2019 ANNUAL REPORT

The California Veteran Community: Looking Forward to Change

California Association of Veteran Service Agencies
(CAVSA)

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*This quote by Johann Wolfgang von Goethe, famous 18th century German scientist and statesman, is used in the opening page of the Institute of Medicine's landmark 2010 report, "Returning Home from Iraq and Afghanistan - Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families" which outlined the needs of U.S. veterans. The quote still applies.

https://californiaveterans.org

> ***"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*
> *U.S.VETS, President and CEO*

> ***"Knowing is not enough; we must apply. Willing is not enough; we must do."***
>
> — Goethe*

ACKNOWLEDGEMENTS

On behalf of the Board of the California Association of Veteran Service Agencies (CAVSA), we are grateful for the opportunity to deliver this 2019 State of the Veteran Community Report to our statewide community. This is our second annual report prepared through the support of the Mental Health Services Oversight and Accountability Commission (MHSOAC).

CAVSA agencies' leadership and dedicated staff work on last year's (2018-19) Action Recommendations has been nothing short of inspiring. 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—both those that explicitly serve veterans and those that have not been aware of serving veterans in years past. Although considerable progress has been made this past year to help close service gaps for our veteran communities, there is still much to be done.

This report strives to celebrate and honor the successes of those who work tirelessly to serve our military veterans, while also highlighting unmet needs and identifying the challenges ahead.

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.

As CAVSA expands our veteran mental health agenda, we are reminded veterans and their families have unique needs that require a culturally competent approach to services and treatment. However, we also 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 must be a critical component of our action agenda.

Even as we work to reduce the unacceptably high number of veterans who live in unsheltered homelessness, burdened by poor mental and physical health, we are also dedicated to celebrating and honoring the many veterans who are attending college, exiting from justice involvement to make better lives for themselves and their families, or serving in the National Guard, and as first responders, putting their military skill set to much-needed use in the civilian sector.

As you read this report containing 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 2019

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PREFACE

More veterans live in California than any other state

California continues to lead the nation as home to more veterans than any other state—about 8% of all U.S. veterans live here. California's estimated 1,578,509-strong veteran community is more than four times the average number of veterans living anywhere else in the United States. California is also home to the largest Selected Reserve population, with 57,031 members including the Army National Guard, Air National Guard, Army Reserve, Air Force Reserve, Navy Reserve, Marine Corps Reserve, and Coast Guard Reserve. Although exact numbers are unavailable, it is estimated about half of California's National Guard are prior-enlisted and, as veterans and citizen-soldiers, warrant support from CAVSA and all Californians who have relied on their service to our nation and state.

USDVA population projection model.
https://www.va.gov/vetdata/Veteran_Population.asp
https://download.militaryonesource.mil/12038/MOS/Reports/2017-demographics-report.pdf

Nearly half of California's veterans are senior citizens

Even with this large population of veterans, California has nearly 104,000 fewer veterans in 2019 than in 2017. This decline in population is projected to continue because nearly half of California's veterans in 2019 are 65 years or older. This demographic reality is at odds with the public's typical image of a "veteran", in part due to the recent focus on post-9/11 veterans. In California, our pre-9/11 and post-9/11 veterans are almost equal in population size, but have quite different needs. Our large and growing community of elderly veterans has clear implications: our state needs targeted elder-care services that are not adequately in place in California's veteran care portfolio today. As California's most senior veterans are living longer—into their eighth decade or older—they, and their caregivers, require special support to manage their mental, physical, and behavioral health needs.

TABLE 1

CALIFORNIA VETERAN AGE PROFILE

Under 30	30-44	45-64	65-74	75-84	85+	TOTAL
90,780 (5.8%)	262,495 (16.6%)	458,952 (29.1%)	371,520 23.5%	245,313 15.5%	149,449 9.5%	**1,578,509 100%**
812,227 CA Veterans Ages under 20 to 64 (approx. 46 year age span) ***51.5% of total***			**766,282 CA Veterans** Ages 65 to 85+ (approx. 35 year age span) ***48.5% total***			

Table 6L: VETPOP2016 LIVING VETERANS BY STATE, AGE GROUP, GENDER, 2015-2045
Numbers accurate within 1000 population.
https://www.va.gov/vetdata/veteran_population.asp
(USDVA, National Center for Veterans Analysis and Statistics, 2019)

This 2019 Report on the State of the Veteran Community builds on the 2018 Report by CAVSA, providing updates on key topics previously identified, and addressing new topics of concern for California veterans and their families. Considering the state's widely varying geography from the more rural North to the highly urban South and the age-related demographics described here, it is very clear a "one size fits all" strategy for programs and care delivery is insufficient. California's highly County-based service delivery system recognizes that solutions must be tailored to local needs, which simultaneously provides challenges to ensuring equitable access and uniformly high quality of care throughout California.

CAVSA member agencies, working in the majority of California's 58 counties, help ensure a shared vision of high quality mental health care is infused in their programs as they provide community education, advocacy, housing, supportive services, and outreach to all of California's diverse veteran community.

WIFE HELPS VIETNAM VETERAN TO WHEELCHAIR
https://www.militarytimes.com/news/pentagon-congress/2019/04/11/here-are-12-big-changes-veterans-caregivers-will-see-in-the-next-year/

MENTAL HEALTH CHALLENGES AFFECT VETERANS OF ALL AGES

The public often associates Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD) with the experiences of post-9/11 veterans. However, the demand for PTSD treatment has steadily increased among Vietnam veterans as they age. As of 2013, older veterans 75 years and older sustained the highest number of TBIs among any age group.[2] Major depression is the most frequent psychiatric disorder post-TBI, affecting nearly 30% of post-injury patients in the first year alone, and may play a role in older veterans having the greatest number of suicides among all veteran age groups.

GULF WAR ERA VETERANS (AUGUST 1990 – PRESENT) COMPRISE CALIFORNIA'S LARGEST "ERA" VETERAN POPULATION

Nearly 300,000 California veterans have served in our nation's longest-running conflict "Post-9/11". Many have had multiple deployments in these 18 years during which more than 7,000 service members have died and 52,865 were "wounded in action". (https://dod.defense.gov/News/Casualty-Status/). As casualties continue, both during service and on the homefront, many young and elderly veterans alike have experienced the loss and injury of friends. These contribute to the invisible wounds of war that can continue to challenge veterans and their families long after they have removed the uniform.

Although dramatic changes in numbers and trends are rare from year-to-year, CAVSA recognizes progress on complex mental health and multi-causal problems such as suicide, homelessness, and opioid-related deaths requires a sustained commitment. Our strategy is therefore to continue to press for success with our 2018-19 Action Agenda and pursue multi-year efforts to achieve lasting results. As a non-governmental independent organization, CAVSA also recognizes both its obligation and privilege to advocate for the veteran community from the ground up by bringing emerging or neglected issues to the attention of policy makers and the larger community. Three such topics of mental health concern include:

California's Rural Veterans – who are experiencing higher opioid misuse, growing homelessness, and high suicide rates.

California National Guard – many of whom are veterans – whose high suicide rates have recently come to light, and whose access to VA and mental health care is variable. Especially when California National Guard have deployed to some of California's most historic and tragic disasters in 2017-18 (Camp Fire in Butte County, Thomas Fire in Ventura and Santa Barbara Counties, and Woolsey Fire in Ventura and Los Angeles Counties), they and their families may increasingly be in need of mental health and other supports. However, publicly available data is very limited both at state and federal levels.

California's Veteran Family Caregivers – subject to burnout, secondary post-traumatic stress, depressive disorders, and lower than average rates of health insurance. This is particularly problematic since veteran caregivers are the "first line of defense" for veterans' care and well-being upon whom the VA, and society at large, heavily rely.

Findings in this report may be familiar to service providers who work with California's veterans and their families on a daily basis. However, for readers outside the "veteran space", it is our hope this report will raise both awareness and concern about the disparities between the mental health and well-being of our veterans and the civilian society they have rejoined after military service. This report on the State of the Veteran Community does not have all the answers to the challenges identified. Rather, it provides data and a perspective that illuminates CAVSA's 2020 Action Agenda. We also hope it will strengthen our collective resolve to work together to reduce and eliminate the identified disparities to improve the lives of California veterans and their families.

REPORT METHODOLOGY

As in our 2018 Report, review of the academic and organizational literature, veteran-related mental health and related reports, and public data sets form the basis of this report. Data on the veteran population, veteran mental health issues and services are primarily from the U.S. Department of Veteran Affairs (USDVA), or by academic and think tank researchers such as the Rand Corporation.

PASADENA CITY COLLEGE VETERANS RESOURCE CENTER, 2019.
https://pasadena.edu/academics/support/veterans-services/index.php

In addition to this data, four in-depth case studies of CAVSA member agency personnel who worked on specific items in CAVSA's 2018-2019 Action Agenda are included. These illustrate the work of individual staff members and highlight the impact of such work in both their local communities and more widely.

A ten-item survey on "Veteran and Veteran Family Mental Health and Well-Being" was also released to participants of veteran-serving coalitions and agencies in the six counties in which the MHSA County Plan Reviews were done. This follow-up to the 2018 statewide community-based survey was done to elicit all survey respondents' knowledge, concerns, and impressions of the availability and quality of services for California veterans and their families and to note any changes in the past year. Due to a technical problem with the online survey portal, responses from only three counties were fully recorded, but they nonetheless

provide an insight into community impressions of the quality and availability of care in specific counties and progress over the last year.

Greater attention has been given this year to discussion of the Mental Health Services Act (MHSA), its recent funding history, and a thorough reporting of the review of six counties' MHSA 3-Year Plans (Alameda, Butte, Fresno, Los Angeles, Napa, and Ventura Counties.) This report section provides extensive detail about the opportunities local counties have to include veteran stakeholders, veteran family members, and veterans themselves in virtually every aspect of mental health services for veterans that are or could be funded by the MHSA county funding.

As in 2018, CAVSA implemented a "secret shopper" study element with the purpose of evaluating availability and ease of access to services in five of the six counties for which MHSA County Plan reviews were completed (Alameda, Butte, Fresno, Los Angeles, and Ventura Counties). Three areas of care for veterans were examined, including (1) provider response or lack thereof, (2) need for follow-up calls, and (3) presence or lack of military cultural competence. Because of the growing concern about opioid use in the veteran population, as well as the growing population of elderly veterans, two additional variables were added to the Secret Shopper call script that included these elements to determine if phone answerers responded appropriately to the severe pain/medication symptoms of the caller or to a potential for a targeted service response for an elderly veteran caller.

Also included in this year's report is a summary of CAVSA's Inaugural Veterans Mental Health Summit held in Sacramento on August 14, 2019. This event brought together dozens of stakeholders from across the state and featured leading medical researchers, program personnel, judiciary members, and legislators as guest speakers.

CAVSA 2019 REPORT CARD

Significant changes in data for large populations like California's nearly 1.6 million veterans do not happen often and can be difficult to detect, especially when variable definitions and available data sets can change from year to year. The color codes provide At-A-Glance interpretations of key measures from 2018 to 2019. The colors signify the following:

1) progress occurring, measurable success (green)

2) stable, but still needs attention (yellow)

3) source of concern, not going well (red)

Table 2 provides a snapshot of the status of California veterans with regard to issues that emerged as leading topics of concern in the 2018 report and remain relevant in 2019 and beyond. The four measures of **Persons in Homelessness, Suicide, Opioid Overdose Deaths, and Justice Involvement (Incarceration)** are gross indicators of mental health at the population level and have been shown to be amenable to programmatic interventions at the individual, community, and policy levels to improve well-being. These topics will be discussed further as continuing issues of concern for California's veterans.

As in 2018, the situation of California veterans compared to veterans nationally and their non-veteran Californian counterparts shows a mixed picture. Because expanded and new data sets have been used to report 2019 data, the 2019 findings cannot be presented as a one-to-one comparison with the 2018 report card, but the 2018 Report Card is included as an Appendix to assist readers with a retrospective look.

TABLE 2

2019 REPORT CARD

California Veteran Mental Health and Well Being Indicators

	U.S. Population	U.S. Veteran Population	California Population	California Veteran Population
PERSONS IN HOMELESSNESS	**552,830** .17% of total U.S. population – 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 2016 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 (INCARCERATION)	**2.3 million** – 698/100K	**181,500** – Estimated just under 8% of U.S. incarcerated population, 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

■ = Progress occurring, measurable success ■ = Stable, but still needs attention ■ = Source of concern, not going well

Data sources on following page

DATA SOURCES

Homelessness:

1. https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf
2. California's estimated total population is 39.78 million according to the World Bank and US Census Bureau: http://worldpopulationreview.com/states/california-population/

Suicide:

3. National Vital Statistics Reports, Vol. 68, No.9, June 24, 2019. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09_tables-508.pdf CA data: p.69; U.S. data: p.33.
4. Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018.
5. National Veteran data https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf
6. CA Veteran data https://www.mentalhealth.va.gov/docs/data-sheets/2016/California_2016.pdf
7. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Violence%20Prevention%20Initiative/CA%20Veteran%20Suicides%202017%20FINALa%203%2011%2019.pdf

Opioid Overdose Deaths:

8. https://www.cdc.gov/drugoverdose/data/statedeaths.html
9. https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/california-opioid-summary
10. https://discovery.cdph.ca.gov/CDIC/ODdash/
11. https://discovery.cdph.ca.gov/CDIC/ODdash/_w_641392b96442624a78da7148e46c304a55f9619567a2fcec/Opioid%20Overdose%20Deaths%202011-2017.pdf
12. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
13. https://www-sciencedirect-com.libproxy1.usc.edu/science/article/pii/S0749379719300765#sec0010
14. Mainly synthetic opioids other than methadone; primarily by illicitly manufactured fentanyl (IMF). Synthetic opioids were involved in 59.8% of all opioid-involved overdose deaths; from 2016-17, this rate increased by 45.2% nationwide. CA was one of 23 states that experienced a statistically significant increase in drug overdose deaths from 2016 to 2017.
15. NOTE: This data is based on VHA patients only; specifically, 6,485 veterans who died from opioid overdose from 2010-2016. Verified data on this variable is lacking in other data sets.

Justice Involvement:

16. https://www.prisonpolicy.org/reports/pie2019.html
17. https://www.prisonpolicy.org/global/2018.html
18. https://www.bjs.gov/content/pub/pdf/vpj1112.pdf
19. https://lao.ca.gov/Publications/Report/3595
20. DVA Reentry Search Service System (VRSS). Data as of June 6, 2019. (Includes 134 female veterans.)
21. 2019 data for California Justice Involved (Incarcerated) Veterans is from the Veterans Re-Entry Search Service (VRSS). VRSS was designed to improve the ability to locate incarcerated veterans for purposes of accelerating their re-entry post-release. The VRSS became available to Veteran Justice Programs at the VA, Correctional Facilities, and Court Systems across the U.S. in 2015. However, many of the roughly 1,300 federal and state, and 3,000 city/county correctional facilities, and 3,000 to 4,000 courts in the U.S. do not routinely use it. CAVSA acknowledges the assistance of the Veterans Integrated Service Network (VISN) 21 who shared the June 2019 number.

WHERE CALIFORNIA VETERANS LIVE

To determine how to best allocate resources and design programs, policy makers and program staff must understand where to find California's veterans and what kind of interventions and supports to deploy. As Map 1 below shows, California's veteran population is heavily concentrated in Southern California, but veterans reside throughout the state in very diverse communities and situations.

VA predictive population projections show 52% of California veterans live in just five Southern California counties (see Table 3 below). More than 70% of California's estimated 1,578,509 veterans live in these twelve (21%) out of California's 58 counties; more than half live in the first five counties cited below in Table 3.

TABLE 3

VETERAN POPULATION BY COUNTY OF RESIDENCE, 9/2019

Data considered accurate to the nearest thousand; percentage is to whole number

COUNTY	VETERAN POPULATION
1. Los Angeles	255,625 (16%)
2. San Diego	238,352 (15%)
3. Riverside	124,144 (8%)
4. Orange	100,210 (6%)
5. San Bernardino	96,018 (6%)
6. Sacramento	78,412 (5%)
7. Santa Clara	48,164 (3%)
8. Alameda	46,748 (3%)
9. Contra Costa	45,884 (3%)
10. Kern	37,531 (2%)
11. Ventura	37,447 (2%)
12. Fresno	37,371 (2%)

MAP 1

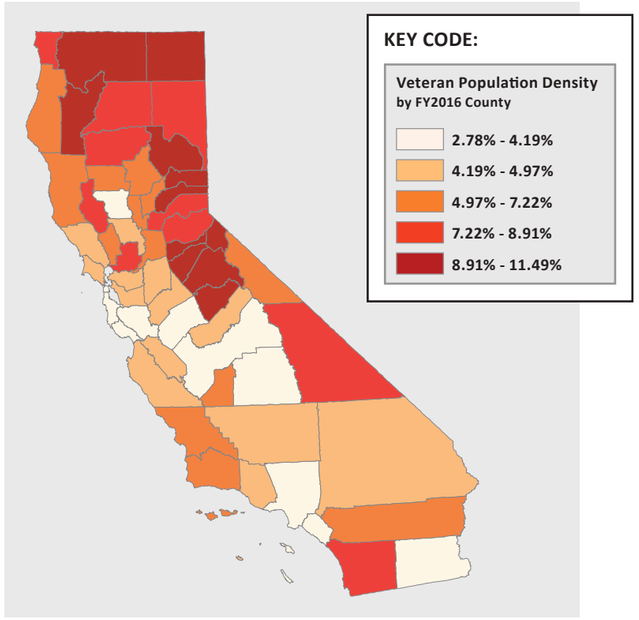
GEOGRAPHIC CONCENTRATION OF CALIFORNIA'S VETERAN POPULATION, FY 2016

www.va.gov/vetdata National Center for Veterans Analysis & Statistics. (most current mapped data)

MAP 2

VETERANS AS PERCENTAGE OF CALIFORNIA COUNTY POPULATION, FY 2016

www.va.gov/vetdata
National Center for Veterans Analysis & Statistics.
(most current mapped data)



Although Map 1 and Table 3 show Southern California counties are home to most of our state's veterans, Map 2 clarifies that veterans comprise a greater percentage of the total population in north and north-central rural counties. U.S. data has also shown over 44% of military recruits come from rural areas, compared to 14% from major cities. Due to their higher rates of military service, many veterans return to rural communities upon discharge from service.

https://www.chausa.org/publications/health-progress/article/may-june-2013/rural-vets-their-barriers-problems-needs

For example, the VA Predictive Analytics and Actuary Office data estimates about 9% of California's three northernmost county populations (Modoc, Siskiyou and Del Norte) are comprised of veterans. Because of the lower population density in these rural counties, this translates to a population of about 7,000 veterans. Even though veterans comprise only about 2.5% of Los Angeles County's population, this translates to about 256,000 veterans. VA data shows veterans are more likely than the general population to live in rural areas and have limited geographic access to VHA facilities, which is true in California as well (see Map 6).

