



# VETERAN SUICIDE TASKFORCE

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FINAL REPORT  
DECEMBER 1, 2016

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## FROM THE CO-CHAIRS

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It is truly an honor and privilege to lead the Veteran Suicide Task Force for the State of Illinois. The task force was created to research and listen to Veterans throughout the State of Illinois and acknowledge their struggles, in addition to identify collaborative relationships between the State of Illinois, the U.S. Department of Veterans Affairs, Veteran Service Organizations and many other groups and organizations.

We would like to personally thank Mr. William Attig, 1<sup>st</sup> Infantry Division, United States Army Veteran, and Mrs. Alexandra Stokman Brackett, United States Marine Corps Veteran, for initially sharing their experiences, which set the mission and direction for this task force.

Most important, we would like to thank the Veterans, Veteran spouses, and community members who stepped forward. Every voice is heard and every participant is acknowledged by the task force for showing bravery and courage to share their experiences and feelings to help their fellow Veteran and prevent another loss of life. One Veteran life lost to suicide is one life too many. We hope that this task force report is the start of a very important conversation and the beginning of a collaboration to identify and meet the needs of the Veteran community in the State of Illinois.

The dedication of our fellow task force members and their commitment to the process of arriving at consensus around these recommendations is also worth acknowledging. The task force members brought diverse perspectives to the table and were able to come together to engage in meaningful dialogue on emotionally charged issues in a respectful and effective manner.

This experience has shown that as a community, we are problem-solvers by nature, and it is our hope that the recommendations included here will contribute to the reduction in Veteran suicide in the State of Illinois.

This report is respectfully submitted to the General Assembly on December 1, 2016.

State Representative Stephanie Kifowit  
Veteran, United States Marine Corps 1990-1994

State Senator Tom Cullerton  
Veteran, United States Army, 1990-1993

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## MEMBERS OF THE TASKFORCE

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### Co-Chairs

Stephanie Kifowit, IL State Representative, IL House of Representatives, Veteran USMC

Tom Cullerton, IL State Senator, IL State Senate, Veteran USA

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### Members

Jeanne Ives, IL State Representative, House of Representatives, Veteran USA

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*The Veteran Suicide Taskforce was established in the 98<sup>th</sup> General Assembly by HJR91; and the deadline extended for completion of this report in the 99<sup>th</sup> General Assembly by HJR4*

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Taskforce Members at the Waubensee Community College hearing with participants.

R-L: Rep. Jeanie Ives, Sen. Tom Cullerton, Col. Steve Foster, participant, Rep. Stephanie Kifowit, participant, Tom Miller, participant



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## ACKNOWLEDGMENTS

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The taskforce received the support from the various community colleges that agreed to host the public meetings. The following community colleges assisted the taskforce in its work: Southwestern Illinois College, Land of Lincoln Community College, College of Lake County, Waubonsee Community College and Triton Community College.

The taskforce was also assisted by Edward S. Landreth, PsyD., U.S. Department of Veterans Affairs, DuPage County Coroner Richard Jorgensen, MD, and IL Department of Public Health UIS Graduate Interns.



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## EXECUTIVE SUMMARY

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Suicide is an issue that affects our community without discrimination, and thus it is important for everyone to be knowledgeable and active in its prevention. While this report is focused on suicide of Veterans who reside in Illinois, suicide is also a public health issue for all citizens. Of the Illinoisans who died of suicide in 2014, 15% were defined as reporting ever serving in the U.S. Armed Forces. For the purposes of this report, we designate between the Illinois Department of Veteran Affairs by IDVA, the Department of Defense by DOD and the U.S. Department of Veterans Affairs by DVA acronyms.

This executive summary provides an overview of the recommendations of the taskforce, which conducted six hearings throughout Illinois to assess the needs of Veterans in all regions of the state. Two hearings were conducted south of I80, one in Southern Illinois (Belleville) and one in Central Illinois (Springfield), three hearings in the collar counties (Sugar Grove and Grayslake), and one hearing near Chicago (River Grove). All hearings were conducted on the campuses of Community Colleges to provide easy access. Five hearings were conducted during the hours of 10:00 a.m. and 2:00 p.m., and the sixth hearing in Grayslake was added in the evening from 5:00 p.m. to 7:30 p.m. These listening session brought the members of the task force together with more than 50 individuals from diverse backgrounds – Vietnam Veterans, Desert Storm Veterans, Iraq/Afghanistan Veterans, spouses of Veterans, parents of service members who died by suicide, mental health professionals, and others. Attendance at the hearings ranged from approximately 5 participants to as many as 30. A small amount of participants were female Veterans, with the primary testimony being offered by male Veterans.

The task force reviewed data compiled by the IL Department of Public Health (IDPH). Their data resulted in helping the task force understand the different dynamics of not only Veteran suicide, but suicide as a whole. In addition, the task force began to understand the gaps in the available data for suicide statistics. Dupage County Coroner Richard Jorgensen, MD, indicated there is a potential that Veteran suicide could be under reported because the Illinois death certificate does not include information about the history of U.S. military service. Dr. Jorgensen suggested that the taskforce explore the ability to add fields to the death certificate to capture the Veteran's status, branch and years of service for all persons with a history of military service.

It quickly became apparent to the taskforce members that our work and report would represent the start of a conversation on how to tackle a problem that is complex in origin and not easily solvable. In many cases, hours of testimony and research produced more questions than answers. We do not claim that this report contains the final word on how to solve this vexing problem. Instead we hope this report can provide ideas and further the conversation among the many Americans who find the current situation unacceptable.



This is a report of the taskforce's work, hearings conducted, and the collective contributions of the task force members. The report is presented as a recommendation document only for purposes of proposing suggested policy changes, rule changes or collaborations in the effort to address the needs of the Veteran population in Illinois and reduce Veteran suicide. This report is not scientific in nature nor is it an academic report. The findings are from testimony received during hearings and are not reflective of the individuals giving testimony and not of any groups, organizations or regions. This report does not contain any financial estimates or costs; however, the task force members feel that working towards a solution would also entail diversifying and identifying multiple revenue streams to fund the vital programs needed to help our Veterans.

The taskforce recommendations, each with action items, are organized around the main topic areas that were evident through the hearings.

**1. Proactive approach to multiple deaths by suicide from one military unit.** There is reason to believe that the level of conflict a military unit encountered could be an indicator to the likelihood of many surviving members to have suicidal tendencies. The State of Illinois should work with the Department of Defense (DOD) to identify returning Veterans who are transitioning from heavy casualty or conflict units and establish a proactive outreach program as soon as they return to Illinois, or if even one former member of that unit dies from suicide.

**2. The State of Illinois should engage in a public awareness campaign or collaborate with entities or nonprofit organizations to produce a public awareness campaign.** This campaign should bring awareness and rebrand trauma and internal injury by Veterans in a way to promote understanding and acceptance to the general public. In addition, the public awareness campaign should also work to dispel the myths associated with grieving, suicide and mental health healing. Evaluation of existing programs, such as the Suicide Prevention Alliance, should be conducted and coordinated following the successful messaging guidelines.

**3. Expand the expertise of the Veteran Service Officer (VSO), and employees of the Veteran Assistance Commissions (VAC) and the Veterans Service Associations (VSA).** It is suggested to provide additional training to frontline employees on mental health services to identify Veterans who might be at risk of suicidal thoughts, in addition to finding combat Veterans to serve as VSOs in order to be able to properly relate to fellow combat Veterans. Examples of these trainings include, Mental Health First Aid training and Amplified Suicide Advanced Training programs. Included in this is assistance for the county Veteran Assistance Commissions and the Veteran Service Associations such as the American Legion, Veterans of Foreign Wars, and AMVETS.

**4. Proper funding of Higher Education and Training Programs.** The State of Illinois should properly fund the Illinois Veterans Grant and the Monetary Award Program (MAP) grant

program to assist Veterans in obtaining a degree or a certificate of completion from an institute of higher education. If possible, identify and prioritize Veterans funding during the budget crisis.

**5. Establish an Educational Success Program for Veterans.** Many Veterans find College experiences to be stressful. The State of Illinois should collaborate with DVA and institutions of higher learning to address environmental factors that could negatively impact the Veteran student's ability to learn in a traditional classroom setting, such factors could include, but are not limited to, expanding Veteran access to on-line learning, desk placement away from windows, crowded hallways or orientation, grouping Veterans together in a class, Veteran only instructional period, etc. Also, proactive outreach to a struggling Veteran should be included in an educational success program because struggling Veterans could have undiagnosed mental health needs which prevent them from succeeding.

**6. Enhance the Veteran Support Program for families of discharged and returning Veterans.** A separate family preparation course should be designed and offered to families prior to the discharge and homecoming of a Veteran. This is help the family unit adjust to the changes in the Veteran and informs the family members of where to go for assistance. It is important to focus on the emotional cycle of deployment that affects not only service members but also family members.

