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January 3, 2024

Steven T. James
House Clerk
State House, Room 145
Boston, MA 02133

Michael D. Hurley
Senate Clerk
State House, Room 335
Boston, MA 02133

Dear Mr. Clerk,

Pursuant to Section 77 of Chapter 177 of the Acts of 2022, *An Act Addressing Barriers to Care for Mental Health*, please find enclosed a report provided by the Veterans Reintegration Advisory Committee entitled "An examination of suicide among veterans and their reintegration into society".

Sincerely,

Jon Santiago

CC:
Senator John Velis, Senate Chair of the Joint Committee on Veterans and Federal Affairs and the Joint Committee on Mental Health, Substance Use, and Recovery
Representative Gerard Cassidy, House Chair of the Joint Committee on Veterans and Federal Affairs
Representative Adrian Madaro, House Chair of the Joint Committee on Mental Health, Substance Use, and Recovery

An Examination of Suicide among Veterans and their Reintegration into Society

December 2023

Legislative Mandate

The following report is issued pursuant to Section 77 of Chapter 177 of the Acts of 2022, *An Act Addressing Barriers To Care For Mental Health* summarized as follows:

(a) The department of veterans' services shall convene an advisory committee that shall consist of: 2 representatives of the Massachusetts chapter of Team Red, White & Blue; 2 representatives of the Red Sox Foundation and Massachusetts General Hospital's Home Base Program; 2 representatives of the Wounded Warriors Project; 2 representatives of the Mass Mentoring Partnership, Inc.; 2 representatives of the Massachusetts Coalition for Suicide Prevention; 2 representatives of the Massachusetts Psychological Association, Inc.; and such other members as the committee deems necessary. The members of the committee shall have experience in mental health or veterans' support services with an emphasis on treatment of post-traumatic stress disorder, depression and anxiety among veterans.

(b) The committee, in coordination with the department of veterans' services and the department of mental health, shall investigate and study: (i) ways to augment services to returning veterans to reduce the rate of suicide and the effects of post-traumatic stress disorder, depression and anxiety; and (ii) the complexity of reintegration into civilian life and issues related to isolation and suicide among veterans.

The committee shall provide support and expertise to reduce isolation and suicide among returning veterans.

The committee shall examine: (i) the impact of having a community peer liaison on a veteran's reintegration into society; (ii) the relationship between isolation and suicide among veterans; and (iii) the impact of having a community peer liaison on symptoms of post-traumatic stress disorder, depression and anxiety in diagnosed veterans.

The committee shall file a report of its findings and any recommendations, with the clerks of the senate and house of representatives, the joint committee on veterans and federal affairs and the joint committee on mental health, substance use and recovery.

Introduction

Suicide affects Service Members, Veterans, and their Families (SMVF) at higher rates than the general population and has widely been recognized as a public health concern for decades.

The Veterans Reintegration Advisory Committee (VRAC), created through a legislative mandate, acknowledges and appreciates the Legislature's longstanding commitment to SMVF. In recent years, through the Governor's Challenge to address SMVF suicide, many members of VRAC worked hard to build bridges and have excellent collaborative relationships. This legislative mandate provided further incentive to break down silos and expand and formalize collaborations with private sector partners, including Home Base at MGH, Wounded Warrior Project, and William James College. VRAC has elevated important voices of those who work tirelessly and those who are too often isolated and unrecognized. **This report elevates the voices of those who provide critical support to one of the Commonwealth's most vulnerable populations: service members, veterans, and their families**. Collectively, VRAC recognizes both the vast need and the deep passion and commitment of the entire membership. Together, the Committee found inspiration and opportunities to amplify the work of others rather than reinventing or duplicating efforts.

With a focus on subject-matter expertise and the guidelines set forth by Section 77 of Chapter 177 of the Acts of 2022, the Executive Office of Veterans Services (EOVS), in coordination with the Department of Mental Health (DMH), appointed a dedicated group of experts from both the healthcare and veteran communities with long-standing experience working on behalf of SMVF from across the Commonwealth to serve on VRAC. Additional members were recommended by the VRAC Co-Chairs and the Secretary of EOVS, which expanded VRAC's depth of knowledge and provided the Committee with a deeper understanding of the SMVF community. The membership hails from both the private and public sector, and both the state and federal level. The working group was comprised of behavioral health professionals including clinical psychologists, licensed social workers, and certified peer specialists; Veterans Service Officers (VSO); veterans with overseas deployments, active-duty service members, national guard members; and suicide prevention experts. VRAC was entrusted with actively investigating, studying, and scrutinizing various aspects of veterans' reintegration into civilian life with the goal of reducing suicide rates and addressing the profound effects of post-traumatic stress disorder (PTSD), depression, and anxiety among veterans.

The co-chairs, organizations, and members of VRAC are listed below:

Dr. John Rodolico (Co-Chair), Executive Office of Veterans Services – John Rodolico is an Army Reserve and Massachusetts National Guard veteran and directs multiple programs at McLean Hospital. He also currently serves as Clinical Advisor to the EOVS SAVE (Statewide Advocacy for Veterans Empowerment) Team.

Dr. Margaret Guyer (Co-Chair), Department of Mental Health – Margaret Guyer is Special Assistant to the Deputy Commissioner of Clinical and Professional Services at DMH and co-lead of the Massachusetts Governor's Challenge to reduce suicide among SMVF.

Team Red, White & Blue – Did not provide representation.

Home Base – Home Base operates the first and largest private sector clinic in America, and the only private sector clinic in New England, devoted to providing lifesaving clinical care and support for the SMVF community. By caring for Veterans, Service Members and their Families in a family-based clinic and working in cooperation with the US Departments of Defense (DoD) and Veterans Affairs (VA), Home Base serves as a replicable model to promote the health and wellbeing of SMVF nationwide.

