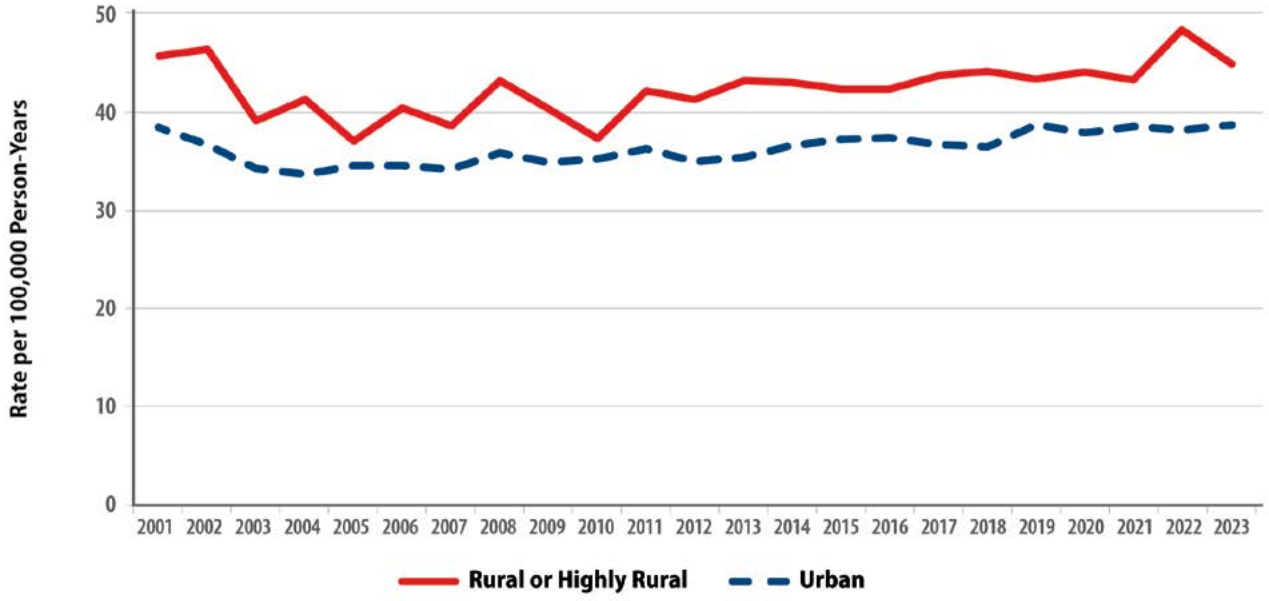
[84] For all other priority groups, reporting is unavailable by age groups in these years due to small numbers.

[85] Sources: Veterans Health Information System Technology Architecture, Oracle Health, MedSAS, and Vital Status File data, based on Veteran self-identified race or staff documentation. For each data-respondent-source combination, we identified the most frequent indication, and if multiple values were documented from a given source, race was coded as Multiple Race. After reviewing all sources, race was classified with highest priority to CDW self-identified data and lowest to Vital Status File data. Information from most recent year with non-missing data was used for all prior years.

Rurality

- Among Recent Veteran VHA Users, suicide rates were elevated for residents of rural areas, compared to urban areas (Figure 33, below). For example, in 2023, for individuals in rural or highly rural areas, the rate was 45.1 per 100,000, and it was 38.9 per 100,000 for those in urban areas.

Figure 33: Suicide Rate, Recent Veteran VHA Users, By Urban, Rural or Highly Rural Status, 2001-23



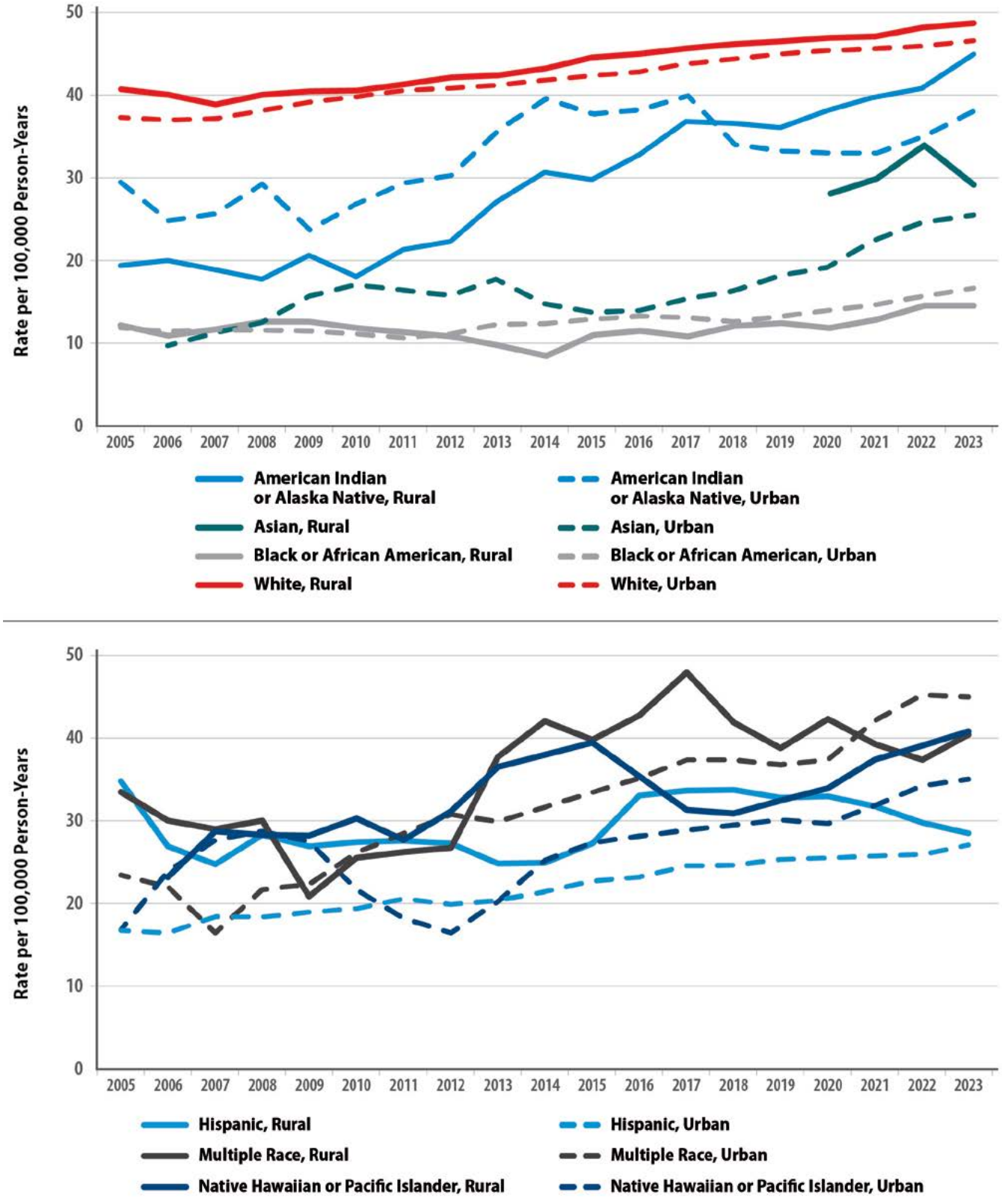
Differences in suicide rates by rural status may relate to the demographic characteristics of Veterans in rural areas.[86]

Below, Figure 34 presents suicide rates by rurality, stratified by race and ethnicity.

- In the most period, the highest suicide rates were among Veterans in VHA care who were white and in rural areas (48.6 per 100,000), followed by White Veterans in urban areas (46.4 per 100,000), American Indian or Alaska Native Veterans in rural areas (44.8 per 100,000), and American Indian or Alaska Native Veterans in urban areas (37.9 per 100,000).
- Veterans in the following groups had higher rates among those in rural versus urban areas: Veterans in VHA care who were White, American Indian or Alaska Native, Asian, and Hispanic. For Veterans in VHA care who were Black or multiple races, suicide rates were elevated in urban areas, compared to rural areas.