**7. The State of Illinois should develop a licensing program for therapy dogs, with possible extension to other therapy animals for Veterans.** Therapy animals have been shown to provide relief from anxiety and companionship for Veterans. However, many businesses do not recognize a therapy animal with a Veteran. There should be a standard for training and identifying therapy dogs with the possible extension to other therapy animals for Veterans. The designation of service dog would be different from the designation of therapy dog.

**8. Develop an in-state Transition Program.** Illinois should work with the DOD to obtain information on returning Veterans and devise an in-state transition program for them to participate in. This program should include a Veteran-to-Veteran connection program and information on organizations that are local to the Veteran that they can access.

**9. Establish a State of Illinois DD214 Automatic Filing System.** Illinois should work with the DOD to file the DD214 paperwork immediately upon discharge on behalf of the Veteran.

**10. Collaborate with the IL Chamber of Commerce to create an employer training program to focus on the needs of Veteran employees.** Devise a training or certificate program that identifies companies that are trained at the unique circumstances that Veteran job seekers are subject to and support Veteran employees.

**11. Establish a peer-to-peer program.** Many Veterans expressed a desire to be able to confide in a peer Veteran. The State of Illinois, in collaboration with existing Veterans organizations, can establish a standard state-wide peer-to-peer training program.

The statements throughout this report are of the opinion of the person that gave testimony and might not be reflective of the current protocols or procedures of the DVA, IDVA, the State of Illinois or other organizations. The taskforce also realizes that testimony is subjective to the participants in the hearings and might not reflect the Veteran population at large. It is important to the task force that every Veteran be heard, and through the Veteran's testimony, the importance of access to care, understanding of their unique situations and factors that have contributed to thoughts of life ending actions be included in this report.

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## INTRODUCTION

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An internet search of any term that includes the word “Veteran” returns hundreds of organizations who want to help them. Many people on their own accord organized nonprofit entities, well intentioned to be a resource to Veterans who were returning from combat, struggling to find a job, needing to become physically fit, or had just given up on life due to despair. The names of these organizations are patriotic and creative; however, for a Veteran the numerous amounts of resources available can be overwhelming and exhausting. A Veteran could spend many days reading, researching and analyzing which organization would be the best fit. In short, the internet is a web of way too much information for a returning Veteran or a Veteran struggling with traumatic injuries from their military service.

An internet search isn’t the only information avenue for Veterans; social media has also been filled with Veteran groups, organizations, support pages and individual unit pages. Through these pages, Veterans can connect with old friends, unit buddies and receive information. The network of today is vast and unlike the Veteran support network pre-technology.

Despite all of the available resources dedicated to helping Veterans, it is tragic that Veterans still take their own lives at alarming rates. A recent comprehensive report by the U.S. Department of Veterans Affairs reported an average of 20 - 22 Veterans a day die from suicide. Part of this situation stems from the increase in the overall suicide rate in our society; however, this overall increase in suicide does not account for the entire tragedy. Recent studies definitively show that Veterans were twice as likely to die of suicide compared to non-Veterans in the general population; in addition, female Veterans die by suicide at six times the rate of their civilian counterparts<sup>1</sup>.

Veteran suicide is not a new problem. Although the taskforce did not have access to data (which, in all probability, does not exist) about the mental health struggles of WWII Veterans, Korean Veterans or other past conflicts, we did receive expert testimony on how Post-Traumatic Stress Disorder (PTSD) was previously referred to as “shell-shock”, “combat fatigue” and “walking wounded”.

Navigating a fragmented and complex system of services and supports only makes getting to the right help more difficult. Thus, it appears to us that Veterans are more isolated today than in previous years. Furthermore, established Veteran Service Organizations such as the VFW and the American Legion are finding it difficult to compete with the ever increasing presence of

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<sup>1</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465754/>

nonprofit Veteran organizations establishing websites on the internet. Despite the wealth of resources and opportunities, some Veterans lag behind the general population in key health and wellness indicators and remain vulnerable to financial, employment, relationship, and legal-related difficulties, as well as homelessness and substance abuse in their transition back to civilian life.

With the extensive resources available to Veterans and their families, it is still a tragedy that Veterans are taking their own lives. Thus, the IL General Assembly formed the Veteran Suicide Task force to study and evaluate how the State of Illinois can become a partner and collaborate in reducing Veteran suicide.

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## TESTIMONY

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### **Sometimes Suicide can be seen as a Logical Solution**

This section is a brief account of the testimony that was shared at the taskforce hearings throughout the state. All hearings were recorded to ensure accuracy and to provide reference in the future. Thus, statements in this section are of the opinion of the person testifying and might not be reflective of the current protocols or procedures of the DVA, the State of Illinois or other organizations. The taskforce also realizes that testimony is subjective to the participants in the hearings and might not reflect the Veteran population at large. It is important to the taskforce that every Veteran be heard, and through the Veteran's testimony, the importance of access to care, understanding of their unique situations and factors that have contributed to thoughts of suicide be included in this report.

This is a sample of testimony that was offered during the taskforce hearings, while it would have been ideal to include all testimony, due to limitations we had to focus on the main theme throughout the hearings.

Much of the testimony heard in the taskforce hearings shared common frustration with the DVA system (as well as access to mental health care throughout the State of Illinois). When the frustration becomes too great, one participant stated "suicide is the logical solution. I don't fear death, I've taken lives and I've seen my buddies die, so death is not that strange of an idea as a solution to a problem". Thus, the governmental bureaucracy of the DVA contributes to intense frustration for the injured Veteran. The taskforce heard hours of testimony describing claims being denied, lengthy appeal processes, and missed deadlines which consequently start the entire process over again. One participant offered testimony that the military lost his record, and another recalled he was denied compensation even though he was injured. These testimonies relate a system of paperwork that, when a Veteran just wants to find care for their ailments, they are subjected to enormous stress with a system that is not "user friendly". While the complete circumstances that faced these Veterans who testified at the hearings were not available to the task force, it is important to address perceptions of frustration, in addition to actual procedural frustrations. Of the few female Veterans that testified, the common theme was lack of access for care specific to their gender.

Many speakers stated that civilian rehab facilities were not perceived as being able to handle or properly diagnose the complete problem associated with combat Veterans and their mental injuries. The civilian model of care was perceived as a "quantity" based system, and the Veteran testimony relayed that Veteran's need a more "quality" based system, where doctors can devote adequate time to dealing with Veteran situations properly. Testimony revealed that frequent terminology is perceived to do more harm than good. Post-Traumatic Stress Disorder (PTSD) is

viewed by some speakers as a perpetual mental disorder instead of a traumatic injury. A recent effort to remove the term “Disorder” and refer to the condition as Post-Traumatic Stress has not seemed to materialize because it is still commonly referred to as “PTSD”.

A conclusion can be made that the State of Illinois should bring awareness and rebrand the trauma felt by Veterans as a more reflective term, speakers shared they would prefer terminology that identified conditions as an Traumatic Stress wound, or terminology that indicated healing and mitigation, not a disorder that implied negative images. In addition, increase the level of VSOs and include a basic mental health training to identify Veterans who are increasingly frustrated with the status of their claims. Possibly refer Veterans who have complex claims, multiple denials, or appeals, to a higher level professional as a precaution before the situation escalates into a more stressful and frustrating situation, where the Veteran might contemplate taking their own life. Many Veterans stated they appreciate working with fellow Veterans who have experienced similar situations while they were in the military; thus an emphasis should be made to maintain and recruit VSOs that can properly relate to combat Veterans.

Many Veterans gave testimony, which relate the condition of their units upon return to civilian life. Through the social network, primarily Facebook, unit members can be updated on their fellow “Battle Buddies”. Many speakers testified to feeling isolation and depressed upon the news of fellow unit Veterans taking their own life when they survived warzone conditions. As multiple members of the unit began to die from suicide, it fueled the other members to consider “if that person couldn’t make it, then maybe I can’t”. It is important for these units to be identified and members of those units who have transitioned into civilian life identified for a “well being” check and make proactive outreach as soon as they return to Illinois or if even one member dies from suicide.

As an Army Veteran described his situation, “all I wanted was for the hurt to go away”. He continued that “Veterans carry suicide in our pockets, like a military challenge coin, ready to cash it in at a moment’s notice”. It is important that all efforts be made to provide support before the Veteran is in crisis.

