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Presenter(s): Claire Hoffmire

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Interviewer: I want to introduce our presenter today. Dr. Claire Hoffmire is an epidemiologist at the Rocky Mountain MIRECC for Suicide Prevention whose public health research focuses on improving better suicide surveillance and understanding gender differences in Veteran suicide risk and prevention strategies. Dr. Hoffmire, can I turn things over to you?

Dr. Hoffmire: Great. Thank you so much for the introduction, and thank you everyone for listening in today. I look forward to talking to you about some of the research that we’ve done which looks at the impact of gender and VHA service use on Veteran suicide risk. I am going to just open up with a question which I think you are usually asked to find out who is here in attendance with us today. We just want to know what your primary role in VA is. You can select any of the following: Student, trainee or fellow; clinician; researcher; manager or policy-maker or other.

Interviewer: Responses are coming in. I will give everyone just a few more moments before we close the poll question and go through the results. It looks like we are slowing down here, so we will close that out and see what we have. The responses we are seeing are 8% student, trainee or fellow; 45% clinician; 21% researcher; 6% manager or policy-maker and 21% other. Thank you, everyone.

Dr. Hoffmire: Great. So just quickly to overview what I am going to talk about today, I think obviously given that this is a suicide prevention cyber seminar series, there is a lot of familiarity with this. Still, I want to set the context of the study results I was asked to speak about.

Interviewer: Claire, I’m sorry to interrupt. You need to click on that button to show your screen again.

Dr. Hoffmire: It didn’t come up. Let’s see.

Interviewer: I can prompt you for it again. Sorry to the audience. You should have it right there.

Dr. Hoffmire: I apologize but it just not working as it did before. Is it hidden. There it is. Okay.

Interviewer: Perfect.

Dr. Hoffmire: Thank you. Sorry about that. So, again, just a presentation overview today. I know most of us, and I’m going to ask you a question in a moment, are quite familiar with suicide prevention. But I’m going to set the context of our study results just within suicide in the general U.S. population and some of what we knew before this study in terms of suicide among VHA Veterans. Then I just want to share with you the specifics of our study: aims, methods, results; some of the implications and next steps that we have seen so far, and, of course, to just remind everyone of the VA suicide prevention resources and given the findings of this study, the complementary women’s health resources that we have available.

So, I am going to go quickly to a second poll question. Basically, as I said, I know this is a suicide prevention cyber seminar series, but I just want to get a sense of who is joining us today in terms of your specific experience related to suicide prevention activities or research or otherwise within our Veteran population, so I can tailor some of these slides to the group.

Interviewer: Responses are coming in well. Let’s give everyone just a few moments again before we close the poll out and go through the results. About 70%. If we can get a few more answers in, we will be able to get this closed out. It looks like we have slowed down. Here we go. So, we’re seeing about 7% said they have no experience, 56% have some experience and 37% have a lot of experience. Thank you, everyone.

Dr. Hoffmire: Great. I had a feeling that it would be a relatively experienced group, which is good to know. I am going to set the stage or you. However, many of us know about the public health burden of suicide in the general U.S. population. It’s really important because this study I’m going to be talking about is very much the epidemiology of suicide among Veterans. I know we do know a considerable amount about risk factors and projected factors. Things like that are not really what I’m going to be getting into today. This is really a relative a risk type study and talk, but I think that that’s very important to set the state in terms of this in terms of the public health burden of suicide. This has been widely recognized that it truly is a public health problem for many years and brought to the forefront of attention and research really with the 2012 National Strategy for Suicide Prevention; although recognized before then. Since 2008, suicide has been seen as the 10th leading cause of death. It is the only leading cause of death for which age-adjusted rates increased significantly from 2011 to 2012. \_\_\_\_\_ [00:06:01] from a public health perspective as in years of potential life lost. It is the 4th leading cause of that marker. Interestingly and importantly from 2005 to 2011, it was really the only cause of death for which years of potential life lost increased. All others remained stable or decreased during that same time period. Another widely recognized important piece of information, especially when we are talking about Veterans is that firearms are the leading mechanism for suicide among men, whereas poisoning in the general population at least is the leading mechanism for women.

Again, a slide that many have seen, but a very important slide in the context of message for this study is that, of course, there is a wide variability in suicide risk and in this case where it falls in terms of the top ten leading causes of death by age group. Of course when we’re talking about Veterans, we are talking about adults, but even within, starting at least with this group, 15-24 and up, again, wide variability, suicide in green there. For the younger age groups, that being the second leading cause of death. Even when we get up to 55-64 years of age when we have so many competing chronic diseases leading to competing mortality risks, suicide still remains the 8th leading cause of death. Certainly well recognized at this point in the general U.S. population of being of public health significance and we have recognized this as well for Veterans over the years.