California does not have good data on the mental and physical health profiles of veterans in rural areas, but 2017 Center of Disease Control data shows rural Americans in general are at higher risk of death from potentially preventable causes than their urban counterparts. Unintentional injury deaths were nearly 50% higher in rural areas and deaths from potentially preventable causes are significantly higher than in urban settings due to longer distances to health care facilities and trauma centers, in addition to higher rates of opioid overdoses.

https://www.cdc.gov/ruralhealth/cause-of-death.html

The VA's Office of Rural Health 2018 report likewise cited the need for "access to high-quality medical care" as a common need among the roughly 5 million veterans who live in rural communities nationwide.

https://www.ruralhealth.va.gov/docs/ORH_Thrive2018_FINAL_508.pdf

In recognition of this need, the 2014 Veterans Choice Act was implemented to permit veterans living more than 40 miles away from VHA facilities to purchase care from non-VHA providers. However, a 2018 study led by the VA Office of Rural Health found this initiative may not improve access to care because rural areas are underserved by non-VHA providers, with special shortages in the area of mental health care.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5972410/

Despite the many challenges of California's rural veterans, they are more likely to be obscured because of their dispersed residence and frequent reluctance to ask for help. The more concentrated and visible problems of urban veterans therefore often take precedence. For example, a still-unknown number of veterans are among the nearly 35,000 residents displaced from the Camp Fire in Butte County in 2018. Hundreds were left jobless and, as of June 2019, more than 1,000 families were still only temporarily housed according to Butte County officials. Other natural disasters in 2017-18, including the Tubbs Fire in Sonoma, Napa, and Lake Counties, are reported to have forced rural and suburban veterans into substandard housing or "under-housed" situations. The problem of homelessness and unsheltered homelessness among suburban and rural veterans is shown in Table 5 and will be included in CAVSA's housing advocacy efforts in 2020. High veteran representation in California's more rural counties may also be an avenue for self-help advocacy and community action which CAVSA will support for veterans and veteran families going forward.

TABLE 4

ACTIVELY LICENSED BEHAVIORAL HEALTH PROFESSIONALS

per 100K Population by Region, 2016

Region	Psychiatrist	Psychologist	LMFT	LPCC	LCSW	Psych Tech
Central Coast	15.2	44.7	120.4	3.6	45.4	55.3
Greater Bay Area	25.0	70.7	117.9	4.6	65.7	20.2
Inland Empire	**7.7**	**15.6**	**41.0**	**1.9**	**26.4**	42.1
Los Angeles	14.9	45.9	80.0	2.4	55.5	9.0
Northern & Sierra	**8.6**	**22.7**	86.0	3.3	46.4	13.8
Orange	10.3	38.6	81.8	3.7	41.6	19.1
Sacramento Area	14.5	35.3	76.4	3.7	57.2	11.2
San Diego Area	16.0	52.1	71.3	3.8	48.4	3.3
San Joaquin Valley	**7.1**	**15.8**	**34.6**	**1.4**	**25.3**	56.3
California	14.7	42.5	79.9	3.1	48.3	23.4

Table 4 from a 2018 study on "California's Current and Future Behavioral Health Workforce" by UCSF found shortages of many types of licensed mental health professionals in rural areas, with the highlighted data showing those regions with the fewest numbers of professionals per 100K population. The report also notes the "pipeline" for expanding the workforce is underdeveloped, despite 45% of psychiatrists and 37% of psychologists being over the age of 60 and preparing for retirement.

https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf

Homelessness Among California Veterans

According to the most recent data on veteran homelessness captured by the Point in Time (PIT) count in January 2018 (AHAR), across the U.S. 37,878 veterans experienced homelessness accounting for nearly 9% of all homeless adults. 10,836—nearly 30% of all U.S. homeless veterans—were residing in California.

Veterans comprise about 8.3% of the 129,972 Californians experiencing homelessness. The overall rate of homelessness among veterans in California decreased by about 5% (600 veterans) between 2017 and 2018, and across the U.S. the number of veterans experiencing homelessness was cut nearly in half (49%), a decline of 36,000 people since 2010. While this is hopeful, California's decline does not represent a significant improvement and is not statistically important. Even though more veterans are being housed, other veterans are becoming newly homeless with the overall rates holding relatively steady. In both 2017 and 2018, women veterans constituted about 9% of homeless veterans, with slightly more women living in unsheltered homelessness than male veterans.

https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

MAP 3

CALIFORNIA VETERANS EXPERIENCING HOMELESSNESS AND UNSHELTERED SITUATIONS

Annual Homeless Assessment Report (AHAR), 2018
https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

TABLE 5

HOMELESS AND UNSHELTERED VETERANS IN CALIFORNIA, 2018

Continuum of Care (COC) Type and Place	Veterans in Homelessness	2018 Percent Unsheltered
Major Cities COCs		
Los Angeles City and County	3,538	75.4%
Oakland, Berkley/Alameda County	526	71.9%
San Jose/Santa Clara City and County	658	68.7%
Sacramento City and County	492	66.5%
Fresno City and County/Madera County	211	59.2%
Other Largely Urban COC		
Vallejo/Solano County	124	84.7%
Largely Suburban COCs		
Imperial County	130	97.7%
Watsonville/Santa Cruz City and County	245	88.6%
Santa Ana, Anaheim/Orange County	419	85.2%
San Bernardino City & County	170	73.5%
Largely Rural COC		
Chico, Paradise/Butte County	109	73.4%

2018 AHAR Part 1. CoCs with Highest Percentage of Homeless Veterans who are Unsheltered, by CoC Category.

Despite California's many innovative programs and attention to veterans' issues, California not only has the greatest number of veterans in homelessness, but also leads the nation with the greatest number of "Unsheltered Homeless" veterans. This represents a major concern for all of CAVSA's member agencies and CAVSA overall. Table 5 shows roughly two-thirds of all California veterans who are experiencing homelessness are unsheltered across a wide geographic array.

"Unsheltered homelessness", defined as living in a "place not designed for sleeping accommodation" or "not suitable for human habitation" (AHAR, 2018), such as under freeway overpasses, on river embankments or sidewalks, etc., is associated with markedly worse health and mental health outcomes and exposes the veteran to an increased risk of violence and injury. Unique veteran mental health challenges worsen in unsheltered settings. As there is an affordable housing crisis across California, CAVSA recognizes the need for appropriate housing for all veterans in all settings and circumstances as a continuing priority in 2020.

Housing is increasingly perceived as a medical necessity to maintain or restore patients' health and mental health and occupied a central place in CAVSA's 2019 Action Agenda. The case study below is an example of CAVSA's advocacy and effectiveness in expanding housing options for veterans during 2019.

CAVSA VETERAN ACTION AGENDA 2018-2019

Address Housing Challenges for Veterans and Expand Advocacy Capacity and Data Collection Efforts

1. ADDRESS HOUSING CHALLENGES FOR VETERANS

a. **Actively engage in state and federal housing policy initiatives. Support an extension of and additional funding for the Veteran Housing and Homelessness Prevention (VHHP) Program.**

b. **Work to improve Veteran Housing and Homelessness Prevention Guidelines and No Place Like Home (NPLH) Guidelines.**

d. **Seek funding for mental health services and other supportive services to better serve VHHP and NPLH Projects.**

3. EXPAND ADVOCACY CAPACITY AND DATA COLLECTION EFFORT

a. **Become a more effective voice for veterans in the development of veteran mental health related legislation.**

Brad Long, MA serves as Executive Director of the Veterans Housing Development Corporation (VHDC) which has played a key role in veteran housing, particularly in rural and Northern California.

Burt McChesney served as the Executive Director of VHDC until Spring 2019 and has been a pivotal influence in Sacramento where he served as a principal consultant for many Assembly members advocating for issues related to veteran housing.

Charles (Chuck) Helget serves as the Executive Director of the California Association of Veteran Service Agencies (CAVSA), and directs CAVSA's advocacy efforts in Sacramento and in Washington, D.C.

Long, McChesney, and Helget are CAVSA's featured "point persons" for 2018 Action Agenda Items #1A, 1B, 1C, and 3A. This team offers over twenty years of experience building veteran housing and advocating for veteran housing funding and support at the federal, state, and local levels of government. With this base of knowledge and effective advocacy, CAVSA's advocacy team was able to move quickly in 2018-19 to ensure funds for veteran housing and mental health supports were intact.

For most people outside the tax or accountancy worlds, discussions of Internal Revenue Service (IRS) decisions are met with glazed eyes and a yawn or two. However, in 2018, the IRS became a focal point of urgent concern among veteran housing stakeholders who counted on using Private Activity Bonds (PABs) to help finance veteran housing. The IRS notified these groups, including VHDC, that PABs could no longer be used to build Veteran-only housing. This unexpected announcement was not based on new legislation, nor were legislators even aware of it. Rather, the IRS had unilaterally reinterpreted the law to say such projects violated the "general public use" element of the statute governing PABs.

Burt McChesney, as VHDC's outgoing Executive Director, worked closely with his successor (Brad Long) to address this alarming change, but in the meantime the changed guidelines stopped countless projects nationwide in their tracks. In California, at least three urgently needed veteran housing projects underway by VHDC to house more than 250 veterans and veteran families were put on hold. These included the Windsor Veterans Village in Santa Rosa, Chico Veterans Village in southside Chico (adjacent to a VA clinic), and Shasta Lake Veterans Village in Shasta Lake. A project on Treasure Island was also threatened.

These planned housing projects, which include transitional and permanent supportive housing, were "shovel ready" but relied on Private Activity Bonds as an element of their financing because they also involved 4% tax credit arrangements which don't come with a lot of capital.

CHICO VETERANS VILLAGE, CHICO

WINDSOR VETERAN VILLAGE, SANTA ROSA

CAVSA's advocacy team, along with other housing stakeholders, initiated a campaign to get the IRS to rethink its policy. After being told any IRS change would take at least 24 months, Long, McChesney, and CAVSA colleagues kicked into overdrive. With urgent calls, visits, and letters, they garnered the support of the California Congressional delegation (including Congressmen Doug LaMalfa, from District 1, Butte County) and were led by Senator Diane Feinstein. The resulting message sent to the IRS was adamant, bipartisan, and unified, urging them to allow PABs for veteran-only projects. These critics of the new IRS policy also cited existing laws that allows "veteran-only projects" to qualify for the PAB's "sister program", the Low Income Housing Tax Credit (LIHTC).

SHASTA LAKE VETERANS VILLAGE, SHASTA LAKE *(above)*

On April 3rd, 2019, the IRS released Revenue Procedure 2019-17 to clarify that projects qualifying for LIHTC also qualify for PABs and Long, McChesney, and hundreds of other veteran housing advocates around the U.S. breathed a sigh of relief. Without this kind of "know-how" and dedication, hundreds of low-income and specialized veteran housing units would only be wishful thinking. Instead, Windsor Veterans Village broke ground in July 2019 and both Shasta Lake and Chico projects are slated to start construction in March 2020. CAVSA advocacy and a powerful bipartisan push from California's congressional delegation forced the IRS to do a 180-degree reversal in less than twelve months, which is virtually unprecedented and a huge achievement for hundreds of veterans and their families. With the Veteran Resource Centers (VRCs) prepared to provide services onsite at these Veteran Villages, the prospects for stable housing and healing began to improve for hundreds of low-income veterans in Northern California.

To meet the foundational need for housing as a precursor to well-being and mental health in Northern California, CAVSA will need to have many more successes on the scale of the IRS win. Since the devastation of the Camp Fire in Butte County in November 2018, the challenge of finding housing has intensified. Brad expressed concern that "the approaching fire season for Northern California is not getting the attention it deserves, and at times there's outright hostility toward Sacramento for not doing more to help."

Having personally been evacuated twice with his family due to the recent fires in Santa Rosa and Paradise, which destroyed thousands of homes and dozens of lives, Long described the housing crisis in Shasta and Butte Counties as "very similar to big city housing problems." With thousands living in makeshift situations due to disaster displacement, Long believes veterans are often getting lost in the shuffle.

Long also sees the situation's visual similarity to a warzone is causing many veterans to be triggered and whole communities to be in need of trauma services and more mental health care. He observed, "Though some veterans could go elsewhere, they choose to stay because the cost of living is lower, and grunt jobs have actually increased because of all the debris and hazardous waste removal that is required. Some are deciding to just permanently camp, fish, and hunt, not only for food, but to decompress in nature."

Veteran Family Caregivers

Veterans living within families are not immune to homelessness. However, having adequate family support and being married have each been shown to be protective against homelessness. Conversely, veteran status has been shown to be a predictive factor for experiencing homelessness.

https://socialinnovation.usc.edu/wp-content/uploads/2018/04/Predictive-and-protective-factors-for-homelessness-Lit-Review-12.20.17...-1.pdf

Finding ways to support veterans in the context of their families and supporting family members' mental health was one of CAVSA's 2019 Action Agenda Recommendations, and will continue as a 2020 CAVSA effort, specifically with regard to veteran family caregivers which is emerging as a growing concern for both younger and older veterans in California.

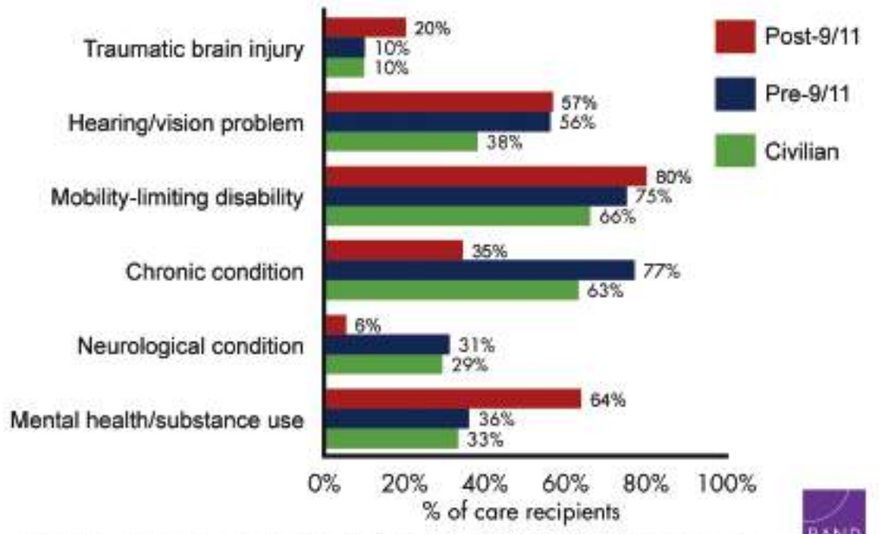
There are an estimated 5.5 million veteran caregivers in the U.S., about 20% (1.1 million) of whom are caring for post-9/11 veterans, with a long future of potential caregiving needs ahead. The other 4.4 million are caring for pre-9/11 veterans (usually at least 45 years old, but typically much older). The vast majority of caregivers are family members, with a pre-9/11 veteran's child serving as the caregiver 47% of the time, and the spouse serving as the caregiver 63% of the time for post-9/11 veterans, according to a Rand national 2014 survey.

https://www.rand.org/well-being/social-and-behavioral-policy/projects/military-caregivers.html

Although they may be a child of a pre-9/11 veteran, these caregivers may be aging themselves. In contrast, 37% of the caregivers for post-9/11 veterans are under the age of 30. All require support to maintain their own mental and physical health while providing care for their veteran family member.

FIGURE 1

MEDICAL CONDITIONS OF CARE RECIPIENTS IN THE U.S.



Source: National survey of caregivers of adults in the U.S., with findings presented in Ramchand R, Tanielian T, et al., *Hidden Heroes: America's Military Caregivers*, RAND Corporation, 2014 (available at www.rand.org/military-caregivers).

The Rand study found 36% of pre-9/11 veterans and 64% of post-9/11 veteran care recipients had a behavioral health condition and 30% of pre-9/11 and 58% of post-9/11 care recipients had a VA disability rating.

In addition, medical conditions cited in Figure 1 influence the ability of veteran caregivers to provide high quality care for their veteran family member while also maintaining their own mental and physical health.

Additional research has shown negative health and mental health outcomes for caregivers are "greater when veterans exhibit behavior problems, require extensive assistance with personal care, and have a greater number of coexisting chronic conditions."

https://www.sciencedirect.com/science/article/abs/pii/S1064748112600943

In May 2019, the World Health Organization developed its definition of "burn-out" as an occupational phenomenon in the 11th International Classification of Diseases (ICD-11) as a "syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism, or cynicism related to one's job, and reduced professional efficiency."

https://www.who.int/mental_health/evidence/burn-out/en/

Recognizing the priceless value of veteran caregivers, the VA seeks to prevent "burn-out" and has established a formal VA Caregiver Support program to provide peer mentoring, stress management, and financial assistance to enable caregivers to receive compensation for their services.

https://www.caregiver.va.gov/support/support_benefits.asp

In an effort to augment the VA's existing caregiver support, the MISSION (Maintaining Internal Systems and Strengthening Integrated Outside Networks) Act of 2018 supports the expansion of the caregiver stipend program in the Program of Comprehensive Assistance for Family Caregivers. Although the primary purpose of federal MISSION Act, implemented in June 2019, is to expand choice of care in the private sector for veterans, it could also significantly impact caregivers. The $52 billion reform bill gives authority to the "Anywhere to Anywhere" telemedicine program to make it easier to treat veterans across state lines with a telemedicine platform, regardless of whether the patient is in a VA facility or not. This may help caregivers facilitate care for their veterans, and also increases the privacy of care, which may help both veterans and caregivers access mental health and supportive services. Monitoring the Act's implementation and caregivers' access to stipends in California is on CAVSA's 2020 agenda as an important step to caring for the caregivers who support the well-being of thousands of California's disabled and needy veterans of all ages.

https://missionact.va.gov

The case study that follows below illustrates how one of CAVSA's member agencies, Swords to Plowshares, has worked over this past year to implement three of the 2019 Action Agenda items.

CAVSA VETERAN ACTION AGENDA 2018-2019

Appropriate Care and Housing for Older Veterans, First Responder Education in Northern California, and Collaboration with CalVet's CalTAP program

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 (VHHP) Program.**

2. EXPAND SUICIDE PREVENTION, INTERVENTION, AND POSTVENTION ACTIVITIES

c. **Train first responders, emergency room staff, county veteran service officers, and employment development department personnel on veteran cultural competency and suicide care activities.**

5. BUILD COMMUNITY AND AGENCY PARTNERSHIPS

f. **Collaborate with CalTAP to put veteran and veteran family mental health curriculum online and provide outreach to military installations with mental health transition information prior to discharge.**

Amy Fairweather, JD is Director of the Swords to Plowshares (STP, or "Swords") Institute for Veteran Policy (IVP), supervises Swords' "Combat to Community" education and technical assistance program, and is a tireless advocate for adequate supportive housing for California's most vulnerable and traumatized veteran communities, with a focus on older veterans.

Megan Zottarelli, MPA serves as Assistant Director of the IVP and works on benefits policy, elderly veteran issues, and community collaborative efforts and education, with an interest and background in suicide prevention.

