Study Finds Decline in Suicide Among Veterans

The number of veterans who commit suicide has gone down slightly since 1999 and has remained comparatively constant; whereas in the U.S. population overall, the percentage of suicides between 2007 and 2010 went up by nearly 11%.

In a recent nationwide study, 22% of all suicides reported during the project period were veterans. If the prevalence estimate is assumed to be constant across the U.S., the researchers say, an estimated 22 veterans died of suicide each day in 2010. More than 69% of suicide deaths were among veterans aged > 50 years, compared with about 37% among those not identified as veterans. Men were overwhelmingly represented; women accounted for < 3% of all suicides among reported veterans, compared with > 26% among suicide deaths without a reported history of military service. Veterans who died of suicide were more likely to be married, widowed, or divorced. Most of the nonfatal suicide attempts were due to overdose or intentional poisoning, although nearly 11% were made with a firearm.

The report, *Suicide Data Report, 2012*, is the most comprehensive study of veteran suicide rates ever undertaken by the VA. In 2010, Secretary of Veterans Affairs Eric Shinseki requested the support of 50 governors to collect suicide statistics. As of the report publication, 34 states had released data, with 8 more having approved data use agreements; data from 21 states had been cleaned and entered into an integrated file. The plan is to expand the information-gathering to U.S. territories, including Guam, Puerto Rico, and the Philippines, due to the presence of a VA facility and large populations of U.S. military veterans in those areas.

The researchers found that death certificates can be used to track the overall rate of veteran suicides, although they found 5% were misclassified. Of the 147,763 suicides reported in 21 states, 27,062 (18%) had death certificates reporting a history of U.S. military service. Veteran status was unknown or not reported for more than 23% of suicides during the project period. Misclassification was "considerably higher" among validated veterans, with 11% of true veterans classified as nonveterans on the death certificate. The ability of death certificates to fully capture female veterans was particularly low, the researchers say: Only 67% of true female veterans were identified.

Since 2008, the VA has mandated that health system facilities track attempted and completed suicides in a national database, the Suicide Prevention and Application Network. Nearly 15,000 suicide events (including multiple attempts) were reported in 2012, compared with more than 16,000 suicide events in 2011.

The real-time data allow the VA to better assess how well its suicide prevention programs are doing, and to identify at-risk groups that might need targeted interventions. For instance, the researchers say the first 4 weeks following service require intensive monitoring and case management for those veterans at risk: The majority of nonfatal events occur within 4 weeks of receiving VHA services, and 10% occur in the second month following the last VHA visit. Moreover, nearly half the individuals with a VHA service visit in the year preceding the suicide event were last seen in the outpatient primary care setting, either a primary care or a mental health facility. This implies, the researchers say, that primary care should be an integral component of VHA suicide prevention programs; further, that primary care clinicians should continue to receive support and training on the identification and management of those experiencing distress.

Between early 2009 and February 2010, the number of calls to the suicide hotline spiked suddenly, perhaps because of the "It's Your Call" campaign to rebrand the hotline from "Veterans Suicide Prevention Line" to "Veterans Crisis Line." About 19% of calls are repeats, perhaps reflecting calls for help with symptoms rather than crises. The Military Crisis Line (for active-duty personnel) was introduced in 2011, and receives substantially fewer calls; the researchers suggest active-duty personnel may be identifying themselves as veterans.

The full findings, *Suicide Data Report, 2012*, are available at http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf.

Sequestration and the NIH

The realities of sequestration for the National Institutes of Health (NIH): fewer grants, delays in medical progress, and risks to the scientific workforce.

In a June 3, 2013 fact sheet, the NIH presented the stark facts of the sequestration's requirement to cut 5% or $1.55 billion of its fiscal year (FY) 2013 budget. While acknowledging that NIH funding is "always a dynamic situation with multiple drivers," the NIH compares FY 2013 with FY 2012 and estimates about 700 fewer competitive research project grants issued, about 750 fewer new patients admited to the NIH Clinical Center, and no increase in stipends for National Research Service Award recipients.