Dr. René Lento – René Lento is the Director of Addictions Services at Home Base, specializing in assisting veterans with PTSD, Substance Use Disorders, and reintegration issues.

Bill Davidson Sr. – Bill Davidson is a retired Command Sergeant Major in the Massachusetts National Guard and serves as the Director of Veteran Outreach and Peer Support at Home Base.

Wounded Warrior Project ®– Wounded Warrior Project ®(WWP) is a national service organization that addresses the pressing challenge of veteran suicide by working to reduce barriers and fears that wounded warriors and their families face when asking for help and supporting them in ways that increase resiliency and improve mental health. WWP serves over 200,000 post-9/11 wounded warriors and 50,000 family members and caregivers with programs and services that address underlying suicide risk factors and innovative resources to increase access and improve outcomes for mental health and brain injuries.

Dr. Erin Fletcher – Erin Fletcher is the Warrior Care Network Director at Wounded Warrior Project and leads collaboration with the four Academic Medical Centers within WWP's Warrior Care Network.

Michael Baird – Michael Baird is an Army veteran and the Alumni Manager at Wounded Warrior Project, overseeing outreach and engagement.

Massachusetts Coalition for Suicide Prevention – MCSP is a broad-based inclusive alliance to prevent suicide. MCSP members come from all backgrounds that actively work to improve state and community linkages to reduce barriers to mental health, substance addiction recovery, domestic violence shelters and other community services.

Paula Tessier – Paula Tessier is the Associate Director for the Massachusetts Coalition for Suicide Prevention and assists the Massachusetts Governor's Challenge.

Deacon James F. Greer – Deacon James F Greer is a retired US Coast Guard, Senior Chief Health Services Technician and an Executive board member for both Massachusetts and Plymouth County coalitions for Suicide Prevention.

Massachusetts Psychological Association – The Massachusetts Psychological Association (MPA) is the professional association for psychologists in the Commonwealth of Massachusetts.

Dr. Miriam Stoll, Worcester Recovery Center and Hospital – Miriam Stoll is a Clinical Psychologist at the Worcester Recovery Center and Hospital, where she develops dual diagnosis programming.

Dr. Angela Taveira-Dick, William James College – Angela Taveira-Dick is the Associate Director of the Military and Veteran Psychology Program at William James College, where she also serves as an Assistant Professor.

Massachusetts Suicide Prevention Program (SPP) at the Department of Health (DPH) – SPP is a critical partner in the work to address SMVF suicide. The SPP is charged with managing, analyzing, and reporting all suicide relevant state data. The SPP also oversees a state network of community coalitions charged with addressing suicide prevention in their local communities and a multitude of community level efforts to deliver community specific culturally appropriate suicide prevention initiatives, including the SAVE team, a peer staffed suicide prevention intervention for SMVF. SPP is the state lead for the national Suicide Prevention Lifeline - 988 and the Veteran's Crisis Line (988, press 1), a 24/7 suicide crisis call line.

Kelley Cunningham, Department of Public Health – Kelley Cunningham served as Director of the Suicide Prevention Program for DPH and was recently promoted to Director for the Division of Violence and Injury Prevention.

White Star Family Member – White Star family members are those who have lost a service member or veteran in their family to suicide. The Secretary of EOVS and Co-Chairs felt that it was important for these families to be represented on the Committee.

Amanda Braga-Tipton – Amanda Braga-Tipton is a Chaplain in the U.S. Army Reserve and a White Star Family Member.

VET Centers – Operated by the Department of Veterans' Affairs (VA), Vet Centers are community-based counseling centers that provide a wide range of confidential social and counseling services to SMVF.

Dr. Elisabeth Parrott, Lowell Vet Center – Elisabeth Parrott is the Director of the Lowell Vet Center, part of the U.S. Department of Veterans Affairs' Readjustment Counseling Service.

Massachusetts Veterans Service Officers Association (MVSOA) – The MVSOA is the statewide organization that focuses on professional development for VSOs, as well as building relationships with public and private organizations to enhance services for veterans. Per Massachusetts state law, VSOs represent every city and town in Massachusetts and must be a veteran. VSOs deliver essential services to eligible veterans and their dependents.

Charly N. Oliva, MSW, VSO – Charly Oliva is an Army veteran and the Director of Veterans Services for Belchertown, Massachusetts. Charly is also the Sergeant at Arms for the Massachusetts Veterans Service Officers Association.

Massachusetts National Guard

LTC Katherine Murphy – LTC Murphy is Director of Warrior Resilience and Fitness for the Massachusetts National Guard and recently completed a temporary active-duty assignment.

U.S. Department of Veterans Affairs

Katherine Nicholas Malvey – Katherine Nicholas Malvey is the Suicide Prevention Program Manager for VA New England (VISN 1), overseeing programming in six states.

Mass Mentoring Partnership Inc. – a nonprofit dedicated to strengthening mentoring programs in Massachusetts through technical assistance, funding, and advocacy.

Lily Mendez – Lily Mendez is the President and CEO of Mass Mentoring Partnership.

The Committee also invited members of the SMVF community to present at meetings, including:

Dan Brennan, SAVE Team
Professor Jay Ball, Framingham Police Department
Carly Wilson, Department of Veteran Affairs

EOVS staff that contributed and provided support to VRAC, and this report:

Nick Bornstein, Policy Advisor
Brian Chase, Chief Information Officer
Matthew Deacon, Chief General Counsel
Sabrina Johnson, Paralegal
Erik Mayberg, Legislative Director

Executive Summary

In Massachusetts, 1 in 9 of all people who died by suicide were current or former military personnel. The Veterans Reintegration Advisory Committee (VRAC) is the culmination of public, private, and nonprofit stakeholders working together to address behavioral health, suicide prevention, and access to statewide data. The Executive Office of Veterans Services (EOVS) worked with several state and federal agencies including the Department of Mental Health, Department of Public Health, and the United States Department of Veterans Affairs, all of which offered essential ties between SMVF and community services. The Massachusetts National Guard was also represented to provide awareness to the challenges of rapid vacillation between deployed and not deployed, recurring community reintegration, and navigating simultaneous military and civilian identities.