Some research has found that while there are some positive attributes, overall social media can be harmful. Through various studies, it has been concluded that social media is addictive, and some sites use positive reinforcement to keep people coming back<sup>2</sup>. While social networking sites can enhance a person’s confidence, users sometimes believe there are no reprisals or commitments. People tend to feel safer on social media sites. The virtual world can become their real world, in turn shrinking their social circle<sup>3</sup>. A study conducted by the University of

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<sup>2</sup> <http://www.medicalnewstoday.com/articles/245251.php>

<sup>3</sup> [http://www.academia.edu/5742134/Psychological\\_impact\\_of\\_Social\\_Networking\\_Sites\\_A\\_Psychological\\_Theory](http://www.academia.edu/5742134/Psychological_impact_of_Social_Networking_Sites_A_Psychological_Theory)

Michigan<sup>4</sup> found that while Facebook should be providing the need for human connection, it is actually undermining well-being. The more people used Facebook, the worse they felt, and became less satisfied. It is of particular importance when discussing social media to mention the suicide contagion, which is exposure to a suicidal peer. Dangerous messages about a service member's or Veteran's suicide can circulate social media in a matter of seconds. Even if they are well-intentioned, these messages can be triggers for those who are depressed or suicidal and grieving the loss of a friend or acquaintance.

The State of Illinois, in conjunction with community partners and the DVA should devise a robust Public Service Announcement (PSA) program to dispel the myths about suicide. Many Veterans do not give themselves permission to cry over fallen unit members and an outreach campaign to encourage and embrace these emotions could be beneficial. The view of the message should be about "managing the memories" instead of trying to forget the memories and recognize where services can be utilized. Struggling Veterans are good at hiding the signs from family members and friends; in fact they can also convince themselves that everything is okay. Through honest testimonials and warm messaging, struggling Veterans might feel comfortable seeking help.

Some of the current outreach is very clinical in nature and not inviting. We have one Veteran say "I'm not going to pick up a telephone or go on my computer, it's too impersonal, and it just doesn't feel right". Adding a human touch to a PSA, commercial or other media outlet could help dispel that impersonal view of the Crisis helpline or online resources. The videos at USMilitaryMatters.org are very clinical and cold; in fact it is doubtful a struggling Veteran could watch a whole hour presentation of a talking person and power point slides. Struggling Veterans need to have a point of connection in order to seek solutions and help; and the current online resources do not seem to have that connection factor. Personable PSAs can be found on the Veteran Crisis Line and help make the connection of shared experiences and support for Veterans- <http://spreadtheword.veteranscrisisline.net/video/>.

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<sup>4</sup> <http://dx.plos.org/10.1371/journal.pone.0069841>



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## U.S. DEPARTMENT OF VETERANS AFFAIRS

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There are approximately 22 million Veterans in the United States and less than half receive healthcare at the U.S. Department of Veterans Affairs (DVA)<sup>5</sup>. Despite this, during the town hall meetings, there was a focus on access and quality of healthcare provided by DVA, and some Veterans blamed the problem of Veteran suicide entirely on the DVA. While the DVA can improve, has improved and continues to improve its performance, we reject the theory that the DVA is responsible for this epidemic. Nevertheless, the DVA was the subject of Veteran testimony and was held, in most cases, in a negative light.

It is important to highlight the dramatic shift that is occurring in the DVA. The DVA, through the U.S. Congress, has dedicated a large amount of resources to helping Veterans in need of mental health services, for example, Congress signing into law the Clay Hunt Suicide Prevention for American Veterans Act (Appendix A-1). DVA has established a robust public service program which includes, but is not limited to, downloadable apps for smart phones, Veterans Crisis Line (Appendix A-2) for phone calls and text messages, and established a Veteran Choice program, which is intended to fill some of the gaps in healthcare. DVA has a staff of over 800 dedicated to Suicide Prevention and there are 300 Suicide Prevention Counselors (Appendix A-3). More recently, DVA has implemented the Mental Health Same Day Access initiative (Appendix A-4) in addition to other measures to reduce Veteran suicide.

Many Veterans who attended the taskforce hearings claimed to be familiar with the DVA and the spectrum of services offered by DVA. The task force is concerned that many Veterans are not knowledgeable or understand the full continuum of services available to them through DVA, including those described above. Veterans in Southern Illinois had a more profound negative view of the services and care the DVA offered to them than Veterans in Northern and Suburban Illinois. It appears that this is mostly due to the lack of DVA facilities available for Veterans to utilize, many stating that they have to travel a significant distance to receive care. While the Veteran Choice program has been implemented, our task force hearings revealed that there are still challenges with access to healthcare. Thus, several of the Veterans who testified in Southern Illinois did not feel properly served by the care provided by the DVA and the lack of DVA services was not compensated by State funded programs or the private healthcare sector. While there was a negative view of the DVA in Southern Illinois taskforce hearings, the other four taskforce meetings yielded a mixed review of the DVA. Due to the proximity to Chicago, the service that Veterans received was more favorably reported; however, there were still instances in which Veterans complained about access to healthcare.

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<sup>5</sup> [https://www.va.gov/vetdata/Veteran\\_Population.asp](https://www.va.gov/vetdata/Veteran_Population.asp)

Access to DVA healthcare, and high quality healthcare outside of DVA, is vital with regards to the prevention of Veteran suicide. As reported in the 2016 DVA report on Suicide among Veterans and Other Americans, “since 2001, the rate of suicide among U.S. Veterans who use DVA services increased by 8.8 percent, while the rate of suicide among Veterans who did not use DVA services increased by 38.6 percent. In the same time period, the rate of suicide among male Veterans who use DVA services increased 11 percent, while the rate of suicide increased 35 percent among male Veterans who did not use DVA services. In the same period of time, the rate of suicide among female Veterans who use DVA services increased 4.6 percent, while the rate of suicide increased 98 percent among female Veterans who do not use DVA services. Thus, based on the 2016 DVA report, while the rate of suicide did increase in those receiving DVA healthcare, the rate was significantly smaller than the rate of suicide in Veterans who did not receive care at the DVA”. In addition, the report states “in 2014, Veterans were 21 percent more likely to die by suicide when compared to their adult civilian peers, adjusting for age and gender”.

Despite the significantly lower number of Veteran suicides for those receiving care at DVA, during the task force hearings, several Veterans expressed dissatisfaction in the quality of care received by the DVA. For example, the committee heard concerns from several Veterans regarding DVA physician prescribing practices including a lack of education for Veterans regarding medication management and medication side effects. It was made clear to the committee that there is a feeling within the Veteran community that Veterans are overly medicated and have a limited ability to offer input into their healthcare decisions. The feedback received by this task force regarding the Veteran’s view of the medication prescribing practices at the DVA is not new information. As a result of similar feedback received by DVA, the Psychotropic Drug Safety Initiative (PDSI) was implemented, which is an evidence based medication prescribing practice that became the standard of care at every DVA medical center and outpatient clinic across the Nation. DVA also follows the Recovery Model, which encourages Veterans and their families to participate in their treatment planning, as well as, questioning and learning about the medications that are being prescribed to them. In addition to concerns about medication prescribing practices, the majority of participants expressed a desire for natural or alternative methods of dealing with their service related mental injuries, and many stated that they have used natural and alternative therapies, such as yoga instruction, art therapy, acupuncture, equine therapy and other naturopathic alternatives.

Throughout the discussions with the task force members, participants conveyed a theme that Veterans preferred healthcare and support services provided by either fellow combat Veterans or civilians who had training and understood Veteran humor, demeanor, military terms, and the overall Veteran experience. Veterans who testified to have received care at the DVA stated that they appreciated and enjoyed the camaraderie of fellow Veterans they met at DVA hospitals and clinics. DVA has initiated a Peer Support program, which is a system of giving and receiving

help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful. A peer support provider is a person, with a mental health and/or co-occurring disorder, who has been trained to help others with these disorders identify and achieve specific life and recovery goals. This person is actively engaged in his/her own recovery, and volunteers or is hired to provide peer support services to other engaged in mental health treatment and is available to assist Veterans. The Illinois DVA sites recently trained peer support providers in evidence based care such as Wellness Recovery Action Plan (WRAP) and Honest, Open and Proud (HOP) which trains peer support providers to assist Veterans with the stigma related to Mental Illness.

A conclusion from the hearings is that there are Veterans who continue to have a negative image of the DVA, possibly based on long held beliefs or founded on past experience of inadequate care. This negative view and misperception of the quality of healthcare offered by DVA could be detrimental to the well-being of Veterans and contribute to Veteran suicide by suppressing a Veteran from seeking out needed mental health services.

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## MENTAL HEALTH STIGMA

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Stigma is one of the most challenging aspects of living with a mental health condition. It causes people to feel ashamed for something that is out of their control and prevents many from seeking the help they need and speaking out. Depression, a leading contributor to suicide, is one of the most common problems affecting people and Veterans suffer from depression at greater rates than the population at large.