The bulk of the NIH budget goes to more than 300,000 research personnel at over 2,500 universities and research institutions. About 6,000 scientists work in NIH's Intramural Research laboratories. The sequestration cuts must apply evenly across all programs, projects, and activities, which are primarily NIH institutes and centers, meaning every area of medical research will be affected.

The impact on medical progress could be substantial. In almost all instances, the NIH says, "breakthrough" discoveries do not happen overnight, but after years of incremental research. Even after the cause and potential drug target of a disease is discovered, it takes an average of 13 years and $1 billion to develop a treatment for that target. The NIH anticipates that cuts to research will mean delayed development of better cancer drugs with fewer adverse effects, research on a universal flu vaccine that "could fight every strain of influenza without needing a yearly shot," and prevention of debilitating chronic conditions.

The NIH also notes that the impact of the cuts to intramural research will have "double the effect," because the cut applies retroactively to spending since October 1, 2012—essentially, a full year's cut has to be absorbed in less than a half year.

However, the NIH is making an effort to economize with minimal damage. For instance, in general, existing grants will not be shortened to accommodate the cuts. And, although fewer patients will be admitted to the NIH Clinical Center hospital (down from 10,695 in 2012 to an estimated 9,945 in 2013), services to patients will not be reduced, the NIH promises. Moreover, there are no current plans to furlough or cut employees at the NIH campus and off-campus facilities. Instead, the NIH is planning cost savings such as delayed/forgone hiring.

Improving Cancer Care for African Americans

For a variety of reasons, African Americans suffer disparities in access to hospice and palliative care services. Because of that, the National Cancer Institute has expanded *Education in Palliative and End-of-Life Care for Oncology (EPEC™-O)*, a multimedia curriculum for health professionals caring for people with cancer, to include new modules specifically focusing on care for African Americans.

The original version, which includes 3 plenary sessions and 15 content modules, covers the knowledge and skills needed to provide palliative care that addresses patients' physical, psychosocial, and spiritual needs. The new *EPEC™-O: Cultural Considerations When Caring for African Americans* adds 5 new or substantially revised plenaries and modules with accompanying videos.

New material includes "Cancer and the African American Experience," a plenary session in which a panel of interdisciplinary African American health care providers discuss the socioeconomic, racial, and cultural factors that contribute to inequalities in cancer screening, diagnosis, treatment, and outcomes for African Americans. The plenary reviews the "uniqueness of the African American cultural heritage," as well as culturally sensitive approaches to improving access to and the quality of cancer care.

Existing material was also revised to include, for instance, models of comprehensive care shown to improve care for African Americans and communication and cultural factors that affect discussion of advance care planning.

Visitors can access the *EPEC™-O* curriculum, including the new modules, by visiting http://www.cancer.gov/cancertopics/cancerlibrary/epeco.

Grants Extend the Reach of Health Care for Veterans

No matter how remote their locations, now more veterans will have better access to health care. According to a July 10, 2013, news release, a new VA initiative supports transportation services for veterans living in far-flung or underpopulated and underserved areas.

The initiative aims to improve health care for those living in "highly rural areas"—counties with fewer than 7 people per square mile. Many of the targeted areas are in the western and southwestern U.S., but at least 25 states have at least 1 highly rural area.

The VA began accepting applications for grants of up to $50,000 to help state Veterans Service Agencies (VSAs) and Veterans Service Organizations (VSOs) operate or contract for services to transport veterans to VAMCs and other facilities that provide VA care.

The VSAs and VSOs are also being encouraged to use "innovative" approaches, says Secretary of Veterans Affairs Eric Shinseki. The results, he adds, "will include better service and better health care for veterans." The transportation services will be free for veterans.

An informational webinar on the Highly Rural Transportation Grants Program is available at http://va-eerc-ees.adobeconnect.com/p552nvc4m5e. The deadline for grant applications, submitted to http://www.grants.gov, is 4 PM EST, September 9, 2013. For copies of the application package, visit http://www.grants.gov/search/basic.do, and use the "search by Catalog of Federal Domestic Assistance (CFDA) number" function, entering the number 64.035 into the search field; call (404) 828-5380; or e-mail HRTG@va.gov.