[86] Of note, as indicated in the figure, rural or highly rural areas included a higher percentage of White Veterans and a lower percentage of Black or African American Veterans than urban areas See: Peltzman T, Gottlieb DJ, Levis M, Shiner B. 2022. The Role of Race in Rural-Urban Suicide Disparities. Journal of Rural Health. 38[2]:346-354.

Figure 34: Five-Year Rolling Suicide Rate, Recent Veteran VHA Users, by Select Race/Ethnicity Categories and Urban or Rural/Highly Rural Status, 2005-23[87]



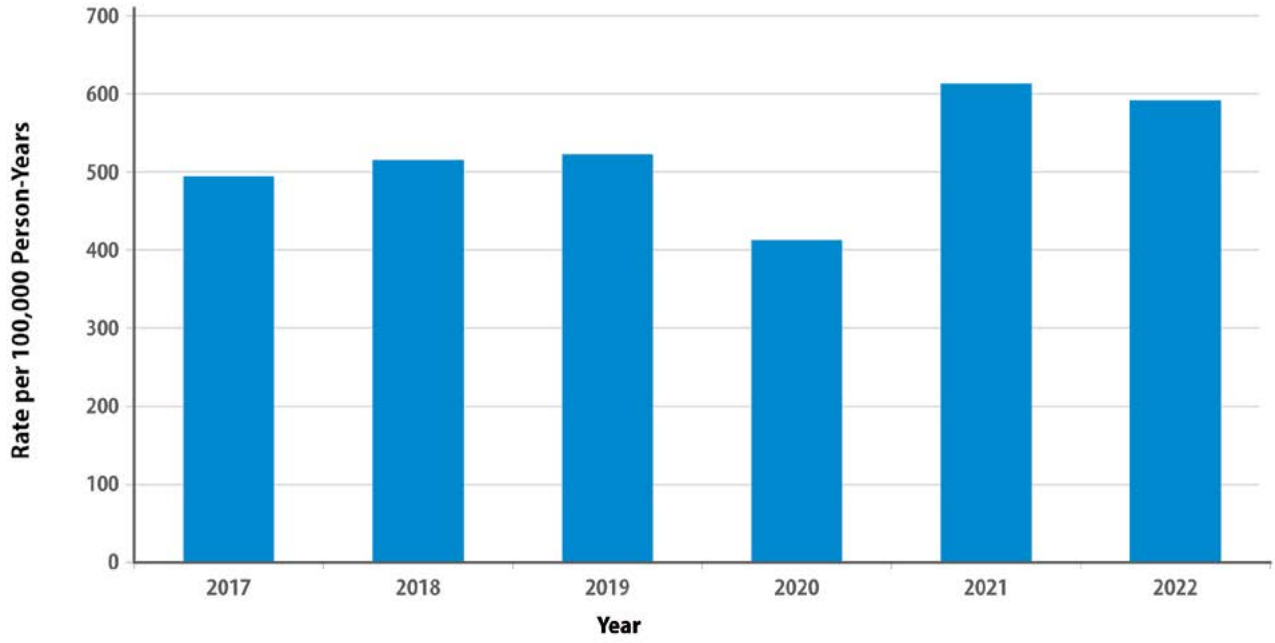
[87] Five-year rolling rates combine numerators and denominators for the year and the prior four years. Asian/Rural rates are suppressed in all years prior to 2021 due to counts less than 10.

Suicide Attempts

Few studies have assessed Veteran suicide mortality following non-fatal suicide attempts.[88,89] Below, Figure 35 presents information on suicide rates in the 12 months following Veterans' first VHA indication of a non-fatal suicide attempt in each year, 2017-22.

- Suicide rates ranged from 416.8 per 100,000 for those with indication of a non-fatal attempt in 2020 to 615.8 per 100,000 for those with indications in 2021.
- For Veterans in VHA care with suicide attempts documented in 2022, the suicide rate over the subsequent 12 months was 590.7 per 100,000.

Figure 35: Suicide Rate, 12 Months Following VHA Documented Non-Fatal Suicide Attempt, Veterans, by Year, 2017-22[90]



[88] Weiner J, Richmond TS, Conigliaro J, Wiebe DJ. 2011. Military Veteran Mortality Following a Survived Suicide Attempt. BMC Public Health, 11(1), 374. doi: 10.1186/1471-2458-11-374.

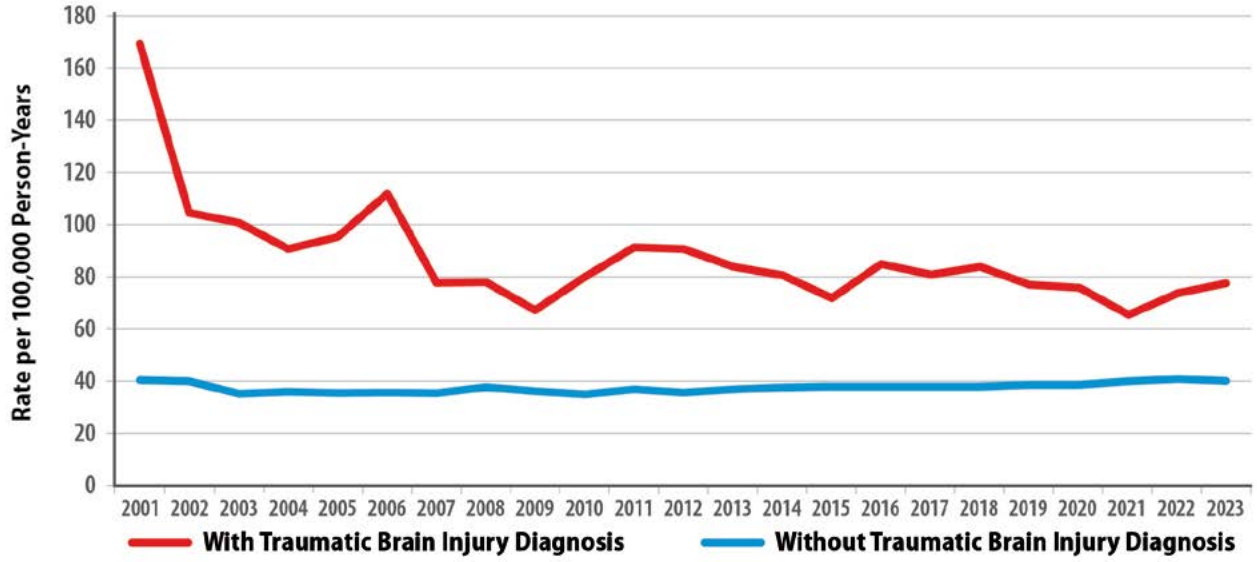
[89] Among Veterans with a VHA diagnosis of a non-fatal suicide attempt in 2005, 1.6% died from suicide over the subsequent 12 years, compared to 0.3% of Veterans without a suicide attempt diagnosis. Suicide rates diminished over time, yet remained elevated over the 12-year follow-up period, exceeding 114 per 100,000 in the ninth to 12th year later. See: Hein TC, Cooper SA, McCarthy JF. 2022. Mortality Following Non-Fatal Suicide Attempts by Veterans in Veterans Health Administration Care. Suicide and Life-Threatening Behavior. 52(2):222-230.

[90] Non-fatal suicide attempts were identified by ICD-10 Codes (T14.91XA, T14.91XD) and VHA site reports (Suicide Prevention Applications Network; Suicide Behavior and Overdose Report; Comprehensive Suicide Risk Evaluation), per the Self-Directed Violence classification system. Risk time began on the day following the non-fatal suicide attempt, if event data was documented, or on the day following the date of diagnosis of the non-fatal suicide attempt, whichever came first in the year. Risk time ended at death or the conclusion of a 365-day follow-up period, whichever occurred first. Analyses were limited to individuals who were alive at the start of the first day of follow-up. Results are presented for annual cohorts, 2017-2022. The number of Veterans included in each cohort was 19,524 in 2017; 21,213 in 2018; 25,126 in 2019; 22,840 in 2020; 23,059 in 2021; and 23,510 in 2022.

Traumatic Brain Injury

Traumatic Brain Injury (TBI) is associated with increased risk of suicide among VHA patients.[91] The prevalence of TBI diagnoses was 2.8% in 2023, up from 0.64% in 2001. Figure 36, below, presents suicide rates for Veterans in VHA care with diagnoses of TBI.

