2020 ANNUAL REPORT

The California Veteran Community: Three Year Review

California Association of Veteran Service Agencies (CAVSA)

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Recognizing that California's 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.

— **Stephen Peck**
CAVSA Board President
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Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.

— **Martin Luther King Jr.**

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www.CaliforniaVeterans.org.

Additional copies of this Report are available from CAVSA at the above address and in PDF format for download at ***www.CaliforniaVeterans.org.***

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ACKNOWLEDGMENTS

On behalf of our Board of Directors, we are grateful for the opportunity to deliver this 2020 Californian Veteran Community Report to our statewide partners. This is our third annual report prepared through the support of the Mental Health Services Oversight and Accountability Commission (MHSOAC).

CAVSA member agencies, their leadership and dedicated staff, worked diligently toward last year's (2019-20) action recommendations. This past year has focused on working in partnership with an array of federal, state, and local elected officials, organizations, and agencies on strategies that will benefit veterans and their families. We are committed to working with a wide diversity of advocates, stakeholders, and policy makers to elevate veteran and veteran family well-being and mental health to a priority position on multiple policy, program, and budgetary agendas.

Legislators at the State and Federal levels have been key allies, as have mental and behavioral health agencies—those who explicitly serve veterans and those that have not been aware of serving veterans.

This report celebrates and honors the successes of those who work tirelessly to serve our military veterans. It does so by highlighting progress made over the past three years, by discussing unmet needs, and by identifying challenges that lie ahead. Considerable progress has been made over the past three years, and there is still much to be done.

CAVSA continues to believe that by working together, with the unparalleled support of public officials and stakeholders,

Californians have the unique opportunity to compassionately and competently address the mental health and welfare needs of our veterans and all Californians.

We recognize our veteran constituents and their families are members of multiple groups with very diverse interests. Crossing barriers and working with other mental health stakeholders has been a critical component of our action agenda.

CAVSA and our member agencies continue to work to reduce the unacceptably high number of veterans who live in unsheltered homelessness and those burdened by poor mental and physical health. We support expanding state and federal housing and service programs to target aging veterans. We are also dedicated to preventing needless deaths due to suicide and opioid overdose. We honor the many veterans who are exiting from justice involvement to make better lives for themselves and their families, and those that continue to put their military skill sets to much-needed use in the civilian sector.

As you read this report including activity updates, new data, and accomplishments, we hope you will be inspired to join us as we forge new partnerships and strengthen collaborations to support California's diverse veteran community.

We look forward to positive change in the coming years.

– **Stephen Peck**
CAVSA Board President
U.S.VETS, President and CEO

STATE OF THE VETERAN COMMUNITY
REPORT 2020

TABLE OF CONTENTS

STATE OF THE VETERAN COMMUNITY
REPORT 2020

TABLE OF CONTENTS

TABLES

FIGURES

APPENDIX

PREFACE

California Association of Veteran Service Agencies (CAVSA) is proud to serve those who have served our country—the brave men and women of the armed forces who live in the great State of California. Starting in 2018, we launched this three-year effort with the support of the Mental Health Services Oversight and Accountability Committee (MHSOAC). Our stated purpose was to work beyond the veteran "silo", expanding our collaboration with other stakeholders to improve California's public mental health services system for veterans and all Californians.

What began by providing a snapshot of the State of the Veteran Community in California has been followed by the determined pursuit of a five-point action agenda. In this report, we continue to highlight the needs of the California veteran community and the veteran-serving agencies that support them. Specifically, we update data and findings, again producing our Report Card on California veteran mental health and well-being indicators (homelessness, suicide, opioid overdose deaths, justice involvement) with a special highlight of veteran family caregivers. We summarize efforts and progress made toward our 2019-2020 action agenda, which culminates in a new 5-point recommendation action plan to guide CAVSA activity into 2021 and beyond. Then, in line with the last two annual reports, we analyze six selected county Mental Health Services Act (MHSA) three-year plans in Imperial, Mendocino, Nevada, San Diego, San Francisco, and San Joaquin counties with regard to veteran services and inclusion of veteran-focused stakeholders in county planning processes. This includes an additive secret shopper survey of mental health

service access in each of these five counties. Finally, because the COVID-19 pandemic brought additional threats to veterans' lives and forced veteran-serving agencies to adapt to difficult circumstances, we review results from a set of surveys that assess how agencies are responding to the pandemic or have adapted veteran services due to pandemic risks and protocols, agencies' greatest needs, and how CAVSA and legislators can best help.

The pandemic has complicated all of our efforts, but despite the challenges we all face, may this annual report serve to demonstrate our commitment to aiding veterans that have served us all in California and across the nation.

We have all been impacted from many directions. The COVID-19 pandemic is something affecting not only the people we serve, but also those providing the services – In this sense it is a great equalizer...it tunes us in toward our common humanity.

— Akilah Templeton,
CAVSA Board Member
Veterans Village of San Diego

EXECUTIVE SUMMARY

In late 2017, CAVSA was awarded a three-year grant by MHSOAC to research and report on the state of the veteran community in California. MHSOAC oversees the implementation of the MHSA funds at the county level.

We are honored to deliver our third and final report of this project and remain committed to working to improve the lives of California's 1,752,454 living veterans. As a result of this project, we are much more informed on the challenges they face. In the following executive summary, we highlight veteran-specific data about homelessness, suicide, opioid overdose deaths, and justice involvement among California veterans. We also review trends from our three-year review of county level MHSA Plans. In 2020, we could not ignore the impact of the COVID-19 pandemic on mental health service availability for veterans throughout the state. Therefore, we review key findings from several surveys we conducted this year to assess the impact. Finally, we conclude this executive summary with recommendations for ongoing attention based on our three years of work under MHSOAC funds.

TRACKING THE DATA

Across the state, MHSA funding and the infrastructure created at the county level to address mental illness in California has had a profound impact. However, the three-year trends in collective challenges that many of California's veterans face—rates of homelessness, suicide, opioid overdose deaths, and justice involvement—suggest more needs to be done. For example, the number of people experiencing homelessness, both in the general and veteran populations, is increasing. Although there was a slight decrease in the suicide rate among veterans in 2018, too many died by suicide in 2019 (526 veterans per 100,000 population). The story in relation to opioid overdose deaths and justice involvement is less clear. Unfortunately, we cannot know what we do not track. We have therefore raised the issue of insufficient data collection in each of our annual reports.

TABLE I

2020 REPORT CARD
California Veteran Mental Health and Well Being Indicators

*Measure**	EXPERIENCING HOMELESSNESS	SUICIDE	OPIOID OVERDOSE DEATHS	CALIFORNIA VETERAN POPULATION
CALIFORNIA VETERAN POPULATION	**10,980** **7,719** **70% unsheltered**	**526** **Unadjusted Rate 29.2/100k (2016)**	**No data available**	**5,169**

**Sources included in the full report*

REVIEWING THE MHSA PLANS

As the MHSOAC-funded veteran stakeholder advocacy group, CAVSA has been reviewing County Three-Year MHSA Plans and Annual Updates to determine how well they are meeting their obligation to provide services to veterans and their families. Each year, we selected five or six counties to evaluate and developed a four-point system of scoring 13 key variables. Along with the plan assessments, we assess service accessibility by telephoning a large selection of service providers in each county, posing as veterans and requesting services to address a mental health need. Table II includes the MHSA Plan review scores along with the "positive disposition" results from survey calls made to service providers within each county (a positive disposition was indicated for each call that resulted in an appointment being offered with a mental health profession or referral to appropriate services). The review scores reflect the degree to which the county MHSA documents tailor specific planning toward the needs of veterans and their families. We code a point each time they include specific mention of veterans and their families, include evidence that the plan was developed with local stakeholders, include veterans and representatives from veterans' organizations, or allocate some of their budget specifically to veteran programs.

Counties with larger veteran populations tended to have higher review scores. Higher scores seem to reflect the presence of established community-based, veteran-serving organizations in the County. Of note is that an active CAVSA member agency is operating in each of the top three scoring counties. For more detailed explanation of the scores, please review the three CAVSA annual reports available at **www.CaliforniaVeterans.org.** No consistent trend is discernible from the positive disposition indicator. Some medium veteran-population counties such as Shasta and Kern outperformed larger veteran population counties such as Alameda and Los Angeles.

TABLE II

COUNTY MHSA AND SECRET SHOPPER RESULTS

COUNTY VETERAN POPULATION PERCENT OF TOTAL COUNTY POPULATION	HHSA PLAN REVIEW SCORE *(MAXIMUM 92)*	SECRET SHOPPER, POSITIVE DISPOSITION	YEAR ASSESSED
Los Angeles County: 305,000 veterans, 3% of County population	**21**	**52%**	**2019**
San Diego County: 249,807 veterans, 7.5% of County population	**20**	**58%**	**2020**
Orange County: 117,000 veterans, 3.7% of County population	**18**	**80%**	**2018**
Riverside County: 133,000 veterans, 5.6% of County population	**17**	**68%**	**2018**
San Francisco County: 24,848 veterans, 3% of County population	**13**	**27%**	**2020**
San Joaquin County: 31,254 veterans, 4% of County population	**12**	**57%**	**2020**
Napa County: 8,525 veterans, 6% of County population	**6**	**55%**	**2019**
Kern County: 46,400 veterans, 5.2% of County population	**5**	**75%**	**2018**
Nevada County: 8,428 veterans, 8% of County population	**5**	**38%**	**2020**
Imperial County: 5,566 veterans, 3% of County population	**3**	**54%**	**2020**
Shasta County: 16,000 veterans, 9% of County population	**3**	**77%**	**2018**
Ventura County: 40,500 veterans, 5% of County population	**3**	**42%**	**2019**
Alameda County: 52,000 veterans, 3% of County population	**2**	**37%**	**2019**
Fresno County: 39,700 veterans, 4% of County population	**2**	**32%**	**2019**
Mendocino County: 5,333 veterans, 6% of County population	**1**	**41%**	**2020**
Butte County: 16,000 veterans, 7% of County population	**0**	**64%**	**2019**
Monterey County: 18,400 veterans, 4.4% of County population	**0**	**66%**	**2018**

KEY TAKEAWAYS FROM COUNTY MHSA PLANS

Across the three years of MHSA Plan and Update Reviews, CAVSA has identified 'key takeaways' that may offer other counties a guide in implementing MHSA funds for veterans. Although not a comprehensive set of recommendations for the use of MHSA funds for veterans, the following themes were identified in counties which scored well in our reviews.

VETERAN STAKEHOLDER ENGAGEMENT

- Use already existing veteran-specific programs, such as local Veteran Service Offices and Veteran Resource Centers, as a referral pathway to build stakeholder involvement
- Use targeted needs assessments to better understand special populations, like veterans
- Leverage INN funds to pilot new veteran programs

VETERAN/MILITARY FAMILY COMMUNITY INVOLVEMENT

- Demonstrate clear budget allocation to veteran specific programming
- Provide military cultural-competency training and resources to providers
- Utilize veterans with lived experience as providers and peer navigators
- Bolster veteran and military family support by including families in services

PROGRAMS WITH HIGH RELEVANCY TO VETERANS

- Integrate PEI funds for veteran specific programming
- Target veteran needs for suicide prevention and homelessness intervention
- Create age and population specific veteran programming
- Identify and track veterans throughout all programming

COVID-19 PANDEMIC IMPACT

By March 2020, the COVID-19 pandemic required the State of California and veteran-serving agencies to take dramatic protective actions to stop the spread of the coronavirus. We pivoted quickly to assess the impact and the changes being made in order to capture real-time information for our 2020 report.

In the normal course of conducting our secret shopper assessment of mental health service access, we detected 45' evidence of early challenges affecting service availability in our selected MHSA plan review counties. Of note in Table III, a high percentage of contacted providers in Mendocino and San Joaquin counties indicated COVID-19 protocols, even though they were not hot spots when the calls were made.

We also conducted two additional targeted surveys assessing in more detail how agencies are responding to the pandemic and how they are adapting veteran services due to pandemic risks and protocols. The full results are available in *Veteran-Serving Providers Speak – Challenges, Adaptations, and Resilience during the Pandemic:* **1) the Statewide Veteran Service Provider Survey (40 agency respondents),** and **2) the CAVSA Member Agency Survey (five agency respondents)**.

Generally, we found that agencies have worked diligently to make difficult but necessary adjustments. Luckily, additional resources from several sources were made available to help. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, Paycheck Protection Program, and the Coronavirus Response and Relief Supplemental Appropriations Act of 2021 each provided needed resources. Project Roomkey was originally funded via state allocation and is now supported largely by FEMA. Local governments and generous donors also stepped up during the pandemic to support CAVSA members and community-based veteran-serving agencies. However, as the pandemic drags on and as funding sources potentially dry up, more will be needed to help veteran-serving agencies and their staff maintain safe, quality services. There is also need for additional informational support, e.g., training on best practices for distance services, telehealth billing rules, and emerging forms of emergency financial support.