VRAC concurred on the following framework for the task of identifying strategies to reduce veteran suicides:

- In examining veteran suicide, PTSD, and the impact of community reintegration, the lens inevitably widens to include active service members, all military families, and all who have served in the military. This is independent of their formal designation as 'veteran'. This report speaks to the need to embrace the larger vision of how to address suicide among SMVF.
- A suicide death represents the confluence of a multitude of factors including but not limited to PTSD, Military Sexual Trauma (MST), social isolation, depression and/or anxiety, chronic pain, and insomnia. Most notably, substance use disorder and opioid addiction must figure prominently in any discussion of SMVF suicide prevention efforts.

Over the course of 6 meetings examining factors contributing to SMVF suicidality, and current programs and resources offered statewide, VRAC identified 4 avenues for addressing systematic gaps:

1. Address the need for systematic collection and use of data to understand individual and system level factors in SMVF suicide deaths, including opioid overdoses, and to inform policy and practice. VRAC recommends establishing an adult suicide fatality review board to provide ongoing analysis of suicide deaths in the Commonwealth with particular attention to SMVF and to opioid overdoses.
2. Facilitate rapid access to competent and effective treatment for SMVF and create clear and easy pathways to services.
3. Invest in established SMVF peer services and expand access to both formal and informal peer support. Establish comprehensive web-based inventory and identify funding and procedures for sustaining reliable information and disseminating it widely.
4. Establish and require a robust training curriculum in military culture and suicide prevention for all healthcare providers. Provide funding for training delivery and for effective implementation of evidence-based treatments for SMVF experiencing PTSD, MST, depression, anxiety, and substance use disorder.

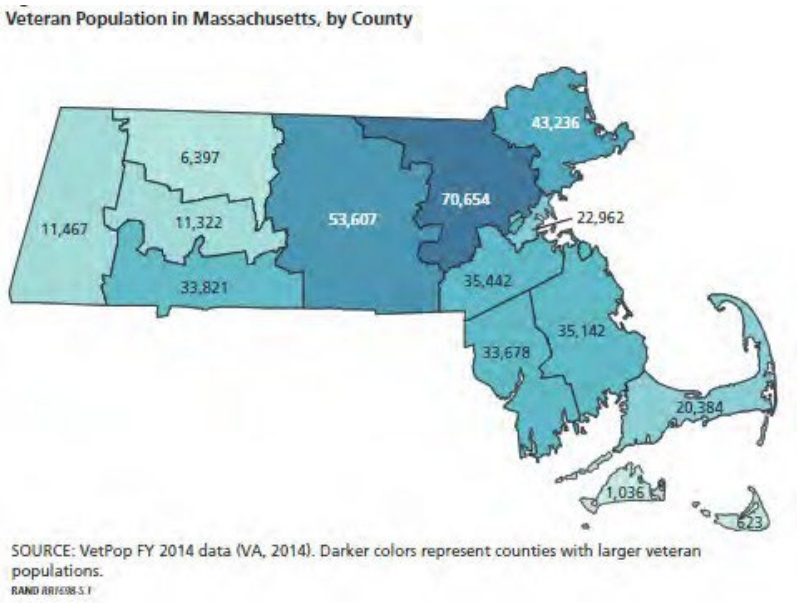
This report seeks to address the questions raised through the course of VRAC's meetings and provide recommendations for consideration by all interested parties.

Findings

How do we understand suicide among Massachusetts' SMVF?

Several studies are available regarding Massachusetts service members, veterans, and their families, including a 2017 report from the RAND Corporation.[1] There is also a wide variety of data that exists regarding veteran suicide prevention and veteran reintegration. To best understand the impact of reintegration and to intervene/reduce risk for suicide among SMVF, it is important to have a baseline of facts, statistics, figures, and trends as a common reference for the discussion and to inform the committee's recommendations.

Who are our SMVF?



The *National Center for Veterans Analysis and Statistics* provides extensive data on the veteran population across the Commonwealth. As of 2017, there are more than 300,000 veterans in Massachusetts.[2] Massachusetts has the 24th largest veteran population in the United States.[2] Of the veteran population, approximately 8% are women, 10% are from a racial and/or ethnic minority group, and more than 57% are over the age of 65.[2] Male veterans and women veterans are equally as likely to have served during wartime (approximately 72% of women veterans and 73% of male veterans in MA are considered to be wartime veterans).[3] Massachusetts is also home to 4,788 active-duty service members, 17,523 National Guard and reserve members, 2,085 active-duty spouses, 3,312 active-duty children, 7,374 National Guard and reserve spouses, and 10,040 National Guard and reserve children.[4]

What do we know about the behavioral health of Massachusetts' SMVF?

In the most recent findings of the Wounded Warrior Project's National Survey, more than two in five veterans (43.5%) screened positive for potential hazardous drinking or active alcohol use disorder, and 42.8% have some degree of problem related to drug

[1] Farmer, Carrie M., Terri Tanielian, Shira H. Fischer, Erin Lindsey Duffy, Stephanie Dellva, Emily Butcher, Kristine M. Brown, and Emily Hoch, Supporting Veterans in Massachusetts: An Assessment of Needs, Well-Being, and Available Resources. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR1698.html. Also available in print form.

