

The California Association of Veteran Service Agencies (CAVSA)
STATE OF THE VETERAN COMMUNITY REPORT

FINAL DRAFT 8.28.18

PREFACE

As this report is published, we will be commemorating the 17th anniversary of the infamous “9-11” attacks that ushered in the “Global War on Terror” (GWT) and launched the U.S. and its All-Volunteer Force (AVF) on an uncharted and arduous path. With its series of Operations* that are ongoing to this day and in which about three million military have served, the GWT is now the United States’ longest war ever. Children born in 2001 are now preparing for adulthood in a nation that has been at war their entire lives.



Photo credit: National Military Family Association.

*Operation Enduring Freedom (OEF), Operation Iraqi Freedom, (OIF) Operation New Dawn (OND) and Operation Freedom’s Sentinel (OFS) – the latter to which 400 California National Guard most recently deployed in August 2018.

California has played a leadership role in these nearly two decades of combat deployments with more military installations than any other state and the largest National Guard force in the U.S. This report challenges California to continue its key role in the deployment cycle by competently and compassionately receiving home our service members as they transition to civilian life as veterans. As home to the largest veteran population in the U.S., California has the unique opportunity to lead the nation with our demonstration of the will and allocation of the means to “do right by” our veterans and their families who served in our stead. If the AVF model is to persist and succeed, our efforts to support our veterans and their families is not only a moral obligation, but an AVF imperative, essential to recruiting a socio-economically and high-quality military of the future.

Unlike the Vietnam-era, there is now a broad societal recognition that wars cause ongoing adverse effects for the service members who were engaged with the war effort – whether in combat or not. And paralleling the years of war, we now have years of research that points us

in the direction of “what to do”, as well as literally thousands of new non-profits and trillions of new private funds dedicated to veteran and military issues. (Institute for Veterans and Military Families, Syracuse University). There has been less acknowledgement of the economic commitment required to help former service members reconstruct their lives and the reality that an “ounce of prevention is worth a pound of cure”. Many of our aging Vietnam, Korean, and WWII veterans who failed to receive the care they needed upon their return have suffered for decades, and society has often suffered alongside them as they’ve occupied jail cells, street corners, unemployment lines, and drug treatment programs over the years. Many thousands more have demonstrated their resiliency and often with help, have led productive and fulfilled lives to the benefit of us all.

As our Post-9/11 veterans become the largest war era population, it is critical that California steps up to ensure that their life trajectory and that of their families is as healthy as possible. Although the U.S. Department of Veterans Affairs (USDVA) currently does not have a website or accessible data base dedicated to OEF, OIF, OND, and OFS veterans, reliable data about this population will be essential for program planning, implementation, and accountability. The absence of reliable California-specific data is noted throughout this report, but should not deter from taking purposeful steps to remedy the identified challenges, while simultaneously working toward better data to inform programs and improve transparency. Findings here about the State of the Veteran Community in California make it clear that long after the “last shot is fired” our veterans require our long-term commitment to help rebuild their lives and thank them for their service with more than words.

ACKNOWLEDGEMENTS

As the Executive Director of the California Association of Veteran Service Agencies (CAVSA) and CAVSA consultant charged with drafting this first State of the Veteran Community report for the Mental Health Services Oversight and Accountability Commission (MHSOAC), we are very grateful for the opportunity to engage with such a meaningful task. The support of CAVSA agency leadership in conceptualizing the scope of work for the report and ultimately distilling it to focus on five of the most critical issues (See **Section VI** Recommendations) for consideration in Year 1 has been very important.

Equally important has been the cooperation of several key organizations, staff, and 201 individuals who participated in the Veteran Mental Health Services Survey which came together in record time from May to July 2018. The organizations that deserve special thanks for encouraging their community's participation in the survey include: the California Department of Veteran Affairs (CalVet), the California Association of Collaborative Courts, the California Association of County Veteran Service Officers, STAR Behavioral Health, the Steinberg Institute, the Center for Judicial Education and Research at the California Judicial Council and each of the CAVSA member agencies: Swords to Plowshares, U.S. Vets, Veterans Village of San Diego, the California Veterans Assistance Foundation, Veterans Resource Centers of America, Veterans Housing Development Corporation, and New Directions for Veterans. (See further information about CAVSA in **Section VII** Postface.) During the peak season for graduations and vacations, we are grateful for everyone who took the time to respond to our survey and share your thoughts and knowledge about your local community's experience with veteran and veteran family mental health concerns.

CAVSA plans to widely share the information from this report to help close the gaps in services for our Veteran communities and honor your shared insights by having them serve as the basis for our upcoming advocacy work. By improving cross-agency and multidisciplinary communication, we can reduce our silo-ed thinking and expand our stakeholder communities to improve California's public mental health services system for Veterans and all Californians. Recognizing that each of our constituents are members of multiple groups, we humbly share the information compiled here and look forward to the opportunity to collaborate on effective strategies and emerging opportunities to deliver improved services for California veterans and their families in the coming years.

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Section I.

INTRODUCTION and 2018 REPORT CARD

The California Association of Veteran Service Agencies (CAVSA) is a consortium of veteran service organizations that provide an array of veteran-specific services to veterans and their families in twenty-five, more than 40%, of California counties and adjacent areas. Each agency's services are based on their individual mission and goals and are informed by the needs of veterans in their regions. The original May-July 2018 Veteran Mental Health Survey research, phone calls, interviews, literature review, and compilation of data for this first report on the "State of the Veteran Community" with regard to mental health in California has yielded findings that have both confirmed CAVSA's overall mission and the focus of its seven member agencies, while also expanding our view of the critical issues for which we must step up our advocacy, services, and education in the coming year.



Table 1 below is CAVSA's "2018 Report Card" that provides a snapshot of the status of California veterans with regard to several key issues that emerged in the development of this report. These four measures of mental health and well-being of California veterans compared to veterans nationally and their non-veteran Californian counterparts show a complex and mixed picture of California veterans' current situation which will be elucidated in the following sections of this report.

Table 1. 2018 Report Card: Comparative Markers of Concern for California Veterans

Measure <i>(Unless specified all rates are age- adjusted)</i>	National General U.S. pop.	National Veteran	California General pop.	California Veteran
Homelessness (PIT count 2017) All data from 2017 AHAR~	T= 553,742 (.17% of total U.S. pop) 438,913 adults 193,900 (35%) unsheltered	40,056 (9% of all homeless adults) 15,366 (38%) unsheltered	134,278 (24% U.S. total) .34% of CA total pop 91,642 (68%) unsheltered	11,472 (29% of all homeless U.S. veterans) .63% of CA total veteran pop 7,657 (67%) unsheltered
Suicide (Rates cited indicate est. range. Top row data from 2015. Bottom row data from 2016.)	17.3/100K* (13.4/100,000^ 2016 pop)	29.7/100K*	13.6/100K* (10.5/100,000^ CA 2016 pop)	28.8/100K*
Opioid Overdose Deaths	13.3/100,000* population (2016 data)	19.85/100,00 person years 2005 VHA patient data.	4.49/100,000*** CA population (2017 data)	No California- specific data or estimate is available
Justice Involvement (Incarceration)	2.3 million^^	181,500~~ (8% of total U.S. adult inmates, 2011-12 data. (most current) (Also about 8% of total U.S. pop, 2016)	138,000^^^ (adult inmates under CDCR) 2017 data	No California- specific data or estimate is available

Homelessness:

~ <https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf>

California's est total population is 39.78 million according to the World Bank and US Census Bureau
<http://worldpopulationreview.com/states/california-population/>.

Suicide:

https://www.mentalhealth.va.gov/docs/data-sheets/2015/California_2015.pdf -data from the top line in "suicide" is not age-adjusted.

^ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) (2017). Accessed June 7, 2018. Available from URL: www.cdc.gov/injury/wisqars. Data in parentheses is 2016 age-adjusted data, suggesting suicide rates may be declining – veterans and non-veterans are included in these data.

Opioid Overdose Deaths:

*2016 WONDER data released 2017 by CDC. Accessed at <http://wonder.cdc.gov/mcd-icd10.html> on January 31, 2018

**"Nearly twice the rate of the general U.S. population", <https://www.ncbi.nlm.nih.gov/pubmed/21407033> Bohnert, et al. "Accidental Poisoning Mortality Among Patients in the Department of Veterans Affairs Health System.

*** California Department of Public Health 2017 Preliminary Data.

<https://discovery.cdph.ca.gov/CDIC/ODdash/>

Justice Involvement:

^^ <https://www.prisonpolicy.org/reports/pie2018.html>

~~ <https://www.bjs.gov/content/pub/pdf/vpj1112.pdf>

^ <https://lao.ca.gov/Publications/Report/3595>

Two issues of major concern that emerged throughout this report development but that are not reflected in **Table 1** due to lack of data and comparative data are:

- 1) the notable absence of knowledge, formal communication, and partnerships between Veteran Service Organizations (VSOs) and non-veteran service organizations, and
- 2) the absence of up-to-date California veteran-specific data on a wide range of issues and categories of veteran populations, for example: women veterans, veterans in substance use disorder treatment, incarcerated veterans, etc.

The absence of California veteran-specific data is obvious in **Table 1** itself. Due to the pervasiveness of these issues, **Section VI** Recommendations #3 and #5 tackle these topics with nine proposed actions to help remedy these problem areas that seem to have an adverse impact on California veterans and their families.

Notwithstanding the limited California-specific data available for **Table 1** measures, California veterans' 2018 status with regard to "Homelessness" is bleak – especially on a measure that is of major concern: *unsheltered homelessness*. While this variable has had dramatic shifts

annually based on the “Point in Time” Count (See **Section IV** for more information) this sobering 2017 data must inform CAVSA and other agencies’ actions in 2018 and beyond to prevent this disturbing finding from becoming a trend. Unlike homeless veterans in other parts of the U.S. where 38% are unsheltered, a shocking 67% of California veterans - as well as their non-veteran counterparts – were unsheltered in 2017’s PIT count. (AHAR) Unsheltered status confers very serious health and mental health morbidity on those in this situation with universal increases in premature deaths among this population. (Morrison) Recommendation #1 in **Section VI** of this report therefore makes addressing veteran housing challenges front and center among the actions that must be taken in the coming year.

While this most recent 2017 situation is alarming, CAVSA has been alert to the life-and-death significance of the status of “homelessness” for many years. A long-standing and increasing focus across all CAVSA agencies is the delivery of services to veterans who are homeless, chronically homeless, or at-risk of homelessness and the attendant mental and physical health and social stability issues that housing insecurity engenders. Although the absolute numbers and percentage of California veterans who are homeless is less than 1% of California’s total veteran population (according to the 2017 Annual Homeless Assessment Report – Part I (AHAR) See **Table 1**), a host of co-occurring problems are linked with homelessness. Research on homelessness has shown associations with increased likelihood of incarceration, stigma, loss of employment, mental illness, substance use disorders, violent victimization, disproportionate use of emergency departments for health care, and, for those who are unsheltered, premature mortality, as mentioned above. (Clough; U.S. Conference of Mayors; Natl. Ctr. On Family Homelessness; Erickson; Greenberg; Larimer; Hunter; Morrison)

Of growing concern, though not evidenced in the gross numbers presented in **Table 1**, is the fact that women veterans across the U.S. constitute a growing number of the homeless veteran population. The number of homeless women veterans reportedly doubled from 1,380 in FY 2006 to 3,328 in FY 2010 and the number of women accessing VA specialized homeless programs or with a homeless identification tripled from 11,016 in FY 2010 to 36,443 in FY 2015. These numbers however include women who were “*at risk of homelessness*” as well as experiencing homelessness; nevertheless, the increased risk is clear. By some estimates, the rate of female veteran homelessness is at least three times greater than their non-veteran civilian peers. As a result, Recommendation #1 in **Section VI** explicitly notes the need to address women veterans’ risk for homelessness. (National Coalition for Homeless Veterans; VA National Center on Homelessness; Gamache)

While **Table 1** provides no comfort about California veterans’ suicide rate, it shows that the predicament of veterans in California is virtually identical to that of their veteran counterparts

in other parts of the U.S.: namely, unacceptably high at roughly two times greater than the general population's rate, taking the range of rates into consideration. As **Section IV** describes, the general U.S. population suicide rate has steadily risen over the past decades, with veteran suicide consistently surpassing non-veteran rates. The more than two-fold discrepancy between non-veteran and veteran suicide rates in California indicates that veteran-targeted suicide prevention efforts are urgently needed in California and are among the advocacy and education work with which CAVSA will engage in the coming year per Recommendation #2. Though not specified here, USDVA data shows that women veterans are at increased risk for suicide compared to their non-veteran peers and their rates of suicide have steadily increased over the past decade, though still remain less than half that of male veterans. CAVSA agencies will therefore expand programs and outreach specifically designed to serve women veterans and homeless veteran families with dependent children who tend to be female-headed households as described in Recommendation #2 in **Section VI**.

Table 1 is unfortunately unclear about the status of California veterans with regard to deaths due to Opioid Overdose; no veteran-specific data is available on this measure at this time. Several academic articles suggest that California veterans have been at increased risk of opioid overdose deaths in the recent past due to VHA prescribing practices. (Seal; NIH) National data on veteran Opioid Overdose Deaths is also lacking with the only veteran-specific data coming from a 2011 study using 2005 data on Veteran Health Administration patient data in a cohort study on "accidental poisonings" which revealed shocking numbers and helped change USDVA prescribing practices throughout the massive VHA system of care. Since a 2012 NIH report validated the problematic prescribing practices, the VA has made concerted efforts to not only change opioid prescribing practices, but to retrieve opioid medications already prescribed. During three events in 2015 and 2016, 113 participating military treatment facilities collected about 29,000 pounds of unwanted, unused, or expired medications and as of September 2016, veterans had returned approximately 48,000 pounds of unwanted prescriptions, including 20,350 pounds by mail and 28,017 pounds of unwanted/unneeded medications deposited in receptacles at VA facilities (Interagency Task Force)

Essentially, the Opioid Overdose Deaths findings in **Table 1** show that California has so far "dodged the bullet". Only three states have lower rates of opioid overdose deaths than California, (Nebraska, Montana and Hawaii) with a couple states having roughly ten-times California's rate (West Virginia and New Hampshire). As discussed further in **Section IV**, 15% of California counties have opioid overdose death rates that are roughly two times or greater than California's overall average rate of roughly 4.5 per 100,000. These primarily rural counties have a disproportionate percentage of veterans in their overall population and are CAVSA's key audiences for targeted messages about the dangers and ineffectiveness of opioid use to treat

chronic pain, per the USDVA/DoD new opioid prescribing clinical practice guidelines (VA/DoD). CAVSA recognizes that now is the time to ensure that California veterans are managing their medications in healthy ways and do not fall prey to illicit opioid markets that have devastated their counterparts in other parts of the U.S.

Like the “opioid overdose deaths” measure, there is no California-specific data nor valid estimate of how many veterans are currently incarcerated in California’s jails and prisons. Neither is there an estimate of the number of veterans who may be in the “churn” of arrestees who are in and out of local jails without subsequent justice system involvement. Extrapolating from the national veteran data suggests that roughly 11,000 veterans are under California’s correctional facilities’ jurisdiction. Per California’s diversion statutes described further in **Section IV**, some of these veterans may be retrospectively eligible for remedies to their sentencing, but the numbers are currently unknown. Because of the immediate impact that action on this topic could have for California’s incarcerated veterans, CAVSA will explore this matter further with the Judicial Council of California and the California Department of Corrections and Rehabilitation.

Although the report is not directed toward a veteran audience, the 2017 report “Pain in the Nation” produced by Trust for America’s Health and the Well Being Trust (TFAH/WBT), calls for a “National Resilience Strategy” to address the epidemics of suicide, co-occurring mental health disorders often manifest among homeless populations, and alcohol and substance use disorders (SUDs), including the epidemic of opioid overdose deaths. The veteran population is unfortunately often mentioned because of the cluster of risk factors that includes mental health issues, chronic pain, depression, substance use disorders, and aging that are also concentrated in California’s vulnerable veteran populations. (TFAH/WBT)

CAVSA is committed to engaging with private foundations, non-profits, and other advocacy groups like the National Coalition of Homeless Veterans, Trust for America’s Health, the Well Being Trust, the Steinberg Institute, Mental Health America, and mental health service providers, county mental health offices and state agencies to serve as an active advocacy voice to improve care for California veterans and their families. Expanding provision of military culturally-competent care, including prevention and early intervention, sensitive approaches to stigma reduction, and appreciation of strength and resiliency-based and recovery-focused treatment will help ensure that California’s veterans’ mental health challenges are better addressed.

Our challenge as advocates is to encourage our veteran population, that has been well-trained to think of itself as invulnerable, to recognize that reaching out for help is a sign of strength and self-respect. Then all Californians must be certain that we are there for our veterans and their families - as friends, service providers, peer navigators, family and neighbors to honor and

support those who have been willing to put their lives on the line in military service on behalf of our nation.

Statement of Task

As a component of CAVSA's response to the MHSOAC's Request for Proposal 16MHSOAC034, CAVSA agreed to develop a Year 1 report on the "State of the Veteran Community in California" with regard to mental health services for Veterans and their families. As mentioned above, the purpose of this report is to establish a baseline upon which CAVSA's further advocacy, education, outreach, service and research efforts can be built.

Due to constraints of time, resources, and improved data, this report does not represent "the final word" on veteran mental health issues in California today. Rather, it is intended to provide insights into areas for further research, need for improved collaborative efforts, availability and quality of mental health services and outcomes data, and highlights of top concerns identified in the literature, through interviews with key leaders in service delivery, and findings from a statewide survey, and county case studies undertaken specifically for this report.

Recognizing that veterans are often involved in California's Justice system, both in criminal court and family court settings -- often secondary to post-traumatic stress disorder (PTSD), trauma, and traumatic brain injury (TBI) -- special attention is given to Veteran Treatment Courts (VTCs) as a remedy with appropriate veteran-specific interventions in diversion programs that are designed to address targeted veteran mental health needs.

Similarly, programs and interventions that address veteran suicide and related veteran family mental health issues are highlighted in this report, as well as a special focus on aging and elderly veteran populations who experience higher rates of suicide than their non-veteran peers in specific age groups. (See **Section IV** for further information).

Section II.

Methodology – Approach to Task

Review of relevant veteran-related mental health reports, public data, and literature, including California-specific, as well as national studies and data that permit extrapolation to California, form a core component of this report. Existing data on veteran mental health issues and services has primarily been generated by the U.S. Department of Veteran Affairs (VA) with either a Veterans Health Administration (VHA) or Veterans Benefits Administration (VBA) point of view, or by academic and think tank researchers, like those at the Rand Corporation. While this information is very valuable, leading to important findings and the generation of evidence-based practices, CAVSA has sought through this report to also gather input, develop case studies, and hear concerns from community-based providers across both Veteran and Non-

Veteran service sectors to get a better sense of how, and if, Veteran and Veteran Family Mental Health Services are perceived across California's highly diverse communities.

Community Based Anonymous Survey

Because shared data platforms and agreed-upon variables for common data collection regarding mental health services are not yet established, current data on this topic is scarce among community-based veteran service providers and between counties. To help remedy this challenge CAVSA facilitated the development of an online survey to gather anonymous information about characteristics of survey respondents, providers of mental health services to Veterans and their families across the state, and information about survey respondents' concerns, knowledge, and impressions of the availability and quality of services for California Veterans and their families in the areas in which they work.

More than two dozen individuals and organizations, including CAVSA member agencies, Cal-Vets, California Association of Veteran Service Officers (CAVSO), the California Judicial Council's Center for Judicial Education and Research (CJER), the STAR Behavioral Health program at UCLA, the California Association of Collaborative Courts, and an array of community-based groups across California helped distribute the survey statewide. Organizations that specifically serve Veterans and military-connected families, as well as general mental health and community-based social service and advocacy organizations that may serve Veterans as part of their general practice were the target audience. Agencies and providers without specific Veteran connections were included because many Veterans and most Veteran family members seek care at community-based agencies where Veteran/military cultural competence and knowledge would be helpful, but may or may not be forthcoming. A better understanding of non-Veteran specific providers is therefore important.