The initial step in increasing resilience to suicide in our Veterans is to increase the knowledge and reduce stigma related to mental health care. First and foremost, testimony was given from Veterans who were exposed to traumatic events, either directly or indirectly, during their service to our country. Equally important is to understand how trauma affects the different genders; the DVA, Public Health Department reported that researchers looked at suicide risk amount active duty, Reserve, and National Guard Veterans who deployed to Operation Enduring Freedom/Operation Iraqi Freedom and left service between 2002 and 2011. They reported that “for males, suicides decreased by 6.1% on average per year. Among females the pattern varied, with a hazard rate of 9.1 in the first year following separation, 6.1 in the second year, 15.0 in the fourth year, and 9.9 in the seventh year.”<sup>6</sup>

Veteran testimony supported the existence of stigma surrounding mental health, which is perpetuated by the military culture and the presumption that those seeking mental health treatment show a sign of weakness. As a result many Veterans are reluctant to participate in treatments for their mental health conditions. It was expressed to the task force that participants hold the belief that seeking mental health treatment could adversely impact their ability to obtain a job, exercise their Second Amendment rights, or if still serving in the reserves, be able to achieve higher rank.

Lastly, speakers testified that they are more isolated and have fewer individuals they can confide in; however, they engage in Facebook groups and other social media outlets. There is a stigma that a closed group of friends is just as helpful as a mental health professional. One Veteran testified that he always feels better when he is with his “Veteran buddies around a fire drinking beers and telling war stories”. Ideally, Veterans who need mental health treatment need to engage in personal interaction instead of virtual interaction over the internet or casual interaction among other Veterans friends.

One program of discussion was the Department of Public Health’s Suicide Prevention Alliance funding. This program, along with other identified beneficial programs must have adequate funding to meet the needs of the Veteran community, as well as the community at large. It has

been discussed that alternative funding sources is imperative to the success of addressing the mental health needs of the Veteran community.

Appendix B contains recommendations from the National Alliance on Mental Illness to help diffuse the stigma associated with mental health.

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<sup>6</sup> <http://www.publichealth.va.gov/epidemiology/studies/gender-differences-suicide-risk.asp>

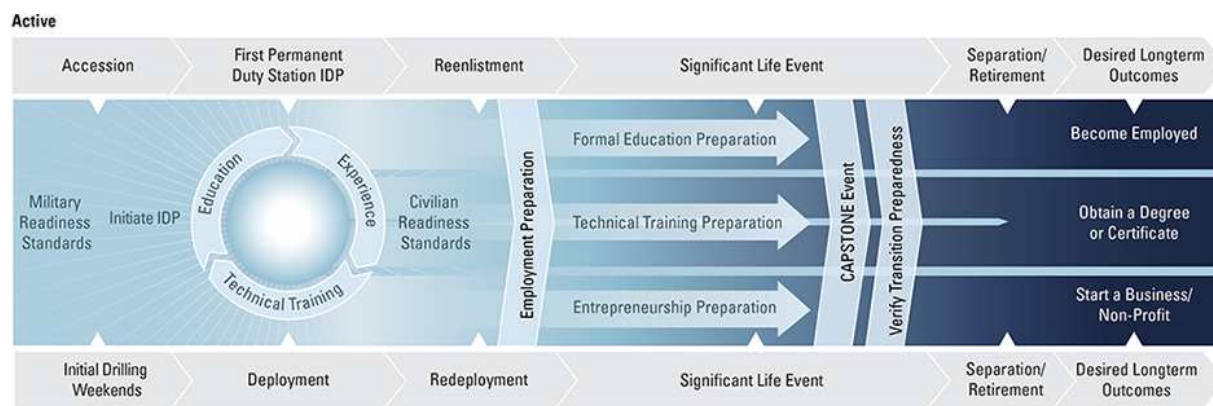
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## TRANSITION FROM MILITARY TO CIVILIAN LIFE

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“Death by Power Point” was the description given by one participant of the two week transition program administered by the DOD. Other participants testified that they were overseas when administered their transition training, and it didn’t help when they were state side. The overall theme from Veterans giving testimony is that the transition program provided by the military did little, if anything to help the returning Veteran. Testimony relayed that the discharging Veteran was filled with emotion of seeing loved ones, returning home and normally could not focus on the important information they were being provided. Further testimony revealed that the presentation was geared as if a person who might feel they suffered from PTSD is an anomaly. One speaker stated “they should just assume we are all affected by some kind of trauma and be honest about it, instead of asking us to check a box if we feel we have PTSD”.

Historically, the military has not done well in providing transition services; however, today the Transition Assistance Program (TAP) is governed by Public Law Title 10 U.S.C 1142, Pre-Separation Counseling; DOD Directive 1332.35, Transition Assistance for Military Personnel; DODI 1332.36 Pre-Separation Counseling for Military Personnel and E.O. 9397. The DOD transition website states, “The Transition Assistance Program (TAP) provides information, tools, and training to ensure Service members and their spouses are prepared for the next step in civilian life, whether pursuing additional education, finding a job in the public or private sector, or starting their own business. This redesigned TAP is the result of an interagency collaboration to offer separating Service members and their spouses’ better, more easily accessible resources and information to make their transitions more successful. Each branch of service has a program to ensure compliance. As with any program, the service member can “check the block” or invest their time in the resources assisting in the healthy transition. The programs heavily centered on employment transition, supplemented by Veteran’s benefits, and financial planning. In section 1142, it describes precisely what the transition counselor covers. No emotional or psychological support is noted. The Marines have a block of instruction on resilient transition. Although each branch has resiliency training, most have not married the training with TAP. For the reserve component, upon returning from deployment, each service member completes TAP before the ending of his or her Title 10 orders. DOD needs to mandate resiliency training as part of TAP. In October 2015, the DOD launched the Military Life Cycle transition preparation model. This model launches transition training at the beginning of the service member’s tenure verses the last year. The model is in its infancy and has yet filtered down to all elements.



Reserve  
<https://www.dodtap.mil/>

Many times, returning Veterans feel they are judged by their families, by civilians and do not fit into the rules of civilian life. Employers often judge behaviors as disruptive or as insubordination if a struggling Veteran has to take an unscheduled or extended break or misses multiple days from work without a doctor’s diagnosis due to a trigger or anxiety attack. Furniture placement can also cause anxiety for a Veteran. Many Veterans feel uncomfortable in front of windows, may feel unsafe if they do not have clean lines of sight or need a quiet work environment to concentrate. Transitioning Veterans are exposed to these unforeseen stress situations and might not know how to handle them or how to approach a boss or superior to express their needs or opinions.

One particular challenge of Iraq and Afghanistan Veterans is rejoining a civilian community that did not serve in either of these wars, and does not have experience with the military. Veterans of other wars are different from our modern day Veterans, today Veterans are not only facing an economy with a high unemployment rate and educated workforce, but are also entering a community that does not have a shared military culture identity. It has been recognized that numerous Veterans “function while suffering.” This means Veterans have the ability to function in the civilian world, but their physical and/or psychological injuries go undiagnosed or untreated causing major barriers to employment and meaningful relationships<sup>7</sup>.

Moral conflict and the unique experience of combat where the use of deadly force as an offense and as a defense is warranted, can potentially affect Veterans who are employed as first responders especially law enforcement personnel. Upon returning to civilian duty these same characteristics necessitate a far greater degree patience and restraint that can create further moral conflict.

It was suggested by several participants that Illinois work with the DOD to obtain information on returning veterans and devise an in-state transition program for them to participate in. This

program can bring together Veterans who are returning at the same time into a class, which can be the beginning of a military family in Illinois for them. The program should not be a “death by power point” but an affirmation that they are now different from the rest of civilian society and that is not bad. Acknowledge that each of them might be affected by trauma and might need to seek assistance, and that is okay.

It was clear from the testimony that female Veterans might need a more specialized transition program due to the fact that many people overlook female Veterans and this can cause unique stresses that are not applicable to male Veterans. If we connect returning Veterans, with organizations and fellow returning Veterans then it is conceivable that the rate of suicide could diminish, because the message conveyed by most of the testimony was suicide resulted from isolation and abandonment. Possible collaborations for these training programs might be with the community college network.

Due to the over saturation of Veteran nonprofit organizations and established Veteran organizations, this transition program can act as a “one stop shop” for Veterans to be able to evaluate and review what organizations might fit their individual needs. In an educational setting, with the emotion of coming home dissipated, the Veteran can more easily decide if they want to engage with a Veteran organization or nonprofit; and this also provides organizations to build their membership with younger members who would benefit from being associated with a military community. This transition program will also help returning Veterans meet the VSO from their county and allow them to develop a relationship with this vital point of contact before any stressful situation arises. Building relationships is the goal of a good transition program to help the returning Veteran, in addition with teaching them coping skills on how to navigate the foreign world of civilian life. Recently the State of Illinois received Title 20 funding to train the VSO's in Illinois with the Mental Health First Aid program; however, additional funding for similar and expansive training for VACs and VSAs is needed.