TABLE III

PROVIDERS WITH SPECIAL PROTOCOLS DUE TO COVID-19

COUNTY	PROPORTION
San Diego	48% (40)
San Francisco	33% (13)
San Joaquin	73% (16)
Imperial	67% (8)
Mendocino	73% (8)
Nevada	50% (6)

ONWARD

Over this three-year period with MHSAOC support, we reported on the state of the veteran community in California and assessed counties' commitment to provide adequate services to veterans. Moreover, we have documented progress toward our five-point action plan which includes efforts to:

1) Address housing challenges for veterans
2) Expand suicide prevention
3) Expand advocacy capacity and data collection
4) Engage the California judicial council on shared interest areas
5) Build community and agency partnerships

In the process, we have learned a lot—particularly that there is still much work to be done. CAVSA and its member agencies will continue to support California's veterans and their families, especially their health, well-being, and material security.

Given what we have learned, we offer the following action areas for ongoing attention by CAVSA and the state-wide network of MHSA stakeholders.

1. LEVERAGE AND INTEGRATE MHSA FUNDING STREAMS FOR INNOVATIVE PROGRAMS

Having reviewed 17 MSHA county plans and updates, we found several examples where counties leveraged Innovation (INN) funds to pilot new veteran programs and integrated Prevention and Early Intervention (PEI) funds for veteran-specific programming. See the work described in Orange County on pages 51-53 and the other counties can be found on pages 43-45.

2. FOCUS ATTENTION ON VETERANS WITHIN CALIFORNIA'S MASTER PLAN FOR AGING

Nearly half of California's living veterans are age 64 years and older (823,313 Californians), yet veterans are only mentioned twice in the recently released Master Plan for Aging. For it to be a true blueprint for an age-friendly California, more attention must be paid to the needs of veterans. For more information see pages 22-23.

3. REINVEST IN THE VETERANS HOUSING AND HOMELESSNESS PREVENTION PROGRAM

Despite progress made in the state to support and house homeless veterans, the data trends show more is needed. Bond authority to fund the Veterans Housing and Homelessness Prevention Program (VHHP) will soon be exhausted. Through five rounds of funding, approximately $394 million has been allocated to produce an estimated 2,625 housing units for veterans and their families throughout the state. CAVSA and our partners statewide are calling for additional funding through a measure to authorize that additional bonds be issued for this program. For more information, see pages 27-29.

4. ALIGN STATE AND FEDERAL FUNDING AND EXPAND PROGRAMS

Existing state and federal programs to serve veterans with complex health and material needs could be enhanced if they worked better together. For example, an enhanced HUD-VASH program—a HUD-VASH for Older Adults Program—could interlace funding[1] to provide services for newly-housed residents who need a higher level of care. For additional details, see page 23.

5. JOIN THE GOVERNOR'S CHALLENGE ON SUICIDE PREVENTION

Far too many veterans die at their own hands, and California has yet to join the Governor's Challenge which provides a framework within which states create communication, collaboration, awareness, and action around veteran suicide. For a complete overview of the Department of Veteran and Department of Health and Human Services (HHS)-led effort, see pages 30-31.

6. ENHANCE DATA COLLECTION AND BOLSTER PUBLIC ACCESS

In our last two annual reports, we identified a lack of consistent and adequate data collection in key areas of general population (and, in particular, veteran) well-being. We suggest expanding efforts such as the recently initiated six-county Full-Service Partnership (FSP) Multi-County Collaborative that will develop standardization practices for FSP service programs by utilizing data-driven strategies and evaluation to better coordinate, improve, and implement FSP services statewide. For more discussion, see page 38.

[1] *Veterans Housing and Homelessness Prevention Program (VHHP), Department of Housing and Community Development (HCD), in collaboration with the California Housing Finance Agency (CalHFA) and CalVet. HUD-VASH, Department of Housing and Urban Development and the Department of Veterans Affairs Supported Housing Program. Supportive Services for Veterans Families (SSVF), Department of Veterans Affairs.*

PART I:
CALIFORNIA VETERAN COMMUNITY: THREE YEAR REVIEW

CAVSA 2020 STATE OF VETERANS REPORT CARD

Our 2018 State of the Veteran Community Report reviewed relevant veteran-related mental health reports, public data, and scholarly literature, including California-specific studies as well as national studies and data that permit extrapolation to California, providing a thorough demographic profile. In it, our 2018 Report Card provided the first snapshot of comparative well-being between Californian veterans, the national veteran population, and all Americans by comparing four measures of mental health and well-being. These population level measures—reports of homelessness, suicide, opioid overdose deaths, and justice involvement—have been shown to be amenable to programmatic interventions at the individual, community, and policy levels to improve well-being and have provided the basis of our annual report updates.

AGE DISTRIBUTION OF LIVING VETERANS IN CALIFORNIA

The U.S. Department of Veteran Affairs produces new estimates of total living veterans every few years. The 2020 estimates are shown in Table 1. The total number of living veterans, 1,752,454, is an 11% increase over the previous data contained in the 2019 CAVSA annual report. These new estimates also present a slightly younger cohort, with living veterans under the age of 65 making up 53% of the total—up one and one-half percentage points from the 2018 USDVA estimate. Despite this trend, many living veterans, 24.4%, are 75 years and older.

Serving aging veterans poses a complex set of challenges for current service providers, especially serving those who have experienced homelessness, poverty, and express physical and mental frailties beyond their age —much of it due to their military service. Specifically:

- The current veteran benefit system does not provide funding for a continuum of care that can allow veterans to age in place rather than move into nursing home facilities prematurely.
- The housing supply for frail older veterans is inadequate, and this will worsen as baby boomers age.
- Older veterans must navigate a complex labyrinth of services, benefits, and agencies in order to create a system of care that meets their needs.

TABLE 1

CALIFORNIA VETERAN AGE PROFILE

UNDER 30	30-44	45-64	65-74	75-84	85+	TOTAL
95,290 (5.4%) 2019 (5.8%)	291,072 (16.6%) 2019 (16.6%)	542,779 (31%) 2019 (29.1%)	394,545 (22.5%) 2019 (23.5%)	259,890 (14.8%) 2019 (15.5%)	168,878 (9.6%) 2019 (9.5%)	1,752,454

929,141 CA Veterans Ages under 20 to 64 (approx. 46-year age span)	**53.0% of total** in 2019 51.5% total	**823,313 CA Veterans Ages 65 to 85+** (approx. 35-year age span)	**47.0% of total** in 2019 48.5% total

** Numbers accurate within 1000 population.*

Source: Table 6L: VETPOP2018 Living Veterans By State, Age Group, Gender, 2018 2048. USDVA, National Center for Veterans Analysis and Statistics, May 2020. https://www.va.gov/vetdata/veteran_population.asp

BETTER CARE FOR AGING VETERANS, SWORDS TO PLOWSHARES

CAVSA member-agency Swords to Plowshares operates permanent supportive housing (PSH) sites throughout San Francisco. Nearly 50 percent of their PSH residents are ages 62 and over. However, current funding sources provide limited funding for providing holistic care. Meeting the needs of increasingly frail veterans requires:

- A coordinated system of extended and targeted care
- On-site medical staff (particularly licensed nurses) to mange chronic medical conditions

A Policy Solution: The HUD VASH program, despite shifting the landscape for housing homeless veterans, does not fund the daily supports required to address their complex needs. To augment the program's service to aging veterans, an enhanced HUD-VASH program—a HUD-VASH for Older Adults Program—would fund staffing embedded within Community Based Organizations (CBOs) to care for residents who need a higher level of care. This solution would fill the gap in supportive housing for senior veterans by including:

- In-Home Health Aides assisting with personal care, household tasks, and errands
- Certified Nursing Assistants (CNAs) helping with health-related tasks.
- Health Navigators/Peer Advocates helping navigate VA and non-VA care and benefits systems and provide transportation.

Such a system would enhance veteran well-being through consistent onsite staffing and would overcome the issues of trust and isolation so prevalent among this cohort.

CASVA REPORT CARD

It is difficult to track changes in data for large populations within short time frames. Comprehensive survey data updates are infrequent and, when they occur, variable definitions and fluctuating data sets can be hard to align for comparison. However, in 2019 and now in 2020, we provide "at-a-glance" interpretations of progress made in the areas of veteran homelessness, mental health and suicide, opioid-related deaths, and justice involvement where possible using the best data available. The status is signified by the following colors:

- ***Progress occurring, measurable success (green)***
- ***Stable, but still needs attention (gold)***
- ***Source of concern, not going well (red)***

2020 DATA SNAPSHOT OVERVIEW

In each annual report, we have shown comparative data highlighting the mental health and well-being of California veterans in comparison to veterans nationwide and their non-veteran counterparts. We present the best available data in each report, and the new sources vary from year to year. Table 2 captures population level data on the number of persons experiencing homelessness, suicide deaths, opioid overdose deaths, and justice involvement found from 2019 and 2020 sources where available. Both the 2018 and 2019 Report Cards are included as Appendix A and B to assist readers with a retrospective look. However, because the best new sources differ, 2020 findings cannot be presented as a one-to-one comparison with the previous Report Cards.

TABLE 2

2020 REPORT CARD

California Veteran Mental Health and Well Being Indicators

	U.S. Population	U.S. Veteran Population	California Population	California Veteran Population
PERSONS EXPERIENCING HOMELESSNESS	567,715 - 37% Unsheltered 210,055	37,085 - 39% Unsheltered 14,566	151,278 - 72% Unsheltered 89,543	10,980 - 70% unsheltered 7,719
SUICIDE	48,344[1] - Age-adjusted Rate 14.6/100K* Male: 22.8/100K; Female: 6.2/100K	6,435[2] - Age-adjusted Rate 27.5/100K Unadjusted Rate 32/100K	4,491[3] - Unadjusted Rate 10.9/100K	526[4] - Unadjusted 2016 Rate 29.2/100K
OPIOID OVERDOSE DEATHS	57,377[5] - Age-adjusted Rate 17.3/100K	4,216[6] - Extrapolated Unadjusted Rate 21.08/100K	4,081[5] - 9.95/100K	No California Veteran-specific data is available - The absence of data is itself a negative indicator
JUSTICE INVOLVEMENT (INCARCERATION)	2.3 million[7] - 698/100K	181,500[8]	94,146[9] Adult Inmates Under CDCR - 164,372 total CDCR population	5,16911[10]

Sources: on page 26

REPORT CARD DATA SOURCES

HOMELESSNESS:

The 2019 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness (huduser.gov)

SUICIDE:

[1]National Institute of Mental Health 2018, NIMH » Suicide (nih.gov)

[2]USDVA 2020, 2020, National Veteran Suicide Prevention Annual Report (va.gov)

[3]CDC 2018, Stats of the State - Suicide Mortality (cdc.gov)

[4]USDVA 2018, California Veteran Suicide Data Sheet (va.gov)

OPIOID OVERDOSE DEATHS:

[5]CDC NVSS 2020

Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2020.

Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)

[6]American Journal of Preventive Medicine. 57(1):106-110. July 01, 2019. "Changing Trends in Opioid Overdose Deaths and Prescription Opioid Receipt Among Veterans"

Changing Trends in Opioid Overdose Deaths and Prescription Opioid Receipt Among Veterans - American Journal of Preventive Medicine (ajpmonline.org)

JUSTICE INVOLVEMENT:

[7] Prison Policy Initiative

Mass Incarceration: The Whole Pie 2020 | Prison Policy Initiative

[8] U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics Special Report December 2015.
Veterans in Prison and Jail, 2011-12 (bjs.gov)

[9] California Department of Corrections and Rehabilitation Division of Correctional Policy Research and Internal Oversight Office of Research. Monthly Report of Population as of Midnight November 30, 2020.
Tpop1d2011.pdf (ca.gov)

[10] Judicial Council of California
lr-2020-collaborative-courts-survey-and-assessment-of-treatment-courts.pdf (ca.gov)

THREE-YEAR INDICATOR SYNOPSIS

HOMELESSNESS

Point in Time (PIT) counts provide the best estimates of people experiencing homelessness. The Department of Housing and Urban Developments requires jurisdictions receiving federal funding to conduct a PIT count every other year. The 2019 Annual Homeless Assessment Report (AHAR) provides the latest snapshot of homelessness across the nation. On any given night, there are 567,715 people experiencing homelessness; 63% of those people are sheltered, while 37% go without shelter. In California 151,278 people were estimated to be experiencing homelessness during the PIT counts with 108,432 of those people being unsheltered.

The Point in Time count also estimates the number of veterans experiencing homelessness. Across the nation, 37,085 veterans were experiencing homelessness, with 14,345 going without shelter.

The latest count in California estimated that 10,980 veterans were experiencing homelessness. From this count, more than half (54%) of all unsheltered American veterans reside in the state of California. When compared to all veterans in California, 70% are unsheltered.

Between 2018 and 2019, the number of veterans experiencing homelessness decreased nationwide, although California saw an absolute increase. Table 3 provides a comparison of national and California trends about veterans experiencing homelessness.

For a closer look: Table 4 shows Imperial County, San Francisco County, and Los Angeles County as the top three areas with the highest percentage of unsheltered homeless veterans. While Imperial County has the lowest number of veterans experiencing homelessness, almost all the 61 homeless veterans are unsheltered.