The survey was released on May 11, 2018 via email using an online link to the survey in Google Forms and was closed on July 22, 2018 when a cleaned sample size of 201 was reached with representation from 75% of California's 58 counties. A modified snowball sampling method was used, a purposive exponential non-discriminative sampling method in which a cover letter was sent via email to recipients who were encouraged to both take the survey and forward it to other colleagues and other agencies whose input they believed would be helpful. This sampling method was selected primarily because it requires minimal resources and there were time constraints for pre-survey planning and post-response analyses. This method has the disadvantage of not permitting us to know the potential sample denominator (how many people actually received the survey but didn't respond), therefore a response rate cannot be calculated. It also has the disadvantage of likely introducing bias into the sample, such as either caring about the topic, or alternately being forced to take the survey by one's supervisor, etc..

Despite these disadvantages, it is preferred over a convenience sample with regard to biased sampling, ie: only talking to VA employees or Veteran Service agencies, etc. as it generates a broader and more varied set of respondents who are unknown to the investigator. (See **Appendix A.** for the online survey.)

County Case Studies: Review of Mental Health Services Act (MHSA) 3-Year Plans and Annual Update

To help assess the degree to which individual County MHSA Local Plans comply with MHSA's requirements that veterans be included at all stages of MHSA-funded services development and programs implementation, CAVSA selected five County MHSA Local 3-Year Plans and Annual Updates or Amendments for review. ***The counties of Orange, Riverside, Kern, Monterey and Shasta*** were selected for their diverse geographic locations and size of service delivery catchment areas. (See **Map 5**) About one-quarter million veterans reside in the large counties of Orange and Riverside combined. Kern County is medium sized and more rural, central valley county with about 46,000 veterans. Monterey is a relatively rural coastal county with about 18,400 veterans and shares a County Veteran Service Officer (CVSO) and many services with adjacent rural San Benito County which is home to about 2,500 veterans. Shasta is a rural northern County with about 16,000 veterans comprising about 9% of the county's total population.

The most current Three-Year MHSA plans for these five counties were reviewed using the criteria described in WIC § 5848 which specifies that Veterans and representatives from Veteran Organizations should be involved in the Stakeholder process, including "meaningful" stakeholder involvement on an array of topics including: "mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations". Furthermore, "CCR § 3300 states that involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process." Plans were reviewed using this guidance to assess Veteran and Veteran Family engagement.

In addition, our reviews of these five counties' MHSA Plans Annual Updates were guided by the MHSA Annual Update Instructions which cite CCR § 3320 and states that "counties shall adopt the following standards in planning, implementing, and evaluating programs:

- Community collaboration, as defined in CCR § 3200.060
- Cultural Competence, as defined in CCR § 3200.100
- Client-Driven, as defined in CCR § 3200.50
- Family-Driven, as defined in CCR § 3200.120
- Wellness, recovery, and resilience-focused, as described in WIC § 5813.5
- Integrated service experiences for clients and their families, as defined in CCR §

3200.190.”

The Annual Update Instructions also describe the need to report on “Other” programs and describe what they could include, for example “stand-alone programs focused on Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention.” Because all of these kinds of programs have considerable applicability for Veterans and their families who tend to perceive stigma related to mental health care-seeking behavior at higher rates than the general non-Veteran population, and who are at increased risk for suicide, notice was taken if Veterans and their families were mentioned with regard to this programming. Additionally, an objective Plan Review scoring sheet was developed to operationalize the MHSOAC Instructions and standardize the Plan Review process to increase the replicability of Plan Review findings.

“Secret Shopper” Mental Health Service Accessibility Calls

In the “secret shopper” component of CAVSA’s County case studies, the mystery consumer’s (“secret shopper”) genuine identity and purpose were not known by the agency that was being contacted and assessed for ease of access to care from a caller posing as an unconnected Veteran in need of mental health services. This project component is explained in a stand-alone CAVSA report, but is referenced here as it informs and is informed by both the Survey findings and the MHSA 3-Year Plan Reviews.

Section III.

CALIFORNIA VETERAN COMMUNITY OVERVIEW

Changing California Veteran Demographics

California is home to more U.S. military veterans than other state. Although the estimated number of veterans living in California varies by as much as 89,000 because of different methods of calculation, the general consensus is that about 1.8 million veterans are living in California in 2018 - roughly 8.7% of all U.S. veterans. Map 1 below provides a snapshot of counties’ Veteran population sizes as well as some general information about the age, gender, era of service, and ethnicity of California Veterans. Up-to-date data on the ethnicity of California’s Veterans is not readily available, so although this VetPop2014 U.S. Department of Veteran Affairs estimate was done September 30, 2016, it seems to be the best estimate and profile of California available. (USDVA) The California Employment Development Department’s (EDD), most current data on Veteran ethnicity was published in January 2011 using 2010 American Community Survey data 2010 data that captured 2009 information. Likewise, CalVet’s published data on California Veteran ethnicity are USDVA VetPop2011 projected

estimates. Given the dynamic nature of the military and veteran population with an estimated 200,000 separating from service and additional thousands retiring each year, the absence of information that is less than a decade old is problematic. Also, problematic- especially for California - is the absence of reliable information about the race and ethnicity of our veteran communities since the very diverse ethno-cultural heritage and backgrounds of our service members have an enormous impact on their transitions back into civilian life. Without improved data on our veteran communities, social support networks, and families, planning for culturally appropriate services is difficult. The upcoming 2020 Federal Census and attendant American Community Service which captures data on veterans and their families is therefore a critical opportunity for veteran advocates to help ensure optimal quality data by engaging military and veteran participation. (USDVA)

As **Map 1** below indicates, Southern California has the largest number of Veterans living there, with about 290,000 in Los Angeles County, 225,000 in San Diego County, 133,000 in Riverside County, 117,000 in Orange County and 111,000 in San Bernardino County – comprising nearly half of California’s Veteran population. However, despite the fact that more than a quarter million Veterans live in Los Angeles County, Veterans nonetheless constitute less than 3% of Los Angeles’s total County population, compared, for example, to Trinity County’s total population of about 13,000, where nearly 12% are Veterans. These kinds of Veteran population variations across the State have significant implications and must be taken into account as service needs are assessed and as constituent influence and advocacy is leveraged among Veteran stakeholder groups statewide.

Increase in Older Veterans

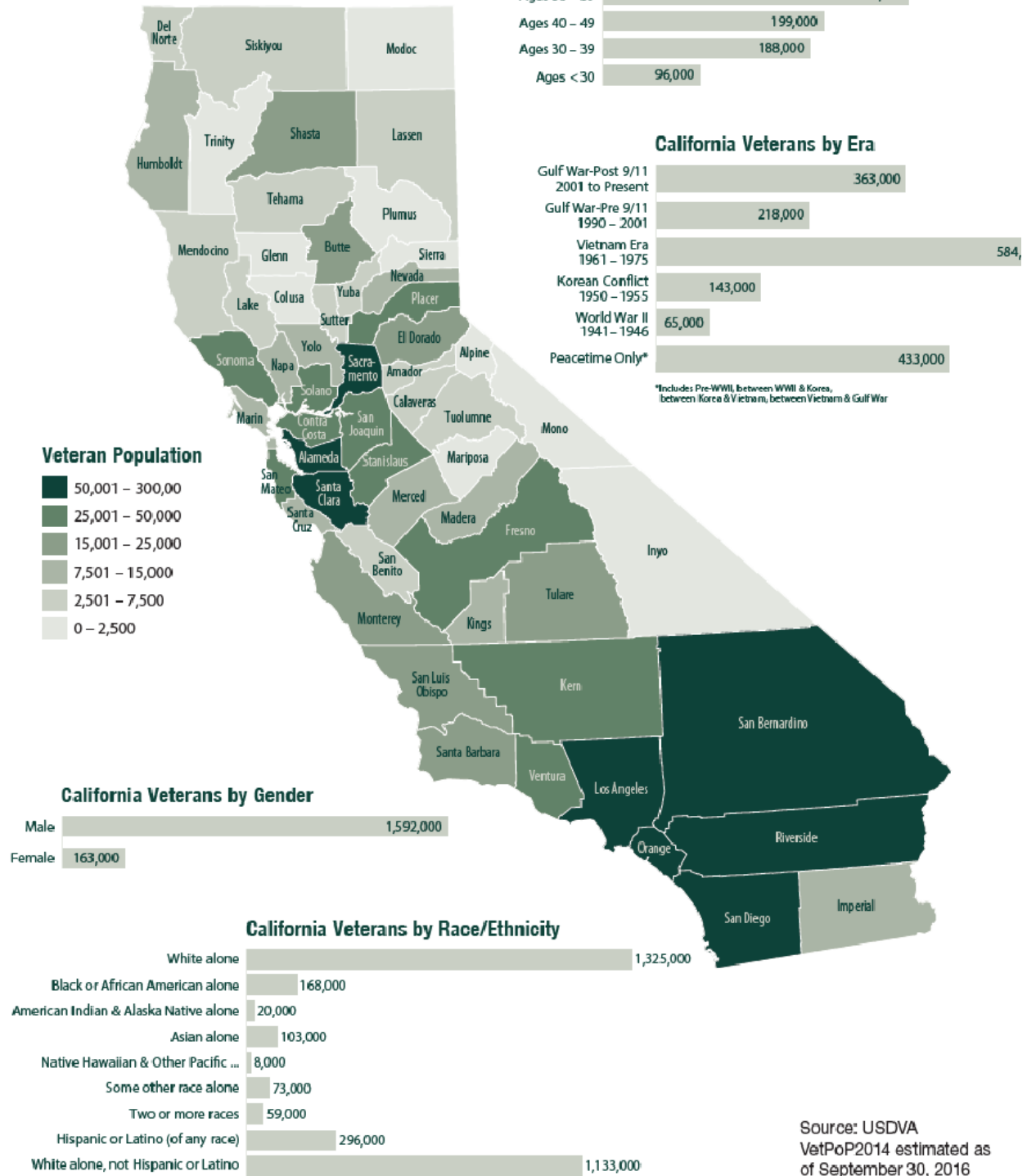
As **Map 1** and **Figure 1** below further elaborates, California currently has an older Veteran population. Nationally, Veterans age 55 and older constitute 67% of the Veteran population in the U.S. with 23% of those over the age of 75 years. California’s current situation of being home to just over 1 million Veterans over the age of 60 is actually on the decline as the roughly 208,000 Veterans from WWII and Korean Conflict eras pass on.

However, as life expectancy increases and coming decade demographics show, California must attend to the majority (69%) of California Veterans who are 55 and older; 25% of whom are over the age of 75. Mental health care, physical care, and appropriate housing situations, along with caregiver and family supports for California’s elderly Veterans is a critical need as California half a million Vietnam-era Veterans join the ranks of the 65+ population. Identification and management of depression, attention to transition from workforce participation to retirement and attendant need for meaningful community engagement, avoidance of polypharmacy, non-opioid and successful pain management, and independent and healthy lifestyle promotion are all elements of healthy aging.

MAP 1. California Veterans Overview

California Veterans by the Numbers

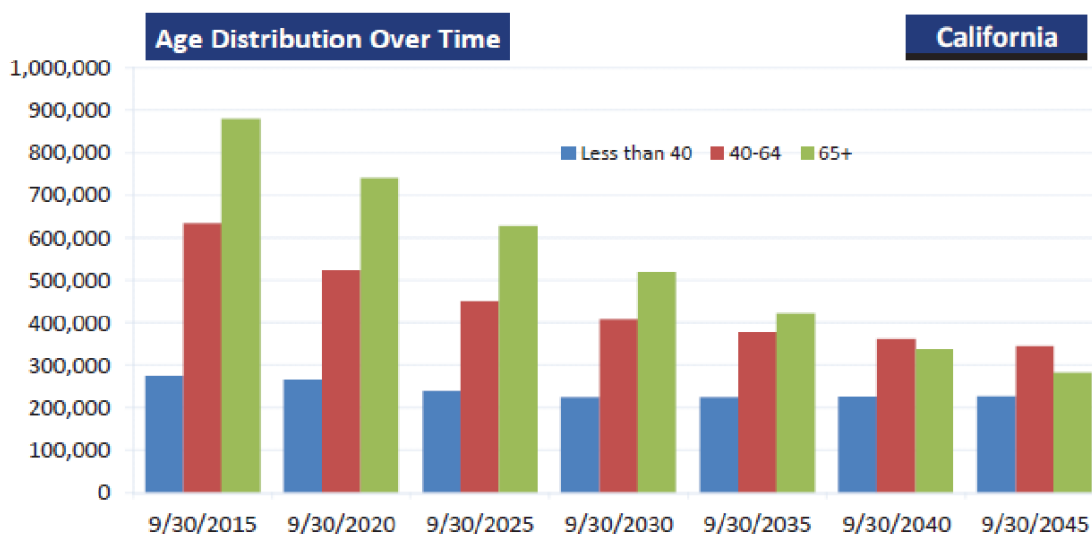
By County as of September 30, 2016



National Center for Veterans Analysis and Statistics. www.va.gov/vetdata



Figure 1: California Veteran Age Distribution 2015-2045



Source: National Center for Veterans Analysis and Statistics, www.va.gov/vetdata.

Women Veterans

Although it is clear that women Veterans are still a minority of California Veterans, data on exactly how many women veterans reside in California is unclear. The quality of California Veteran data is a serious concern and hindrance in considering issues related to the State of the California Veteran community and the needs of emerging subpopulations. This is true at both the State and Federal levels and may be especially true for issues related to women Veterans. In fact, Goal 1 of the never-released final report of the USDVA Report of the Women Veterans Task Force “Strategies for Serving Our Women Veterans. Draft for Public Comment. May 1, 2012” was to “Collect High Quality gender-specific data to meet stakeholder needs” with Goal 2 being to “Use data to evaluate services to address women Veteran needs. (USDVA)

Like the question of veteran ethnicity, agreed-upon current numbers are not available. CalVet’s most current online published data states that California has 184,257 women veterans based on 2011 USDVA “Veteran Population”. Subsequent USDVA numbers, like that on **Map 1** above by the USDVA VetPop2014, as of September 30, 2016 state that California was home to 163,000 women Veterans. Another VA site published 143,211 as the number of women Veterans in California in November 2017. (Office of Enterprise Integration, National Center for Veterans Analysis and Statistics2)

While the discrepancy in numbers is likely due to different estimation methods that may each have equal merit, the difference of 41,046 women Veterans is significant for California. Furthermore, it casts doubt on important discussions that must be had about budget allocations, program planning, and the true magnitude and significance of women veterans' unique concerns when consensus about numbers is difficult to achieve. 2011 data from the California Research Bureau's "California Women Veterans: The Challenges and Needs of Those Who Serve" stated that 7% of California's National Guard are women, with 54% having a 4-year college degree. It also described women Veterans as the fastest growing segment of the Veteran population, with 46% self-reporting a mental health condition, 20% reporting "military sexual trauma" (MST), 56% reported experiencing sexual harassment, and 33% reported experiencing sexual assault. If the numbers to which these percentages apply vary by tens of thousands, the services needed are difficult to plan for.

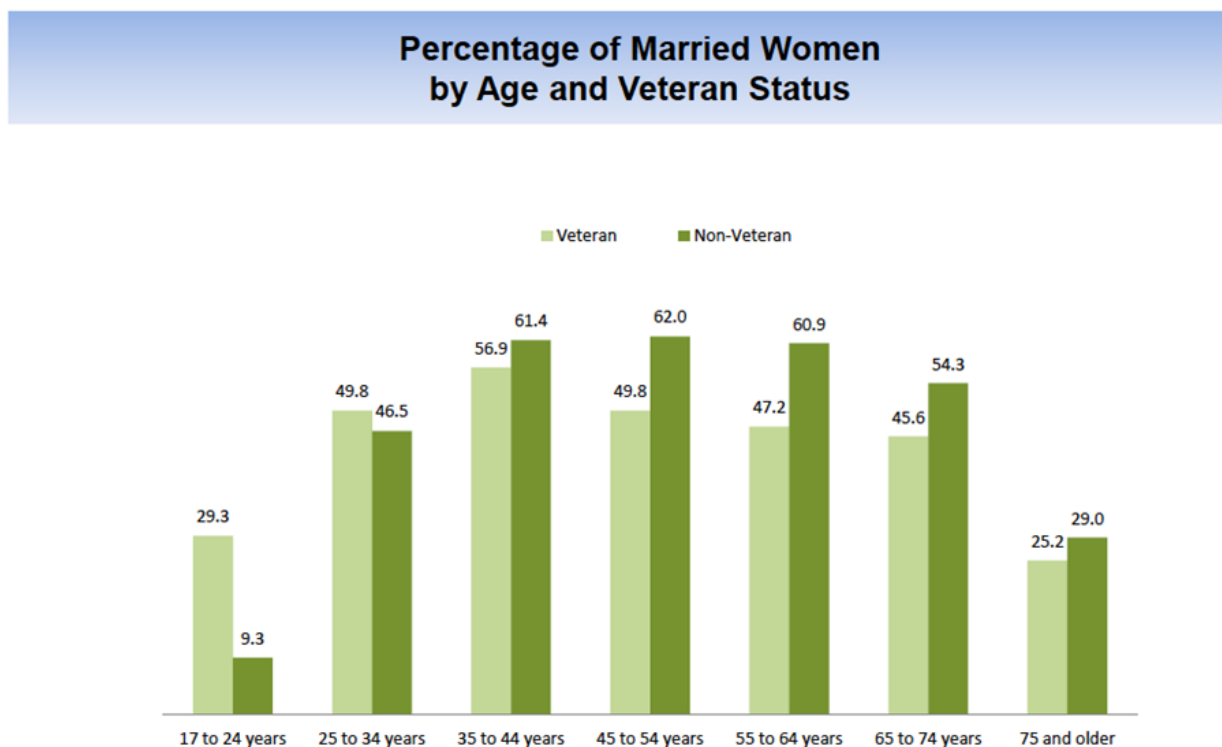
It is worth noting however that the USDVA has directed some attention to the women Veteran population with positive results. (Office of Enterprise Integration). One of the variables evaluated in FY15 was "Veteran Household Child Status", which data had never before been collected and has special importance for women veterans who are disproportionately single heads of household with dependent children, compared to both male veteran counterparts and female civilian counterparts (male veterans appear to also be single heads of household with dependent children disproportionate to their civilian counterparts). This analysis found that California is second only to Texas with 511,729 veteran households with children and, as expected, since California has more veterans than any other state, also has more veteran households without children. Although the status of the veteran households with children is unknown (ie: married, single, divorced, male-head or female head of household) the finding that 30% of California veteran households have dependent children has important policy and program implications for services, housing, child care, VHA clinic hours and waiting room set up, as well as other services needed for veteran families. Advocacy efforts to respond to this finding are part of CAVSA's agenda for the coming years. (See Recommendation **Section VI**)

With about 16% of the U.S. military comprised of women, there has been an increase in dual military families which numbered about 84,000 in 2014 with family formation and childbearing occurring at younger ages than among the civilian population. (Clever & Segal). However, as **Figure 2** below shows, from 45 years on, veteran women are less likely to be married than their civilian counterparts. Because the state of being married has protective health, as well as financial benefits in a public health context, this lower marriage rate for women veterans can be considered a risk factor.

While divorce rates of service members while they are enlisted have historically been roughly the same as civilian populations at about 3.6% annually, the Department of Defense showed

that about 7% of women service members divorce while in service, almost twice the comparable figure of the married civilian population who divorce. Upon discharge from military service, divorce rates increase for all branches of service to about twice that of their civilian counterparts. Women veterans tend to have higher divorce rates than their male counterparts and, as mentioned above often have primary custody of minor children with the attendant challenges, financial and other burdens that divorce and possibly single parenthood and/or child support issues entails. (See **Figure 3** below for percentage of women veteran divorced status across the lifespan). At all ages, veteran women are more likely to be divorced.