It was also suggested that Illinois also work with the DOD to file the DD214 paperwork immediately upon discharge on behalf of the Veteran. This will provide an invaluable service to the Veteran in terms of receiving the benefits they have earned in a more timely fashion

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<sup>7</sup> <http://cir.usc.edu/wp-content/uploads/2015/06/Suicide-in-the-Military.pdf>



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## TRANSITION FROM MIDDLE LIFE TO LATE LIFE

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Testimony was given by Veterans who were retired at each hearing of the task force. One Vietnam Veteran recalled that he was married for over 30 years, and the reason for his success in marriage was because he was a workaholic. His occupation kept him preoccupied to the point that when he retired, his life fell apart, he got divorced, started heavily drinking and became suicidal because he had never confronted his mental scars from war.

The Hemingway Effect<sup>8</sup> encapsulates the problems senior citizen Veterans are facing. Hemingway died by suicide at the age of 61. He was a civilian that served in three wars; he participated in direct combat, collected and sorted body parts, and led a group of French fighters (for which he was tried as a civilian in a military court and later acquitted.)

His father, brother, and sister died by suicide. He suffered from chronic pain, and was addicted to alcohol. He possessed an expert knowledge of firearms, and had depression and possible PTSD. His social support was disrupted and weakened with the death of immediate family members and the loss of his friends. These are all risk factors for suicide, and it can be particularly distressing when other Veteran friends die. The transition from middle life to late life increases feelings of burdensomeness and lack of belongingness due to physical and psychological deterioration, thus increasing the risk of suicide.

The following recommendations were made by Castro & Kintzle (2014):

- Identify when senior citizen Veterans enter transition phase.
- Develop initiatives and interventions to be implemented that address physical and psychological health.
- Do not wait until a Veteran is in crisis to provide support.
- Create program(s) aimed at assisting the Veteran in developing a sense of community belongingness that recognizes their service and sacrifice.
- Continue to assess and monitor the wellbeing of Veteran two to three years after transition.
- Stop comparing one generation of Veterans to another. Appreciate each generation for their accomplishments. Especially stop comparing today's Veterans to those of WWII.

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<sup>8</sup> <http://cir.usc.edu/wp-content/uploads/2015/06/Suicide-in-the-Military.pdf>

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## ILLINOIS JOINING FORCES

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Recognizing the transition problems Veterans have and the issues navigating the systems of services and supports, the Illinois Departments of Veterans Affairs' and Military Affairs through an inter-governmental agreement launched Illinois Joining Forces (IJF) in November 2012 as a statewide public-private network of military and Veteran serving organizations working together to improve services to Illinois' military and Veteran communities. IJF does not seek to replace any entity that is helping Veterans. Rather, IJF was initiated to leverage Illinois' "sea of goodwill" of resources and services for service members, Veterans and their families (SMVF). Organized around the following focus areas these working groups strive to increase awareness and connectivity among its member organizations so that they and those we serve, can better navigate the systems of service and supports.

1. Behavioral Health
2. Benefits and Emergency Assistance
3. Education
4. Employment and Job Training
5. Families, Children and Survivors
6. Financial Literacy
7. Homelessness and Housing
8. Legal Support
9. Women Veterans

Each IJF member organization signs a memorandum of understanding agreeing to collaborate in-person via up-to three (3) of the nine (9) working groups. Each of the working groups has an elected working group chair that represents the member organizations on the board of directors. Working Groups meet at least quarterly, and many have monthly calls and events. Through this collaboration, the experts in each working group can create efficiencies, synergy and resourcing for new programming, identify service gaps, educate, and work together to create not only a more approachable network of services and supports, but an enhanced and informed collection of service providers culturally competent to better serve the military and Veteran community.

Illinois Joining Forces website: [www.illinoisjoiningforces.org](http://www.illinoisjoiningforces.org)

In addition to the in-person collaboration, IJF has a website that offers a mechanism and forum for organizations to collaborate online. The IJF website is a web-based platform that brings government agencies, Veteran service organizations, and service providers from across Illinois together in an unparalleled attempt to better communicate and coordinate services. It also provides service members, Veterans, and their families, direct access to the organizations that might have the resources they need to successfully transition and navigate civilian life. The website content is member-driven, with IJF member organizations regularly posting their events, and updating their program details, service descriptions, hours of operation, and locations.

To help ensure sustainability and scalability the Illinois General Assembly passed Public Act 09-0986 creating the Illinois Joining Forces Foundation on August 18 2014. Subsequently, to provide continuity for the IJF name the Illinois Secretary of State approved the Illinois Joining Forces Foundation to do business as Illinois Joining Forces (IJF).

From testimony received by the task force, there has not been widespread knowledge to the Veteran community about IJF. There appears to be misconceptions and false information regarding IJF and it is recommended that IJF begin to work more closely with the Veteran community and work to reach out to communities outside Chicago.

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## MISSED EDUCATIONAL OPPORTUNITIES

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Upon completion of active service, many Veterans qualify for the GI Bill, Post-9/11 grants, Illinois Veterans Grants, MAP grants, Pell Grants and possibly others. College is emphasized as a way to obtain gainful employment and opportunities for returning Veterans.

It goes without saying that Veterans are suffering along with the other university students who rely on grants for assistance. The State of Illinois has underfunded the Illinois Veteran Grant to institutions of Higher Education, where some schools look to utilize the Post-9/11 benefits first and are not honoring the Illinois Veteran Grant. With the current budget impasse, many Veterans who also relied on MAP grants for assistance have found those unfunded. It is important for the State of Illinois to properly fund Higher Education, but for Veterans who are already suffering from extreme transition stress, adding financial stress on to a Veteran might exasperate the situation.

When Veterans attend college, they face additional stressors that are inherent to the college experience. Testimony at the hearings reflect a disconnect with the average college population. Veterans are typically older than the average college student; they have more life experiences and might have gone through traumatic situations. One Veteran testified “I can’t handle these spoiled college kids; they don’t know what it’s like. I’ve been through so much, and all they do is complain about stupid things. I can’t handle being in class with them”. Some Veterans do not connect well with younger civilian students, and they often find themselves angry to have to share their world with civilian students. One Veteran student relayed that he had to leave class when a student complained about having to do homework. During the taskforce hearings, Veteran students relayed their experiences. Some Veterans do not feel safe in large crowds of strangers and found orientation to be unnerving, similarly crowded hallways and pathways at the schools caused great anxiety for Veteran students as well.

From the testimony, it was clear that many participants would appreciate a Veteran’s only orientation, and possibly classes offered with Veteran priority. It was also mentioned that it would help Veterans if faculty were more aware of the needs of Veteran students, such as needing to leave class early to avoid crowds, taking an unscheduled break when stress is causing the Veteran student to lost focus, or just grouping student Veterans together in the class. Faculty members can play a key role in helping Veterans by self-identifying if they served in the Armed Forces and work to identify which students in their class are Veterans. It would be beneficial if student’s Veteran designation was included in the class roster for the instructors. The consensus that could be derived is Veterans feel isolated when they are the only Veteran student in the classroom; it would be beneficial for institutions of higher education to strive to create a course selection program where Veterans can select classes that are more Veteran friendly or where they

would know if there are other Veterans in the class. It was conveyed in the hearings that Veteran students found the Veterans offices overwhelmed with Veterans and understaffed to meet the needs. It was stressed that initiatives need to be a campus-wide initiative and institutions of higher education are also encouraged to work with the DVA on implementing the Veterans Integration to Academic Leadership (VITAL) initiative to provide the successful integration into college and university campuses ([www.mentalhealth.va.gov/studentveteran/vital.asp](http://www.mentalhealth.va.gov/studentveteran/vital.asp) ).

Students who struggle with undiagnosed mental stress or traumatic injury often find themselves dropping classes or simply stop attending class. This leads to another negative event; the struggling Veteran student cannot maintain the grade point average to continue the grant funding for their classes. Thus, the Veteran student desires to do well in school, but an undiagnosed condition prevents success and the student Veteran will incur fees and tuition bills that can cause depression. Some Veterans would benefit if schools put identifiers into Veteran students' records, which would trigger prevention measures to bring assistance to the Veteran student before despair and potentially suicidal thoughts come to play. Some Veterans drop out of college all together and find work either in the trades through "Helmets to Hard Hats" or other opportunities that have less crowds and more visual surroundings, while others relayed that they transfer to a smaller school that has online learning opportunities because being out of a classroom and being able to learn remotely reduces stress levels.

Below, task force members are engaging with the speakers.



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## THE ROLE OF THE FAMILY

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A significant portion of the hearing speakers who offered testimony recalled their past failed marriages. One Veteran stood out as being married for over 30 years. When asked “what was the secret to your successful marriage, when so many other Veterans testified to having broken marriages”, he replied “my wife had brothers who went to war and she knew what to expect when I got back from war and was able to be there for me”. This statement shows how important it is to not only address the needs of the Veteran but also the needs of the Veteran’s family.

