



Minnesota Department of Veterans Affairs Veteran Suicide Prevention Plan

February 2026

Dedication

This plan is dedicated to the Veterans whose lives have been lost to suicide, those who are experiencing suicidal thoughts or distress, and the friends, loved ones and communities who have been impacted. The primary goals of this plan are to both align with the Minnesota State Suicide Prevention Plan and articulate a plan that focuses specifically on preventing Minnesota Veterans from having suicidal experiences and improving the lives of those who are struggling, so they know they are not alone, help is available, healing is possible and there are pathways to care.

Contents

Dedication	2
Contents	3
Note from the MDVA Commissioner	4
Legislative Direction	5
Overview of the Veteran Suicide Prevention Plan	6
Statement of Recognition.....	7
Impact of Veteran Suicide in Minnesota	8
Figure 1. Minnesota Veteran Suicides by Year	8
Figure 2. Veteran Suicide Mechanism of Injury	9
Figure 3. Characteristics of Veteran Suicide Deaths in Minnesota	10
MDVA Infrastructure Improvement Plan	12
MDVA Veteran Suicide Prevention Plan	14
Goal 1. Strengthen Veteran Suicide Prevention Infrastructure & Cross-Sector Leadership.	14
Goal 2. Promote Protective Factors, Belonging & Stability for Minnesota Veterans.....	16
Goal 3. Improve Early Identification & Veteran-Informed Response Across Systems.....	17
Goal 4. Strengthen Veteran Access, Navigation & Continuity of Care	17
Goal 5. Support Veterans, Families & Communities Impacted by Suicide.....	18
Goal 6. Advance Data-Driven Decision Making and System Improvement	19
Implementation of MDVA Plan	20
Action Plan.....	20
Evaluation Plan	21
Appendices: Wilder Research.....	22
Appendix A: Legislation	22
Appendix B: Logic Model	23
Appendix C: Wilder Foundation Report	31
Key findings	31
SMVF generally feel supported	31
Recommendations	31
Detailed findings.....	33



MINNESOTA DEPARTMENT OF VETERANS AFFAIRS
Office of the Commissioner

20 W 12th St, St Paul, MN 55155
Phone: 651-757-1582 • Email: Brad.Lindsay@state.mn.us
MinnesotaVeteran.org • 1-888-LinkVet

February 15, 2026

MN Laws, Chapter 30, directed the Minnesota Department of Veterans Affairs (MDVA) to create a comprehensive Veteran Suicide Prevention Plan. Veteran suicide awareness and prevention have been a longstanding priority for the Agency. We are grateful for the Legislature's support of our ongoing efforts and appreciate the opportunity to share in detail our updated plans to address this tragedy.

On average, Minnesota loses 100 Veterans a year to suicide. As MDVA strives to support the mental health and well-being of our Veterans, we have collaborated with other organizations to identify risk factors and create an innovative, cooperative way to reverse this trend.

Veteran suicide is often the result of a combination of factors, including mental or physical illness, alcohol or drug abuse, painful loss, exposure to violence, social isolation and access to lethal means. Veterans are at a higher risk for suicide than the civilian population.

Recent research shows that a renewed effort is needed to increase awareness and prevent future Veteran suicide. Our plan details a multi-faceted approach to engage the broader community while addressing root causes of mental health challenges through upstream approaches. We are confident that we can make a difference. We must make a difference.

Losing another Veteran to suicide is not acceptable. With your ongoing support, we will expand our efforts across the state to improve the mental health and wellbeing of Minnesota Veterans.

Respectfully,


Bradley S. Lindsay
Commissioner

Serving Minnesota Veterans and Their Families

MDVA is a Veteran-friendly, equal opportunity and affirmative action employer and service provider. This document can be made available in alternate formats. Contact MDVA's Diversity, Equity and Inclusion Line at 612-548-5961 or your preferred telecommunications relay service.

Legislative Direction

This report and project are intended to meet the following mandate from Minnesota 2025 Regular Session, Chapter 30, Article 1, Section 3, Subdivision 3(d):

The commissioner shall develop a comprehensive plan to prevent Minnesota Veterans from dying by suicide. The plan must include:

1. Community integration and collaboration strategy that brings together Veteran-serving organizations to provide Veterans with coordinated services and supports, including services and supports related to employment, health, housing, benefits, recreation, education and social connections;
2. Strategies to promote a sense of belonging and purpose among Veterans by connecting Veterans with each other, with civilians, and with Veteran communities through a range of activities including physical activity, community service and disaster response efforts;
3. Implementation strategy that identifies opportunities to coordinate existing efforts with federal, state, local and Tribal governments and nongovernmental entities and includes a description of the policy changes and resources that are required to prevent Veteran suicides.

The commissioner must submit a report containing the required plan to the chairs and ranking minority members of the legislative committees with jurisdiction over Veterans affairs policy and finance by February 15, 2026.

Overview of the Veteran Suicide Prevention Plan

The MDVA Veteran Suicide Prevention Plan builds on efforts that began in 2019 when MDVA first approached the Legislature requesting support to address this tragedy. The work began with membership in the “Governor’s Challenge” to eliminate Veteran death by suicide, a collaborative effort with the U.S. Department of Veterans Affairs (VA), Veterans Health Administration (VHA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA partners with the U.S. Department of Veterans Affairs (VA) to bring the “Governor’s Challenge to Prevent Suicide Among Service Members, Veterans, and their Families” to states and communities across the nation.

Since that time, MDVA has strengthened relationships with numerous organizations providing Veteran mental health and suicide prevention services. We have also distributed thousands of gunlocks in an effort to remove quick access to this commonly used lethal mean and conducted hundreds of training classes such as Mental Health First Aid and Applied Suicide Intervention Skills Training.

This updated and expanded plan establishes a coordinated, statewide approach to strengthening prevention, intervention, crisis response and postvention for Veterans and their families. The plan is grounded in evidence-based practices and aligned with the VA / SAMHSA Governor’s Challenge framework, recognizing that suicide prevention requires sustained, cross-sector collaboration and strong public health infrastructure. The plan is grounded in Veteran-centered practices and is intentionally aligned with the Minnesota State Suicide Prevention Plan and the VA National Veteran Suicide Prevention Plan, ensuring consistency with statewide public health priorities and national Veteran suicide prevention strategies.

This plan is designed to guide the work of MDVA by providing a shared roadmap for policy, program development, partnerships and resource alignment across state, local, Tribal, federal and community-based Veteran-serving organizations. While MDVA serves as the convener and backbone organization, the plan supports collective action among partners who influence Veteran well-being across health care, housing, employment, education, benefits and social connection.

The plan also incorporates recommendations from Wilder Research and reflects legislative direction and guidance, translating research findings and statutory intent into actionable strategies. These recommendations put the plan’s emphasis on collaboration, system integration, equity and data-informed decision making.

The infrastructure components of the plan focus on strengthening the systems that make prevention possible. This includes improving coordination among partners, enhancing Veteran navigation across services, organizational capacity and strengthening

data sharing and analytic capabilities. Together, these elements ensure that the Veteran experience is seamless, timely and Veteran centered rather than fragmented or duplicative service.

The goals section translates this infrastructure into action by targeting key drivers of suicide prevention. These goals emphasize strengthening protective factors and connectedness. Improving early identification of suicide risk; expanding equitable access to culturally responsive, evidence-based services; strengthening postvention supports for Veterans, families and communities affected by suicide; and advancing data collection and use to better understand risk, disparities and system performance.

Progress will be measured through an integrated evaluation and continuous quality improvement approach. MDVA will use performance measures, partner reporting and available state and federal data to track implementation, outcomes and gaps. Findings will be used to inform course corrections, guide resource allocation and support transparency and accountability ensuring the plan remains responsive to Veteran needs and evolving best practices over time.

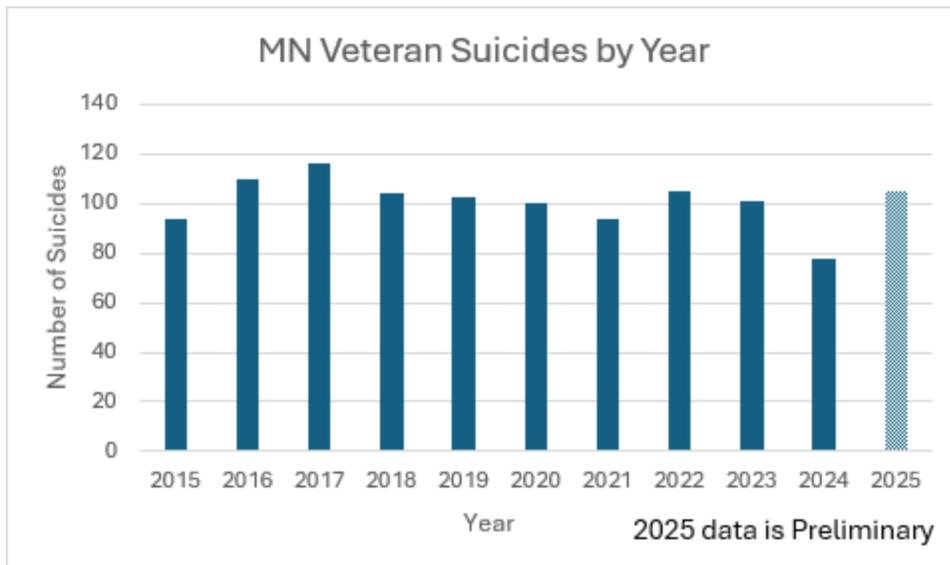
Statement of Recognition

This plan aligns with state and national suicide prevention priorities, including the Minnesota State Suicide Prevention Plan, the VA/SAMHSA Governor’s Challenge, and the VA National Suicide Prevention Strategy, and incorporates Wilder Research findings specific to Minnesota Veterans. Operating within a four-year strategic framework (2026–2029), the plan is implemented through annual action plans and ongoing collaboration with the Minnesota Department of Health (MDH), ensuring continuous refinement, accountability, and long-term commitment to Veteran wellness.

Impact of Veteran Suicide in Minnesota

Minnesota loses approximately 100 Veterans to suicide each year. Firearms continue to be the leading means of suicide related deaths among Minnesota Veterans. Over the past decade, Veterans aged 55 and older have consistently represented the highest number of suicide deaths annually. Consistent with national trends, individuals who have served in the military are at a higher risk of dying by suicide compared to those who have not served.

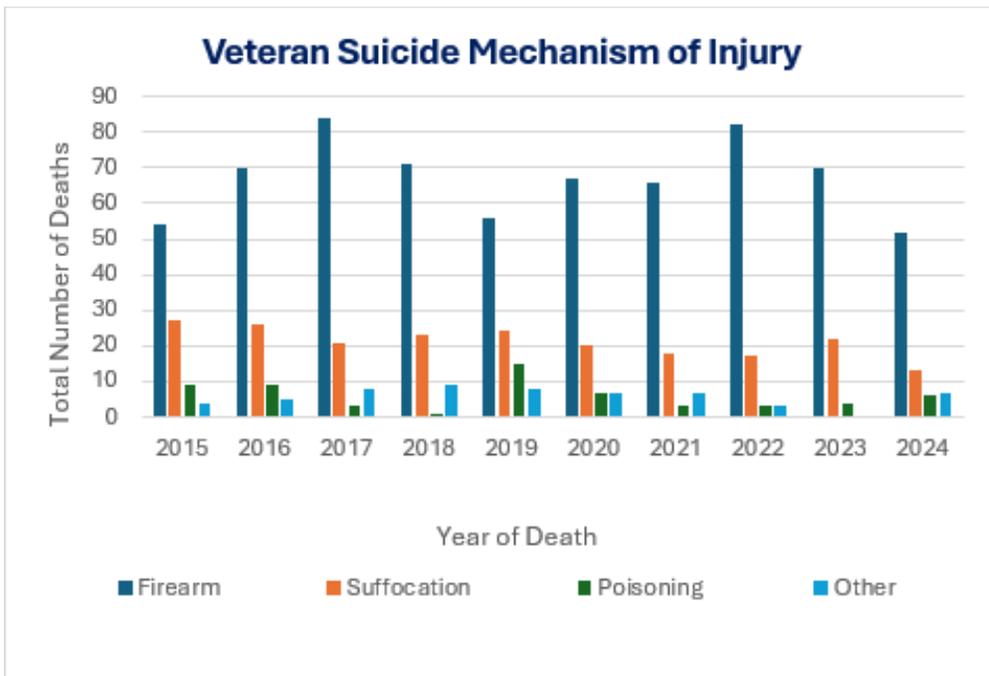
Figure 1. Minnesota Veteran Suicides by Year



Despite focused prevention and outreach efforts by MDVA, suicide deaths among Minnesota Veterans continue to be influenced by a wide range of complex and interrelated factors. Over the past five years, broader societal disruptions such as the COVID-19 pandemic have compounded risk through temporary closures of treatment centers, reduced access to support services, employment instability, and increased substance use, including intentional overdoses. Although the overall Minnesota Veteran population has declined, the number of Veteran suicide deaths has remained at approximately 100 per year. Veterans often face a combination of individual, military, and societal risk factors, including higher rates of depression, anxiety, post-traumatic stress disorder, substance use disorders, prior suicide attempts, sleep disturbances, emotional regulation challenges, chronic pain, and traumatic brain injury. Military-specific stressors such as military sexual trauma, combat exposure, moral injury, and the loss of military identity, structure, or sense of purpose may further elevate suicide risk within this population.