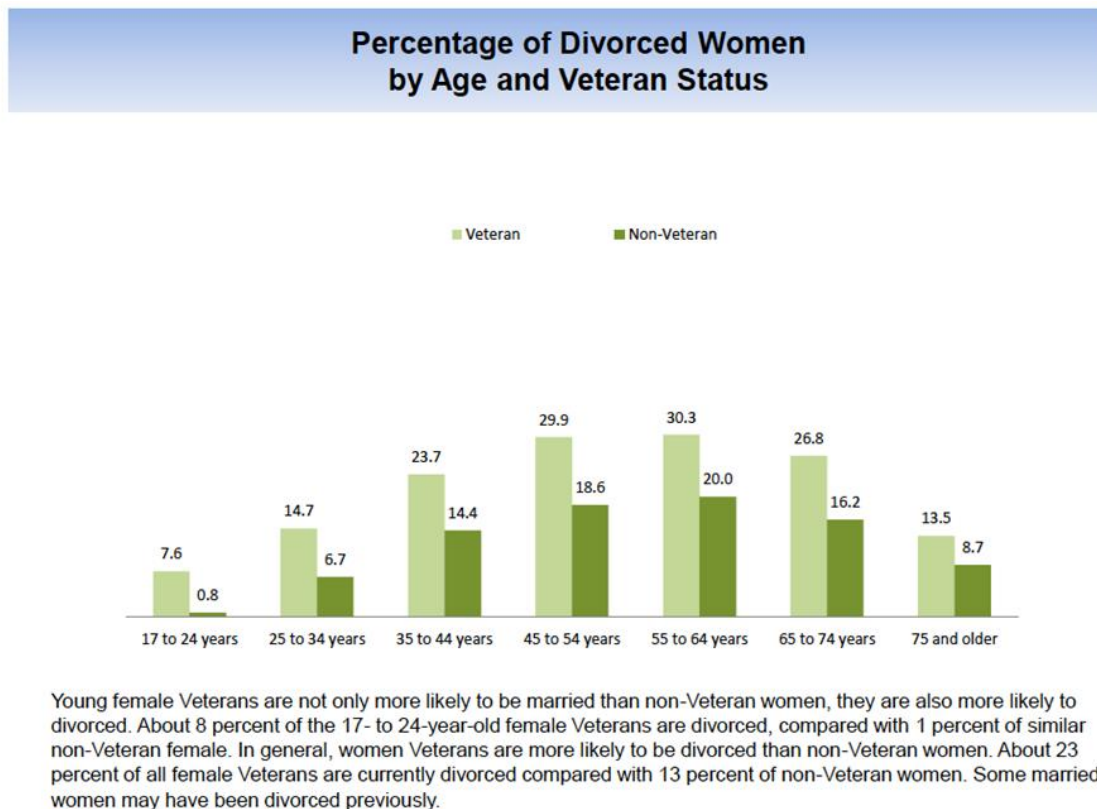
Figure 2. Percentage of Married Women by Age and Veteran Status. Source: U.S. Census Bureau American Community Survey PUMS. 2011. National Center for Veteran's Analysis and Statistics.



Female Veterans tend to get married at a younger age than non-Veteran women. About 29 percent of the 17- to 24-year-old female Veterans are married, compared with only 9 percent of the non-Veteran women of the same age.

Source: U.S. Census Bureau, American Community Survey PUMS, 2011
Prepared by the National Center for Veterans Analysis and Statistics

Figure 3. Percentage of Divorced Women by Age and Veteran Status. Source: U.S. Census Bureau American Community Survey PUMS. 2011. National Center for Veteran's Analysis and Statistics.



Source: U.S. Census Bureau, American Community Survey PUMS, 2011
Prepared by the National Center for Veterans Analysis and Statistics

Although data quality issues also exist regarding women veteran homelessness, women veterans are experiencing increased rates compared to their male veteran counterparts and their non-veteran civilian female counterparts. According to AHAR 2017, out of a population of more than two million women veterans, about 9% of homeless veterans were women. From 2016 to 2017, the number of homeless women veterans increased by 7%, compared to 1% for their male counterparts. Available information also suggests that African American women veterans and those age 18-24 have a greater risk of becoming homeless. Trauma exposure prior to enlistment coupled with trauma experienced while in the military from military sexual trauma (MST) is a common theme among homeless women veterans. (Hamilton, et.al, Gamache,et.al, NCVH, Washington, et. al.)

Another disturbing demographic trend reported among women veterans is their heightened rate of suicide compared to both their male Veteran and female civilian counterparts. This will be discussed further in **Section IV**.

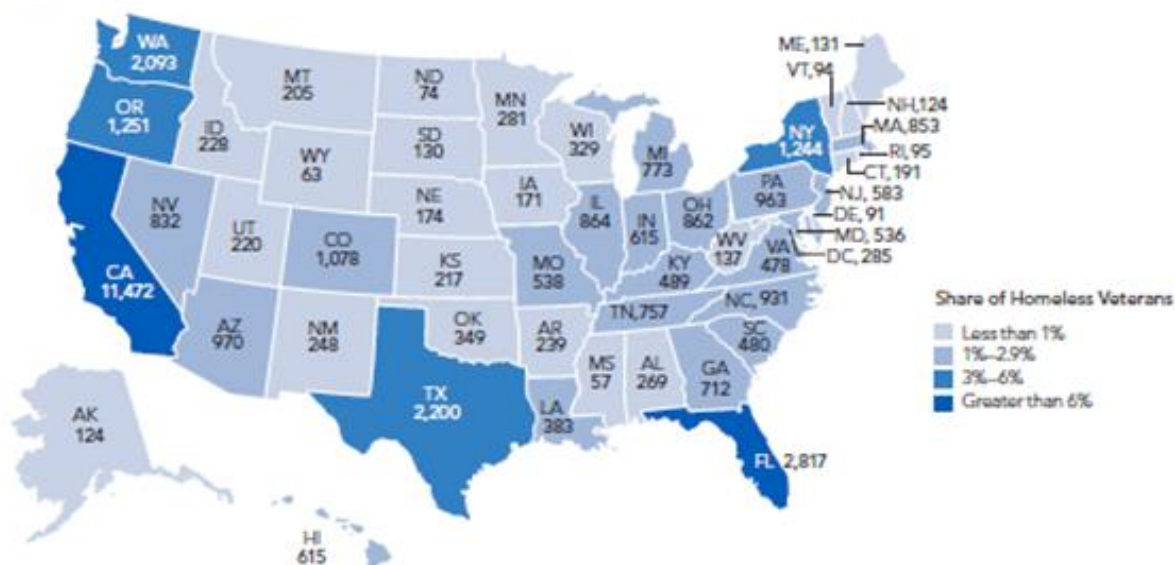
Homeless Veterans

Based on the U.S. Department of Housing and Urban Development (HUD) Annual Homeless Assessment Report (AHAR) 2017 California has the largest estimated Point in Time (PIT) number (134,278) of homeless people in the U.S., constituting 25% of all homeless persons nationwide. California also has the third highest rate of homelessness (34 per 10,000), as well as the highest rate of unsheltered homeless. Overall California's rate of homeless increased by 13.7% between 2016 and 2017, an increase of 16,136 persons.

As with California's general population of homeless persons, veterans in California also faced rising numbers and rates of homelessness. 28.6% (11,472) of all homeless veterans nationwide resided in California at this PIT estimate, of which 7,657, two-thirds of all homeless California Veterans, were unsheltered. See **Map 3** below. Homeless veterans constitute 8.5% of California's total homeless population, almost identical to the national picture where just over 9% of all homeless adults are veterans. This data represents a 19.4% (1,860 veterans) increase from 2016 to 2017 in California's homeless veteran population, with veterans representing 11.5% of California's overall 2017 increase of 16,136 persons mentioned above.

Map 3. Point in Time (Jan 2017) Estimates of Homeless Veterans (N=40,056) Source: AHAR 2017 Report.

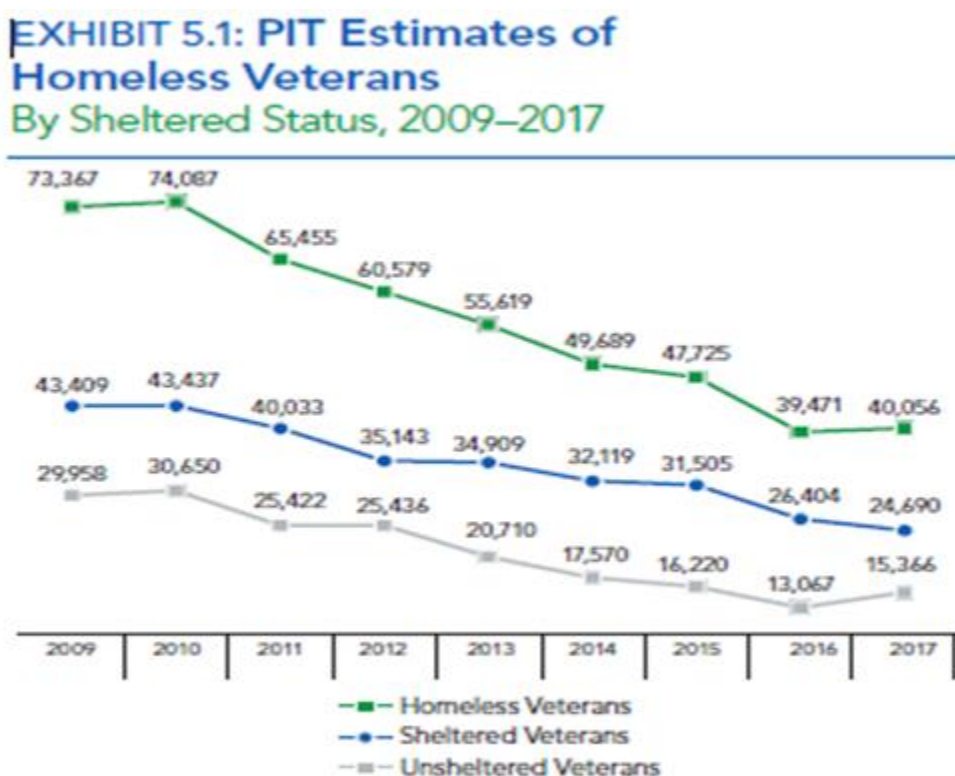
EXHIBIT 5.5: Estimates of Homeless Veterans
By State, 2017



As in past years, the biggest concentration of unsheltered homeless veterans is in California's most urban areas with 64.7% (7,418) homeless and mostly unsheltered veterans residing in just five Continuum of Care (CoC) regions: LA City and County, San Diego City and County, San Francisco, San Jose/Santa Clara City and County, and Oakland/Alameda County. (AHAR)

In the context of the steady national decline in the number of homeless and unsheltered veterans from 2009 to 2017 depicted in **Figure 4**, the magnitude of California's one-year increase in both homeless and unsheltered Veterans is of concern and reason to focus efforts on our unsheltered Veterans whose welfare and mental health tend to quickly deteriorate as their periods of homelessness become chronic. This will be further addressed in **Section IV**.

Figure 4: Point in Time Estimates of Homeless Veterans Nationally by Sheltered Status, 2009-2017. Source: AHAR Report. 2017



IV. LEADING CONCERNS IN CALIFORNIA VETERANS' MENTAL HEALTH AND WELFARE

Veteran Suicide

According to the Center for Disease Control (CDC) suicide was the 7th leading cause of death for males in the general U.S. population in 2015, the most recent year for which verified data is available. (NCHS, National Vital Statistics System, Mortality). For both men and women overall, suicide ranked as the 10th leading cause of death nationally. The suicide rate has increased

among the general U.S. population by an average of 25% from 1999 to 2016 and has commensurately increased among the Veteran population. The 2014 suicide rate was 21% higher among Veterans when compared with U.S. civilian adults, including 18% higher among male Veterans and 2.4 times higher among female Veterans. (USDVA. Office of Mental Health and Suicide Prevention).

In 2018 CDC found a 10% higher risk of suicide among people who had served in the military, including both those still serving as well as veterans. (CDC) Although veterans comprise only about 8.5% of the U.S. adult population, veteran suicides are overrepresented in suicide statistics at about 18% of all U.S. adult suicides. Across the U.S. approximately 20 veterans die by suicide per day; some sources suggest that this rate may be too low, and that the actual suicide rate is much higher. (Bryan et al). As 2015 California veteran suicide data below shows, 516 veteran deaths were determined to be suicides or 1.4 veteran suicide deaths per day in California alone.

Researchers have identified over 75 biopsychosocial risk factors for suicide and suicidal ideation in military Veterans (Barnes et al). Leading risk factors for veteran suicide include: being male, elderly (65+ years), having a diminished social support network, medical and psychiatric conditions associated with suicide (behavior and mood disorders), and the availability and knowledge of firearms. An acknowledged limitation of this list is the fact that much of the veteran suicide research has been based on Vietnam-era veterans, so may be less relevant for our current Gulf War-era veterans (Kaplan et al).

Notwithstanding this limitation, when compared to non-veterans, military veterans are at an increased risk of suicidal ideation, and thus, increased risk of suicide. Risk is increased if the veteran has experienced trauma or a traumatic event at any point in their life, if they, a loved one, or friend has attempted suicide, if they use drugs or alcohol, if they have access to firearms, and if they have negative psychiatric symptoms, such as PTSD or a mood or behavioral disorder (Bryan et al). Being underweight, having disrupted sleep, or 65+ years, also is associated with increased risk of suicidal ideation (Kaplan et al).

Moral injury is now also thought to elevate risk of suicide among U.S. veterans. “Morally injurious events can include situations in which an individual is required to perpetuate or cause harm to others (e.g., aggression, disproportionate violence, killing), are unable to prevent a negative outcome (e.g., saving a friend’s life), or witness events that violate their moral beliefs (i.e., severely injured children)” (Bryan et al). Veterans may engage in suicidal ideation that is persistent, intermittent, then fleeting and resurging over time, while others may engage in active suicidal ideation. Because a number of these increased risk factors are more likely to be prevalent among veterans than non-veteran populations, it is critical that mental health and

other social service providers have cultural competence in military culture in order to successfully support at-risk veterans.

An additional risk factor that is more widespread among veterans is having a traumatic brain injury (TBI) of varying severity. As the “signature injury” of the recent Gulf Wars due to improvised explosive devices (IEDs) (Brenner et al), TBI is defined as a serious concussive or percussive impact on the head which results in measurable physical and mental health effects (Barnes et al). Depending on the type of TBI (mild, moderate, severe) suicide rates among individuals with a history of TBI are estimated to be between 2.7 and 4.0 times higher as compared to the general population. (Brenner et al). This results in an 8.1% lifetime rate of suicide attempts post-TBI compared with 1.9% for the general population. Clinically significant suicidal ideation has been identified in 21% to 23% of individuals with a history of TBI compared to 1% of the total sample of those who served in [the Iraq Gulf War] that endorsed some suicidal ideation. (Brenner et al) These findings strongly suggest that better assessment for TBI, which is often misdiagnosed as PTSD and other behavioral problems, is warranted and preventive resiliency building strategies employed with this population universally.

Recent media reports have highlighted the rising rates of suicide among women overall (both veteran and non-veteran) because the percent increase in rates was higher in women for the first time ever, but it’s worth noting that men continue to have a three to five times higher rate of death by suicide than women.

Findings for California veterans are cited in the following **Table 2, Table 3, Figure 5 and Figure 8** from the VA National Suicide Data Report 2005–2015, Office of Mental Health and Suicide Prevention, U.S. Department of Veteran Affairs, June 2018.

Table 2. California Veteran, Total California, Western Region & National Suicide Deaths by Age Group, 2015

California Veteran and Total California, Western Region², and National Suicide Deaths by Age Group, 2015^b

Age Group	California Veteran Suicides	California Total Suicides	Western Region Total Suicides	National Total Suicides	California Veteran Suicide Rate	California Suicide Rate	Western Region Suicide Rate	National Suicide Rate
Total	516	4,067	10,905	42,790	28.8	13.6	18.8	17.3
18–34	61	1,031	2,999	11,452	32.3	10.7	16.4	15.4
35–54	127	1,395	3,835	15,687	31.6	13.4	19.4	18.7
55–74	190	1,186	3,045	11,940	25.1	15.6	19.7	17.4
75+	138	455	1,026	3,711	31.1	20.6	23.5	18.4

Taking population age differences into account, California’s overall veteran suicide rate (28.8) is significantly higher than the national general population (non-veteran) suicide rate of 17.3 and more than twice that of California’s general (non-veteran) suicide rate of 13.6.

Table 3. California, Western Region and National Veteran Suicide Deaths by Age Group, 2015

California, Western Region^a, and National Veteran Suicide Deaths by Age Group, 2015^b

Age Group	California Veteran Suicides	Western Region Veteran Suicides	National Veteran Suicides	California Veteran Suicide Rate	Western Region Veteran Suicide Rate	National Veteran Suicide Rate
Total	516	1,583	6,115	28.8	34.6	29.7
18–34	61	207	785	32.3	44.5	39.1
35–54	127	428	1,777	31.6	38.9	34.8
55–74	190	622	2,310	25.1	31.3	26.0
75+	138	325	1,241	31.1	31.8	27.1

Although still too high, California’s veteran suicide rate among all age groups is lower than both neighboring states in the VA Western Region, as well as lower than the national veteran suicide rate through all age groups. Veterans age 75+ constitute the only age group in which California veterans’ suicide rate is higher than the national rate and is comparable to California’s neighboring Western Region.

Figure 5. Percentage of Veteran VHA Users With Diagnoses of Mental Health (MH) Conditions or Substance Use Disorders (SUD), by Year

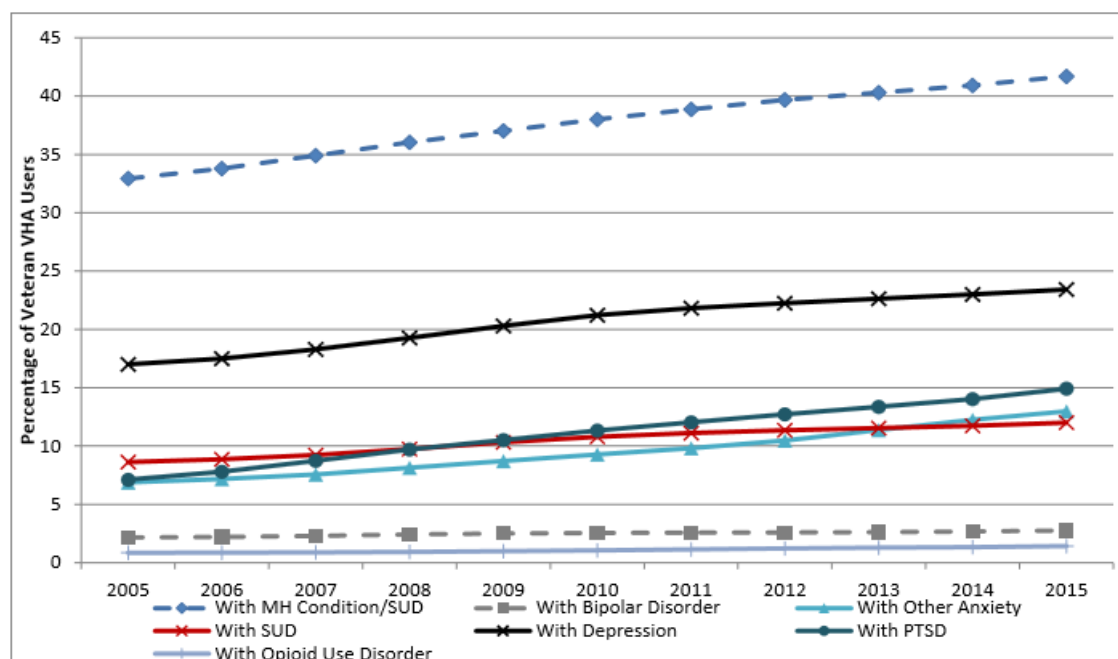


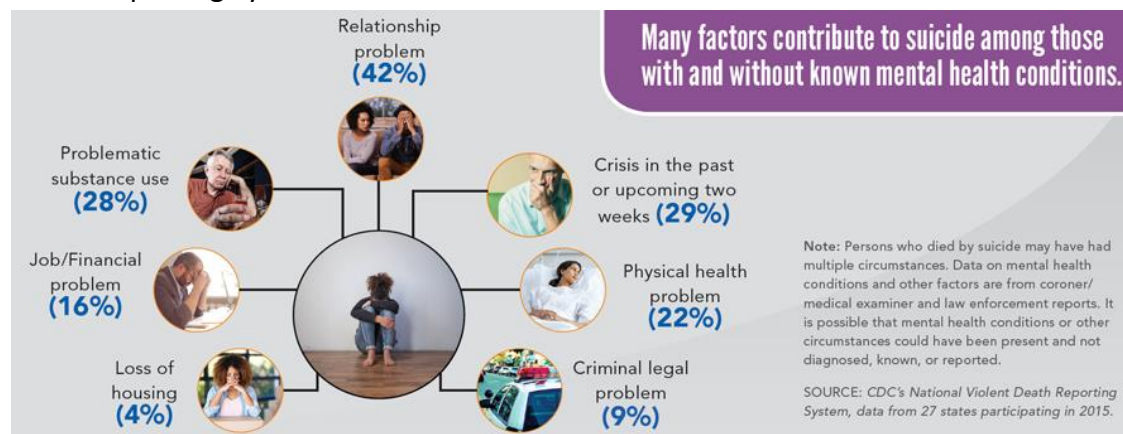
Figure 5 above from the VA National Suicide Data Report 2005–2015, Office of Mental Health and Suicide Prevention, U.S. Department of Veteran Affairs, June 2018, shows steady increases in diagnoses of mental health conditions, including depression and substance use disorders

(SUDs) over the past decade among veterans at VHA. Veterans served by VHA with diagnoses of depression had the highest rate of suicide and those diagnosed with opioid use disorder had rates comparable to depression. The epidemic of synthetic opioids fentanyl and Carfentanil in combination with prescription opioids or other substances has increased the likelihood of both intentional and accidental overdose deaths.