TABLE 3

NATIONAL AND CALIFORNIA POPULATION TRENDS
Among Veterans Experiencing Homelessness, 2018-2020

PERSONS EXPERIENCING HOMELESSNESS	NATIONAL POPULATION	NATIONAL VETERAN POPULATION	CALIFORNIA POPULATION	CALIFORNIA VETERAN POPULATION
2020	**T= 567,715** 210,055 37% unsheltered Total is .17% of total U.S. population	**37,085** 14,345 39% unsheltered Total is 6% of all U.S. homeless adults	**151,278** 108,432 72% unsheltered Total is 26% of U.S. total; .37% of CA total	**10,980** 7,719 70% unsheltered Total is 30% of homeless U.S. veterans; 7.3% of CA homeless
2019	**T= 552,830** 194,467 35% unsheltered (.17% of total U.S. pop)	**37,878** 14,566 38% unsheltered (9% of all U.S. homeless adults)	**129,972** 89,543 69% unsheltered (24% U.S.; 34% of CA totals)	**10,836** 7,214 67% unsheltered (29% of homeless U.S. veterans; 8.3% in CA)
2018	**T= 553,742** 193,900 (35%) unsheltered (.17% of total U.S. pop)	**40,056** 15,366 (38%) unsheltered (9% of all homeless adults)	**134,278** 91,642 (68%) unsheltered (24% U.S. total; .34% of CA)	**11,472** 7,657 (67%) unsheltered (29% of homeless U.S. veterans; .63% in CA)

Source: *The 2019 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness (huduser.gov).*

Los Angeles County has an estimated total population of 10,039,107, with 3,538 homeless veterans, and 78% of those veterans are unsheltered. This number is not ideal, but when compared to San Francisco County with an estimated total population of 881,549, with 608 homeless veterans, and 80% of those veterans unsheltered, it is evident there is a struggle to shelter homeless veterans no matter the location.

TABLE 4

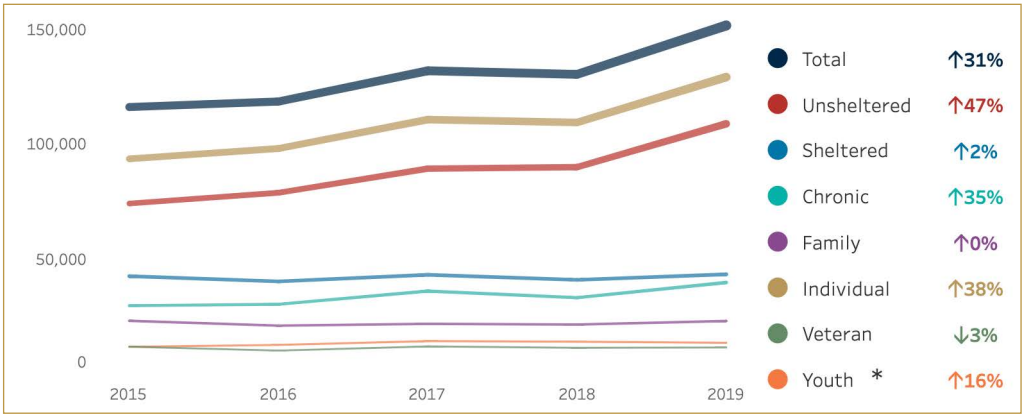
HOMELESS AND UNSHELTERED VETERANS IN CALIFORNIA, 2019

CONTINUUM OF CARE (COC) TYPE AND PLACE	VETERANS IN HOMELESSNESS *(PERCENT OF TOTAL)*	PERCENT OF VETERANS IN HOMELESSNESS, UNSHELTERED
Major Cities CoCs		
Los Angeles City and County	*3,538 (6.3%)*	*78.4%*
Sacramento City and County	*667 (12.0%)*	*73.2%*
**San Diego City and County*	*1,068 (13.2%)*	*39.7%*
**San Francisco City and County*	*608 (7.6%)*	*80.8%*
Other Largely Urban CoCs		
**Stockton/San Joaquin County*	*153 (5.8%)*	*46.4%*
Oxnard, San Buenaventura/Ventura County	*106 (6.4%)*	*75.5%*
Largely Suburban CoCs		
**Imperial County*	*61 (4.3%)*	*98.4%*
Santa Ana, Anaheim/Orange County	*311 (4.5%)*	*68.2%*
Largely Rural CoCs		
**Mendocino County*	*16 (2.0%)*	*56.3%*
**Nevada County*	*35 (8.4%)*	*60.0%*

** County MSHA plan reviewed by CAVSA; results presented below.*

FIGURE 1

CHANGES IN THE STATE OF HOMELESSNESS, CALIFORNIA 2015-2019



STATE HOMELESSNESS BY POPULATION:
Between 2015 and 2019, **California's total** homeless population changed by **↑31%**, the **Sheltered** population changed by **↑2%**, and the **Unsheltered** population changed by **↓47%**.

See Figure 1 for statistics on other populations.

Source: www.endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-dashboards/?State=California

From left to right, John Bigley VP of Urban Housing Communities, partner with VHDC in the Windsor Veterans Village, Councilwoman Esther Lemus, Windsor Town Council, Supervisor James Gore, Sonoma County Board of Supervisors, Burt McChesney, CAVSA Board Member and Special Advisor, VHDC, and Vito Imbasciani, MD, Secretary California Department of Veterans Affairs

POSITIVE STRIDES TO HOUSE VETERANS, VHHP & NATION'S FINEST

In 2014, California voters authorized $600 million in bond authority from the 2008 Veteran's Bond Act be repurposed to fund multifamily housing for veterans through the Veterans Housing and Homelessness Prevention Program (VHHP). The first four rounds of funding awarded $311 million to 70 developments, producing an estimated 2,463 housing units for veterans and their families throughout the state. In 2019, a fifth round allocated just over $83 million for an additional 421 units of housing.

Despite its success toward producing housing for extremely low-income veterans, the limit of bond funding for VHHP will soon be exhausted. CAVSA and our partners statewide are calling for additional funding so ground can be broken on more needed housing for Californian veterans. At the beginning of the 2021-22 legislative session, Senators Atkins, Caballero, McGuire, Rubio, Skinner, and Wiener introduced SB-5 (the Housing Bond Act) as a vehicle for additional funding for housing. Assembly Member Irwin introduced the Veterans Housing and Homeless Prevention Bond Act of 2022 to authorize the issuance of bonds for up to $600,000,000 to provide additional funding for the VHHP. CAVSA supports both bills.

VHHP HIGHLIGHT

CAVSA member-agency Nation's Finest partnered with the City of Rancho Cordova and Mercy Housing to build 100 units of permanent supportive housing and 60 units of transitional housing on the old Mather Air Force base. Using VHHP funding, this is the first permanent supportive housing built in the Sacramento region for homeless veterans with disabilities. Amenities include a community room with a kitchen and lounge area, onsite parking, laundry facilities, and a computer lab. Also, a spectrum of supportive services is provided at the village including counseling, job training, medical assistance, and group and individual therapy.

REPORTED SUICIDE

The most up-to-date information on veteran suicide rates is reported in the VA's 2020 National Veteran Suicide Prevention Annual Report, which shows rates from 2005 to 2018. Nationally, there was not a significant increase in veteran suicide rates. In California, the USVDA 2018 State Data Sheet does shows a slight decrease from 640 veteran suicides to 526 veteran suicides per 100,000 population.

In addition to tracking data, the United States Department of Veteran Affairs (VA) Veterans Health Administration (VHA) partners with the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration on the National Strategy for Preventing Veteran Suicide. In this 10-year suicide prevention strategy, they outline a framework for state and local entities for prioritizing efforts to end veteran suicide. Under this strategy, two operational plans have been developed: 1) Suicide Prevention 2.0 (SP 2.0), and 2) the Suicide Prevention Now (Now) initiatives. SP 2.0 focuses on implementing new community- and clinic-based programs, while the Now initiative focuses on enhancing current programs to best serve veterans immediately. See Figure 2 for a complete overview.

SP 2.0 includes the Governor's/Mayor's Challenge. The goals of the Challenge align with CAVSA action priorities and concern about veteran well-being. There are currently 27 states participating in the Governor's/Mayor's Challenge; California is not one of them. However, Los Angeles (L.A.) is participating in the Mayor's Challenge. As home to the most veterans in the nation, we see California joining the Governor's Challenge as a way to unite forces among our member agencies and other organizations across the state to address this pressing issue.

TABLE 5

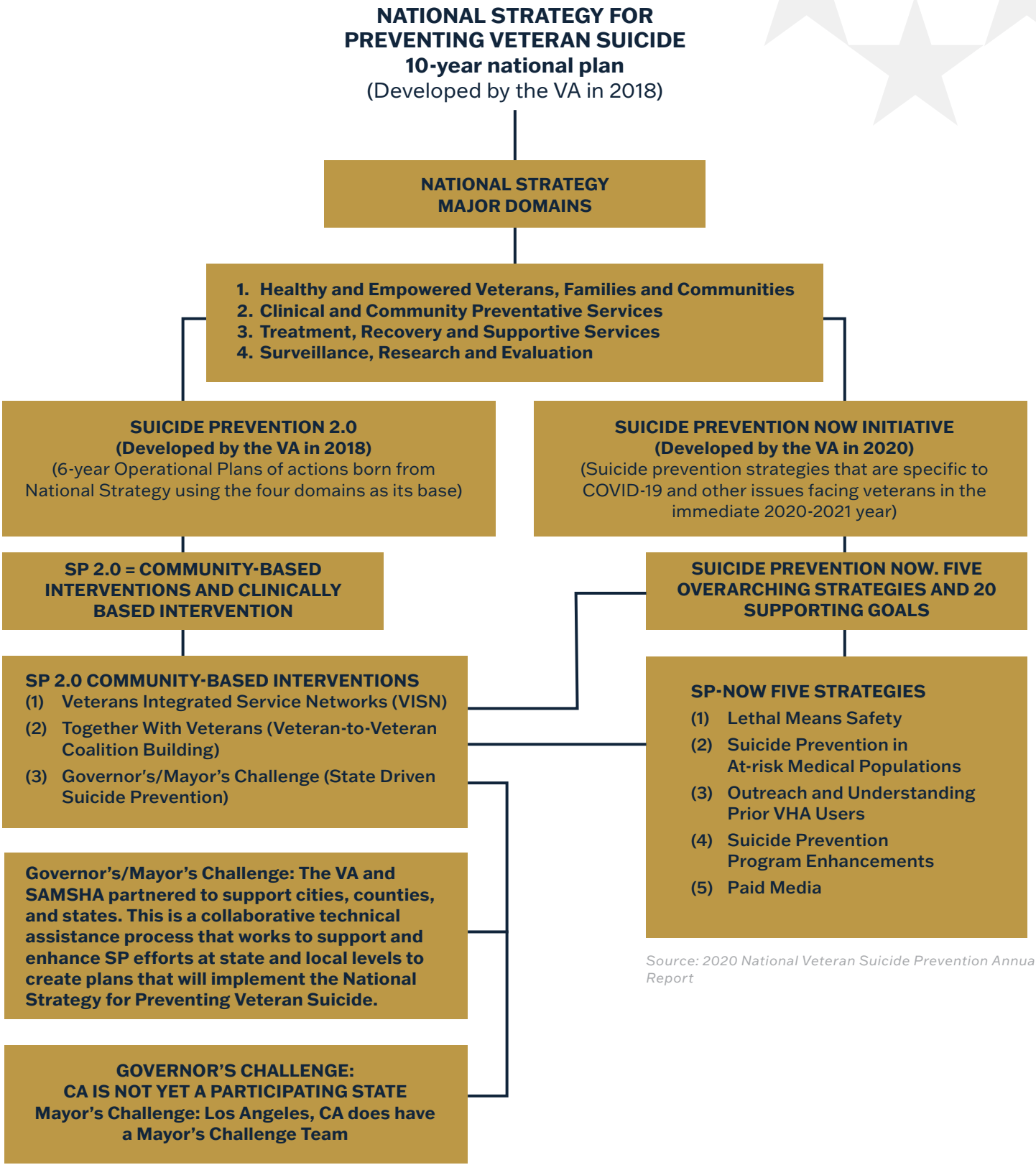
NATIONAL AND CALIFORNIA
Suicide Rates Among Veterans

PERSONS EXPERIENCING HOMELESSNESS	NATIONAL POPULATION	NATIONAL VETERAN POPULATION	CALIFORNIA POPULATION	CALIFORNIA VETERAN POPULATION
2020	**48,344** 14.6/100,000 Male: 22.8/100k Female: 6.2/100k	**6,435** Age-adjusted rate 27.5/100,000 Unadjusted Rate 32/100k	**4,491** - Unadjusted Rate 10.9/100K	**526** - Unadjusted Rate 29.2/100k
2019	**47,173** 14.5/100K (age-adjusted rate) (Male: 22.9/100K; Female: 6.3/100K age-adjusted rates)	**6,079** 26.1/100K (age-adjusted rate) 30.1/100K (unadjusted rate)	**4,312** 10.5/100K (age-adjusted rate) 10.9/100K (unadjusted rate)	**640** - 28.2/100K (unadjusted 2016 rate)
2018	**17.3/100K**	**29.7/100K**	**13.6/100K**	**28.8/100K**

FIGURE 2

NATIONAL STRATEGY FOR PREVENTING VETERAN SUICIDE

Suicide Rates Among Veterans



Source: 2020 National Veteran Suicide Prevention Annual Report

OPIOID OVERDOSE DEATHS

The annual number of opioid overdose deaths has not only increased nationally, but also in California. Unfortunately, the data available does not lend itself to valid extrapolation to assess opioid death rates among veterans. In California, the number of overdose deaths has nearly doubled from 2,197 to 4,081 since 2019, as reported by the National Vital Statistics System.

