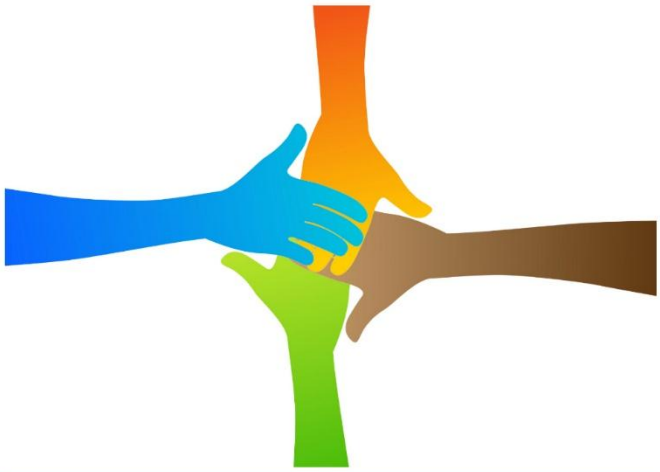
2016 VETERANS MENTAL HEALTH SUMMIT



FINDINGS REPORT

Swords to Plowshares

VETS HELPING VETS SINCE 1974

INSTITUTE FOR VETERAN POLICY

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Swords to Plowshares

VETS HELPING VETS SINCE 1974

VA

AMERICAN FOUNDATION FOR Suicide Prevention

KQED Veterans Coming Home

SUMMARY

The 2016 Veterans Mental Health Summit was held on August 12, 2016. It was co-hosted by the San Francisco Department of Veterans Affairs Health Care System (SFVA) and Swords to Plowshares (Swords), with the American Foundation for Suicide Prevention and KQED Veterans Coming Home. The aim of the Summit was to strengthen collaboration between the SFVA and community organizations that serve veterans in the San Francisco Bay Area; with a focus on enhancing suicide prevention and access to care. Three community strategy sessions during the Summit focused on specific groups of veterans:

A. Veterans with other than honorable discharges (bad paper)
B. Aging veterans, and
C. LGBTQ and women veterans.

Presentations were made on suicide and access to care, and a general discussion was held at the end of the Summit. A debrief session was held with Summit panelists on September 23, 2016, to prioritize the multiple discussion points and recommendations from the Summit, and plan next steps. Resulting action items are in the following report.

For further details, see accompanying presentations from the Summit (linked within the report), and fact sheets in the appendices.

ACTION ITEMS

TOPIC AND GOAL	ACTION
BAD PAPER	
Train VA staff (Member Services, Mental Health Services, Social Work Services)	Charter a team including Swords, Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and the Vet Center to review content. Swords to conduct training.
PSAs on VA and Swords Facebook pages for suicide prevention	Post VA PSAs viewed at the Summit. Add links in the next Swords newsletter.
AGING	
Event to focus on identifying needs and sharing information among groups	Swords to host a Roundtable February 2017. Invite Social Work Service staff as well as Mental Health Services from the VA.
Create resources for reference	Compile a list of VA services, including VA-funded services in the community.
LGBTQ/WOMEN	
Target anti-suicide and access messages to these groups	Work with the VA Central Office to produce branded materials.
Clarify eligibility for VA MST care	Consult with the MST Coordinator.
ACCESS TO CARE	
Update information for VA service users	Review brochure for Psych Emergency to make sure it includes Same Day Clinic.
VA Social Work and Mental Health to provide joint training on services (including Choice and MST), for Swords and other community groups	Identify trainers, plan content, and identify venue(s).
Veteran cultural competency training for onboarding new VA staff	Identify trainers, plan content, and identify venue(s).
Give feedback to the VA Central Office about difficulties with Choice	Compile veteran feedback and submit to the VA Central Office.
SUICIDE	
Updated data on ethnicity and suicide	Find out when the VA Central Office will release ethnic breakdown of new suicide data.
PROCESS	
Quarterly meetings to track progress on above action items	Set up quarterly meetings of leadership from San Francisco VA Mental Health and Swords to Plowshares.