Shannon Kissinger, MSW is a Policy Associate with IVP, a Navy Seabee veteran, and implements the Combat to Community program across California with a focus on more rural areas and first responders, including all types of law enforcement.

Fairweather, Zottarelli, and Kissinger are CAVSA's featured "point persons" for Action Agenda Items #1A, 2C, and 5F described above.

The Institute for Veteran Policy (IVP) was the brainchild of Michael Blecker, JD, Swords' Executive Director since 1982, who believed it was important to have the capacity to do policy that grows out of the experience of direct services and adds on research and advocacy. IVP was originally known as the "Iraq Vet Project" (IVP) established in 2005 to identify needs and shape policies for the returning OIF and OEF veterans. As a Vietnam veteran, Mr. Blecker was determined to ensure this new era of veterans would receive better care than his cohort. With Amy Fairweather's legal training and 6-year background in trauma work, she was tapped to lead IVP (Iraq Vet Project) which, under her dedicated and broad-thinking leadership, became the "IVP" Institute for Veteran Policy in 2007.

For the past dozen years, IVP has helped gather and articulate the data and other relevant information to focus policy attention on the most pressing problems of California's veteran community and translate those concerns into action.

Leading the list of urgent issues for Fairweather is the overwhelming need for more thoughtful and realistic preparation for appropriate care for California's veterans who are 55 years or older. According to the VA's population projection model for September 2019, 526,642 Vietnam veterans reside in California—8.4% of all U.S. Vietnam veterans and about 33% of all California's.

https://www.va.gov/vetdata/veteran_population.asp

They join veterans of the WWII, peacetime, and Korean eras in being 64 or older, but are the group of aging veterans who bore the brunt of a dramatically unpopular war at a time when our nation did not distinguish the warrior from the war which left them with what Swords calls a "Legacy of Neglect". "This legacy is ours to redress now by providing the care our aging veterans have been denied for so many years," said Fairweather as she delivered a presentation on the plight of older veterans.

VIETNAM VETERAN GENERATION

THE LEGACY OF NEGLECT

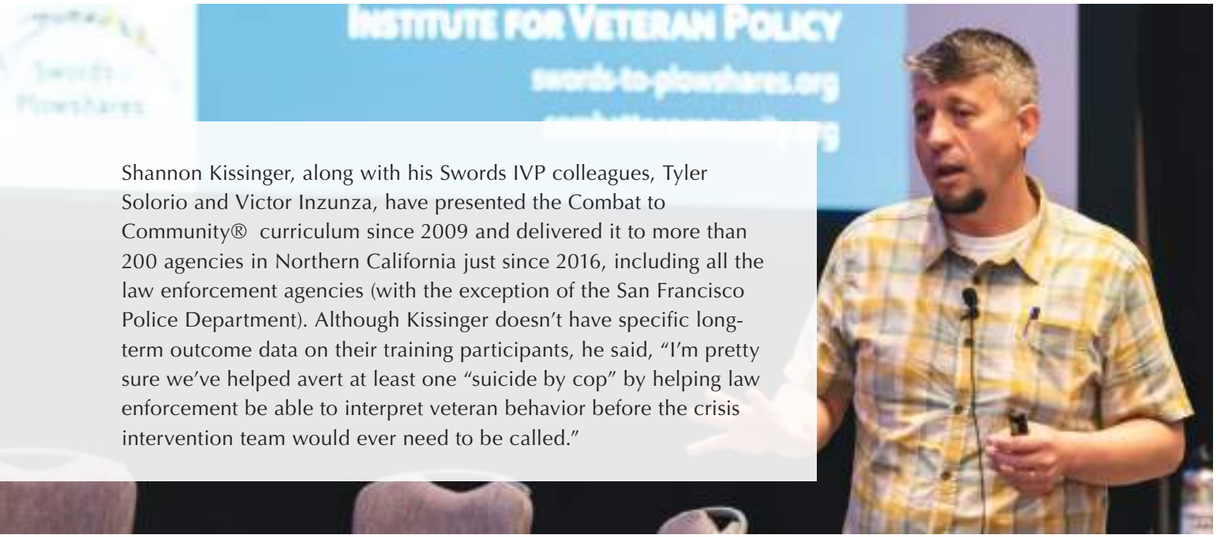
VIETNAM WAR
Birth Years: 1914 - 1955
Battle years: 1964 - 1975

- Social Isolation
- Divorce
- Community Neglect
- Unemployment
- Homelessness
- Mental Illness
- Physical Disabilities

At her Swords office, based in San Francisco—ranked the second most expensive U.S. city in which to live, with a cost of living 96.3% above the U.S. average (http://coli.org/)—Amy bears daily witness to the fact that nearly half the homeless veteran population in the Bay Area are older and are disproportionately African American. Seeing veterans aged beyond their chronological years due to long periods of unsheltered homelessness and serious physical and mental health problems, she continues to be a vocal advocate for higher levels of care to be built into permanent supportive housing, in addition to the urgency to rethink veteran housing needs.

Recognizing that the demographics of California's and veteran communities across the U.S. skew towards the elderly, Fairweather lamented that, "the lack of higher levels of care embedded in housing drives our finally-stabilized veterans out of veteran-specific care. This is a shame because it's so therapeutic". What services are needed? According to Fairweather, and based on IVP research, "access to skilled nursing, live-in-aides, and medication management support would all provide cost-benefit and allow veterans to age in place in permanent supportive housing. This would benefit the veterans and communities grappling with the challenges of growing numbers of unsheltered persons."

Amy Fairweather's outspoken advocacy and dogged devotion doesn't stop at her concern about the injustices experienced by our state's historically neglected, now-elderly veterans. As part of her IVP leadership, she has overseen the development of one of the most influential and compelling training curricula on military/veteran culture in the country. Developed with the input of many veterans, the "Combat to Community" training helps social service, mental health and medical providers, law enforcement and other first responders, and other veteran-specific service agencies better understand the "disconnect" and challenges so many veterans experience as they transition from military to civilian life.



Shannon Kissinger, along with his Swords IVP colleagues, Tyler Solorio and Victor Inzunza, have presented the Combat to Community® curriculum since 2009 and delivered it to more than 200 agencies in Northern California just since 2016, including all the law enforcement agencies (with the exception of the San Francisco Police Department). Although Kissinger doesn't have specific long-term outcome data on their training participants, he said, "I'm pretty sure we've helped avert at least one "suicide by cop" by helping law enforcement be able to interpret veteran behavior before the crisis intervention team would ever need to be called."

SHANNON KISSINGER DELIVERING 'COMBAT TO COMMUNITY' TRAINING

As a service-connected disabled veteran himself, who also worked as a social worker for the VA, Kissinger knows VA services from both sides of the desk. He also worked for several veteran-specific service agencies before coming to Swords and found that, even among vet-serving agencies (including the VA), there was a lot of impatience toward the current era of post-9/11 veterans. "Lots of well-meaning staff might not say 'why are you such a hot mess?', but they conveyed that to the veteran and the veteran felt it and internalized it, which contributes to the stigma and unwillingness to get help. They don't want to perpetuate the stereotype of a messed-up vet, so they stuff it," he said.

Two of Kissinger's goals as a Community Educator with hospitals, law enforcement, and across most of his trainings, is to

1. Help reduce the sense of Vets as "the other", and
2. Help frame access to appropriate services.

For this second priority, he analogized by saying, "You wouldn't treat a HIV+ person the same way if the source of their exposure was risky sex or IV-drug use; why would you treat PTSD caused by military experiences the same way as if it was caused by an auto accident? These are different processes." Kissinger is encouraged that the Combat to Community training convinces providers and responders across the board to believe etiology (the cause of a disorder) truly matters in selecting the best treatment approach.

SLIDES FROM THE 'COMBAT TO COMMUNITY' TRAINING THAT PROVIDE AN EXAMPLE OF VETERAN PERCEPTIONS WHICH CAN CAUSE PROBLEMS AS VETERANS TRANSITION TO CIVILIAN LIFE

Over the course of his hundreds of training sessions, Kissinger has also seen that biases and preconceptions about veterans cloud views of veteran clients/patients/traffic stops: "Perception of the military and veterans has changed since the military became an All-Volunteer Force. There's a lot of vilification or valorization of vets—neither of which is generally true", he said.

Kissinger's vision for improved mental health and well-being of veterans and their families rests on the hope that "our systems (law enforcement, medical care, colleges, etc.) develop military-cultural competence so that veterans can be included in the mainstream, (while) ensuring that those systems interact appropriately with their (military/veteran) subculture, just like any other culture group". He observed that a lot of the behavior of many younger, Post 9/11 veterans are ingrained and were beneficial in a warzone, but don't work on the "homefront". He added, "they're still processing the effects of their military service and just beginning to realize that it will never go away. It can take years, their lifetime, to process."

To help veterans process their military experiences and successfully navigate the transition from service member to civilian, Megan Zottarelli, alongside Amy Fairweather, has collaborated with the California Department of Veterans Affairs (CalVet) to reimagine its CalTAP (California Transition Assistance Program) curriculum. The initially available CalTAP core curriculum relied heavily on federal Veterans' Association (VA) content, but as CalVet sought to upgrade the content, they turned to Swords IVP for assistance. Zottarelli and Fairweather spent several months in 2018-19 developing more accessible content and crafting more California-specific information for CalTAP. This material will be available in streaming modules for veterans to access at any time.

https://www.calvet.ca.gov/VetServices/Pages/CalTap-Core-Curriculum.aspx

> *"The 93% or more of us who don't have military service need to take it on. It gives a measure of peace and healing to advocate on behalf of veterans who served in my place."*
>
> — *Megan Zottarelli*

Zottarelli has been with Swords since 2007 and served as the Associate Director of IVP with Amy Fairweather for three years. Prior to stepping into this position, which she described as her "dream job", Zottarelli was a Senior Policy Analyst, conducting research and writing curriculum related to behavioral health and social justice issues for veterans. Her work on the CalTAP curricula was a perfect match for both her and CalTAP leadership. Before working at Swords, she helped develop suicide intervention strategies and developed and coordinated curricula for the San Francisco Suicide Prevention's (SFSP) HIV/AIDS program, a highly regarded program with state-of-the-art prevention and intervention strategies for suicide.

Like a tragically growing number of Californians and families nationwide, Zottarelli has experienced the suicide of a veteran family member and is committed to reducing the stigma surrounding the topic. Although there is still an enormous need for more public awareness and willingness to dialogue about depression, anxiety, and suicide, she is encouraged that progress is being made. She commented, "2019 is a different time than when a majority of OIF/OEF service members were coming home. There's a lot of work on understanding moral injury, the importance of peer support, and learning that it's okay to seek mental health care. Veterans are still vastly overrepresented among those at risk for suicide, but great strides are being made for front-end interventions."

With a Masters in Public Administration and emphasis on public policy, Zottarelli also strongly believes mental health should not just be a topic within the purview of psychologists or counselors, but should instead require everyone's participation. Working with CalVet to redevelop the CalTAP curriculum, which includes behavioral health and resilience topics, is a big step in the right direction. Seeing her work online for veterans and their families—and anyone who wants to access CalTAP's website—affirms her feeling she's got a "dream job." She added, "It's even more than a "dream job"—it's a social responsibility. The 93% or more of us who don't have military service need to take it on. It gives a measure of peace and healing to advocate on behalf of veterans who served in my place."

SUICIDE

Overall, California non-veteran suicide rates were lower than national rates for 2017, the most current year for which data is available (see Figures 2 and 3). The suicide rate for California veterans was not able to be calculated because the California Department of Public Health (CDPH) did not have reliable estimates of the veteran population with regard to definitions and numbers. What is known is that 640 veterans died by suicide in California in 2017, which represents 15.3% of all suicides and 1.2% of all veteran deaths.

(CDPH, 2017)

FIGURE 2 **CALIFORNIA SUICIDE RATES BY AGE, 2017**

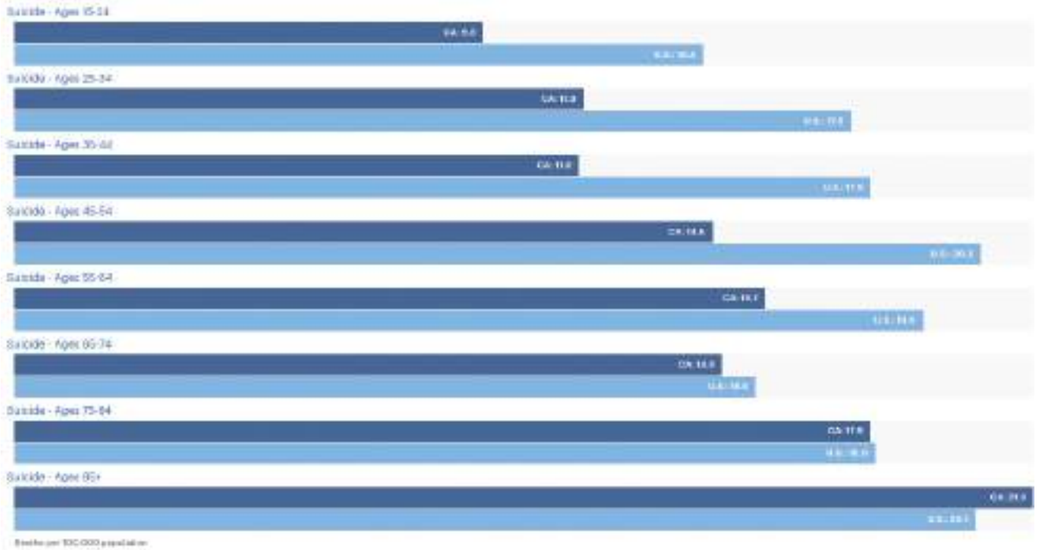


FIGURE 3 **CALIFORNIA SUICIDE RATES BY SEX, 2017**

https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/CA

TABLE 6

DEMOGRAPHIC CHARACTERISTICS OF SUICIDE DECEDENTS BY VETERAN STATUS, CALIFORNIA RESIDENTS AGED 18 YEARS AND OLDER, 2017

	Veteran	Non-Veteran
Sex		
Male	619	2588
Female	21	883
Age		
18-19	3	96
20-24	18	319
25-44	121	1194
45-64	154	1308
65-84	256	488
85+	88	66
Race/Ethnicity		
White	506	2144
Black	33	138
Hispanic	66	784
American Indian	6	26
Asian/PI	27	370
Other/Unknown	2	9
Total	**640**	**3471**

TABLE 7

MECHANISM OF SUICIDE AMONG CALIFORNIA RESIDENTS AGED 18 YEARS AND OLDER BY VETERAN STATUS, 2017

Mechanism of Suicide	Veteran	Non-Veteran
Firearm	420	1137
FHanging/Suffocation	109	1239
Poisoning	61	574
Suicide/Other	21	265
Cut/Pierce	17	96
Jump	12	160
Total	**640**	**3471**

97% *MALE*

79% *WHITE*

Table 6 shows that the greatest percentage of veteran suicides (54%) occurred among the 65-85+ age group, compared to 16% of suicides in that age group of non-veterans. This is partly because of the older age structure of veterans, but still skews higher among veterans. 97% of suicides among veterans were male and 79% white.

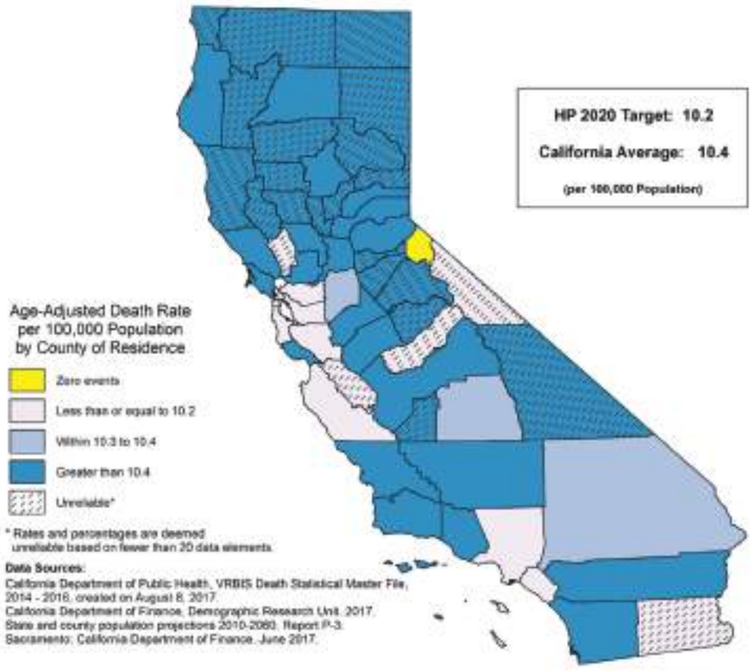
https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Violence%20Prevention%20Initiative/CA%20Veteran%20Suicides%202017%20FINALa%203%2011%2019.pdf

Table 7 shows firearms were used in 66% of veteran suicides, twice as often as among non-veterans (33%). This data points to the necessity of expanding our public health dialogue about management of "access to means" (of lethality) and improved provider and community education on this potentially life-saving topic.

Counseling at-risk veterans to safely store their firearms is a required component of the national VA's Suicide Prevention Safety Plan and is an element in the VA's 2018 National Strategy for Preventing Veteran Suicide. CAVSA is committed to exploring all paths to suicide prevention efforts and evidence-based interventions with veterans, veteran families, and friends.

MAP 4

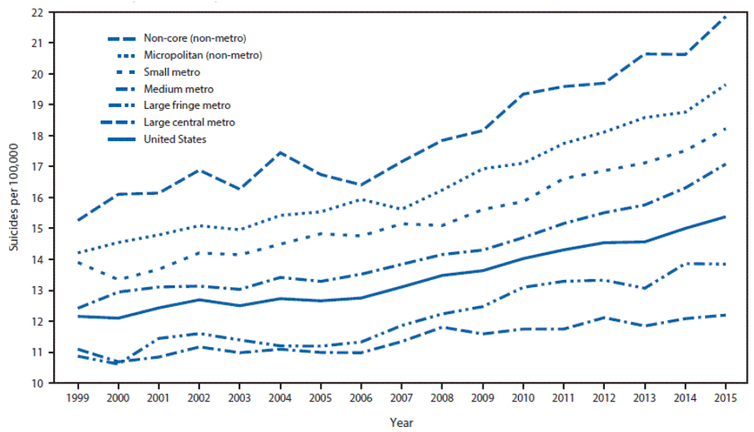
CALIFORNIA SUICIDE DEATHS, 2014-16



https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP-County%20Profiles%202018.pdf

FIGURE 4

SUICIDE RATES* BY LEVEL OF COUNTY URBANIZATION — UNITED STATES, 1999–2015



*Per 100,000 residents aged ≥ 10 years, age-adjusted to the year 2000 standard.

https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a2.htm

Map 4 shows the highest rates of overall (veteran and non-veteran) deaths due to suicide in California are concentrated in the more rural counties. Likewise, Figure 4 shows the the highest rate of increase and highest absolute rate of suicide across the U.S. (for both veterans and non-veterans)is in the least urban settings. Map 2 shows California's highest concentration (not highest numbers) of veterans is in rural areas where 46% report gun ownership, compared with 28% of those who live in the suburbs and 19% in urban areas.