Here is a quick slide, just a transition to what we know \_\_\_\_\_ [00:07:41] from the 2012 VA Suicide Data Report. We see here from 1999 to 2010 that, although there has been a bit of a decrease, about 20 or greater than 20% of adult suicide decedents do have an indication of Veteran status or military history on their death certificate. This comes from a state Mortality Database, which I will talk to you a little bit about, the database that we used for this specific study we are going to talk about today. Of note, this is just a sample of eight states in this particular slide. So, of course, this is an estimate but certainly points out the importance of understanding Veteran suicides in particular. We have known for some time; although I’m going to talk to you about some new information we have on Veterans overall, there certainly has been information on suicide rates among our VHA Veterans, and those are those who use VHA services. This graphic and the next come from the 2014 update to the VA Suicide Data Report, reporting suicide rates per 100,000, stratified by gender. Here we have the males compared to U.S. males. We see that, indeed, among our VHA Veterans, there are higher suicide rates than have been since 2001 among our Veteran population compared to the U.S. males. This was also seen for females. Among our VHA-utilizing female Veterans, the suicide rate is higher than that we observed over the same time period for U.S. females overall.

Although we really do believe that the suicide rate is higher than that for non-Veterans, we felt and we knew that better empirical data was needed for the full Veteran population that is not only those receiving VHA services, which is what I just showed you for the last two slides. Although this information is incredibly valuable and important for our patient population, we know that it can’t eliminate the full picture of Veteran suicides and, quite simply put, that is because more than 70% of the 22 million living Veterans in 2012 were not enrolled in and/or using VHA services. So, in fact, it is the majority of our Veterans who do not use VHA services and it is much harder for us as researchers within the VA to gain information on any health information on those Veterans, but very important as really we are charged with caring about and working towards the health for all Veterans and also because we need to learn about how to better engage Veterans when we know that we have great programs to help them and reach those groups of Veterans we need to better engage and things like that. This is no different for suicide and we are very interested in learning about the epidemiology of suicide for Veterans as a whole.

There also was \_\_\_\_\_ [00:10:45] on the study that I am going to share findings from and growing considerably since then as well, an interest in better understanding suicide among our women Veterans, which indeed are the fastest-growing Veteran subpopulation. We know that findings derived from all Veterans or male Veterans specifically aren’t likely to generalize \_\_\_\_\_ [00:11:08] and with females the largest growing subpopulation, we really want to know more. A couple quick graphics here that demonstrate how important the growth of this subpopulation really is. Here, we see the growth of women in Active Military and here we see the projected percentage of females in the Veteran population. So, it is growing rapidly and something we need to learn more about.

This is the study in particular that I was asked to speak with you today and I am excited to share the findings. I know a lot of people have heard about it, but this is certainly an interesting and impactful study, very important for a jump-off for further research. Essentially exactly what I have said up to this point. We wanted a more complete picture of the absolute and relative risk of suicide within meaningful Veteran subgroups, in particular those who do not use VHA services and our women Veterans. We wanted this information so that we can appropriately target and evaluate treatment and prevention programs, allocate our suicide prevention resources and track changes in suicide rates over time. The aims I don’t need to repeat. They are basically exactly what I’ve said, to look at Veteran suicide risk over all compared to non-Veterans and then the impact of gender and VHA service.

In terms of the methods, statistically it did not outline this in a lot of detail. I want to spend a couple more minutes from a method standpoint in the next few slides talking about the database that we used. Just quickly, the results when I get to that slide, essentially very simple, like I said, in terms of we are not looking at risk factors in the study. The only factors we are really looking at considering are age and gender. We are looking at crude and age-adjusted suicide rates, and we are comparing rates between our different subpopulations of interest, primarily using standardized mortality ratios. Again, not to get heavy into the statistics, but the reason for doing this really comes down to sample size. Sometimes it asked and some people prefer the direct look with relative risk to standardized mortality ratios for those who are not familiar is essentially an estimate for relative risk so you can think about it in the same way. It’s just computed in a different way, and it allows you to be able to look at a measure of relative risk when you have smaller sample sizes. An important thing with that is that because we have this strong interest on the intersection between gender and VHA use, as I said, only about 30% of our Veterans of all use services. Then we have a minority of Veterans who are women. When we want to look both at females who use VHA services, that gets to be relatively small, especially in certain age groups and we need to account for age differences. So, this is just a method to ensure that our estimates are as accurate as possible. Again, if you’re not super familiar with it, that’s okay. You can just think of them as relative risk. Essentially those relative risks are age-adjusted using the methods to compute the standardized mortality ratio. In all of the results I will show you, they are also either gender adjusted or most of the results I will show you are gender stratified.