According to the CDC, mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor and what are often called risk factors for suicide may be chronic conditions. “Warning signs” that a person may act on suicidal ideation may also be chronic symptoms among veterans who, as **Table 1** indicates have different rates and patterns of suicide than the general population. (Suicide is Preventable). Recent research by the Rand Corporation has garnered attention as it suggested that more research is needed to test “warning signs” for their validity as suicide intervention tools. Education campaigns that teach warning signs may not be relevant for preventing suicide among those already engaged with mental health treatment or involved in the criminal justice system. (Ramchand, et.al.)

Figure 6 below graphically demonstrates some of the precipitating factors in suicide deaths in the general U.S. population. While many of the factors are also shared with veterans, prevention and postvention programs designed for the general population must be adapted to be culturally competent for veterans, and the venues in which such services are offered may differ from those for the general population.

Figure 6. Precipitating Factors in Suicides in General U.S. population. CDC National Violent Death Reporting System. June 2018.



A study by Kaplan et al supports this concept of highly varying precipitating factors in suicide. Using 2003-2008 suicide data stratified by age on both veterans and non-veterans, they found that within the veteran population, suicide was influenced by different precipitating factors at various stages of life; mental health, substance abuse, and financial and relationship problems

were more common in younger than in older veteran suicide decedents, whereas health problems were more prevalent in the older veterans. Among half (49.7%) of the 18-34 year old Veterans and nearly half (47.3%) of the 35-44 year old veterans “intimate partner problems” was the identified precipitating event prior to their suicide, figuring more prominently in the analysis than any other factor, including “crisis”, substance abuse, alcohol, criminal justice, job, health, or financial problems, or mental health problems, diagnosis, or “depressed mood”. Given high rates of divorce, serial relationships and marriages especially among younger veterans, it is highly relevant to include family members and relationship concerns in Veteran mental health programs with an emphasis on strength-based resiliency skills building for both the veteran and all relevant veteran family and support network members.

Relatedly, there is compelling evidence that exposure to suicide increases the risk of subsequent suicide in those who have been exposed. Because of the prevalence of veteran suicide and growing prevalence of active-duty suicide, veterans, and their family members to a lesser degree, are disproportionately exposed to suicide, thereby increasing their own risk. According to the Tragedy Assistance Program for Survivors (TAPS), a non-profit program that provides peer support for those affected by active duty military deaths, for every death, 10 people, on average, are significantly impacted. In 2017, the top leading causes of death represented by new survivors coming to TAPS were: Suicide: 31.2%, Illness: 24.7%, Accident: 21.1%, and Hostile: 8.7%. The 2017 survivors affected were:

- 26.4% children (includes minor, adult, and stepchildren)
- 24.7% parents (includes stepparents)
- 21.6% spouses (includes ex-spouses)
- 11.2% siblings
- 16% fiancés or significant others, grandparents, aunts, uncles, nieces, nephews, cousins, in-laws, friends, etc.

Although TAPS is not available for most veterans, the need for peer support postvention, that also serves as prevention with a population known to be at heightened risk themselves could be a model worth considering in California. (Tragedy Assistance Program for Survivors)

CDC data supports the finding mentioned above that many (CDC data shows 54%) who die by suicide are not known to have a diagnosed mental health condition at the time of death.

Figure 7 below shows that males constitute 84% of suicides in the general population in which no mental health condition was known, with 55% using a firearm to kill themselves. This may speak to the fact that men are less likely in general to seek or receive psychological health services and more likely to conceal stresses and plans to end their lives than women. Among those with known mental health conditions, the most common method of suicide (41%) is also

firearm, which has implications for management of access to lethal means as a key avenue for suicide reduction in both populations. Most male veterans used firearms for suicide, and nearly all elderly veterans did so.

Figure 7. Known Versus No Known Mental Health Conditions and Suicide Methods Among the General U.S. Population Overall. CDC, 2018.

Differences exist among those with and without mental health conditions. People without known mental health conditions were more likely to be male and to die by firearm.

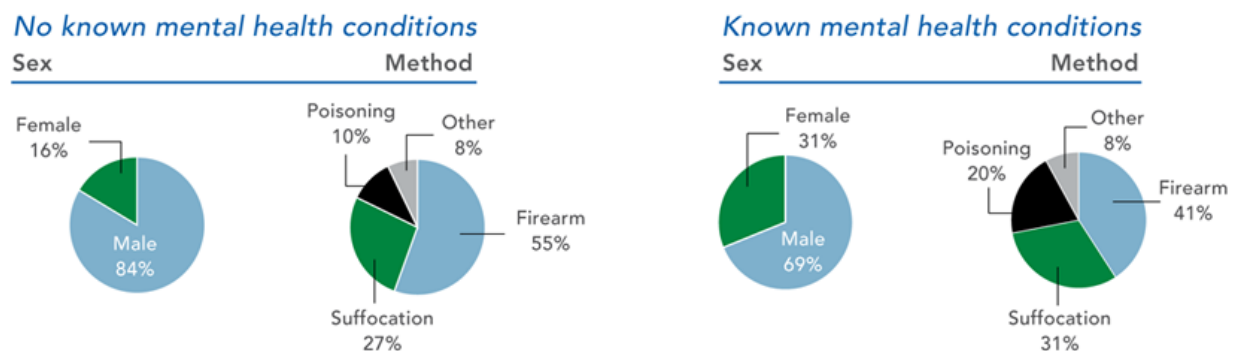


Figure 8. California Veteran and Total California, Western Region and National Suicide Deaths by Method, 2015

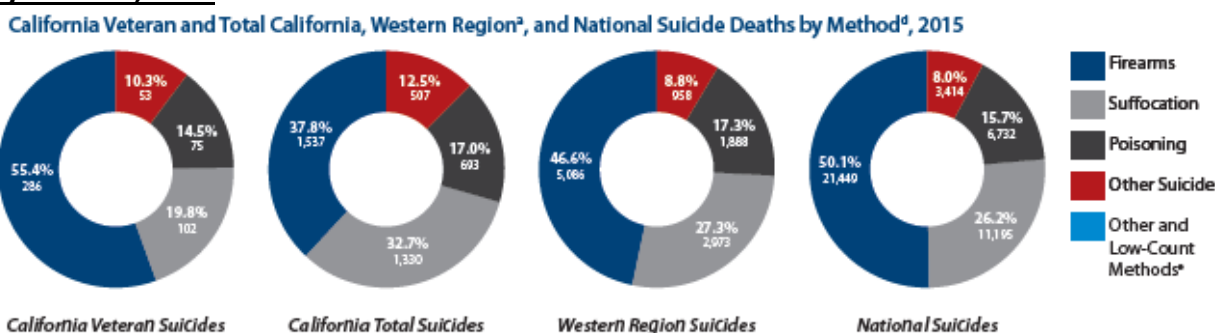


Figure 8 above from the VA National Suicide Data Report 2005–2015, Office of Mental Health and Suicide Prevention, US Department of Veteran Affairs, June 2018, shows that firearms are the primary method of suicide death across all populations considered with 55.4% of California’s veterans using firearms, compared to 37.8% of non-veteran Californians. This finding has implications for firearm access policies and safety issues in the context of suicide prevention.

Substance Use Disorders (SUDs) and Opioid Concerns

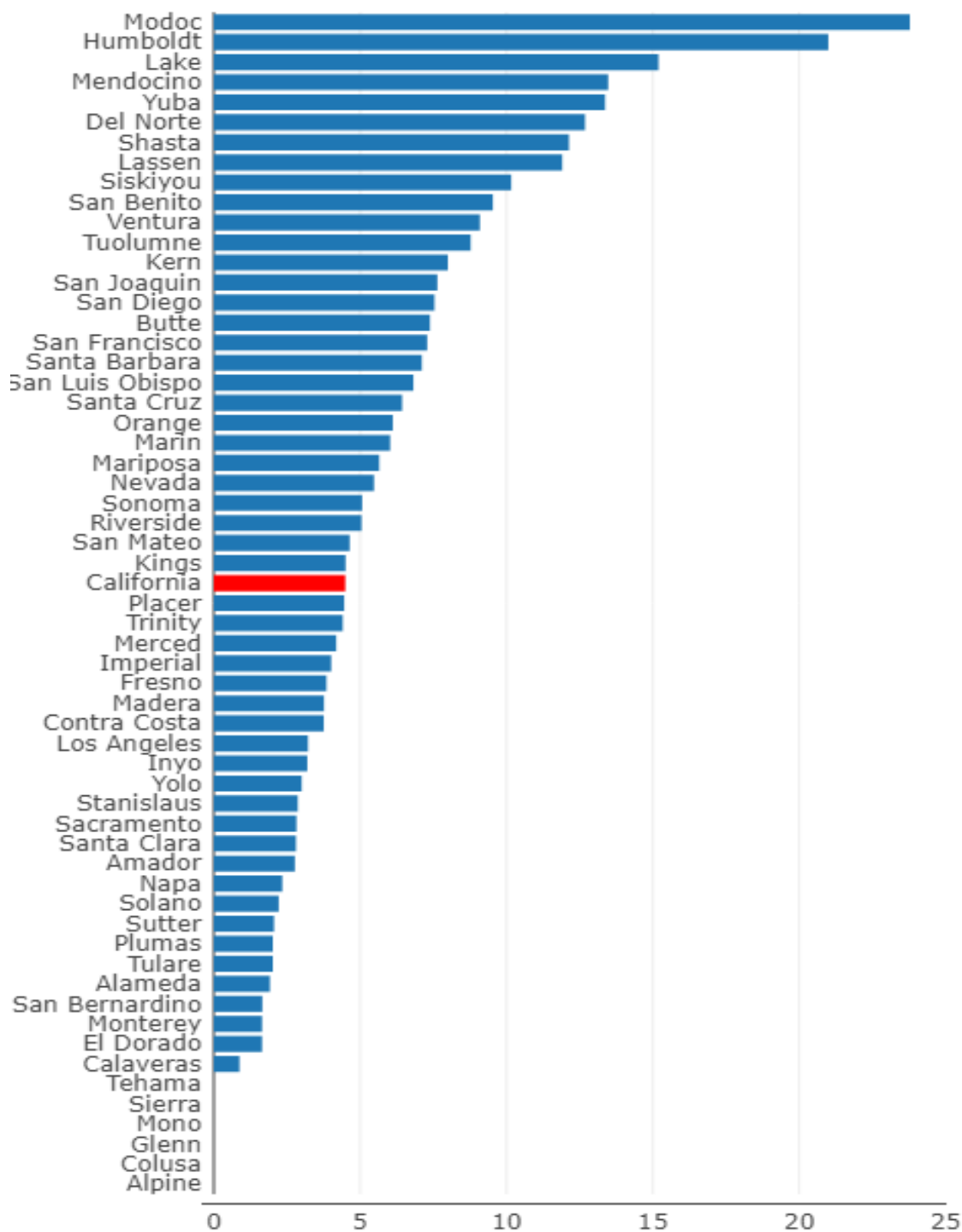
As **Table 1** showed using data extrapolated to the national level, veterans have an increased rate of opioid overdose deaths. Since the early 1990s there has been a steadily growing increase in the use of prescription drugs, primarily narcotics due to an increased recognition of the importance of treating pain. Paralleling this prescribing practice, the rates of prescription opioid misuse and overdose have soared to the point that opioid overdoses are now a leading cause of death nationwide. (CDC) A large-scale 2012 study at the San Francisco VA found that Iraq and Afghanistan veterans with mental health diagnoses, especially those with PTSD, were at particularly high risk of opioid misuse and death in the context of the rates of co-occurring substance use disorders (SUDs) among veterans with PTSD. (Seal, et.al)

As a population, veterans were in the forefront of our nation's recognition that opioids were being radically overprescribed for the treatment of chronic pain for which they are not the treatment of choice. As a result of this recognition, the VHA launched its Opioid Safety Initiative (OSI) and issued new opioid prescribing guidelines in 2017. These actions have resulted in a nearly two-thirds decrease in narcotic prescriptions at VHAs nationally, but has also been viewed as causal in driving narcotic-dependent veterans to street drugs as VHA treatment for withdrawal and ongoing pain symptoms has not keep pace with the changing prescribing practices. (USDVA/DoD)

According to the American Society of Addiction Medicine (ASAM) four out of five heroin users started by using or mis-using prescription painkillers. (ASAM). As we approach 2019, the two intertwining epidemics of prescription narcotic abuse and illicit drug abuse - primarily heroin often laced with fentanyl - have appeared in pockets of California, but have not become widespread. The California Department of Public Health (CDPH) is conducting surveillance to detect changes in use patterns, but "veteran status" is not one of the variables currently collected in their data base. (CDPH)

Figure 9 below graphically shows California counties' rates of opioid overdose deaths with a significant number of more rural counties having the highest rates. Modoc at 23.78/100,000, Humboldt at 20.99, Lake at 15.19, Mendocino at 13.47, and Yuba at 13.37 (all "per 100,000 residents age-adjusted) rank as California's top five counties with the highest opioid overdose rates. Referring to **Map 2** shows that these northern counties also have the highest concentration of veterans per capita population. Del Norte, Lassen, Shasta and Siskiyou ranked in the top ten counties with the highest rates of opioid overdose deaths in California, and also have very high concentrations of veterans in their populations – all cause for grave concern that warrant immediate targeted education, prevention and early intervention programs for these counties among their veteran communities.

Figure 9. Total California Population. All Opioid Overdose Deaths: Age-Adjusted Rate per 100,000 Residents



California Department of Public Health Opioid Dashboard. 2017 preliminary data.

There is also a concern about the geographical distribution of VHA SUDs treatment programs in California and the resulting lack of specialized treatment available through the VA. Currently the VA lists eleven sites: Oakland, Sacramento at Mather, San Francisco, Palo Alto, Fresno, Long Beach, North Hills (North LA), Downtown Los Angeles, West Los Angeles, Loma Linda (East Los Angeles), and San Diego – more than half of which are located in Southern California. Considering that the largest population of veterans live in this region, these locations may be reasonable, however the absence of services north of Sacramento may represent a barrier to care for veterans concentrated in the northern counties where the need appears to be highest for opioid treatment and where private providers are scarce. VA Medical Centers without specific SUD treatment programs often offer treatment through their mental health clinics, as do many Vet Centers and VA Community Based Outpatient Clinics, but further investigation into the availability of services for California's rural veterans is needed and urgent action may be warranted.

Older Veterans Mental Health Challenges

As described in **Section III**, a disproportionate percentage of California's veterans are older who by virtue of age alone are at risk for increased health problems. However, in addition to their age-related risk factor, research suggests that the VA patient population has poorer health status than the general (non-VHA) patient population. Veterans who use the VA experience age-related health risks beyond their chronological years, thereby predisposing them to a variety of both acute and chronic conditions. (Steinman et al) According to Swords to Plowshares staff, the San Francisco VA Health Care System (VAHCS) cited older veterans as having an average of 10-15 medications, which is difficult to manage and puts patients at increased risk for adverse drug effects and adverse psychological outcomes. This kind of polypharmacy is linked to negative clinical outcomes in the elderly. (Maher, et al)

According to the VA's National Registry for Depression, 11% of veterans aged 65 and older have a diagnosis of major depressive disorder (MDD), a rate more than twice that found in the general population of adults aged 65 and older. (VA, 2011) This may be an underestimate because dementia and depression are sometimes confused and a MDD diagnosis is often not made. Additionally, older veterans are increasingly being diagnosed with Post-traumatic stress disorder (PTSD), which is associated with high rates of morbidity and mortality and is one of the most common sequelae in older veterans. (Dohrenwend et al; National Center for PTSD) PTSD symptoms can worsen later in life with many older veterans endorsing PTSD symptoms more than fifty years after the traumatic exposure. Demand for treatment of PTSD among Vietnam veterans, in particular, has increased. (Hermes, 2015) Combat veterans with PTSD report more current and chronic health problems than combat veterans without PTSD and is associated with greater healthcare use and an increased risk of developing a wide range of medical conditions. Older veterans with PTSD symptoms significantly more likely to report poor general health including cardiovascular disease, diabetes, gastrointestinal disease, fibromyalgia, chronic fatigue syndrome, musculoskeletal disorders, autoimmune disease. (Durai et al, 2011) The

deterioration of physical health can exacerbate or even trigger the onset of PTSD symptoms as veterans age. (Chaterjee et al, 2009)

Research shows male veterans diagnosed as having PTSD were at a 2-fold-higher risk of developing dementia compared with those without PTSD, (Yaffe K, et al) and research also shows the same 2-fold risk of dementia for older veterans with dysthymia or depression compared with those with no dysthymia/depression. (Byers et. al) One study on traumatic brain injury (TBI) among older veterans in California shows TBI increases the risk of dementia by 60 percent in veterans aged 55 and older, as well as prompting earlier onset. (Barnes, et al, 2014) PTSD and TBI have been known for at least a decade to be risk factors for Alzheimer's disease with brain injury possibly causing earlier onset or acceleration of Alzheimer's disease. (Plassman et al; Institute of Medicine)

According to data obtained by Swords to Plowshares through Freedom of Information Act on San Francisco Department of Veterans Affairs (SFVAHCS) patients ages 55 and older, the top five most frequent physical health diagnostic code categories are circulatory (56%), vision loss (46%), pain (42%), high cholesterol (35%), and diabetes (22%). The top four mental health diagnostic code categories are substance abuse disorders (17%), depression (16%), PTSD (9%), and anxiety (8%) – all of which constitute risk factors for suicide and warrant additional supportive services as a targeted preventive measure. Furthermore, the pharmacologic management of pain, anxiety, and depression, especially in older patients with multiple chronic conditions can be difficult and burdensome for the patient, caregiver, and providers.