PURPOSE OF THE SUMMIT

Veteran suicide is a preventable tragedy, and veterans who are enrolled and engaged in VA healthcare are less likely to complete suicide. The San Francisco Department of Veterans Affairs (SFVA) and community-based providers alike are committed to easing access to veteran-specific care by lowering cultural and bureaucratic barriers, and strengthening our collective networks of care.

COMMUNITY STRATEGY SESSIONS

Three break-out community strategy sessions were held regarding the theme subjects: suicide prevention and access to care, as they relate to: A) veterans with other than honorable discharges (bad paper), B) aging veterans, and C) LGBTQ and women veterans. Each panel was comprised of a community-based provider, a VA mental health clinician and a member of the SFVA Suicide Prevention Team. Panelists provided brief comments regarding their service area, challenges and key initiatives. The sessions then turned to group discussions focusing the themes and cohorts around three questions:

1. What can the VA do?
2. What can the community do?
3. What are the next steps?

A. VETERANS WITH "BAD PAPER"

Issue:

Veterans who receive other than honorable discharges (OTH; referred to as bad paper) are not eligible for VA medical center services. They are eligible for Vet Center services, which include counseling, but need to rely on community resources or securing a Change of Character of Discharge (COD) from the Veterans Benefits Administration (VBA) in order to access healthcare, including mental healthcare and medication. Bad paper is a severe risk factor for inaccess to mental healthcare as well as suicide. This session focused on risk for suicide among this cohort, how the community, VA Medical Center and Vet Center addresses need and access, as well as how all partners may assist in shepherding the veteran through the COD process to gain access to healthcare and benefits. *See Appendix A, Page 14 for more facts.*

Panelists:

- Elizabeth Fleming, LMFT, San Francisco Vet Center Team Leader, discussed Vet Center eligibility, services and client base.
- Claire White, JD, Equal Justice Works AmeriCorps Veterans Legal Fellow, Swords to Plowshares discussed the Change of Discharge Status application process and the relationship with mental healthcare.
- Rodney Roberson, Certified Peer Specialist SFVA Acute Recovery Center, Suicide Prevention Team discussed interactions and follow-up with bad paper veterans who have been admitted in psychiatric crisis.

Discussion:

The San Francisco (and other) Vet Centers serve veterans who've served in any combat zone, and those who have experienced military sexual trauma (MST) with all discharge statuses (except fully dishonorable). Both licensed and unlicensed providers offer counseling free-of-charge. There are no predetermined limits on sessions, and if eligible, veterans remain eligible throughout their lifetime. Treatment is provided for PTSD, anxiety, and

depression for individuals and couples with duration of treatment depending on individual need. Veterans who are ineligible for services (dishonorable) are seen for limited services on a humanitarian basis. If completely barred from VA or Vet Center care, veterans are referred for services elsewhere (often through Swords to Plowshares).

Other than dishonorably discharged veterans may receive Vet Center counseling but are ineligible for SFVA mental or physical healthcare, including prescription medications, and are also referred to community-based healthcare through Healthy San Francisco. A significant percentage, approximately 50 percent of SF Vet Center clients do not have access to VAMC.

The SFVA psychiatric intensive care also sees patients whose discharge otherwise bars them from care as they are admitted in crisis, often 5150'd, as a danger to self or others. Once stabilized, a social worker assists bad paper veterans in identifying and securing community-based care. Bad paper status inhibits recovery not only because of denial of VA care but because of the stigma and feelings of betrayal and shame associated with the label 'other than honorable.'

Swords to Plowshares provides housing, employment, and other services regardless of discharge status. In addition, the legal department represents clients in VA disability and compensation claims, including VBA Change of Character of Discharge (COD) and/or with military discharge status review applications. Clients are represented by staff attorneys and Bay Area pro-bono attorneys, and onsite legal clinics are held in San Francisco at Fort Miley and the Downtown Clinic (as well as the Menlo Park and Palo Alto Medical Centers). Swords to Plowshares legal staff are also engaged in national advocacy, having filed a rule change petition with the VBA, which would increase access to care for some veterans with OTH discharges. The VBA Rule Change Petition can be accessed at: https://www.swords-to-plowshares.org/2016/03/30/Underserved.