So, to get from a method standpoint into the database, we use I think—Sometimes people are familiar with this but not everyone. The VA and especially Dr. Robert Bossarte has led an effort to improve the data we have available to study Veteran suicide, both for the Veterans in our care at VHA but also the broader population of Veterans. Two initiatives to do this are the Suicide Data Repository which is receiving NDI data in a collaborative effort with the DOD. That is collecting data on all Veterans and Active Military in terms of their death records directly from the CDC, the NDI data. This is from the other initiative which is State VA collaborative project. It’s the Office of Public Health State Mortality Database. It was initiated in 2010 when then-VA Secretary Shinseki requested the collaboration and support of all states to basically share with us directly their death certificate data for all suicides, both Veterans and non-Veterans. We didn’t ask them to distinguish at all based on Veteran status, just wanted all the records for anyone who died in their state from suicide. Records data back to 1999. We have through 2015 and it can continue to be collected. It’s not set to finish at 2015. We collect the standard information from the death certificate records, so it’s certainly just demographic information. Again, we don’t have clinical information; although we do have identifiers which would allow us to link that for our VHA-utilizing population. We don’t have parallel information on that for our non-VHA Veterans. So, this study really is just focused on the demographic information, particularly age and gender. So, the unique thing about this is that it is a resource, as I said, that studies suicide among all Veterans. Also, it allows us to directly compare to their non-Veteran peers because we don’t just receive information on those with a history of military service.

The study that we did look at results from the first 23 states with complete information from 2000 to 2010, and this was just under 174,000 suicide decedents, 25% of which we identified as Veterans; 5% were VHA-utilizing Veterans, 20% were not. You can see the states listed here. We obviously realize this is a sample of 23 states only, so these are estimates. However, the suicide rates by state range from 8 to 23.1 per 100,000, which is very similar to the national range for 2010. Shown here, 10 were at or below, 13 were above that national average of 12.4 per 100,000 lives at risk.

Another kind of piece of the message for this study that I am often asked about is the Veteran Status Validation Process. That is that, although we request and death certificates do have an indicator of military service history, that is not what we use to decide whether someone is a Veteran or not. What we do is take the identifying information: Social Security Number, name, date of birth \_\_\_\_\_ [00:18:20] and others, so you can see there are kind of two. You can see my arrow, I believe. There is kind of two input points. We have all the information we would like to have up top here or, if we only have name and date of birth, we don’t have Social Security Number \_\_\_\_\_ [00:18:32] because we need the Social Security Number for this first step. Essentially what we are doing is we are feeding everyone. These are not just those with indicated military service indicated on the death certificate, just everyone. All suicide decedents get fed in to VCA, DOD, electronic systems to identify their service history essentially. If they pop out at any point, they are validated as a Veteran and we remove them and we don’t continue that if Person A has been identified here if they are a Veteran, they don’t go on to step two. In the end, if we have no matching records in any of these systems that we check and the decedent is less than 65 years of age, we consider them a validated non-Veteran. This is because the electronic records are very good up to this point. We have a little bit more of a challenge using the electronic records to validate those who are 65 years of age or older at the time of death. Thus, in this case, if they are greater than 65 years of age and the death certificate indicates positive military history, we do validate them as a Veteran. If we have not caught them anywhere up here and they are not indicated to have military service listed on the death certificate, they are validated as a non-Veteran. This process has been updated over time and continues to be updated. I believe we have some better information for this older age group to improve our validation, but the strength of this database for sure is something that we focus on.

To describe again the sample that we are looking at in a different way; although not directly related to the results of this study, something we are often asked and we find quite interesting is how the methods vary between our Veterans and non-Veterans by gender. As I mentioned, in the general U.S. populations, firearms are the number one method for suicide among males and poisoning among females. What we see for males is, as expected; although a larger proportion of firearm suicide is seen among the male Veterans than male non-Veterans. Very interestingly, among females, non-Veterans look exactly how I described for the general U.S. population, with poisoning \_\_\_\_\_ [00:21:05] outnumbered the poisoning decedents, something we have also looked at in other analyses of this database.