Protective factors play a critical role in reducing suicide risk and supporting recovery. Past MDVA suicide prevention efforts include strengthening family and peer connections, fostering community belonging, promoting lethal means safety, enhancing crisis response and navigation through LinkVet, and expanding access to timely, culturally responsive mental and clinical health care. While we believe these efforts have raised awareness, we have yet to achieve a long-term decrease in the number of Veteran deaths by suicide.

Figure 2. Veteran Suicide Mechanism of Injury



This figure illustrates the mechanism of injury in Veteran suicide deaths in Minnesota from 2015–2024. Across all years shown, firearms are consistently the leading mechanism, accounting for most suicide deaths among Veterans. While the total number of deaths fluctuates year by year, the overall pattern remains stable, with firearm-related deaths far exceeding other mechanisms.

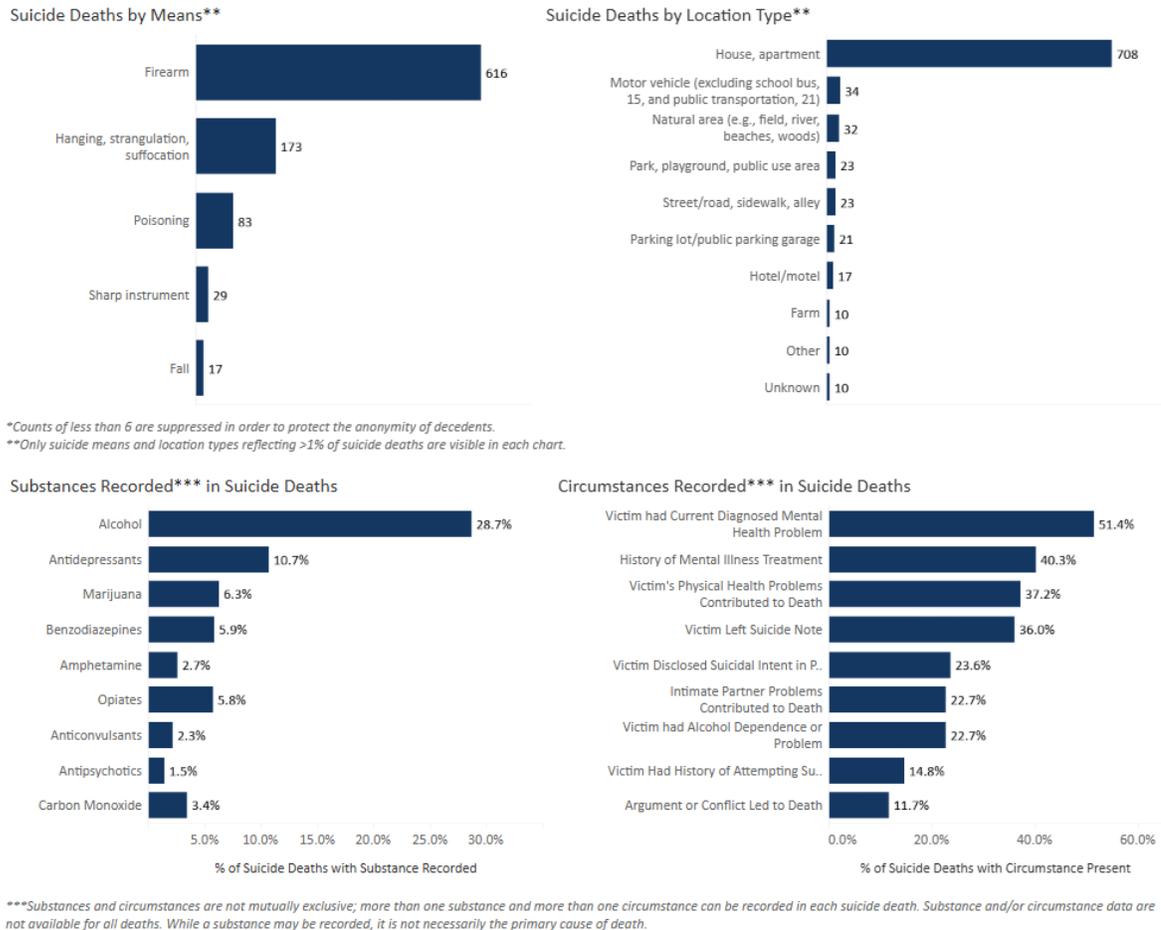
Suffocation is the second most common mechanism, followed by poisoning and other methods, which account for a substantially smaller proportion of deaths. Although non-firearm mechanisms vary modestly over time, they remain consistently lower compared to firearm-related deaths.

The predominance of firearm deaths underscores the importance of lethal means safety as a critical suicide prevention strategy, particularly during periods of elevated risk. Evidence shows that suicide attempts involving firearms are more likely to result in death, making access to highly lethal means a key factor influencing suicide outcomes.

Minnesota Veteran Suicide Prevention Plan

These findings reinforce the need for prevention approaches that combine crisis response and mental health support with safe storage education, temporary separation during crises, and culturally responsive conversations about firearm safety.

Figure 3. Characteristics of Veteran Suicide Deaths in Minnesota
Suicide deaths by means, location type, substances recorded, and circumstances present



Minnesota Department of Health. 2026. MN Suicide Deaths. [Dashboard]. Retrieved 1/26/2026, from [Minnesota Violent Death Reporting System Dashboard - MN Dept. of Health](#)

This figure summarizes key characteristics of Veteran suicide deaths in Minnesota, highlighting means of injury, location, substances recorded, and circumstances present at the time of death. Together, these data provide important context for understanding patterns of risk and identifying opportunities for prevention.

Disclosure

Substance and circumstance data are not mutually exclusive; more than one substance or circumstance may be recorded for a single death. Data availability varies, and

Minnesota Veteran Suicide Prevention Plan

substance presence does not imply causation. Counts less than six are suppressed to protect privacy.

National data further underscore the urgency of this work. According to the 2025 National Veteran Suicide Prevention Annual Report, more than 6,000 Veterans died by suicide nationally in the most recent reporting year, with firearms remaining the leading method. Importantly, a majority of Veterans who died by suicide were not engaged in VA health care in the year prior to their death. These findings reinforce that Veteran suicide prevention must extend beyond clinical settings and into coordinated, community-based systems of identification, outreach, and support.

MDVA Infrastructure Improvement Plan

Leading Minnesota’s comprehensive public health approach to preventing Veteran suicide, MDVA aligns its 2026–2029 Veteran Suicide Prevention Plan to the strategic framework of the Minnesota State Suicide Prevention Plan. While MDVA serves as the statewide lead for Veteran specific suicide prevention efforts, this work is carried out in collaboration with the MDH to ensure alignment with statewide priorities and national suicide prevention strategies.

This four-year framework establishes a durable foundation for coordinated system change. This approach ensures continuity, accountability, and a unified, data-driven effort to protect those who served, while allowing strategies to evolve based on emerging evidence and statewide direction.

Data-Driven Plan

MDVA is committed to a data-driven approach that emphasizes learning, transparency, and continuous system improvement. To strengthen evaluation, reporting, and data integration, MDVA will:

- Provide regular public and legislative reporting on progress toward Veteran suicide prevention goals.
- Coordinate data sharing and reporting so Veteran outcomes are visible within statewide suicide prevention metrics.
- Implement Veteran-focused Suicide Mortality Reviews, beginning with an initial pilot in Hennepin County, to identify actionable system improvements.
- Align data across systems where feasible.
- Use data and review findings to inform prevention strategies, policy development, and system improvement, with a learning-focused, non-punitive approach.

Coordination and Collaboration

Suicide prevention involves many systems (health care, behavioral health, Veteran services, community support and more). Effective prevention requires intentional coordination and collaboration between governmental and non-governmental partners.

To strengthen coordination and reduce duplication, MDVA will:

- Lead and align suicide prevention efforts across MDVA so work is coordinated and effective.
- Strengthen internal MDVA systems by assessing current initiatives and identifying opportunities for integration and efficiency.
- Build internal MDVA capacity by equipping staff across divisions to embed mental health promotion and suicide prevention in their work.

Minnesota Veteran Suicide Prevention Plan

- Clearly define the role of MDVA's as the statewide connector that supports communities, aligns partners, and strengthens prevention systems.
- Convene and lead the Minnesota Veteran Suicide Prevention Collaborative to foster cross-divisional learning, coordination, and best practice sharing.
- Strengthening partnerships by improving how existing systems work together, rather than creating new structures.

Plan Duration, Phasing, and Review Cycle

The MDVA Veteran Suicide Prevention Plan is designed as a four-year strategic framework with a long-term commitment to Veteran wellness and suicide prevention infrastructure.

Recognizing that suicide prevention requires coordinated system development over time, MDVA will implement this plan through planning, annual reporting, and continuous refinement. The Implementation Action Plan will be updated annually to reflect emerging data trends, Suicide Mortality Review findings, partner feedback, and legislative direction.

As national and state data evolve, MDVA will continue to incorporate emerging findings from future annual releases of the National Veteran Suicide Prevention Report, the Minnesota State Suicide Prevention Plan, and the Governor's Challenge Framework to inform subsequent planning cycles.

This approach ensures the plan remains responsive, data-informed, and aligned with statewide and national priorities, while establishing a durable framework for coordinated, Veteran centered suicide prevention efforts across Minnesota.

MDVA Veteran Suicide Prevention Plan

The goals, objectives, and strategies outlined in this plan focus on preventing suicidal experiences among Minnesota Veterans and strengthening the systems that support their mental health and well-being. This is a living, working framework designed to guide coordinated action, inform decision making, and adapt as new data, evidence, and Veteran feedback emerge. This framework is grounded in the belief that Veterans should know they are not alone, that help is available, and that healing is possible through coordinated, Veteran centered supports.

Phased Implementation (2026–2029)

MDVA will implement this plan through a four-year, phased approach to ensure sustainable system change:

- Phase 1: Foundation & Alignment (2026) establish governance, infrastructure, baselines, and pilot initiatives.
- Phase 2: Expansion & Integration (2027) scale effective strategies and embed them across partner systems.
- Phase 3: System Change (2028) integrate proven practices into policies, workflows, and data systems.
- Phase 4: Evaluation & Strategic Refresh (2029) assess impact and prepare the next multi-year framework.

This approach ensures accountability, adaptability, and a long-term commitment to Veteran wellness and suicide prevention statewide.

Goal 1. Strengthen Veteran Suicide Prevention Infrastructure & Cross-Sector Leadership

MDVA will serve as the statewide coordinating backbone for Veteran suicide prevention by strengthening governance, cross-sector collaboration, communication systems, and long-term sustainability.

Legislative Directive	State Suicide Prevention Plan
Goal 1. Community integration and collaboration Goal 2. Promote belonging and purpose Goal 3. Implementation strategy across government entities	Goal 1. Infrastructure and Capacity

Objective 1.1. Strengthen MDVA’s Internal & Cross-Sector Prevention Capacity

MDVA Strategies

- Coordinate and/or provide education opportunities for MDVA staff and program areas on their role in promoting Veteran mental health and preventing suicide (Phase 1-2).
- Provide Veteran suicide prevention strategies and coordination with internal and external stakeholders (e.g. housing, employment, legal, and reintegration initiatives) (Phase 1-3).
- Clarify roles and expectations for cross-sector partners participating in Veteran suicide prevention efforts (Phase 1).
- Conduct and maintain regional Veteran asset mapping to inform outreach priorities and referral pathways (Phase 1–2).

Objective 1.2. Formalize Collaborative Leadership & Shared Accountability

MDVA Strategies

- Convene the Minnesota Veteran Suicide Prevention Collaborative as a structured statewide action and learning body (Phase 1).
- Establish 3–5 annual prevention priorities with measurable outcomes (Annual).
- Provide an annual progress summary for partners and legislative stakeholders (Annual).
- Conduct annual partner feedback surveys to inform continuous improvement (Annual).
- Track progress on Collaborative priorities quarterly and use findings to adjust implementation in real time (Phase 2–4).

Objective 1.3. Strengthen Communication & Shared Prevention Tools

MDVA Strategies

- Centralize Veteran suicide prevention training calendars, outreach materials, and messaging tools (Phase 1).
- Standardize Veteran-centered language, Ask the Question workflows, and referral messaging across partners (Phase 2).
- Conduct annual Veteran suicide prevention messaging audits to reduce duplication, conflicting information, and stigma (Phase 3–4).