Without access to reliable data on the veteran opioid deaths in California, we produced a table to present a relative sense of veteran opioid overdose risk in the six counties with the highest per 100,000 population rates in the state. We also included the remaining four 2020 MHSA Plan Review Counties for comparison. The top six list includes San Francisco and Mendocino Counties, two of the six counties for which we assess three-year MHSA plans later in this report; therefore, we added the other four to Table 7 for comparison. The table includes the county per 100,000 population opioid overdose death rate, and the county per 100,000 population veteran resident rate.

Obtaining an overall picture of veteran opioid overdose rates in this manner is not ideal, although we have raised the issue of insufficient data collection in each of our last three annual reports. CAVSA will continue to monitor data availability and work with our members and partners to advocate for improvement.

TABLE 6

NATIONAL AND CALIFORNIA
Opioid Overdose Deaths Among Veterans, 2018-2020

OPIOID OVERDOSE DEATHS	NATIONAL POPULATION	NATIONAL VETERAN POPULATION	CALIFORNIA POPULATION	CALIFORNIA VETERAN POPULATION
2020	**57,377** - 17.3/100K	**4,216** - 21.08/100K	**4,081** - 9.95/100K	No data is available - The absence of data is itself a negative indicator
2019	**47,600** - 14.9/100K Age-adjusted Rate	**Missing data** - 21.08/100K	**2,196** - 5.23/100K (all overdose deaths; not opioid)	No data is available - The absence of data is itself a negative indicator
2018	**13.3/100K*** population	**19.85/100K** person years	**4.49/100K** CA population	No California specific data is available

TABLE 7

VETERAN OPIOID OVERDOSE RISK IN CALIFORNIA BY HIGH RISK COUNTIES

CALIFORNIA COUNTIES W/LARGEST OPIOID OVERDOSE DEATH RATE	POPULATION	VETERAN POPULATION	OPIATE OVERDOSE DEATHS
Lake	64,822	4920	32.46/100,000
*San Francisco	896,047	24,848	26.15/100,000
Lassen	30,160	2,010	23.47/100,000
Mariposa	17,539	1,583	23.4/100,000
*Mendocino	87,424	5,333	19.71/100,000
Trinity	12,153	1,012	19.65/100,000
*Nevada	100,002	8,428	10.45/100,000
*San Diego	1,447,100	249,807	8.92/100,000
*Imperial	180,907	5,566	7.02/100,000
*San Joaquin	771,805	31,294	5.30/100,000

** Indicates the six counties selected for MHSA plan review included later in this report.*

Sources: *Veteran Population - National Center for Veterans Analysis and Statistics; 2020 World Population by Country; CA Opioid Dashboard.*

JUSTICE INVOLVEMENT

Over the past three years, it has also proved challenging to identify data regarding justice involved veterans. As shown in Table 8, the number of veterans incarcerated nationally has been steady. It is estimated that about eight percent of 2.3 million incarcerated people are veterans.

As for California, the CDCR releases monthly reports of the total CDCR population. A report released 11-30-20 records the total CDCR population at 164,372 (this includes parole, alternative custody programs, camps, etc.). The total institution population is 94,146. This is a significant reduction, even from 4-30-20, where the total CDCR population was 178,982 and the total institution population was 112,537. As a response to COVID-19, prisoners have been released or not accepted to facilities. According to estimates by the Bureau of Justice Statistics, there has been a slight decrease in incarcerated veterans since 2019 in California.

TABLE 8

NATIONAL AND CALIFORNIA POPULATION TRENDS Among Justice-Involved Veterans, 2018-2020

JUSTICE INVOLVEMENT	NATIONAL POPULATION	NATIONAL VETERAN POPULATION	CALIFORNIA POPULATION	CALIFORNIA VETERAN POPULATION
2020	2.3 million	No New Estimate	94,146 - (institution total) 164,372 total CDCR population	5,169
2019	2.3 million	181,500	138,000	5,769
2018	2.3 million	181,500 - (8% of total U.S. adult inmates, 2011-12 data)	138,000 - (adult inmates under CDCR)	No California Veteran-specific data or estimate is available

However, in their report they warn that, due to COVID-19 and the dramatic decrease in the prison population for California, this estimate may not be an accurate reflection of incarcerated veterans in California.

The Judicial Council Assessment and Survey of Veterans Treatment Courts that was called for per SB-339 in 2017 was just being implemented when we released our 2019 report. This year, in June 2020, a final assessment was released. The authors surveyed 32 courts from 29 counties, yielding promising results, and pointing to areas that require more growth. See Table 9 and Table 10 for details.

Photo: San Diego Veterans Treatment Court Hon. Laura Birkmeyer, DDA Harrison Kennedy, DPD Solomon Rouston, and DCA Caroline Song

TABLE 9

PROMISING OUTCOMES RELATED TO VETERAN TREATMENT COURTS*

RECIDIVISM: The arrest rate for VTC participants is lower than for VJO participants. However, further research is needed for more robust results.
MENTAL HEALTH AND SUBSTANCE ABUSE: Most veterans with mental health and substance abuse needs in both groups were connected with treatment options at program exit, although more veterans in the VTC group were connected with treatment than in the VJO group.
HOMELESSNESS: Participants in the VTC group were more stably housed than were the VJO participants. In addition, longer involvement in the program correlated with better housing outcomes.
EMPLOYMENT: Although both VTC and VJO participants had similar employment statuses for three years before entering the program, VTC participants reported more full-time employment and less unemployment at exit.
SOCIAL STABILITY: For participants who remained in the program for longer than six months, VTC participants showed higher levels of social stability at program exit than did VJO participants.

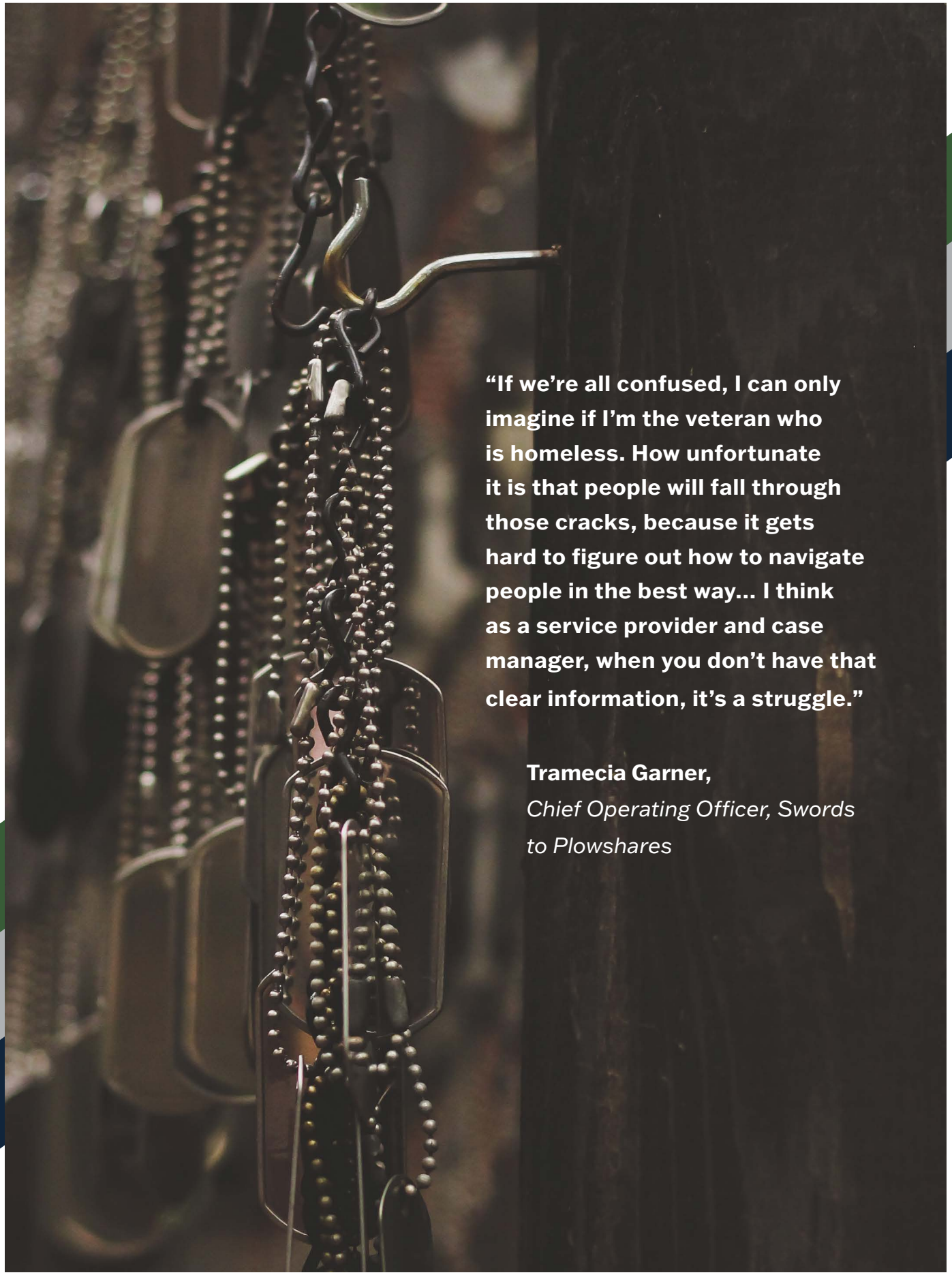
**This is a data set of 1,057 veterans who both received VJO services and participated in a VTC. This group was compared to a group of 1,394 veterans who received VJO services but did not participate in a treatment court and is referred to as the "VJO group."*

TABLE 10

GROWTH AREAS FOR VETERAN TREATMENT COURTS

Improve Identification of Veterans and Notification Rights
Review Eligibility Requirements to Expand Caseload Sizes in VTC Counties
Utilize Existing Local Resources Rather Than Creating Regional VTCs
Collaborate with Justice System Partners for a Systemwide Approach
Identify and Utilize Array of Local Resources

Phenomenal work is being done across the state of California to provide the best services for our justice-involved veterans. Veterans Treatment Courts are a testament to that. Over the last three years that CAVSA has been reporting on JIV and VTCs, there has been an increasing awareness of the success that these courts can produce, yet the inability to identify veterans in the system has been an ongoing issue that has been reported time and again. While the Judicial Council Assessment and Survey of Veterans Treatment Courts final report points out that, after the surveys were conducted, scripts were created by the Judicial Council for the courts to inform veterans of their rights in the hopes of creating more continuity across jurisdictions, there is more that needs to be done. More training for court officials and law enforcement is needed to help screen and identify veterans. Expenditures would be best spent trying to find a real, working solution, rather than spent on multiple reports all attesting to the same fact. It is in our justice-involved veterans' best interest to break down the barrier of identification in order to connect them to services that will allow them to build the best lives that they see for themselves.



“If we’re all confused, I can only imagine if I’m the veteran who is homeless. How unfortunate it is that people will fall through those cracks, because it gets hard to figure out how to navigate people in the best way... I think as a service provider and case manager, when you don’t have that clear information, it’s a struggle.”

Tramecia Garner,
Chief Operating Officer, Swords to Plowshares

PROGRESS ON OUR ACTION AGENDA

The value of CAVSA is in the combined and collective work of our Board members and the activities pursued by our member agencies. In what follows, we describe such efforts and the dedication of those working across the state to advance the CAVSA action agenda to improve support for California's veterans.

1. Addressing housing challenges for veterans

CAVSA member-agency, Swords to Plowshares co-hosted the Alameda Veteran Mental Health Roundtable with the Alameda County Veterans Service Office, bringing together key partners including veteran-serving agencies, mental health service providers, housing and aging service providers, and community college staff to discuss concerns and identify opportunities for collaboration. Participants highlighted discontinuities in care, barriers to care, opportunities for collaboration, and concluded with recommendations for appropriate measures to address those topics. As a result, the roundtable, with funding from CalVet and the Mental Health Services Act, will convene a series of bi-monthly meetings (the first of which will be held in February 2021) to identify programs, trainings, and methods to improve collective work and offer a venue to connect with colleagues. Furthermore, the group intends to establish a coordinated entry or intake system for veterans when they first sign up for housing or other community-based services so their other needs (e.g., accessing VA benefits, employment and training, mental health services) can be addressed. This system would help to streamline access, standardize entry points, and bolster information-sharing between providers, as well as keep track of veterans so they do not fall through the cracks.

2. Expanding suicide prevention, intervention, and postvention activities

Robert Stohr, Executive Director for CAVSA member-agency U.S.VETS, oversees programs and operations at Patriotic Hall in downtown Los Angeles. Mr. Stohr oversees four distinct programs covering employment, housing, and mental health resources for veterans, and is in charge of launching a brand new effort for mental health support for women veterans. Drawing on his previous experience as Division Director for the Suicide Prevention Center of Los Angeles at Didi Hirsch Mental Health Services, Stohr worked in collaboration with the L.A. Suicide Prevention Network and CalVet to expand the annually held Suicide Prevention Summit to include a full day dedicated to Veterans and First Responders Suicide Prevention on September 11, 2020.