Family members, who anxiously await the return of their loved ones, are caught off guard by the changes between the person who left and the Veteran who returns. As one mother stated “you go through a re-orientation of your own life.” Participants testified to acknowledging their first wives were not able to be supportive after they returned from active duty, the Veteran would turn to self medicating with alcohol. We did not receive testimony from any female Veterans, but it can be assumed there are similar issues, if not more stressors, within a marriage with a female Veteran.

Some parents also found themselves lost without any knowledge on how to provide support for their adult children who were now Veterans. Parents testified that they were denied information about their Veteran children mental health conditions, unable to consult with doctors about behaviors they witness, or to obtain any advice on how to help and support those who were living at home. One mother testified that she was repeatedly frustrated with the DVA and her son eventually took his own life. Parents who are suffering from the loss of a Veteran child due to suicide often are confronted by large amounts of paperwork, unable to find services to help them cope with their loss, or simply can’t find someone to talk to because their civilian network cannot understand their grief. To add insult to injury, Veterans who commit suicide in a war zone are not included in any war memorial or recognition ceremony as being a casualty of war. One father testified his son died by suicide while deployed, theoretically because his son was an officer in charge of a unit which suffered casualties. The happiness for a family because their loved one has survived a combat situation, is devastated when they lose their loved one to suicide. These feelings are unique to survivors of Veteran suicide.

Testimony was given that a separate family preparation course be designed and administered that will prepare family members for a returning Veteran. To provide family with contacts of individuals they can turn to during struggles, resource professionals that can help if the Veteran engages in substance abuse, and to provide advice. It would be beneficial to ensure family members have all proper documentation to assist in the health care of the Veteran, such as permission to view records, discuss diagnosis or help make appropriate health decisions. A

struggling Veteran might not be able to make appropriate health care decisions. It might also be advantageous to work with the DVA and civilian health care professionals to create a health care ombudsman for Veterans. An individual who can help a Veteran navigate the health care system either in the DVA or in a civilian setting.

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## MENTAL HEALTH SUPPORT

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The state of Illinois needs to refocus the importance of mental health for all our residents. Testimony was given that since the mid 1980's, mental health has steadily been redefined as not a medical necessity and severe restrictions to care were put into place. The standard model of care is now defined as an outpatient service. However, testimony was given that sometimes struggling Veterans need to find a safe environment to dwell on memories and experiences in order to find peace, which cannot be done on an outpatient basis but on an inpatient bases. Unfortunately, hospitals have had to cut mental health services due to funding constraints. Acknowledging the budget crisis in Illinois, there needs to be attention given to funding mental health services, either in conjunction with the DVA or as complementary programs to existing DVA programs to provide more comprehensive mental health services for struggling Veterans. Southern Illinois Veterans struggle to find any mental health services and could benefit with a partnership with existing civilian providers to help. It was also relayed the frustration with civilian providers that are unaware on the unique circumstances that Veterans face. Thus, it would be advantageous for the State of Illinois, in conjunction with the DVA to offer supplemental courses for civilian mental health professionals to become skilled at working and identifying unique circumstances, such as moral injury, that can arise with the Veteran population, especially in southern Illinois.

Some struggling Veterans expressed to the taskforce that they simply distrust anything related to the government and are averse to seeking care. Other factors that come into play as a barrier to care is Veteran pride, the feeling that seeking help is an act of defeat or weakness. Unfortunately, the Veteran has left behind the support network that was developed in their unit to find them isolated and struggling to transition without any military support network; thus this is why in the DVA report the increase in suicide is dramatic for Veterans who do not seek help.

A study published in Journal of American Medical Association Psychiatry is of particular concern. Notably, in the all-volunteer era, men with military service had twice the odds of reporting forced sex before the age of 18 years. In addition, had more than twice the prevalence of experiencing four or more categories identified on the Adverse Childhood Experience module<sup>9</sup>. This offers one possible explanation for the high rates of suicide in enlisted men<sup>10</sup>.

Informal organizations have begun to appear to meet this need. Peer to peer groups from Team Red, White and Blue to motorcycle groups have emerged as a pseudo military family of Veterans longing for that close bonding they once felt while on active duty. Unfortunately, testimony to

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<sup>9</sup> <http://www.cdc.gov/violenceprevention/acestudy/index.html>

<sup>10</sup> <http://jamanetwork.com/journals/jamapsychiatry/fullarticle/1890091>



these groups ranged from exercising together to “sitting around the fire telling war stories and drinking”. The underlying need for connection to something familiar is strong; however, members of these informal groups lack the knowledge to properly identify a struggling Veteran. The most famous example of this is the tragic story of Chris Kyle, who was killed by a struggling Veteran he was attempting to help.

It would be beneficial for the State of Illinois, in conjunction with other relevant organizations, to develop a standard training program for peer to peer organizations. The program ideally could be conducted through a community college or established Veteran organization such as the VFW, American Legion; and would offer basic skills for identifying and helping struggling Veterans. This program could be a certificate program in nature but would be vital to identifying Veterans who would need a higher level of care and equip Veteran friends with the skills needed to try and motivate the struggling Veteran to seek care. This program would embrace the “meet Veterans where they are” philosophy instead of a “Veteran come to us” mentality. These groups also meet the need of recreating the military family that was left behind, and the Veteran might feel safer talking to an individual that is trusted, than going directly to a governmental facility that could instill distrust immediately.

The taskforce was briefed on the benefits of therapy animals, primarily dogs, for struggling Veterans. Many Veterans suffer from anxiety in crowds or unfamiliar places. Having a calm animal by their side often can bring comfort to the Veteran by stroking the animal’s fur or just being around the animal’s relaxed demeanor. Animals also fill the void of family, by having a constant companion so the struggling Veteran does not feel alone or isolated. Another benefit for a Veteran to have a service animal is a sense of duty; a Veteran will be less likely to take their own life in fear of the animal not being taken care of. As presented, it appeared that the dependent animal, in the case of our speaker – he referred to his dog – brought out the sense of duty that is often found in a service member. Therapy dogs can be a mixed breed and vary in nature. Because of this, many establishments often refuse access to their businesses for therapy dogs. Participants testified that Illinois should establish a standard identification of a service dog for Veterans, which could include an official patch and official paperwork with a State seal that can be presented to businesses. These identification items should also be accompanied by an approved training program to reduce the amount of fake therapy dogs for Veterans. One program in Chicago was mentioned, the VALOR (Veterans Advancing the Lives of Rescues) program with the Safe Humane Chicago organization, who administers an in-house 8 week program for Veterans and dogs. It would be beneficial for a standard program of study for Veteran therapy dogs. Other programs for Veteran therapy dogs were mentioned from other states. Denver has a program for non-violent offenders to train therapy dogs for Veterans and Tennessee has a program named Patriot Paws.

A support program should also be implemented to help with the care of the therapy dog, or animal. Many times the Veteran who is struggling might not be financially able to properly care for a therapy dog, but the therapy dog should be viewed as a mental health necessity and participants who offered testimony stressed that their therapy dog is viewed as just as important as crutches or any other piece of medical supplies.

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## BARRIERS TO EMPLOYMENT

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Gainful employment can decrease the chance of a Veteran from taking their life. Financial struggles often contribute to the already stressful situation of transitioning into an unstructured civilian society from a structured military society.

Testimony was given that the Veterans who had structured jobs were transitioned better than individuals who testified they couldn't find a job or could not fit into jobs they were offered. An example given was that "the railroad held job openings just for Veterans, and they were good jobs". It was often the case that some railroad companies actively sought out Veterans due to the nature of the work and the dependability of the Veteran employee. In addition, one can surmise that a job with a railroad company is a fairly structured employment, ideal for a Veteran. We also had testimony from correctional officers and other quasi-military type of employment who stated their job was one of the primary reasons they did not attempt suicide.

There was some discussion on barriers to employment for Veterans that the State of Illinois, in collaboration with business groups, can address. It is unfortunate that no business groups or employers participated in our taskforce hearings despite being invited. Several barriers discussed by the taskforce include: military job descriptions are difficult to translate into civilian skills for job seekers; employers now use screening software that tend to reject Veteran applications due to lack of key words or easily identifiable skills; employers do not take the time to fully understand the benefits of actively employing returning Veterans in a position that utilizes their skill set – there have been accounts of employers only placing Veterans in token positions, such as call centers or entry level routine positions that are well below the actual leadership skill and abilities of a highly skilled Veteran, and finally there have been accounts of businesses attending military job fairs, but do not offer any Veterans jobs. The State of Illinois could develop an employer awareness program focusing on the unique benefits of hiring Veterans in collaboration with the IL Chamber of Commerce to identify businesses who obtain a certificate from this program that acknowledges they are Veteran friendly and aware of the challenges facing Veterans today.

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## THANK YOU!