Now, I have a tendency to talk quickly and I feel like I am. I do apologize. I’ll try and slow down. Here are those results from our study. The Crude Veteran and non-Veteran Suicide Rates. Again, these are crude and certainly there are differences in the age distribution between our Veterans and non-Veterans. So, in this slide with table of results, I encourage you to look down the columns more than across, especially when you are comparing the male non-Veteran to the male Veteran. You really want to be able to directly compare those. Age adjustment is very important. We will get into that on the following slide. Crude rates are still very important. They set the context. The important thing, these are the true rates. When we age adjust or we do relative risk, those age-adjusted rates are meant to be tools for comparison. They are not the actual rates. So, we want to ground what we are looking at in the changes in those rates over time using these crude rates. If you look down the columns, you can see how the suicide rates change within these two subgroups. Another thing to note about this table before I highlight the results is that in the Veteran column, we do compare VHA and non-VHA male and female, but we do not break out crude rates by gender and VHA use. That’s because in this 23-state \_\_\_\_\_ [00:22:48] is still too small to really feel that those results are stable enough to share. What you will see is very interesting about the methods is that using those standardized mortality ratios, we can make comparisons that about relative risk with this smaller group of 23 states and basically this small number of female VHA Veterans. Although in some age groups for males also. But the comparative specifics that I will show you in a moment are very valuable. Here, a couple of the most interesting things that we can look at increases over time within the given group change, which are bigger in Veteran versus non-Veteran. So, we see the 12% increase for non-Veterans overall, 6% for males and a larger increase even in the non-Veteran population for females of 13% from 2000 to 2010. We also see an increase in our Veterans overall, a larger increase, a 25% increase over this time period. As we always see, I think I mentioned before, that overall number really mirrors often what we see for males, 25% increase for males. What is striking here and caught a lot of attention is the 40% increase in the crude suicide rate for our female Veterans over this time period. Another very interesting and important piece of this table \_\_\_\_\_ [00:24:15] that dramatic increase among females is that the only column across the table for which we see an decrease are among our VHA Veterans, which is quite striking. I’m sorry I didn’t calculate it out here, but it’s about a 20% decrease from 34.5 per 100,000 lives at risk in 2000 to the 27.6 per 100,000 lives at risk in 2010. That’s a very important piece of this study.

Here are the direct age-adjusted Veteran and non-Veteran suicide rates. Again, as I encouraged you before, not to really compare across those columns as much as down the columns in the previous slide. Here, you can compare the lines side by side a little better because we have directly age-adjusted. Essentially, that just means we have accounted for differences in the distribution of age allowance in our Veteran and non-Veteran population. So, we cannot do this for the VHA compared to non-VHA Veterans but we can do this for the total just to kind of round those rates from the previous slide a little bit from a comparative standpoint. You see across the board here for total male and female, the rates are higher on our Veteran side than for our non-Veterans. Even after age adjusting, there could be even within a population changes in the age distribution over time. As our Veterans age we do expect it. So, it is even important over time to take into account changes in the age distribution. We do see a trend increasing in all three of these lines total and the two gender stratified lines. There is still an increase among the non-Veterans; however, it is clearly much flatter, and that represents \_\_\_\_\_ [00:26:02] especially 12 versus 25% and some of that changes a bit obviously as your age drops. \_\_\_\_\_ [00:26:16]

This slide is really a little small. Hopefully it’s legible. I will walk you through it. This is really the meat of our studies in a lot of ways. This is a graphic which shows a standardized Veteran Suicide Mortality Ratios. This basically looks at whether there is assessed risk in terms of the number of deaths we observed from suicide among our Veterans compared to what we would expect if their suicide rates were the same as their non-Veteran peers. \_\_\_\_\_ [00:26:49] computes exactly but, again, pretty much interpret it as an estimate for relative risk.

The first panel in the top left is Veterans compared to non-Veterans. These are gender and age-standardized. They are not gender stratified. We do adjust for this difference in distribution of genders between Veteran and non-Veteran. Clearly there is a much higher proportion of males in the Veteran population than in the overall U.S. non-Veteran population. That’s important. What we see is that there is an overall decline here among VHA Veterans relative to increases among non-VHA Veterans or the total non-VHA Veterans again mirror the total because 70% of our Veterans don’t use VHA services. We would simply expect that. When we compare these two different Veteran subgroups to their non-Veteran peers after accounting for age and gender, we see this difference, where there is a decline among VHA Veterans in the suicide rates and an increase in the non-VHA Veterans.