Goal 2. Promote Protective Factors, Belonging & Stability for Minnesota Veterans

MDVA will advance upstream prevention strategies that strengthen connection, purpose, safety, and social stability for Veterans across communities.

Legislative Directive	State Suicide Prevention Plan
Goal 1. Community integration and collaboration	Goal 2. Protective Factors
Goal 2. Promote belonging and purpose	

Objective 2.1. Integrate Suicide Prevention into Social Determinants of Health Efforts

MDVA Strategies

- Coordinate Veteran suicide prevention efforts across housing, employment, justice-involved, financial stability, and reintegration initiatives (Phase 1–2).
- Expand Veteran suicide prevention engagement into non-traditional sections (e.g. housing providers, workforce development systems, legal services, corrections, and faith-based organizations) (Phase 2–3).
- Embed prevention messaging into Veteran facing community programs (Phase 2–3).

Objective 2.2. Promote Veteran Belonging & Peer Connectedness

MDVA Strategies

- Encourage Veteran Service Organizations to adopt structured peer check-in models (e.g., Buddy Checks) (Phase 2).
- Partner with networks and local coalitions to promote purpose and connection (Phase 2–3).
- Elevate mission-driven engagement, service, and mentorship opportunities (Phase 3–4).

Objective 2.3. Expand Lethal Means Safety & Safe Storage Practices

MDVA Strategies

- Coordinate statewide distribution of firearm safety devices through trusted partners (Phase 1–2).
- Coordinate training on Counseling on Lethal Means (CALM) training across Veteran-serving sectors (Phase 1–3).
- Coordinate or provide safety planning conversations in both clinical and non-clinical settings (Phase 2–4).

Goal 3. Improve Early Identification & Veteran-Informed Response Across Systems

MDVA will ensure Veterans experiencing mental health challenges are identified early and supported by systems that understand military culture and Veteran experiences.

Legislative Directive	State Suicide Prevention Plan
Goal 1. Community integration and collaboration Goal 2. Promote belonging and purpose	Goal 3. Identify and support individuals at risk

Objective 3.1. Expand Veteran-Informed Suicide Prevention Training

MDVA Strategies

- Deliver evidence-based Veteran-informed suicide prevention trainings statewide (Phase 1–2).
- Expand military cultural competency training across healthcare, behavioral health, social services, and first responder sectors (Phase 1–3).
- Train suicide prevention educators on tailoring messaging to Veterans (Phase 2–3).
- Review and update the Veteran Suicide Prevention Education Strategy annually to ensure alignment with emerging data and best practices (Annual).

Objective 3.2. Strengthen Veteran Identification in Healthcare & Community Systems

MDVA Strategies

- Expand implementation of Ask the Question in non-VA healthcare systems (Phase 1–2).
- Provide technical assistance for workflow integration and referral alignment (Phase 1–3).
- Monitor Veteran identification rates and system adoption metrics (Phase 2–4).

Goal 4. Strengthen Veteran Access, Navigation & Continuity of Care

MDVA will simplify system entry points, standardize referral pathways, and strengthen care transitions to ensure Veterans do not fall through service gaps.

Legislative Directive	State Suicide Prevention Plan
Goal 1. Community integration and collaboration Goal 3. Implementation strategy across government entities	Goal 4. Increase access to care and continuity of care

Objective 4.1. Standardize Referral & Navigation Pathways

MDVA Strategies

- Align referral workflows connecting Veterans (e.g. VA, CVSOs, 988 (Press 1), LinkVet, and community resources) (Phase 1).
- Coordinate connection of non-VA healthcare systems to Community of Practice (Phase 1–2).
- Pilot and evaluate navigation models prior to statewide expansion (Phase 2).
- Track referral completion and warm handoff success (Phase 2–3).

Objective 4.2. Strengthen Crisis Response & Care Transitions

MDVA Strategies

- Participate in Crisis Intercept Mapping to identify system gaps (Phase 2).
- Reinforce timely follow-up expectations following crisis or hospitalization (Phase 2–4).
- Strengthen coordination between VA and non-VA systems (Phase 2–3).

Goal 5. Support Veterans, Families & Communities Impacted by Suicide

MDVA will promote healing, safe communication, and sustained support for those impacted by suicide.

Legislative Directive	State Suicide Prevention Plan
Goal 1. Community integration and collaboration Goal 2. Promote belonging and purpose Goal 3. Implementation strategy across government entities	Goal 5. Postvention

Objective 5.1. Strengthen Veteran-Informed Postvention Practices

MDVA Strategies

- Promote safe communication and Veteran-informed postvention best practices (Phase 2–3).
- Distribute Veteran-specific postvention toolkits and guidance (Phase 2).

Objective 5.2. Provide resources to support those who have lost someone to suicide.

MDVA Strategies

- Promote and connect individuals to Veteran-informed grief supports and referral resources.

Objective 5.3. Support Survivors, Attempt Survivors & Families

MDVA Strategies

- Promote access to Veteran-informed grief and bereavement supports (Phase 2–4).
- Strengthen follow-up connection pathways for attempt survivors and families (Phase 2–3).

Goal 6. Advance Data-Driven Decision Making and System Improvement

MDVA will use timely, actionable data to strengthen prevention strategies, inform policy, and drive measurable system improvement.

Legislative Directive	State Suicide Prevention Plan
Goal 3. Implementation strategy across government entities	Goal 6. Data and surveillance

Objective 6.1. Improve Timeliness & Transparency of Veteran Suicide Data

MDVA Strategies

- Provide regular updates on Veteran suicide-related trends (Annual).
- Improve timeliness of reporting and dissemination (Phase 1–3).

Objective 6.2. Implement Veteran-Focused Suicide Mortality Review & Policy Translation

MDVA Strategies

- Pilot and expand Veteran-focused Suicide Mortality Review (Phase 1–3).
- Identify 3–5 actionable system-level improvements annually (Annual).
- Track implementation quarterly and report progress on structural change, not only activity metrics (Phase 2–4).
- Inform legislative and policy recommendations based on findings (Annual).

Implementation of MDVA Plan

Action Plan

In addition to the goals, objectives, and strategies outlined in this plan, MDVA will operationalize this four-year strategic framework (2026–2029) through annual Implementation Action Plans. Each annual Action Plan will translate strategic priorities into defined work plans with assigned leads, timelines, and measurable deliverables aligned to the implementation phases outlined in this framework.

MDVA is not beginning from zero. Core Veteran suicide prevention infrastructure is already in place and will continue to be strengthened through this framework, including:

- Coordination of the Veteran Health Navigator Program to strengthen referral pathways and care transitions across VA, non-VA, and community systems.
- Delivery of Veteran-informed suicide prevention training statewide, including lethal means safety and military cultural competency.
- Distribution of firearm safety devices through trusted Veteran-serving partners.
- Initial implementation of Veteran-focused Suicide Mortality Review in partnership with local jurisdictions.

Available funding will sustain, expand, and institutionalize these efforts by:

- Increased regional coordination, with the hiring of two rural Veterans Community Health Coordinators to reduce service duplication and strengthen cross-sector collaboration.
- Expanding training reach in rural and underserved communities.
- Scaling the Veteran Health Navigator model to additional healthcare systems.
- Coordinating Veteran Suicide Mortality Review expansion and data alignment efforts.
- Strengthening evaluation and reporting infrastructure to monitor outcomes and inform policy decisions.

Implementation Action Plans will be reported annually, and progress will be reviewed in alignment with updates to the Minnesota State Suicide Prevention Plan and other relevant state and federal strategies.

All implementation activities will be evaluated through a Veteran equity lens, prioritizing rural, Tribal, minority, and historically underserved Veterans disproportionately impacted by access barriers. Quantitative and qualitative data will be disaggregated where feasible to inform equitable resource allocation and strategy refinement.

Annual Action Plans will identify priority activities based on data trends, emerging needs, Suicide Mortality Review findings, and legislative direction. Progress will be monitored through clearly defined output and process measures, including system adoption metrics, training reach, referral utilization patterns, partner engagement indicators, and implementation of system-level improvements.

MDVA will use both quantitative and qualitative data to assess effectiveness and will adjust strategies as needed to ensure resources are directed toward approaches demonstrating measurable impact, sustainability, and alignment with statewide prevention priorities.

Disclosure

Through this structured implementation approach, state funding directly supports scalable, evidence-informed strategies that strengthen prevention infrastructure, improve care coordination, and expand access to timely support for Minnesota Veterans.

Evaluation Plan

MDVA will work with an external evaluation partner (e.g. Wilder Research) to determine appropriate process and outcome measures aligned with the goals and objectives of this plan. The evaluation will use community-gathered, state and publicly available data to document progress toward implementation and measure impact, particularly for priority populations.

The evaluation will use a Plan–Do–Study–Act (PDSA) approach, which incorporates ongoing data review and facilitated collaborative reflection with MDVA and community partners. This approach supports learning and continuous quality improvement by making data actionable and guiding program decisions.

Appendices: Wilder Research

Appendix A: Legislation

This report and project are meant to meet the following mandate from Minnesota 2025 Regular Session, Chapter 30, Article 1, Section 3, Subdivision 3(d):

The Commissioner shall develop a comprehensive plan to prevent Minnesota Veterans from dying by suicide. The plan must include:

1. Community integration and collaboration strategy that brings together Veteran-serving organizations to provide Veterans with coordinated services and supports, including services and supports related to employment, health, housing, benefits, recreation, education and social connections;
2. Strategies to promote a sense of belonging and purpose among Veterans by connecting Veterans with each other, with civilians and with Veteran communities through a range of activities including physical activity, community service and disaster response efforts;
3. Implementation strategy that identifies opportunities to coordinate existing efforts with federal, state, local and Tribal governments and nongovernmental entities and includes a description of the policy changes and resources that are required to prevent Veteran suicides.

The Commissioner must submit a report containing the required plan to the chairs and ranking minority members of the legislative committees with jurisdiction over Veterans affairs policy and finance by February 15, 2026.

Strategic planning and data collection process with Wilder Research

In 2025, MDVA contracted with Wilder Research to inform the development of this plan and fulfill the legislative mandate to assess suicide prevention efforts and partnerships in Minnesota and identify strategies for optimizing this work. This project included the development of a logic model; a survey of key partners; a survey of service members, Veterans, and their families or caregivers (SMVF); and two co-interpretation and strategic planning sessions with MDVA and selected partners. This document presents findings from both surveys and the co-interpretation and strategic planning sessions. Details regarding each methodology can be found in their respective sections of this report.

Appendix B: Logic Model

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
<p>Training and education</p> <p>Deliver/expand access to evidence-based suicide prevention and mental health trainings for service members, Veterans, professionals, family members, friends, and community members.</p> <ul style="list-style-type: none"> • Changing the Narrative • Mental Health First Aid • Applied Suicide Intervention Skills Training (ASIST) • Question, Persuade, Refer (QPR) • SafeTalk • Counseling on Access to Lethal Means (CALM) • VA S.A.V.E. • Psych Armor <p>Develop a 2025-2027 Suicide Prevention Training Strategy (SPTS) to guide implementation, including both an internal and external training focus.</p> <p>Organizational investment into staff overall well-being.</p>	2	<p>MDVA staff</p> <p>Minnesota Department of Health (MDH)</p> <p>VA community engagement & partnership coordinators (can assist with VA S.A.V.E. training and connection to resources)</p> <p>Service members, Veterans, and families (SMVF) and other partner organizations</p>	<p># of MDVA staff trained</p> <p># of SMVF organizations trained</p> <p># of SMVF in attendance</p> <p># of trainings</p> <p># of referrals to partner organizations</p> <p># of completed trainings with partner organizations</p> <p># of individuals trained across the state</p>	<p>MDVA staff, leadership, and partners</p> <p>Increase knowledge of:</p> <ul style="list-style-type: none"> – suicide risk – safety planning – lethal means safety <p>Increase belief that:</p> <ul style="list-style-type: none"> – suicide prevention is a shared responsibility across all levels of the agency – staff well-being is important and impacts the SMVF they work with – MDVA values them as staff members and as individuals <p>SMVF</p> <p>Better understand:</p> <ul style="list-style-type: none"> – common challenges to good mental 	<p>MDVA staff, leadership, and partners</p> <p>Integrate suicide prevention into daily practice</p> <p>Start incorporating safety planning and lethal means counseling into their interactions with at-risk SMVF</p> <p>Increase integration of suicide prevention goals into broader agency planning and performance measures</p> <p>Prioritize staff well-being to be able to better care for the SMVF they work with</p>	<p>Reduce/prevent SMVF suicide</p> <p>SMVF experience a sense of belonging and purpose</p> <p>Service members, Veterans, and families connect to each other to build support networks</p> <p>Increase coordination across all sectors to improve military service screening and identification, referral pathways to appropriate services, and suicide prevention for service members, Veterans, and their families</p> <p>SMVF receive improved quality of</p>