This special program included speakers from several CAVSA member agencies and panels titled, "Who watches the watchers? Protecting and serving those who protect and serve" and "Bringing hope to life: What suicide prevention means to me." For the full program, see: **LASuicide Prevention Network.**

CAVSA member agencies and their dedicated staff are enhancing services and expanding awareness of the challenges our veterans face. This specific effort will be repeated in subsequent years, bringing the issue of veteran suicide into the mainstream of suicide prevention and suicide ideation support.

3. Expanding advocacy capacity and data collection efforts

LEGISLATIVE TRACKING – CALIFORNIA

The COVID-19 pandemic quickly altered the plans of the Legislature in 2020. Authors were asked by leadership to prioritize legislation, with many members opting to keep only measures that were COVID-related. Despite the shortened timeline and COVID dynamics, CAVSA played a pivotal role working with a broad coalition to help passage of measures related to housing/homelessness and mental health.

- SB 803 (Beall) requires the Department of Health Care Services (DHCS) to seek any federal waivers it deems necessary to establish a Medi-Cal demonstration or pilot project for the provision of peer support services in counties that agree to participate and provide the nonfederal share of funding for a demonstration or pilot that includes a certified peer support specialist as a Medi-Cal provider type. This represents a significant win, as the same proposal was vetoed by the Governor the previous year.
- SB 855 (Wiener), which faced strong opposition from insurers and business groups, repeals California's mental health parity law and replaces it with a broader requirement on health plans and disability insurers to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions.
- AB 240 (Irwin) limits the term of a lease of real property at a California Department of Veterans Affairs (CalVet) Veterans' Home to five years, except under specified conditions, and requires that any use of property by a third party at a Veterans' Home meet specified criteria.

LEGISLATIVE TRACKING – FEDERAL

The whirlwind of electoral politics engulfed much of Washington, D.C. during the last two quarters of the year, slowing or stopping many legislative initiatives of interest to CAVSA and veterans in California. The most obvious casualty of the election year jockeying was the much-anticipated second large COVID relief bill. While the House of Representatives passed the $3.4 trillion HEROES Act in May, the Senate only countered with their $500 billion HEALS act in September. Neither bill was likely to be enacted and the American people remained in limbo with record levels of unemployment and stubbornly high COVID-19 infection rates. Late in December, a 5,593-page $900 billion aid package was approved, the details of which will take some time to untangle and understand.

MHSA AND OTHER DATA COLLECTION ADVANCES

"Water, water everywhere, but not a drop to drink." In our last two annual reports we identified lack of consistent and adequate data collection in key areas of veteran well-being. We recognized the need to 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 programs, and we committed CAVSA to support the collection of mental health treatment and referral data through relational databases, building necessary access and data linkages, and we focused on improved data collection for women veterans, veteran opioid addition, aging veterans, and veteran incarceration.

In addition to our own efforts, we would like to highlight an effort proceeding with MHSOAC leadership, with which CAVSA hopes to retain ongoing involvement and promote attention to veterans' needs. Six counties were approved to participate in a Full-Service Partnership (FSP) Multi-County Collaborative: Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura. Together, innovation funds will be used to develop standardization practices for FSP service programs by utilizing data-driven strategies and evaluation to better coordinate, improve, and implement FSP services statewide.

Initial plans suggest the collaborative will collect data and evaluate system-level impacts from surveys and qualitative interviews that will be completed by participating counties and state agencies. Additionally, data will likely be used to evaluate client-level impacts. In their proposal, the counties suggest coordinating local data collection systems, such as those from local housing agencies, local jails, billing records from local hospitals, and FSP provider data. If successful, this would provide a useful template for state-wide adoption.

4. *Engaging with California Judicial Council on Shared Interest Areas*

CAVSA staff and board continued to monitor statewide efforts to advance Veteran Treatment Courts (VTCs). As reported in Collaborative Justice: Survey and Assessment of Veterans Treatment Courts, about one in five justice-involved veterans (JIVs) is being served by VTCs in California. Table 9 above outlines promising outcomes related to VTCs, including lower arrest rates for VTC participants, and increased service connection rates for those in need of mental health and substance abuse treatment. Due to COVID-19, we have found it difficult to engage directly with the California Judicial Council on VTC efforts, although contact was established at points through conference and training participation by CAVSA members. We anticipate further engagement in this expanding initiative.

5. *Building community and agency partnerships*

Increasing attention on older veterans: two CAVSA member agencies, U.S. Vets and Nation's Finest (formerly Veterans Resource Centers of America), have worked collaboratively on projects this year dedicated to senior veterans. Each agency provides direct, comprehensive services, including housing and counseling. 24% of U.S. Vets and 37% of Nation's Finest's clients this year were over the age of 62. Both organizations are working to establish and maintain the necessary partnerships to expand services to older veterans. Some of those efforts include:

- Expanding home health nursing for acute medical care (e.g., palliative, wound care, diabetes management), medication management, and ongoing medical care for chronic medical conditions.
- Conducting safety evaluations that would identify safety concerns and needed durable medical equipment (e.g., shower chairs or commode seats) to keep veterans safe and living independently.
- Exploring partnership with nurse case managers within the health plan for instance IEHP, MediCare HMO or private health insurance to facilitate medical authorizations for care to keep veterans supported in independent living situations.
- Engaging neurological/memory care/ behavioral health providers to assist veterans in independent living given increased correlation of these issues with increased age.
- Leveraging existing staff in collaboration with VA Geriatric programs and community senior programs for senior specific social/ recreational activities and exercise.
- Promoting volunteer community programs that spend quality time with senior veterans to manage for loneliness, isolation, and boredom.

RATING OUR PROGRESS

This first report on the state of California's veteran community ended with a set of five recommendations and 22 proposed actions. In 2019, we marked progress towards this agenda by highlighting CAVSA board member and member agency activities (see Appendix C for the Action Agenda 2019-2020 Recommendations Table).

Table 11 highlights areas of progress and concern related to the status of actions taken in 2020. The status is signified by the following colors:

- ***Progress occurring, measurable success (green)***
- ***Stable, but still needs attention (gold)***
- ***Source of concern, not going well (red)***

TABLE 11

ACTION AGENDA 2020 PROGRESS

RECOMMENDATION	PROPOSED ACTIONS
1. Address Housing Challenges for Veterans	A. Actively engage in state and federal housing policy initiatives. • Support 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. • Advocate for inclusion of veterans as a population of focus in the state's Master Plan on Aging • Support expanding state housing and service programs to target aging veterans. • Continue work to ease leveraging federal funding for pay for services for aging veterans in supportive housing developments.
	D. Seek funding for mental health services and other supportive services to better serve VHHP and NPLH Project.
2. Expand Suicide Prevention, Intervention, and Postvention Activities	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 and prevention strategies for veteran families and possible collaboration. Activity DISCONTINUED in 2019-20; Military TAPS unable to expand to veteran families.
	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-specific mental health funding at local, state, and federal levels. • Increase attention on older veterans and veteran-family caregivers.

RECOMMENDATION	PROPOSED ACTIONS
3. Expand Advocacy Capacity and Data Collection Efforts	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 programs. • Expand data tracking of the needs of aging veterans across state and federal systems of care.
	C. Ensure tools to collect mental health treatment and referral data through relational data base, e.g.: 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. COMPLETED.
4. Engage with California Judicial Council on Shared Interest Areas	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	A. Build connections with community-based, non-veteran-specific providers of mental health and social services to serve as their Technical Assistance support on veteran- and military-connected family issues.
	B. Engage proactively with Veteran Service Organizations (VSOs).
	C. Collaborate with CalTAP to a) put a veteran and veteran family mental health curriculum online and b) outreach to military installation family readiness officers to provide transition information prior to discharge. COMPLETED.
	D. Develop Veteran Agenda materials for MHSA Stakeholder meetings on how to adapt programs to be more effective for the 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.

PART II:

MHSA COUNTY PLAN REVIEW

MHSA BACKGROUND AND COUNTY PLANNING REVIEW

The Mental Health Services Act (MHSA), also known as Prop 63, was approved by California voters in 2004 to place a one percent surtax on individual incomes above one million dollars. For the past 14 years, counties have received about $2 billion annually in State support for various mental health programs.

The MHSA addresses a broad continuum of prevention, early intervention, and service needs as well as providing funding for infrastructure, technology, and training for the community mental health system. The MHSA specifies five required components:

1) ***Community Services and Supports (CSS)***
2) ***Capital Facilities and Technological Needs (CF/TN)***
3) ***Workforce Education and Training (WET)***
4) ***Prevention and Early Intervention (PEI)***
5) ***Innovation (INN)***

The 2020-21 Governor's Budget indicates approximately $2.4 billion was deposited into the MHSF in Fiscal Year (FY) 2018-19. The Governor's Budget also estimates $2.4 billion will be deposited into the MHSF in FY 2019-20 and FY 2020-21, respectively. The Governor's Budget also estimates $53.7 million and $61.3 million will be transferred to the Supportive Housing Program Subaccount, Mental Health Services Fund (3357) per WIC Section 5890(f) in FY 2019-20 and FY 2020-21, respectively.

Ultimate accountability and authority for the disbursement and expenditure of funds is the purview of the California Department of Health Care Services (DHCS) and the MHSOAC. As the veteran stakeholder advocacy group since 2018, CAVSA has been responsible for helping to ensure counties are planning to provide adequate services to veterans in their state-mandated, MHSA Three-Year Plans and that there is a correlation between their Plans and actual accessibility and delivery of services to veterans and their families in their communities. To accomplish this, CAVSA provides a systematic review of County 3-Year MHSA Plans and Annual Updates to determine how well they are meeting their obligation to provide services to veterans and their families.

FIGURE 3

MHSA PRIORITY POPULATIONS STAKEHOLDER ADVOCACY GROUPS

Clients and consumers
Diverse racial and ethnic communities
Family members of clients and consumers
Immigrant and Refugee Communities
LGTBQ communities
Parents and caregivers of children and youth
Transition-age youth
VETERANS

https://mhsoac.ca.gov
http://mhsoac.ca.gov/fiscal-reporting-tool

MHSA PLAN REVIEW METHODOLOGY OVERVIEW

CAVSA has reviewed a selection of counties' MHSA Plans each year since 2018 to explore the degree to which counties include veterans and their families in mental health services. This year, Imperial, Mendocino, Nevada, San Diego, San Francisco, and the County of San Joaquin were selected for the diversity of their geographic locations, size of their veteran populations, and characteristics of their catchment areas. (2018: Kern, Monterey, Orange, Riverside, Shasta; 2019: Alameda, Butte, Fresno, Los Angeles, Napa, Ventura).

CAVSA established a baseline standard for evaluating MHSA three-year plans in our 2018 report. We evaluate plans according to three broad categories of interest—Veteran Stakeholder Engagement, Veteran Community Involvement, and Programming Relevant to Veterans. They are assessed via 23 total specific variables created based on requirements outlined in the Welfare and Institutions Codes and the California Code of Regulations that reference MHSA planning. Please see the CAVSA 2018 and 2019 Annual Reports for an in-depth review of how this methodology was established; also see Appendix D for a full explanation and descriptions of each category of interest and the corresponding key variables.

Our research team applied the same methodology in 2020 when reviewing the MHSA 3-Year Plans, (FY2021-2023). The six documents were uploaded to MAXQDA Analytics Pro 2020 Version 20.3.0 for analysis. Terms related to veterans were highlighted throughout each plan. Research assistants then identified the context within which veterans were referenced in order to assess the extent to which veterans were meaningfully incorporated into mental health service plans. (For example, veterans may have simply been listed as a demographic item in a survey, or veterans may have been more meaningfully described as participating in planning, services and/or outreach.) Next, the research team coded relevant segments of text according to 23 variables, each weighted by a score from zero to four (0, not evident in plan; 1, present in plan; 2, involvement or programing is described; 3, involvement or programing is meaningfully described, as evidenced by a description of impact; 4, involvement or multiple programs/services are described throughout the plan). Table 12 on the following page, provides a description of variables coded. These values were tallied to produce a "Total Score" for every county plan. The maximum possible score a plan could receive was 92.

FIGURE 4

MHSA PLAN REVIEW COUNTIES MAP

- *Imperial County*
- *Mendocino County*
- *Nevada County*
- *San Diego County*
- *San Francisco County*
- *San Joaquin County*

TABLE 12

DESCRIPTION OF MHSA PLAN REVIEW VARIABLES AND POSSIBLE SCORING (MAXIMUM 92)

VETERANS TAKEHOLDER ENGAGEMENT *(MAX. 40 POINTS)*	• Veteran stakeholder • Veteran organization representative stakeholder • Veteran family member stakeholder • Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations.
VETERAN COMMUNITY INVOLVEMENT *(MAX 32 POINTS)*	• Veteran program or services • Veteran family member program or services • Community collaboration with veteran organizations • Military/veteran cultural competence awareness/training • Veteran client-driven • Veteran/military family-driven • Wellness, recovery, and resilience-focused for veteran/military • Integrated service experiences for veteran clients and their families
PROGRAMMING RELEVANT TO VETERANS *(MAX 20 POINTS)*	• Other stand-alone programs with high relevance for and reference to veterans. 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 population, stigma and discrimination reduction, suicide prevention.