In the second panel here, number two, the top right, we are looking at the standardized mortality ration for VHA Veterans specifically compared to non-VHA Veterans. That is because we want to really get a good look at the difference here. So, what we see is that VHA Veterans fare better than non-VHA Veterans in 2003. What I mean by that is that it crosses one eventually here around 2003, meaning that the number of suicides we observed among our VHA Veterans is less than what we would have expected to see if they had suicide rates the same as their Veteran peers who don’t use VHA services. That would be kind of the exact interpretation of that. This is gender stratified, so you do see that for females down here the dash line, those in VHA services fared better than the Veterans that do not receive VHA care across the time period of interest. However, we don’t see as much of a change. We see a decline here, which is good, and perhaps indicates the fact that our services are working. Here it’s not that it doesn’t indicate that they’re working. They are definitely doing better, but we don’t see that change over time for non-VHA Veterans, which creates different questions to be asked essentially.

Then here, these are both gender stratified. So, these are male Veterans compared to male non-Veterans Veterans. And this is female Veterans compared to female non-Veterans on the bottom right. The stratification variable here is the VHA services. Again, the total tends to mirror who \_\_\_\_\_ [00:29:56] VHA services. Let’s just look at the two different dash lines. For male Veterans compared to male non-Veterans, we see the rate of suicide relative to that for the non-Veterans increasing, but we see a pretty good drop here for the male Veterans who use VHA services. Although, there is some increase after that, a little bit stead here, a little peak and then a decline. We don’t know what happened following that. This could be kind of random. There’s a larger trend here of decrease considerably.

For the females, it’s a very different picture. You can see the males look very similar to the Veterans overall. Again, as we expect, it’s really this interest in the female box to the right here that is very novel information from the gender standpoint and the scale here is different as well. It’s important to point out the scale is essentially different in all of them so that you can visualize. Again, the scale for the FMR \_\_\_\_\_ [00:30:56] interpretation of relative risk is about 0 or 1 to 1.8 in these three others, but look here for the women it’s considerably different. That just shows the greatest assessed risk is among female Veterans when compared to their non-Veteran peers. That is especially true for those outside the VHA care system. So, we see about a 500% increase or a relative risk of 6 and it’s averaging out here for those non-VHA females compared to their non-Veteran female peers, and a doubling for relative risk or FMR of approximately 2 for those inside the VHA care system compared to their non-Veteran female peers. Again, the \_\_\_\_\_ [00:31:45] for our VHA-utilizing females, we don’t see a trend of increase over time. Whereas there is a bit more of a trend, especially in this time period here, among female Veterans who do not use VHA services towards an increase accessed risk for suicide compared to their non-Veteran peers.

There is a trend here on this slide recognized that is really good to look at it all together in order to get a big picture, so I wanted to fit it all in one. Happy to take all questions at the end. I understand there is a good amount of information there. I will also just point out that, although the graphics don’t show specific numbers, a lot of people want to know what the specific numbers, and in the reference slide, it references this manuscript that I am discussing with you today, but I will let you know. I think I forgot to mention it specifically. There is also an online supplement for it, and you can get specific FMR on estimates. \_\_\_\_\_ [00:32:49] That’s helpful if people are after specific numbers, and I’ve found that they are. There is also an online supplement to look for, or if you want to contact me directly I can send you both.

Just to summarize all of that, the number of observed Veteran suicides was significantly higher than expected \_\_\_\_\_ [00:33:12] at age and gender-specific suicide rates the same as those observed for non-Veterans. This extra was about 20% overall for Veterans in 2000 and increased to over 60% in 2010. As I just said, the increase in relative rates for Veterans were more pronounced among our females, and that has certainly been something that has received a lot of attention since we did this analysis. I think that maybe more attention than the other piece; although both pieces are very important. The other piece being that since 2003, the Veterans Mortality Ratios for the VHA Veterans compared to non-Veterans has been less than 1. What this means is, as I described before, the observed number of suicides was less among our VHA Veterans than we would have expected if their rates had been similar to those of their non-VHA Veteran peers. This is certainly an indication that the services we offer are helping our Veterans. It does not, and I think it is important to point out and indicate which services, and certainly there are other factors which may explain this as well, but it does seem to be quite clear that being in VHA care can be helpful, which is great news. The decline, however, in relative risk among VHA Veterans, as I pointed out on those graphics, was primarily observed for males, with no clear periods of change for female VHA Veterans who did experience approximately 80% fewer suicides than expected compared to female Veterans outside the VHA system across the board from 2000 to 2010. Again, the greatest assessed risk was observed among female Veterans, particularly those not in VHA care.