Minnesota Veteran Suicide Prevention Plan

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
<p>Data reports will be developed by SAMHSA.</p>			<p>SPTS developed (done)</p>	<p>health that may precede suicide ideation</p> <ul style="list-style-type: none"> - how to recognize warning signs of suicide - where to seek help in a crisis <p>Increase confidence in:</p> <ul style="list-style-type: none"> - recognizing warning signs - taking action to help someone in crisis 	<p>SMVF, friends, and community members</p> <p>Normalize conversations about mental health</p> <p>Recognize and effectively respond to warning signs</p> <p>Public health communications systems</p> <p>Increase the visibility of Veteran-specific suicide prevention resources through coordinated messaging and outreach campaigns</p>	<p>care and experience improved health</p> <p>SMVF receive care that is culturally competent</p> <p>Expanded access to evidence-based suicide prevention training for both professionals and community members</p>
<p>Outreach and community engagement</p> <p>Host quarterly meetings of the MN Veteran Suicide Prevention Collaborative to align efforts and share progress.</p>	<p>1, 3</p>	<p>MDH Mental Health & Suicide Prevention Team</p>	<p># of materials disseminated</p> <p># of meetings of MN Veteran Suicide</p>	<p>Veteran Suicide Prevention Collaborative</p> <p>Better understand current statewide strategies, efforts,</p>	<p>Veteran Suicide Prevention Collaborative aligns strategies and resources with MN State Suicide Prevention Taskforce</p>	

Minnesota Veteran Suicide Prevention Plan

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
<p>Develop a Veteran Suicide Prevention Outreach Strategy (VSPOS).</p> <p>Plan for Veteran community health coordinators to implement a regional suicide prevention plan using a multi-sector, community-based approach. Priorities:</p> <ul style="list-style-type: none"> • Address urgent need for Veteran suicide prevention • Expanding outreach to underserved communities • Enhancing education for Veterans and stakeholders • Increasing efficiency and reducing service gaps <p>Integrate comprehensive considerations for SMVF of all identities and cultures.</p>		<p>Veteran and other partner organizations</p> <p>Cultural groups,</p> <p>Tribal organizations, Wilder, local governments</p> <p>MDVA Veterans Community Health Team</p>	<p>Prevention Collaborative hosted</p> <p># of partnerships throughout Minnesota</p> <p># of new partnerships and collaborations</p>	<p>resources to prevent suicide among SMVF</p> <p>Community members and stakeholders</p> <p>Better understand:</p> <ul style="list-style-type: none"> – importance of connectedness – their role in supporting SMVF mental health <p>Increase belief that:</p> <ul style="list-style-type: none"> – SMVF suicide is preventable through community-based action and connectedness <p>Veteran/partner organizations/Tribal health/local government</p> <p>Better understand:</p>	<p>to strengthen statewide coordination and impact</p> <p>MN State Suicide Prevention Taskforce integrates Veteran-specific strategies into its statewide plan in alignment with the VA National Strategy and Governor’s Challenge</p> <p>Veteran/partner organizations/ Tribal health/ Local government</p> <p>Increase referrals of SMVF to appropriate mental health and crisis resources</p> <p>All agencies are more aligned with one</p>	

Minnesota Veteran Suicide Prevention Plan

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
				<ul style="list-style-type: none"> - evidence-based suicide prevention priorities Increase belief that - community-based support networks are vital to preventing SMVF suicide - early intervention and cross-sector coordination can reduce SMVF suicide risk - culturally grounded approaches are essential to effective suicide prevention for Native SMVF Increase skills in: - cultural competency 	<p>another in evidence-based suicide prevention priorities, including outreach and education efforts, and messaging</p> <p>Expand outreach and referral systems to ensure Veterans and their families are connected to appropriate mental health and benefits resources</p> <p>Start integrating culturally-competent suicide prevention strategies into their SMVF support services</p> <p>Prioritize suicide prevention as a core service area, consistent with the MDVA Strategic Plan 2020–2027 and legislative mandates</p>	

Minnesota Veteran Suicide Prevention Plan

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
					for SMVF health and well-being	
<p>Veteran health navigator program</p> <p>Launch pilot program to embed Veteran health navigators (community health workers or social workers) in non-VA healthcare systems.</p> <p>Coordinate care and connect Veterans and families to benefits and services through embedded MDVA claims representatives.</p> <p>Implement the “Ask the Question” campaign in electronic medical records: “Have you or a loved one ever served in the military?”</p> <p>Building a community of practice in those healthcare systems.</p>	1	<p>Pilot program: Regions Hospital, Sanford Health</p> <p>Implementing “Ask the Question”:</p> <p>Mayo Clinic</p> <p>Hennepin Healthcare</p> <p>M Health Fairview</p> <p>Avera Health</p>	<p># of non-VA healthcare system partners</p> <p># of non-VA healthcare systems adopting Ask the Question screening</p> <p># of embedded Veteran health navigators</p> <p># of referrals/successful referrals to VA</p> <p># of referrals/successful referrals to SMVF community</p>	<p>Non-VA healthcare system staff/community healthcare providers</p> <p>Better understand how to:</p> <ul style="list-style-type: none"> – identify Veterans in their care – coordinate appropriate follow-up services/mental health resources/benefits <p>Increase belief that:</p> <ul style="list-style-type: none"> – identifying Veteran status is essential to providing appropriate care and support – screening for military service is a critical step in suicide prevention 	<p>Non-VA healthcare system staff/community healthcare providers</p> <ul style="list-style-type: none"> – start asking about military service as part of their standard intake process – start embedding SMVF-specific care coordination into their standard discharge and follow-up processes – adopt screening and referral practices (Ask the Question) that are supported by state and federal technical assistance frameworks – improve healthcare transitions for SMVF 	

Minnesota Veteran Suicide Prevention Plan

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
<p>Lethal means safety</p> <p>Promotion and support of current efforts throughout Minnesota.</p> <p>Distribute free gun locks and promote safe storage practices.</p> <p>Create and distribute Safety Planning Cards/pocket cards for providers.</p> <p>Clarify and communicate MDVA’s position on lethal means: safety vs. means restriction.</p> <p>Crisis planning</p> <p>Conduct crisis intercept mapping.</p> <p>Provide military specific training for mobile crisis units.</p>	<p>1, 3</p>	<p>Protect MN VA Minneapolis VA</p> <p>Local/county governments and crisis response teams</p>	<p>organization s</p> <p># of gun locks distributed</p> <p># of Safety Planning Cards/ pocket cards distributed</p>	<p>Local crisis response teams and county partners</p> <p>Better understand:</p> <ul style="list-style-type: none"> - how to improve care transitions - how to reduce suicide risk during crisis points - how to identify Veteran status during crisis and transitions 	<p>Local crisis response teams and county partners</p> <p>Improve care transitions with the intent of reducing crises and getting SMVF help sooner</p> <p>Reduce suicide risk during crisis points</p> <p>Better identify Veterans in their care</p> <p>Conduct earlier interventions</p> <p>Provide the right resources back to care such as VA care</p> <p>Increase cross-sector coordination</p>	

Minnesota Veteran Suicide Prevention Plan

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
<p>Strategic alignment and governance</p> <p>Further development and partnership of the MN Veteran Suicide Prevention Collaborative with the State Suicide Prevention Taskforce to streamline governance and resource sharing.</p> <p>Ensure consistency with the VA Suicide Prevention Strategy, SAMHSA’s Governor & Mayor Challenge, and alignment with the MN State Suicide Prevention Taskforce Plan.</p> <p>Data and evaluation</p> <p>Leverage internal data to track trends and outcomes from 2015 to present.</p> <p>Leverage external data for data interpretation and current trends.</p> <p>Communicate the progress of SMVF suicide prevention work across the state of Minnesota.</p>	<p>1, 3</p>	<p>Krysta Stanenas (Data and Applied Analytics Liaison with Minnesota Department of Veterans Affairs)</p> <p>Stefan Gingerich (Senior Epidemiologist with MDH)</p> <p>David Holewinski (Mpls VA Suicide Prevention Program Manager)</p>	<p># of joint meetings</p> <p># of aligned strategies</p> <p># of data dashboards</p> <p># of reviews conducted</p>	<p>MDVA and statewide data and evaluation systems</p> <p>Better understand</p> <p>– what is happening with SMVF suicide and suicide prevention across the state</p>	<p>Statewide data and evaluation systems</p> <p>have better ability to track SMVF suicide trends and evaluate the impact of prevention strategies through partnerships like the Suicide mortality Review committee</p> <p>MDVA aligns its Veteran Suicide Prevention strategies with the One Minnesota Plan and the FY2026–27 Biennial Budget priorities, ensuring sustainable funding and policy support for outreach, training, and navigator programs</p> <p>MDVA is better able to communicate progress of statewide strategies</p>	

Minnesota Veteran Suicide Prevention Plan

Activities	Legislative mandate item*	Partnerships	Outputs	Short term outcomes	Intermediate outcomes	Long term outcomes
					to partners and stakeholders	

* Corresponds to the numbered requirements in the [legislative mandate](#).

Appendix C: Wilder Foundation Report

Key findings

This section covers key findings from the survey of MDVA partners (N=30), the survey of SMVF (N=222), and input provided by MDVA staff and partners that participated in the co-analysis and strategic planning session. More details regarding methodology and results can be found in the [co-analysis and strategic planning session summary section](#), the [partner survey section](#), and the [SMVF survey section](#) of this report.

SMVF generally feel supported

In general, a majority of SMVF responding to the survey reported feeling a sense of belonging, sense of purpose, and are motivated and able to seek help if they or another service member or Veteran were struggling.

Belonging

<p>91%</p>	<p>Know at least one place where they feel welcome</p>
<p>90%</p>	<p>Have people they can count on</p>
<p>82%</p>	<p>Feel like they belong in their community</p>
<p>77%</p>	<p>Feel connected to other Veterans and service members</p>

Purpose

<p>90%</p>	<p>Have a sense of purpose in their day-to-day lives</p>
------------	--

Finding help

	Would seek help for themselves or another service member/Veteran who is struggling
	Know how to find help

With regard to resources, SMVF were most likely to be familiar with VA resources, Veteran service organizations, the 988 suicide and crisis lifeline, and County Veteran Service Offices.

MDVA has many strengths

Partners identified several strengths of MDVA, and they generally view their partnership with MDVA positively. They described MDVA as:

- Team-oriented
- Creative
- Responsive
- Respectful
- Approachable
- Open to feedback
- Passionate
- Dedicated
- Well-informed
- Knowledgeable

They agreed that the partnership is strong and collaborative and helps achieve their organization’s goals, and they perceive MDVA as valuing partner contributions.

	Agree the MDVA SPT values the contributions of partner organizations
	Agree their organization has a strong, collaborative relationship with MDVA SPT
	Agree the partnership helps their organization achieve its goals

Recommendations

This section covers recommendations informed by the findings from the survey of MDVA partners (N=30) and the survey of SMVF (N=222). More details regarding methodology and results can be found in the [co-analysis and strategic planning session summary section](#), the [partner survey section](#), and the [SMVF survey section](#) of this report.

Consider ways to strengthen partnerships with existing partners

Most partners agreed that a stronger partnership with MDVA is possible, and over half felt that coordination and communication could be improved.

 <p>84%</p>	<p>Agree a stronger partnership is possible</p>
 <p>58%</p>	<p>Agree the MDVA SPT could better coordinate with their organization on suicide prevention issues</p>

Specific suggestions for strengthening partnerships included:

- Clarify expectations and roles
- Define intent of partnerships
- Define specific asks and improve delegation
- Communicate/engage regularly and proactively
- Concretely define meeting agendas
- Build trust among partners
- Ensure consistent attendance at meetings and events
- Collect input and ensure it is used
- Determine shared goals in collaboration with partners
- Develop streamlined pathways for information and resource sharing, including available services
- Ensure a safe and comfortable space for partners to share and ensure all voices are heard
- Develop effective channels for resource and information sharing (e.g., database of partners and available services, creating shared web pages such as Dropbox)

Some partners mentioned specific partnerships that could be stronger, including the Minnesota Department of Health, faith and community leaders, other MDVA programs and services (e.g., Veteran homes, healthcare division), CVSOs, and the American Legion.

Discussion participants agreed that there is currently a wide range of available services for people in crisis, but navigating those services can be extremely challenging. When a person is in crisis and is given a list of resources it can be overwhelming to sift through and figure out what they qualify for, what is geographically accessible, and if it meets their unique therapeutic, cultural or linguistic needs. Rather than increasing the number of organizations MDVA works with, discussion participants suggested strengthening relationships with current partners to focus on some of the barriers that prevent SMVF from accessing support.