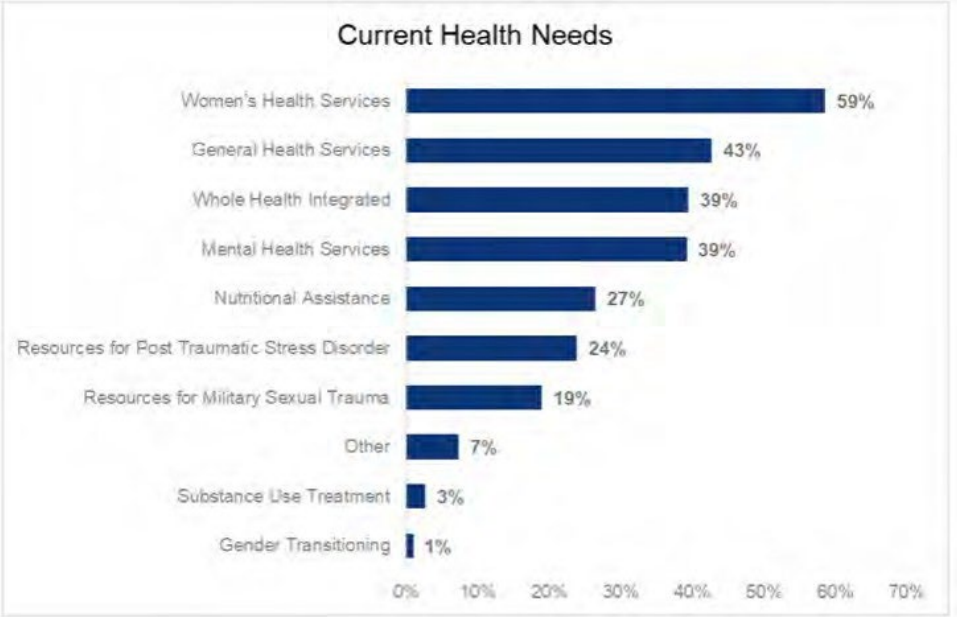
[2] National Center for Veterans Analysis and Statistics. Sources: VA Veteran Population Projection Model, VA Geographic Distribution of Expenditures, VA Annual Benefits Report, U.S. Census Bureau, American Community Survey. 2017.

[3] MA Department of Veteran Services Women Veterans' Network Study. Public Consulting Group, 2022.

[4] Department of Defense Workforce Report and Publication, Military State Policy Source, Dec 31 2022

use.[5] The WWP report also found that unemployment rates for Wounded Warriors were substantially higher than the rest of the U.S. general population and U.S. Veteran population.[5]

RAND (2017) conducted extensive surveys, focus groups, interviews, analyses, and a qualitative assessment of available programming for Massachusetts veterans, service members, and families, as well as unmet needs. Their goal was to create an understanding of the demographics of Massachusetts veterans and the landscape of services available throughout the Commonwealth. RAND found that veterans in Massachusetts had higher positive screening rates for PTSD and depression symptoms than civilian estimates. 37% of respondents screened positive for PTSD, 22% for depression, and 29% for unhealthy alcohol use – all figures that exceeded the civilian rate at the time of the study. Analyses found that veterans who had served during the War on Terror were far more likely to screen positive for PTSD and admit to binge drinking more than their counterparts from the Vietnam era or earlier, suggesting that increased behavioral health support is needed to best serve the post-9/11 veteran population in Massachusetts.[1]



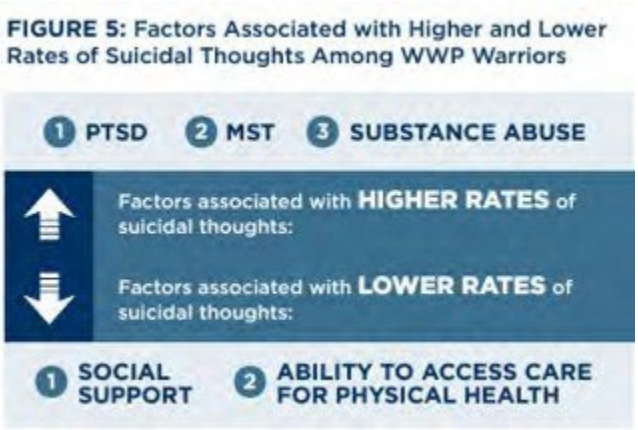
In a study conducted by the Public Consulting Group, 39% of women veterans reported the need for mental health services, 24% reported the need for PTSD resources and 19% cited the need for MST resources.[3]

Irrespective of era of service, surveyed veterans reported that their mental health hampers their productivity and reduces the quality of task performance in work settings. 38% of respondents stated that in the month prior to a job interview, they accomplished less than they had hoped due to their emotional health. Many veterans reported that they have access to and can frequently use health care services, but only 41% agree or strongly agree that their usual healthcare provider understands military culture. A large portion of veterans feel that their healthcare provider is not "military culturally competent" and lacks background in the specific challenges that service members face.[1]

[5] Mayara Fontes Marx, Ph.D. Sarah Evans, MSc Elizabeth Odom Lara Berghammer, MPH Nicole Chisolm, MPH, Wounded Warrior Project Annual Warrior Survey, 2022.

Veteran spouses and partners also face mental health challenges associated with the stresses of life in a military family. While the data collection method was not ideal (veterans were asked to report on their spouse's mental health rather than spouses being asked directly), the findings suggested that in some cases, the rate of spouses experiencing depression or anxiety was twice as high as the figure amongst veterans. Many mental health resources are centered on serving veterans, and there is a persistent need to expand programming to include components tailored to family members.[1]

What do we know about Massachusetts SMVF and suicide?