Some additional discussion points are that this was the first study to directly compare Veterans and non-Veterans in terms of suicide risk. Again, very importantly, we use the validated variable for Veteran status. There have been some studies that use the National \_\_\_\_\_ [00:35:29] reporting system and they do have the death certificate indication of military history. We have found—And I didn’t put the information up there. Perhaps I should at least as a supplementary slide. But we have looked into this validated variable for Veterans status further and found that it certainly is important that, especially the sensitivity of that death certificate classification of military history is pretty low in certain subgroups and certain T-subgroups when we have not only shown the misclassification that happens. We have seen at least one publication to date. We have also shown that misclassification can affect assessment of relative risk in another publication when we compared two findings which used the NVDRS and used the death certificate indicator. So, we feel very confident that when we are comparing Veterans and non-Veterans that, indeed, we have a clean group in both cases. We also know that we are able to clearly differentiate using our records who do and do not use services, and the way we identify that is in the year prior to their death. That could be defined in many different ways, so they are at least not current or recent VHA service numbers when we break into VHA and non-VHA utilizers. The study findings clearly suggest that Veterans without a history of VHA service use are at particularly high risk for suicide.

Again, I started to talk about this on the prior slide. We do believe that this has to do with the quality of care that the large integrated and diverse suicide prevention program that we do have is very unique. However, there are other reasons that certainly are going to play into the difference we see. Veterans may choose not to use VHA services for a variety of reasons. Some may not be eligible. Some may be eligible but unaware of their eligibility. Some who are eligible and want to access care may have difficulty accessing care. There are maybe misconceptions regarding the quality of care that keep individuals from coming to the VA. Certainly, from a larger public health view of suicides, there is perceived stigma surrounding seeking mental health care. So, there is a different group of individuals who may, whether VVA or otherwise. Just to note, the VA Suicide Prevention Program really \_\_\_\_\_ [00:38:12] in 2007 following the Joshua Omvig Suicide Prevention Act, we see the decline starting following 2003. We also see a plateau observed from 2004 to 2009, in contrast to the rising suicide rates we observed among our non-VHA-utilizing Veterans. It is that time period where we see this plateau in our VHA-utilizing Veterans, where our VA Mental Health Enhancement Initiative and the Suicide Prevention Program really launched and took off. That plateau is just as important as the prior decline in a lot of ways, because it suggests that the VA has been successful in countering a larger rising Veteran suicide rate. Some may question those time periods but looking at it overall, that plateau is quite important as well.

Let’s talk about some implications and next step. For me as researcher in the VA, this analysis has been a learning experience in a lot of ways. It has gained considerable impact both within the VA, outside the VA. It’s creating a media response which is great in a lot of ways. It’s called attention to an important issue. Sometimes drawing attention to one side of that issue and not to the others, so we want to make sure the message is heard in both ways. As I said, the findings we see among women Veterans is very important and showing us the need for further research and thought in terms of gender sensitive prevention strategies. We also are very hopeful with what we’ve seen among our VHA Veterans, both for males and females. It shows that we need further research to understand which components of our VA Suicide Prevention are the most effective. In addition to media response, the results sparked a parallel increase in further research. A lot of this is with \_\_\_\_\_ [00:40:19] but I think it has really drawn attention to making sure our efforts are gender stratified, looking for differences among females to help understand what’s going on. There is continued efforts not only to analyze the seed data, but as I mentioned, Dr. Bossarte has really led an effort overall to enhance the data sources available for studying suicide among our Veteran populations, so we have continued efforts to analyze NDI data \_\_\_\_\_ [00:40:49] Suicide Data Repository as well overall, just to fully understand Veteran suicide risk and the epidemiology of Veteran suicide.

I will show you on the next page just an example of that. A study that Kim Bullman in the Office of Public Health led and I had a pleasure to be a part of, where we looked at conditional suicide risk over time for OEF/OIF Veterans by gender related to their times in separation. I will show you those result that are summarized here in just a moment. There have also been some interesting policy implementations that have started in terms of inquiries and recently introduced the Female Veterans Suicide Prevention Act pretty directly in response to that. It’s been a great study, propelling further research. I think a lot of investigators across the VA are working on this and a lot of really important findings that will surely come out of those continued efforts.