Confusion regarding eligibility is apparent throughout the community, from frontline staff to medical professionals, to community providers and veterans themselves. Veterans with OTH do not know that they can get services at the Vet Center. There is also confusion among providers for veterans who are in the claims process for simple service connection (without discharge issues) which may further complicate treatment.

Participants report that frontline VA Medical Center staff mistakenly turn away veterans as ineligible though that determination is a VBA function and is not automatically triggered by seeking care at a VA medical facility. Mental health providers would like to understand the nuances of eligibility, the availability of COD services, and how they can help clients through the process. Some assume though, that any engagement in the process is a conflict with the VBA and fear to take more than a hands-off approach to clients' discharge (or other) claims process. They can be of assistance, however, by providing notes, letters describing client diagnosis and experience, and by simply being aware of veterans' experiences through the claims process and its impact on their mental and emotional health.

Veterans, likewise, find eligibility, discharge status and the COD process confusing and many do not approach the VA or Vet Centers at all. If they do approach the VHA, they may assume that asking for and being denied care is the same as applying for benefits, or that it triggers the eligibility and benefits process which is conducted by the VBA.

There are also significant barriers to care based on the real or perceived notions that VA staff are all gatekeepers ready to turn them away rather than navigators to guide them into care. Participants noted that clinicians and staff may assume that a patient who is applying for benefits or COD is motivated simply by monetary benefits and thus dismiss underlying health need. This is particularly troubling as community-based direct service staff sometimes find that the availability of financial benefits for impoverished veterans can serve as an incentive to seek care which in no way negates the presence of serious mental health need.

These dynamics are opportunities for veterans to drop out of the process and data reveals that veterans who do not use VA health services are at a much greater risk of suicide. In addition, stigma of shame associated with OTH status creates obstacles to seeking care and can exacerbate mental health need.

VA representatives stressed that community-based providers should refer Post-9/11 veterans to Transition and Care Management representatives at the VA to coordinate care. Veterans with bad paper who have experienced MST should be directed to MST coordinators as they may have more access to mental healthcare because of MST.

Legal and community advocates stressed that VA clinicians, nurses and others can write letters on behalf of veterans' COD claims. The standard of proof is 'more likely than not' this veteran has a mental health issue which occurred during service and contributed to the bad paper discharge. They do not need to demonstrate actual knowledge. In addition, the VBA accepts lay evidence of mental health need associated with discharge and social worker case notes are very helpful. Additionally, OTH veterans are still eligible for GPD transitional supportive housing programs.

Participants also pointed out that VA mental health apps are available to anyone regardless of discharge status or willingness to seek in-person care and that they are very helpful. (https://mobile.va.gov/appstore).

Recommendations:

1. Train VA mental health staff on bad paper, the VBA processes and letters of support. Swords and SFVA Mental Health are planning this training.
2. Train member services and front desk staff on eligibility. Swords is planning this training.
3. Refer veterans to a clinician rather than turn away. If in doubt, refer veterans to Vet Centers.
4. Note bad paper as a risk factor in suicide risk assessments.
5. Add suicide PSAs to VA and community organization Facebook pages (and other social media).

B. AGING VETERANS

Issue:

Aging veterans are the largest cohort of veterans and have the highest risk of suicide. Their access to VA healthcare may be compromised by lack of knowledge of eligibility, mobility, and housing issues. San Francisco has a critical lack of affordable, appropriate housing, especially for veterans who need increased assistance due to physical health need coupled with chronic or worsening mental healthcare need.

Panelists:

Leo Joslin LMFT, Clinical Director at Swords to Plowshares discussed the needs of aging clients at Swords' six housing sites in San Francisco which serve formerly homeless veterans with an average age of 60, including permanent supportive housing at three sites.

Thais Williams, LCSW, Suicide Prevention Coordinator at SFVAHCS said VA Suicide Prevention has continued to expand and evolve since its inception in 2007, and through extensive data collection and collaboration with multiple national indexes, VA Central Office Suicide Prevention is able to establish a clear understanding of which veterans are at greatest statistic risk for suicide.