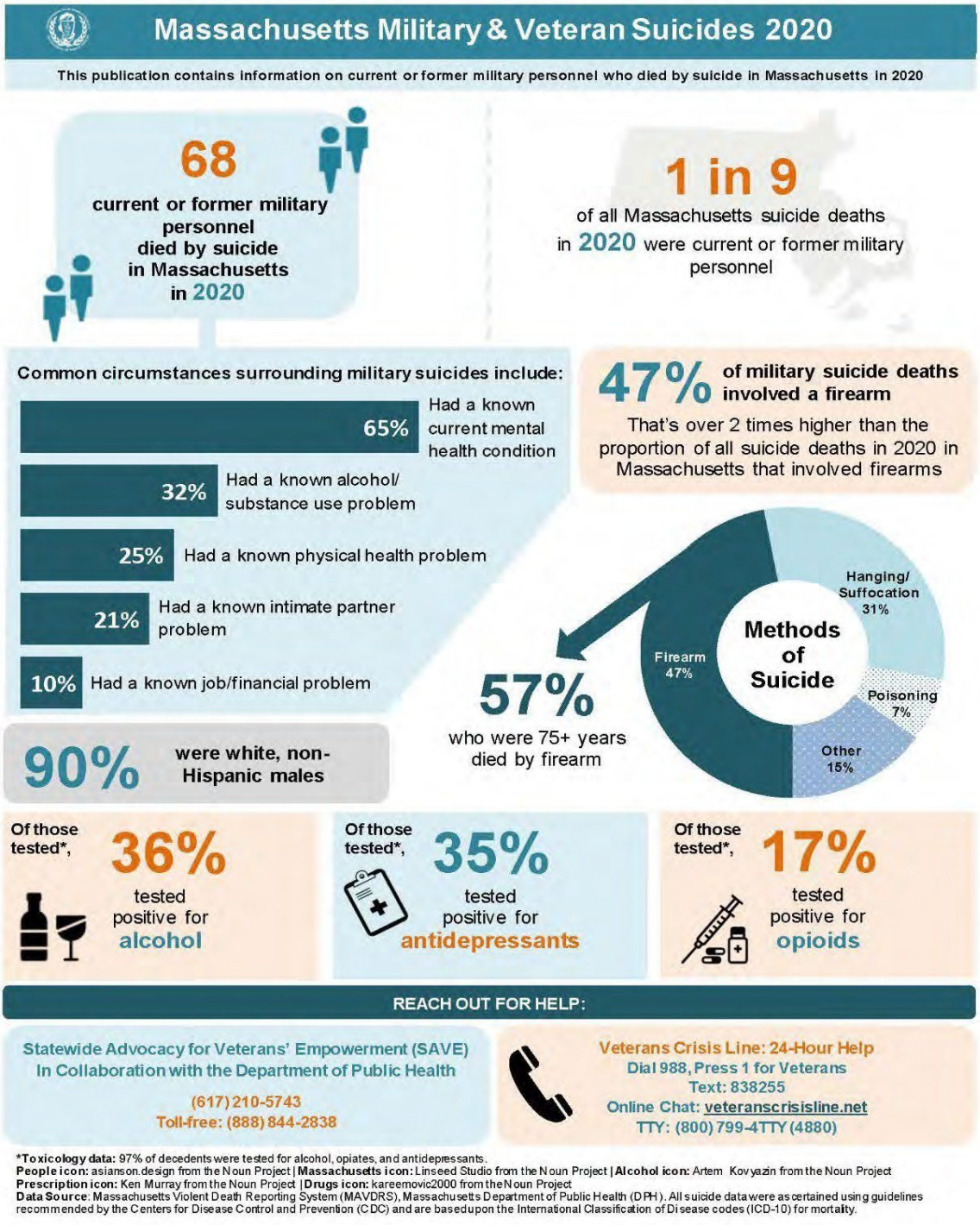
WWP found that 28.3% of Wounded Warriors surveyed nationwide had suicidal thoughts in the past 12 months and of that group, 72.0% had suicidal thoughts in the past two weeks. Unfortunately, suicidal thoughts amongst SMVF continues to grow. In 2021, 15.5% of Wounded Warriors reported attempting suicide at least once in their lifetime, and in 2022, 18.5% reported the same.[5] Suicidal thinking is particularly complex in the veteran population. Veterans who experienced trauma early in life, MST, PTSD, or substance use disorders, are highly vulnerable to suicidal thinking and suicide. However, when a veteran has social support and access to behavioral and physical healthcare this vulnerability decreases.

In Massachusetts, the Suicide Prevention Program's (SPP) most recent report on Veteran Suicide found that 1 in 9 of all Massachusetts suicide deaths were current or former military personnel.[6] 65% of military suicides in Massachusetts include those who had a current mental health condition, 49% tested positive for either alcohol or opioids, 21% had an intimate partner problem, and 10% were experiencing problems with their job or finances.[6]

Opioid addiction and suicide: Several studies suggest that suicidal motivation can contribute to opioid overdose fatalities in people with opioid use disorder.[7] Opioids pose a greater risk to

[6] Massachusetts Suicide Prevention Program, Massachusetts Violent Death Reporting System (MAVDRS), Massachusetts Department of Public Health (DPH). All suicide data were ascertained using guidelines recommended by the Centers for Disease Control and Prevention (CDC) and are based upon the International Classification of Disease codes (ICD-10) for mortality

[7] Hilary S. Connery, Roger D. Weiss, Margaret L. Griffin, Catherine D. Trinh, Jungjin Kim, Ian R.H. Rockett, R. Kathryn McHugh,Suicidal motivations among opioid overdose survivors: Replication and extension, Drug and Alcohol Dependence, Volume 235, 2022,



In 2020, 17% of confirmed veteran suicides tested positive for opioids in the Commonwealth.[6]

veterans than any other drug class of an intentional overdose proving to be lethal, because of their respiratory depression effects and narrow therapeutic window. Approximately 40% of overdose suicide deaths in the United States involve opioids.[7] However, the relationship between opioid prescribing and suicide risk is complex and needs continued investigation.

For example, when veterans are being treated for pain with opioids and then tapered, they can become desperate if their pain becomes uncontrolled or if they experience serious withdrawal

symptoms, no matter the reason they received opioids. Long-term opioid exposure can also promote depression, which in turn increases the risk of suicide by intentional and unintentional overdose.