Clarify goals, objectives and strategic direction

Most partners agreed that MDVA could clarify and define specific goals and an overarching strategic direction to guide their work. Additionally, they also emphasized the importance of communicating these directly and clearly to partners and the SMVF population. Suggestions included:

- Clarify and communicate MDVA’s mission as it relates to SMVF suicide prevention
- Clarify and communicate the purposes of initiatives, work groups, and meetings
- Clarify and communicate MDVA’s roles and responsibilities
- Define measurable goals and outcomes

Stakeholders in the co-analysis and strategic planning session mentioned that the mission should be concrete, achievable, clearly articulated and more narrowly defined. One community partner representative said they would prefer to have MDVA articulate a clear direction with strategies for engaging partners to meet mission-driven goals. One stakeholder said MDVA needs to “pick a plan and move forward” because they are currently spread too thin. Another stakeholder said “Coordination without direction is just a meeting.”

Better communicate the mission of MDVA’s collaborative with partners, stakeholders and SMVF

In addition to having a clearer mission and goals, stakeholders would like to see MDVA communicate the mission and goals more clearly, as well as identify the ways MDVA can support partners to meet those goals.

Consider shifting MDVA’s efforts to focus on a coordination role

Several respondents to the partner survey suggested that MDVA could act as an overarching “umbrella organization” that focuses on building the capacity of partner organization to serve SMVF. This also came up in the discussion. MDVA could focus on supporting direct services that partner organizations provide. One example of this is that there are already a wealth of trainings provided by different groups. MDVA could work to connect partner organizations with needed trainings rather than providing those trainings themselves.

As part of MDVA’s shift to focusing on coordination, there were several suggestions for areas to focus on to fill gaps. Partners and service members, Veterans, and their families identified a range of service and programming gaps to prevent suicide among service members and Veterans. They described a lack of resources, services, and providers, identifying the need to:

- Increase clinical and direct services.
- Increase prevention and early intervention services.
- Improve integration into other sectors and care coordination.
- Address long wait lists and provider shortages.
- Provide more behavioral health trainings (e.g., ASIST, Mental Health First Aid, trainings for law enforcement for working with SMV experiencing crises). Partners also generally reported lower levels of familiarity with MDVA-provided trainings compared to other services or resources provided by MDVA.
- Provide more peer support and social support opportunities.
- Improve providers’ abilities to effectively work with SMV populations and understand military culture.
- Address geographic challenges and greater gaps in rural areas compared to urban ones.

They also mentioned MDVA’s limited capacity, staff, and funding as challenges.

Suggestions for specific services included:

- Crisis services
- Substance use services
- Peer support and opportunities to engage with others
- Services for wartime Veterans
- Children’s mental health services
- Services for individuals experiencing housing instability
- In-person services (vs. telehealth)
- Life skills and coping skills
- Support groups for military sexual trauma
- Equine therapy
- Culturally responsive services
- Spiritual support
- Traditional healing services
- VA-provided mental health care

Respondents also described a lack of awareness of available services among the SMVF population and how the complexity of the service system makes it difficult for individuals to access care quickly. About a quarter of SMVF respondents identified not knowing where to go as one of the biggest barriers to accessing care. Moreover, more than a third of partners reported they were slightly or not at all familiar with suicide prevention services and resources provided by non-MDVA entities. Tribal Indian Health Services and urban Indian Health Programs; lethal means safety resources and education; and trainings (e.g., QPR, ASIST, safeTALK) had the lowest familiarity among SMVF. Partners suggested providing navigation support and implementing promotional activities to raise awareness of available services and how to access them.

Lastly, respondents identified insurance eligibility and process challenges that prevent SMVF from accessing care. This includes eligibility limitations to VA-sponsored healthcare coverage, how many clinics and providers do not accept VA-sponsored healthcare coverage, and long delays and burdensome processes for accessing benefits.

Strengthen alignment with Minnesota Department of Health

Discussion participants also clearly agreed that the MDVA collaborative needs to strengthen its alignment with MDH, particularly by determining and clearly communicating how MDVA fits into the state’s suicide prevention plan without duplicating efforts. The state has a clear plan for suicide prevention, but there is less clarity on how MDVA, as a state organization, fits into that plan. With a better-defined mission and goals, MDVA will be able to find that alignment. Discussion participants were clear that there is a role for MDVA within the state plan, but there needs to be better alignment without duplication and better communication to partner organizations about how the two entities work together.

Continue and expand ways to raise awareness of suicide-related issues

Partners and SMVF identified a need to raise awareness and provide education and educational materials regarding suicide and behavioral health, address stigma, and distribute educational materials and resources (e.g., toolkits). In addition, stigma or fear of judgment was the most commonly reported barrier to accessing services among SMVF.

Partners view one-on-one communication or word of mouth, social media, trusted organizations and community leaders, email, and presentations and events as the most effective channels for reaching SMVF. SMVF most often said email, trusted organizations, in-person events, and websites as their preferred communication channels.

Detailed findings

Co-analysis and strategic planning session summary

Findings from the partner and SMVF surveys were shared with key stakeholders from the MDVA, the Minnesota Department of Health, Disabled American Veterans, Minnesota Assistance Council for Veterans, the Minneapolis VA Medical Center, and the VA of St. Cloud. Wilder Research facilitated a two-day co-analysis and strategic planning session that involved data sharing and a co-analysis process and a discussion of potential strategies and opportunities for MDVA to improve their partnership networks. This section includes a thematic summary of the discussions.

Clarify and communicate the mission of MDVA’s collaborative

After reviewing the survey and interview results stakeholders agree that a primary strategic target for the coming year is to clarify and better communicate the mission of MDVA’s collaborative. Further, stakeholders said that the mission should be concrete, achievable, clearly articulated and more narrowly defined. One community partner representative said they would prefer to have MDVA articulate a clear direction with strategies for engaging partners to meet mission-driven goals. In addition to having a clearer mission and goals, partnership would like to see MDVA communicate the mission and goals more clearly, as well as identify the ways MDVA can support partners to meet those goals. One stakeholder said MDVA needs to “pick a plan and move forward” because they are currently spread too thin. Another stakeholder said “Coordination without direction is just a meeting.”

Consider shifting MDVA efforts to a coordination role

Several respondents to the partner survey suggested that MDVA could act as an overarching “umbrella organization” that focuses on building the capacity of partner organization to serve SMVF. This also came up in the discussion. MDVA could focus on supporting direct services that partner organizations provide. One example of this is that there are already a wealth of trainings provided by different groups. MDVA could work to connect partner organizations with needed trainings rather than providing those trainings themselves.

Strengthen alignment with Minnesota Department of Health

Discussion participants also clearly agreed that the MDVA collaborative needs to strengthen its alignment with MDH, particularly by determining and clearly communicating how MDVA fits into the state’s suicide prevention plan without duplicating efforts. The state has a clear plan for suicide prevention, but there is less clarity on how

MDVA, as a state organization, fits into that plan. With a better-defined mission and goals, MDVA will be able to find that alignment. Discussion participants were clear that there is a role for MDVA within the state plan, but there needs to be better alignment without duplication and better communication to partner organizations about how the two entities work together.

Focus on strengthening existing partnerships

Surveys and interviews with partners showed that there is a need to focus on strengthening existing partnerships, rather than adding new partnerships. Discussion participants agreed that there is currently a wide range of available services for people in crisis, but navigating those services can be extremely challenging. When a person is in crisis and is given a list of resources it can be overwhelming to sift through and figure out what they qualify for, what is geographically accessible, and if it meets their unique therapeutic, cultural or linguistic needs. Rather than increasing the number of organizations MDVA works with, discussion participants suggested strengthening relationships with current partners to focus on some of the barriers that prevent SMVF from accessing support.

Barriers to accessing services

Surveys with service members, veterans, and family members indicate that there are clear needs that could be addressed by MDVA and their partners. These needs could suggest potential goals for MDVA in the coming years. These barriers include:

- **Tailor services for SMVF.** Veterans and their families have unique experiences that result in needs that may differ from the general population including long deployments away from family, exposure to combat, and reintegration struggles. Similarly, SMVF who speak languages other than English, LGBTIQ+ veterans, or veterans of color may need services that are tailored to meet their unique cultural needs. MDVA could focus their training efforts on building the capacity of partner organizations to meet the unique needs of SMVF.
- **Bridge the gap.** Discussion participants noted that many SMVF survey respondents are familiar with a wide range of services available to them but do not use them at the expected number, creating a gap between awareness and use. While this datapoint needs further explanation, MDVA could focus on understanding and bridging the gap by making services more accessible to SMVF. Some factors behind the gap could be stigma about discussing mental health, feeling overwhelmed about how to access services, lack of available services in rural areas, transportation, or a lack of services that meet cultural and linguistic needs.
- **Address root causes.** Discussion participants said that the root causes of suicidality and mental health crises in veterans could be as wide ranging as marital issues, finances, housing, or reintegration. Increasing suicide prevention efforts at points where SMVF seek help for these issues could be an effective strategy.
- **Additional suggestions.** Other suggestions that arose during the discussions included hosting listening sessions with current partners to identify specific needs, revising MDH's recommendations from 2024, building the Navigator Program, train MDVA employees about suicide prevention, provide SMVF specific training to partners, focus on primary prevention in addition to crisis management, reduce stigma by meeting veterans where they are, and simplify points of entry for people in crisis.

Partner survey

This section includes a more detailed overview of the partner survey results. The MDVA team developed a list of partners to invite to participate in a survey regarding their partnership with MDVA. Partners had the option of completing the survey via a web survey or via telephone with a Wilder Research staff member. Invitations to participate were sent out to 52 partners. Thirty partners participated, with one respondent completing the

Minnesota Veteran Suicide Prevention Plan

survey by phone. Responses to open-ended items were grouped into themes. Given the relatively small number of responses, all themes for open-ended items are reported, including those only shared by one respondent.

Most partners reported that their organization serves the entire state of Minnesota (87%; Figure X).

X. What geographical areas are supported by your organization? (Open-ended response themes)

	Count	% (N=30)
Minnesota statewide	26	87%
Metro area	4	13%
Greater Minnesota	1	3%
Tribal nations	1	3%
Other states or countries	2	7%

Partners were asked to describe the ways in which they serve service members, Veterans, and their families. Partners most often described activities related to organizational operations, events, and coordination, including hosting meetings, providing trainings, working with or sharing data, and legislative advocacy efforts (73%; Figure X). Most partners also shared that they provide one-on-one or direct support to service members, Veterans, and their families, such as clinical or service navigation support (68%).

X. In what ways do you work or volunteer with service members, Veterans, and their families (SMVF)? (Open-ended response themes)

	Count	% (N=30)
Administration, operations, coordination, providing trainings, sharing data, or legislative advocacy	22	73%
Provide one-on-one or direct support	15	68%
Clinical services for physical or behavioral health	5	17%
Outreach, events, or conferences	3	10%
Unspecified (i.e., “a lot”)	1	3%

Most partners reported that they serve all Veterans or no specific population (83%; Figure X).

X. Does your organization serve any specific SMVF populations (e.g., women, service members of color, LGBTQ+ Veterans, etc.)? (Open-ended response themes)

	Count	% (N=30)
All Veterans or no specific population	25	83%
Older adults/aging Veterans	2	7%
Veterans that have complex health needs, cognitive impairment, or need intensive support	2	7%
Families of Veterans	1	3%

Minnesota Veteran Suicide Prevention Plan

More than half of partners reported that they collaborate with the MDVA suicide prevention team often (57%), followed by sometimes (21%) and never (14%; Figure X).

X. How often do you collaborate with the MDVA suicide prevention team on service members, Veterans, and their families suicide prevention issues?

	Count	% (N=28)
Often	16	57%
Sometimes	6	21%
Rarely	2	7%
Never	4	14%

Partners were asked to describe their partnership with the MDVA suicide prevention team. They most often described activities pertaining to collaborating across organizations, including attending meetings, serving on committees, and strategic planning. They also frequently reported event coordination, including tabling, presentations, and trainings; and activities related to data and information sharing.

X. Can you describe your partnership with the MDVA suicide prevention team (e.g., what you partner on most often, what does that collaboration look like)? (Open-ended response themes)

	Count	% (N=26)
Strategic planning, organizational collaboration, attending meetings, and serving on committees	14	54%
Tabling events, organizing events, presentations, and providing educational or training opportunities	8	31%
Data reporting, data sharing, information sharing, and soliciting guidance from subject matter experts	6	23%
Communications and marketing	3	12%
Legislative advocacy and seeking legislative funding	2	8%
Very limited or no partnership currently	2	8%
Other responses ^a	5 (N=1 each)	19%

^a Responses included sharing meeting space and volunteers, all aspects (unspecified), desire to collaborate more, collaboration has improved, need to improve collaboration with specific partners (e.g., CVSOs, service organizations, the National Guard, MDH).

Partners agreed or strongly agreed with several statements regarding strong partnerships with the MDVA suicide prevention team, including that the SPT values partner contributions, their organization has a strong and collaborative relationship with the SPT, the partnership helps their organization achieve its goals, the SPT is responsive to feedback, and communication is timely and effective (67-78%; Figure X).