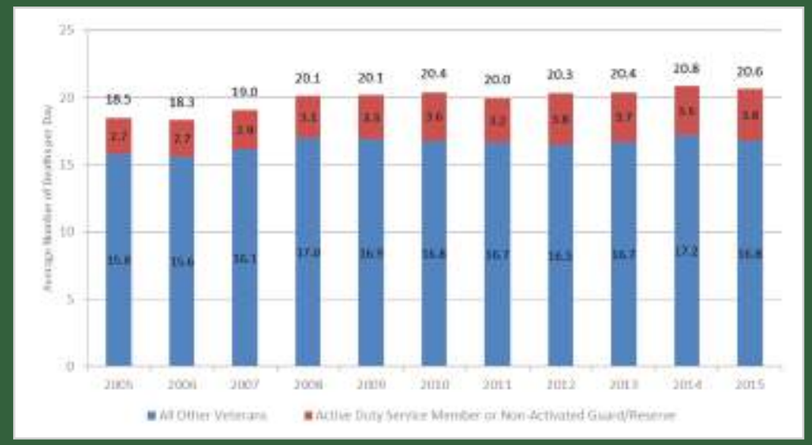
https://www.pewsocialtrends.org/2017/06/22/the-demographics-of-gun-ownership/

Taken together, these data indicate California's older, more rural veterans are particularly at risk for suicide. CAVSA will engage with community and ongoing public mental health efforts in 2020.

Data on suicide among military service members, National Guard, Reservists, and veterans has evolved considerably in 2018 and 2019 with an explicit definition of who counts as a veteran. In 2018, the Veterans Administration reported the often-cited statistic of "20 veteran suicides per day" is not just "veterans". According to the VA, it has "always included deaths of active-duty servicemembers, and members of the National Guard and Reserve and Other Veterans", and was revealed as such for the first time in the 2018 report, shown in Figure 5 below.

FIGURE 5

AVERAGE NUMBER OF SUICIDE DEATHS PER DAY AMONG ACTIVE-DUTY SERVICE MEMBERS, NON-ACTIVATED GUARDSMEN OR RESERVISTS, AND OTHER VETERANS, 2005–2015



https://www.mentalhealth.va.gov/docs/data-sheets/2015/OMHSP_National_Suicide_Data_Report_2005-2015_06-14-18_508.pdf

The "2019 National Veteran Suicide Prevention Annual Report" notes that, "This report is specific to Veterans as defined by Title 38: 'a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.' *(https://www.ssa.gov/OP_Home/comp2/D-USC-38.html)* For this reason, results should not be directly compared with information presented in previous reports."

https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

This clarification of the numbers and statistics is helpful, but also requires persons using this information stay current with the changes and are as accurate as possible in interpreting the data. Discussion of this new data was phrased as "highlighting a common source of confusion regarding who is and who is not considered a 'veteran' ", and the "key message is that suicides are elevated among those who have ever served."

https://www.stripes.com/news/us/va-reveals-its-veteran-suicide-statistic-included-active-duty-troops-1.533992

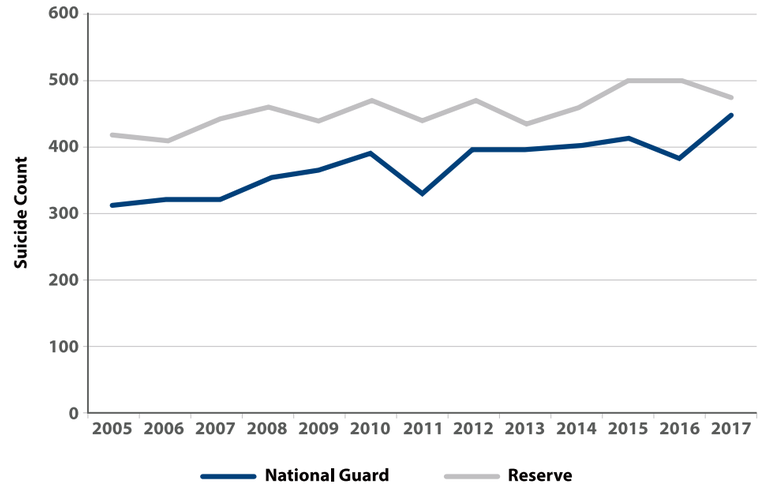
https://www.pdhealth.mil/sites/default/files/images/docs/TAB_B_DoDSER_CY_2017_Annual_Report_508_071619.pdf

This separation of the active-duty service member and non-activated Guard/Reserve from the Veteran population revealed the high Guard and Reserve component suicide rates, with the 32.2 per 100,000 rate for never-federally-activated former National Guard members as a serious cause for concern, shown in Figure 6. Because former National Guard and Reserve members are former service members who do not have Veteran federal legal status due to their type of service, they typically do not have access to VA benefits and services under current laws and regulations. Many California National Guard members who have been summoned for state service by the Governor to manage natural disasters, etc. have extensive periods of service, but do not qualify for federal VA benefits.

FIGURE 6

SUICIDE RATES AMONG NEVER FEDERALLY ACTIVATED FORMER NATIONAL GUARD AND RESERVE MEMBERS (2005–2017)

https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf



Unfortunately, comparable data about California's National Guard suicide rates and numbers is not publicly available, but may deserve attention in future years since their service and well-being is central to our state's domestic welfare.

In addition to new data about National Guard and Reserve suicide rates, information about military family member suicide rates was released by the Department of Defense in 2019. Collection and release of this data was ordered by Congress in 2015, but the data delivered was only for 2017 and therefore not very informative. This data was criticized by many within the military family community as being incomplete without "backdata, critical to better understanding how protracted wartime stress may have impacted families."

https://www.militaryfamily.org/military-family-suicide-rate/

The report showed that 186 military family members died by suicide—122 among active-duty families, 29 among Reserve families, and 35 within National Guard families. 17 spouse suicides were service members themselves, with firearms as the primary mechanism of death among all spouses, which differs from the general population.

Additional suicide data that emerged in 2019 is accumulating evidence that a history of traumatic brain injury (TBI) increases the risk of death by suicide by up to twofold. This has particular significance for the care of post-9/11 veterans for whom the signature injury is TBI. Additional research on the "polytrauma clinical triad"—a co-occurring diagnosis of TBI, post-traumatic stress disorder (PTSD) and chronic pain—was associated with suicide, other violence, and opioid use. This information offers another opportunity for CAVSA to advocate for improved cultural competence in mental health risk assessment and treatment for veterans in the context of suicide prevention and management of frequent diagnoses in our veteran community.

https://www.ncbi.nlm.nih.gov/pubmed/30909230

https://www.ncbi.nlm.nih.gov/pubmed/29526669

Improved past-year understanding of veteran suicide rates suggests the goal of suicide reduction in California's veteran community may require a two-pronged strategy which:

- addresses individuals in rural areas who are at highest risk
- implements evidence-based prevention and monitoring programs in the most populated areas that account for the greatest numbers (despite lower rates) of suicides (e.g., managing access to lethal means, screening National Guard for suicidal ideation, improving treatment of TBI, etc.)

California's Reserve Component: National Guard and Reserve

Both the DOD and VA have focused new attention on the very high suicide rates among the Reserve component nationally. As the largest National Guard in the U.S. with an authorized force of more than 23,000, California Guard members have served outside the continental states (OCONUS) tens of thousands of times since September 11, 2001. In 2017-2019, thousands of Guard members have deployed to wildfire, mudslide, flood, and earthquake-affected areas in California, at times leaving their own families in tenuous situations in order to serve the larger community with little advance notice.

CAVSA is concerned about the welfare and mental health of the roughly 18,000 Army and 5,000 Air Guard members who convene in 95 armories across the state for drills and other exercises, but who have only eight dedicated behavioral health specialists, along with referrals to civilian clinicians and programs.

https://calguard.ca.gov/bh/

Although exact numbers are not available, it is estimated about half of California's National Guard members are prior-enlisted who are likely eligible for various VA benefits—and about half are ineligible (as discussed above, due to their non-federalized service).

Frequent shifting between military and civilian status—accompanied by shifting health care coverage and higher rates of underemployment and unemployment—is a stark reality for many Guard members. Often distant from military resources and living in civilian communities, Guard members must rely on non-military community-based care, and their families often do not identify as "military". With just 16 Family Assistance Centers for Army Guard members and 4 Airman Family Readiness Offices across the state to provide referrals and support to families during deployments, Guard members and their families routinely fall through the cracks in policies and services between the DOD, the California Military Department, the VA, and community-based care. In most military and veteran-connected reports, the category of "National Guard member" does not exist and they are often uncounted and overlooked in reports of veterans, civilians, and active duty military because their status changes with considerable frequency. For example, the number of California Guard who are homeless is unknown. Even so, several armories are aware of this problem and make cots available for Guard members to stay onsite for a limited time when not on drill. Many do not have health care insurance of any kind, except when on drill. To help address some of these challenges, two bills were introduced in the House

of Representatives in May 2019, watched by CAVSA for their possible implications for California. HR 2629, the Care And Readiness Enhancement Act (CARE Act), would amend Title 38 USC to expand eligibility for mental health services at the VA to include members of the National Guard and Reserve, and would also amend HR1812 (the Vet Center Eligibility Act) which would require the VA to provide mental health counseling at Vet Centers for Guard members, Reservists, and their families. Both were referred to the House Veterans Affairs Committee for discussion.

https://www.govtrack.us/congress/bills/116/hr2629/text

https://www.cbo.gov/publication/55269.

https://calguard.ca.gov/family-programs/

Women comprise about 19% of the combined Guard and Reserve component, roughly 4% more women than in active duty military, with a high of 27% women in the Air Force Reserve. Gender-specific care received attention in the form of Senate bill S.1615, the MOMS (Mothers Of Military Service) Leave Act. It was introduced in the U.S. Senate in May 2019 to amend Title 10 and 37 USC, and to provide credit for retired pay purposes and compensation up to the equivalent of six drill periods for maternity leave taken by members of the Reserve and National Guard. Currently, Guard members who give birth are penalized both in credit for time served and pay if they miss drill weekends or any other military commitments following pregnancy and childbirth. HR 937, the House companion bill, was introduced with identical language with bipartisan support.

https://download.militaryonesource.mil/12038/MOS/Reports/2017-demographics-report.pdf

https://www.govtrack.us/congress/bills/116/s1615

If passed, these proposed legislative changes could provide support to thousands of CalGuard members and Reservists. In the meantime, education can be done at the county and state levels in California. As a leading advocate for the mental health and well-being of all who have served our state and nation, CAVSA will explore opportunities to partner with other organizations to support the CalGuard, Reserves, and their families in the coming years.

Additionally, because of DOD's heavy reliance on the Guard and concern about their mental health and welfare, FY2019 DOD appropriations allocated $4.0 million each in new funds to the Army and Air National Guard for pilot preventive mental health programs.

https://www.ngaus.org/legislation/accomplishments/improved-mental-health-care-guardsmen

CAVSA VETERAN ACTION AGENDA 2018-2019

Veteran Resource Centers for Prevention and Early Intervention for College-based Services

Dr. Miatta Snetter, U.S.VETS Outside the Wire

2. EXPAND SUICIDE PREVENTION, INTERVENTION AND POSTVENTION ACTIVITIES

d. Advocate for veteran- and veteran family member-specific mental health funding at local, state, and federal levels.

5. BUILD COMMUNITY AND AGENCY PARTNERSHIPS

d. 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.

Miatta Snetter is CAVSA's featured "point person" for Action Agenda Items #2.d. Expand Suicide Prevention, Intervention, and Postvention Activities and #5.d. Build Community and Agency Partnerships. As a clinical psychologist, Dr. Snetter has helped accomplish these action items primarily by working with Community Colleges in Orange County.

In academic year 2017-18, California Community Colleges (CCC) reported having an estimated 54,368 students with veteran, active duty, or active Reserve or National Guard status (CCC Chancellors Office, Student Success Metrics, Jan 31, 2019), constituting just .26% of the 2.1 million students enrolled in CCC. This "less than 1%" statistic is similar to the percentage of the U.S. overall population who have ever served in the U.S. military, and often results in them being hard to find or overlooked. CCC is comprised of 114 colleges, and is the largest system of higher education in the U.S. As such, it is committed to improving veteran and military student services, which includes expanding both the number and quality of Veteran Resource Centers at CCCs.

As a licensed clinical psychologist in the U.S.VETS program, "Outside the Wire" (OTW), which provides veterans with intensive and extended counseling as well as targeted referrals, Dr. Snetter is heavily involved in building connections with non-veteran-specific providers of social services and mental health. Although OTW is based at Bob Hope Patriotic Hall in downtown Los Angeles (LA County's "one-stop-shop" for veteran and military services), Dr. Snetter spends most of her time at seven community colleges in Orange County who have welcomed her clinical expertise with open arms.

Working at Coastline, Cypress, Fullerton, Golden West, Irvine, Santa Ana, and Orange Coast Colleges on a weekly basis, with expansion underway to Pasadena City College, Dr. Snetter offers onsite clinical mental health services to veterans at the VRCs and support to their staff. With the awareness that veteran students face special challenges—for example, having vastly different life experience, being older than the average student, and adjusting to the much less disciplined and unstructured campus environment—Dr. Snetter uses a strength-based approach with veterans, and offers simple mental health and well-being assessments (e.g.: the OQ45 and MHI5) to identify those who are particularly struggling or at risk.

DR. MIATTA SNETTER WITH A VETERAN COLLEGE STUDENT

Providing essential technical assistance support on veterans issues to the CCCs is critical not only for the well-being of veteran students, but for their academic success, which is in turn related to their overall welfare and mental health. According to national 2014 data, an average of only 15% of full-time students receiving GI Bill funds to attend community colleges graduated with their 2-year degree in two years, and just 7% of those attending part-time graduated in three years. These very slow graduation times are concerning because GI Bill benefits cover a maximum of 36 cumulative months in college, often leaving veterans unable to pay for a bachelor's degree with GI Bill funds if they take longer. Reasons for dropping out are often related to inability to juggle the multiple demands of school, work, family, and poor mental health.

https://www.theatlantic.com/education/archive/2017/04/why-is-the-student-veteran-graduation-rate-so-low/523779/

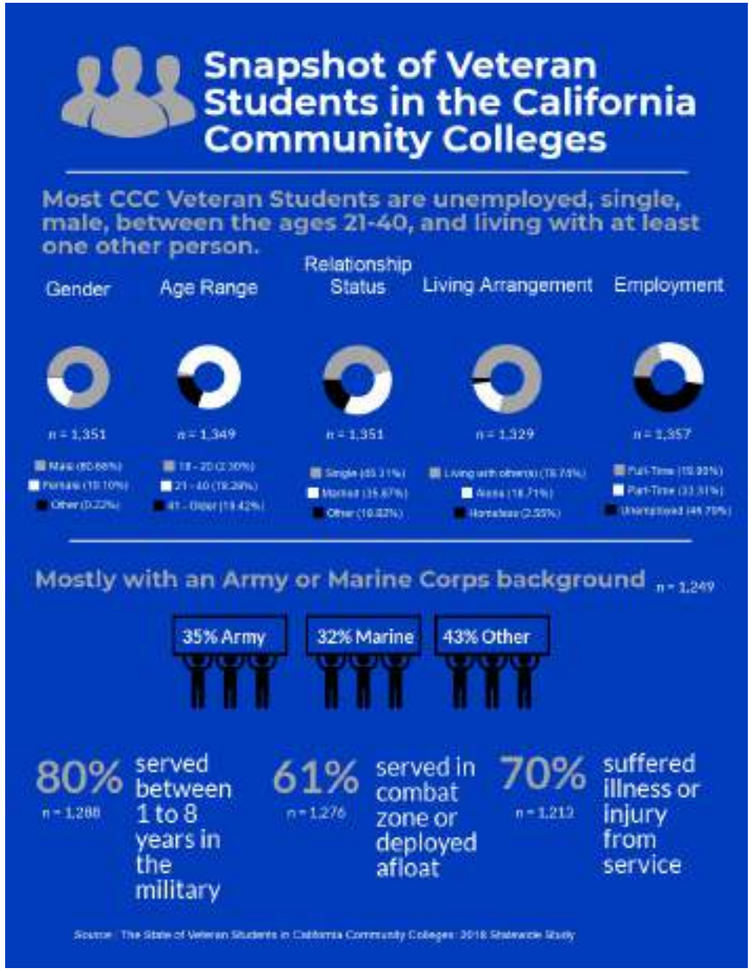
Since veterans are often reluctant to ask for help and students are busy with academics, how does Dr. Snetter manage to reach them with mental health services at VRCs? Oddly enough, the answer may lie in the very challenges veterans face with GI Bill paperwork requirements, class eligibility questions, funding during school vacations, and other issues related to navigating complex VA education benefits.

The silver lining of these problems is that veterans often come to the VRC for case management help, and leave with mental health care and a new self-care resource. An experienced case manager, as well as 3 doctoral interns, a case manager, and 2 MFT or LCSW interns assist Dr. Snetter with the range of CCCs Outside the Wire work, and who, she says, make the job doable, as well as help build a workforce that can leverage the positive aspects of military culture in order to meet the future head-on.

Looking to the future welfare of the veteran-competent workforce is something on Dr. Snetter's mind often and which she puts into practice by participating in mental health advocacy in many ways, from personal student interaction to policy. Soon after the March 2019 release of "The State of Veteran Students in California Community Colleges. 2018 Statewide Report", Dr. Snetter accompanied several dozen Veteran CCC students as they visited their legislators in Sacramento to share the study findings and urge further support for dedicated VRC staff and mental health services statewide. Funding from the U.S.VETS Outside the Wire program makes Dr. Snetter's work possible with these seven VRCs, but others aren't lucky enough to have her support.

https://www.womenveteransalliance.org/wp-content/uploads/2019/04/State-of-CCC-Veteran-Student-Final-2018.pdf

From Dr. Snetter's point of view, she's the one who is fortunate to interact with the VRC students. Miatta reports she frequently hears back from veteran students after graduation who share their stories of empowerment and changed life trajectories because of their experiences in her care at the VRC. Their enthusiasm and courage energize and encourage her to keep making those long drives among the seven VRC campuses, knowing the veteran students she's worked with over the years are having tremendous positive impacts across the world.