Veteran Justice System Involvement

CAVSA agency member Swords to Plowshares conducted a literature review on “Veterans and Criminal Justice” in 2011 that summarized the situation with regard to veterans and their involvement with the criminal justice system which remains essentially unchanged today -- namely that veterans without effective care for their mental health conditions and economic and social support can experience overwhelming challenges that often leads to self-medication, abuse of alcohol and drugs, job instability, poverty, and homelessness. Theft, property crime, and violent crime - which is significantly more frequent for veterans, than non-veterans – leads to arrests, convictions, and incarceration. (Culhane, et al 2011, Noonan, 2010, Swords to Plowshares, 2011.) While this bleak scenario could and does happen to citizens other than military Veterans, the Veteran community, the Veteran him/herself, and society often have different expectations for the behavior and ethical conduct of those who have been military service members. The level of stigma is therefore often greater, both self-imposed and perceived, and the level of compassion and therapeutic support society is willing to provide is also proving to be greater than it has been in the past.

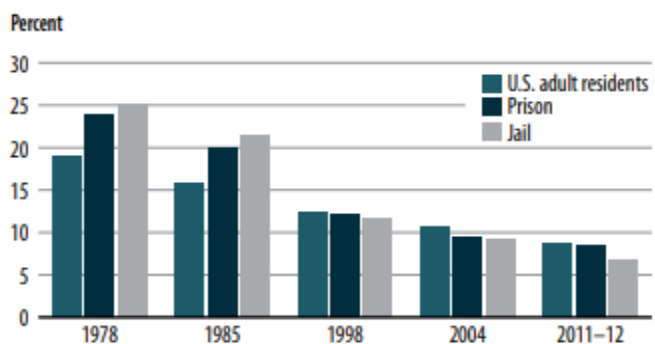
The exact number of veterans who are “justice involved”, jailed or imprisoned, in California is unknown because law enforcement and Corrections have not typically tracked veterans in jail

or prison. As a result of this lack of data and relative newness of this concept, this report has included information from the “grey literature” of news outlets, social media, webinars, etc. provide information with more currency.

Figure 10. Estimated percent of veterans in the U.S resident population, in prison, and in jail.

Source: Bureau of Justice Statistics (BJS). Special Report. December 2015.

Estimated percent of veterans in the U.S. resident population in prison and jail, 1978, 1985, 1998, 2004, and 2011–12



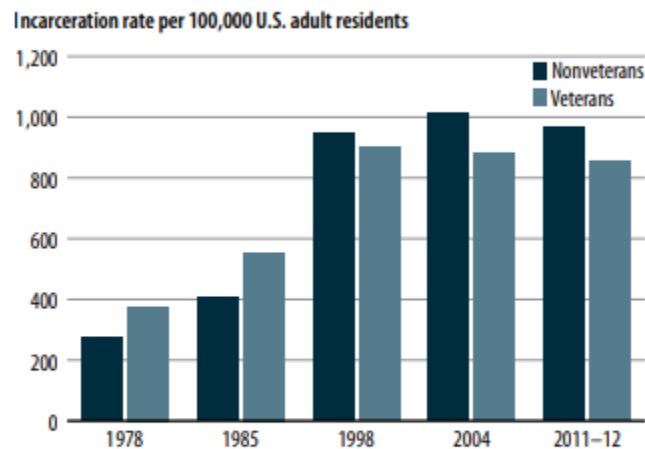
Note: For years in which prison or jail inmates were not surveyed, the total prison or jail population was multiplied by the veteran distribution from the most recent survey. See *Methodology*.

Figure 10 shows that the percentage of inmates who had previously served in the military peaked in the late 1970's at 24%, shortly after the close of the Vietnam War. The percent of veterans in jail or prison instead of in the general civilian community has declined since that time, but now holds steady at approximately 8%. This graph shows that in 1978, 19% of U.S. adult residents, 24% of prisoners, and 25% of jail inmates were military veterans. By 2011–12, veterans accounted for 9% of the general population, 8% of state and federal prisoners, and 7% of jail inmates.

Figure 11 below shows that since 1998 veterans have actually been incarcerated at lower rates than non-Veterans; by 1998, 948 non-veterans per 100,000 adult U.S. nonveteran residents were incarcerated in prison or jail, compared to 882 veterans per 100,000 adult U.S. Veteran residents, which had not been the case for decades and is a significant and little-known finding. This data counters prevailing societal beliefs that veterans are inherently criminal. This data, coupled with the information below, though not California-specific, provides further evidence for the value of Veteran Treatment Courts (VTC) and other veteran diversion programs. A controversial challenge for California's VTCs is how to manage violent crimes by veterans, which include domestic and intimate partner violence.

Figure 11. Incarceration rate of veterans in prison and jail. Source: Bureau of Justice Statistics (BJS). Special Report. December 2015.

Incarceration rate of veterans in prison and jail, 1978, 1985, 1998, 2004, and 2011–12



Note: Incarceration rates are based on the U.S. resident population of persons age 18 or older. Rates for nonveterans are based on the number of nonveterans in the U.S. adult resident population. Rates for veterans are based on the number of veterans in the U.S. adult resident population.

Source: Bureau of Justice Statistics data collections on prison and jail inmates and U.S. Census Bureau population data collections. See table 1 for complete list.

Additional highlights of the BJS report include:

- A greater percentage of veterans (64%) than nonveterans (48%) were sentenced for violent offenses.
- An estimated 43% of veterans and 55% of nonveterans in prison had four or more prior arrests.
- More than three-quarters (77%) of incarcerated veterans received military discharges that were honorable or under honorable conditions.
- Veterans in prison (23%) were twice as likely as nonveterans (11%) to report that a mental health professional ever told them they had post-traumatic stress disorder (PTSD).
- About half of all veterans in prison (48%) and jail (55%) had been told by a mental health professional they had a mental disorder.
- Over 60% of those diagnosed as needing mental health treatment had been in combat.

Building on the success of Drug Treatment Courts introduced during the “crack epidemic”, California was the first state in 2006 to establish an alternative sentencing option in California PC § 1170.9 for Veterans and military members with service-related mental health issues, allowing them to be sentenced to therapy at a federal VHA instead of incarceration. After completing the program Veterans may have their charges reduced, records expunged, rights restored, and do not have to report the conviction on employment or other legal applications.

This law is the basis for California's 33 operating VTCs which are listed in **Table 4** below although it can be applied in any court setting.

Table 4: Operating Veteran Treatment Courts in California Counties

COUNTY	COURT*	VETERANS _a	OEF/OIF _b	POPULATION _c
Orange	Yes (11/08)	116,917	6,227	3,183,011
Santa Clara	Yes (11/08)	56,011	2,726	1,927,888
San Bernardino	Yes (1/10)	110,655	7,280	2,139,570
Tulare	Yes (2/10)	17,901	1,097	466,339
Los Angeles Downtown	Yes (9/10)	289,609	17,470	10,241,335
Ventura	Yes (11/10)	40,999	2,884	856,508
San Diego	Yes (2/11)	225,299	28,666	3,288,612
San Joaquin	Yes (4/11)	34,569	1,640	733,383
Santa Barbara - Santa Maria	Yes (11/11)	22,270	1,167	446,717
Riverside	Yes (1/12)	133,115	8,235	2,347,828
El Dorado	Yes (2/12)	15,196	407	183,750
San Mateo	Yes (5/12)	27,020	1,084	766,041
Santa Barbara - Santa Barbara	Yes (7/12)			
Placer	Yes (9/12)	29,796	1,219	373,796
Los Angeles Lancaster	Yes (3/13)			
San Francisco	Yes (4/13)	23,882	1,076	866,583
Kings	Yes (4/13)	12,977	1,555	150,373
San Luis Obispo	Yes (6/13)	20,474	753	277,977
Alameda	Yes (11/13)	54,222	2,278	1,627,865
Sacramento	Yes (7/14)	84,381	4,614	1,495,297
Solano	Yes (9/14)	33,197	3,099	431,498
Lake	Yes (9/15)	6,455	132	64,306
Butte	Yes (9/15)	17,341	701	224,601
Santa Cruz	Yes (10/15)	10,998	306	275,902
Sonoma	Yes (11/15)	27,569	834	501,959
Calaveras	Yes (1/16)	5,531	104	45,207
Monterey	Yes (1/16)	18,399	1,149	437,178
Stanislaus	Yes (2/16)	25,340	1,214	540,214
Fresno	Yes (6/16)	43,073	2,524	984,541
Del Norte	Yes (10/16)	2,529	72	26,811
Madera	Yes (10/16)	8,305	338	155,349
Merced	Yes (7/17)	10,854	596	271,579
Contra Costa	Yes (8/17)	51,627	1,890	1,123,429

Table 4 Footnotes* Court founding date a. Source: Veteran population estimates, as of September 30, 2016, published by the USDVA National Center for Veterans Analysis and Statistics as "VetPop 2014." b. Source: DoD as of 2010 (based on last known home address at discharge) c. Source: California Department of Finance, 2016

A related law PC § 1001.80 became effective in 2014 to permit pre-trial military diversion for misdemeanors. Qualifying veterans completing therapy can have their charges dismissed.

Although not all Counties initially embraced VTCs, some, like San Diego County, started them as “Pilot Projects”, and they have spread rapidly compared to other “Collaborative” or “Problem Solving” Court formats (such as mental health or homeless courts). The explanation for the relatively rapid expansion, even popularity, of VTCs includes the idea that Veterans today are considered to be more “worthy of a second chance” than non-Veterans especially in the context of the “Longest Wars” of OEF/OIF in California -- home to 26 military installations.

Additional reasons for the spread of VTCs in California and across the country is because they are effective and generate cost savings. Often with support or technical assistance from Justice for Vets, based at the National Drug Court Institute in Virginia, VTCs are encouraged to follow evidence-based practices and assisted in doing evaluations to ensure that good outcomes and practice are maintained, as well as making outcomes known for accountability sake.

The San Diego VTC is an excellent example of an effective Court team that yielded a zero percent recidivism rate, which is believed to be related to its systematic data collection process that was used to inform individualized treatment plans for participants. (Derrick, et. al. 2017)

Additional outcomes indicated that San Diego County and the State of California avoided \$1,415,435 in jail and prison costs due to 41 participants being monitored by the court in the community, rather than being jailed. San Diego County also avoided more than \$712,000 for housing and therapy costs covered by the VA for client residential treatment (CVLTF, 2013).

One of the resources that was developed at San Diego’s VTC out of a need to provide culturally competent treatment for combat veterans who have been convicted of Intimate Partner (IPV) or Domestic Violence (DV) was the creation of the *Family Recovery Program (FRP)*. The FRP is part of an array of treatment services offered by the San Diego Vet Center and has provided treatment to 60 veterans since its first group in January, 2012. The FRP is based on the connection between combat trauma, domestic violence, and the damaged relationships within the veteran’s family. The group intervention program is 52-weeks in length and is designed to cover the State-mandated DV curriculum topics and additional treatment to address the unique needs of veterans with trauma exposure and other military-related behavioral problems. By providing an alternative approach to the dominant “Power and Control Wheel” explanation and approach for treating DV, the FRP has supported hundreds of veteran family members through difficult transitions with reintegration of the Veteran into the family and community.

Despite the existence of VTCs for several years, no evaluation of these courts throughout CA took place until the Fall of 2015 when the California Veterans Legal Task Force (CVLTF), a community-based legal advocacy and pro bono services coalition, developed a survey to learn what was actually happening in California VTCs. Twenty courts responded to the survey which has provided a snapshot of VTCs. Some of the key findings described by the authors were:

“With only 8 courts providing data, the most common offenses of participants were:

- 1) Driving Under the Influence 30%*
- 2) Drug possession 17%*
- 3) Domestic violence 15% (even though some VTCs do not admit DV cases)*
- 4) Other violent offenses 12%*
- 5) Crimes against property 12%*

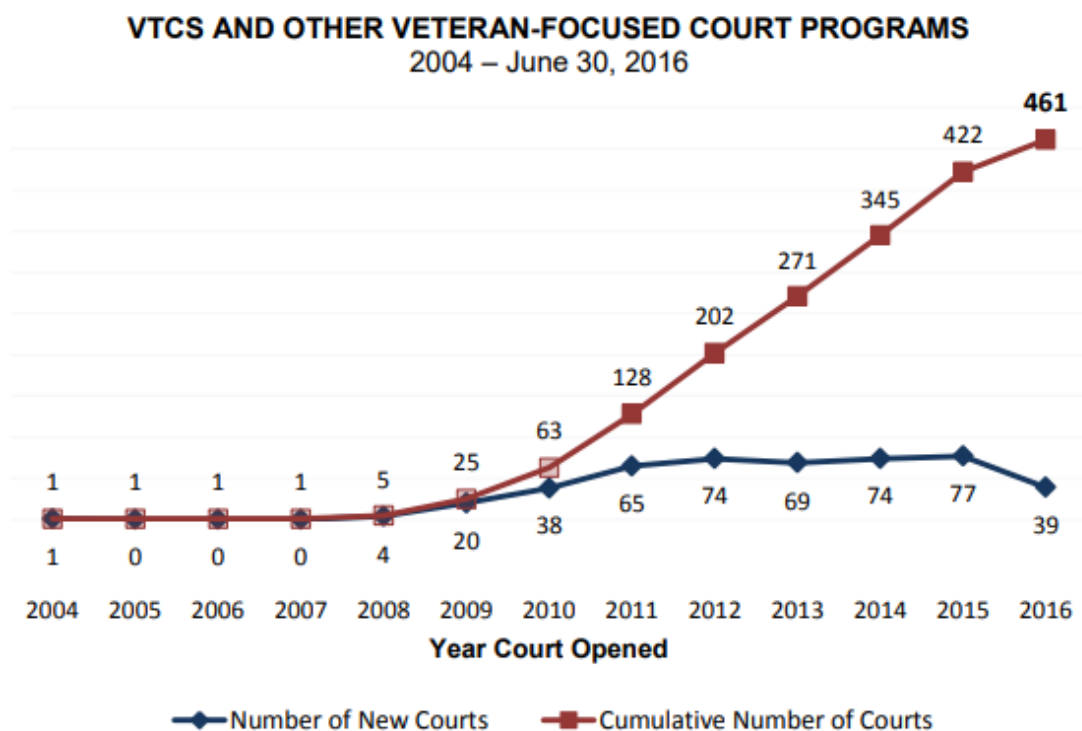
These data suggest tendencies of veterans toward self-medication and violent behavior. Also, nearly half of VTCs created a veteran-specific alternative to the mandated batterers’ intervention program, authorized by PC § 1203.097(a)(6). Plus, a majority of VTCs entertain family reunification, in contrast to the usual approach to DV; this approach sometimes includes modifications to protective orders. Very few removed protective orders prior to graduation from the VTC program.

- VTCs adopt a wide variety of eligibility criteria. One-fourth of them require VA eligibility in order to be admitted to the court.*
- Numerous agencies, including VA, identify and refer veterans in their systems to VTC, where, for the most part, admission decisions are made following discussion among the VTC teams.*
- During supervision, a wide variety of service providers are utilized in the creation of treatment plans. But VTC teams have little knowledge of the mental health treatment capabilities of local military installations.*
- Less than 40% of VTCs divide their programs into phases or levels. Phases are differentiated mostly by frequency of court appearances.*
- Despite the fact that PC § 1170.9 paragraph (h), which provides for restoration of rights to compliant VTC graduates, has been in effect for three years, less than half of VTCs had provided restorative relief thus far.”*

The full report and raw data are available at: <http://www.cvltf.org/files/120643618.pdf>. This brief, but helpful survey summary has not generated much concrete action to date, however a study about the needs of counties without VTCs and the functioning of existing VTCs was begun in June 2018 by CJER with a report due in June 2020. This timing may provide an opportunity for collaboration across the VTC community with Veteran mental health service providers and CAVSA advocates.

Figure 12. Operating Veteran Treatment Courts Nationwide as of June 30, 2016.

Source: USDVA. Veteran Justice Outreach Program .



Although **Figure 12** reflects national data, this shows the rapid rate at which VTCs have been implemented across the country. Considering that California has more veterans, more military installations, and the largest State National Guard of any state, it is worth exploring why California’s VTC growth trajectory has not been greater.

As described in **Section V**, the Veteran Mental Health survey findings showed the perception of support for VTCs in the respondents’ local communities throughout California, however also revealed considerable confusion about how they operate, eligibility questions, and whether or not they were still operating. These basic questions voiced by many who self-describe as “veteran advocates” is of concern and suggests that more education, outreach, and statewide activities to raise the profile of VTCs is required. Since the diversion from serving jail and prison sentences and the critical expungement of conviction records has been a long-sought policy achievement and judicial reform for our veterans, it is imperative that California ensures that access to these important Court settings is made available and taken advantage of by all eligible veterans in California.

With just 33 VTCs in California (as of 2017), with limited and variable caseloads, it’s clear that

not all justice-involved Veterans will be able to participate in a VTC. As was mentioned earlier, even though PC § 1170.9 and PC § 1001.80 can be used to provide relief from sanctions and opportunities for therapeutic diversion outside of formal VTCs in any Court, they are not widely used nor even widely known. Because many misdemeanors carry little jail time, often due to jail crowding, and because VTCs require a long-term commitment and therapeutic engagement, some veterans choose the conviction as a more expedient way of dealing with an arrest without full appreciation of the long-term consequences of having a conviction on their record when an expungement could be available.

To help inform veterans of the benefits of these diversion programs, as well as the Service Members Civil Relief Act (50 App. U.S.C. 501-597(b)) the “Mil 100 Form” was created by the California Judicial Council to also improve identification of Veterans in Court. Not all Courts use the form even though it is intended for use in all dockets, including Family and Civil cases. (California Judicial Council). Creating educational programs to inform veterans of these therapeutic options is another avenue veteran advocates can embrace.

Veteran Treatment Courts are one of the strategies promoted in the “Comprehensive Addiction and Recovery Act” and the “21st Century Cures Act”, federal laws passed in 2016 to help combat the opioid epidemic which disproportionately has affected veterans nationwide. CARA expands access to prevention and treatment services for veterans at risk of an opioid related overdose in several ways. First, CARA provides grant-based funds to states, local governments, or nonprofit organizations for establishment or expansion of one of the following programs to provide Substance Use Disorder (SUDs) and Opioid Use Disorder (OUD)-related services for qualified veterans:

- Veteran Treatment Courts (VTCs);
- Peer-to-peer services;
- Practices that identify and provide treatment, rehabilitation, legal, transitional, and other appropriate services to qualified Veterans who have been incarcerated; or
- Training programs to teach criminal justice, law enforcement, corrections, mental health, and substance abuse personnel how to identify and appropriately respond to incidents involving qualified veterans.

CARA also requires the VA to expand its Opioid Safety Initiative (OSI) to include all VA medical facilities, to ensure that all VA physicians treating Veterans for pain have access to state Prescription Drug Monitoring Programs (PDMPs) to determine whether the patient has been prescribed opioids outside of the VA facility, to expand its Overdose Education and Naloxone Distribution program, and eliminates naloxone copayments for veterans at high risk of opioid overdose, as well as provides education to veterans overdose reversal. (Hernandez-Delgado,

2016) As of October 2017, California was one of only four states that requires PDMP only on a weekly basis; most other states require daily reporting, and Oklahoma has real-time reporting which has proven very successful in increasing prescriber compliance and improved monitoring. (Pew Charitable Trusts, 2016)

With the recognition by many Sheriffs and Correctional Officers that their jails and prisons have become defacto community psychiatric units, they are developing “Veteran dorms” or “vet pods” to enable veterans to receive therapy and behavioral health support while serving their sentences. As of 2012 only Santa Clara and San Francisco Counties in the Bay Area tracked veterans in their jails (Veterans Behind Bars), however similar programs now exist across the state.

The San Francisco program, “COVER”, has a special case manager whose position is paid for with pre-trial diversion funding to provide services for non-VA eligible veterans who often fall through the cracks in other jurisdictions. As of 2014, San Diego County also began tracking veterans in their jails and had opened two “Veteran Dorms” in their jails exclusively to house veterans in therapeutic settings. VA Veteran Justice Outreach (VJOs) workers also support the “dorms” with case management to support veterans and assist them with benefits applications and re-entry support to ease the jail to society transition more smoothly than the military to civilian transition took place. No studies or research publications are yet available on these programs so their effectiveness is unknown. A webinar lead by Major Evan Seamone describes the approach and what is known to date about the experience. (Seamone)

To learn more about the viability and concerns with this model, engagement with San Diego’s jail would be very valuable to consider for many reasons. The old adage of “3 hots and a cot” describing jail as better than homelessness and isolation, may be especially applicable for veterans for whom loyalty, group purpose, attachment to their Unit, and barracks identity may be healthily replicated in the jail “Veteran dorms”. Several newspaper accounts in the San Diego Tribune and the Washington Examiner describe the current status of this uncontrolled experiment, but no systematic evaluation has yet been published.