Figure 36: Suicide Rate, Recent Veteran VHA Users, by Traumatic Brain Injury Diagnosis[92]



- Among Recent Veteran VHA Users, suicide rates were elevated for those with a recent TBI diagnosis across all years. In 2023, the rate was 77.6 per 100,000. This was 94.3% higher than among those without a recent diagnosis of a TBI (39.9 per 100,000).

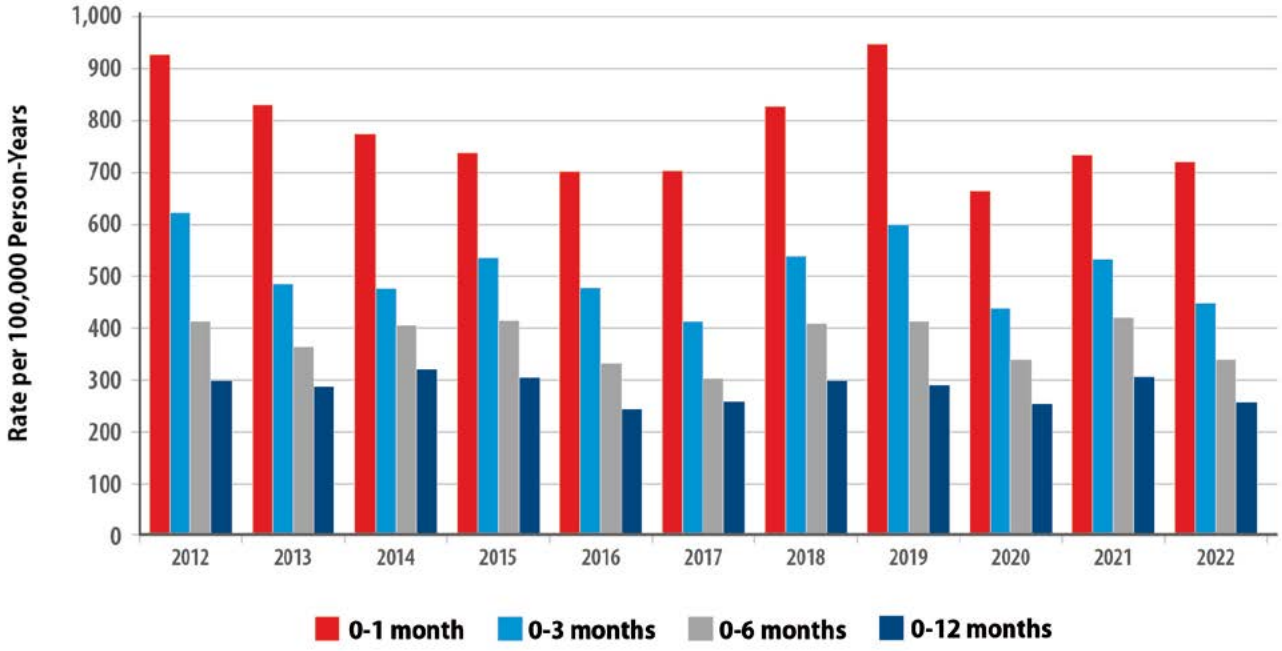
[91] Brenner LA, Ignacio RV, Blow FC. 2011. Suicide and Traumatic Brain Injury Among Individuals Seeking Veterans Health Administration Services. J Head Trauma Rehabil. 26(4):257-264.

[92] Traumatic brain injury diagnosis was assessed in the year of interest or in the prior calendar year. Diagnoses aligned with the definitions reported by Maihofer AX, Chanfreau-Coffinier C, Kellogg MA, VA Million Veteran Program, Merritt VC. 2025. An Evaluation and Comparison of Traumatic Brain Injury Data Sources Within the VA Million Veteran Program: A Descriptive Epidemiological Study. Journal of Psychiatric Research. 187:85-94.

Veterans Crisis Line Use

- Prior work shows that VHA patients with documented contact with the Veterans Crisis Line have elevated suicide risks.[93] Below, Figure 37 presents information on suicide rates in the one, three, six, and 12 months following first documented contact with the Veterans Crisis Line (including by phone, text, or chat) for Veterans who received VHA health care encounters in the prior 24 months.[94] For Veterans in VHA care with Veterans Crisis Line contacts in 2022, the suicide rate was 718.4 per 100,000 in the subsequent 30 days and 254.5 per 100,000 through 12 months.
- The suicide rate in the 30 days following an initial documented Veterans Crisis Line contact in 2022 was 718.4 per 100,000. This was 24.2% lower than for comparably identified Veterans in 2019 (947.3 per 100,000).
- The suicide rate for Veterans in VHA care during the 30 days following initial Veterans Crisis Line contact in 2022 was 2.1% lower than for those in 2021.
- The suicide rate for Veterans in VHA care during the 365 days following initial Veterans Crisis Line contact in 2022 was 16.1% lower than for those in 2021.

Figure 37: Suicide Rate after Veterans Crisis Line Contact, Veterans with VHA Care in Prior 24 Months, by Time Since Contact, 2012-22



[93] Hannemann CM, Katz IR, McCarthy ME, Hughes GJ, McKeon R, McCarthy JF. 2020. Suicide Mortality and Related Behavior Following Calls to the Veterans Crisis Line by Veterans Health Administration Patients. Suicide and Life-Threatening Behavior. 51(3):596-605.

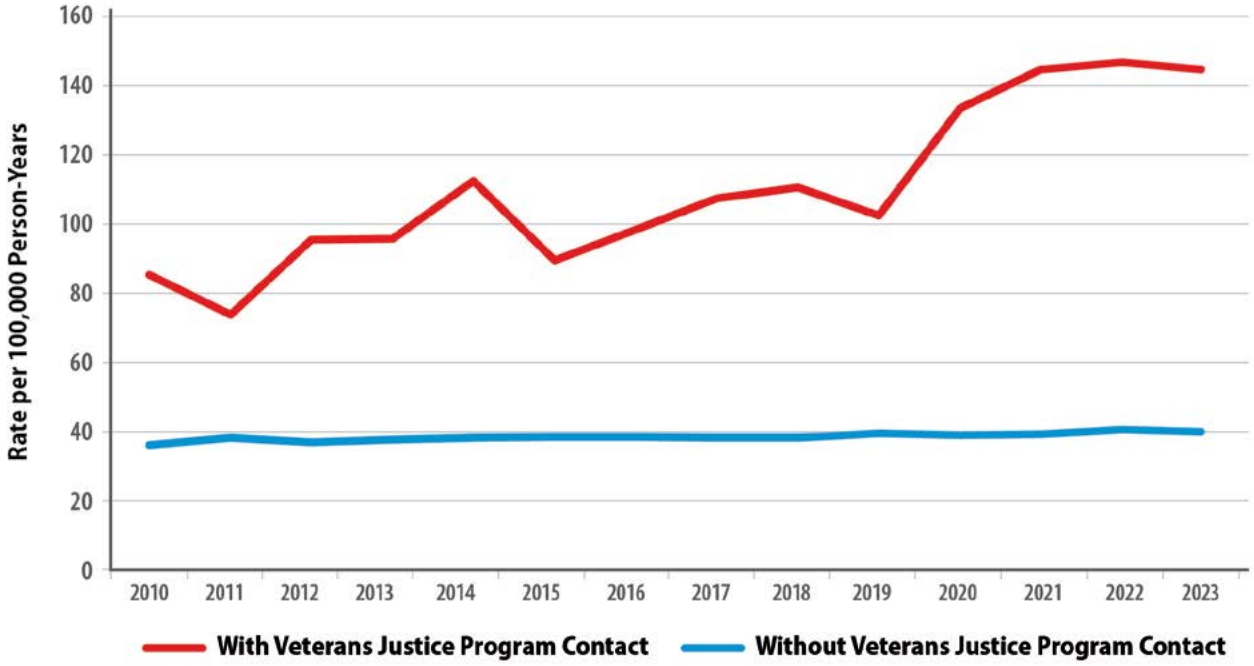
[94] Risk time begins on day following the first Veterans Crisis Line contact date. Analyses exclude individuals who died on that day.