Bobby Singh, MD, Psychiatrist, Geropsychiatry, SFVAHCS discussed the progress of geriatrics practice and the changing perceptions of what we understand and misunderstand about older people.

Discussion:

Ensuring the safety and well-being of aging veterans is a significant and growing challenge, and service providers are struggling to make sure veterans age in place, in their homes and communities due to a lack of resources. Accelerated aging and Agent Orange exposure are two significant issues facing Vietnam War veterans as is isolation and loneliness among all senior veterans. On top of these risk factors for suicide and pre-disposition for serious health issues, we are heading toward a housing crisis for low income veterans in addition to seriously deteriorating physical and mental health. How do we ensure we care for our aging demographic?

Currently 64 percent of U.S. veterans are aged 55 or older, and that number is growing. We will need a considerable number of skilled professionals specialty trained to work with older veterans. PTSD predicts an increased risk for dementia which has implications on treatment and a need for a higher level of care and support.

Despite the changing perceptions of older adults as no longer being helpless, vulnerable and dependent, older veterans continue to be an invisible population unable to advocate for their own care. Cultural norms may also perpetuate reluctance to reach out. Physicians and clinicians both mentioned that many of the veterans they see may feel stigma stemming from misperceptions and thus are accustomed to hiding true answers when screened for mental health status or questions about suicidal ideation.

Isolation is a critical factor in both their health outcomes and their care, and many older veterans lack a support system to help them navigate the aging process. Limited mobility increases this isolation as well. For example, they may have limited ability to do simple things such as turning on a shower either because of dementia or a lack of strength and agility. Older people often cannot keep up with the rapid growth to our digital culture and as a result, left out of online and social media outreach and communications. This contributes to increased isolation and no ability or desire to seek care through the growing VA applications and technology.

We know the rate of attempted suicide is higher among older veterans, and some theories about suicide among older veterans include what is described as a perfect storm: a lack of belonging, feeling as if they are a burden, and a desensitization to pain from chronic illnesses and other higher level of hospital visits.

The Bay Area has a serious lack of housing options. There is no board and care in San Francisco that can be covered by VA benefits, and resource availability and eligibility for aging veterans is difficult to navigate—even for providers. An additional constraint: San Francisco community providers do not screen for veteran status and despite only a third of San Franciscans enrolled in VA care, we have no clear picture of the provision of services to San Francisco aging veterans in the community system while this housing crisis looms.

Recommendations:

1. We must increase resources for permanent supportive housing with expanded staffing, retirement communities, and assisted living to enable veterans to age in place. If possible, community systems should access city and state funding for aging adults receiving care in the community.
2. We must assess and leverage the landscape for seniors in San Francisco. We should cross communicate between the VA and community systems to gain a deeper understanding of the provision of services in both systems. We need to develop a clear concise listing of what the VA does for aging veterans and what the community does for aging veterans; including referral names and POCs.
3. VA or VA contracted funding needs to be increased for 24/7 permanent supportive housing staff to provide round-the-clock care and for facilities to be updated for ADA compliance and senior needs.

C. LGBTQ AND WOMEN VETERANS

Issue:

Lesbian, gay, bisexual, transgender, queer (LGBTQ) and women veteran communities are both underrepresented and high risk veteran populations. While the VA and community systems are tailoring a more thoughtful approach to reaching and serving LGBTQ and women veterans, adversity, trauma, and suicide risk remain. More research is needed on how to effectively reach and serve these populations.

Panelists:

Brian "Tate" Guelzow, Staff Psychologist on the San Francisco VA Healthcare System's Suicide Prevention Team opened the panel with an overview of research conducted on LGBTQ and women veteran populations, background information gathered through existing research, and highlighted the overall challenges of research on these populations.

Dr. Michael Burnias, Staff Psychologist at the San Francisco VA Medical Center (SFVAMC) and Downtown Clinic (DTC) and Coordinator for the Inter-Professional LGBTQ Health Care Post-Doctoral Psychology Fellowship at the SFVAMC discussed changing the face and message of the VA on all levels to show that they are taking the necessary steps toward communicating to a population that can feel invisible and marginalized that they have a safe space in VA care and services.