OPIOID OVERDOSE

Overall opioid overdose deaths in California show a geographic pattern similar to deaths due to suicide as Map 5 and Map 6 show. Research has shown up to 30% of opioid overdose deaths may actually not be unintentional, and might be suicides. Suicides involving opioids quadrupled in those aged 55-64 from 1999 to 2014, and increased significantly in all other age groups except for 15-24 year olds. Opioid involvement in suicides has doubled among all age groups in the past 15 years which, according to researchers, is likely an underestimate of self-injury with opioids.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5296683/pdf/AJPH.2016.303591.pdf
https://www.nimh.nih.gov/about/director/messages/2019/suicide-deaths-are-a-major-component-of-the-opioid-crisis-that-must-be-addressed.shtml

MAP 5

ANY OPIOID-RELATED OVERDOSE DEATH, PRELIM. 2018

California Opioid Overdose Surveillance Dashboard

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

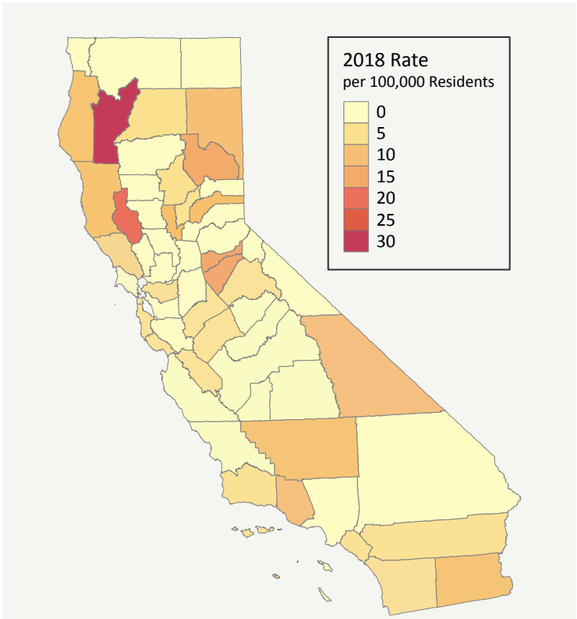


TABLE 8

TOP 10 COUNTIES WITH HIGHEST RATES OF OPIOID OVERDOSE DEATHS

CA's Age Adjusted Opioid Overdose Rate Deaths Per 100,000 Residents in 2018	
Trinity	33.53
Lake	23.01
Plumas	18.11
Calaveras	17.41
Amador	15.69
San Francisco	14.96
Mendocino	14.64
Lassen	14.53
Inyo	14.45
Ventura	10.66
Statewide	5.54

California Opioid Overdose Surveillance Dashboard
https://discovery.cdph.ca.gov/CDIC/ODdash/

Due to poor national and state data on veteran population opioid overdose deaths (see Table 2), information about such deaths can only be inferred by comparing Maps 1, 2, and 6 to look for overlap. Because improved data about the opioid epidemic's impact on the veteran community and their families is imperative in order to adequately address it, CAVSA will continue to advocate for better data collection and sharing among responsible agencies. In the meantime, CAVSA member agencies are educating their personnel and exploring ways to improve veteran-serving agencies' knowledge about life-saving medication assisted treatment (MAT) and naloxone as a component of cultural competence in serving veterans.

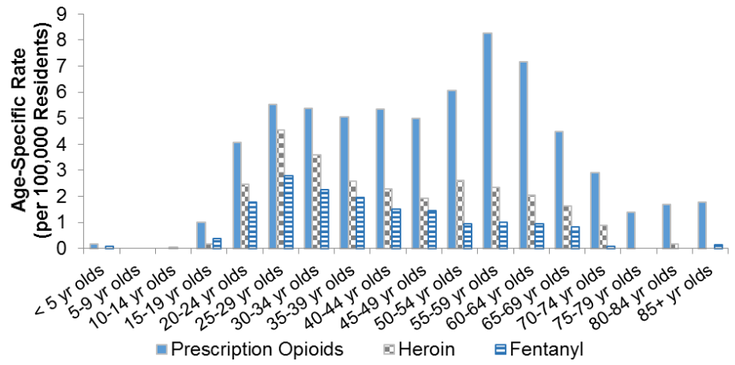
Map 5 shows changes in the patterns of overdose deaths among California's counties over the past year. Modoc, Humboldt, Lake, and Mendocino had ranked as the top four counties with the highest overdose death rates in 2017. All of Lake has shown dramatic improvement, but Trinity, which had been below the state average in 2017, now ranks as the county with the highest opioid overdose death rate in the state. This virtually real-time data is invaluable for targeting interventions and support services in a timely way.

California Opioid Overdose Surveillance Dashboard
https://discovery.cdph.ca.gov/CDIC/ODdash/

Table 8 provides a listing of the counties shown in Map 5. Although this data is not veteran-specific, recognizing which counties have high concentrations of veteran residents can assist agencies in targeting their outreach efforts and developing intervention strategies responsive to the opioid epidemic threat.

FIGURE 7

OPIOID-RELATED OVERDOSE DEATH RATES BY OPIOID TYPE AND AGE GROUP, GENERAL POPULATION (NOT VETERAN-SPECIFIC) CALIFORNIA, 2017



https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/Injury%20Data%20Brief%20Opioid%20Overdose%20Deaths%202011-2017_ADA.pdf

Although overdose deaths may involve more than one opioid, or more than one drug, Figure 7 above shows older age groups in California have higher rates of prescription opioid overdose deaths, with the highest rate of 8.27 per 100,000 among the 55-59 age group. Younger age groups have higher rates of fentanyl and heroin overdose deaths, with the highest rates among the 25-29 year old age group: 4.54 per 100,000 for heroin, and 2.78 per 100,000 for fentanyl.

The above graph is not specific to veterans. However, older veterans who have received care at the VA over time were more likely to have been prescribed an opioid medication and "had nearly twice the rate of fatal accidental poisoning compared with adults in the general US population (standardized mortality ratio=1.96; 95% confidence interval: 1.83, 2.08). Opioid medications and cocaine were frequently mentioned as the agents causing poisoning on death records."

https://www.ncbi.nlm.nih.gov/pubmed/21407033

Only with this awareness can they help ensure the mental and physical well-being of veterans they serve in the context of prescription medications contributing to the disproportionate rate of overdose deaths among veterans described here.

As recently as 2017, the VA conducted an extensive Healthcare Inspection on "Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care" because managing the pharmacy benefits and monitoring prescriptions offered within the "Veteran's Choice Program" (VCP) had become challenging. This report determined that: "with the expansion of community partnerships (in the VCP), a significant risk exists for patients who are prescribed opioid prescriptions outside of the VA. Patients suffering from chronic pain and mental health illness who receive opioid prescriptions from non-VA clinical settings where opioid prescribing and monitoring guidelines conflict with the guidelines in place within the VA may be especially at risk."

https://www.va.gov/oig/pubs/vaoig-17-01846-316.pdf

The report also noted, "over 63% of veterans receiving chronic opioid treatment from the VA for pain also have a mental health diagnosis. Pain management becomes even more complicated when a patient's chronic pain occurs in the setting of comorbidities such as PTSD, depression, traumatic brain injury, and substance use disorder." This issue was addressed earlier in this report (p. 43) in the context of suicide within the polytrauma clinical triad.

Although CAVSA member agencies and other California VSOs are not typically medical care providers, it is a matter of cultural competence and ethical practice for VSOs to be aware of the medical status of their veteran client populations and their exposure to potentially life-threatening substance use disorders. Only with this awareness can they help ensure the mental and physical well-being of veterans they serve in the context of prescription medications contributing to the disproportionate rate of overdose deaths among veterans described here.

Although challenges persist in managing a highly complicated patient population, the VA, which was once a leading prescriber of opioids to address chronic pain, has reduced opioid dispensing by more than 50% over the past 6 years, representing a dramatic decrease in narcotic medication availability among the U.S. veteran population. Most of this reduction has been achieved by not initiating new, long-term opioid therapy in newly presenting veterans with chronic pain, which is a disproportionate problem among veterans. Due to its innovative approaches to chronic pain management, many veterans have been weaned from opioids entirely. The VA strategy to address the opioid epidemic among veterans has successfully employed behavioral pain management techniques, risk mitigation, education, use of medications for addiction treatment (MAT), and substance use disorder counseling.

Complementary therapies include care such as acupuncture, yoga, chiropractic medicine, and mindfulness practices.

https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5237

California Justice-Involved Veterans and Veteran Treatment Courts

California has continued to develop its robust network of veteran treatment courts (VTC) spanning 30 counties, with the first started in 2008. Most of these courts are about 5-6 years old. Although no new VTC has been added in the past year, work has been done at the county and state levels to continue improving the quality of services and jurisprudence provided in these settings. With judicial officer turnover, new judges are frequently joining this bench and augmenting the practices of the VTCs.

MAP 6

VETERAN TREATMENT COURTS IN CALIFORNIA

Map 6 shows the 34 California counties that have operational Veteran Treatment Courts (VTCs) and also notes Kern County operates a veteran diversion program using the same principles and operates with an approach shared with other VTCs, but has chosen not to identify as a VTC per se.

Source: California Judicial Council, 2018.

NOTE: Kern County has a "Veteran Justice Program" that operates like a VTC, but is not officially recognized as such.

https://www.bakersfield.com/news/veterans-justice-program-provides-second-chance-for-those-who-have/article_2686094e-fd6a-11e7-8d35-d7405f413a6a.html

The California statutes serving as the basis for the operations of many VTCs are California's Penal Code §1170.9, first enacted in 1982, and most recently amended in 2012, is the most prescriptive, requiring:

1. the defendant to be former or current military,
2. be suffering military sexual trauma (MST), TBI, PTSD, a substance use disorder, or mental health problem as a result of the military service,
3. with the offense having occurred as a result of the condition,
4. treatment is available to address the problem,
5. the defendant participates in treatment, and
6. the defendant is eligible for probation.

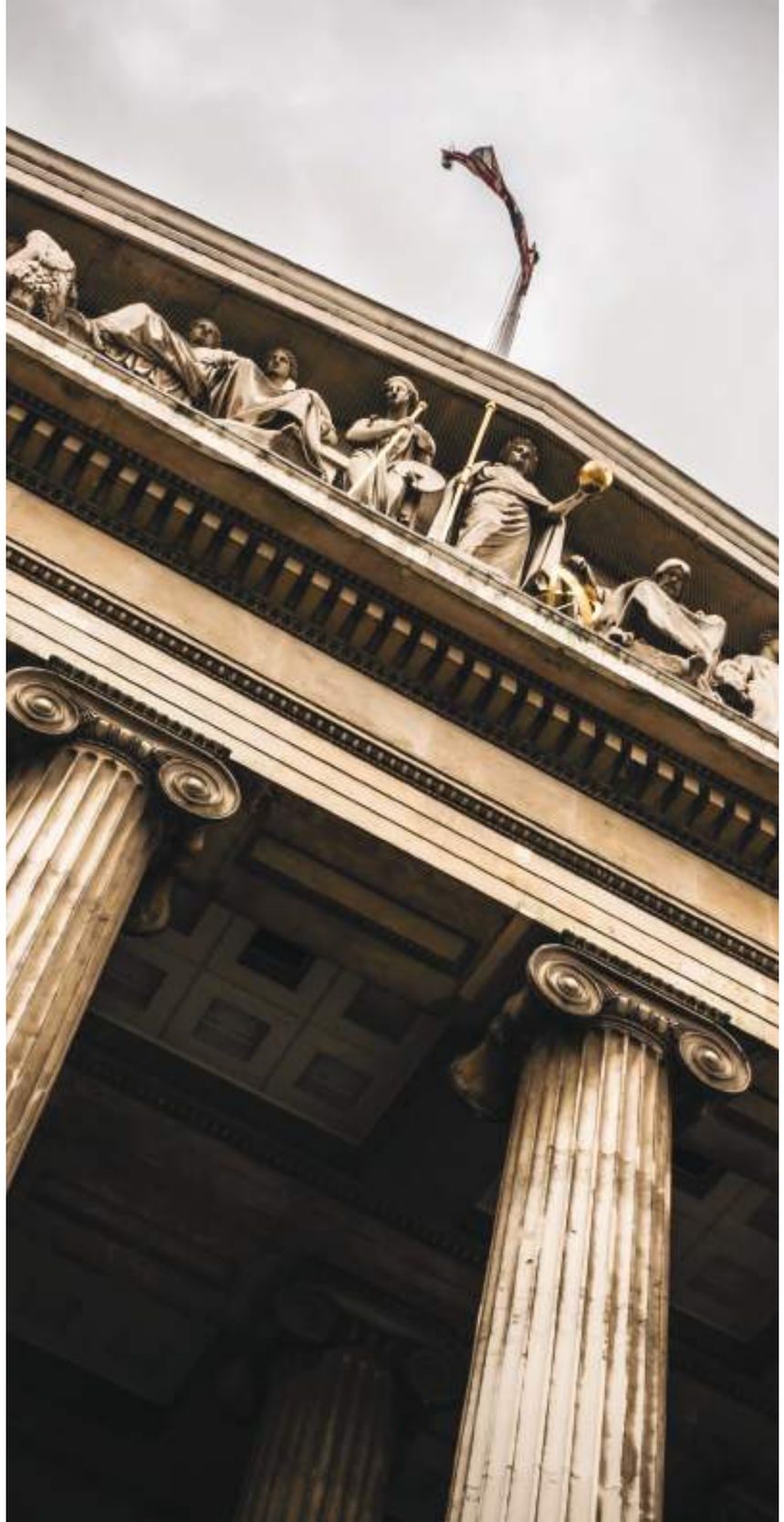
If all of these conditions are met, the defendant may have charges reduced, records expunged, and/or rights restored, and will not have to report the conviction on any legal or employment applications. This latter matter is significant since persons with a history of convictions experience severe discrimination in the workforce.

§1001.80 allows for diversion of misdemeanor offenses if the defendant is or was a member of the U.S. military and is suffering from military sexual trauma (MST), TBI, PTSD, a substance use disorder, or a mental health problem as a result of the military service, and is typically used in DUI cases.

The third statute, §1170.91, went into effect January 1, 2019, and allows veterans convicted of a felony to request resentencing if they are suffering from any of the conditions listed in §1001.80 in which case judges are mandated to consider these clinical factors when resentencing. This last statute has implications for California's veteran inmate population of just under 6,000, as noted in Table 2. An underlying intent in all these statutes is to provide treatment instead of punishment for legal infractions that may have arisen as a result of the individual's military service. All of these statutes may be applied outside of the context of a VTC, which the statutes do not specify, but most counties have employed §1170.9 in the VTC setting only, and often use §1001.80 in VTC contexts as well to help support successful diversion. §1170.91 is too new to have information available on its implementation to date.

Map 5 shows 34 counties have VTCs and Kern County has a program similar to a VTC. About 90% of California veterans reside in those 35 counties, but creative strategies are needed to ensure statewide access. In 2019, the California Judicial Council established a VTC Strategic Plan Working Group to address a number of issues related to the possible expansion of VTCs and quality improvement. Among these is the issue of identification of veterans who tend to not self-identify in justice-involved situations. Shame and stigma are cited as the primary reason for this failure. According to the California Department of Corrections and Rehabilitation (CDCR), only 2.7% of inmates self-identified as inmates, compared to 7.7% who were identified when using the Veteran Affairs Re-entry Search Service System (VRSS) which matches inmates with their veteran credentials to identify them for possible diversion and supportive services both at the beginning and end of justice system involvement. This system is presently used by less than two dozen entities in California, although it is available for use by law enforcement and the Courts to identify and outreach to veterans who are justice-involved and potentially eligible for diversion and other services and benefits, and to prepare them for reentry from their justice involvement with VA benefits and services. Jails are currently the primary intercept where veterans are found by VA-employed Veteran Justice Outreach (VJO) workers to offer them the benefits of the VTCs if they are eligible.

SB 339 (2017) Judicial Council Assessment and Survey of Veterans Treatment Courts, was implemented in 2019, leading to the development of Map 5 and verification of the status of the 34 VTCs across the state. The California Judicial Council's continuing interest in identifying barriers to VTC program implementation at the county level and evaluating recidivism, mental health and substance use disorder treatment needs, and employment outcomes among VTC participants forms the basis for their ongoing work with a report due to the legislature in June 2020. An additional issue being examined in the context of SB 339, which was supported by CAVSA, is the mental health "nexus" between military experience and criminal behavior, which is a difficult connection to prove and also poses ethical questions for some VTC practitioners who find the requirement of a nexus to be problematic. Additional issues regarding the wide variability in VTC capacity,, eligible case types, and mentor training are critical to improving veterans' opportunities to take advantage of California's treatment and diversion statutes, and will continue to be part of the Judicial Council's task in the context of SB 339.



An additional area of possible growth for VTCs involves the inclusion of families in the veteran's treatment and the importance of providing specific trauma-informed care for the family members, especially children and youth in the veteran's life, even those without primary or physical custody. The Strategic Planning Committee for the VTCs noted there are more veterans in family court addressing issues related to child custody, divorce, temporary restraining orders, etc. than in criminal court, presenting missed opportunities for therapeutic intervention and challenges of veteran family dynamics and intergenerational welfare. Orange County has implemented cross-collaboration between its VTC and Family Court in a preliminary manner to date and San Diego implements a veteran-specific domestic violence intervention program to address the root causes of violence which often stem from trauma exposure and lack of emotional regulation skills to manage triggers.

The California Judicial Council and the California Association of Collaborative Courts are both engaged in expanding VTC services, including specific ways VTCs can therapeutically address the needs of veteran families and children. This is in recognition of the intergenerational trauma and relevance of family support for children and parents – especially in context of stressful experiences.

Although there is considerable interest, there is a scarcity of outcome studies on Veteran Treatment Courts (VTCs), but those that have been conducted have found moderate positive outcomes in various domains, including criminal justice, housing, employment, and access to VA benefits.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5776060/

In the context of the lethality of substance abuse and opioid overdoses discussed above, VTCs provide a promising therapeutic and rehabilitative option for drug law violations, which are the most common type of criminal offense seen in VTCs. 60% of individuals arrested for most types of crimes test positive for drugs at the time of their arrest. Substance abuse treatment is often mandated as part of sentencing in VTCs, but several studies suggest substance abuse problems persist among VTC participants and underscore the importance of proper sentencing and tailoring of mandated addiction treatment, including Medication Assisted Treatment (MAT) if opioids are involved.

CAVSA VETERAN ACTION AGENDA
2018-2019

Veteran Treatment Court with Model Veteran-Tailored Curriculum (Marilyn Cornell, Clinical Director, Veterans Village of San Diego)

4. ENGAGE WITH CALIFORNIA JUDICIAL COUNCIL ON SHARED INTEREST AREAS

a. Coordinate with the Judicial Council's Collaborative Courts Committee, Mental Health Subcommittee, and Subcommittee on Veterans and Military to support ongoing education regarding veterans, veteran family mental health, and related justice issues.

b. Connect with Family Courts at state and county levels to build diversion programming and co-calendars with Veteran Treatment Courts, Family Court dockets, and family treatment programs.

c. Continue to explore legislative and policy paths to help expand Veteran Treatment Courts in California.

Marilyn Cornell is CAVSA's "point person" for Action Agenda Item #4: Engage with California Judicial Council on Shared Interests. She has primarily done this by working close to home in San Diego where their Veteran Treatment Court is continuing to grow to be a model for California and beyond.