TABLE 13

COUNTY PLAN REVIEW SCORES

COUNTY *(NUMBER OF VETERANS, PERCENT OF TOTAL POPULATION)*	REVIEW SCORE *(OUT OF MAXIMUM 92)*
IMPERIAL *(5,566 veterans, 3% of total population)*	**3**
MENDOCINO *(5,333 veterans, 6% of total population)*	**1**
NEVADA *(8,428 veterans, 8% of total population)*	**5**
SAN DIEGO *(249,807 veterans, 7.5% of total population)*	**20**
SAN FRANCISCO *(24,848 veterans, 3% of total population)*	**13**
SAN JOAQUIN *(31,254 veterans, 4% of total population)*	**12**

325,277 veterans – about 20% of CA total veteran population. (0.8% of total CA population)

TABLE 14

HIGHLIGHTS FROM 2020 COUNTY MHSA PLANS AND UPDATES

COUNTY	HIGHLIGHTS	PROPOSED FUNDING FOR FY2-21
NEVADA	The *Veterans' Services and Therapy* is a program which provides mental health services and therapy to local veterans.	**$54,000**
SAN DIEGO	*Courage to Call* provides confidential outreach, peer counseling, and support services to veterans and their families. In FY 2018-19 2,988 unique clients were served.	**$1,291,264**
SAN FRANCISCO	During population-focused surveying, this county estimates 21% of clients served are veterans. Throughout their Plan and Update, *veterans are integrated into standard programming.* Additionally, eight beds are reserved for veterans in Full-Service Partnership (FSP) housing.	***Integrated funding***
SAN JOAQUIN	The local Veteran Service Office (VSO) *demonstrated clear partnership in the stakeholder engagement.* As a result, funding was allocated for the local VSO.	**$160,000**

MHSA PLANS REVIEW FINDINGS

Taken across the whole of each plan, the degree to which these counties tailored specific planning toward the needs of veterans and their families was limited. However, most counties made notable efforts to include specific mention of veterans and their families in planning for mental health services. Furthermore, all county plans included evidence that it was developed with local stakeholders, including veterans and representatives from veterans' organizations. Four out of the six counties (Nevada, San Diego, San Francisco, San Joaquin) allocated some of their budget specifically to veteran programs. As a result, these four counties also had veteran-specific programs. All but two counties (Nevada and Mendocino) demonstrated integrated service experiences for veteran clients and their families. And half of the counties (San Diego, San Francisco, San Joaquin) had stand-alone programs with high relevancy and reference to veterans. Interestingly, only two counties had suicide prevention programs (San Diego and San Francisco) that were relevant and referenced to veterans.

The Review Scores, tallied from the coding for each MHSA Plan Review, are displayed in Table 13 below, followed by Table 14 which include highlights from the 2020 County MHSA Plans and Updates. The county names in Table 13 include hyperlinks to stand-alone summaries of the county MHSA plan review.

ASSESSING ACCESS TO MENTAL HEALTH SERVICES: A SECRET SHOPPER TELEPHONE SURVEY

In addition to reviewing each county's three-year MHSA plans and annual reviews, CAVSA sought to assess how easy it might be for a veteran to access care from mental health service providers in each of the selected counties. A brief version of the methodology and summary of results will be presented here. For the full methodology description, a copy can be requested from CAVSA at **www.californiaveterans.org.**

The central question driving this assessment was: "When a veteran concerned about their own symptoms of anxiety reaches out for help, can they find and access appropriate services to assess and meet their needs?" We used a secret shopper phone-survey method, calling providers in each county (Imperial, Mendocino, Nevada, San Diego, San Francisco, San Joaquin) to assess three areas of the veterans-care system:

- Provider response (e.g., providing an appointment or referral for services) or lack of response
- Necessity to make follow-up calls
- Military cultural competence

We intended to follow the protocol from previous years, recruiting residents from a local permanent supportive housing program for veterans, and staff from a regional Veterans Resource Center. However, the procedures were changed this year to accommodate restrictions introduced by the pandemic. Thus, our research assistants and the project contractor performed all calls.

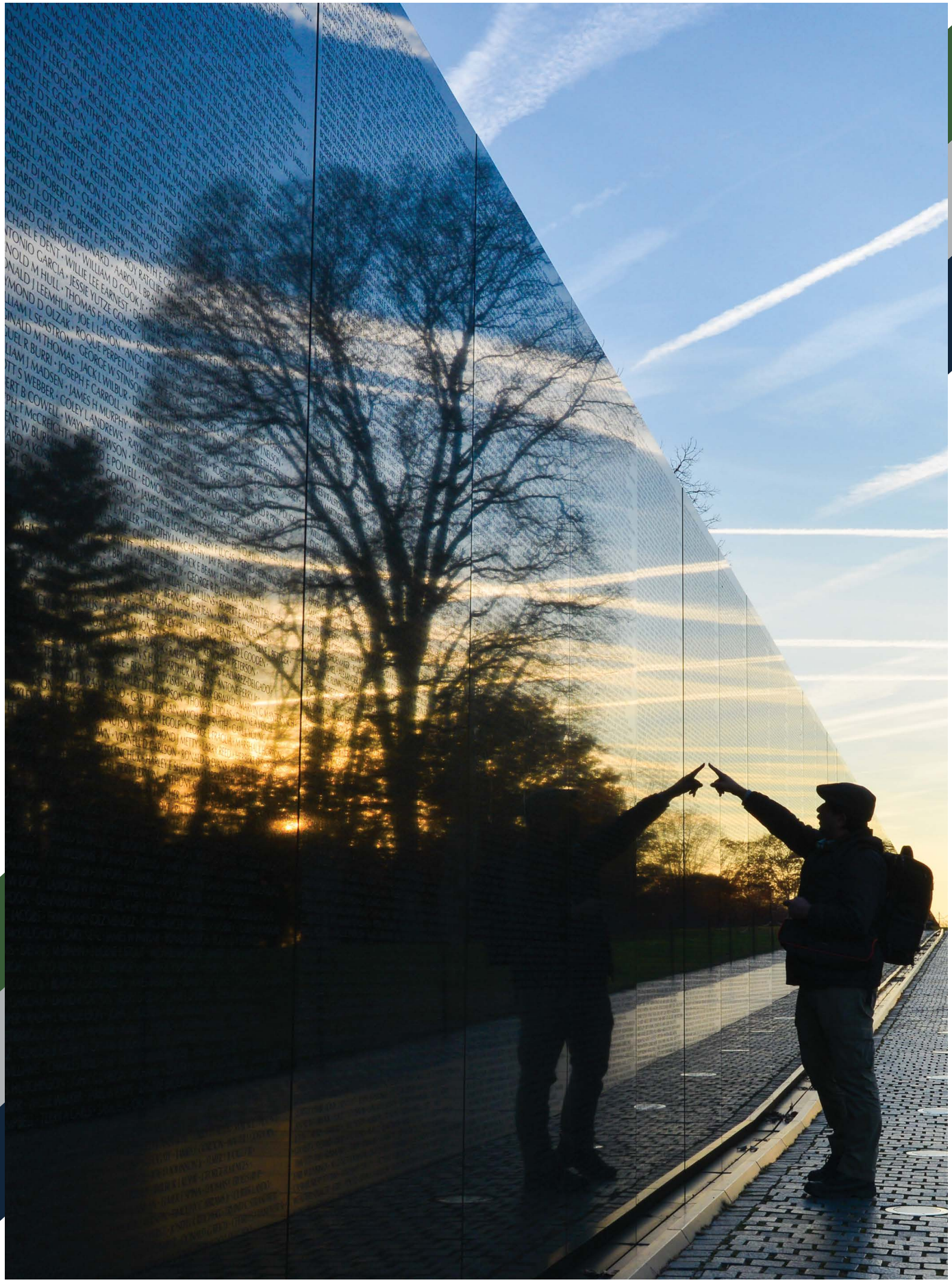
In assessing each of the six counties in 2020, our team made nearly 400 provider contact attempts, as detailed below in Table 15.

TABLE 15

NUMBER OF SERVICE PROVIDERS AND CONTACT ATTEMPTS BY COUNTY

COUNTY	SERVICE PROVIDERS SAMPLED	VETERAN-SPECIFIC SERVICE PROVIDERS	TOTAL CONTACTS	NUMBER OF VETERANS *(ESTIMATE 2020)*
IMPERIAL	12	2	26	5,566
MENDOCINO	11	3	23	5,333
NEVADA	12	1	26	8,428
SAN DIEGO	83	23	189	249,807
SAN FRANCISCO	39	11	87	24,848
SAN JOAQUIN	22	4	47	31,294
TOTAL	179	44	398	325,277

**Estimate source: USDVA, VetPop 2018.*



The scenario script presents a person experiencing anxiety who is seeking mental health services. Callers started the call saying, "I want to see someone about my mental health. I'm a veteran and don't have insurance," explaining, "It has been pretty bad lately. I'm anxious all the time; I keep getting upset over nothing." Each caller then asked, "What is the process to see a doctor or counselor, or get set up with some services?" The scenario is meant to present a serious need for mental health services centering on anxiety that, simultaneously, does not raise concern about a threat of immediate danger, as this could trigger an unwarranted emergency response with law enforcement.

These six counties differ greatly in their populations, veteran needs, service provider concentration, and infrastructure adequacy. Table 16 shows that San Diego county had the highest rate of service provider contact (60%) on the first call attempt, while San Francisco county had the lowest rate (27%). Nevada and San Francisco counties had the highest voicemail rates for first call attempts (46% and 42%, respectively), but also the lowest call back rates (25% and 20%, respectively).

First impressions are important, especially when a veteran is attempting to contact a service provider with a concern about their mental health.

While presented in combined tables, generalizing the findings from this evaluation is difficult due to heterogeneous veteran populations and services across counties for which the survey method does not adjust. Therefore, the summary results for each county are to be read individually in Table 17. More detailed individual county analyses are presented in the full report available from CAVSA at **www.californiaveterans.org.**

The second column of Table 16 shows the percentage and number of contact attempts that ended with either no contact, or when a message left was not returned. "Negative Disposition" in the third column reports instances when the successfully contacted provider offered neither services nor a referral. The last column, "Positive Disposition," summarizes the attempts that ended with the caller being offered either an available appointment, or being given appropriate referral information for obtaining assistance with their mental health concern.

Table 18 combines the first and second column from Table 17 to show the percent of all call attempts for which the callers ultimately received no help. This means that either: 1) upon contact, no appointment was available and no referral was given, or 2) that no contact was established. In three counties, more than half of the attempts resulted in no help (San Francisco 73%, Nevada 62%, Mendocino 59%).

TABLE 16

FIRST CONTACT ATTEMPT OUTCOMES

COUNTY	TALKED TO A PERSON	SENT TO VOICEMAIL	CALLBACK RATE	WRONG NUMBER	NO ANSWER	DISCONNECTED
IMPERIAL	58% (14)	25% (6)	33% (2)	8% (2)	8% (2)	0% (0)
MENDOCINO	50% (11)	18% (4)	25% (1)	5% (1)	27% (6)	0% (0)
NEVADA	37% (9)	42% (10)	20% (2)	4% (1)	17% (4)	0% (0)
SAN DIEGO	60% (100)	29% (49)	45% (21)	4% (6)	5% (8)	2% (3)
SAN FRANCISCO	27% (21)	46% (36)	25% (9)	14% (11)	12% (9)	1% (1)
SAN JOAQUIN	52% (23)	25% (11)	27% (3)	9% (4)	14% (6)	0% (0)

TABLE 17

DISPOSITION OF ALL CONTACT ATTEMPTS BY COUNTY

COUNTY	UNIQUE-CALLER ATTEMPTS	NO CONTACT NO CALLBACK	NEGATIVE DISPOSITION	POSITIVE DISPOSITION
IMPERIAL	24	33% (8)	13% (3)	54% (13)
MENDOCINO	22	50% (11)	9% (2)	41% (9)
NEVADA	24	58% (14)	4% (1)	38% (9)
SAN DIEGO	166	29% (48)	13% (21)	58% (97)
SAN FRANCISCO	78	67% (52)	6% (5)	27% (21)
SAN JOAQUIN	44	41% (18)	2% (1)	57% (25)

TABLE 18

NO HELP BY COUNTY

COUNTY	NO APPOINTMENT	TOTAL ATTEMPTS
SAN DIEGO	42% (69)	166
SAN FRANCISCO	73% (57)	78
SAN JOAQUIN	43% (19)	44
IMPERIAL	46% (11)	24
MENDOCINO	59% (13)	22
NEVADA	62% (15)	24

SUMMARY

Our findings suggest veterans are having trouble receiving direct services and/or being directed to other services that may be available to address their mental health concerns. In only three of the counties, just over half of the call attempts resulted in a positive disposition (San Diego 58%, San Joaquin 57%, Imperial 54%). The county with the fewest calls resulting in an appointment or referral is San Francisco, at 27% of attempted contacts.

The volume of contact attempts that resulted in no help is concerning. In three counties, that percentage is 59% or above (San Francisco 73%, Nevada 62%, Mendocino, 59%). Unreturned voicemail messages drive this result. In five of six counties, messages were returned less than one third of the time; the county with the best rate was San Diego (45%), which is less than half.