Veterans Justice Outreach Programs

Among Veterans in VHA care, those with legal system involvement are at increased risk of suicide-related behavior.[95] VHA connects with Veterans who are at various points in the legal system through Veterans Justice Programs. These support Veterans in prison through the Health Care for Re-entry Veterans program, and they support Veterans in courts, jails, and law enforcement settings through the Veterans Justice Outreach Program. Figure 38, below, presents information on suicide rates among annual cohorts of Recent Veteran VHA Users who received services through these programs.

- In each year, suicide rates for Recent Veteran VHA Users were elevated among those with Veterans Justice Program services compared to those without such contact. In 2023, the suicide rates for Recent Veteran VHA Users who received Veterans Justice Program services (144.6 per 100,000) was 263.7% higher than for Veterans in VHA care who did not receive these services.

Figure 38: Suicide Rate, Recent Veteran VHA Users, by Receipt of Veterans Justice Program Services, 2010-23[96]



Behavioral Health Autopsy Program Reviews

For Veterans whose suicide deaths are reported to VHA suicide prevention teams,[97] the VA Behavioral Health Autopsy Program (BHAP) gathers information that may help to prevent future suicides. Through BHAP, suicide prevention teams perform standardized reviews of health records to identify factors relevant to Veteran suicides, considering all available information.[98] VHA electronic health record reviews include assessment of clinical diagnoses and conditions (for example, notes regarding pain), life circumstances and psychosocial factors. Findings provide a unique resource for understanding the characteristics and contexts of Veteran suicide deaths among Recent Veteran VHA Users.[99]

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[95] Palframan KM, Blue-Howells J, Clark SC, McCarthy JF. 2020. Veterans Justice Programs: Assessing Population Risks for Suicide Deaths and Attempts. Suicide and Life-Threatening Behavior. 50(4):792-804.

[96] Per outpatient encounters codes 591 (Health Care for Re-entry Veterans) or 592 (Veterans Justice Outreach) or encounters for which "Justice Outreach" was listed as the activity type in the year or the prior year.

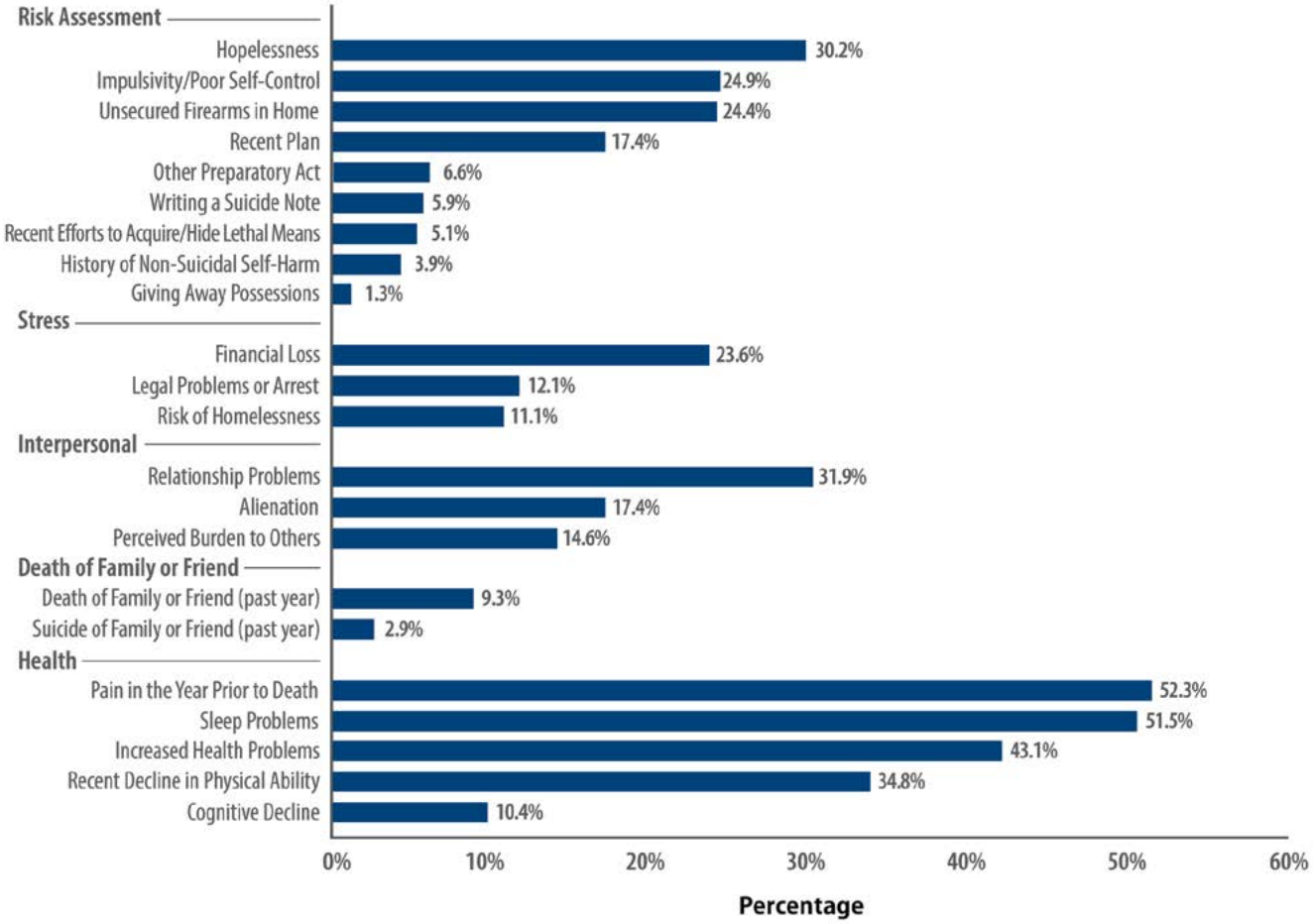
[97] Palframan KM, Szymanski BR, McCarthy JF. 2021. Ascertainment of Patient Suicides by VA Facilities and Associations with Veteran, Clinical, and Suicide Characteristics. American Journal of Public Health. 111(S2):S116-S125.

[98] Sources include health records, coroner and medical examiner reports, death certificate records, reports from law enforcement agencies, media and news outlets, and information shared by family members.

[99] Caution should be exercised when drawing conclusions, as the absence of documentation of a characteristic does not necessarily indicate that the Veteran did not experience the risk factor. It only indicates that no documentation of this risk factor was located within the medical chart or any other available source of information.

Below, Figure 39 presents the prevalence of documented risk factors in the year prior to death among 2,765 Recent Veteran VHA Users whose suicide deaths occurred in 2021-23 and were reported to VHA suicide prevention teams. Results are presented in five domains related to risk assessment, stress, interpersonal factors, death of family or friend, and health. The most frequently identified risk factors were pain (52.3%), sleep problems (51.5%), increased health problems (43.1%), recent declines in physical ability (34.8%), relationship problems (31.9%), hopelessness (30.2%), impulsivity (24.9%), and unsecured firearms in the home (24.4%).

Figure 39: Documented Suicide Risk Factors, Percentage, Recent Veteran VHA Users Who Died by Suicide in 2021-23 and Received BHAP Reviews