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The members of the Veterans Suicide Taskforce would like to express our deepest appreciation to the brave men and women who served our country for sharing their thoughts, views, feelings and sincere experiences in our quest to end Veteran Suicide.

Sharing experiences and being open about how trauma and military conflict affect our Veterans ranging from Vietnam War Veterans to include present day Veterans is valuable and necessary for the taskforce to make relevant and effective recommendations.



## APPENDIX A

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### **Veteran Health Administration Suicide Prevention Efforts**

- 1) The U.S. Congress developed the Clay Hunt Suicide Prevention for American Veterans Act and on February 12, 2015, President Obama signed it into law. This Act gives DVA additional authority to advance suicide prevention efforts for Veterans within the DVA and in partnership with the community. Basically, the act requires that an independent evaluation of Mental Health (MH) care and suicide prevention programs occur by a contracted independent third party to refine methodology that meets the intent of the program evaluation required by the Clay Hunt Act. The Act requires that DVA publish an internet website to provide information about mental health services and a pilot program for repayment of educational loans for certain psychiatrists in an effort to recruit and fill Psychiatry staffing gaps. This will address critical DVA health care workforce needs in the area of mental health. The Act also directs DVA to piloting a program using community outreach and peer support to engage Veterans in care and increasing collaboration on suicide prevention efforts between DVA and nonprofit organizations. Finally, DVA is working towards expanded period of eligibility for approximately 995 combat Veterans discharged between January 1, 2009, and January 1, 2011, who did not enrol in the DVA health care during their initial 5 year period of eligibility.
- 2) Another recent DVA initiative is the implementation of a Veteran Crisis Line Automatic Call Transfer System (VCL). The core mission of the VCL is to provide crisis intervention services for Veterans who have thoughts of suicide (or their concerned family members or friends). The new system allows Veterans to reach the VCL directly by pressing 7.
- 3) The primary responsibility of the SPC is to identify, follow and establish relationships with those Veterans at high risk for suicide. Many of the high risk for suicide Veterans connect with their assigned SPCs at a minimum of one time per week. Many SPCs will also assist with the implementation of the Recovery Engagement and Coordination for Health - Veteran's Enhanced Treatment (REACH VET) initiative. The program will use statistical approaches to help identify Veterans utilizing DVA health care services who are calculated to be at increased risk for suicide and other adverse events, and notifies facilities and providers about them. This program complements other VHA initiatives focused on improving access by identifying specific Veterans who may require increased access to services as well as enhancements to their care.

The SPCs complete a Behavior Autopsy for every Veteran suicide that is reported to DVA. This includes Veterans who are not enrolled in DVA care. Basically, DVA collects as much demographic information as possible regarding the Veteran's death.

The information is then forwarded to DVA Central Office and the data is analyzed with an emphasis on Veteran suicide prevention. SPCs also reach out to the families of the Veteran to provide support and assistance.

<https://www.youtube.com/watch?v=18cQHTzZTIs&feature=youtu.be>

- 4) Another initiative to decrease Veteran suicide and increase access to Mental Health care is the commitment made by DVA to ensure same day access to Mental Health. MyVA, Putting Veterans First initiative calls for the DVA medical centers to provide timely care, including same day services in Primary Care and Mental Health care. The sites are required to offer follow up options to Veterans, upon leaving clinic and DVA works to integrate community providers, as appropriate, to enhance access. The DVA medical centers offer Veterans extended clinic hours, and/or virtual care options, such as Telehealth, when appropriate. MyVA Putting Veterans First initiative ensures that every Veteran seeking care is provided prompt and personal attention by providers. The goal of this initiative is to provide any Veteran voicing suicidality, in urgent need for care, or identified as being suicidal by a licensed provider, immediate care either by phone or in person.
- 5) Other DVA attempts to reduce Veteran suicide include requiring that Veterans discharged from inpatient or residential care settings must receive follow-up Mental Health evaluations within 1 week of discharge. Research shows that Veterans are especial vulnerable for suicide within 7 days of discharge from an acute psychiatric unit. As a result, DVA wants to ensure that Veterans have contact with a mental health professional within a week of discharge from the psychiatric unit. Veterans flagged for high suicide risk, as identified by the DVA suicide monitor, are to be seen within 7 days of discharge and for the following 3 consecutive weeks.

### **Get the Help You've Earned**

#### **Active Duty/Reserve and Guard**



The Military Crisis Line, online chat, and text-messaging service are free to all Service members, including members of the National Guard and Reserve, and Veterans, even if you are not registered with the U.S. Department of Veterans Affairs (DVA) or enrolled in DVA health care. In Europe call 00800

1273 8255 or DSN 118\*. In Korea call 0808 555 118 or DSN 118.

The Military Crisis Line is staffed by caring, qualified responders from DVA — some of whom have served in the military themselves. They understand what Service members have been through and the challenges members of the military and their loved ones face.

The Military Crisis Line staff can connect you with services to help get your life back on track. Calls can be referred to local DVA Suicide Prevention Coordinators and other providers who offer support.

### Veterans



The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring DVA responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive

confidential support 24 hours a day, 7 days a week, and 365 days a year. Support for deaf and hard of hearing individuals is available.

### Family/Friends

Whether you are a Veteran's spouse, child, parent, sibling, grandparent, friend, or caregiver, the Veterans Crisis Line is here for you. If you are concerned about the safety and well-being of a Veteran, stand by them. Call **1-800-273-8255** and **Press 1**, chat online, or send a text message to **838255** to receive free, confidential support from an experienced, caring DVA responder. Responders at the Veterans Crisis Line are specially trained to help Veterans' families and friends make sure their loved ones get connected to care.

### Spread the Word

To raise awareness of the Veterans Crisis Line, visit <http://spreadtheword.Veteranscrisisline.net/> to view and download ready-to-use materials and share them to help spread the word about this toll-free, confidential resource that connects Veterans in crisis and their families and friends with qualified, caring DVA responders.

## APPENDIX B

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### Ending Mental Health Stigma

Stigma is not something that will go away on its own, but if we work together as a community, we can change the way we perceive mental illness in our society. Do your part by pledging to be stigma free today. The following is from the National Alliance on Mental Illness (NAMI).

#### **Talk openly about mental health.**

Mental illness touches so many lives and yet it's still a giant secret. Be brave and share your story.

#### **Educate yourself and others about mental health.**

Challenge people respectfully when they are perpetrating stereotypes and misconceptions. Speak up and educate them.

#### **Be conscious of your language.**

Saying or using (or even mentioning) the "N" word is politically incorrect, but it still seems fine to throw around words like crazy, psycho, and lunatic or retarded. These are hurtful words and they continue to support the stigma of mental illness.

#### **Encourage equality in how people perceive physical illness and mental illness.**

Mental illness is similar to any other illness. When someone acts differently or "strange" during diabetic shock we don't blame them for moral failings. Show empathy and compassion for those living with a mental health condition. We can all use more education, but that will not make people change their opinions. When you love and respect people, love and respect all of them. You have a desire to learn more about whom they are and what their life is like.

#### **Stop the criminalization of those who live with mental illness.**

Professionals and families together need to talk to neighborhood groups, law enforcement, hospitals and legal experts to share experiences and knowledge on interacting with mentally ill.

#### **Push back against the way people who live with mental illness are portrayed in the media.**

Push back hard against the media and politicians and pundits that simply deflect real social issues such as gun control to the realm of "psychos" causing mass shootings.

#### **See the person, not the illness.**

Talk about mental illness with your family and friends with an open heart, love, and real information about the real human being that they are; *they are not their condition.*

#### **Advocate for mental health reform.**

Empower people whenever and wherever you can, writing legislators, talking in front of a board of commissioners to advocate for continued mental health funding and so on, doing the right thing and treating others justly,



## APPENDIX C

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### **Connectedness: A Strategy to Prevent Suicidal Behavior**

Connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance for prevention. For this reason, the Centers for Disease Control and Prevention (CDC) adopted as its theme “Promoting individual, family, and community connectedness to prevent suicidal behavior” to define this area of prevention. Connectedness is the degree to which a person or group is socially close, interrelated, or shares resources with other persons or groups. This definition encompasses the nature and quality of connections both within and between multiple levels of the social ecology. Connectedness as a suicide prevention strategy is comprised of three specific categories.

**Connectedness between Individuals** - Suicide prevention through connectedness between individuals is the first category. Research indicates that individual connectedness can impact a person’s access to social support and influence whether a person uses adaptive or maladaptive coping behaviors when he or she is experiencing suicidal thoughts and feelings. Additionally, social integration is found to be an important protective factor in preventing suicidal behavior.