Dr. Caitlin Hasser, Director of the Women's Mental Health Program at the San Francisco VA Medical Center discussed common barriers to care among women veterans, and insights on their needs from a clinical perspective.

Jerri Lee Young, LMFT, Assistant Director for Residential Programs at Swords to Plowshares provided a community system perspective, particularly the Swords to Plowshares supportive housing model and provided insights on LGBTQ and women veterans within these models.

Discussion:

How do we address the stigma, adversity, and trauma to these populations on a systemic level?

There are higher rates of adversity and trauma, and similar barriers in access to care and suicide ideation among both LGBTQ veterans and women veterans. How can we address the cultural barriers to care on a systemic level?

Despite an end to *Don't Ask, Don't Tell* in 2011, homophobia remains, and adversity and harassment of LGBTQ service members is still reported. Stigma among the LGBTQ veteran population may prevent them from disclosing their sexual or gender identity for fear of losing care, or getting worse treatment; presenters mentioned these assumptions are based on fear and how comfortable they are accessing care.

There is a lack of research of LGBTQ veterans, and particularly transgender veterans, described as a "minority within a minority." Understanding their health outcomes and service needs is critical to creating culturally informed services both at the VA and in the community.

How do we engage with transgender veterans, bring them in for services, and how do they access care? It's difficult to even define their first access point as transgender veterans are not properly identified in the VA and most community systems. We need to figure out access points, then how to streamline the path to culturally informed and appropriate services as many transgender veterans do not know on where and how to comfortably access the system.

The VHA directive on proper healthcare for transgender and intersex veterans begins to address culturally appropriate care, yet concerns remain. Educating frontline staff as well as providers in mental and primary health at the VA and community systems is crucial to ensuring we are culturally competent in our care approach.

Women are the fastest growing population in the military and increasingly involved in direct combat; yet remain under-researched and poorly understood. Their rate of VA use nearly doubled from 2000 – 2009. Despite this, only one in four women go to the VA for their care. The rest, presumably go to community systems.

Overall, women veterans want women-specific care, want integration with primary care and mental health, and want to be included and recognized for their service by the VA. According to the presenters, women also want their issues with the service environment addressed, in particular creating safe spaces at the VA for women. One particular concern is group treatment, a common program for VA mental health which has proven to reduce stigma associated with mental illness yet can trigger women with histories of trauma, especially if they are the only woman in the group.

Women veterans who are not accessing care have had more experience with military sexual trauma (MST). They often experience distrust of the VA, a higher barrier to care because of this distrust, and more severe unaddressed mental health needs. MST can heighten self-isolation, thus their needs become increasingly difficult to address.

Locally, we have a challenge of securing enough psychiatric patient beds for someone who is having a crisis, although women are typically priority enrolled. Despite the challenge of securing stable housing and psychiatric beds, there is a recent uptick in women residents, particularly at Swords to Plowshares.

Worryingly, a high number of veterans in a Swords to Plowshares high acuity housing facility have had at least one suicide attempt. The recent data from the VA on women veteran suicide is alarming, and shows that women outside of VA care are at a very high risk of dying by suicide. Because women are under-researched, we don't have a deep understanding of these suicide outcomes, their service needs, and effective prevention services.

Recommendations:

1. We must take steps toward communicating to a population that can feel invisible and marginalized, that they have a safe space in VA care and services. We must coordinate and work alongside each other as community partners to connect people to the services that they need.
2. We must ensure the VA and community spaces are safe and accessible for women and LGBTQ veterans.
   - Same-day drop-in clinics provide a partial solution to the barrier for veterans experiencing full on crisis, making it easier for people to come in and access care right away.
   - Separate entrances and escorts for women and traumatized veterans is always ideal for the comfort of veterans but is not always practical given the spaces they have to use. The VA should expand service areas to include safe entrances.
   - Peer support is a care enabler for women and LGBTQ and is something the VA has recently started implementing on a more formal basis. Research should be conducted on the effectiveness of peer support. Studies have shown that social support and identification with positive role models is a protective factor against suicide.
   - Women only groups are important in addition to integrated groups and should be implemented.
   - Creating support groups for women who are experiencing PTSD, anxiety and depression as a result of intimate partner violence is crucial. The VA should do more research and create additional opportunities for specific programs to address IPV.