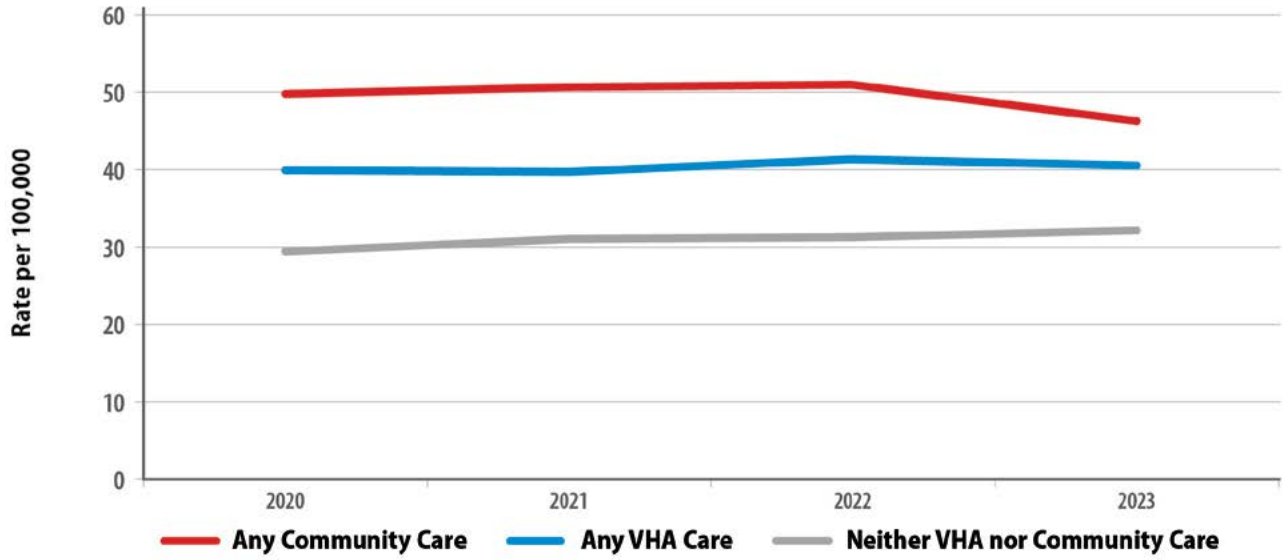


VHA Community Care

Figure 40, below, presents suicide rates among Veterans who received VHA direct care and VA-funded Community Care services, by year, for 2020-23.[100]

- In each year, suicide rates were highest for Veterans who received any Community Care services followed by Veterans who received any VHA direct care, and suicide rates were lowest among Veterans who did not receive either Community Care or VHA direct care.[101]

Figure 40: Suicide Rate, Veterans with Any Community Care and Veterans with Any VHA Care[102] in Year or Prior Year, 2020-23



[100] Services receipt was measured by any care in the calendar year of interest or in the prior year. Veterans who received VA-Funded Community Care services between January 1 of the prior year and July 1 of the current year, and who were alive as of July 1 of the current year, were included as current year Community Care users.

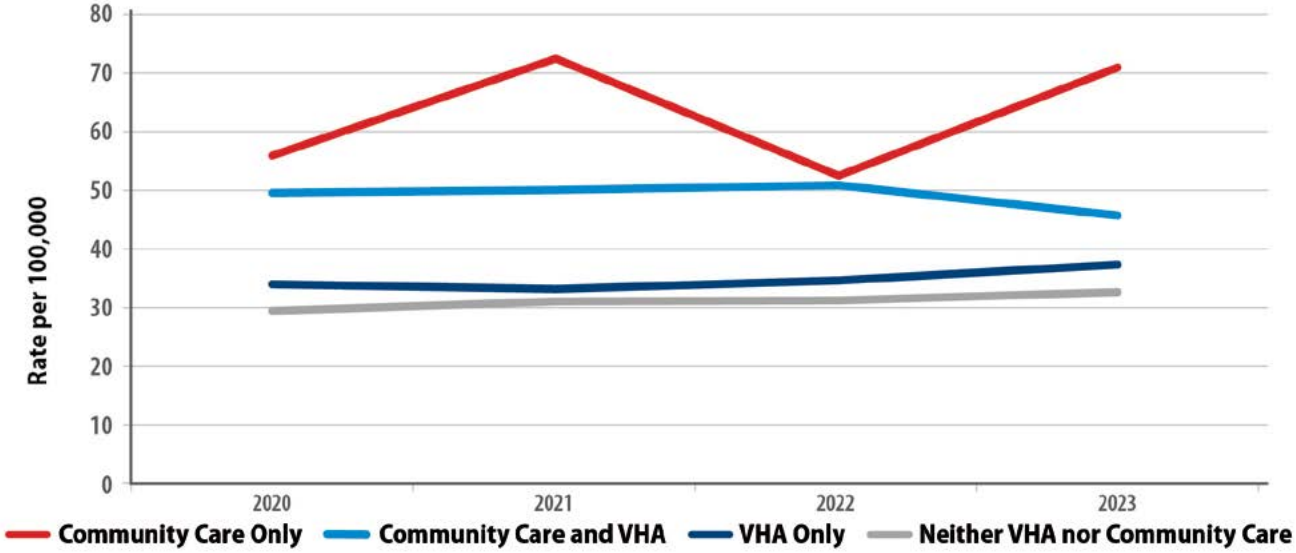
[101] The categories "Any Community Care" and "Any VHA Care" were not mutually exclusive.

[102] Here and throughout this report, VHA care refers to VHA delivered care by VHA providers, also known as VHA direct care. Community Care refers to VA-purchased care. See: https://www.va.gov/COMMUNITYCARE/programs/veterans/CCN-Veterans.asp. (Accessed 1/15/2026.)

Below, Figure 41 presents suicide rates among Veterans by mutually exclusive categories of VHA direct care and VA Community Care services receipt in the year or prior year, for 2020-23.

For all years, among those receiving care through VHA, when comparing those solely receiving VA Community Care services versus those receiving VHA direct care services, Veterans who "received Community Care services only" had higher suicide rates than those who "received VHA direct care alone."

Figure 41: Suicide Rate, Veterans, by Mutually Exclusive Categories of VHA and VA Community Care Services Receipt, by Year, 2020-23



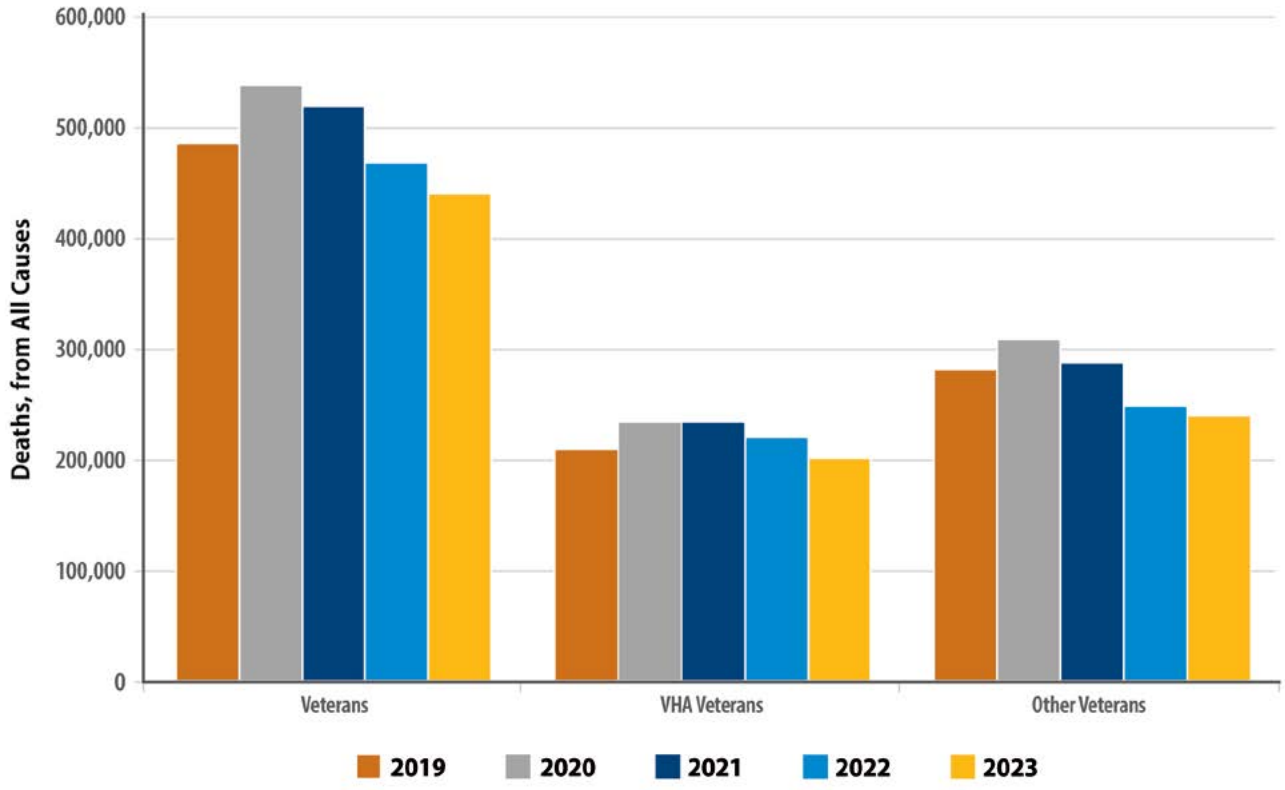
For additional information, see the "2018-23 National Veteran All-Cause Mortality Data Appendix" that accompanies this report, which includes descriptive data regarding Veterans in 2023 who received VHA and/or VA-funded Community Care in 2022-23.