Veteran Homelessness

Unfortunately, veteran homelessness is not a new concern for California or the nation, rather it remains a leading and foundational problem underlying or intertwined with the above leading concerns of substance use disorders, suicide, general mental health, and justice involvement that are priorities for CAVSA veteran agencies and advocates. Thirty years ago the Institute of Medicine (IOM) described homeless-related health problems as 3-pronged: health problems caused by homelessness, health problems that cause homelessness, and health conditions that are difficult to treat because of homelessness (IOM, 1988). This reality persists today and is a core premise of the “Housing First” model that posits that people are better able to move

forward with their lives if they are first housed. While this model has had considerable success, it also is challenged in its implementation with chronically homeless persons with mental health challenges for whom the routines of daily living are sources of distress and for whom traditional shelter has become foreign. Nonetheless, the “housing first” premise is in keeping with Maslow’s 1943 “Hierarchy of Needs” (Maslow) (**Figure 13** below) which asserts that shelter is foundational to human motivation, welfare and optimal development. With this value in mind, CAVSA agencies are committed to continue to advocate for improved housing options and supportive services to provide homes for all of California’s veterans and their families.

Figure 13. Maslow’s Hierarchy of Needs. Reminder of shelter as a fundamental need.



Community-based veteran service providers across the State as well as the VHA and VBA have been and are currently actively addressing the needs of homeless veterans with many varied approaches. The AHAR 2017 report, CalVet resources, the National Coalition for Homeless Veterans, as well as the CAVSA member agencies all provide a window and expertise onto this issue. Challenges with housing for veterans has emerged as the topic of greatest concern, cross-cutting other mental health issues as this report has been developed. (NCHV; CalVet; AHAR) Outreach programs, adaptations of Housing First models, VA Homeless Patient Aligned Care Team (H-PACT) programs that feature social determinants of health in care delivery, and innovative programs like Safe Parking that has been implemented since 2004 and is re-emerging as an stopgap measure for unsheltered veterans are viewed as the arsenal in this intransigent Homefront battle.

According to the AHAR 2017 report, Los Angeles is at the epicenter of the current halt in progress toward ending veteran homelessness, experiencing the largest increase in veteran homelessness, with 3,046 more individuals with chronic patterns of homelessness in 2017 than in 2016 – 33% of the total increase nationally in the “major cities” Continuum of Care (CoC) category. “While the number of unsheltered individuals with chronic patterns of homelessness in major cities in 2017 was lower than it was in 2007, it has risen steadily since 2014. Much of the variability is related to fluctuations in the number of unsheltered chronically homelessness

individuals in Los Angeles. Removing Los Angeles from analysis shows unsheltered chronic homelessness in major cities declining each year between 2011 and 2016, but increasing by 34 percent in the last year.” (US.HUD., AHAR, 2017)

One of the primary problems cited by veteran housing advocates in California, as well as nationally and repeatedly expressed in the open-ended responses to the Veteran Mental Health Survey discussed in **Section V**, is the absence of a dedicated and adequate funding stream to provide mental health and related supportive services to veterans in the context of housing. Although California is leading the nation with progressive legislation like the Veterans Housing and Homelessness Prevention Program (VHHP) which provided \$600 million in 2014 via voter-approved Proposition 41 to fund affordable multifamily rental, supportive, and transitional housing, very little housing has been built due to legal challenges. This progressive legislation is especially important for California with its large population of National Guard members because of the particularly broad definition of “veteran” for whom it applies. VHHP extends eligibility to “veterans” to include National Guard called to Active Duty or services for at least 90 consecutive days and also includes service members discharged with “Other Than Honorable” (OTH) discharge status, unlike other housing eligibility guidelines. It is hoped that the VHHP implementation challenges can be resolved with the passage of Proposition 1 and Proposition 2 on the 2018 ballot, but the equally great challenge of providing supportive services will remain unsolved.

Currently, the requirement that VHHP settings provide supportive services is typically met through the use of Veteran Affairs Supportive Housing (VASH) project-based vouchers (funds that stay with the project when/if the housed veteran moves) in which case management and clinical services are provided by the VA, however these services are frequently inadequate and lead to poor outcomes and high housing turnover for veterans. The over-reliance on HUD-managed VASH vouchers with services managed by the VA has been a source of poor service delivery and congested bureaucracy which many advocates had hoped would be eased with the MHSA prioritization of veterans as a special category for service delivery. Although MHSA special status for veterans has only recently been established, CAVSA’s 2017 review of several County MHSA plans and this report’s review of five counties, described in **Section V**, indicate that compliance is spotty. Given that the need for mental health and supportive services alongside access to housing is critical for California’s veterans and their families, it is urgent that MHSOAC establish measures for accountability and transparency of veteran services planning and funds disbursement, along with the other special populations – many of which overlap with veteran communities as well.

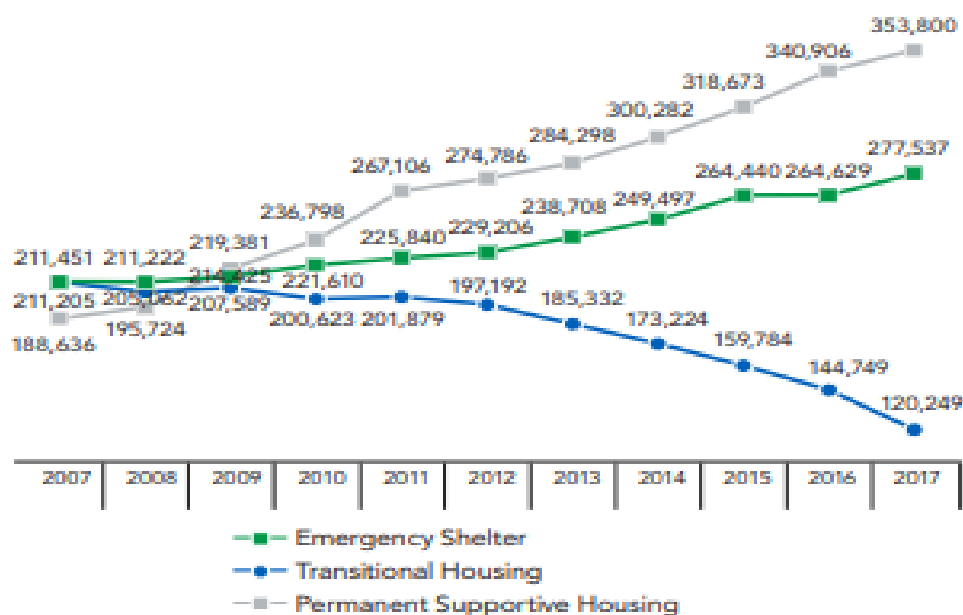
As older veterans (age 51 or older) have come to represent 50% of all homeless veterans, the cost of care is projected to increase dramatically with this population’s chronic health problems and anticipated increase in homeless veterans over the age of 55 over the coming decade. Post-Vietnam-era veterans represent a growing portion of the veteran homeless population but are underserved by federal assistance programs. For instance, eligibility for VA Non-Service-Connected Pension benefits is limited to those veterans who served during wartime. This large

segment of today's homeless veterans are not eligible for these subsistence pensions, although it is established that access to this important benefit reduces risk.

Without stable housing and access to supports described above, many homeless veterans cycle from one emergency system to the next – to shelters, public and VA hospitals, psychiatric institutions, detox centers and back to the streets. The lack of funding for sufficient clinical and case management staff to cover PSH sites which increasingly house very high acuity, chronically homeless veterans, translates into the inability to keep these veterans housed, stable, and safe. Both human and economic terms, there's an enormous cost to this "institutional circuit", where a series of institutions provide sequential stints of housing instead of stable, supportive, community-based housing.

Figure 14. Inventory of Beds for Homeless and Formerly Homeless (in PSH) with Decline in TH.
Source: AHAR Report 2017.

EXHIBIT 7.1: Inventory of Beds for Homeless and Formerly Homeless People 2007–2017



Note: The number of Permanent Supportive Housing beds in 2015 is lower than originally reported in the 2015 AHAR. The PSH inventory was reduced by 539 beds in the Riverside City and County CoC.

To try to address this, 16% of all beds nationally (141,541 beds) were dedicated to households with veterans. More than 70% of beds dedicated to veterans were Permanent Supportive Housing (PSH) beds. PSH beds dedicated to veterans accounted for 28 percent of all PSH beds. (AHAR, 2017) Simultaneously, transitional housing has dropped dramatically over the past 7 years as **Figure 14** above shows, creating "catch 22s" for many Veterans who are trapped in PSH settings, which cause them to forego employment and momentum towards independence

due to the need to maintain their eligibility for PSH. This may be especially true for women Veterans and those with children who are often prioritized for PSH, even without meeting the PSH entry criteria of having permanent disabilities, chronic illness, severe mental illness or SUDs or long-term or repeated homelessness. Finding the balance in housing settings and directing the right individuals to those settings defines the task ahead.

Veteran Health Administration (VHA) Utilization in California

A commonly held belief is that 1) all Veterans are eligible for free care at the “VA” and 2) that most Veterans use the “VA” for care. Distinctions are often not made between the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) although they provide different services and benefits - both of which are relevant to the mental and behavioral health of California’s Veterans. In fact, according to the VA’s Expenditure and Utilization data for 2017, only 30% of Veterans (6.1 out of 20 million, VA 2017 data) use VHA services and less than half receive benefits from the VBA nationally with State variability. For example, North Dakota has a 37% utilization rate, whereas only 27.7% of California’s Veterans (465,607 out of an estimated 1,681,730) received any care at a VHA facility in 2017. (USDVA, NCVAS) Swords to Plowshares recent data for senior Veterans (age 55+) use of the San Francisco VHA (SFVAHCS) corroborates this data, finding that 71% of Veterans in this age bracket are not enrolled in VA healthcare. Furthermore 61% (3,089) of San Francisco resident SFVAHCS patients ages 55 and older have non-VA insurance coverage and seek care outside of VHA for additional care.

Although the VA is routinely criticized for flaws, the VHA leads the nation today in the provision of specialized geriatric care. As a specialization that is inherently one of the most difficult and often depressing for both physicians and support staff, there is an enormous shortage of geriatric care across the country. At a time when the general population is aging, the VHA competes with private sector systems for talent and has developed an excellent reputation for high quality training programs and leading-edge work on palliative care. The “gerischolars” program is an example that encourages work with community-based providers and caregivers as well.(USDVA, Geriatric Scholars)

With 45 FTE geriatric/palliative providers across the VA system, no health system has as many care teams, known as Geri-PACTS (Patient Aligned Care Teams), dedicated to the geriatric population. Like the H-PACTS mentioned earlier that specifically specialize in caring for homeless Veterans, Geri-PACTS have unique staffing requirements that differ from the private sector with support staff, such as case managers, psychologists, social workers, physical and occupational therapists, etc., as key drivers of both productivity and improved patient outcomes. With the recognition that wait times, transportation issues, and other challenges are issues, Veterans have been given increasing options for choosing their care providers (for example through the CHOICE program. (USDVA, VCP-CHOICE)

When older veterans access care from the community, the Geri-PACTs are forced into a co-managed care model which can be significantly less productive and problematic for all concerned. Patients and both VHA and private sector providers face challenges with test results, care documentation, procedures, etc. that can be economically and medically costly.

Overall, throughout California, Veterans have not been tracked outside of VA and veteran-specific services. Providers of mental health and other services are generally unaware how frequently and how veterans engage with and access non-VA systems-of-care. Given that such large numbers of veterans do not access VHA care, it is crucial to research this population who are often in multiple systems of care.

VA Access Issues Coupled with Challenges of Veteran Population

California's relatively low utilization rates occur despite having 10 Inpatient Care sites, 60 Outpatient Care sites, 30 Vet Centers, 13 National and State Cemeteries, and 3 Regional Offices - comprising 5 to 10% of those facilities nationally. As **Map 4** below depicts, California's vast geography with mountain, desert and forest natural barriers means that VA facilities may be a half-day or more drive away. Especially for Northern and Eastern California Veterans, it is often easier to access care in Arizona, Nevada, or Oregon rather than Los Angeles, San Francisco, or Sacramento facilities. Or, as is the case for those who have alternative health insurance, they get care elsewhere, or forego care altogether rather than navigate the VA. Because Veterans are entitled to services and so many Veterans do not have alternate care options, important discussions must occur to ensure that community providers and the VHA work together to improve access, patient monitoring, and cross-systems care management. Telemental health options have expanded considerably to help support services for California's rural veterans with promising outcomes suggested by a large-scale 2012 study; further coordination of these services is warranted with community providers. (Godleski, et al)

Table 5. Gulf War Veterans: Largest Veteran Cohort as of 2017

Rank	Cohort	Veteran Population
1	Gulf War* Era	7,271,000
2	Vietnam Era	6,651,000
3	Korean Conflict Era	1,475,000
4	World War II Era	624,000

* The Gulf War veteran cohort includes those who served anytime after August 2, 1990 during Operation Desert Shield and Desert Storm to the present recent Post-9/11 veterans.

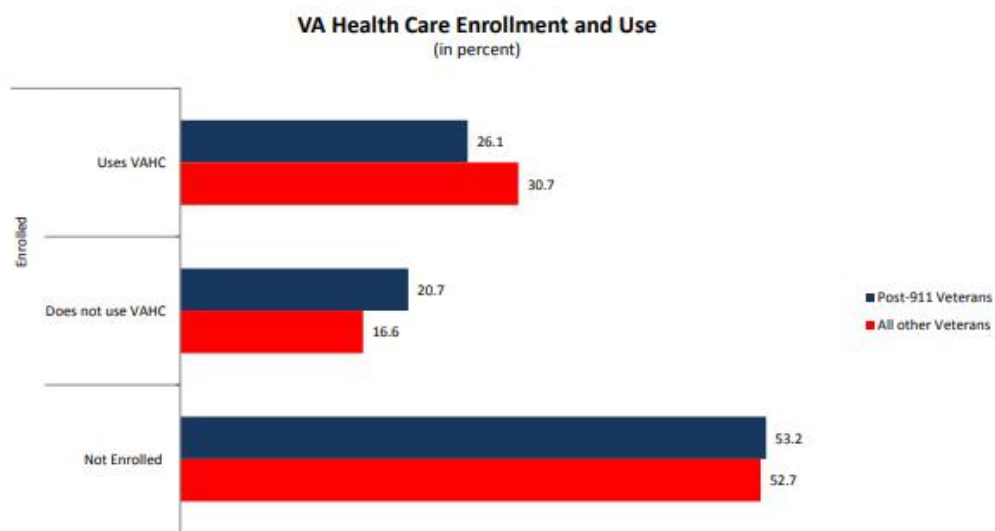
Map 4: Facilities in California



Increasing care for California's aging Veteran population must occur while also expanding access to short and longer-term services needed to care to our Gulf War-era veterans who became the largest veteran group in the U.S. beginning in 2017.(See **Table 5** above.) (USDVA, NCVAS)

Figure 15. Post-9/11 Veterans Low Utilization of VHA Nationally

A lower percentage of Post-9/11 Veterans enrolled in VA health care than all other Veterans. Of those enrolled in VA health care Post-9/11 Veterans used VA health care at a lower rate than all other Veterans.

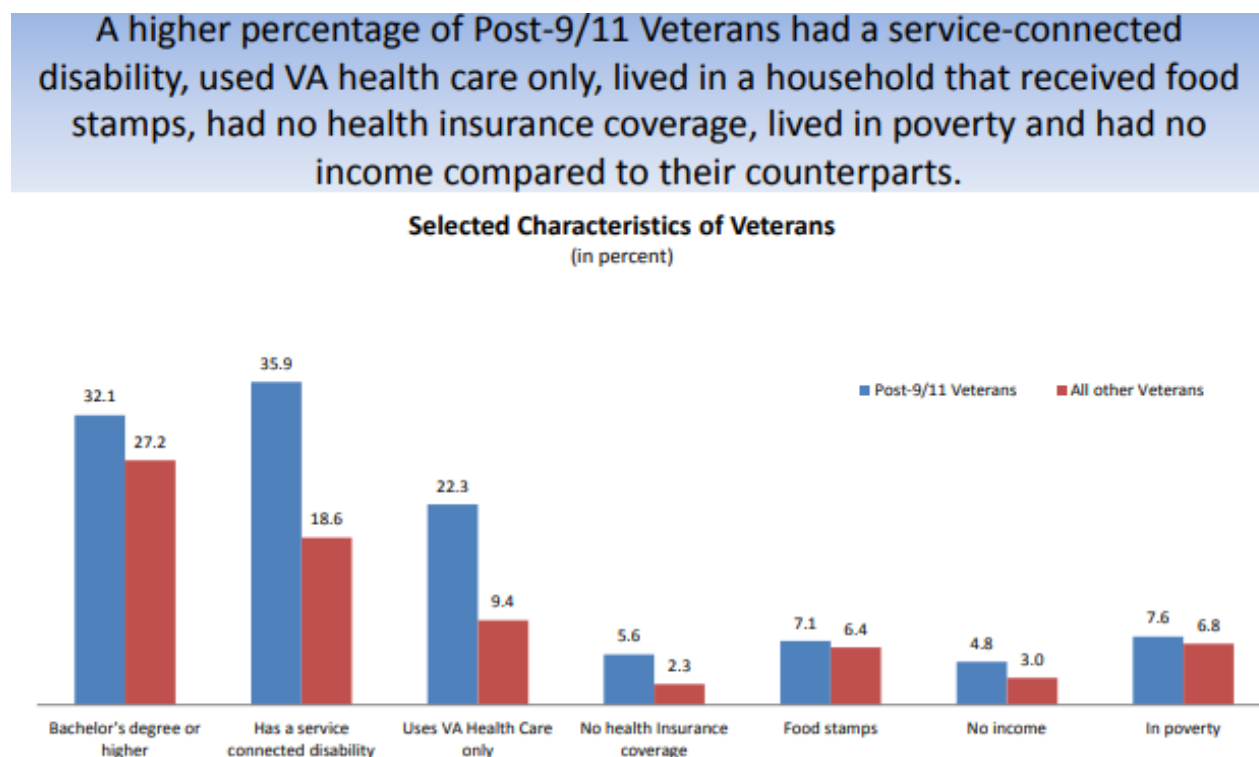


Source: USVETS, 2015
Prepared by the National Center for Veterans Analysis and Statistics

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Figure 15 shows national data on Post-9/11 Veterans enrollment in and VHA utilization compared to all other era Veterans. This cohort's lower use of federal VA services coupled with their higher rates of service-connected disability and related livelihood challenges shown in **Figure 16** below is cause for concern. In the context of the recent increasing rates of homelessness, suicide, and justice involvement discussed above, it's important that communities become proactive about Veteran mental health.

Figure 16. Higher Percent of Post-9/11 Veterans with economic and health challenges



V. VETERAN MENTAL HEALTH SERVICES IN CALIFORNIA

For nearly fourteen years, since the passage of the Mental Health Services Act (MHSA) in 2004, California has been fortunate to have a relatively steady funding stream for not only the delivery of mental health services, but for the overhaul of the systems of delivery as well as cultural norms, stigma, and biases about those with mental illness. “The goal of the Act is to transform the community mental health system into one that is client- and family-driven, accessible, culturally competent and recovery-oriented.” (CA DMH, 2005) From its outset the California State Department of Mental Health (DMH) prioritized services to target populations, including transitional age youth (TAY), children, youth and families, and older adults with mental health needs.