- The VA is just beginning to include alternative care, including yoga and acupuncture. We see the ways in which equine therapy for instance, can be extremely effective. We need to start thinking about how these alternative practices can work cohesively.

3. There are LGBTQ veteran care coordinators at every VA site to help get people the care they need, and who have experience providing clinical care to LGBTQ veterans, so we must get the word out to veterans that these care providers are available to them.
4. The recently passed Women Veterans Suicide Prevention Act examines which VA suicide prevention services are actually effective and helpful for women veterans, and allows for preferences of women veterans in access to and quality of care.
5. There is a strong need for further research to find out how we can prevent suicide and self-harm.

SUICIDE PREVENTION SESSION

Presentations on suicide prevention by Gordon Doughty from the Greater SF Bay Area Chapter of the American Foundation for Suicide Prevention and Dr. Megan McCarthy, Deputy National Director, Office of Suicide Prevention—VA Central Office reviewed VA and non-VA resources and discussed the newly released VA 2016 Suicide Data Report, "*Suicide Among Veterans and Other Americans, 2001-2014,"* which now is available at mentalhealth.va.gov. Discussion about these presentations took place in the community strategy sessions described above. Links to their presentation materials are available at http://www.slideshare.net/VetsHelpingVets.

ACCESS TO CARE SESSION

Dr. John McQuaid, Interim Associate Chief of Staff for Mental Health – SFVAHCS**,** presented information on the My VA Access Program overall and local improvements to timeliness and ease of access to care; including:

1. Implementation of same day referrals to mental health for suicide prevention and primary care-mental health integration (PCMHI).
2. Immediate care for ANY veteran voicing suicidality or an urgent need or identified as being suicidal by a licensed provider either by phone or in person.
3. Initial brief screening by a licensed provider the same day for new patients requesting or referred to mental health in person.
4. New patients to mental health without an urgent need who call for an appointment, receive an initial brief screening the same day or next calendar day by a licensed provider.
5. Same day care for urgent needs for established patients.
6. Expansion of PCMHI, which is often the entry point for care.
7. Under the Choice Program non-VA care provided by senior psychologists, psychiatrists, pharmacists, and other health professionals who treat veterans with PTSD is paid for by the VA.

The San Francisco VA catchment area reports that 90 percent of patients are male and the largest group is the Vietnam cohort. They are experiencing increased referrals for psychotherapy. This may be in part due to the increased ease in access, delivery methods and outreach including: inclusion of mental health in primary care; increased use of video care in veterans' homes, availability of urgent mental healthcare at the medical center and new same day and Saturday morning clinics.

Increased outreach and ease of access also includes 'care that comes to you' through Mental Health Intensive Case Management (MHICM), for serious mental illness, regular presence at City College and outreach to other schools, and Home-Based Primary Care and Tele-Mental Health (to clinic or home).

Discussion:

Participants expressed frustration with the Choice Program which was rolled-out under strict timelines and has logistical problems. Participants and patients report that outside providers are not getting paid, which has led to providers dropping out, and/or veterans accumulating bad credit. Another example raised was non-VA emergency room care bills not being paid. Patients report receiving multiple bills from the emergency provider which can impact credit, cause stress and negatively impact mental health. In both instances, veterans can turn to the Patient Experience Office (formerly Patient Advocate) for assistance. SFVA is sending specific stories to the VA Central Office to support legislative work underway to improve the program.

Several attendees asked that the VA provide access, education and guidelines for medical marijuana within the VA healthcare system. Federal law currently prevents this and there is not enough research at present to support adopting cannabis use. A participant reported many veterans he knows are taken off opiates due to cannabis use. Regarding opiates, it was explained that VA Prescription Opioid Safety Teams main focus is to reduce dangerous combinations of opiates and benzodiazepines. Some veterans are currently using medical marijuana for mental health and pain management. There are some limited non-VA studies currently in progress.