Current substance use treatment models may indirectly contribute to suicide risk among SMVF. Community based substance use services typically operate with an abstinence framework. SMVF (and others) who are in abstinence-focused housing programs often lose their housing when they relapse. Homelessness is a significant risk factor for SMVF suicide, and homelessness among SMVF with addiction amplifies suicide risk because of the deleterious impact on their ability to access other essential treatment services. There is also a limited amount of harm reduction framework programs available to individuals who may not be ready for recovery. Training regarding harm reduction for healthcare and behavioral health providers is limited, and there needs to be additional efforts to teach and empower SMVF to make safe decisions.

What helps?

Peer to peer support: Peer support increases social connection and helps mitigate risk for suicide. For decades, our culture has acknowledged the power of peer-to-peer advocacy, support, and intervention. However, it was not until recently that this psychological phenomenon was investigated using an empirical method. Peer support is defined as "emotional support, frequently coupled with instrumental support that is offered by someone who has had a similar clinical situation".[8] For veteran peers, however, the key similarity is military service. Veteran peers may or may not have similar mental health issues or other lived experiences, but the mutual military experience connects them and provides interpersonal support. Peer services also produce similar clinical outcomes, including decreased hospitalizations and symptom severity to non-peers. [9] However, peer services also had a greater impact on recovery-oriented outcomes such as hope, quality of life, and empowerment. There are several programs in the Commonwealth that provide peer intervention-based services: MGH Home Base, Wounded Warrior Project, Veterans Inc., the SAVE Team and several others.

In particular, the SAVE team (part of the Executive Office of Veteran Services), provides an important peer connection to veterans in the community. SAVE in many cases is the first hand that reaches out to veterans who are homeless, justice involved, in need of economic assistance, and/or in need of behavioral health and substance use referrals. Many of these connections and interventions are made while veterans are in hospital emergency departments or brief incarcerations. Organizations such as SAVE clearly demonstrate the impact that peer-to-peer advocacy and connection have on veteran suicide prevention. Peer support activities

[8] Soloman, P (2004) Peer support/peer provided services underlying processes, benefits, and critical ingredients, Psychiatric Rehabilitation Journal, Spring;27(4):392-401

[9] Bellamy, C, Davidson T, (2017) An update on the growing evidence base for peer support, Mental Health and Social Inclusion, Volume 21 Issue 3

also have the potential to positively influence the well-being of SMVF on a holistic level across multiple health domains.

Peer services provide the benefit of connections with a peer who can empathically impart wisdom and hope from a shared place of 'I've been there.' Additionally, peer staff may facilitate access to services by reducing stigma and other intrapersonal barriers to treatment engagement. They also provide information about available services that may not be knowable to the SMVF in need.

Early identification of military connection: The VALOR Act (I and II) recognized the importance of identifying veterans, service members, and their families, and established the requirement that health care personnel in certain settings 'ask the question.' This recognition is important so that health care providers are attuned to the specific needs of the person, may understand the context for the person's presenting problem, and may assist them with accessing appropriate services. SMVF are more likely to engage with healthcare providers who demonstrate familiarity with military culture.

Screening for suicidality: Universal screening for suicidality is associated with an increased detection of individuals experiencing suicidality across healthcare settings. Identifying a service member, veteran, or family member, then asking about suicide, sets the stage for mobilizing SMVF specific resources and supports, e.g., peer support offered by the SAVE team. Normalizing conversations about suicide provides opportunities for SMVF to engage collaboratively with healthcare providers and to address support and safety needs.

Increasing lethal means safety awareness: Weapons are an integral part of identity and sense of safety for many SMVF. Proactive collaboration with SMVF to develop a plan for maintaining safe access to weapons, particularly during a suicide crisis, reduces suicide deaths. Additional training on lethal means awareness should be accessible to all in the community (providers, family members, veterans and other military connected individuals).

Psychological treatment: Several evidence-based practices have well established efficacy to address depression, PTSD, MST, substance use disorder, chronic pain, insomnia, and other behavioral health needs among SMVF. It is critical to recognize that some of the most effective treatments include the family.

Where are the gaps?

Access to treatment: Despite well-established treatments for PTSD, MST, depression, suicidality, chronic pain, insomnia, and substance use disorders, access to treatment remains a huge factor in suicide deaths and access is impeded in several ways. Beliefs about behavioral health and behavioral health treatment among SMVF may include the belief that acknowledging the need for treatment is a weakness and/or that seeking behavioral health services jeopardizes active-duty status or access to weapons. Many people first seek help through their primary care provider (PCP). Many PCPs may not ask about SMVF status and/or suicide, substance use, or other behavioral health matters in such a way that the individual experiences an invitation to disclose their suicidality. PCPs may not have information readily at hand or support staff who can assist

with providing an effective warm handoff to a behavioral health provider. Approximately 50% of people leaving an emergency department following a suicidal crisis do not keep the behavioral health appointment set up for them.[10] Additionally, access to transportation based on the SMVF's location can be an issue.

National Guard Members on State-Active-Duty status do not receive health insurance and are not eligible for VA medical care without other qualifying periods of service. There were many state activations in recent years outside of traditional weather-related emergencies/disaster relief. State-Active-Duty members who require mental health or substance use disorder treatment must pay out of pocket or apply for compensation benefits through the state to cover any treatment or evaluation costs, as they are considered short term state employees without healthcare benefits.

Once a person is willing to seek treatment, several variables come into play:

- Insurance dictates what providers the person may use.
    - Co-pays and changing insurance status are further barriers.
- Long waitlists (3 to 6 months) for intake appointments with providers who may or may not take the individual's insurance.
- Once an individual arrives at a provider, the provider may or may not have familiarity and comfort with military culture and they may or may not have experience in the treatments needed.