Upon closer examination of the notes documented by callers, lower positive disposition rates among veteran-specific programs appear to be due to how calls to VA clinics were handled. In many instances, the service provider informed the caller they must first be registered in the VA system before an appointment could be made. The provider then directed the caller to start the VA eligibility process. However, due to the pandemic, in-person applicants were discouraged. In many instances, callers were simply told to access the web-based application or a phone line. In several cases, VA representatives failed to communicate whether the caller could visit a walk-in clinic. Given our protocol, if no referral to a service was given, the call was recorded as "no appointment/service" and "no additional service referral" (e.g., negative disposition). The granularity of these results can help direct interventions by counties at different service points to at least reduce the no contact/callback rates.

The summative conclusion that can be drawn from this effort is that veterans reaching out for help cannot be assured of receiving it on a consistent basis, even when calling agencies or services like the VA that are designed to deliver behavioral and mental health supports. This finding offers an opportunity for CAVSA to engage with such agencies across the State to provide military cultural competence training in future years.

LOOKING BACK: REVISITING OUR 2018 MHSA PLAN AND UPDATE OVERVIEW

In 2018 Annual Report, CAVSA implemented the first review of MHSA Plans and Updates. The following provides an overview of the current status of the five counties reviewed: Kern, Monterey, Orange, Riverside and Shasta. To avoid drawing inaccurate comparisons, the research team did not use the methodology previously utilized by the CAVSA team, as the previous scores were given for a different fiscal year. Rather, the following provides an update on the current standing of MHSA-funded programs that are specific to veterans and their families. Each overview covers themes from the variables contained in the previously used methodology (please see CAVSA Annual Report for review of methodology on page 43). The core themes include veteran stakeholder engagement, veteran/military family community involvement, and programs with high relevancy to veterans.

Researchers reviewed each of the five counties' MHSA Annual Updates from FY 2019-20 and MHSA Three-Year Plans for FY 2021-23. Researchers discovered that three counties did not demonstrate substantial changes from their original reports for the core themes in their current MHSA Updates and Plans: Kern, Riverside, and Shasta County (see CAVSA 2018 for original findings). However, two counties did demonstrate substantial changes: Orange and Monterey. The following highlights Orange and Monterey counties' continued progress and improvements in regard to the core themes since the initial CAVSA MHSA review in 2018.

ORANGE COUNTY MHSA PLAN AND UPDATE OVERVIEW

Orange County demonstrates a strong understanding of veterans and military families' mental health needs throughout their MHSA Updates and Plans, as evidenced by veteran specific programs, integration of veterans in standard programming, and clear veteran stakeholder involvement. Since the 2018 Update and Plan Review completed by CAVSA, the programs described below have continued, as well as new veteran-specific projects added. Orange County has age-specific and population specific programming for veterans, rather than a stand-alone-one-size fits all veteran program (See Table 19 for program descriptions). Furthermore, they have leveraged two funding streams to explore new programming for veterans and their families through INN and PEI funds (See table 19 and 20 for more information). Additionally, they seamlessly integrate veterans into standard services. This is most clearly demonstrated by their use of CSS funds to house veterans (see Table 21 for more information). Lastly, throughout the above programs there is clear evidence of veterans involved in the stakeholder engagement and community planning process. At each level of the planning and evaluations of outcomes, veterans are considered, as evidenced by clear tracking of veterans served, military cultural competency trainings for providers, and the use of veteran peer navigators and providers. Orange County continues to be resourceful with funding by further considering proposals for new veteran-specific programs. For example, a proposal for current INN funding is to create the Older Veterans Support Program, which will aim to serve isolated older veterans in need of socialization. Orange County continues to provide an example to the veterans' mental health service community by demonstrating unique use of MHSA funds and innovative programming. Please see Orange County's Three-Year Program and Expenditure Plan, Fiscal Years 2020-2021 through 2022-2023 for more specific details.

https://www.ochealthinfo.com/sites/hca/files/import/data/files/116403.pdf

TABLE 19

ORANGE COUNTY MHSA-FUNDED VETERAN SPECIFIC PROGRAMS

PEI FUNDS			
PROJECT	**PROGRAM DESCRIPTION, VETERAN TARGET POPULATION AND SERVICES**	**OUTCOME (FY19-20)**	**FUNDS (FY20-21)**
Veteran School-Based Intervention (formerly College Veterans Program)	• ***Target Population:*** veterans transitioning to civilian life; main referral source: college campus-based Veteran Resource Centers • ***Services:*** screening and assessment, brief counseling, case management, referral and linkage to appropriate community resources (e.g., Veterans Court, Peer Navigator), outreach and engagement activities and community trainings (p.g.138)	**82 veterans served**	**$400,000**
OC4VETS	• ***Target Population:*** any veteran and their family members; main referral source: local VSO • ***Services:*** same services as above, initial referral source different	**118 veterans served**	**$1,000,000**
Behavioral Health Services for Military Families	• ***Target Population:*** all members in the military family, specific aim to address prevent the onset and/ or worsening of mental health conditions that are especially relevant to veterans and their families such as PTSD, TBI and SUD • ***Services:*** short-term counseling, family therapy to address impact of trauma, peer navigators for case management, peer support, and referrals	**105 families served** **413 individuals served**	**$1,000,000** *(formerly INN)*

TABLE 20

ORANGE COUNTY MHSA PILOT PROGRAMS

INN FUNDS		
PROJECT	**PROGRAM DESCRIPTION**	**FUNDS (FY20-21)**
Continuum of Care for Veteran and Military Children and Families	This program targets Family Resource Centers throughout Orange County in an effort to expand service providers' knowledge about the needs of military-connected families so providers feel competent and willing to identify and serve the veteran population (pg. 223).	**$962,445**
Older Veterans Support Program	This potential program aims to identify isolated senior veterans and enroll them into an engaging socialization program (page 256)	**TBD**

TABLE 21

ORANGE COUNTY MHSA INTEGRATION OF VETERANS IN STANDARD SERVICES

INN FUNDS		
PROJECT	**PROGRAM DESCRIPTION**	**FUNDS (FY19-20)**
MHSA Special Needs Housing Program (SNHP)	This program targets Family Resource Centers throughout Orange County in an effort to expand service providers' knowledge about the needs of military-connected families so providers feel competent and willing to identify and serve the veteran population (pg. 223).	**$40 million** **SNHIP funds total** *(an unknown % was given for veteran specific housing)*

LESSONS LEARNED FROM ORANGE COUNTY MHSA UPDATE AND PLAN REVIEWS

- Create age- and population-specific veteran programming
- Leverage INN funds to pilot new veteran programs
- Integrate veterans into already existing services
- Collect demographic data on veterans to identify and track needs
- Provide military cultural competency training for providers
- Utilize veterans with lived experience as providers and peer navigators
- Use already existing veteran specific programs, such as local Veteran Service Office and Veteran Resource Centers, as a referral system and pathway to build stakeholder involvement

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MONTEREY COUNTY MHSA PLAN AND UPDATE OVERVIEW

The 2018 CAVSA Annual Report originally identified that Monterey County demonstrated limited awareness of veterans' mental health needs throughout their 2017-20 MHSA Plan and 2017-18 Update. However, after a review of their most current MHSA Update and Plan, there has been a dramatic shift. Their current Update provides clear information on their Veterans Reintegration Transition Program (VRTP) funded through PEI funds in their Access Regional Service. This program is based in their walk-in clinic and provides peer support, screening, and referrals. Their current Plan demonstrates an even deeper awareness of veterans' unique mental health needs. First, during the community planning process (CPP), the county completed a Needs Assessment where veterans were identified as a special population in need of further service. Specifically, veterans were mentioned in core themes of the Needs Assessment related to culturally responsive and trauma-informed practices, as well as a need for expanded services for veterans (page 8). Furthermore, the county began to demonstrate screening and tracking of veteran statuses among their standard programming. In addition, data were also gathered for the veteran-specific program indicating that roughly 320 veterans were served in FY2018-219.

LESSONS LEARNED FROM MONTEREY COUNTY MHSA UPDATE AND PLAN

- Use Needs Assessments to establish understanding for special populations, like veterans
- Identify and track veterans throughout all programming
- Leverage PEI funds as a starting ground for veteran specific programming

AREAS FOR GROWTH

- Identify budget allocations for special population programming in MHSA Plans
- Create programming for military families
- Utilize WET funds for cultural competency training that are veteran and military family specific

PART III:

COVID-19 PANDEMIC SERVICE IMPACT AND RESPONSE

COUNTY REVIEW SECRET SHOPPER STUDY

By March 2020, the COVID-19 pandemic forced the State of California and veteran-serving agencies to take dramatic protective actions to stop its spread. CAVSA, our members, and veteran-serving agencies across the state scrambled to assess impacts to veterans experiencing or at risk of mental health crises, suicide, homelessness, or substance abuse while we continued to provide ongoing and emergency response services.

In the normal course of conducting our secret shopper assessment of mental health service access, we detected evidence of early challenges affecting service availability in our selected MHSA plan review counties. Therefore, our caller script was adapted to collect information on protocols that agencies were putting in place because of the pandemic and related State orders. When contact was made, our callers asked, "Is there anything special I need to do or know in relation to COVID-19?"

Any information related to service accessibility and the pandemic obtained during calls, including information stated on recorded messages, was noted. The percentage of providers where a specific protocol was highlighted varied by county. As shown in Table 22, a high percentage of contacted providers in Mendocino and San Joaquin counties indicated COVID-19 protocols even though they were not hot spots at the time of the call.

Table 23 shows counts of special procedures used by providers due to the pandemic. Caller notes indicate the "other" categories include additional protocols such as conducting phone and video appointments, rescheduling non-emergency appointments until a specific date, and offering additional referral options.

ADDITIONAL TARGETED SURVEYS ON COVID-19 PANDEMIC IMPACT

Seeing the challenges already mounting in June 2020, we conducted two additional targeted surveys—the first to veteran-serving agencies statewide, and the second to CAVSA members. For a list of agencies that responded, please see Appendix E. The questions were focused toward assessing in more detail how agencies are responding to the pandemic or have adapted veteran services due to pandemic risks and protocols, their greatest needs, and how CAVSA and legislators could best help. The full results are reported in two stand-alone reports, Veteran-Serving Providers Speak – Challenges, Adaptations, and Resilience during the Pandemic: 1) the Statewide Veteran Service Provider Survey (40 agency respondents), and 2) the CAVSA Member Agency Survey (five agency respondents). A summary of findings follows in Table 24.

TABLE 22

PROVIDERS WITH SPECIAL PROTOCOLS DUE TO COVID-19

COUNTY	PROPORTION
San Diego	48% (40)
San Francisco	33% (13)
San Joaquin	73% (16)
Imperial	67% (8)
Mendocino	73% (8)
Nevada	50% (6)

TABLE 23

PROVIDERS THAT INDICATED SPECIAL PROCEDURES DUE TO COVID-19

COUNTY	CALLER ASKED TO LEAVE A MESSAGE	NO NEW PATIENTS	PHONE PRE-SCREEN /INTAKE	MASKS REQUIRED	TEMPERATURE CHECK	WEB INFORMATION/ APPLICATION	OTHER
IMPERIAL	1	1	24	13	2	1	13
MENDOCINO	2	1	10	2	0	0	1
NEVADA	0	0	6	4	5	2	6
SAN DIEGO	0	1	10	2	1	1	3
SAN FRANCISCO	0	0	5	5	1	2	2
SAN JOAQUIN	0	1	3	3	1	0	1

TABLE 24

SUMMARY OF FINDINGS FROM *VETERAN-SERVING PROVIDERS SPEAK— Challenges, Adaptations, and Resilience during the Pandemic.*

Challenges

- Housing – affordability, accessibility, availability.
- Social isolation is affecting mental health and increasing substance use
- Clients have lost income
- VA offices had been closed; limited walk-ins and general service availability

Changes agencies made

- Most agencies moved intake assessments to virtual platforms, and had some staff work remotely; more than one-third switched some in-person counseling to telehealth
- All agencies implemented multiple measures to support their staff, such as allowing for flexible schedules and offering financial assistance
- All agencies adjusted workspaces (e.g., adding barriers, increasing distancing, conducting screenings with temperatures, supplying hand sanitizer)
- One added mental health or emotional counseling for staff

Resilience and Creativity

- With additional funding made available, few agencies reported laying off staff.
  - "Our doors have remained open to any that are in crisis."
- Creative new programs and efforts to combat social isolation were initiated
  - Distributing food and diapers
  - Playing movies in community rooms with distancing protocol
  - Hosting remote couples and family-oriented games
  - Organizing drive-through events for holidays such as Memorial Day

What legislators can do

- Respondents said their legislators could do the following to help:
  - Extend rent and utility payment moratoriums
  - Retain reimbursement and allowances for telehealth services
  - Increase funding for direct program support, and permanently increase funding for supportive housing programs
  - Allow access to COVID funding for mental and behavioral health programs

How CAVSA can help

- CAVSA member agencies suggested that the following would help:
  - Offer a webinar on best practices for remote interaction with clients
  - Share resources and information on COVID-related grants and loans
  - Summarize telehealth regulations

In general, the survey findings show that these agencies have worked diligently to make difficult but necessary adjustments; luckily, additional resources from several sources were made available to help. However, as the pandemic drags on and as funding sources potentially dry up, more will be needed to help veteran-serving agencies and their staff maintain safe, quality services. There is also a need for additional informational support—for example, training on best practices for distance services, telehealth billing rules, and emerging forms of emergency financial support. The following cumulative recommendations are made in the two reports.