Between 11% and 19% of partners reported they were unsure, and 25% disagreed or strongly disagreed that their organization has a strong and collaborative relationship, the SPT is responsive to feedback, and communication is timely and effective).

Minnesota Veteran Suicide Prevention Plan

X. Please indicate how much you agree or disagree with the following statements. (N=27-28)

	Strongly agree or agree	<i>Strongly agree</i>	<i>Agree</i>	Strongly disagreed or disagree	<i>Disagree</i>	<i>Strongly disagree</i>	Unsure
The MDVA suicide prevention team values the contributions of partner organizations.	78%	48%	30%	4%	4%	0%	19%
My organization has a strong, collaborative relationship with the MDVA suicide prevention team.	75%	39%	36%	15%	11%	4%	11%
The partnership with the MDVA suicide prevention team helps us achieve our organizational goals.	74%	37%	37%	7%	7%	0%	19%
The MDVA suicide prevention team is responsive to partner feedback and concerns.	70%	44%	26%	15%	15%	0%	15%
Communication with the MDVA suicide prevention team is timely and effective.	67%	41%	26%	15%	15%	0%	19%

Respondents were also asked to share their thoughts about strengthening the partnership between their organization and the SPT. Most partners agreed that a stronger partnership is possible (84%) and that the SPT could better coordinate with their organization (58%; Figure X). One quarter of partners reported they weren't sure whether the SPT could improve their coordination.

X. Please indicate how much you agree or disagree with the following statements. (N=24)

Minnesota Veteran Suicide Prevention Plan

	Strongly agree or agree	Strongly agree	Agree	Strongly disagreed or disagree	Disagree	Strongly disagree	Unsure
A stronger partnership between the MDVA suicide prevention team and my organization is possible.	84%	38%	46%	13%	13%	0%	4%
The MDVA suicide prevention team could better coordinate with my organization on suicide prevention issues.	58%	25%	33%	17%	17%	0%	25%

Strengths of partnerships (N=22)

Partners were asked to share the strengths of their collaboration with the MDVA suicide prevention team and the ways the partnership is working well.

Collaborative approach (N=8)

Partners most often described how MDVA takes a collaborative, team-oriented, responsive approach, and that they listen to input and feedback from others.

Team members are responsive, approachable, and open to feedback.

The MDVA team is consistently open to conversation, feedback, and coordination with [our organization], creating space for ongoing dialogue and relationship-building.

Information sharing (N=7)

They reported effective information sharing, including specific communication channels.

The MDVA has a good system in finding, attending and hosting events for my organization to be a part of.

Suicide prevention expertise (N=4)

Partners described how MDVA is well-informed on suicide prevention issues. They specifically mentioned how MDVA focuses on evidence-based practices, incorporates guidance from subject matter experts, and provides effective trainings.

They are the subject matter experts on suicide prevention.

Education has been very helpful to our staff members to become more comfortable with identifying possible signs and symptoms that could lead suicidal ideation, the steps to take, and best practices for conversing with someone who may be experiencing suicidal ideation.

Committed (N=4)

Partners described the MDVA team as passionate, dedicated, persistent, and patient.

Their team approaches the work extremely informed, passionate, realistic and very helpful.

Minnesota Veteran Suicide Prevention Plan

Shared goals (N=2)

Two partners described shared goals or a common understanding of suicide prevention-related issues between MDVA and its partners.

Both agencies share a clear commitment to reducing suicide among Service Members, Veterans, and their Families, which creates a strong foundation for continued alignment.

Securing legislative funding (N=2)

Two respondents described effectively securing legislative funding as a success for MDVA and its' partnerships.

Other responses (N=1 each)

Other responses included:

- Creativity
- Physical co-location and shared infrastructure
- Positive comment about how MDVA hiring a Community Health Director was helpful and provided direction
- Suicide prevention is a challenging topic and it is difficult to measure impact
- Need to improve partnerships with Veteran groups
- Offer monthly in-person meetings across the state
- Need to promote Be the One through post commanders
- Engaging others in MDVA and in the community is difficult, partly due to stigma
- Don't know

Barriers to partnership (N=25)

Partners were asked to identify the barriers they encounter when partnering with the MDVA suicide prevention team and how it could be improved.

Need to improve coordination and communication (N=6)

Partners often described a need to improve coordination and communication with other organizations. This included clarifying expectations and roles, ensuring effective delegation, consistently attending events facilitated by other organizations, collecting input and ensuring it is used, ensuring people feel comfortable sharing their thoughts and intentional about engaging others during meetings, and clarifying team members and who to contact about what.

Sharing between organizations; communication of expectations; understanding who is responsible for which tasks.

Not aware of the team or who is on it or how to contact them.

Improve scheduling coordination. When members of the SPT are at events or activities in the community, ensure that outreach to the teams in the area (Field Operations, CVSOs, MDVA Memorial Affairs/Veterans Homes locations) are aware of those activities and can support or participate.

Minnesota Veteran Suicide Prevention Plan

Lack of strategic direction (N=6)

Partners also frequently described a lack of strategic direction, including clarifying and communicating MDVA's mission and the purposes of specific initiatives, work groups, and meetings. They also described a need to define measurable outcomes.

[Lack of a] clear mission, intent, and measurable outcomes.

Limited resources (N=3)

Partners identified a lack of resources as a barrier, including limited capacity, staffing, and funding.

The capacity of the team... There are 3 people on the team to do statewide work. It is a lot for a small team.

Increase focus on specific populations (N=2)

Two partners suggested focusing on specific populations, including service members and Veterans who live in communal or dependent living situations and service members and Veterans who are not receiving direct care at VA facilities.

Need more integration (N=2)

Two partners described a need to strengthen integration into other teams, including other MDVA teams and American Legion healthcare teams.

No barriers (N=8)

Eight respondents reported that there are no barriers to partnering with MDVA.

Other responses (N=1 each)

- Many resources are available but there is low familiarity among Veteran populations
- Need to improve knowledge among other non-MDVA organizations
- Learn from mistakes and try new ideas
- Collaboration has improved

Strategies to strengthen partnerships (N=22)

Partners were asked for their suggestions to strengthen collaboration between the MDVA SPT and their organization.

Improve communication, build trust, and proactive engagement (N=11)

Respondents most often identified a need to improve communication, build trust, and proactively engage partners. They suggested ensuring all perspectives are heard, consistently participating and attending external events and conferences, and holding regular meetings that are streamlined, not redundant, have a clear purpose, and an attendee list that is intentionally developed.

More conversations, understanding and awareness of the Veteran community in Minnesota. This will produce more trust, which is badly needed to get things done with Veteran advocacy in Minnesota... Cultivate trust among partners so that those partners then do the work for MDVA SP, [such as] carrying the message, holding the events, etc.

Minnesota Veteran Suicide Prevention Plan

Members of the committees should feel they have stake in the game... There have been many silent partners in meetings, but it's important all voices be shared.

Short, recurring meetings to touch base on more limited topics and outreach event coordination. Limit the participation to only Suicide Prevention SMEs and a few of the relevant team members. Many meetings feel like they have too many participants to be effective.

More consistent participation and leadership with the coalition.

Define strategic direction and Identify shared goals with partners (N=8)

Partners described a need to identify shared goals in collaboration with partners, including the intent of the partnership and ensuring MDVA's work aligns well with partners' activities and goals.

Clear mission or intent of partnership.

Better communication and planning. What does MDVA need from us? What are the goals? Have those goals been identified in collaboration with partners ahead of time?

Understand the goals of the suicide prevention team and what goals, if any, overlap with or are particularly applicable to the population of my facility.

Hash out a monthly agenda to ensure our organizations stay aligned in priorities, messaging.

Improve information sharing (N=2)

Two partners identified a need to improve information sharing, including communicating services and resources available and best practices regarding suicide prevention.

Sharing of best practices.

Better databases of services available.

Other responses (N=1 each)

Other responses included:

- Partnership is already strong
- Continue quarterly planning calendar
- Continue brainstorming about mutual assistance options
- Continue existing meetings
- Need to better understand the Veteran population

Service and resource familiarity

Most partners reported they are somewhat (42%) or very familiar (42%) with suicide prevention services and resources provided by MDVA (Figure X).

X. How familiar are you with the SMVF suicide prevention services and resources provided by MDVA?

	Count	% (N=26)
Very familiar	11	42%

Minnesota Veteran Suicide Prevention Plan

	Count	% (N=26)
Somewhat familiar	11	42%
Slightly familiar	3	12%
Not at all familiar	1	4%

Respondents were asked to indicate whether they have heard of specific services or resources offered by MDVA. More than half of respondents reported they had heard of every resource or service (58-96%; Figure X). Gun lock access (96%), Veteran 988 training and marketing materials (85%), general presentations on Veterans suicide prevention (85%), Mental Health First Aid Training (81%), and partner connections (77%) had the highest percentages of familiarity.

X. Which of the following MDVA services/resources have you heard of prior to this interview? Select all that apply.

	Count	% (N=26)
Access to gun locks	25	96%
Access to Veteran 988 training and marketing materials	22	85%
Overall presentations on Veterans suicide prevention	22	85%
Mental Health First Aid Training	21	81%
Connection to partners (e.g., MN National Guard, VA, Minnesota Department of Health)	20	77%
LinkVet Training	18	69%
Applied Suicide Intervention Skills Training (ASIST)	16	62%
Connection to SMVF resources	16	62%
Changing the narrative Training	15	58%
Question, Persuade, Respond (QPR) Training	15	58%
Another service/resource, please describe (i.e., Veterans Resilience Project, safe storage coalitions, Veteran Service Organizations)	3	12%

Respondents reported lower levels of familiarity regarding suicide prevention services and resources provided by other entities outside of MDVA, with 26% very familiar and 27% somewhat familiar (Figure X).

X. How familiar are you with the SMVF suicide prevention services and resources provided by other entities in your region of Minnesota (local non-profits, federal programs, etc.)?

	Count	% (N=27)
Very familiar	7	26%
Somewhat familiar	10	37%
Slightly familiar	9	33%
Not at all familiar	1	4%

Minnesota Veteran Suicide Prevention Plan

Unmet needs (N=22)

Partners were asked to share the unmet needs they have observed among the SMVF population related to mental health or suicide prevention.

Lack of services (N=8)

Partners most often described a lack of services, providers, and resources. They identified a need to improve timely access to care and a lack of specific services, including crisis services, substance use services, services for peacetime Veterans, resources to help individuals experiencing housing instability, and children's mental health services. They also described how some service members and Veterans prefer in-person services rather than telehealth, and reported a lack of availability for in-person services. Some specifically mentioned a lack of services and resources in rural areas.

Access to timely substance abuse treatment, particularly in more rural settings.

Clear gaps in the COMPACT Act. Wartime Veterans almost always have access to the care they need... We need to do a better job of providing care to our peacetime Veterans.

The COVID-19 pandemic either burned-out providers or made it much easier for them to work remotely, and many Veterans... prefer counseling options in person, at least initially.

Lack of awareness and need for service navigation support (N=6)

Partners reported a lack of awareness of available services among SMVF, emphasized the complexity of the service system, and identified a need to provide service navigation support.

Lack of knowledge the Veteran population has regarding what is available to them... Shortage of mental health providers, not just with VA but in healthcare as a whole. I believe the VAMC and CBOCs provide extremely valuable and informed MH care options, but due to the size of their organization it can be very confusing for Veterans to navigate.

need to strengthen collaboration (N=5)

Partners identified a need to improve collaboration and strengthen partnerships and information sharing. Specifically, they suggested partnering with faith and community leaders, collaborating more with other MDVA programs and services (e.g., Veteran homes, education), and helping organizations build capacity by connecting partners with training, data, and best practices related to suicide prevention.

Engagement within MDVA, other programs within MDVA. What would it look like to bring them together such as homeless programs, programs and services, Veteran homes, and education? How can we be more united in what we are doing across programs?

Mental health education and stigma (N=2)

Two partners described a need to address stigma related to mental health and increase mental health education efforts.

Military stigma issues... Normalizing help-seeking behavior for currently serving is important for proper referrals to happen

Minnesota Veteran Suicide Prevention Plan

Other responses (N=1 each)

Other responses included:

- Need to provide social connection with other SMV
- Increase efforts related to data
- Focus on high risk populations
- 988 has been valuable

Program or strategy expansion and implementation (N=19)

Partners were asked to identify any suicide prevention programs or strategies that should be introduced or expanded in Minnesota.

Clinical or navigation services (N=9)

Partners most often identified clinical or navigation services, such as peer support, the VA healthcare navigation program, service navigation support, placing suicide prevention specialists in Veteran housing, crisis services and training for law enforcement, and life skills and coping skills coaching.

Start and strengthen the Healthcare Navigation program. This needs to be rolled out correctly in order to take advantage of the many benefits it can offer (referring Veterans to their CVSO, enrolling them in VA healthcare, making them aware of what they qualify for, re-building their sense of pride in their Veteran status, there are so many more).