As home to California's largest concentration of military, San Diego has more than 130,000 active duty military personnel and nearly 226,000 veteran residents (U.S. Census estimates, 2017). With large numbers of current-era veterans separating from service in San Diego, the trauma of combat and warzone experiences make the transition to civilian life difficult for them, their families, and their friends. According to the San Diego VA, over 18% of OEF/OIF Veterans coming to their VA have been diagnosed with PTSD.

https://www.sandiego.va.gov/features/ptsd_combatvets.asp

One tragic result of this situation is that dozens of veterans are booked into detention facilities on a weekly basis in San Diego County. A 2019 county report noted there was a significant increase in the number of veterans booked into regional jails over the past three years with one county jail receiving 637 veterans in 2018, with an average of three bookings per veteran.

https://timesofsandiego.com/military/2019/06/04/military-veterans-in-vista-jail-may-get-more-job-help-county-services/

Although one person cannot take on this issue alone, Marilyn Cornell (M.S., LMFT, Clinical Director, Veterans Village of San Diego [VVSD]) has been a driving force to bring together the resources, compassion, and programming to get the San Diego County Veterans Treatment Court (VTC) launched and keep it going for the past eight years. Launching it required several years of organizing and lobbying, which Cornell was motivated to do for a combination of reasons. During her 22 years as a probation officer in San Diego County, she had contact with many veterans as they became justice-involved and interacts daily with veterans since coming to VVSD in 2007.

Her experiences with veterans over the years also included getting to know Dr. Jon Nachison, soldier turned psychologist, who started the first Veteran Stand Down in 1988 at which Cornell volunteered and has continued to do for 31 of its 32 years. In 1989, long before the VTC started, the first Homeless Court in the nation was convened at Stand Down, where thousands of criminal cases involving veterans have been resolved over the years with many dismissed onsite, including dozens at Stand Down 2019.

Witnessing firsthand the challenges veterans experience as they transition from the military to civilian life and act in ways resulting in legal involvement propels her passion about VTCs: "I've learned to separate the person from the behavior and realize that I'm not in control of them, they are, and they can make amazing changes! Change is really possible." Cornell's belief in change is not hollow. She's seen evidence of lives transformed throughout her work at VVSD and at the VTC: "I know it saves lives, and it certainly makes the community safer. Hearing a veteran say, 'I've regained my honor'—that's an emotional paycheck! And a number of our graduates have come back to be mentors—they continue to heal themselves by being of service to others. It's why I'm still here," she said.

So what is it that keeps Cornell so fully engaged with the VTC and residents at VVSD after her self-described career of "51 years of working with people with problems"? Her answer: "There's always more to do and ways to improve." The opportunities for innovative collaborations with colleagues are also "so rewarding"

she said. Her VTC teammates feel the same way. Harrison Kennedy, San Diego Deputy DA and VTC team member, said: "Marilyn is the glue that holds us together; we wouldn't know what to do if she ever decides to retire—she can't!"

Indeed, Cornell's work with Joy Villavicencio (LCSW) of the San Diego VA and Karen Schoenfeld (PhD) with the San Diego Vet Center yielded evidence the VTC saved San Diego County and the State of California $1,415,435 in avoided jail and prison costs due to 41 VTC participants being monitored by the court in the community, rather than being incarcerated. This was one of the key findings enabling the original VTC to become a permanent Collaborative Court in 2014.

THE TRAUMA WHEEL

Created by Marilyn Cornell, MFT and David B. Wexler, Ph.D.
Relationship Training Institute
www.rtiprojects.org

> *"I've learned to separate the person from the behavior and realize that I'm not in control of them, they are, and they can make amazing changes!"*

In addition to helping ensure the longevity of San Diego's VTC, Cornell, along with her colleagues Schoenfeld, Villavicencio, and Dr. David Wexler, developed a veteran-tailored curriculum, the "Family Recovery Program" (FRP) to address the charges of domestic violence and intimate partner violence (DV/IPV) so frequently seen in VTCs. Created out of the need to provide culturally competent treatment for combat veterans who have been convicted of DV/IPV, the premise of the FRP is that, for many veterans, their aggressive behaviors toward loved ones are not driven by "power and control" (the "Duluth model")—rather, they are triggered by trauma. Cornell explained, "Most of the veterans in the VTC had no prior inclination toward violence and once we shifted the paradigm from blame to the contextual issues of TBI (traumatic brain injury)—which the majority have been diagnosed with—and trauma, the returning veteran and our adjunct providers (treatment providers, probation officers, etc.) all understood the connection." The FRP model also notes shame and guilt are elements of military-specific trauma, which can lead to self-harm, culminating in suicide, if not appropriately treated.

In the coming year, CAVSA and Marilyn will work to share the FRP more widely beyond the criminal court based VTCs to include Family Courts settings, thereby addressing Item B in the Action Plan.

Understanding the need for families to be safe and heal, as well as the importance of family to the veteran, couples counseling is available, when appropriate, after ninety days of programming and is based on clinical and VTC Team assessment. Cornell noted, "we're very, very careful, with a mind to safety issues with any couple counseling. The DA on the team is from a Family Protection Unit (and) so scrutinizes cases very diligently." She noted restraining orders (RO) are in place throughout the 52 weeks, with "no negative contact" on the RO, and that couple counseling cases are actually quite rare, but not impossible. Parenting classes are also offered, including a program called "Mending Fences" designed to help veterans reunite with older, sometimes adult children with whom contact has often been lost.

The FRP meets all the requirements of California's 52-week DV state-mandated curriculum topics and has had very high retention and low recidivism rates since it was first implemented at the Vet Center in 2012 as a key element of VTC programming. Because many VTC clients are also residents at VVSD, Cornell is often the bridge supporting the veteran as they move through the 4-phase programming.

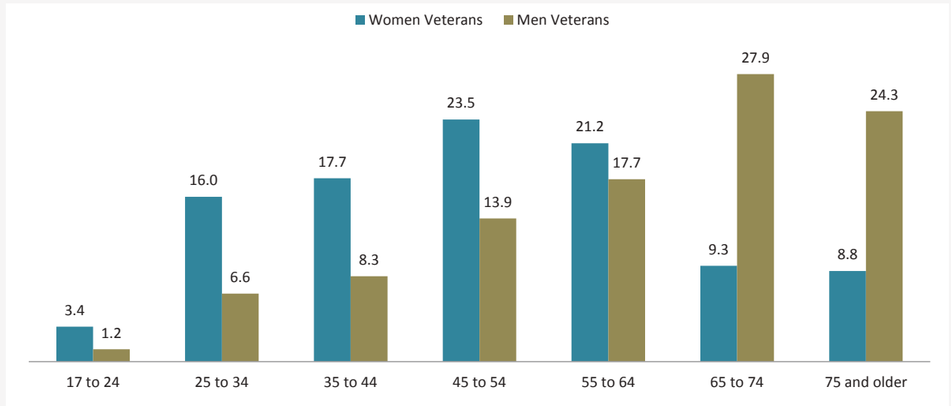
Because Family Courts have a high number of veteran cases with DV/IPV allegations often related to dissolution (divorce) proceedings, there is a need for culturally competent programming in Family Court settings as well. At this time, only the Orange County Family Court has any veteran-specific programs. In the coming year, CAVSA and Cornell will work to share the FRP more widely beyond the criminal court based VTCs to include Family Courts settings, thereby addressing Item B in the Action Plan.

Women Veterans

While elderly, mostly male veterans constitute nearly half of California's veteran population (see Table 1) and will increasingly require special services to address their unique mental health and well-being challenges, California's women veterans have different challenges. Like women veterans across the U.S., (see Table 9) California's women veterans are typically younger than men and therefore will constitute a higher percentage of our veteran population in future years. Across the U.S., the female veteran median age is 50, compared to the male veteran median age of 65.

FIGURE 8

AGE RANGE OF US VETERANS BY GENDER: 2015 (PERCENT)



U.S. Census Bureau, American Community Survey, 2015. National Center for Veterans Analysis and Statistics
https://www.va.gov/vetdata/docs/specialreports/women_veterans_profile_12_22_2016.pdf

Although California has the third largest population of veteran women in the U.S. (see Table 10), women constitute just 9% of California's total veteran population. According to the National Center for Veteran's Analysis and Statistics, a national increase of approximately 18,000 women per year are expected to transition from military to veteran status for the next decade, with a large influx predicted for California. The average age at which female service members separate from service and transition to veteran status has varied considerably over the past two decades due to the Gulf War conflicts and within service branch, but the great majority of women veterans are well within their childbearing years as they begin their civilian lives as veterans.

Table 9 shows that 74% of California's 142,805 women live in just twelve (21%) California counties and 78% of veterans of childbearing age (17-44 y/o, although 49 is often used as bound since the average age of menopause in U.S. is now 51 years) live in those same counties. Nearly half (61,006, 43%), of California's women veterans are of childbearing age and 55% of those reside in just four Southern California counties. Understanding this geographic concentration of women veterans is important for planning services related to general and reproductive health, mental and behavioral health, housing, and social services, including transition assistance, job training, and childcare supports. Strategic targeting of resources, development of interest, and age-segmented outreach campaigns can be aided with such demographic profiling.

Table 10 uses the outside bound of 49 years to define "childbearing years" which results in half of California's women veterans falling within childbearing years, while just over 22% of California's women veterans are 65 years or older. Because women's reproductive cycles and sexual health affect suicide risk, it is important that VSO and social service providers are sensitive and culturally competent in understanding women's health issues across their life cycles.

TABLE 9

CALIFORNIA WOMEN VETERAN POPULATION CONCENTRATION IN TWELVE COUNTIES: CHILDBEARING AGE PROFILE

CA County	CA Women veterans ALL AGES (17 – 85+) 9/2019 projected pop.	CA County 9/2019 projected pop.	CA Women veterans childbearing age (17-44)
1. San Diego	28,148 (20% of total)	**1. San Diego**	15,509 (25% of total)
2. Los Angeles	20,268 (14%)	**2. Los Angeles**	8,369 (14%)
3. Riverside	12,252 (9%)	**3. Riverside**	5,238 (9%)
4. San Bernardino	9,136 (6%)	**4. San Bernardino**	4,160 (7%)
5. Orange	7,149 (5%)	**5. Sacramento**	3,040 (5%)
6. Sacramento	6,964 (5%)	**6. Orange**	2,619 (4%)
7. Solano	4,469 (3%)	**7. Solano**	1,954 (3%)
8. Alameda	4,080 (3%)	**8. Kern**	1,561 (3%)
9. Contra Costa	3,876 (3%)	**9. Fresno**	1,378 (2%)
10. Kern	3,403 (2%)	**10. Alameda**	1,340 (2%)
11. Ventura	3,241 (2%)	**11. Ventura**	1,277 (2%)
12. Fresno	3,241 (2%)	**12. Contra Costa**	1,233 (2%)
21% of CA's 58 Counties	**106,187 (74%) of All CA Women Veterans (142,805)**		**47,678 (78%) of CA Women Veterans of childbearing age***

Source: Predictive Analytics and Actuary, Office of Enterprise Integration. Dept of Veteran Affairs. Table 6L. June 2017
If "childbearing age" is increased to age 49, an even greater percentage of this population reside in these dozen counties.

TABLE 10

U.S. WOMEN VETERANS BY STATE WITH LARGEST WOMEN VETERAN POPULATION AND AGE

State	<20 – 49 y/o (childbearing age*)	50-64 y/o	65-85+ y/o	Women Veterans/State All age groups
1. Texas	101,485 (55%)	54,078 (29%)	29,591 (16%)	185,184
2. Florida	64,027 (44%)	50,838 (35%)	30,784 (21%)	145,649
3. California	**71,437 (50%)**	**40,563 (28%)**	**30,807 (22%)**	**142,805**
4. Virginia	56,035 (52%)	37,846 (35%)	13,651 (13%)	107,533
5. Georgia	47,602 (52%)	32,010 (35%)	12,443 (13%)	92,057
6. North Carolina	45,580 (53%)	28,133 (32%)	12,861 (15%)	86,575
	386,166 (41% of U.S. <20-49 Total) Total U.S. = 928,898 (48%)	**243,468** (39% of U.S. 50-64 Total) Total U.S. = 627,262 (33%)	**130,137** (36% of U.S. 65-85+ Total) Total U.S. = 364,805 (19%)	**759,773** 40% of all U.S. women veterans live in 6 states U.S. TOTAL = 1,920,965

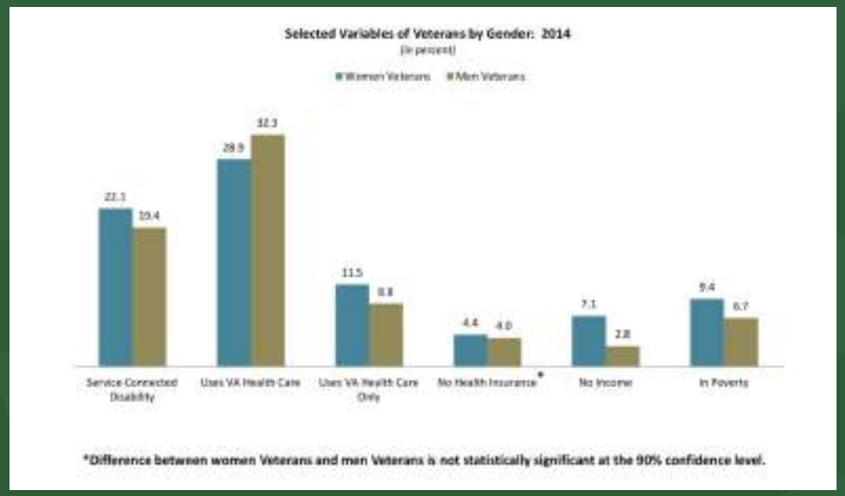
Source: Predictive Analytics and Actuary, Office of Enterprise Integration. Dept of Veteran Affairs. Table 6L. June 2017
*"Childbearing age" is bounded at 49 y/o in this profile.

FIGURE 9

RELATIVELY FEW WOMEN VETERANS USE VA HEALTH CARE

Source: Data Sourcebook, Vol. 4. 2018.
https://www.womenshealth.va.gov/WOMENSHEALTH/sourcebookvol4onlineappendix.asp

A higher percent of women veterans have a service connected disability, have no income, and are in poverty than man veterans. A lower percent of women veterans us VA health care, but a higher percent only use VA health care compared to men veterans.



- **70% of women veterans do not use VA health care**
- **Only 11.5% of women use VA health care exclusively**
- **OB care is outsourced**
- **Non-VA private providers require training**

Figure 9 shows that few veteran women use VA health care. However, the VA also has noted that, between 2000 and 2009, the number of women receiving care grew by 83%, but that represented just 19% of all eligible women veterans. From 2000 to 2015 there was a 175% increase in VA health care use by women veterans, but this still represented less than half of eligible women veterans.

Therefore, women veterans are receiving their care elsewhere, but those providers are often unaware of the foregoing information and may not be culturally competent in their provision of care. With veterans at greater risk for suicide and mental health challenges than their civilian counterparts, the effects of reproductive health and menstrual cycles are uniquely relevant for women. Women's Health providers, especially those located in counties with high concentrations of women veterans of reproductive age, can help by assessing women veterans for risks uniquely affecting them.

https://www.mentalhealth.va.gov/suicide_prevention/docs/Literature_Review_FSTP_Womens_Sexual_and_Reproductive_Health_508_FINAL_06-18-2019.pdf

CAVSA's work in expanding suicide prevention activities and veteran cultural competence training to targeted communities and provider types can promote improved well-being for California's women veterans and their families.

TABLE 11

SEXUAL ASSAULT PREVALENCE BY SERVICE BRANCH

DoD Annual Report on Sexual Assault in the Military FY 2018.
Spotlight: FY18 Data

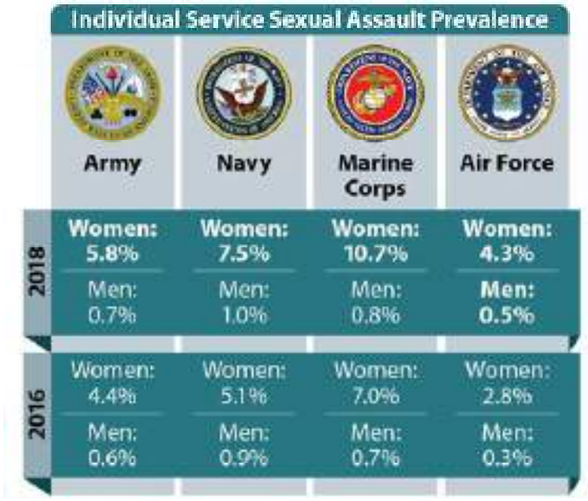


Table 11 shows the increase in reported sexual assault by branch of service between 2016 and 2018, with all rate increases in all branches being statistically significant for women, as well as for men in the Air Force.

Military Sexual Trauma (MST) is reported by 25-40% of women veterans receiving services at the VA, with both harassment and assault being associated with an array of physical and mental health problems, including major depressive disorder, migraines, lower back pain, and PTSD.

https://onlinelibrary.wiley.com/doi/abs/10.1002/nur.20453

Ensuring the cultural competence of VSOs in addition to civilian mental and physical health providers about the widespread nature of this issue is critical to ensure appropriate, high quality care.

MHSA Background and Review

The Mental Health Services Act (MHSA), also known as Prop 63, was approved by California voters in 2004 to place a 1% 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 2019 Governor's Budget (May Revise) indicates $2,094.8 billion was deposited into the Mental Health Services Fund (MHSF) in Fiscal Year (FY) 2017-18. The 2019 Governor's Budget also projects that $2,398.1 billion will be deposited into MHSF in FY 2018-19 and $2,377.6 billion will be deposited into MHSF in FY 2019-20. Approximately $2,085.5 billion was expended from MHSF in FY 2017-18. Additionally, $2,294.1 billion is estimated to be expended in FY 2018-19 and $2,250.1 billion is estimated to be expended in FY 2019-20.

https://mhsoac.ca.gov/sites/default/files/documents/2019-05/FOC-Report_19-MayRevise-19.05.20-Final.pdf
https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSA_Expenditure_Report-Jan2019.pdf

This substantial funding is allocated to counties based primarily on population with county Departments of Behavioral/Mental Health held responsible for:

1. ensuring compliance with W&I Code Section 5892(a), which specifies that counties must expend funds according to W&I §5892(a)(3), (5), and (6), whereby 80% is for Community Services and Supports (CSS), 20% is for Prevention and Early Intervention (PEI), and 5% of the amount allocated to CSS and 5% of the amount allocated to PEI must be spent on Innovation (INN) (see Table 1)

2. having a local Mental Health Services Fund in which interest earned remains in the fund to be used for MHSA expenditures to help support fluctuations in state funding and month to month variability in delivery of funds from the state to the counties,

3. preparing a Three Year Program and Expenditure Plan as well as Annual Updates

4. ensuring all MHSA expenditures are in accordance with an approved Plan

5. ensuring MHSA funds are not used to supplant existing resources

To help provide funding guidance, the Mental Health Services and Accountability Commission (MHSOAC) has directed counties to allocate their MHSA funds to the following five areas:

TABLE 12

MHSA MANDATED COMPONENT FUNDING

1. Capital Facilities and Technological Needs (CFTN)*
2. Community Services and Supports (CSS) (80%)
3. Innovation (INN) (5% from CSS + 5% from PEI)
4. Prevention and Early Intervention (PEI) (20%)
5. Workforce Education and Training (WET)* see below

MHSOAC: *http://mhsoac.ca.gov*

In addition to providing funding oversight to counties, MHSOAC administers funding for Stakeholder Advocacy Groups for the following groups, which may be viewed as priority populations for funding.