Families: Families are an integral part of the support system for service members and/or veterans, particularly through community reintegration. At the same time, conflict with family and changing family constellations and/or family roles is a significant stressor. Interpersonal conflict and relational loss are major risk factors for suicide. Families are too often overlooked for their roles as supporters and caregivers and military families would benefit from support and treatment. Families who experience the death of a service member or veteran to suicide, overdose, or another cause of death are too often left alone and disconnected. These families suffer from a lack of systematic processes for outreach when a service member or veteran dies. Creating a system that shares information across the multitude of services about a person's death and/or to provide family with clear information about benefits and available resources is critical.

Continuity of Care: When a person presents for care, critical information about the person and the services and resources available to them is not readily obtainable because it is distributed across private, state, and federal systems. This endangers the people we serve and creates an undue burden on all providers. Too often, information about a person's history of suicidality or opioid overdoses is not accessible to the provider charged with assessing the person's imminent risk.

Coordination and support through community reintegration while having access to an individual's military status and benefits would enhance this process.

[10] Stanley B, Brown GK, Currier GW, Lyons C, Chesin M, Knox KL. Brief Intervention and Follow-Up for Suicidal Patients With Repeat Emergency Department Visits Enhances Treatment Engagement. Am J Public Health. 2015 Aug;105(8):1570-2. doi: 10.2105/AJPH.2015.302656. Epub 2015 Jun 11.

Data: One of the key findings of the committee was the lack of a systematic compilation of veteran suicide data. Understanding the heterogeneity of who our SMVFs are in terms of race, ethnicity, and gender is important. However, what is lacking are other elements such as a centralized veteran database that would include discharge status, past medical treatment, legal history, and whether a National Guard and/or Reserve member did not achieve veteran status. There also needs to be more input from the Medical Examiner's Office to make this database more robust and accurate.

Recommendations:

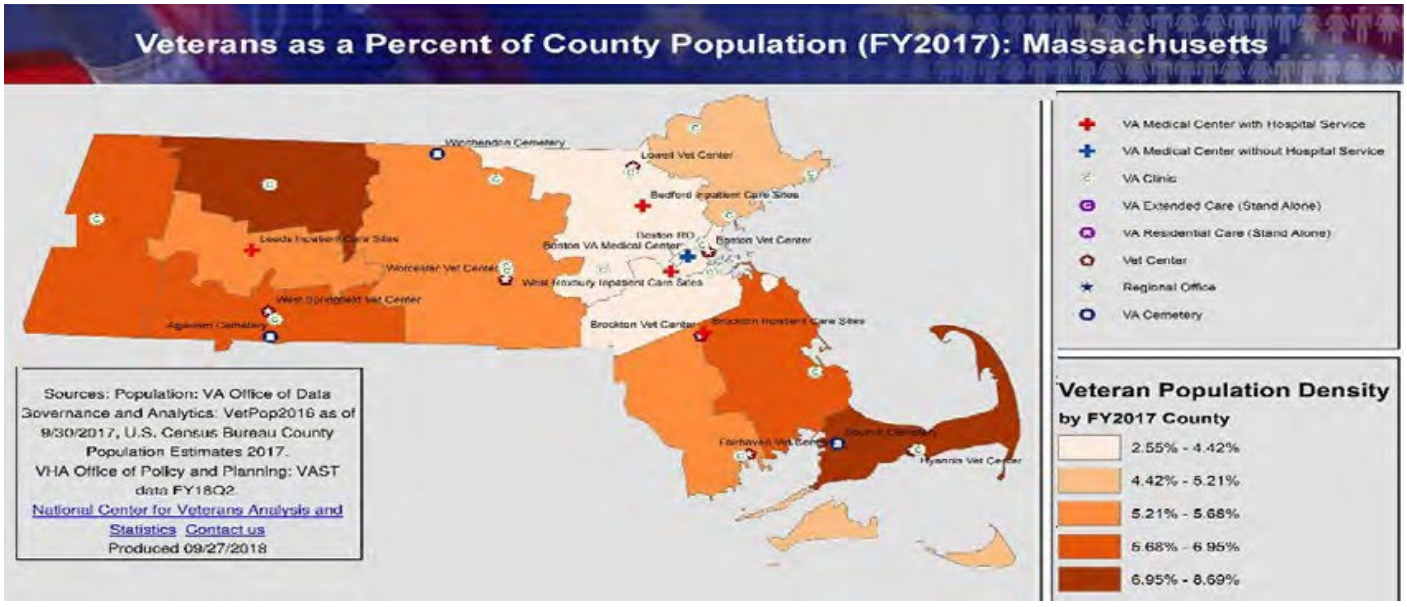
1) **<u>Address need for systematic collection and use of data to understand individual and system level factors in SMVF suicide deaths, including opioid overdoses, and to inform policy and practice.</u>**
    - Establish an adult suicide fatality review board to include SMVF suicide and opioid overdose deaths in the Commonwealth. The adult suicide fatality review board would provide critical data/analysis on these fatalities with the goal of better understanding individual and system level factors in SMVF suicide deaths. By providing a better understanding of fatal incidents, the review board should be charged with including further recommendations for creative/effective strategies to reduce suicides amongst SMVF.
        - Work with the Medical Examiner to ensure accurate information is included in death data.
    - Convene workgroup to address challenges of siloed data from VA, DOD, National Guard, MA Medical Examiner, etc. Access to population-based data is essential to any effort to understand SMVF and suicide in MA. DPH and the Massachusetts Suicide Prevention Program (SPP) at DPH are critical partners in the work to address SMVF suicide. Under G.L.C. 111, §237, DPH is charged to "collect, record and analyze data, and shall assemble and maintain data systems, necessary to analyze population health trends … The [DPH] commissioner may identify and determine additional priorities for the reduction of morbidity and mortality." The SPP is charged with managing, analyzing, and reporting all suicide relevant state data.

2) **<u>Facilitate rapid access to competent and effective treatment for SMVF.</u>**

    - **Create clear and easy pathways to services for SMVF.**
        - Establish workgroup to identify procedures for assuring ready access to private, state, and federal information about an individual's eligibility for health services, benefits, and to critical personal health information at any point that a person seeks services (first responders, emergency room, mobile crisis, etc.).