Recommendations:

1. Include Fact Sheets with access information in VA outreach materials and train Swords to Plowshares and other community provider staff.
2. Identify pathway for Choice Program difficulties to be voiced and advocate for improvements.
3. Identify pathway for cannabis requests to be voiced.
4. Educate VA providers about Swords to Plowshares eligibility services; train VA staff.
5. Refer veterans to Swords to Plowshares for eligibility difficulties.

CLOSING SESSION

The day closed with a general discussion, focused on key findings and opportunities to increase collaboration in suicide prevention and access.

Discussion:

Participants expressed a strong interest in organizing and attending follow-up events throughout the year. Indeed, distributing this report is the first step in an effort to address action items raised during the course of the day and to invite community and VA mental health providers and stakeholders to engage in activities related to suicide prevention and access to care for older veterans, LGBTQ and women, and veterans with bad paper prior to the next annual summit.

The major shared themes were to change the culture, to be as liberal as possible regarding eligibility, and to benefit from continued communication and feedback. Other areas where we may combine efforts to improve access to care include outreach and post-release supports for incarcerated veterans, more attention and acknowledgement of non-combat veterans, recognition of bad paper status as a risk factor for suicide, and research regarding race, gender and suicide.

Importantly, more support for aging veterans is desperately needed in the short term. This group represents the highest number of veterans, the highest risk for suicide and is particularly vulnerable. The lack of affordable housing in San Francisco and the need for more staff support for homeless veterans to age in place, presents a crisis which will deepen if we do not act.

Swords to Plowshares and the SFVAMC will continue to work together to improve our community's response to veteran access to care and suicide prevention beginning with the action items described in this report.

THE SAN FRANCISCO VA HEALTH CARE SYSTEM is a comprehensive network that provides health services to veterans through the San Francisco VA Medical Center (SFVAMC) and six community-based outpatient clinics (CBOCs) in Santa Rosa, Eureka, Ukiah, Clear Lake, San Bruno and downtown San Francisco.

Main Line: (415) 221-4810 / Advice Nurse: (800) 733-0502 / Mental Health Emergency: (415) 750-6674
Mental Health Access Center and Same Day Clinic: (415) 221-4810, ext. 24824.
www.sanfrancisco.va.gov/services/mentalhealth.asp

THE INSTITUTE FOR VETERAN POLICY AT SWORDS TO PLOWSHARES (IVP) works to strengthen systems-of-care for veterans and their families. IVP's policy and community education efforts are unique, reflecting decades of experience in direct community-based care, access to housing, benefits, mental and physical healthcare, and employment services. We inform best practices in veteran care and support throughout the nation. We recognize that community-based programs have the ability to respond to changing needs and differentiate services for veterans, including all eras of service, women, aging, LGBTQ, or otherwise underserved. We are a trusted source of expertise by all levels of government, foundations and philanthropists, behavioral health providers, law enforcement and community partners.
www.swords-to-plowshares.org

APPENDIX A

VETERANS WITH BAD PAPER: FACTS ON VA UTILIZATION + SUICIDE

INSTITUTE FOR VETERAN POLICY AT SWORDS TO PLOWSHARES
AUGUST 2016

BACKGROUND ON VETERANS WITH BAD PAPER

- Service members may receive a less than honorable discharge as a result of alleged or actual misconduct. This may happen for many reasons; for being late to formation a couple times, having an argument with a superior, or for more serious infractions, some as a result of behavior stemming from a service-related injury.
- Service members "at mental health risk" are 32% more likely to be separated from service within a year of deployment than service members not "at mental health risk."[1]
- Marines who deployed to combat and were diagnosed with PTSD were 11 times more likely to receive misconduct discharges than those who did not have a PTSD diagnosis. They were eight times more likely to have substance abuse discharges.[2]