Section C: Suicide as a Leading Cause of Veteran Mortality

All-Cause Mortality

Figure 42, below, shows the number of Veteran deaths from all causes, 2019-23.

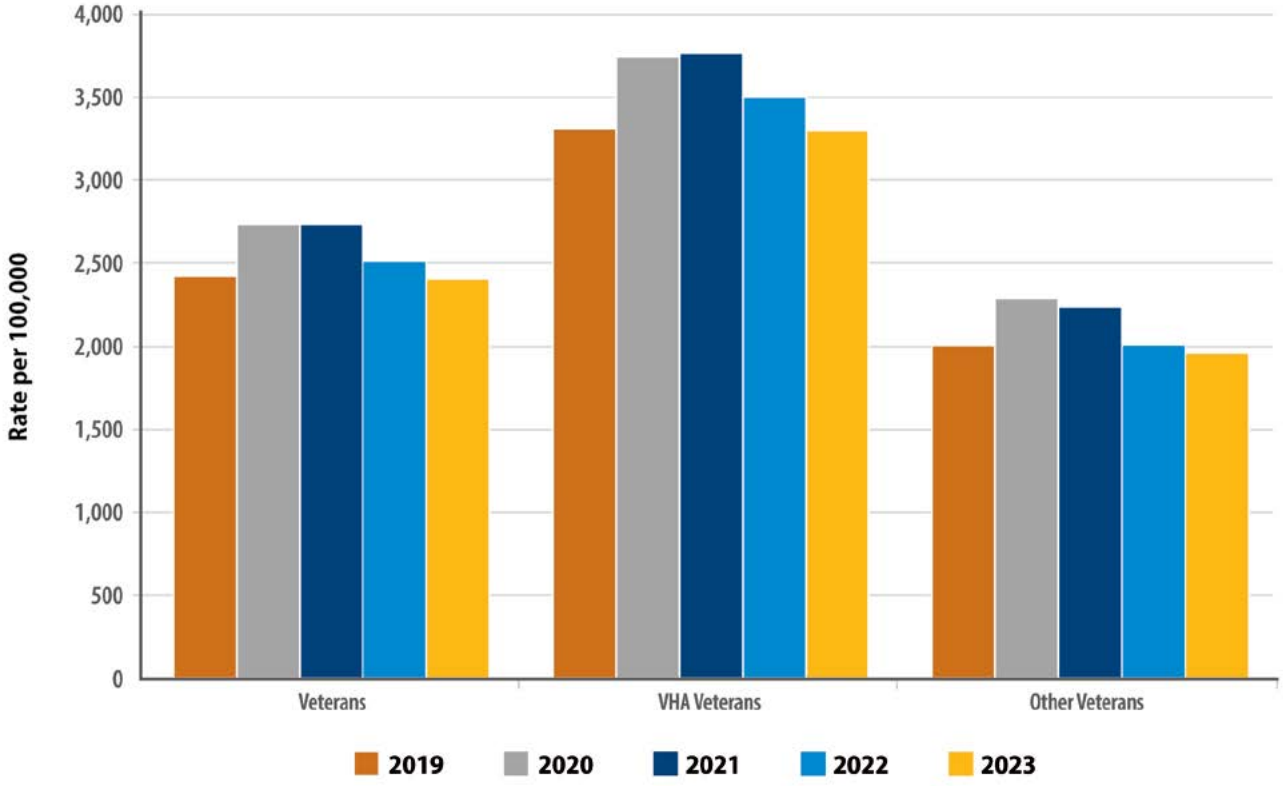
Figure 42: Deaths, Veterans, Overall and by VHA Engagement, 2019-23



- For the entire Veteran population, the annual number of deaths from all causes was highest in 2020 (537,386) and lowest in 2023 (438,260).
    - Among Recent Veteran VHA Users, total annual deaths were highest in 2021 (233,231) and lowest in 2023 (202,160).
    - For Veterans without VHA care in the year or prior year, total deaths were highest in 2020 (305,326) and lowest in 2023 (236,100).
- In 2023, suicide deaths represented 1.46% of all Veteran deaths, 1.24% of deaths among Recent Veteran VHA Users, and 1.65% of deaths among Other Veterans.

Below, Figure 43 shows Veteran all-cause mortality rates, 2019-2023.[103] All-cause mortality rates were elevated in 2020 and 2021, the initial years of the COVID-19 pandemic, and rates fell in 2022 and 2023.

Figure 43: All-Cause Mortality Rate, Veterans, Overall and by VHA Engagement, 2019-23



- Consistent with reports of increased morbidity among Veterans who seek VHA care, all-cause mortality was greater for Recent Veteran VHA Users than for Other Veterans.[104]

Leading Causes of Death

This section provides information on suicide as a leading cause of death among Veterans in 2023. For each leading cause, we also report age-adjusted cause-specific mortality rates for 2021, 2022, and 2023.[105]

[103] Understanding patterns of all-cause mortality over this period is helpful to understanding trends in suicide risk factors, including medical morbidity and stressors and patterns of risk across Veteran populations.

[104] These findings highlight the increased burdens of morbidity and mortality among Veterans during the pandemic years and the greater morbidity and mortality among Veterans who seek care from the VA health system.

[105] For more detailed information, please see the "2018 to 2023 National Veteran All-Cause Mortality Data Appendix," which accompanies this report.

Veterans, Overall

Below, Table 9 presents the top 15 leading causes of death among Veterans in 2023, ranked by the number of deaths.[106] Suicide was the 12th-leading cause of Veteran mortality.

Table 9: Leading Causes of Death, Veterans, by Number of Deaths, 2023

	Cause of Death	Number	Percent of Deaths
1	Heart Disease	110,848	25.3
2	Cancer	92,166	21.0
3	Chronic Lower Respiratory Diseases	23,834	5.4
4	Stroke	21,455	4.9
5	Unintentional Injuries	21,015	4.8
6	Diabetes	14,052	3.2
7	Alzheimer's Disease	13,684	3.1
8	COVID-19	8,493	1.9
9	Parkinson's Disease	8,258	1.9
10	Kidney Disease	8,015	1.8
11	Influenza and Pneumonia	6,422	1.5
12	Suicide	6,398	1.5
13	Chronic Liver Disease and Cirrhosis	5,930	1.4
14	Septicemia	5,638	1.3
15	Hypertension	5,592	1.3

Supplemental information regarding Veteran cause-specific mortality and leading causes of death is available in the "2018-23 National Veteran All-Cause Mortality Data Appendix" that accompanies this report. For example, these results document that:

- Suicide was the second-leading cause of death among female Veterans aged 18-34 and among male Veterans aged 18-44 Suicide was the 11th-leading cause of mortality among Veterans in 2018 and 2019, then fell to 13th in 2020 and 2021, and then rose to be the 12th-leading cause in 2022 and 2023.
- Among Recent Veteran VHA Users in 2023, suicide was the 15th-leading cause of death. For this population, suicide was the 13th-leading cause in 2018 and 2019, then fell to 13th in 2020 and 2021, then fell to be the 15th-leading cause of death in each year, 2020-23.
- Among Other Veterans in 2023, suicide was the 11th-leading cause of death.
- While sharing the same top-two leading causes of death (heart disease and cancer), Recent Veteran VHA Users and Other Veterans differed in the ranking of other leading causes of death.
- Despite suicide having a lower rank among leading causes for Recent Veteran VHA Users than for Other Veterans, Recent Veteran VHA Users had a higher age-adjusted suicide mortality rate.
- For Veterans who were not Recent Veteran VHA Users, that is Other Veterans, suicide was the 11th-leading cause in 2018 and 2019, the 12th-leading cause in 2020, and the 11th-leading cause in each year, 2021-2023.

[106] 69,237 deaths were from causes that were not ranked (15.8% of all Veteran deaths in 2023).