Support for stakeholder advocacy and community-based initiatives to improve mental health services has also been longstanding. In 2011, when DMH was dissolved and responsibilities for mental health were transferred to the Mental Health Services Oversight and Accountability Commission (MHSOAC), veterans were added to the list of stakeholder groups to be funded on a competitive basis. This CAVSA report is funded within the MHSA stakeholder advocacy program. Additional funds are allocated by MHSA to the California Department of Veteran

Affairs (CalVet) to support resources and referrals links to County Mental Health and non-profit agencies for Veterans seeking mental health services. (CalVet, Mental Health)

The Legislative Analyst Office (LAO) January 2017 report “Understanding the veteran Services Landscape in California ” was directed by the Legislature due to 2016-17 budget discussions interest in better understanding California’s state-funded system of eight Veterans’ Homes. Like other long-term care facilities, the Veterans Homes primarily serve older veterans with about 80% of veteran residents over the age of 65 and 34% 85 years or older. Prior to the allocation of \$600 million through the California Veterans Housing and Homelessness Prevention Program (Prop 41), the Veterans Homes funding of \$315 million General Fund in 2016-17 was the largest single State allocation for veterans direct services. Although neither of these programs are mental health programs per se, the Veterans Homes provide basic mental and behavioral health support, on par with private sector assisted- living “nursing homes” or “senior living facilities” without the capacity to assist veterans with complex mental and behavioral health needs. Reports from referral agencies indicate that most of the State-run Veteran Homes will not accept veterans with histories of mental health or substance abuse, citing inadequate staffing to adequately care for such residents. About \$90 million of the \$315 million was estimated to be offset by USDVA reimbursement, Medi-Cal, and Medicare reimbursements and about \$25million from resident “member fees”. (CA LAO)

The LAO report’s concluded that the mental and behavioral health services system that was available for Veterans is offered through the federal VHA and is comprised of Vet Centers, Community Based Outpatient Clinics, and VHA Medical Centers as shown in **Table 6** below.

Table 6. Mental and Behavioral Health Services Offered at VHA Facilities in California. Source: CA LAO Report.

Mental and Behavioral Health Services Offered at VHA Facilities	
Facility Type	Services Available^a
Medical Centers	General and specialized outpatient programs. Immediate onsite emergency care. Some inpatient programs available. Medications available onsite.
Community-Based Outpatient Clinics (CBOCs)	General and specialized outpatient programs and medications available onsite and via telemedicine.
Vet Centers	Free readjustment counseling for veterans and their families. Does not require VHA health care eligibility.
^a Reflects services generally available at each facility type, though specific services may vary by location.	

Key Interviews Summary

As part of developing this report, the report consultant (K. West) held scheduled interviews in May, June and July with five Veterans Services leaders to gain their insights into the most important issues they perceive with the State of the California Veteran Community today.

The interviewees were selected on the basis of their expertise in their topical area, experience in and commitment to the field of Veteran advocacy and services, as well as their long familiarity with Veteran work in California. Two of the male and one female interviewees are veterans from the Vietnam era, and the other two interviewees are non-veteran females. Four of the five interviewees are currently located in more urban areas, with one in a semi-rural area; all have worked in multiple sites and capacities in their careers with Veterans.

The interviews each took about an hour and followed an open-ended format led by their answers to the topics. De-identified notes from the conversation are available upon request. A summary of the issues they brought to the discussion are listed below:

Leading Concerns of Key Interviewees, Leaders in California Veterans Services Delivery:

1. Older Veteran care issues with emphasis on growing percentage of homeless older Veterans; access to and management of care services; slide into poverty; increased risk for suicide; chronic conditions lead to costly care that ultimately may be futile and failure to provide more appropriate, lower-cost preventive care earlier in their care history; polypharmacy issues
2. Housing challenges and transportation to all resources in semi-rural setting – which requires additional funding and support staff; “catch 22” of PSH when (low) income eligibility criteria inhibits residents from taking initiative to improve or gain work situation. “Warm hand-off” referrals and after-hour solutions for crisis mental health care between community-based providers and medical providers for example with suicidal ideation; access to and “compliance” with VHA providers appointments at great distances can inhibit gainful employment.
3. Veteran Treatment Court services for veterans with Domestic Violence convictions in criminal setting; concern about stigma associated with perpetrators of domestic violence among Veterans without regard for effective targeted Veteran-specific treatment distinct from non-veteran perpetrators; based on careful assessment; need for therapeutic housing to cushion against SUDs relapse in Court setting; importance of coordinating VTC with other open court cases, ie: family court, traffic, etc.

4. Housing in continuum of settings: Pros/cons of transitional housing vs PSH and need to find beds - any bed, regardless of type - for women veterans and especially for women as heads of household with minor children; need to manage female veteran MST issues sensitively while acknowledging that more male vets (numbers, not percent) experienced MST and experience trauma and stigma in disclosing; absence of choice in appropriate bed types (ie TH, vs PSH) leads to rush to placement when a setting becomes available; concern re: long-term issues with PSH as dominant preference.
5. Value for funds invested and need to maximize funding streams; need to connect and enroll (file claims) eligible veterans with all services for which they are eligible; “knock on all doors”; monetary value, social connectedness and support; unexpected opportunities and patience/skill-building in having systems navigation skills modeled for young veterans especially those with little experience; rural area advocates rely on networks to get things done and match services to client needs to degree possible.

In the course of these interviews, the topic of housing and homelessness were repeatedly raised – both as stand-alone concerns in direct client services and clinical care, and with regard to allocation of resources, types of housing settings required in various counties in California at this time, and policies that inhibit higher functioning veterans served in Permanent Supportive Housing from becoming more autonomous and potentially moving from PSH settings to work and independent living, including availing themselves of Veterans Home Loan programs. Since PSH settings now constitutes the majority of veteran housing in California this is a concern. Such services and housing supports are clearly needed for veterans with high acuity, but the decline in transitional housing has translated into veterans – especially women veterans with children – being placed in housing settings that does not match their needs nor encourage a trajectory of healing and self-determination.

Highlights of Findings from Veteran Mental Health Services Survey

The CAVSA Veteran Mental Health Services Survey was developed to allow for more voices to be heard and directly included in this first “State of the Veteran Community” report. The survey findings augment the Key Interviews and generate a snapshot of the current impressions and experiences of a wide-range of Californians who are working in mental health and related areas that affect California Veterans and their families in 2018.

The full “Preliminary Findings report of the CAVSA 2018 Veteran Mental Health Services Survey” is available as a stand-alone report.

Primary strengths of the survey are:

- 1) the relatively large sample size of N=201, representing input from three-fourths of California's counties,
- 2) the local knowledge that was shared about Veteran mental health services and challenges throughout the State, and
- 3) the rich narrative input that was generated through the open-ended responses that were elicited.

Biggest Challenges

Open-ended Question 64: *“The biggest challenge you face in serving Veterans in your county is:…_____”* is an example of a question that generated lengthy and thoughtful responses with an overwhelming majority of responses including “housing” as their biggest challenge. Affordable and safe housing dominated responses from every part of the State, often in connection with other issues, including substance abuse treatment, mental health issues, transportation, and funding as top concerns.

Open-ended Question 63: *“From your experience the most pressing problem your county has faced in working with Veteran families is: …_____”* yielded similar answers to #64 with regard to Housing being the most frequently reported challenge, however the additional comments included, stigma, inability of providers to serve Veteran families since eligibility is only for Veterans, lack of services, and domestic violence.

Veteran Families

Services for Veteran families are largely unavailable; 60.2% of respondents reported that their agencies do not allocate funds for families; 20.4% were not sure, and 19.4% reported that their agencies do allocate funds for families but only 23% of those who said “yes” gave actual amounts of funding, with most saying they didn’t know but believed some funds were allocated. 27% didn’t know. About half of respondents said their agency keeps track of veteran family members served, 33% said no. Of those that kept track of veteran family members served, the median was 10% of total clients. The majority of respondents didn’t know much about Veteran family members; 43% said they didn’t know if there were mental or behavioral health services for families in their counties, 25% said no, and 32% reported yes. There was also general, though slight disagreement (mean of 2.5 and 3.0 median on 5-point scale) that “Veteran Family Members have their mental health needs met”.

The absence of services for Veteran families is of serious concern. Families not only are the primary support network for Veterans and often the first to identify mental health problems

that Veterans themselves may deny or fail to recognize, but segments of Veteran family members are at disproportionate risk for anxiety, substance abuse, suicide, and school drop-out and now constitute an at-risk group themselves.

Veteran Mental Health Providers & Services: source, funding adequacy, type of service

More than half of survey respondents (56%) Agreed /Strongly Agreed that the VA is the Primary provider of mental health services for Veterans in California; only 14% disagreed. Some of the expanded comments about this included varying perspective that Veterans DO or Do NOT prefer the VA compared to civilian providers for mental health care. Long wait times in both VA and non-VA systems were mentioned with discussions of the Veterans' CHOICE program and availability of non-VA providers as an issue.

The notion that the VA is the primary provider of Mental Health Services was borne out further among providers who are not at Veteran Service agencies: 85% replied "yes" to Question 75, "when veterans come to your agency, do you refer them to the VA for mental health services?" with those that did not reply "yes", often saying "as needed" or commented that they try to find the best service the client is eligible for and send them there.

While most believe the VA is the primary provider of mental health services, 55% also believe that mental health services are available from County-funded providers for Veterans in their counties with only 15% disagreeing. Many cited MediCal services as a County-based mental health resource for Veterans who may be ineligible for VA care due to discharge status or other issues.

Although respondents felt that County services for Veterans are available, 56% Strongly Disagreed/Disagreed that "mental health services for Veterans are adequately funded to meet the needs of the Veteran population in my County". 35% were uncertain and 9% Agreed/Strongly Agreed. A few in the small percentage that agreed offered comments including: "HHS is doing a good job", and "yes, but not in a focused manner", "yes, but not for hiring high quality personnel". Others commented that "it would be great to have behavioral health staff who were veteran-specific counselors" and another that "there's funding but it's scattered to a lot of different agencies...."

Unlike above questions about availability of care and providers, there was considerable ambiguity about the statement "From your experience, most veterans in your county are able to access mental health services when they need them". 37% Agreed/Strongly Agreed; 34% Strongly Disagreed/Disagreed, and 29% were unsure. This range, with nearly two-thirds being unsure or saying No, was elaborated on in comments indicating unmet need: "Veterans are

routinely denied county MH services. The VA and Medical-accepting MH services take 4-6 weeks to access unless the client is in crisis.”, “Not all qualify for VA health or Medi-Cal”. Those that agreed tended to reflect a minority theme: that services are available when needed, but veterans are unwilling or unable to use them. Stigma related to mental health issues was one of the reasons given for this issue.

Survey item #40 asked respondents to comment about the adequacy of service providers delivering mental health care to Veterans and elicited very negative responses with half 50.3% Disagreeing/Strongly Disagreeing that the “type and quantity of service providers” was adequate to meet the need. 25% were unsure and 25% agreed/Strongly Agreed. The issues for those disagreeing are that veterans continue to suffer with current levels of support and that there is a general lack of awareness of veteran-specific issues and appropriate training for staff as well as a lack of access, especially for those dealing with substance use, suicidal ideation, and homelessness. Even those who agreed, provided comments that support is lacking, especially for rural veterans, and that support was only really available to veterans who sought it out.

Among non VSA staff, 80% replied affirmatively to the question if they had received military/veteran cultural competence training with 75% strongly agreeing/agreeing that it was “helpful in better understanding military/veteran clients”. This is encouraging and suggests that such training is valuable and appreciated.

As suicide has become tragically endemic in California’s veteran population, 54% of respondents think that their Counties are providing “Veteran-focused programming related to suicide prevention, intervention and postvention and/or follow-up services”. Another 29% don't know and 17% don't think these services are offered. Given the significance of this topic, it’s of concern that nearly a third of respondents don’t know whether or not these services exist locally. It’s also encouraging, if borne out by evidence, that Veteran-focused suicide related services are available and known about.

As women veteran suicides continue to grow, the majority of respondents either did not know (30%) or stated that their county does not provide services specifically for Women-Veterans (32%). 37% said their counties provide targeted services to women veterans. Some noted that women-veterans are chronically underserved and that only limited services targeted women veterans specifically, so women rely on general services – either targeted to male veterans or to female civilians. Those who were aware of services noted that they were “few and far between” and cited a lack of funding, awareness, and general support for military-connected women.

Barrier of Stigma

Question 50, “from your experience, stigma associated with getting mental health care is a significant barrier to care for Veterans in your County” elicited more “Agree” and “Strongly Agree” responses than any other, with 62% of respondents concurring. Less than 15% disagreed or strongly disagreed, saying that stigma was not a barrier and they were able to successfully make referrals to mental health, in part because many of their clients are very desperate (eg: homeless veterans). The neutral respondents said that they did not know or that it depended on the age of the veteran, with younger veterans being more open to care. Those who felt stigma is a barrier noted that veterans worry about appearing “weak” or “crazy” if they seek help and that institutions, like college and sports teams, along with the “Warrior Ethos” and small communities where others will “talk about them” exacerbate these challenges.

A very positive finding about stigma is that Veteran status is not perceived as stigmatizing by survey respondents; 41% “disagreed strongly” and 23% “disagreed” for a total of 64% rejecting the idea that “there is a negative stigma associated with being a Veteran in your County”. 10% agreed and 26% were neutral. Some of the comments noted that this represents a marked societal shift and enormous progress from the experience of Vietnam-era veterans which may still affect them adversely as they age.

Given the widespread sense that stigma in accessing mental health continues to present a significant barrier to veterans getting care but that Veteran-status is not viewed negatively, more peer education and positive messaging about accessing care may be warranted to help reduce this unnecessary barrier to care.

Veteran Treatment Courts (VTC)

Given that a disproportionate number of veterans are justice involved, the survey asked an array of questions about VTCs, including the most basic: is there a VTC in your county? 16% said they Didn’t Know, 9% said No, and 75% of respondents stated Yes. However even among those who said “yes” there was confusion about VTCs when they were asked to elaborate; some were unsure if in fact they were still operating, and were unclear about what they do. 42% were unsure if the VTCs received high levels of support, 17.5% disagreed with that statement and 40.5% agreed that VTCs receive the support of relevant systems in their Counties. This high level of uncertainty about VTCs indicates that education about the programming and its relevance for Veterans is needed.

More survey analyses will be conducted and shared with veteran stakeholders as they become available.

Highlights of Findings from MHSA 3-Year Plan Reviews

Since California counties receive more than \$4.5 billion annually in State support for various mental health programs, including MHSA programs that should fund veteran services, veterans should be receiving adequate funding for their care. (Mental Health Services Oversight and Accountability Commission, MHSOAC) The MHSOAC Fiscal Reporting Tool (See link in **Section VII, References**) enables counties to learn their funding allocation and MHSA online county plans further permit identification of funded programs.

CAVSA as an advocacy group and key stakeholder is eager to help ensure that:

- 1) Counties are committing to provide adequate services to veterans in their 3-Year Plans and

- 2) that there is a correlation between their Plans and actual accessibility and delivery of services to veterans and their families in their communities.

Although ultimate accountability and authority for the disbursement and expenditure of funds is the purview of the DHSC and MHSOAC, the 2018 State audit of MHSA funds made it clear that there has been a large scale failure to do this. As of 2018 such data is not available. (CA State Auditor)

In this context, CAVSA selected five Counties for MHSA Plan review to shed some light on the degree to which counties are including Veterans and their families in their Plans and Annual Reports. The counties of Orange, Riverside, Kern, Monterey and Shasta were selected for the diversity of their geographic locations (See **Map 5**), size of their veteran populations, and characteristics of their catchment areas. MHSOAC's "MHSA 3-Year Plan Instructions" (MHSOAC Plan Instructions) are therefore critical to ensure that despite the wide range of environments that California Veteran service providers and veterans experience, there is a minimum "floor" for mental health services. The Plan Instructions help serve as guideline whereby progress toward the goal of equitable access to mental health services in every California county can be measured.

The full detailed Plan Reviews are available in a separate CAVSA 2018 report.

Map 5. Five Counties MHSA 3-Year Plan Review



As described in **Section II**, CAVSA made an effort to standardize the Plan Review process by using the “MHSA 3-Yr Plan Instructions” as the criteria for evaluating the Plans. The resulting seventeen variables were identified and a scoring system of 1-4 was devised as noted below.

Thirteen Key Variables assessed in MHSA 3-Year Plans and Annual Updates

- 1) Veteran stakeholder (VS)
- 2) Veteran organization representative stakeholder (VORS)
- 3) Veteran family member stakeholder (VFS)
- 4) County demonstrates partnership on:
 - a. Mental health policy
 - b. Program planning

- c. Implementation
 - d. Monitoring
 - e. Quality improvement
 - f. Evaluation
 - g. Budget allocations – any involvement or reference to Veterans on these
- 5) Veteran program or services (VPs)
 - 6) Veteran family member program or services (children, spouse, parents, siblings, etc) (VFPs)
 - 7) Community collaboration with Veteran organizations (CCVO)
 - 8) Military/Veteran cultural competence awareness/training
 - 9) Veteran client-driven
 - 10) Veteran/Military family-driven
 - 11) Wellness, recovery, and resilience-focused for Veteran/military
 - 12) Integrated service experiences for Veteran clients and their families
 - 13) Other stand-alone programs with high relevance for and reference to Veterans
 - a. Outreach for Increasing Recognition of Early Signs of Mental Illness
 - b. Access to Treatment
 - c. Improving Timely Access to Services for Underserved Populations
 - d. Stigma and Discrimination Reduction
 - e. Suicide Prevention.

Scoring:

0= Absent from Plan

1= Present in Plan

2= Involvement or programming is described

3= Involvement or programming is meaningful as evidenced by a description of impact

4= Involvement or multiple programs/services are described or otherwise evidenced throughout the Plan

(Not simply repetition of same program, staff, or stakeholder in multiple places).

In addition to the numeric score, brief narrative description of Veteran programming is included.

Using this scoring tool, the Report Consultant and Research Assistant reviewed a sample of the same plans to gauge interrater reliability and found high agreement. For the counties for which little Veteran involvement was evidenced, there was very high congruity. It became slightly less congruent for Plans with more detailed content and divergence arose regarding which variable to “credit” a score regarding a program or staff member when they had multiple purposes and/or varied roles. Although claims about scientific validity cannot be made, this approach helps to introduce some objectivity about the County Plans resulting in an improved capacity to interpret the review findings on a comparative “apples to apples” basis.

Table 7: Secret Shopper Outcomes Compared to MHSA Plan Review Scores

	CAVSA "SECRET SHOPPER"						
	Comparison of Positive Disposition and Number Services Identified with County Scoring for MHSA 3-Year Plans and Annual Updates						
County & Number & % Vet Pop[^]	MHSA Plan Review Score	Positive Disposition %	Number Services Identified	Attempted Contacts	Negative Disposition	% No Appt, No Referral	% No Contact
Orange 117K 3.7%	18* 24~	80%	20	40	20%	5%	15%
Riverside 133K 5.6%	17	68%	14	28	32%	7%	25%
Kern 46.4K 5.2%	5	75%	12	24	25%	4%	21%
Shasta 16K 9.0%	3* 3~	77%	13	26	23%	3%	19%
Monterey 18.4K 4.4%	0	66%	16	29	35%	17%	17%
All	NA	73%	75	147	27%	7%	19%

**MHSA 3-Year Plan*

~MHSA Annual Update

[^]Number and % Veteran Population were included as possible variables of interest; ie: might a greater Veteran presence in numbers/percent yield more positive disposition on calls? This sample is too small to answer definitively, but that hypothesis is not supported with this data.

As **Table 7** Column 1 above shows the MHSA Review Scores ranged from 0 for Monterey County, meaning that no mention of Veterans was made anywhere in its MHSA FY18-20 3-Year Plan, to a score of 24 (out of a perfect possible score of 52) for Orange County's 18/19 Annual Update. The table further shows that Riverside County had a score of 17, Kern had a score of 5, and Shasta County scored 3 for both its 3-Year Plan and Annual Update.