Here’s just a graphic, again just one of the further research efforts that I was involved in; although there are many others that I was or was not. Here we see that conditional suicide risk stratified by gender for OEF/OIF Veterans based on years in separation. Another, again, very interesting gender difference and I think something I’ve come to recognize which is overall, I’m sure this is true of many outcomes and many diseases, but when it comes to suicide among our Veterans, you look for a gender difference and you will find it. I think that that is incredibly important because it reminds us that we need to be careful about generalizing our findings because of the small proportion—Although it’s the largest growing population, it relatively remains a small subportion of our Veterans. So, we see a decline over time from separation among our males that we checked for statistical trend. There is no true change over time for our female Veterans in terms of time from separation and how this relates to their suicide risk. Again, it doesn’t say exactly what is going on but shows us that there is something different going on.

Resources. Again, this group very knowledgeable in VA suicide prevention, so I don’t think I’m saying anything new here. I will just remind you and link out for new information a few things. The VA Suicide Prevention Program is certainly set out to reach both male and female Veterans. It is not only set up to reach Veterans within the VHA healthcare system. It is actually great at reaching Veterans outside our VHA healthcare system in terms of the efforts that are made. The Crisis Hotline covers the websites, online chat. All of that is accessible to any Veteran. The Suicide Prevention Coordinators are, of course, assigned to VA medical centers in large outpatient clinics and perhaps more accessible to Veterans using our care, but they do a lot of outreach as well to reach out to Veterans outside of the VHA healthcare system and will help to identify and track high risk Veterans even if the identification of a suicide event may be their first entry into VHA care. The VA Suicide Prevention Program is definitely working to reach the broader Veteran population which is great.

\_\_\_\_\_ [00:44:28], women’s health services. Not all of it, but again, with some of the inquiries we’ve gotten over time as a result of this study, we found it very important to point out that, although this is not a lot of information about our women Veterans, it is not that there are not a lot of resources already available. The VA Suicide Prevention Coordinator has a Women’s Veterans Program Manager in our VA Medical Center. There is a Women’s Veterans Call Center much more recently established than the crisis line, also a great resource. The VA offers a full continuum of mental health services to women Veterans, just a few of which are outlined here.

I know we are coming up on needing some time for questions. I have a last poll question for you. There has just been some curiosity about whether both those within the VA, outside the VA would like to have more information on this topic. A couple ideas were thrown out to us. Twitter chat perhaps being one option or there she is a new option for VA Vantage meeting. We’re just curious on what this group may want in terms of future information and maybe what platforms may be most desirable. So, if you could take a moment to answer that, that would really help us out for the future.

Interviewer: You can click all that apply. You don’t need to just pick one favorite. Responses are coming in. It looks like people are putting a little bit of thought into this one. They’re coming in a little bit slower. I will give everyone just a few more moments before we close it out and go through the results here. It looks like we are slowing down a bit. We will close that out. We are seeing 37% say no, this presentation was sufficient; 50% for personal correspondence; 9% for Twitter chat and 37% for VA Vantage meeting. Thank you, everyone.

Dr. Hoffmire: Thank you. Appreciate your feedback for future planning on that for sure. I know a lot of people picked personal correspondence. So for future reference, you can reference that but feel free to contact me. On the last slide in a moment I will pop up my contact information and I’m happy to help point you in the right direction. Quick set of acknowledgements. My co-authors on this manuscript are Dr. Bossarte, who I mentioned, who has led this data effort. Jan Kemp who was a great resource for us and has helped with this publication and, of course, Caitlyn Thompson, the current National Director for Suicide Prevention is always very supportive, helping to get the word out. I know that she also is there if I can’t answer your questions, I will put you on with Kaitlyn or, as I said, with someone who can. Again, here is my contact information, and I am happy to take any questions.

Interviewer: We do have a few pending questions out here for the audience. If you do have any questions, please use that question screen and go to webinar to submit those. I’m just going to start from the top and work our way down. The first question. How can other researchers access the OPH Stage Mortality Database?

Dr. Hoffmire: Right now, I would have to direct you to Dr. Bossarte for that. I can’t give out concrete information on how that can be accessed at this time. He’s the PI on that project and I directly collaborate with him on that. If anyone is interested and wants to contact me, I would be happy to facilitate questions about that.

Interviewer: Great. Thank you. The next question here. If a Veteran has a flag, how often to I check on this Veteran?

Dr. Hoffmire: I am guess that’s a clinical question and as a non-clinician, I am not going to give a specific answer on that. I don’t really have one for you. I can just, from a general standpoint, there are policies surrounding the high risk flags which I would advise that you use for that. I am not a clinician, so I am not going to give a recommendation on that. Sorry.