TABLE 13

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

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

* *CF/TN and WET funds management and distribution to counties operate differently than the CSS, PEI, and INN funds from MHSOAC and have both come to the conclusion of their original allocations of $453.4 million and $444.5 million respectively as of June 30, 2018. Current WET funds for FY 2018-19 include $10 million in one-time funding to support a stipend program and support for Psychiatric Mental Health Nurse Practitioner Programs. Because of allowances made for reallocation of unspent funds, some CF/TN and WET programs may continue to be funded going forward.*

As the Veteran Stakeholder Advocacy group, the California Association of Veteran Service Agencies (CAVSA) is responsible to help ensure counties are committing to provide adequate services to veterans in their 3-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 is systematically undertaking a thorough 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.

Although 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, the recent State Auditor's review of MHSA funds made it clear this task has been poorly executed.

https://www.auditor.ca.gov/pdfs/reports/2017-117.pdf

Despite MHSOAC's efforts to make funding mechanisms and programming transparent for public scrutiny, it has been difficult for CAVSA to access granular data on how counties are spending their MHSA funds. In an effort to improve access and transparency, MHSOAC developed a MHSOAC Program Search Tool in summer 2019 with a searchable database available at:
http://transparency.mhsoac.ca.gov/searchpage

MHSA Funds Subject to Reversion by County and Component-2017 & AB114 Resolution

In addition to the challenge of making MHSA funding more transparent, MHSOAC as of April 2019 DHCS and MHSOAC have not yet developed a final process whereby unspent MHSA funds that revert from the counties are reallocated. W&I § 5892(h)(1) provides that counties have three years to expend funding for CSS, PEI, and INN components, and ten years to expend funding for CF/TN and WET components. W&I § 5892(h)(3) provides that counties with a population of less than 200,000 have five years to expend CSS, PEI, and INN components. This has been a pressing issue because counties with unspent funds are faced with returning (reverting) unspent funds. As of July 2017, nearly $400 million in mental health funds from FY 2005-06 to FY 2014-15 have been deemed reverted and reallocated.

To prevent this dramatic reversion of funds from badly-needed mental health services, CA AB 114, was enacted in July 2017 to allow each county to submit a plan by July 1, 2018 for expending their funds that were subject to reversion/ reallocation by June 30, 2020. This is relevant for the 2019 CAVSA report and future monitoring of planned veteran services because all counties should have submitted and have approval of their plans to restore their reverted funds, thereby increasing available MHSA funds by more than $390 million for future use.

The following table, compiled and approved by DHCS as of September 12, 2018, provides a summary by county of the amount of unspent MHSA funds accumulated over the first ten years of the MHSA experience. Among the six counties reviewed in this report, the total funds deemed subject to reversion were nearly $211 million, or about 54% of the reverted total. Los Angeles County alone accounted for nearly 47% of total reverted funds.

https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA_Reversion_Funds_Report.pdf

As of March 2019, the MHSOAC Reversion Guidance for counties, including a methodology for calculating redistribution of reverted funds and updated details on Annual Revenue and Expenditure Reporting requirements and other data reporting elements, was not yet finalized. While this is concerning, it also offers an opportunity for veteran and military-connected family stakeholders to engage in MHSA community planning at the county level to articulate the needs of veterans and advocate for increased allocation of MHSA funds to expand veteran and veteran family mental health services.

https://mhsoac.ca.gov/sites/default/files/documents/2019-02/MeetingPacket_MHSOAC_Complete_022819.pdf

Annual MHSA Revenue and Expenditure Reports by county are available through FY 2016-17 for all counties and for FY 2017-18 for about 30% of counties as of May 2019.

https://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx

MHSA FUNDS SUBJECT TO REVERSION AS OF 7.1.2017, BY COUNTY AND COMPONENT

NOTE: If counties submitted plans by July 2018 for use of these funds, they again became available for county use due to one-time stopgap legislation, AB 114, until MHSOAC/DHCS develops reversion guidance and appeal instructions.
NOTE: yellow highlights indicate counties whose plans are reviewed in this CAVSA report.

* The data for this report includes county appeals and Annual Revenue and Expenditure Reports (ARERs) approved by DHCS as of this date.

† Amounts are subject to change based on county appeal.

‡ Funds subject to reversion includes only those fiscal years for which DHCS obtained complete expenditure data.

Indicates unable-to-determine funds subject to reversion; Annual Revenue and Expenditure Report (ARER) data incomplete.

$ - No funds deemed reverted and reallocated.

Counties	Total Funds Deemed Reverted and Reallocated					
	CSS Reverted Funds	PEI Reverted Funds	INN Reverted Funds	WET Reverted Funds	CFTN Reverted Funds	Grand Total Reverted Funds
Alameda	$ -	$ -	$ 5,013,354	$ 1,387,480	$ 7,530,171	$ 13,931,005
Alpine	$ 935,308	$ 1,186,461	$ 480,537	$ 450,000	$ 788,500	$ 3,840,806
Amador	$ -	$ 174,413	$ 607,196	$ 155,163	$ 220,468	$ 1,157,239
Berkeley City	$ -	$ 243,843	$ 336,825	$ 121,105	$ 1,322,116	$ 2,023,889
Butte	$ -	$ -	$ 763,386	$ -	$ -	$ 763,386
Calaveras	$ -	$ 46,061	$ 140,264	$ 32,305	$ 31,001	$ 249,631
Colusa	$ 1,975,725	$ 83,502	$ 485,632	$ -	$ -	$ 2,544,859
Contra Costa	$ -	$ 2,059,690	$ -	$ 167,226	$ -	$ 2,226,916
Del Norte	$ -	$ 305,376	$ 435,949	$ 225,673	$ 832,232	$ 1,799,230
El Dorado	$ -	$ 1,435,140	$ 1,783,832	$ 13,732	$ 354,617	$ 3,587,322
Fresno	$ -	$ 1,240,689	$ 3,805,077	$ 3,006,194	$ 1,381,341	$ 9,433,301
Glenn	$ -	$ -	$ 104,392	$ 79,075	$ -	$ 183,467
Humboldt	$ -	$ 25,898	$ 534,157	$ 185,760	$ -	$ 745,815
Imperial	$ 131,375	$ 691,964	$ 1,486,028	$ -	$ -	$ 2,309,367
Inyo	$ -	$ -	$ 318,727	$ 153,926	$ -	$ 472,653
Kern	$ -	$ 6,372,861	$ 5,572,881	$ -	$ -	$ 11,945,742
Kings	$ -	$ 577,480	$ 914,698	$ -	$ 1,087,498	$ 2,579,676
Lake†‡	$ -	$ 853,283	$ 150,000	$ -		$ 1,003,283
Lassen	$ -	$ 862,141	$ 380,358	$ -	$ -	$ 1,242,499
Los Angeles	$ -	$ 83,313,682	$ 78,004,664	$ 16,350,424	$ 4,772,132	$ 182,440,901
Madera	$ -	$ 157,051	$ -	$ -	$ -	$ 157,051
Marin	$ -	$ -	$ 1,469,567	$ -	$ 536,660	$ 2,006,227
Mariposa	$ -	$ 263,790	$ 328,034	$ 97,007	$ -	$ 688,831
Mendocino	$ -	$ 679,476	$ 1,232,818	$ 203,001	$ 462,115	$ 2,577,410
Merced	$ -	$ 2,224,470	$ 2,387,590	$ 20,569	$ -	$ 4,632,630
Modoc	$ -	$ 271,956	$ 74,612	$ 52,141	$ 512,138	$ 910,847
Mono	$ -	$ 395,362	$ 170,023	$ 66,709	$ 306,021	$ 938,115
Monterey†‡	$ -	$ -	$ 1,437,968			$ 1,437,968
Napa	$ -	$ -	$ 844,141	$ 95,619	$ 145,770	$ 1,085,530
Nevada†	$ 80,061	$ -	$ 493,460	$ 52,265	$ -	$ 625,786
Orange	$ -	$ 12,302,705	$ 13,389,300	$ -	$ 2,973,207	$ 28,665,212
Placer	$ -	$ -	$ 471,335	$ -	$ 1,603,580	$ 2,074,915
Plumas†‡	$ 1,537,671	$ 314,381	$ 438,367	$ -		$ 2,290,419
Riverside	$ -	$ 1,413,257	$ 10,897,188	$ 615,684	$ -	$ 12,926,129
Sacramento	$ -	$ 3,779,050	$ 7,889,409	$ 535,755	$ -	$ 12,204,214
San Benito†‡	$ -	$ 342,769	$ 766,396	$ 167,171		$ 1,276,336
San Bernardino	$ -	$ -	$ 2,690,676	$ -	$ 2,962,931	$ 5,653,607
San Diego	$ -	$ -	$ 7,223,768	$ -	$ 8,782,281	$ 16,006,049
San Francisco	$ -	$ -	$ 1,733,351	$ -	$ -	$ 1,733,351
San Joaquin	$ -	$ -	$ 3,281,376	$ 526,242	$ 2,066,001	$ 5,873,619
San Luis Obispo	$ -	$ -	$ 429,296	$ 76,125	$ -	$ 505,421
San Mateo	$ -	$ -	$ 3,832,545	$ 423,610	$ -	$ 4,256,155
Santa Barbara	$ -	$ 2,702	$ 259,372	$ 431,577	$ -	$ 693,651
Santa Clara	$ -	$ 2,854,964	$ 8,352,439	$ -	$ 3,423,132	$ 14,630,535
Santa Cruz	$ -	$ -	$ -	$ -	$ -	$ -
Shasta	$ -	$ -	$ 1,784,476	$ -	$ -	$ 1,784,476
Sierra	$ 478,607	$ 991,309	$ 494,824	$ -	$ 532,083	$ 2,496,824
Siskiyou†‡	$ -	$ 244,523	$ 774,104	$ -		$ 1,018,627
Solano	$ -	$ 370,701	$ 1,429,797	$ 547,223	$ 338,660	$ 2,686,381
Sonoma	$ -	$ -	$ -	$ -	$ -	$ -
Stanislaus	$ -	$ -	$ 1,682,916	$ -	$ -	$ 1,682,916
Sutter-Yuba†	$ -	$ 1,856,763	$ 1,575,878	$ 339,974	$ -	$ 3,772,614
Tehama	$ -	$ -	$ 53,667	$ 26,046	$ -	$ 79,713
Tri-City	$ -	$ 235,009	$ 799,187	$ -	$ -	$ 1,034,196
Trinity	$ -	$ -	$ -	$ 14,284	$ -	$ 14,284
Tulare	$ -	$ -	$ 4,385,312	$ -	$ -	$ 4,385,312
Tuolumne	$ -	$ -	$ -	$ -	$ -	$ -
Ventura	$ -	$ -	$ 2,712,429	$ 377,576	$ -	$ 3,090,005
Yolo	$ -	$ -	$ 386,700	$ -	$ 268,922	$ 655,622
TOTAL	**$ 5,138,747**	**$ 128,172,722**	**$ 187,490,277**	**$ 26,996,641**	**$ 43,233,577**	**$ 391,031,965**

MHSA Plan Review Methodology

In the context of efforts to make county MHSA Plans more widely accessible and understood, CAVSA selected six counties for MHSA Plan review to explore the degree to which counties are including veterans and their families in their Plans and Annual Updates. The counties of Alameda, Butte, Fresno, Los Angeles, Napa, and Ventura were selected for the diversity of their geographic locations, size of their veteran populations, and characteristics of their catchment areas (see Map 7).

In order to establish a baseline standard whereby progress toward the goal of equitable access to mental health services in every county can be measured, the Plan Review methodology employed here used MHSOAC's "MHSA 3-Year Plan Instructions" to derive thirteen key variables and a 4-point scoring system to facilitate standardized Plan reviews. Plan review is described below using the MHSOAC Instructions about development of the Program and Expenditure Plans.

http://archive.mhsoac.ca.gov/Meetings/PriorMeetings_2013/docs/Meetings/2013/Services_061913_Tab5_FY14-15_MHSA3YrPlanInstructions.pdf

One of CAVSA's primary criteria of interest related to veterans is described in WIC § 5848 and specifies, "each Plan shall be developed with local stakeholders, including….veterans and representatives from veterans' organizations".

The instructions further specify, ***"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."***

CCR § 3300 further states that "involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process." Descriptions of how the stakeholder involvement was meaningful, as well as any substantive changes made to the proposed plan based on stakeholder interest and public comment, is also required.

In addition, reviews of these six counties' MHSA Plans Annual Updates—when available—were guided by the MHSA Annual Update Instructions which cite CCR § 3320 and state, "counties shall adopt the following standards in planning, implementing, and evaluating programs:

- **Community collaboration,** as defined in CCR § 3200.060
- **Cultural Competence,** as defined in CCR § 3200.100
- **Client-Driven,** as defined in CCR § 3200.50
- **Family-Driven,** as defined in CCR § 3200.120
- **Wellness, recovery, and resilience-focused,** as described in WIC § 5813.5
- **Integrated service experiences for clients and their families,** as defined in CCR § 3200.190."

The Annual Update Instructions also describe the need to report on "Other" programs and describe what they could include. For example, "stand-alone programs focused on Outreach for Increasing Recognition of Early Signs of Mental Illness, Access to Treatment, Improving Timely Access to Services for Underserved Populations, Stigma and Discrimination Reduction, and Suicide Prevention." Because all of these kinds of programs have considerable applicability for veterans and their families who tend to perceive stigma related to mental health care-seeking behavior at higher rates than the general non-veteran population, and who are at increased risk for suicide, notice was taken if veterans and their families were mentioned with regard to this programming.

To operationalize the Plan Review process and ensure a measure of standardization and objectivity with regard to involvement of veterans and representatives from veteran organizations and development of programming and services that includes veterans and veteran family members, each county's Plan was rated using a numeric scale to gauge the degree to which Plans and Annual Updates comply with MHSOAC instructions. The variables assessed and scoring system is described in the Plan Review Scoring section to the right.

In addition to the numeric score, a narrative description of veteran programming and participation in the Local Plan and Annual Updates is included in the following reviews.

Although claims about scientific validity cannot be made for this methodology, this approach helps introduce some objectivity about the county Plans, resulting in an improved capacity to interpret the review findings on a comparative "apples to apples" basis.

Plan Review Scoring:

Possible TOTAL SCORE = 92 (including subcategories in items 4 and 13; e.g., 23 items x 4)

0 = Absent from Plan
1 = Present in Plan
2 = Involvement or programming is described
3 = Involvement or programming is meaningful as evidenced by a description of impact
4 = Involvement or multiple programs/services are described or otherwise evidenced throughout the Plan (not simply repetition of same program, staff, or stakeholder in multiple places)

THIRTEEN KEY VARIABLES

ASSESSED IN MHSA 3-YEAR PLANS AND ANNUAL UPDATES

1. Veteran stakeholder (VS)

2. Veteran organization representative stakeholder (VORS)

3. Veteran family member stakeholder (VFS)

4. County demonstrates partnership on:
   a. mental health policy
   b. program planning
   c. implementation
   d. monitoring
   e. quality improvement
   f. evaluation
   g. budget allocations—any involvement or reference to veterans on these

5. Veteran program or services (VPs)

6. Veteran family member program or services (children, spouse, parents, siblings, etc.) (VFPs)

7. Community collaboration with veteran organizations (CCVO)

8. Military/veteran cultural competence awareness/ training

9. Veteran client-driven

10. Veteran/military family-driven

11. Wellness, recovery, and resilience-focused for veteran/military

12. Integrated service experiences for veteran clients and their families

13. Other standalone programs with high relevance for and reference to veterans
    a. Outreach for Increasing Recognition of Early Signs of Mental Illness
    b. Access to Treatment
    c. Improving Timely Access to Services for Underserved Populations
    d. Stigma and Discrimination Reduction
    e. Suicide Prevention

COMPARATIVE COUNTY DESCRIPTIONS

For purposes of better interpreting the findings of this report which includes cross-county comparisons, Map 7 and brief descriptions of the selected counties are included below. The range of environments veteran service providers and veterans experience in California are illustrated here.

Alameda County is home to about 52,000 military veterans (2017 USDVA data) or about 3% of the total county population. As part of both the San Francisco-Oakland-Hayward Metropolitan Statistical Area and the San Jose-San Francisco-Oakland Combined Statistical Area, the majority of Alameda's population is largely urban with a population of 1800/sq mile. Oakland is the biggest city and is also the county seat where a VA Outpatient Clinic and Behavioral Health Clinic are located. The inpatient Livermore VA Hospital is located in the SE part of the county and is part of the larger VA Palo Alto Health Care System serving the Bay Area. Many veterans get care across the Bay in San Francisco.

Butte County is mostly rural, with a population density of about 130/sq mile, located in Northern California with a landmass of approximately 1,650 sq miles. With a total population of about 222,000, of whom 16,000 are veterans (about 7%), Butte was recently in national news due to the devastating Camp Fire in November 2018 which was California's most destructive and deadliest fire. It destroyed the town of Paradise, eighty people died, 50,000 people were displaced, 20,000 buildings were destroyed and 200,000 acres were burned. Chico, as the biggest city in Butte and the site of the Butte County Veteran Service Office (VSO) and a VA Outpatient Clinic, has experienced an increase in homeless and unemployed residents, including a large but unspecified number of veterans and their families. The closest VHA inpatient facility is about 100 miles south of Chico (which is located roughly in the center of Butte County) in Mather, north of Sacramento. Veterans in northern Butte County sometimes access care at the Redding VA Outpatient Clinic in Shasta County. Beale Air Force Base, with a population of about 15,000, is located in adjacent Yuba County.

Fresno County has about 39,700 veterans (about 4%) out of a total population of about 994,400 in its roughly 6000 sq miles. The county is part of California's vast, rural, and agricultural Central Valley with a population density of 150/sq mile. Naval Air Station Lemoore Navy Base, with a population of almost 11,000, is also located in Fresno County with part of it also situated in adjacent Kings County. CalVets operates a 300-bed Veterans Home in Fresno located on 30 acres with an array of services. Fresno is the largest city in the county, and a VA inpatient hospital and VA outpatient clinic are also located there. Because of the vast distance, some Fresno County veterans are eligible for the Veteran CHOICE program for health and mental health services since even traveling to Fresno is more than 40 miles for veterans living in the more remote areas of the county. Rural homelessness in the county is reportedly increasing among veterans, with a growing number living in unsheltered situations.