I would love to see a Healthcare specific hotline/text line for our current residents, especially those in the Domiciliary. I would love to see clinical suicide prevention specialist(s) in our Homes working with our residents on safety plans, risk assessments/levels, interventions, and resources. We have a great social work team that help with these, but they do not have the time to meet and work in-depth with our residents that may need extra support or would benefit from having someone make a safety plan with them before one is needed.

Immediate crisis intervention and law enforcement training in how to deescalate Veteran situations.

Outreach and awareness raising (N=4)

Some partners suggested increasing outreach and efforts to raise awareness of suicide prevention related topics, including services that service members and Veterans are eligible for, promoting 988, creating and distributing a toolkit to support people in crisis, and distributing prevention materials at bars and pull-tab booths.

Get the 988 number out as many places as we can and make that as "normal" as 911.

Many Veterans don't realize they qualify to access the Vet Centers or other services that could help them in times of trouble, before chronic existential issues set in.

Collaborations and collecting input (N=4)

Some partners emphasized the need to focus on collaborations, partnerships, and collecting input from specific audiences. They suggested collecting input from clinicians; working more closely with federal partners, including

Minnesota Veteran Suicide Prevention Plan

the VHA; holding listening sessions with key community partners; and strengthening collaboration with mobile crisis teams.

I strongly recommend that there is a clinician focus group assembled and their feedback/experience with Veterans choosing to take their life by suicide is further explored and considered.

Specific trainings (N=3)

Partners mentioned implementing specific trainings, including Mental Health First Aid, ASIST, and Just Fucking Ask.

Expand services in rural areas (N=2)

Two partners described the need to increase services and resources available in rural areas.

Urban Veterans seem to be plagued with an overabundance of resource options that can cause them confusion, whereas rural Veterans are struggling with access to care and a lack of resources.

Prevention and early intervention (N=2)

Two partners suggested providing more prevention and early intervention services and resources.

Other responses (N=1 each)

Other responses included:

- Expand and improve funding for Veterans' centers and CBOCs
- Need for more data regarding Veterans' needs
- Focus on high risk populations

Opportunities for improved coordination

Partners were asked for their recommendations to better coordinate efforts with partners.

Communication and collaboration (N=11)

Respondents most often made suggestions regarding communication, including improved information sharing and holding regular meetings with partners (N=11):

- Communicate with more advanced notice
- Intentional one-on-one communication with partners to better build relationships
- Ensure goals are identified in collaboration with partners
- Hold regular meetings with partners
- Support partner events and proactively share information about events with partners
- Provide more information about SMV suicide prevention to partners
- Focus on systems-level communication instead of trainings (e.g., improving mobile crisis coordination and notifying clients about new Veteran residents)
- Ensure activities are collaboratively developed with partners
- Collaborate with partners to offer joint trainings, capacity-building, and create shared communication pathways

Minnesota Veteran Suicide Prevention Plan

Within these themes, partners specifically mentioned the Minnesota Department of Health, American Legion Service Officers, MACVSO, and the Hennepin County Suicide Prevention Coalition.

Communicate with more advanced notice. Collaborate with us in identifying goals, rather than identifying their own goals and notifying us of those goals.

Major Veteran Holidays, or even simple days such as Flag day. Any patriotic calendar day, The American Legion and the MDVA should be doing something or know what the other is a part of. This way, we can assist verbally with info and knowledge or physically be a part of each other's events.

Be intentional about communicating with partners. Look for opportunities to meet one on one, rather than in large groups. This gives people the opportunity to ask questions and learn more. If we can cultivate more relationships with partner organizations, the monthly Collaborative meetings will be much more effective.

Ensuring that all suicide prevention activities are aligned under the statutory authority of MDH would create a clear statewide framework and reduce duplication of effort.

Engaging SMV directly (N=4)

Some respondents mentioned efforts to better engage and reach SMV directly, including specific settings and tailoring information to specific populations.

More visits to colleges and universities with both static displays and active engagement.

Active participation with higher-functioning Veterans in the MVH domiciliaries.

We both could share their efforts more with our Veterans. Finding more ways to find/identify Veterans that are struggling is critical.

Other responses (N=1 each)

Other responses included:

- Legislative advocacy
- Focus on organizations that serve high-risk populations (e.g., justice-involved, housing instability, older adults, isolated SMV)
- Interest in learning about the priorities of other entities and how to effectively collaborate

Recommendations for increasing awareness of suicide prevention resources among partners (N=18)

Partners were asked to share their recommendations for increasing awareness of existing suicide prevention resources among partners.

Communication and collaboration (n=9)

Respondents most often made suggestions related to communication and collaboration, including:

- Public call to action inviting others to the table
- Identify a specific ask and assign actionable items
- Effectively convey the importance of the partnership
- Continuous grassroots outreach
- Work more with non-VA behavioral health providers

Minnesota Veteran Suicide Prevention Plan

- Hold an “Intro to MDVA SP” meeting
- Communicate accomplishments and the impact of MDVA’s work to build trust
- Engage more with the Veteran Collaborative
- Leverage existing network to promote consistency and reduce duplication rather than starting new initiatives
- Direct and consistent communication, including meeting regularly

I would love to see our SPT working more with behavioral health organizations that may be outside of the Veteran focus to be a referral source for Veterans that may be getting counseling from providers that are not in the VA healthcare system.

Continued outreach to Veteran organizations at a grassroots level.

Having an “introduction to MDVA SP” [session for partners]... I also think MDVA SP needs better actionable items for their staff. It is not clear what they do, or how much they do it... Is there a way they can showcase their work a little clearer? That may buy more trust with others.

Strengthening its engagement and coordination with partner organizations through the existing Veteran Collaborative. The Collaborative offers a vehicle for communication, shared learning, and dissemination of information across agencies and community partners that serve Service Members, Veterans, and their Families (SMVF).

Resource and information sharing (N=4)

They also made recommendations related to resource and information sharing, including:

- Create a database of partners and the services/resources they provide
- Focus on sharing existing resources rather than new “structures or campaigns” (e.g., regular resource spotlights, coordinated messaging, joint training opportunities within the Collaborative).
- Create a tool to improve resource sharing (e.g., Dropbox)
- Identify and standardize an IT solution to improve resource sharing in local communities and pair with standardized messaging

Some sort of drop box or tool to share resources.

If we standardized an I.T. platform with all of the various suicide prevention resources in a particular geographic area while agreeing on key messaging/communication with the Veteran public, I think it would make a big impact.

Master database of who does what that can be shared.

Other responses (N=1 each)

Other suggestions included:

- Distribute more flyers in more areas
- Focus on high-risk populations
- Radio
- Need to better understand effective strategies for raising awareness of existing resources among SMV

Minnesota Veteran Suicide Prevention Plan

Two respondents reported they didn't have a recommendation or encouraged MDVA to continue the work they're already doing.

Sectors and organizations to engage (N=16)

Partners were asked to identify any organizations or sectors that should be more involved in SMVF suicide prevention efforts. They suggested:

- The physical health care sector, including MDVA healthcare division (N=4)
- Criminal/legal system (N=2)
- Housing (N=2)
- Gambling concerns (N=2)
- All people or sectors that work with Veterans or the importance of engaging other sectors beyond behavioral health (N=2)
- Other MDVA teams (N=1)
- Behavioral health care, including training and ensuring access to non-VA providers to work with SMV (N=1)
- Private sector (N=1)
- Financial wellbeing (N=1)
- Education (N=1)
- Employment (N=1)
- Commanders Force/VFW/vet services (N=1)
- No others, including suggestions to focus on existing priorities and partnerships and MDVA's strategic direction (N=5)

Communication channels (N=18)

Partners were asked to share the communication channels they view as most effective for reaching SMVF populations in their area. They identified:

- One-on-one direct communication and word of mouth (N=5)
- Social media, including Facebook (N=5)
- Relationships with community leaders, organizational leaders, and other partners that can share information, including CVSOs (N=4)
- Email (N=4)
- Presentations and attending or tabling events (N=4)
- Flyers (N=2)
- Don't know (N=2)
- Advertising at companies that offer Veteran discounts (N=1)
- Websites (N=1)
- Radio (N=1)
- Newspaper (N=1)
- Newsletters (N=1)

One respondent emphasized the importance of repetition throughout multiple channels.

Underrepresented stakeholders and communities (N=18)

Partners were asked to identify the stakeholders or communities that are currently underrepresented in MDVA's suicide prevention partnerships.

- Rural/outstate Minnesota (N=2)
- Faith leaders (N=2)

Minnesota Veteran Suicide Prevention Plan

- Middle-aged Veterans (N=1)
- MACVSO (N=1)
- LGBTQIA2S+ (N=1)
- BIPOC (N=1)
- Veterans who are homeless (N=1)
- Healthcare providers, including mental health providers (N=1)
- Education sector (N=1)
- Veterans who are incarcerated (N=1)
- Don't know, need more information about who is represented, or suggestion to conduct a partnership analysis (N=7)
- None (N=3)

One respondent suggested strengthening engagement and partnership with existing partners and organizations to clarify goals and ensure consistency rather than building new partnerships.

SMVF survey

This section includes a more detailed overview of the SMVF survey results. A total of 222 service members, Veterans, and family members or caregivers completed the survey. Most respondents identified as a Veteran (58%), followed by family members and caregivers (33%) and current service members (9%; Figure X).

X. Which of the following best describes you?

	% (N=222)
Veteran	58%
Family member (e.g., partner, child, sibling, parent) or primary caregiver of a service member or Veteran	33%
Current service member (Active Duty, Guard, or Reserve)	9%

Respondents were asked a series of questions regarding their familiarity with existing resources, their sense of purpose, and their sense of social connection. Most respondents agreed they knew at least one place where they feel welcome (91%), they have people they can count on (90%), they have a sense of purpose (90%), they would seek help if they knew a service member or Veteran struggling (89%), they know how to find help (86%), they feel like they belong in their community (82%), and they feel connected to other Veterans and service members (77%; Figure X).

X. Please indicate how much you agree or disagree with the following statements. (N=201-203)

	Strongly agree or agree	<i>Strongly agree</i>	<i>Agree</i>	Strongly disagreed or disagree	<i>Disagree</i>	<i>Strongly disagree</i>	Unsure
I know at least one place (group, activity, or organization) where I feel welcome.	91%	37%	54%	6%	5%	<1%	2%
I have people I can count on when I need support.	90%	38%	52%	7%	6%	1%	3%

Minnesota Veteran Suicide Prevention Plan

	Strongly agree or agree	<i>Strongly agree</i>	<i>Agree</i>	Strongly disagreed or disagree	<i>Disagree</i>	<i>Strongly disagree</i>	Unsure
I have a sense of purpose in my day-to-day life.	90%	34%	56%	7%	4%	3%	3%
I would seek help if I or a service member/Veteran that I care about is struggling.	89%	45%	44%	4%	4%	0%	6%
I know how to find help if I or a service member/Veteran I care about is struggling.	86%	42%	44%	9%	8%	1%	5%
I feel like I belong in my local community.	82%	24%	58%	13%	11%	2%	4%
I feel connected to other Veterans/service members.	77%	29%	48%	20%	19%	1%	3%

Note: Percentages may not total 100% due to rounding.

Respondents were asked to indicate their level of familiarity with specific suicide prevention services. Familiarity was highest for VA resources, with 82% of respondents reporting they are very or somewhat familiar, followed by Veteran service organizations (79%), 988 suicide and crisis lifeline (78%), and County Veteran Service Offices (76%; Figure X). Familiarity was lowest for tribal, Indian Health Service, and urban Indian Health programs (28%).

X. How familiar are you with each of the following suicide prevention services? (N=198-199)

	Very or somewhat familiar	<i>Very familiar</i>	<i>Somewhat familiar</i>	A little familiar	Not at all familiar
VA Resources (e.g., VA Medical Center)	82%	57%	25%	15%	3%
Veteran service organizations (e.g., VFW, American Legion)	79%	57%	22%	17%	5%
988 Suicide & Crisis Lifeline (Veterans Press 1)	78%	53%	25%	14%	9%
County Veteran Service Office (CVSO)	76%	59%	18%	12%	12%
Community events to build service member/Veteran connection and belonging	56%	27%	30%	26%	18%
Faith/community-based programs	52%	19%	34%	23%	25%
MDVA programs (e.g., LinkVet)	51%	25%	26%	21%	28%
Peer support or mentorship programs	50%	20%	30%	21%	29%
Training (e.g., QPR, ASIST, safeTALK)	47%	26%	22%	18%	35%
Lethal means safety resources and education	46%	22%	25%	24%	30%
Tribal/IHS or urban Indian Health Programs	28%	11%	17%	17%	56%
Other resources (e.g., non-profits, food supports, other crisis services)	15%	15%	13%	10%	62%

Note: Percentages may not total 100% due to rounding.