Interviewer: Okay. Thank you. The next question. Do you have specific data that you can share with the participants with respect to the New York state’s data?

Dr. Hoffmire: There has been some information about states. Again, that has to be a direct request to the State Mortality project. So, that would be something to reach out to me directly. We don’t share that information publicly right now. It does get shared upon request, but it depends on who is requesting. So, feel free to reach out to me and I can put you in contact.

Interviewer: Great. Thank you. The next question. Regarding the women who commit suicide, is there an associated diagnosis, for instance, depression, sexual assault or other?

Dr. Hoffmire: There is a lot of research ongoing about relationships between clinical diagnoses and suicide risk, both in the women and men Veterans. As it relates to this study, I can’t say anything. As I said, especially for the women Veteran population as a whole and for those outside the VHA care system, because we use death certificates, we unfortunately don’t have that clinical data on the vast majority that we are looking at in this study. We can link the state mortality data to VHA records; however, we don’t do that because honestly the NDI, the Suicide Data Repository didn’t used to do that and there is a formal request process for that. Yeah, from this project’s standpoint, we can’t answer that question. For the broader female Veteran population using this data set. But there is plenty of research ongoing in general.

Interviewer: Great. Thank you. The next question. Is there a gender-specific suicide risk assessment tool available for clinicians?

Dr. Hoffmire: There is not as of right now, to my knowledge. Again, I am not a clinician, but I am quite sure that would be the answer. Not right now.

Interviewer: Okay. Thank you. The next question. Are there discussions about outreach for suicide prevention much like we do for homeless Veterans?

Dr. Hoffmire: Are there discussions, you said?

Interviewer: Are there discussions about outreach?

Dr. Hoffmire: I don’t know if I completely understand the question but there is outreach that happens for suicide prevention, and the suicide prevention coordinators are largely responsible for that. They do, I believe, there are multiple outreach activities per month. They go to Veteran service organizations and other venues where there may be a lot of Veterans, and provide a lot of information on our Veteran Suicide Prevention Program and make sure there is information about the crisis line and other programs. So, there is a lot of outreach, like I said, into the community, so that the Suicide Prevention Program is aiming to reach Veterans outside our care as well. I don’t know if that answered what you said about discussion related to it, but yes, there is certainly outreach going on.

Interviewer: Okay. Great. Thank you. That should answer the question, but if not, send in a clarifying question. The next one I have here. The Veterans Crisis Online Chat is predominantly staffed by males. Has there been any consideration to a female-only crisis line?

Dr. Hoffmire: I don’t think—Again, out of my realm to answer specifically. I know that we have the women’s—I can go back for you really quick. So, there is the Women’s Veteran’s Call Center, but that is not a crisis line. As far as a crisis line, there is—Again, not my area of research particularly, but there is definitely been some research. I believe it’s ongoing, that looks at this a bit. Women respondents speaking with the women who call in and things like that, trying to understand how important that is and what their experiences are and things like that. I don’t envision the crisis line separating. I’m not the person to answer that but I think that there is certainly a potential going on to making sure that there are female respondents available at the call centers; although there may be more males than female responders as well.

Interviewer: Okay. Great. Thank you. The next question here. I notice that my state was missing from the participation list. Is there a way we can encourage our state to participate in the data collection?

Dr. Hoffmire: So, if their state was missing from that participation list, that just meant that the state was missing from the first 23 states which we had complete data from the time period when we analyzed it. We analyzed it from a couple years back now. It was recently published. But there have been—We have information from many more states. We have some form of information pretty much from every state. I would say contact me directly. I can check into the status of what your specific state participation status is and there may be things that can be done, but we do have contacts at every state. It is not that the 23 states that we analyzed for this study are all that we currently have, though. They are the states that were included in this analysis because it was sort of what we had at the time. So, your state may or may not—We may or may not have information. I don’t know which state, but if you would like to contact me directly with an inquiry about that I can find out for you.

Interviewer: Okay. Sounds great. That actually is all of our questions. Dr. Hoffmire, I’m not sure if you want to make any final remarks before I close things out here today.

Dr. Hoffmire: I do not. Thank you all for calling in and listening today. I look forward to any further questions that anyone may have.

Interviewer: Wonderful. Also, for the audience, as I close things out here in a moment, you will be prompted with a feedback form. Please take a few moments to fill that out. We really do read through and appreciate all of your feedback. Thank you, everyone, for joining us for today’s cyber seminar. We look forward to seeing you at a future session. Thank you.

[End of audio]