Los Angeles County has an estimated population of 10,118,759, making it the most populated county in California. It is also quite diverse, ranging from highly urban Los Angeles City to more rural Lancaster and areas in the Angeles National Forest, all located in its 4,058 sq miles yielding a population density of 2493/sq mile. LA County is home to an estimated 281,067 (USDVA 2017) to 325,000 veterans (Census projections; estimated average is 305,000), with an estimated 148,000 aged 65 and older, compared to an estimated 133,000 aged 18 to 64. It is also the site of two Veterans Homes run by CalVet: the West Los Angeles home with 396 beds, and the 60-bed Home in Lancaster. LA County is also home to the Los Angeles Air Force Base at El Segundo with a military population of just over 5,000.

Despite the large number of veterans, veterans comprise about 3% of the total population, but about 7% of the total homeless population. LA County has the greatest number of homeless and unsheltered veterans in CA as well as nationwide based on the Point in Time (PIT) count in 2018 (2018 Homeless Assessment Report [AHAR]), with 76% of homeless veterans unsheltered. According to the 2019 Greater Los Angeles Homeless Count, the percentage of unsheltered veterans was 75% (an insignificant change from 2018 to 2019), but the percentage of chronically homeless veterans declined to 1,302 in 2019, a decrease of 14% from 2018. LA County veterans have access to the Greater Los Angeles Veterans Hospital in West LA, the Sepulveda VA, and the downtown clinic or the Long Beach VA Hospital in southeastern Los Angeles.

Napa County is home to 8,525 veterans, about 6% of the total population of 140,386 spread across 789 sq miles for a population density of 170/sq mile. Veterans receive services at the Yountville VA Hospital, where the Yountville Veterans Home (with 1,120 beds operated by CalVets on a 900-acre campus) is also located. Travis Air Force Base, with a population of almost 20,000, is in adjacent Solano County giving the wine-growing region a relatively large military-veteran community in this semi-rural county.

MAP 7 SIX COUNTY MHSA PLAN REVIEWS

Ventura County has 40,547 veterans (USDVA, 2017) who comprise about 5% of the estimated 2018 population of 850,967 in its 2,843 sq miles, with a population density of 370/sq mile. CalVets operates the Ventura Veterans Home (which houses 60 beds) in partnership with the Greater Los Angeles Area VA providing medical services through which many veterans receive care. Naval Base Ventura is also located in SW Ventura at Point Mugu/Port Hueneme with a population of about 13,500 and is the largest employer in the county, increasing the county's familiarity with military/veteran issues. The primary site for veteran medical care is at the Veteran's Affairs Community-Based Outpatient Clinic, which is planning to expand its capacity by about a third by 2021, with the Vet Center offering behavioral health care and related services.

MHSA Plan Review Overall Findings

The MHSA Plan Review Score comparisons are shown on the facing page.

The primary findings in this review of the six MHSA County Plans are:

1. attention to providing services to veterans is scarce, and
2. descriptions of program impact is generally absent even from the Annual Updates.

Although veterans comprise a small percentage of each county population, they are disproportionately represented in underserved populations in need of mental health services at all levels of care—prevention, early intervention, and treatment. Military service during both war and peace has consequences for service members at all stages of their life transitions—from active duty to civilian, and through the course of their life trajectories through retirement—and for their families, generation to generation.

With California's good fortune to have an ongoing source of Mental Health Services Act funds to develop mental health services, it is imperative the veteran community takes its place at the table to help shape county Mental Health Plans for the benefit of veterans, their families, and communities in each of California's 58 counties.

TABLE 14

MHSA PLAN REVIEW SCORES

County	Veteran Population (est) Percent of Total County Population (est)	MHSA Plan Review Score (out of maximum 92)
ALAMEDA COUNTY	52,000 veterans *~ 3% of total county population*	2
BUTTE COUNTY	16,000 veterans *~ 7% of total county population*	0
FRESNO COUNTY	39,700 veterans *~ 4% of total county population*	2
LOS ANGELES COUNTY	305,000 veterans *~ 3% of total county population*	21
NAPA COUNTY	8,525 veterans *~ 6% of total county population*	6
VENTURA COUNTY	40,550 veterans *~ 5% of total county population*	3
	461,775 veterans *~ 27% of total CA veteran population* *(1.2% of total CA population)*	

Secret Shopper Telephone Survey

CAVSA implemented a "secret shopper" survey element with the purpose of evaluating availability and ease of access to services in five of the six counties in which MHSA County Plan reviews were completed (Alameda, Butte, Fresno, Los Angeles, and Ventura Counties). Three areas of care for veterans were examined, including provider response or lack thereof, the need for a follow-up call to access services, and presence or absence of military cultural competence.

Because of the growing concern about opioid use and overdose in the veteran population, as well as the growing population of elderly veterans, two additional variables were added to the Secret Shopper call script. These included script elements to determine if phone answerers responded appropriately to the severe pain/medication symptoms of the caller or to a potential for a targeted service response for an elderly veteran caller.

The methodology employed scenario scripts portraying a serious need for mental health services centering on anxiety, but not to the degree of a threat of immediate danger. Volunteer callers from a veterans' permanent supportive housing program and staff from a regional Veterans Resource Center were recruited and trained to make the majority of the secret shopper calls. The remaining calls were made by research assistants. Of the 21 volunteer callers, all but two were actual veterans.

As the tables show, findings varied between counties. For example, the positive disposition percentage was highest in Butte (64%) and the lowest was in Fresno (32%). Table 3 may have the least encouraging finding, as it demonstrates more than half the calls made (51%) concluded without the veteran being immediately given an appointment, knowing whether they could walk in for an assessment, or being given another number to try for help.

For both the scenarios described above, which were related to the caller either being a senior or in pain (which might suggest a substance abuse problem), outcomes were difficult to track for the volunteer callers. We learned that, in this instance, the Secret Shopper approach was more effective assessing delineated outcomes and call dispositions rather than nuanced acknowledgements. Despite this limitation, it was clear from the secondary depression/pain scenario that in nearly no instance did the person spoken to specifically acknowledge the pain and depression in a targeted way. Nor did the answerer inquire about the presenting veteran's set of symptoms or to a potential for targeted services for the depressed or elderly caller. This represents a missed opportunity for education or preliminary screening by agencies contacted in this survey and is concerning.

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 (such as the VA) 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.

TABLE 15

NUMBER OF SERVICES AND CONTACT ATTEMPTS BY COUNTY

County	Number of Services Sampled	Number of Veteran-Specific Services	Attempted Contacts
Alameda	20	3	60
Butte	11	4	33
Fresno	19	4	57
Los Angeles	141	14	396
Ventura	12	4	36
Total	**203**	**29**	**582**

TABLE 16

DISPOSITION PERCENTAGE OF CALL ATTEMPTS BY COUNTY
(ANXIETY SCRIPT)

County	% Negative Disposition	% Positive Disposition	% Left Message	Total Attempts
Alameda	18% (11)	37% (22)	45% (27)	60
Butte	27% (9)	64% (21)	9% (3)	33
Fresno	42% (24)	32% (18)	26% (15)	57
Los Angeles	23% (92)	52% (207)	25% (97)	396
Ventura	19% (7)	42% (15)	39% (14)	36
Total	**24% (143)**	**49% (283)**	**27% (156)**	**582**

*attempt numbers appear in parentheses

TABLE 17

PERCENTAGE NO HELP BY COUNTY

County	% No Help	Total Attempts
Alameda	63% (38)	60
Butte	36% (12)	33
Fresno	68% (39)	57
Los Angeles	48% (189)	396
Ventura	58% (21)	36
Total	**51% (299)**	**582**

*attempt numbers appear in parentheses

County Based Follow-Up Surveys to 2018 Statewide Needs Assessment

Based on the success and positive input from more than 200 respondents to CAVSA's 2018 Veteran Mental Health Services Survey, a ten item survey was developed to allow for more local voices to be heard from the six counties where the MHSA 3-Year Plan Reviews were done: Alameda, Butte, Fresno, Los Angeles, Napa, and Ventura. Due to a technical problem with the online survey portal, responses from only Los Angeles, Ventura, and Butte counties were fully recorded, but they nonetheless provide an insight into community impressions of the quality and availability of care for veterans and their families in specific counties, in addition to helping gage progress over the last year.

For ease of review, the survey is included below with the response which generated the highest number of responses highlighted; in circumstances of a "tied" response, either from the same or different counties, both responses are highlighted. Numeric responses and open-ended comments are recorded in the following tables. A sample of some representative comments are also included here. A total of 64 responses were recorded, with 34 from LA County, 22 from Ventura County, and 8 from Butte.

Overall, the replies tended toward being optimistic, with care for women veterans being most uniformly unfamiliar to respondents (generating the most "don't know"s). Los Angeles County recorded the highest number of positive replies, and Butte the least. Because of the small sample size, it is difficult to determine any causality. However, this positive perception does match with the findings of the MHSA 3-Year Plan Review, which showed LA County as being the most proactive in mental health programming for veterans and their families among the six counties reviewed this year.

VETERAN AND VETERAN FAMILY MENTAL HEALTH AND WELL-BEING SURVEY
2019 UPDATE

1. **How easy is it for veterans to get appropriate mental health services from non-Veteran specific providers in your County?** (for example, County-funded programs or non-profit agencies) *(please circle one)*

   Easy

   B. Not easy but possible

   Difficult

   Don't know

   Respondents Sample Comments: *"it seems veterans have trouble identifying where to start", "it depends on what part of the county you're in", "resourceful vets are getting services"*

2. **For most Veterans in your County, the VA is the primary provider of mental health services.** *(please circle one)*

   A. Yes, I think so

   No, I don't think so. If no, where do veterans primarily receive mental health care?

   Don't know

   Respondents Sample Comments who replied "No": *"private health care", "County Dept of Mental Health", "only vets with honorable discharge"*

3. **How easy is it for Veteran FAMILY MEMBERS to get appropriate mental health services in your County?** *(please circle one)*

   Easy

   B. Not easy but possible

   Difficult

   Don't know

4. **Are most Veterans getting the legal support services they need in your County?** *(please circle one)*

   Yes, I think so

   B. No, I don't think so. If no, what kinds of legal service do Veterans need that they are not receiving?

   Don't know

   Respondents Sample Comments who replied "No": *"filing claims for disability benefits", "child support modifications", "parking ticket fees", "civil and family court help, not just criminal"*

5. **My County is making progress in addressing the situation of Veterans in homelessness.** *(please circle one)*

   Yes, I think so

   No, I don't think so. If no, what more should be done to address Veterans' housing in your County?

   Don't know

   Respondents Sample Comments who replied "No": *"better collaboration with non-profits", "more actual housing shelters", "move more quickly with the resources they have"*

6. **My County is making progress in providing Veteran-focused suicide prevention and related follow-up services.** *(please circle one)*

   A. Yes, I think so

   No, I don't think so. If no, what more should be done to address suicide prevention in your County?

   C. Don't know

7. **How easy is it for women Veterans to get appropriate services in your County?** *(please circle one)*

   Easy

   B. Not easy but possible

   Difficult

   D. Don't know

   Respondents Sample Comments: *"services are there, but do they know?", "they just need to know where to go", "it depends on where they live and what they need"*

8. **Stigma about seeking help for mental health services continues to be a barrier to care in your County.** *(please circle one)*

   A. Yes, I think so

   No, I don't think so

   Don't know

   Respondents Sample Comments: *"yes, but childcare and transportation are also big factors", "not as much, but better if co-located with other health services", "mental health ads help reduce stigma"*

9. **Funding for Veteran-specific mental health services has improved in my County.** *(please circle one)*

   A. Yes, I think so

   No, I don't think so

   C. Don't know

   Respondents Sample Comments: *"need more opportunities for funding to go to nonprofits doing innovative work", "more transparency on where funds are going would be helpful", "still need more screening and early detection"*

10. **Please add any additional comments or suggestions you have about Veteran Mental Health and Well-Being in your County:**

CAVSA Inaugural Veterans Mental Health Summit

Held in Sacramento on August 14, 2019, this one-day summit was convened to bring together veteran agencies and other stakeholders from across the state for the purpose of educating the community, policy makers, and legislators about cutting-edge issues facing California with regard to the mental health of our veterans and their families. An additional purpose was to afford opportunities for state agency representatives to interact with community-based Veteran Service Organizations like CAVSA's member agencies and also to engage with personnel from the Mental Health Services Oversight and Accountability Commission (MHSOAC) from which MHSA funding supports this work.

More than 100 registered for the free-of-charge CAVSA Summit, with nearly as many in attendance throughout the day. The day opened with remarks by Steve Peck, the president and CEO of U.S.VETS, followed by a panel on aging featuring two physician researchers from UCSF and the San Francisco VA Medical Center, Drs. Anne Fabiny and Arnaldo Moreno. Also on their panel was Thomas Martin of CalVet, who has been leading the effort to develop a strategic plan for housing California's elderly veterans into the future.

A summary report of the 2019 State of the Veteran Community was delivered by Kathleen West, CAVSA consultant, with commentary and an introduction by Toby Ewing, Executive Director of MHSOAC.

Dr. Jonathan E. Sherin, Director of Mental Health Services for Los Angeles county provided the inspirational lunchtime keynote address, followed by a panel on suicide prevention featuring Miatta Snetter of U.S. Vets Outside the Wire, David Weiner of the VA Long Beach Police Department, and Adriana Ruelas of the Steinberg Institute.

A panel on veteran treatment courts followed, featuring San Diego VTC Judge Laura Birkmeyer, Matt Stimmel of the U.S. Department of Veteran Affairs Justice Outreach Program, and Michael Worrell, VTC graduate and mentor and Marine combat veteran.

The closing panel featured State Senators Tom Umberg (SDist 34) and Bob Archuletta (SDist 32), along with Assembly Member Susan Talamantes Eggman (ADist 13).

At the close of the Summit, CAVSA presented Assembly Jacqui Irwin with our Legislator of the Year award for her tireless work on behalf of veterans and their families.

Response to this Inaugural Summit was overwhelmingly positive and planning for a 2020 Summit is underway.

Table 16 on the following page provides an At-A-Glance review of the status of CAVSA actions taken in the previous year using the color code system used in Table 2, a fraction of which is described in this report. It also represents a culmination of the research, stakeholder outreach, and policy formulation work CAVSA has promoted to help identify important issues to tackle in the future.

As described earlier, most of these actions in this Action Agenda require sustained, multi-year work and will be continued in the coming year. Comments about shifts in emphasis and additional concerns are noted in the Recommendation column and reflect data summarized here and expanded upon in the full report.

TABLE 18

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 alongside 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 Post-vention Activities *Increase attention on older rural veterans, National Guard members, 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 strategy 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.*	D. 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. E. 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. F. Continue to explore legislative and policy paths to help expand Veteran Treatment Courts in California.
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 veteran- and military-connected family issues. B. Engage proactively with Veteran Service Organizations (VSOs) to build stakeholder base. C. Collaborate with CalTAP to a) put the 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 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.

CAVSA BOARD OF DIRECTORS
2019-2020

Stephen Peck, President | U.S.VETS President and CEO

Stephen Peck is a veteran of the Marine Corps. He has served as U.S.VETS President/CEO since 2010. He started the Far From Home Foundation, helped with the Comprehensive Homeless Program at the West Los Angeles VA Medical Center, and has produced two feature films about veterans, *Heart of the Warrior* and *Far From Home*. In 2011, the USC School of Social Work honored him with the W. June Simmons Distinguished Alumni Award.

Michael Blecker, Secretary | Swords to Plowshares Executive Director

Michael Blecker is a Vietnam-era Army veteran who has been with the agency since 1976, becoming its Executive Director in 1982. He has guided its transformation from a grassroots group into an agency with a $19 million annual budget. He co-founded the National Association for Homeless Veterans and the Coalition for Iraq and Afghanistan Veterans. Mr. Blecker has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, and the National Agent Orange Settlement Advisory Board. From 2015 to 2016, he served on the federal Commission on Care, examining veteran access to VA care. The City and County of San Francisco declared November 7, 2016 as Michael Blecker Day, in honor of his service to veterans.

Chris Johnson, Treasurer | Veteran Resource Centers of America President and CEO

Chris Johnson has over 25 years of leadership in business strategy, brand development, fundraising, and communications in both the for-profit and nonprofit sectors. He joined VRC in July 2019 after serving as Interim Executive Director of Evergreen Treatment Services (ETS), a nonprofit based in Seattle providing medication-assisted treatment and wraparound services for opioid dependence as well as street-based outreach services to vulnerable, chronically-homeless adults struggling with addiction.

Leo Cuadrado, Board Member | New Directions for Veterans Executive Director

Leo Cuadrado achieved the rank of Captain in the U.S. Marine Corps. He had a succession of roles at Camp Pendleton, culminating in School Adjutant before he retired from the service. He served as the Chief Operating Officer for A Place Called Home and New Directions for Veterans before assuming the position of Executive Director for New Directions in October 2018.

Deborah Johnson, Board Member | California Veterans Assistance Foundation President and CEO

Deborah Johnson is a decorated veteran of Operation Desert Shield/Desert Storm. She has provided supportive services in various roles to veterans for more than 23 years. She was honored in 2016 at the "Spirit of Veterans Day – Saluting Community Service Excellence" Ceremony in Sacramento co-hosted by the VFW and Rep. Doris Matsui.

Brad Long | Veterans Housing Development Corporation

Brad Long previously oversaw the Eureka, Chico, and Redding operations of Veterans Resource Centers of America. Prior to VRC, he was the Admissions Director at Skyway House Rehab Center in Chico. Brad has a B.S. in Organizational Leadership from Azusa Pacific University and an M.A. in Theology from Claremont, and he served in the U.S. Navy from 1985 to 1989 as a Radioman Petty Officer Second Class.

Burt McChesney, Board Member

Burt McChesney served as a helicopter gunner in Vietnam. He has advocated for housing for homeless veterans and mental health-related supportive services to complement veteran housing projects. Mr. McChesney has served as Special Assistant to the Speaker of the California Assembly, as Chief Consultant to the Chair of the Assembly Democratic Caucus, and as advisor to the Budget Conference Committee.

Kimberly Mitchell, Board Member | Veterans Village of San Diego President and CEO

Kimberly Mitchell served in the United States Navy for 17 years as a Surface Warfare Officer, achieving the rank of Lieutenant Commander. Hand-selected by the Secretary of the Navy and the White House, she served as a White House Military Social Aide between 2007 and 2012. In her final two years of active duty, she served as the Deputy Director of the Chairman of the Joint Chiefs of Staff Office of Warrior and Family Support. Prior to joining VVSD in 2017, Ms. Mitchell was the president and co-founder of Dixon Center for Veterans and Military Services.

Chuck Helget, Executive Director | CAVSA

Charles Helget served in the U.S. Army from 1973 to 1977, where he achieved the rank of Captain, holding positions as a combat arm's unit commander and senior legal officer. Mr. Helget is Director of Government Affairs for Republic Services, responsible for waste sector public policy development. In January 1991, he formed Sector Strategies, a government affairs firm. As its president, he developed extensive experience in California and the western United States in organizing government affairs strategies for public organizations and private corporations.

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