Years of Potential Life Lost

A measure of the relative impact of different causes of death is their contributions to premature mortality, measured in terms of Years of Potential Life Lost (YPLL).[107] Suicide was the 4th-leading cause of premature mortality among Veterans in 2023.[108]

How to Refer to This Report

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

U.S. Department of Veterans Affairs, Office of Suicide Prevention. 2025 National Veteran Suicide Prevention Annual Report. 2025. Retrieved {date} from <<location>>.

[107] Here we apply the YPLL measure calculated consistent with CDC reporting. Of note, YPLLs for individuals who died before age 75 are calculated as the difference between 75 and age at death, and for individuals who die at 75 or older YPLLs are set to zero (1,604 Veteran suicide deaths in 2023.) See Greville, TN. 1948. Comments on Mary Dempsey's article on "Decline in Tuberculosis: The Death Rate Fails to Tell the Entire Story." American Review of Tuberculosis, 57(4), 417-419. An alternative form of YPLL, indicates that when age-specific life expectancies at the time of death are applied for deaths in 2023 for Veterans age 18 to 115, then suicide would be the 7th-leading cause of years of potential life lost. See: https://www.cdc.gov/mmwr/preview/mmwrhtml/00001773.htm. (Accessed 1/15/2026).

[108] The average number of years of premature mortality per Veteran suicide increased from 17.5 in 2022 to 17.9 in 2023. In 2023, the 6,398 Veteran suicide deaths resulted in an estimated 114,711 years of potential life lost, 7.7% of all YPLL for Veterans who died in 2023.

Appendix: Methods Summary

Overview

This document provides background regarding the methods used by the U.S. Department of Veterans Affairs (VA) Office of Suicide Prevention (OSP) to assess suicide mortality among Veterans.

This work is conducted by the OSP Suicide Prevention Program Data and Surveillance Team, which includes staff from the Center of Excellence for Suicide Prevention and the Serious Mental Illness Treatment Resource and Evaluation Center. Suicide surveillance data presented in this report results from ongoing coordination with staff at the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC) National Death Index (NDI).

This document summarizes VA mortality surveillance processes used for creating this report, including conduct of joint VA/DoD annual searches of death certificate data from the NDI, data processing, and determination of Veteran status for decedent.

The report includes Veteran mortality data from all 50 states and the District of Columbia. Accompanying the report are suicide data sheets for each state, the District of Columbia, Puerto Rico, and U.S. Island territories.

Annual VA/DoD NDI Search: Building Search List

VA analysts coordinate with staff at the DoD Defense Manpower Data Center (DMDC) to compile a list of identifiers for all known Veterans, current and former Service members, and other VA-engaged persons. To develop this list, data is combined from multiple sources, including Veterans Health Administration (VHA) clinical, administrative, and enrollment records; the United States Veterans Eligibility Trends and Statistics (USVETS) database maintained by the VA Office of Enterprise Integration; and service-era rosters and registry files maintained by the VA Health Outcomes Military Exposures (HOME) program. To this data, DMDC staff adds records of all current and former Service members from DoD personnel files.

National Death Index

The combined list of identifiers is sent to CDC NDI staff to be used to identify possible matching death certificates. Data available from the NDI includes reports of mortality from vital statistics systems in all 50 U.S. states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Deaths from Guam, American Samoa, and the Northern Marianas are included as available. CDC conducts checks and validation of these records. Additionally, the NDI includes some records of out-of-country deaths of U.S. military personnel; no information is available on the out-of-country deaths of civilian U.S. citizens.

Identifying Death Records

The NDI returns all submitted records to VA/DoD. Match records are returned with a score indicating the probability that a given set of provided identifiers matched to a death certificate present in the NDI. Following receipt and initial review of the results returned by the NDI, analysts use an algorithm to identify what is considered true match death certificate data.

- Death certificate data were determined to be matches if they met any of the following five criteria:
    - nine digits of Social Security Number (SSN), sex, and two or more parts of birth date match;
    - seven or more digits of SSN, sex, full birth date, first name, last name, and middle initial match;
    - seven or more digits of SSN, sex, first name, last name, and middle initial match, and the death date matches a confirmatory source[109];

[109] Confirmatory date of death sources include the VA Death Ascertainment File, the Social Security Death Master File, and the VA Vital Status File.

- nine digits of SSN, full birth date, first name, and last name match; or
- nine digits of SSN, first name, and last name match, and the death date matches a confirmatory source.

Decedent data regarding age or sex may be missing where: (1) information was missing or inconsistent across sources, and (2) where the search record matched with NDI data on other criteria, per above.

Matching results returned from the NDI, although derived from state death certificate data, do not include any added demographic information. Rather, they indicate whether select identifiers (for example, SSN, name, birth date, sex) that were submitted to the NDI for the search corresponded with those of a potentially matching NDI death certificate record. Results of VA/DoD searches of the NDI are maintained in the VA/DoD Mortality Data Repository.

Suicide deaths are identified based on the underlying cause of death recorded on the death certificate per the NDI data. Suicides include all deaths with International Classification of Diseases, Tenth Revision (ICD-10) underlying cause-of-death codes X60-X84, U03, and Y87.0. Method of injury for suicide deaths are identified based on ICD-10 codes: firearm (X72-X74), suffocation (X70), poisoning (X60-X69), and all other (U03, X71, X75-X84, Y87.0).

Veteran Status

VA analysts use a data-defined approach to best identify a decedent's Veteran status at their time of death, relying on the most current data available from DMDC and from VA. Specifically, for this report and based on the available data, Veterans are identified as persons who served on Federal active duty, other than for training, and were not currently serving at the time of their death. For all military Service members with service after 1974, when the DoD electronic personnel data begins, DMDC provides VA with data indicating whether a given decedent has a personnel record and was federally activated and whether the individual died while still in service. DMDC information is used to distinguish Veterans from those who were currently serving at their time of death or without indications of having been federally activated other than for training.

For decedents not identified in DMDC electronic personnel data sources (for example, military service prior to 1974), VA data, including USVETS, administrative patient records, service-era rosters, and the VA/DoD Identity Repository (VADIR), is used to determine if individuals were Veterans.

Additional Notes on Death Certificate Data

State death certificates include "ever served in the U.S. armed forces." This has a broader definition than the identification of Veteran status per this report. "Ever served in the U.S. armed forces" would include decedents who were never federally activated other than for training and those who were current Service members at their time of death. In addition to identifying a different population, this information recorded on the state death certificates can be unreliable.[110] Regardless, CDC does not make this information available through the NDI and VA does not have access to this data.

At present, there is no comprehensive roster of all Veterans, particularly those who served prior to the implementation of DoD's electronic personnel data in the 1970s. The largest single data source, the USVETS database, acknowledges that identification of Veterans over age 65, estimated to refer to those born in the 1950s or earlier, is incomplete. For this report, we rely on a broad combination of data sources, including available DoD personnel data, USVETS, and HOME service-era rosters, to identify the entire Veteran population. Individual data sources are updated over time, and each annual VA suicide report includes the most current available data. Consequently, annual report information is updated and enhanced with each new report. This improves ongoing Veteran suicide surveillance.

The NDI is limited to deaths occurring in the 50 U.S. states, the District of Columbia, and Puerto Rico from 1979 onward. Deaths in other U.S. territories are included as available but are not considered complete for all years. U.S. citizen civilian deaths outside the United States and territories or any deaths prior to 1979 are not included in the NDI.

[110] Hoffmire CA, Piegari RI, Bossarte RM. 2013. Misclassification of Veteran Status on Washington State Death Certificates for Suicides from 1999 to 2008. Annals of Epidemiology. 23(5):298-300.

Population Estimates

Overall Veteran population estimates were derived from the Veteran Population Projection Model 2023 (VetPop2023), which is VA's official Veteran population projection.[111] VetPop2023 includes information from the American Community Survey (ACS, US Census Bureau)[112] and from VA and DoD sources.[113,114] VetPop2023 blends information from VA and DoD person-level data with ACS estimates to account for limitations in the administrative data on older Veterans. VetPop2023 provides estimates for the Veteran population by year, state and other characteristics.[115]

National Center for Health Statistics (NCHS) population estimates[116] were used for the general U.S. adult population.

The non-Veteran adult population was estimated by subtracting Veterans from the general U.S. adult population.