These findings reveal that Veterans and their families were given specific attention in only two of the five Counties reviewed: Orange and Riverside. Veterans were very rarely mentioned in Shasta and Kern County Plans and nowhere in Monterey. This indicates a significant need for county-based education and advocacy to 1) increase County mental health providers' awareness of veterans and their families as key constituents for their services and 2) equip

them to competently develop and deliver the range of services from prevention to treatment and referral, that California veterans need and are entitled to.

The purpose of displaying the Plan Review comparisons in **Table 7** below was to determine if the Plan Review Scores correlate with the “Secret Shopper” findings to the degree that they are an indicator of service availability, user-friendliness, military cultural competence, etc.

The wide variation in County MHSA Plan Review scores may have several implications:

- 1) it is possible for Counties to follow MHSOAC’s Plan Instructions to develop strong Veteran and Veteran family programming as evidenced by Orange County’s Plans,
- 2) using the Plan Instructions as a criteria for objectively assessing the Plans may be able to serve as an Indicator of actual services performance, at least for counties that are outliers, like Monterey with a score of zero, and
- 3) although the range in scores was large among these MHSA Plan Reviews, they all performed quite closely and positively (14% spread between Monterey with 66% and Orange with 80%) on their Secret Shopper “positive disposition” on calls.

Since the “Secret Shopper” methodology did not actually measure services, only responsiveness to a phone inquiry from a Veteran about services, it is still unclear to what degree the Plan Reviews or the Call Investigation actually reflect service quality for Veterans and their families. With such a small sample, interpretation is open to question, however this preliminary investigation may suggest that County compliance with the key 13 variables in MHSOAC’s Instructions for Plan Development does translate to some degree with improved County Veteran Mental Health Services as MHSOAC intended.

Section VI.

Recommendations

This first report on the state of California’s Veteran community with regard to mental health has tried to be comprehensive in scope within the limits of time and resources. Much more could be said, but actions are needed more than words. To that end, the following five recommendations with twenty-two proposed actions are set forth as they flow from the multiple sources of information discussed in this report, including the Veteran Mental Health survey, MHSA Plan Review, Key Interviews, and reports and data gleaned from the literature.

Table 8. State of the Veteran Community 2018 Recommendations

Recommendation	Proposed Actions
1. Address Housing Challenges for Veterans	<ul style="list-style-type: none">A. Actively engage in state and federal housing policy initiatives. . Support an extension of and additional funding for the Veteran Housing and Homelessness Prevention Program.B. Work to improve Veteran Housing and Homelessness Prevention (VHHP) Guidelines and No Place Like Home (NPLH) Guidelines.C. Focus on older veterans, women veterans, and Post-9/11 veteran families with children as priority populations for housing.D. Seek funding for mental health services and other supportive services to better serve VHHP and NPLH Projects.
2. Expand Suicide Prevention, Intervention, and Postvention Activities	<ul style="list-style-type: none">A. Engage with judicial personnel (Veteran Treatment, Family, Dependency, Domestic Violence, Mental Health, and Homeless Collaborative Courts) to educate about veteran and veteran family suicide.B. Connect with the Military Tragedy Assistance Program for Survivors (TAPS) program and the California Transition Assistance Program to explore postvention/prevention strategy for veteran families and possible collaboration.C. Train first responders, emergency room staff, county veteran service officers, and Employment Development Department personnel on veteran cultural competency and suicide care activities.D. Advocate for veteran- and veteran family member-specific mental health funding at local, state, and federal levels.
3. Expand Advocacy Capacity and Data Collection Efforts	<ul style="list-style-type: none">A. Become a more effective voice for veterans in the development of veteran mental health related legislation.B. Develop key variables and promote the adoption of required demographic and other relevant information (including substance use disorder treatment and opioid overdose data) for veteran mental health indicators across California programsC. Ensure tools to collect mental health treatment & referral data through relational data base; ie: necessary access and data linkages (shared with permissions through networks and MOUs). Focus on improved data collection for women veterans, veteran opioid addition, aging veterans and veteran incarceration.D. Work with VA and rural counties to develop targeted data on opioid addiction rates and programs in high risk rural counties.E. Monitor the October 2018 release of mental health expenditures by DHCS and prioritize in Y2.

Recommendation	Proposed Actions
4. Engage with California Judicial Council on Shared Interest Areas	<ul style="list-style-type: none"> A. Coordinate with Judicial Council’s Collaborative Courts Committee Mental Health Subcommittee and Subcommittee on Veterans and Military to support ongoing education regarding veterans and veteran family mental health and related justice issues. B. Connect with Family Courts at State and County levels to explore diversion programming and co-calendars with Veteran Treatment Courts and Family Court dockets and family treatment programming. C. Continue to explore legislative and policy paths to help expand Veteran Treatment Courts in California.
5. Build Community and Agency Partnerships	<ul style="list-style-type: none"> A. Build connections with community-based non-veteran-specific providers of mental health and social services to serve as their Technical Assistance support on Veterans and Military-connected family issues. B. Engage proactively with Veteran Service Organizations (VSOs) to build stakeholder base. C. Collaborate with CalTAP to a) put veteran and veteran family mental health curriculum online and b) outreach to military installation family readiness officers to provide transition information prior to discharge. D. Develop Veteran Agenda materials for MHSA Stakeholder meetings on how to adapt programs to be more effective for veteran and veteran family population and how to include veterans and their families in the program planning process. E. Continue review of County Mental Health Plans to determine level of program and funding support for veterans among all MHSA-funded agencies. F. Engage more effectively with County mental health plan development to ensure veteran representation.

How we view the State of the California Veteran Community in 2018 with regard to mental health services, mental health status, and well-being of the veterans and their families is based to some degree on one’s point of view, temperament, biases, and sphere of reference. For example, directly addressing the stigma of suicide, confronting the issues of military sexual trauma (MST), and reacting with empathy for our homeless veterans is viewed as progress by some when compared with the past. Some view the persistence of these situations as evidence of lack of progress. How you answer “Is the glass half empty or half full?” may be subjective because California still lacks shared baseline data and agreed-upon variables whereby progress

can be measured. Going forward CAVSA hopes to bring more information to these reports as better data becomes available.

This report is CAVSA's Year 1 effort to bring together objective information using the best, albeit flawed, data available. Coupling this with the most current insights and lived experiences of on-the-ground veteran advocates and mental health providers via the Survey, we have tried to shed light on the most pressing mental-health-related issues facing veterans and their families today in California. It is CAVSA's intention to be proactive in the use of this information to galvanize our current stakeholders and expand our stakeholder base to ensure that the above Recommendations, that directly address the concerns identified in **Section I. Table 1**, are acted upon in the coming year.

To improve data collection internally, as well as ensure accountability and transparency in our actions, CAVSA will develop the means to objectively measure our progress as we undertake the twenty proposed actions over the coming year. We plan to release progress reports on the measures listed and will revisit them as the months proceed to ensure that we are accurately assessing and responding to the changing State of California's Veteran Community. Through collaborative dialogue and actions, we pledge to ensure that the glass is filling – both objectively and subjectively, in the lives of our constituents and fellow citizens and that the mental health and well-being of our veterans and their families has measurably improved by our Years 2 and 3 reports.

Section VII.

Postface

Founded in 1995, the California Association of Veteran Service Agencies (CAVSA) is a consortium of seven non-profit veteran service providers working in partnership to address the needs of California's veterans. CAVSA's geographic diversity facilitates the delivery of direct services in both urban and rural regions throughout the state, stretching from Eureka to San Diego.

As community-based direct service providers, we draw upon our experience working directly with veterans to inform policy and advocate for adequate and accessible services and support. We understand that the obstacles veterans face — including homelessness, poverty and disability — are interrelated and require an integrated network of support within the community and a continuum of mental health and health care. Together we work to improve services for California's veterans and educate our communities about the unique needs of military veterans and their families.

As CAVSA Board Members we are very pleased to be able to share this **2018 State of the Veteran Community Report** with our constituent groups, as well as the public at large, but simultaneously are deeply concerned at the sobering picture it reveals about the many challenges our veterans and their families are facing today. Although our agencies have been, and will continue to, work diligently to address the critical issues identified here, clearly CAVSA cannot solve these problems alone.

We are eager to embark on the actions proposed in this report's **Section VI Recommendations**, including the "Building Community and Agency Partnerships" described in Recommendation 5. CAVSA agencies understand that California's veterans are a very diverse group, sometimes with U.S. military service being their only common denominator. Recognizing that our veterans have many identities as civilians, CAVSA is eager to work beyond the veteran "silo" to better meet the needs of our veterans and their families at all times and in all circumstances. We also hope to help non-veteran service agencies become more aware of the veteran clients they are already serving, and, in that process, help us gather better data to understand where California veterans and their families are receiving care, how they're faring, and what needs are yet unmet.

As the CAVSA Board (listed below) prepares for 2019, we do so with high hopes and with deep appreciation to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for their commitment to veterans as a priority population with regard to mental health services. MHSOAC's vision of equitable access to mental health care for California's veterans has been matched by their willingness to explore how to best fund such care and for that we are very grateful. We are confident this Report will move us closer to achieving improved care for our veterans and their families and look forward to a productive work year ahead.

Sincerely,
Stephen Peck
Stephen Peck, CAVSA Board President
U.S. Vets, President & CEO
www.usvetsinc.org

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Appendix A. Online Veteran Mental Health Survey Questionnaire

CAVSA 2018 Veteran Mental Health Services Survey

The California Association of Veteran Service Agencies (CAVSA) is assessing the Mental Health Services situation for Veterans and their families in California in order to increase, improve and help coordinate access for our growing population of Veterans and family members.

You have been selected to participate as a member of a wide community who either directly works with veterans, work in an area that impacts mental health, or provide mental health services to the general community.

Your insights, opinions and experience are important and your assistance in completing this survey is greatly appreciated! The survey takes about 15 to 20 minutes to complete and your answers are anonymous.

Please share this survey with others in your workplace whose input you think we should have by sharing this link with them. Results of this survey will be shared with all participating agencies.

Thank you for your candid responses!

At the end of the survey you will have the chance to share further information or suggestions in written form.

*** Required**

Demographic questions.

Please answer a few workplace and demographic questions

1. Geographic location by County *

Please select a county from the drop down options below Mark only one oval.

Alameda	Kings	Placer	Sierra
Alpine	Lake	Plumas	Siskiyou
Amador	Lassen	Riverside	Solano
Butte	Los Angeles	Sacramento	Sonoma
Calaveras	Madera	San Benito	Stanislaus
Colusa	Marin	San Bernardino	Sutter
Contra Costa	Mariposa	San Diego	Tehama
Del Norte	Mendocino	San Francisco	Trinity
El Dorado	Merced	San Joaquin	Tulare
Fresno	Modoc	San Luis Obispo	Tuolumne
Glenn	Mono	San Mateo	Ventura
Humboldt	Monterey	Santa Barbara	Yolo
Imperial	Napa	Santa Clara	Yuba
Inyo	Nevada	Santa Cruz	
Kern	Orange	Shasta	

2. Please write in any other counties you work in below:

3. Please select the geographic areas where your clients are from (not necessarily where your worksite is located) * Select all that apply Check all that apply.

Rural Suburban Urban

4. Please elaborate on your above answer here

5. Please select your main field of work: * Mark only one oval.

Veteran Service Agency	Court Criminal	Social Services
Mental/Behavioral Health not veteran focused	Court Family	Legal
Mental/Behavioral Health veteran focused	Court Civil	Medical
	Substance Abuse Treatment	Research/Evaluation
	Housing	Other:

6. Other fields you also work in: If applicable, please select any others that apply: Mark only one oval.

Veteran Service Agency	Court Civil	Legal/Advocacy
Mental/Behavioral Health	Substance Abuse Treatment	Medical
Court – Criminal	Housing Services	Research/Evaluation
Court Family	Social Services	Other:

7. Your primary role at work * Mark only one oval.

Veteran Treatment Court (or comparable veteran court) Member	State Administrator	Advocate
Local Services Coordinator/Administrator	Direct Service Provider (Community Based)	Peer Navigator
	Volunteer	Researcher/Evaluator
		Other

8. Your secondary role at work * Mark only one oval.

Veteran Treatment Court (or comparable veteran court) Member	State Administrator	Advocate
Local Services Coordinator/Administrator	Direct Service Provider (Community Based)	Peer Navigator
	Volunteer	Researcher/Evaluator
		Other:

9. Are you a County employee? * Mark only one oval.

Yes	No
-----	----

10. Is your position primarily County funded? * Mark only one oval.

Yes	No	I don't know
-----	----	--------------

11. Your field of study * For example, business, mental health, substance abuse treatment, law, social work, etc.

12. Your education * Mark only one oval.

High School	Bachelors	Professional (JD, MD, PhD, etc), please specify:
Associates	Masters	

13. Years working in this area *

14. Years working with veterans and/or their families *

15. Gender * Mark only one oval.

Female	Prefer not to say
Male	Other:

16. Military Connected Status * Select all that apply Check all that apply.

Veteran	National Guard Family Member	None
Current National Guard	Reserve Family Member	Other:
Current Reserve	Active Duty Service Member	
Veteran Family Member	Active Duty Family Member	

17. Age * Mark only one oval.

15 to 19 years	40 to 44 years	65 to 69 years
20 to 24 years	45 to 49 years	70 to 74 years
25 to 29 years	50 to 54 years	75 to 79 years
30 to 34 years	55 to 59 years	80 to 84 years
35 to 39 years	60 to 64 years	85 years and over

Funding and access to veteran services

18. Does your agency specifically allocate funds to provide mental health services to veterans? * Mark only one oval.

Yes No I don't know / I'm not sure

19. If yes, what funding amount/range annually?

20. Does your agency specifically allocate funds to provide mental health services to veteran family members? * Mark only one oval.

Yes No I don't know / I'm not sure

21. If yes, what funding amount/range annually?

22. Does your agency keep track of the number of veterans served annually? * Mark only one oval.

Yes No I don't know / I'm not sure

23. If yes, roughly how many were served last year?

24. Does your agency keep track of the number of veteran family members served annually? * Mark only one oval.

Yes NO I don't know / I'm not sure

25. If yes, how many were served last year?

26. What percentage of your total client population are veterans? * Estimates are fine

27. What percentage of your total client population are veteran family members? * Estimates are fine

Health service questions

28. From your understanding, the VA is the primary provider of mental health services for Veterans in California. * Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

29. Please elaborate on your above answer here

30. From your understanding, mental health services are available from County funded providers for Veterans in your County. * Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

31. Please elaborate on your above answer here

32. From your experience, most veterans in your county are able to access mental health services when they need them. * Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

33. Please elaborate on your above answer here

34. From your experience, Veteran FAMILY MEMBERS have their mental health needs met in your County.

* In other words, there is no need to expand capacity for services offered to them Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

35. Please elaborate on your above answer here

36. There is at least one Veteran Treatment Court (VTC) operating in your County. * Mark only one oval.

Yes

No

Don't know

37. Please elaborate on your above answer here

38. From your understanding, Veteran Treatment Courts receive high levels of support from the

relevant systems in your County that are involved in VTC cases. * Ex: mental health, substance use treatment, family court, probation, housing, etc. Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

39. Please elaborate on your above answer here

40. From your experience, the type and quantity of service providers delivering mental health services to Veterans in your County is adequate to meet the need. * Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

41. Please elaborate on your above answer here

Services offered to veterans

42. From your understanding, your County provides Veteran focused suicide prevention, intervention, and/or follow up services. * Mark only one oval.

No

Don't Know

Yes

43. If yes, please elaborate if you wish:

44. From you understanding, your County has adequate mental health, crisis intervention, and/or other programs to address suicide and related concerns of violence towards self and others in your veteran population * This could include domestic violence, intimate partner violence, child abuse, "suicide by cop", gun violence, etc. Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

45. If you agree or strongly agree, please elaborate if you wish:

46. From your understanding, your County provides targeted services to Women Veterans. * Mark only one oval.

No

Don't Know

Yes

47. If yes, please elaborate if you wish:

48. From your understanding, targeted mental/behavioral health and/or strength based services/programs are available for Veteran children and Veteran families in your County. * Mark only one oval.

No

Don't Know

Yes

49. If yes, please elaborate if you wish:

50. From your experience, stigma associated with getting mental health care is a significant barrier to care for veterans in your County. * Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

51. Please elaborate on your above answer here

52. From your understanding, there is a negative stigma associated with being a Veteran in your County.

* Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

53. Please elaborate on your above answer here

54. You have received training (in person, online, webinar, etc) on Trauma informed care (and/or trauma responsive, or trauma competent care) for your work setting. * Mark only one oval.

No

Don't Know

Yes

55. If yes, did this training include specific issues related to Veterans and/or military connected families? Mark only one oval.

No

Yes

Other:

56. Please elaborate on your above answer here

Health service questions continued

57. From your experience, the type and quantity of service providers delivering mental health services to Veteran Family Members in your County is adequate to meet the need. * Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

58. Please elaborate on your above answer here

59. You can name at least one agency/provider that specifically provides direct mental health services to Veteran Family Members, including children, in your County. * Mark only one oval.

Yes

No

Other:

60. Please provide the name of the agency(ies) providing services to veteran family members in your County *

61. From your experience, mental health services for Veterans in my County are adequately funded to meet the needs of the Veteran population in your County. * Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

62. Please elaborate on your above answer here

63. From your experience, the most pressing problem your county has faced in working with Veteran families is: *

64. The biggest challenge you face in serving Veterans in your county is: *

65. Are you a direct service provider? * Mark only one oval.

Yes Skip to question 66.

No Skip to question 82.

Direct service provider status

66. Are you a direct service provider at a VSA? * Mark only one oval.

Yes Skip to question 67.

No Skip to question 73.

For direct service providers at VSAs

67. Have you received adequate training about mil/vet culture and mental health issues prior to working within the program? * (Check the box below that best fits your answer) Check all that apply.

Yes

No

68. Please elaborate on your above answer here

69. From your experience, do you believe there is adequate ongoing training and education to assist staff in your county who work with Veterans? * (Check the box below that best fits your answer) Check all that apply.

Yes

No

70. Please elaborate on your above answer here

71. From your experience, do Veteran families have adequate access to mental health services in your county? * (Check the box below that best fits your answer) Check all that apply.

Yes

No

72. Please elaborate on your above answer here

Skip to question 82.

For direct service providers not at VSAs

73. In your workplace, do you always know if the client/participant is a Veteran or military connected family member because you ask this question in your intake? * (Check the box below that best fits your answer) Check all that apply.

Yes

No

74. Please elaborate on your above answer here

75. When Veterans come to your agency, do you refer them to the VA for mental health services? * (Check the box below that best fits your answer) Check all that apply.

Yes

No

76. Please elaborate on your above answer here

77. Have you received military/veteran cultural competence training? * (Check the box below that best fits your answer) Mark only one oval.

Yes Skip to question 78.

No Skip to question 80.

Was training helpful?

78. Was the military/veteran cultural training helpful in better understanding military/veteran clients? * Mark only one oval.

1 2 3 4 5

I strongly disagree that it was helpful

I strongly agree that it was helpful

79. Please elaborate on your above answer here

Skip to question 82.

Interest in training

80. Do you believe you could benefit from military/veteran cultural training to better understand military/veteran clients and their families? Mark only one oval.

1 2 3 4 5

I strongly disagree I strongly agree

81. Please elaborate on your above answer here

Skip to question 82.

Special Court for Veterans membership

82. Are you a member of a Veteran Treatment Court (VTC) or comparable court that provides special services to veterans? * Mark only one oval.

Yes Skip to question 83.

No Stop filling out this form.

Court role and questions

83. Please select your role at your VTC or comparable court below *

Mark only one oval.

Judge	Coordinator	VA Case manager
Defense Attorney/Public Defender	Drug/alcohol Treatment provider	Mentor
Prosecutor	Vet Center treatment provider	Other, please specify

84. Please respond to the following question: From my understanding, my County's VTC or comparable court takes veterans who have a domestic violence allegation/conviction. * Mark only one oval.

No Don't Know Yes

85. If you answered "Yes", does your VTC or comparable court refer veterans to veteran specific DV intervention programming? * Mark only one oval.

No Don't Know Yes