**Connectedness of Individuals and their Families to Community Organizations** - The second category is suicide prevention through connectedness of individuals and their families to community organizations. For persons at risk of suicide, maintaining connectedness on this level would include having positive relationships with supportive family members; staying connected to their workplace, spiritual and religious communities, schools and universities, and community centers. Having these connections is important to a person’s sense of purpose and usefulness which in turn serves as a protective factor. These networks can also offer support and direction to an individual who they suspect of being at risk for suicide if the aforementioned entities are engaged in connectedness with social institutions that offer services for people at risk for suicide. Families of at risk persons also benefit from these connections because they are better able to locate the services and educational materials they need to support and encourage their family member who is at risk for suicide.

**Connectedness among Community Organizations and Social Institutions** - Suicide prevention through connectedness among community organizations and social institutions is the last category but perhaps the most important. This level of connectedness is instrumental in ensuring people who are identified as at risk of suicide are able to locate and receive the services they need. When social institutions and community organizations work together, people at risk for suicide are better supported because all parties involved remain abreast of the latest services available and offered in their communities.

For more information on the research behind connectedness as a protective factor for suicide prevention, see [CDC’s Strategic Direction for Suicide Prevention \(CDC, 2011\)](http://www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf) - [http://www.cdc.gov/ViolencePrevention/pdf/Suicide\\_Strategic\\_Direction\\_Full\\_Version-a.pdf](http://www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf) .

**Applying CDC's Approach of Connectedness to Helping Veterans** - For Veterans who are returning from deployment and re-adjusting to life outside the military, establishing connectedness on all three levels can be especially difficult because of the unique challenges facing Veterans. Many service members who attempt to connect on an individual level with people will potentially encounter difficulties because the Veterans' backgrounds are vastly different from the person who has not served in the military. Special care has to be taken to ensure Veterans are given opportunities to connect with other Veterans in an effort to promote this strategy. One way to accomplish this is through the use of peer support groups. These groups need to be identified by local organizations who service Veterans. This will ensure Veterans can be referred to the groups for support.

*Information was compiled from the U.S. Centers for Disease Control and Prevention*

## APPENDIX D

### Framework for Successful Messaging <http://suicidepreventionmessaging.org/>

As the public conversation grows about the burden of Veteran suicide, it is essential that the messaging to the public about suicide and suicide prevention is safe and successful. A framework was created by the National Action Alliance for Suicide Prevention to outline the four key factors to consider when developing public messages about suicide.

One of the intentions of the task force report is to increase the conversation around Veteran suicide. The task force members want to ensure information about the framework is available to those who are sharing the message. This may include suicide prevention organizations, military and Veteran organizations, governmental officials, mental health organizations, researchers, community-based organizations, institutions conducting suicide prevention activities, advocacy groups and individuals speaking to the public about their personal experiences, including survivors of suicide attempts, survivors of suicide loss and consumers of mental health services.

All of our messages and materials contribute to the public's perceptions about suicide and suicide prevention. "Public messaging" is defined broadly as any communications released into the public domain. Examples include education and awareness campaigns or materials, organizational websites, newsletters, fundraising appeals, publicity for events and observances, social media, press releases, media interviews, public presentations, publicly-available advocacy materials and any other public-facing messages or materials.



The four factors of the framework include:

1. **Strategy** – involves planning and focusing messages to increase effectiveness.
2. **Safety** – avoiding content that is unsafe.
3. Conveying a “**Positive Narrative**” – ensuring that the collective voice of the field is “promoting the positive” in the form of actions, solutions, successes or resources
4. Following applicable **guidelines** – using an existing guidance or best practice that applies.

 National Action Alliance for Suicide Prevention  
Framework for Successful Messaging

*Information was compiled from the National Action Alliance for Suicide Prevention.  
For more information about the framework visit <http://suicidepreventionmessaging.org/>.*

## APPENDIX E

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### Legislation to Assist Veterans by the State of Illinois

#### PUBLIC ACT INFORMATION

SB 2245 PUBLIC UNIV-ENROLLMENT-VETERAN (Righter/Cloonen) 8/12/2013 Public Act 98-0316

HB 3686 VETS & MILITARY DISCOUNT CARD (Wallace/Stadelman) 8/17/2015 Public Act 99-0374

HB 6149 VEH CD-VETERANS' HOMES PLATES (Frese/Bush) 8/15/2016 Public Act 99-0814

HB 5003 VETERANS COURTS-MANDATES (Winger/Link) 8/15/2016 Public Act 99-0807

HB 2173 SOS-VETERAN ID AND LICENSE (Althoff/Franks) 7/15/2016 Public Act 99-0544

HB 3721 NATIONAL GUARD-REEMPLOYMENT (Bryant/Hastings) 7/21/2015 Public Act 99-0088

HB 3122 VETERANS-EMPLOYMENT PREFERENCE (Pritchard/Hastings) 7/28/2015 Public Act 99-0152

HB 3721 NATIONAL GUARD-REEMPLOYMENT (Bryant/Hastings) 7/21/2015 Public Act 99-0088

HB 1548 EXPUNGEMENT-CLASS 3&4 FELONIES (Bost/Murphy) 8/16/2013 Public Act 98-0399

HB 3186 EMS SYSTM-EMT-MILITARY EXPERNC (Moffitt/Frerichs) 7/8/2013 Public Act 98-0053

HB 2563 VETERAN CDL APPLICATIONS (Pritchard/Munoz) 7/8/2013 Public Act 98-0052

SB 2245 PUBLIC UNIV-ENROLLMENT-VETERAN (Righter/Cloonen) 8/12/2013 Public Act 98-0316

HB 3346 WOMEN VETERANS TASKFORCE (Wheeler/Althoff) 8/12/2013 Public Act 98-0310

SB 0107 PROP TX-ACCESSIBILITY (Link/Conroy) 8/17/2015 Public Act 99-0375

SB 1457 IBHE-MILITARY PRIOR LEARNING (Althoff/Chapa LaVia) 8/18/2015 Public Act 99-0395

## APPENDIX F

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### Military Suicide Prevention and Mental Health Information by Branch

- Defense Suicide Prevention Office (DSPO) <http://www.dspo.mil/>
- Air Force
  - <http://www.af.mil/SuicidePrevention.aspx>
- Army
  - <http://www.armyg1.army.mil/hr/suicide/>
- Coast Guard
  - [http://www.uscg.mil/worklife/suicide\\_prevention.asp](http://www.uscg.mil/worklife/suicide_prevention.asp)
- Marines
  - <http://www.mccsmcrd.com/MarineAndFamilyPrograms/BehavioralHealth/SuicidePrevention/index.html>
- Navy
  - [http://www.public.navy.mil/BUPERS-NPC/support/21st\\_century\\_sailor/suicide\\_prevention/Pages/default.aspx](http://www.public.navy.mil/BUPERS-NPC/support/21st_century_sailor/suicide_prevention/Pages/default.aspx)
- National Guard
  - <https://www.jointservicessupport.org/PHP/Default.aspx>
- Air National Guard
  - <http://www.wingmanproject.org/>
- Army Reserve
  - <http://www.usar.army.mil/resources/ForSoldiers/Pages/Suicide-prevention-is-everyone%27s-business.aspx>
- Navy Reserve
  - <https://www.navyreserve.navy.mil/Pages/suicide-prevention-and-awareness.aspx>

## APPENDIX G

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### Resources

- Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury [http://www.dcoe.mil/PsychologicalHealth/Suicide\\_Prevention.aspx](http://www.dcoe.mil/PsychologicalHealth/Suicide_Prevention.aspx)
- DOD Suicide Event Report - <http://t2health.dcoe.mil/programs/dodser>
- Interagency Taskforce on Military and Veterans Mental Health (2013) - [https://www.whitehouse.gov/sites/default/files/uploads/2013\\_interim\\_report\\_of\\_the\\_interagency\\_task\\_force\\_on\\_military\\_and\\_veterans\\_mental\\_health.pdf](https://www.whitehouse.gov/sites/default/files/uploads/2013_interim_report_of_the_interagency_task_force_on_military_and_veterans_mental_health.pdf)
- Make the Connection <http://www.maketheconnection.net>
- National Action Alliance for Suicide Prevention (NAASP) <http://www.actionallianceforsuicideprevention.org>
- NAASP Military/Veterans Taskforce - <http://actionallianceforsuicideprevention.org/task-force/military>
- Suicide Prevention Resource Center <http://www.sprc.org>
- Tragedy Assistance Program for Survivors <http://www.taps.org/>
- U.S. Department of Defense Military Health System [http://www.health.mil/news\\_and\\_multimedia/special\\_features/suicide-prevention-awareness.aspx](http://www.health.mil/news_and_multimedia/special_features/suicide-prevention-awareness.aspx)
- U.S. Department of Veterans Affairs [http://www.mentalhealth.va.gov/suicide\\_prevention/](http://www.mentalhealth.va.gov/suicide_prevention/)
- Vets 4 Warriors <http://www.vets4warriors.com/>