INCREASE FUNDING FOR DIRECT PROGRAM SUPPORT

- Permanently increase funding for transitional and supportive housing programs
- Allow greater access to pandemic-related funding for mental and behavioral health programs|

PROGRAM DELIVERY AND STAFF SUPPORT

- Add planning and budget resources for mental health or emotional counseling for agency staff
- Institute or maintain “critical mission” incentive pay
- Expand peer-to-peer virtual connection programs for veterans living in supportive living communities
- Develop sharing platforms for best practices to combat social isolation while practicing necessary social distancing
- Support training on virtual meeting tools and the provision of needed technology or equipment for agencies and their clients

PARTICULARLY IN RURAL COMMUNITIES

- Enhance transportation services to provide safe transport to and from services
- Target funding for smaller agencies

COVID-19 RESPONSE HIGHLIGHT: NATION’S FINEST MOBILE SERVICE UNIT FLEET

Before the pandemic providers struggled with serving veterans in rural areas or remote locations with high quality complete wraparound services. With its onset, public safety closures, a lack of regular office locations, and inconsistent hours of operation made it difficult to reach veterans with even basic services. Therefore, Nation’s Finest, a CAVSA member agency with 10 offices in California, launched a new Mobile Service Unit (MSU) fleet consisting of customized vans operated by Nation’s Finest case managers using their brick-and-mortar facilities as hubs. These MSUs drive out to underserved rural communities to locate and assist veterans in need. New to the industry, MSUs were successful from the very beginning, providing much-needed shelter for our clients and connecting them to services during these trying times.

Each Mobile Service Unit is a transport van configured as a fully functional mobile office. Services onboard the MSU include general counseling and service referral, veteran status verification, document request completion, and benefit application assistance (VBA, SOAR etc.).

Strategic deployment of Nation's Finest staff in MSUs is establishing regular and consistent locations and hours of operation in remote rural communities. The presence of MSUs is developing service recognition in areas long underserved, providing veterans a reliable access point to discuss their unique challenges with a professional case manager or counselor. Nation's Finest continues to bolster this initiative by building productive positive collaborative relationships with community partners in these communities. Additionally, the new MSU outreach capacity is being used to bolster connections with distant mainstream VA or other social services benefits.

SUCCESS IN LASSEN COUNTY

In Susanville, community residents had long worked to help a local veteran known around town as Cowboy Joe. Multiple times over the past three years, residents and Cowboy Joe worked to establish a service connection, only to have each effort eventually fall apart. When the Redding Veteran Resource Center MSU arrived in the parking lot of the Lassen County Veterans Service Office, the VSO brought Cowboy Joe out to meet the MSU team. Within two hours, he was enrolled in the SSVF program, provided temporary emergency shelter in a motel, and had food to eat. Cowboy Joe continues to work with Nation's Finest case managers through the MSU to secure permanent stable housing.

FINDING PERMANENT HOUSING SOLUTIONS FOR HOMELESS VETERAN YOUTH

CAVSA member agency, California Veterans Assistance Foundation (CVAF) took on serving a new subpopulation of homeless veterans in 2020 during the pandemic. "Homeless veteran youth" are individuals between the ages of 18 – 24 who meet the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act definition of homeless. The biggest identifier for this group is eligibility for additional financial and programmatic support through targeted homeless youth programs.

Youth veterans experiencing homelessness often have high-level mental health concerns, coupled with a tendency to refuse mental health services. When working with these youth, it is common to learn that their discharge from the military was other than honorable (OTH) due to mental health, substance use, or criminal activities in service. Without targeted assistance, these youth face multiple barriers to regaining stability.

HOMELESS VETERAN YOUTH STORY:
Richard, a 22-year-old veteran, was living in his parent's truck after he surrendered his permanent housing to his spouse. Because Richard had an OTH discharge, he was not eligible for VA Healthcare or housing assistance. When he first presented for services, Richard was diagnosed with generalized anxiety disorder, major depressive disorder, and concentration deficit disorder and was referred to community partners as a homeless youth to explore other housing options.

Having successfully seen a doctor, and then having been connected to the local Veterans Service Department, CVAF helped Richard applied for service connected disability. Within five months, he was rated at 90% for mental and medical health issues and will be receiving a discharge upgrade. This upgrade will allow ongoing support for his mental health care, and with CVAF assistance Richard's life is turning around; he is now permanently housed without a subsidy.

APPENDIX A

2018 REPORT CARD:
Comparative Markets of Concern for California Veterans

MEASURE *(UNLESS SPECIFIED, ALL RATES ARE AGE- ADJUSTED)*	NATIONAL GENERAL U.S. POPULATION	NATIONAL VETERAN	CALIFORNIA GENERAL POPULATION	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 U.S. 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	**13.3/100K** - population (2016 data)	**19.85/100K*** - person years (2005 VHA patient data)	**4.49/100K** - CA population (2017 data)	**No California Veteran-specific data is available** - The absence of data is itself a negative indicator
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**

APPENDIX B

2019 REPORT CARD:
California Veteran Mental Health and Well-Being Indicators

MEASURE *DATA SOURCES ON FOLLOWING PAGE)*	NATIONAL GENERAL U.S. POPULATION	NATIONAL VETERAN	CALIFORNIA GENERAL POPULATION	CALIFORNIA VETERAN
PERSONS IN HOMELESSNESS	**T= 552,830** (.17% of total U.S. pop.) - 35% Unsheltered 194,467	**37,878** (9% of all U.S. homeless adults) - 38% Unsheltered 14,566	**129,972** (24% U.S. total; .34% of CA total) - 69% unsheltered 89,543	**10,836** (29% of all homeless U.S. veterans; 8.3% of all CA homeless) - 67% Unsheltered 7,214
SUICIDE	**47,173** - Age-adjusted Rate 14.5/100K Male: 22.9/100K; Female: 6.3/100K)	**6,079** - Age-adjusted Rate 26.1/100K Unadjusted Rate 30.1/100K	**4,312** - Age-adjusted Rate 10.5/100K* Unadjusted Rate 10.9/100K*	**640** Age-adjusted rate unavailable Unadjusted Rate 28.2/100K
OPIOID OVERDOSE DEATHS	**47,600** - Age-adjusted Rate 14.9/100K - (67.8% of all drug overdose deaths)	**Missing numeric data** - Extrapolated Unadjusted Rate 21.08/100K	**2,196** (range = 2,193-2,199) - 5.23/100K (5,308 total overdose deaths, 2018, not exclusively opioid)	**No California Veteran-specific data is available** - The absence of data is itself a negative indicator
JUSTICE INVOLVEMENT	**2.3 million** - 698/100K	**181,500** - (Estimated just under 8% of U.S. incarcerated pop., 2016)	**138,000** Adult Inmates Under CDCR, 2017 data - 581/100K	**5,769** (veteran inmates + 2,200 under parole supervision or in transition) - (about .34% of total CA veteran population

APPENDIX C

ACTION AGENDA
2019-2020 Recommendations

RECOMMENDATION	PROPOSED ACTIONS
1. Address Housing Challenges for Veterans *Increase focus on older veterans and added attention to rural veteran housing and services*	A. Actively engage in state and federal housing policy initiatives. Support 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 Project.
2. Expand Suicide Prevention, Intervention, and Postvention Activities *Increase attention on older, rural veterans and National Guard and specific support for veteran family caregivers in Item D.*	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 strategies for veteran families and possible collaboration. ***Activity DISCONTINUED in 2019-20 due to Military TAPS inability to expand to veteran families at this time.***
	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 *Reliable data is essential to informed policy and programs. Items B, C, and D will be re-evaluated in 2019-20 to explore opportunities for CAVSA to expand its current scope of work and funding to collaborate with key agencies on these tasks whose job it is to implement data collection efforts.*	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 Programs.
	C. Ensure tools to collect mental health treatment and referral data through relational data base, i.e.: 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. **COMPLETED**.
4. Engage with California Judicial Council on Shared Interest Areas *Explore additional ways to share positive results of Judicial Council's work with CAVSA stakeholders*	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.

(CONTINUED ON NEXT PAGE)

APPENDIX C *(CONTINUED)*

ACTION AGENDA
2019-2020 Recommendations

RECOMMENDATION	PROPOSED ACTIONS
5. Build Community and Agency Partnerships *Item D will focus on County-specific advocacy since counties have varying protocols for community engagement and stakeholder involvement*	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 a stakeholder base.
	C. Collaborate with CalTAP to a) put a veteran and veteran family mental health curriculum online and b) outreach to military installation family readiness officers to provide transition information prior to discharge. **COMPLETED.**
	D. Develop Veteran Agenda materials for MHSA Stakeholder meetings on how to adapt programs to be more effective for veteran and veteran family populations 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.

APPENDIX D

HISTORY OF THE MHSA PLAN REVIEW METHODOLOGY BY CAVSA

The Plan Review methodology was derived from the MHSOAC's *MHSA 3-Year Plan Instructions*. As a result, CAVSA researchers created 13 key variables and a four-point scoring system to facilitate standardized Plan reviews. Each of the 13 key variables were created based on key Welfare Institution Codes (WIC) and the California Code of Regulations (CCR). WICs are the general statutory law of California governing the provision of public mental health services. CCR is the code of regulations adopted by the state agencies charged with enforcing the implementation of MSHA funds. WICs provide counties the laws which must be followed in developing plans to spend MHSA funds, and CCR provides counties guidance on how to interpret those laws. Therefore, the 13 key variables incorporate important descriptions from WICs and the CCR. The following describes the three overview categories—*Veteran Stakeholder Engagement, Veteran Community Involvement, and Programming Relevant to Veterans*—that are assessed through 13 variables.

VETERAN STAKEHOLDER ENGAGEMENT

WIC § 5848 and CCR § 3300 informed the creation of variables related to Veteran Stakeholder Engagement. WIC § 5848 specifies that,

> *"Each plan shall be developed with local stakeholders, including […]Veterans and Representatives from veterans' organizations […]"*

CCR § 3300 further clarifies that stakeholder involvement must be meaningful, which is defined by substantive changes based on stakeholder feedback:

> *"[…]counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on: mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations […]"*

Together, the law and regulation informed the development of the following variables: veteran stakeholder, veteran organization representative stakeholder, veteran family member stakeholder, and the Counties shall demonstrate a partnership with constituents and stakeholders.

VETERAN COMMUNITY INVOLVEMENT

WIC § 5800-5886 and CCR § 3320 informed the creation of variables five through twelve related to Veteran Community Involvement. WIC § 5800-5886 describes how counties will serve individuals with severe mental illness in the public sector, and highlights the requirement to include vulnerable groups such as veterans. CCR § 3320 then specifies how counties can ensure they are following this mandate. It states,

> *"[…] 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."*

Together, the law and regulation informed the development of the following variables: veteran program or services, veteran family member program or services (children, spouse, parents, siblings, etc.), community collaboration with veteran organization, military/veteran cultural competence awareness/training, veteran client-driven, veteran/military family-driven, wellness, recovery, resilience-focused for veteran/military, and integrated service experiences for veteran clients and their families.

PROGRAMMING RELEVANT TO VETERANS

Finally, variable thirteen is based upon a recommendation to consider "stand-alone programs" which have a high relevance to veterans, such as programs that address trauma, suicide, and the mental health stigma. Together, this informed the subcode creation of: outreach for increasing recognition of early signs of mental illness, access to treatment, improving timely access to services for underserved population, stigma and discrimination reduction, and suicide prevention.

APPENDIX E

AGENCIES THAT RESPONDED TO COVID-19 SERVICE IMPACT SURVEY

RESPONDING AGENCIES	
A Combat Veteran's Hope	Operation Dignity
Alexandria House	Paralyzed Veterans of America, Cal-Diego
Cal Voices	PATH (People Assisting the Homeless)
Central Valley Homeless Veterans Assistance Program (CVHVAP)	Retired Activities Office, Marine Corps Base Camp Pendleton
California Veterans Assistance Foundation	Swords to Plowshares
CAPSLO, SSVF	The Hire Target
Center for Living and Learning	Third Avenue Charitable Organization
Community Action North Bay	United States Mission Corp
Community Catalysts of CA	U.S. Vets
County of San Luis Obispo	VA, Northern California System
CVSO, Lake County	VA, Readjustment Counseling Services
CVSO, Placer County	VA, San Francisco Health Care System
CVSO, San Luis Obispo County	Vet to Vet
CVSO, Solano County	Veterans Accession House
CVSO, Yolo County	Veterans Association of North County
Delivering Innovation in Supportive Housing	Veterans Partnering With Communities, Inc.
Disabled American Veterans, AMVETS	Victory Village, Inc.
Interfaith Community Services	Veteran's Village of San Diego
Nation's Finest	Working Wardrobe, VetNet

2020 ANNUAL REPORT SUMMARY
THE CALIFORNIA VETERAN COMMUNITY: LOOKING FORWARD TO CHANGE

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