Minnesota Veteran Suicide Prevention Plan

Respondents were asked whether they or their service member/Veteran have used specific services or resources in the past 12 months. The most commonly used services or resources were VA resources (72%), followed by County Veteran Service Offices (48%), and Veteran service organizations (48%; Figure X). Very few respondents reported utilization of Tribal, Indian Health Service, or urban Indian Health programs (5%), lethal means safety resources and education (7%), nor the 988 suicide and crisis lifeline (9%).

X. In the past 12 months, have you or your family OR you or your service member/Veteran used any of the resources listed? (Select all that apply; N=165-187)

	Yes	No	Unsure
VA Resources (e.g., VA Medical Center)	72%	28%	0%
County Veteran Service Office (CVSO)	48%	51%	1%
Veteran service organizations (e.g., VFW, American Legion)	48%	51%	1%
Community events to build service member/Veteran connection and belonging	39%	58%	3%
Faith/community-based programs	29%	68%	3%
Peer support or mentorship programs	21%	76%	3%
Training (e.g., QPR, ASIST, safeTALK)	17%	80%	3%
MDVA programs (e.g., LinkVet)	15%	84%	2%
988 Suicide & Crisis Lifeline (Veterans Press 1)	9%	91%	0%
Lethal means safety resources and education	7%	89%	4%
Tribal/HIS or urban Indian Health Programs	5%	92%	3%
Other resources, please specify (e.g., employee resource groups, “non-VA/MDVA resources,” service animal group)	6%	89%	5%
None – I have not used any resources	8%	89%	3%

Note: Percentages may not total 100% due to rounding.

Respondents who reported utilization of one of the resources in the previous question were asked to rate how helpful the resource was. Most respondents ranked each resource as “very” or “extremely” helpful (from 10 out of 16 respondents that used the 988 Suicide and Crisis Hotline to 8 out of 8 respondents that used Tribal/Indian Health Service or urban Indian Health Programs; Figure X).

X. [Among respondents who reported they used one of the resources in Figure X] How helpful were the resources you or your family used?

	Count	Extremely or very helpful	Extremely helpful	Very helpful	Somewhat helpful	A little bit helpful	Not at all helpful
Tribal/Indian Health Service or urban Indian Health Programs	8	8/8	1/8	7/8	0/8	0/8	0/8
Peer support or mentorship programs	34	88%	50%	38%	9%	3%	0%

Minnesota Veteran Suicide Prevention Plan

	Count	Extremely or very helpful	Extremely helpful	Very helpful	Somewhat helpful	A little bit helpful	Not at all helpful
Lethal means safety resources and education	13	11/13	4/13	7/13	1/13	1/13	0/13
Training (e.g., QPR, ASIST, safeTALK)	29	79%	34%	45%	14%	7%	0%
Veteran service organizations (e.g., VFW, American Legion)	84	75%	35%	40%	17%	4%	5%
County Veteran Service Office (CVSO)	83	74%	59%	14%	12%	10%	5%
Community events to build service member/Veteran connection and belonging	68	72%	34%	38%	24%	3%	1%
Faith/community-based programs	48	71%	46%	25%	21%	8%	0%
VA Resources (e.g., VA Medical Center)	123	69%	40%	29%	21%	7%	3%
MDVA programs (e.g., LinkVet)	25	68%	28%	40%	20%	4%	8%
988 Suicide & Crisis Lifeline (Veterans Press 1)	16	10/16	5/16	5/16	2/16	2/16	2/16
Other resources	10	8/10	8/10	0/10	2/10	0/10	0/10

Note: Percentages may not total 100% due to rounding. Given the small number of respondents, fractions are used for items with less than 20 respondents. Use caution when interpreting findings for these items.

Respondents were asked to identify the biggest barriers to accessing suicide prevention or mental health services in their areas. About a third of respondents selected stigma or fear of judgment (34%) and lack of understanding of military culture (32%), followed by long wait times (25%) and not knowing where to go (23%; Figure X).

X. What are the biggest barriers you or others face when trying to access suicide prevention or mental health services in your area? (Select all that apply; N=222)

	% (N=222)
Stigma or fear of judgment	34%
Available services do not understand military culture	32%
Long wait times	25%
Not knowing where to go	23%
Cost/lack of insurance	21%
Services are not available in my area	19%
Lack of culturally competent care	18%
Lack of a VA diagnosis	18%
Not being eligible for services	14%
Lack of transportation	11%

Minnesota Veteran Suicide Prevention Plan

	% (N=222)
Other barrier, please describe	14%
Lack of effective services (e.g., services aren't useful, VA isn't receptive to effective programs, "over-commercialization of prevention programs")	N=7
Personal reasons (e.g., "convincing myself help is there," "I get overwhelmed and then it's difficult to express my needs," "don't feel like their issue is enough," "they do not want to go," "fear of facing the war inside my heads")	N=6
Lack of services, including scheduling challenges (e.g., services for non-crisis situations, limited services generally, lack of suicide prevention outreach, work schedules don't align with times services are available)	N=5
Provider relational issues (e.g., not being believed, gaslighting, lack of understanding, lack of trust)	N=3
Other (i.e., bureaucratic delays, health data privacy laws, veterans and service members aren't prioritized enough))	N=5
I don't know	5%
I haven't experienced any barriers	16%

About one third of respondents agreed there are needed but inaccessible mental health or suicide prevention services or resources in their area (31%; Figure X). When asked to specify services or resources, they most often identified challenges with general service availability, including waitlists and limited availability in rural areas (37%). They also identified specific types of services that are needed (15%).

X. Are there any mental health/suicide prevention services or resources that service members and Veterans in your area currently need but can't access?

	% (N=172)
Yes	31%
No	69%
[If yes] Please explain what mental health/suicide prevention services or resources are needed but currently not accessible. (Open-ended response themes)	% (N=46)
Increase service availability, including addressing waitlists and ensuring timely care and broad geographic access, particularly in rural areas	37% (N=17)
Provide specific types of services, including support groups for military sexual trauma, equine therapy, in-person services (vs. remote), culturally-competent services, spiritual support, traditional healing options, VA-provided inpatient mental health care, and greater service integration and care coordination	15% (N=7)
Expand eligibility for VA-sponsored health insurance coverage and the number of clinics and providers that accept VA-sponsored health insurance coverage	13% (N=6)
Social support, peer support, and community spaces	11% (N=5)
Ensure high-quality care	9% (N=4)
Services specifically tailored to Veterans and service members, including providers who are Veterans and crisis response teams	9% (N=4)

Minnesota Veteran Suicide Prevention Plan

	% (N=172)
Raise awareness of mental health, suicide, available services, and other related topics, including offering events and navigation support	7% (N=3)
Affordable services	4% (N=2)
Other social determinants of health supports, including transportation, food assistance, and emergency assistance	4% (N=2)
Streamline process for accessing benefits and address bureaucratic delays	4% (N=2)
Providers that aren't affiliated with the VA but understand military culture	4% (N=2)
Other (e.g., support for caregivers, not wanting to admit they need help, improved training for law enforcement to respond to PTSD concerns, firearm suicide prevention initiatives, stigma, "proactive community-led response to vets in need")	13% (N=6)

Respondents were asked to share their preferred way to receive information about suicide prevention or mental health resources. They most commonly selected email (59%), followed by a trusted organization (43%), in-person events (42%), and websites (41%).

X. What is your preferred way to receive information about suicide prevention/mental health resources? Select all that apply.

	% (N=173)
Email	59%
Through a trusted organization (e.g., my local CVSO)	43%
In-person events	42%
Website	41%
Social media	35%
Text message	29%
Printed materials	29%
Other, please specify (e.g., VA health care provider, friends and family, personal phone call, television, podcasts, news, individual contact/connection, Veteran leaders, the governor)	6%

Respondents represent a wide range of counties across Minnesota. Ten percent live in Hennepin County, followed by 9% in Dakota County, and 6% in Washington County (Figure X). Three percent of respondents said they live on a federally-recognized Native American reservation.

X. What county do you live in? Do you live on a federally-recognized Native American reservation?

	% (N=174-181)
Anoka	5%
Beltrami	1%
Benton	2%

Minnesota Veteran Suicide Prevention Plan

	% (N=174-181)
Blue Earth	1%
Carlton	1%
Carver	3%
Cass	2%
Chippewa	1%
Chisago	2%
Clay	2%
Clearwater	1%
Cook	1%
Cottonwood	1%
Crow Wing	1%
Dakota	9%
Dodge	1%
Faribault	1%
Filmore	2%
Goodhue	1%
Hennepin	10%
Hubbard	2%
Isanti	1%
Jackson	1%
Kandiyohi	2%
Lac Qui Parle	1%
Lake	2%
Lyon	1%
Mahnomen	1%
Martin	1%
McLeod	1%
Mille Lacs	1%
Morrison	1%
Nicollet	1%
Nobles	1%
Norman	1%
Olmsted	1%

Minnesota Veteran Suicide Prevention Plan

	% (N=174-181)
Otter Tail	1%
Polk	1%
Ramsey	5%
Rice	1%
Roseau	2%
Scott	2%
Sibley	1%
St. Louis	3%
Stearns	4%
Stevens	1%
Swift	1%
Todd	3%
Wadena	1%
Waseca	1%
Washington	6%
Winona	2%
Wright	3%
Yellow Medicine	1%
<i>Lives on a federally-recognized reservation</i>	3%

Note: Percentages may not total 100% due to rounding.

About half of respondents identify as men (52%), with 43% identifying as women (43%; Figure X).

X. Do you identify as...

	% (N=180)
A man	52%
A woman	43%
Another identity (please describe)	0%
Unsure/don't know	0%
Prefer not to answer	6%

About a quarter of respondents are age 40 to 44 (24%), followed by age 45 to 49 (13%) and age 55 to 59 (12%; Figure X).

X. What is your age?

Minnesota Veteran Suicide Prevention Plan

	% (N=177)
18-21	0%
22-24	1%
25-29	4%
30-34	3%
35-39	8%
40-44	24%
45-49	13%
50-54	9%
55-59	12%
60-64	9%
65-69	3%
70-74	7%
75-79	3%
80-84	2%
85+	1%

Note: Percentages may not total 100% due to rounding.

Most respondents identify as white (94%), followed by American Indian or Alaska Native (6%; Figure X).

X. What is your race? Select all that apply.

	% (N=174)
American Indian or Alaska Native	6%
Asian	1%
Black or African American	2%
Native Hawaiian or other Pacific Islander	1%
White	94%
Other, please specify	3%

Four percent of respondent identify as Hispanic or Latino (Figure X).

X. What is your ethnicity?

	% (N=164)
Hispanic or Latino	4%
Not Hispanic or Latino	96%

Minnesota Veteran Suicide Prevention Plan

Respondents were asked to share any other comments regarding suicide prevention efforts in Minnesota. Responses varied widely. Most commonly, respondents described frustration with MDVA or the VA (20%), followed by emphasizing the importance of prevention and early intervention efforts (15%) and the importance of increasing service availability (13%; Figure X).

X. Is there anything else you'd like to share about suicide prevention resources or support for service members, Veterans, or their families in Minnesota? (Open-ended responses)

	% (N=54)
Frustration with VA or MDVA ^a	20% (N=11)
Need to focus more on prevention, root causes of suicide, and early intervention, including promoting social support and addressing stigma	15% (N=8)
Increase service availability, address wait times, expand geographic reach of services, including rural areas and reservations	13% (N=7)
Need for community-led, grassroots efforts, including within MDVA, and ensure Veterans and service members are asked for their input	13% (N=7)
Challenges navigating and accessing services, including eligibility issues	9% (N=5)
Conduct outreach, educational, and promotional efforts	7% (N=4)
Promotion of existing resources or positive comment about existing resource	7% (N=4)
Care quality concerns	6% (N=3)
Need for more funding, including funding for mental health services generally and funding for local organizations	6% (N=3)
Importance of SMV-competent care, providing training to providers, hiring Veterans as providers	6% (N=3)
Appreciative comment (e.g., thank you for doing this)	4% (N=2)
Need to support Veterans transitioning to civilian life	4% (N=2)
Need to celebrate SMV and focus more on the needs of SMV	4% (N=2)
Other responses ^b	15% (N=8)

^a Themes included lack of impact from MDVA's suicide prevention efforts or the Governor's Challenge group, MDVA's suicide prevention goals and direction are unclear, MDVA declining to approve legislative funding "for the majority of Veteran nonprofits," focuses too much on VA services at the neglect of other providers, sense that suicide prevention is not being taken seriously by MDVA, and the sense that MDVA is disconnected from or doesn't listen to the SMV community.

^b Themes included no resources are needed, need for non-pharmacological treatment options, need for creativity and innovation, create a list of vet-friendly employers, politicians and leaders don't seem to prioritize SMV suicide prevention, concern that discussing suicide may lead to more suicides, don't focus on guns, the importance of one-on-one connection rather than general outreach.