Mortality Rate Calculations

Unadjusted suicide rates are calculated as the number of suicide deaths in the year divided by the "population at risk." For the Veteran population, risk time was assessed using the mid-year (July 1) population estimate derived from VetPop2023.[117] For Veteran subpopulations where data enabled calculation of time at risk for suicide for each individual (subpopulations of Recent Veteran VHA Users and Veterans with separations from active military service in the prior 12 months), rates are presented as "per 100,000 person-years." For analyses stratified by age or sex, analyses were specific to decedents with non-missing age or sex data.

Calculating adjusted rates (for example, age-adjusted) enables rate comparisons while adjusting for population demographic differences. Per standard practice, age-adjusted rates reported are directly adjusted, using the 2000 U.S. projected population as the standard.[118]

2025 Updates

The 2025 report incorporates several areas of new or enhanced content, including:

- The algorithm for identifying death certificates was updated to include additional confirmatory data sources and to add additional match acceptance criteria.
- Annual Veteran population estimates, used for 2001 to 2023 rate calculations, are based on the estimated July 1 population of the year, now derived from the most recently updated VetPop2023. Compared to the estimates from VetPop2020, the overall annual population estimates increased by 0.6% on average (range: 0.3%, 1.3%).
- Use of exact risk time for calculating suicide rates among Recent Veteran VHA Users with mental health and substance use disorder diagnoses.

The present report represents the most complete, current assessment of Veteran suicide mortality, and findings from this report supersede information reported previously.

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[111] Veteran Population Projection Model 2023 (VetPop2023), Predictive Analytics and Actuary, Office of Enterprise Integration, Department of Veterans Affairs. https://www.va.gov/vetdata/veteran_population.asp. (Accessed 1/15/2026.)

[112] U.S. Census Bureau. 2022. American Community Survey. Suitland, MD.

[113] ACS is an ongoing annual survey administered by the Census Bureau, based on a sample of approximately 3 million households per year.

[114] See footnote 112.

[115] Department of Veterans Affairs. VetPop2023: A Brief Description. https://www.va.gov/VETDATA/docs/Demographics/New_Vetpop_Model/VetPop2023_ABrief_Description.pdf (Accessed 1/15/2026.)

[116] Centers for Disease Control and Prevention, National Center for Health Statistics, Single-Race Population Estimates, United States, 2022. July 1 resident population by state, age, sex, single-race, and Hispanic origin on CDC WONDER online database. Vintage 2022 estimates released by U.S. Census Bureau on June 22, 2023. wonder.cdc.gov/single-race-single-year-v2022.html. (Accessed 1/14/2026.)

[117] Linearly interpolated estimates from VetPop2023 were used in calculating rates for the Veteran population. These estimates were calculated to reflect the Veteran population estimate as of July 1st. The interpolated July 1st Veteran population estimates were generated by calculating the population difference between year of interest and prior year estimates on September 30th provided in VetPop and multiplying by an adjustment factor for the time difference between July 1st and September 30th.

[118] Klein RJ, Schoenborn CA. Age Adjustment Using the 2000 Projected U.S. Population. Healthy People Statistical Notes, No. 20. Hyattsville, Maryland: National Center for Health Statistics. January 2001. The report includes age-adjusted rates stratified by sex. Age- and sex-adjusted rates, standardized to the U.S. adult population of 2000, are included in the national data appendix for the purpose of comparison to prior reporting.

2024 Updates

The 2024 report incorporated several areas of new or enhanced content, including assessment of suicide rates for Veterans with VHA diagnoses of attention-deficit hyperactivity disorder, cancer, COVID-19 infection, nicotine use, and menopausal hormone therapy; with VHA documented non-fatal suicide attempts and behavioral patient record flags; with positive screening assessments for military sexual trauma; and with documented contacts with the Veterans Crisis Line. For recipients of VA-funded Community Care, new content included population demographic, clinical, and health care utilization indicators. New content also included suicide rates following military separations for Veterans with Defense Health Agency diagnoses indicating suicide attempts, suicidal ideation, mental health conditions, or substance use disorders.

2023 Updates

The 2023 report incorporated several areas of new or enhanced content, including:

1. Annual Veteran population estimates, used for 2001-2021 rate calculations, were based on the estimated July 1st population of the year, derived from the Veteran Population Projection Model 2020 (VetPop2020). Compared to the estimates from VetPop2018, the overall population estimates increased by 0.06% on average (range: -0.7, +0.3).
2. Information regarding suicide decedents and suicide rates among Veteran subpopulations as defined by engagement with the VHA and the Veterans Benefits Administration (VBA). VHA delivers health services for Veterans and VBA supports Veterans in five areas of benefits and entitlements: Compensation and Pension; Education; Home Loan Guaranty; Insurance; and Veteran Readiness and Employment.
3. Expanded reporting on Veteran all-cause mortality to include years of potential life lost (YPLL) and stratified findings by recent VHA use status to further contextualize Veteran suicide mortality among the leading causes of death for Veterans.
4. Added new information regarding Recent Veteran VHA Users with indications of homelessness or contact with Veterans Justice Programs. Also, for Recent Veteran VHA Users whose suicide deaths were reported to VHA Suicide Prevention teams, the report includes information on potential suicide risk factors, per chart reviews conducted as part of VA's Behavioral Health Autopsy Program.

2022 Updates

The 2022 report incorporated several areas of new or enhanced content, including:

1. Information regarding suicide among Veteran subpopulations as defined by engagement with the VHA and the Veterans Benefits Administration (VBA). VHA delivers health services for Veterans and VBA supports Veterans in five areas of benefits and entitlements: Compensation and Pension; Education; Home Loan Guaranty; Insurance; and Veteran Readiness and Employment.
2. The evaluation of potential pandemic effects on Veteran suicide by comparing patterns of Veteran suicide and COVID mortality, and for the first time, contextualizes Veteran suicide mortality among the leading causes of death for Veterans.
3. The addition of Veteran suicide data by race and ethnicity to the national and state appendix files.

Glossary

Term	Brief Explanation
adjusted rate	Adjusted rates translate the unadjusted rate for a population into a measure of what the rate would be if the compared populations had the same distributions of the demographic factors that are adjusted for (for example, age).
Department of Veterans Affairs (VA)	A Federal cabinet-level executive department, with a mission of providing benefits and other services to Veterans and their families. VA includes three organizations: Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration.
Lethal Means	Lethal means describes the method by which a person dies by suicide, categorized as firearm, poisoning (including intentional overdose), suffocation, and other means (including cutting, drowning, falling, fire, motor vehicle, being struck, or an unspecified injury).
Other Veterans	In this report, annual cohorts of "Other Veterans" are defined as Veterans who were alive as of the start of the year of interest and who were not categorized as "Recent Veteran VHA Users" that year.
person-years	"Person-years" in this report refers to the cumulative amount of time (expressed in years) at risk for the specified outcome of interest in a population during a defined period, summing time contributed by each person, in units of years.
rate	A measure of how commonly something occurs in a population, with time explicitly included in the denominator. A rate is calculated as the number of events divided by the cumulative person-years at risk for the event in the population.
rate ratio	A method of comparing rates in two populations. The rate in the first population is divided by the rate in the second population. If the ratio is greater than 1.0, that means the rate is greater in the first population. If the rate is exactly 1.0, that means the rates are the same. If the ratio is less than 1.0, that means the rate is greater in the second population.
Recent Veteran VHA Users	In this report, "Recent Veteran VHA Users" are defined as Veterans who were alive at the start of the year of interest and received direct VHA health care that year or in the prior year.
standardized mortality ratio (SMR)	A method of comparing mortality in two populations that controls for demographic differences, calculated as the ratio of the number of deaths observed in a population to the number of deaths that would be expected in the population if the population experienced the same rates as those of a comparison population. An SMR greater than 1.0 indicates more deaths than expected. An SMR less than 1.0 indicates fewer deaths than expected.
suicide	Death caused by self-injury or self-harm, with the intent to die. In this report, suicide deaths are identified based on the underlying cause of death indicated on the death certificate.
suppression	To protect privacy, counts or rates of overdose mortality are suppressed (that is, not reported) when based on fewer than 10 deaths.
Veteran	For this report, Veterans are defined as people who served on Federal military active duty, other than for training, and were not currently serving at the time of their death.