- Leverage opportunities for increasing public awareness and to promote positive resilience-based view of behavioral health services (MA Behavioral Health Helpline outreach and engagement, MA SPP community awareness campaigns, etc.).
- Distribute funding to organizations that provide insurance-blind and military status neutral behavioral health programs to SMVF.
- Review and update health and disability benefits for those service members on State-Active-Duty status to ensure improved access to care.
- Collaborate with VA, National Guard, and other stakeholders to identify, and reach out/provide individual and group postvention services to families of service members/veterans who have died by suicide or overdose.

3) **<u>Invest in established SMVF peer services and expand access to both formal and informal peer support.</u>**
   - **Expand the State Advocacy Veterans Empowerment (SAVE) program**. The SAVE team was established to address SMVF suicide. Presently, the SAVE team has one team member in southeastern Massachusetts covering the three counties of Bristol, Plymouth, and Barnstable. In western Massachusetts, the SAVE team has two members covering three geographically large counties. This coverage is thin because while these counties may not have large overall populations, they have some of the largest populations per capita of veterans in the Commonwealth.



- **Establish comprehensive web-based inventory of formal and informal peer support and identify funding and procedures for sustaining reliable information and disseminating it widely.**

4) Expanding the behavioral health workforce to better serve SMVF.

- **Establish robust training curriculum and training requirements for healthcare, behavioral health, and other direct-service providers.**
  - Invest in ongoing development and delivery of training curriculum and implementation support in military culture, suicide prevention, lethal means safety, substance use and harm reduction, and evidence-based treatments relevant for SMVF experiencing PTSD, MST, depression, anxiety, chronic pain, insomnia, and substance use for community members, first responders, health care providers, and behavioral health providers.
    - Institute requirements for all healthcare providers and behavioral health providers to complete training in military culture and suicide prevention as part of their licensure renewal.
  - Require Massachusetts Veterans Service Officers to complete trainings in suicide prevention, substance use disorder, lethal means safety, and peer-to-peer support as part of their annual training through EOVS.
  - Establish funding mechanisms to offset costs for providers to participate in training and ongoing implementation requirements necessary to assure access to competent and effective treatment, e.g., regular supervision with subject matter experts.

- **Invest in SMVF as behavioral health professionals.**
  - **Support ongoing initiatives to review and update MA professional certification and continuing education requirements for Behavioral Health Certified Peer Specialists and Certified Recovery Coaches.**
    - Provide funding to develop suicide prevention and military culture training curriculum in collaboration with DMH (Certified Peer Specialists (CPS)), the Bureau of Substance Addiction Services at DPH (Certified Recovery Coaches (CRC)) and the MA Suicide Prevention Program at DPH.
    - Establish workgroup with DMH, Bureau of Substance Addiction Services at DPH (BSAS), and MA Suicide Prevention Program (SPP), Veterans Administration and others to review ongoing supervision requirements, continuing education requirements, and re-certification process for CPS and CRC.
    - Convene EOVS-led workgroup with DMH, BSAS, and SPP to establish a 'specialized training' curriculum for CPS and CRC to work as SMVF peers.

- **Provide dedicated sustainable funding for career development programs at institutions of higher learning for returning veterans.**
  - Provide formal opportunities for SMVF to obtain formal education and training opportunities in behavioral health to expand SMVF representation in behavioral health workforces. Several Massachusetts colleges/universities have military/veteran health tracks of study.

- The Train Vets to Treat Vets Program at William James College (WJC) in Newton is a regionally accredited professional school of psychology with a special program designated to help returning veterans complete graduate school and enter the fields of psychology, mental health, and leadership. It is home to a total of 57 student veterans who are currently enrolled across WJC programs for the 2023-2024 academic year. In the past 5 years, 56 veteran students have graduated from WJC programs (32 student veterans with doctoral degrees, 8 from post graduate certificate programs, 13 with Master of Arts, and 3 from the new Bachelors Completion program). Since its inception, the Train Vets to Treat Vets program has facilitated the direct training of students who have provided 201,323 hours of mental health services to SMVF at approximately 15 veteran and military sites located in the greater Boston community. WJC's program also involves student veterans in research, and the development and delivery of training for community clinicians to support the wellness needs of veterans and their families. Students have facilitated veteran oriented community outreach events reaching a total of 4,893 veterans, clinicians, and community members to date. Increasing support and resources for the Train Vets to Treat Vets program (and others like it), will allow a proven program to expand and increase its capacity to serve even more veterans across the Commonwealth.

Conclusion

Through the Veterans Reintegration Advisory Committee, staff from a variety of public and private organizations spent several weeks collaborating in open dialogue, exploring available programs and resources, and sharing best practices. All members were committed towards the goals of addressing mental health challenges, preventing suicide, and increasing access to critical data.

In addition to the recommendations listed in this report, the Committee membership wishes to express its support for a component of the HERO Act, a comprehensive veterans legislative package filed by Governor Healey on November 9th, 2023. The Committee strongly supports the provision in the HERO Act to make behavioral health outpatient therapy reimbursable under EOVS' Chapter 115 benefits program.

Additionally, there is widespread hope that a structure is created to allow this working group to continue to meet to develop programming and increase awareness of resources to treat SMVF mental health. Overwhelming support was expressed for continuing the work of the Committee in perpetuity. A few notable suggestions included combining this group with the ongoing work of the Governor's Challenge, or to reorganize into a more EOVS-driven committee overseen by the Secretary of EOVS.

The Veterans Reintegration Advisory Committee is honored for the opportunity to serve the Commonwealth with the goal of addressing the profound effects of PTSD, depression, and anxiety among service members, veterans, and their families, and seeking to improve veterans' reintegration into civilian life.