VETERANS WITH BAD PAPER AND VA UTILIZATION

- 45% of misconduct discharges make service members presumptively ineligible for VA services.[3] This is higher for some services than others: 81% of Marine misconduct discharges are presumptively ineligible for VA services, while only 14% of Air Force misconduct discharges are presumptively ineligible.
- 6.5% of veterans who have served since 9/11 are excluded from the VA – twice the rate for Vietnam era veterans and nearly 4 times the rate for World War II era veterans.
- 3 out of 4 veterans with bad-paper discharges who served in combat and who have post-traumatic stress disorder (PTSD) are denied eligibility by the Board of Veterans' Appeals.
- Contrary to the text and intent of the 1944 G.I. Bill of Rights, which established the current VA eligibility standard, the VBA has precluded veterans with other than honorable and misconduct discharges from receiving services at the VHA. The VBA recently stated it will initiate rulemaking proceedings to improve and clarify its regulations.

VETERANS WITH BAD-PAPER AND SUICIDE RISK

- Veterans discharged for misconduct are twice as likely to commit suicide as those honorably discharged.[4]

[1] Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War. *JAMA.* 2007;298(18):2141-2148. doi:10.1001/jama.298.18.2141.

[2] Highfill-McRoy RM, Larson GE, Booth-Kewley S, Garland CF. Psychiatric diagnoses and punishment for misconduct: the effects of PTSD in combat-deployed Marines. BMC Psychiatry. 2010 Oct 25;10:88. doi: 10.1186/1471-244X-10-88. PubMed PMID: 20974004; PubMed Central PMCID: PMC3020681.

[3] Defense Manpower Data enter, "Active Duty Military Discharges, 2004-2011", available at http://www.dod.mil/pubs/foi/foiaLibrary.html. One type of misconduct discharges leaves the veteran eligible for VA benefits ("General"), and the other types of misconduct discharges leave the service member presumptively ineligible for VA benefits ("Other than Honorable" and "Bad Conduct". "Dishonorable" discharges never received VA benefits). These figures are calculated by dividing the number of presumptively ineligible discharges (OTH, BCD, DD) by the number of all performance or misconduct discharges (General, OTH, BCD, DD).

[4] Janet E. Kemp, Veterans Health Admin., Suicide Rates in VA Pati ents Through 2011 with Comparisons with Other Americans and Other Veterans Through 2010 (Jan. 2014), http://www.mentalhealth.va.gov/docs/suicide_ data_report_update_january_2014.pdf.

APPENDIX B

WOMEN VETERANS: FACTS ON VA UTILIZATION + SUICIDE

INSTITUTE FOR VETERAN POLICY AT SWORDS TO PLOWSHARES
AUGUST 2016

DEMOGRAPHICS OF WOMEN VETERANS

- Women comprise nearly 10% of our veterans,[5] 15% of our active duty force, 19% of National Guard and Reserves, and 20% of new recruits.[6]
- Despite previous combat exclusion policies, women have served in combat yet have had difficulty gaining recognition for combat service.
- Women make up 10% of all homeless veterans and are 4 times as likely to be homeless as civilian women.

WOMEN VETERANS AND VA UTILIZATION

- 1 in 4 women veterans seeks services from the VA. Current era women veterans make up 12% of Iraq and Afghanistan veterans utilizing VA healthcare.[7]
- While the number of women veterans is growing, they remain a distinct minority and are less likely than men to self-identity as veterans or to seek treatment. Despite tremendous efforts by the VA to provide services to women, many women veterans aren't aware of state and federal benefits and services available to them, and many are accessing services from community systems-of-care.[8]

SUICIDE RISK AMONG WOMEN VETERANS [9]

- Risk for suicide is 2.4 times higher among women veterans when compared with civilian women.
- Among women veteran VHA patients, the highest rates of suicide were observed for women 40–59 years of age, a pattern that generally held from 2001–2014.
- Rates of suicide among men and women VHA users have remained relatively stable in recent years, although rates of suicide among younger women users of VHA services have increased in recent years.
- Since 2001, the rate of suicide among veterans who use VA services increased by 8.8%, while the rate of suicide among veterans who do not use VA services increased by 38.6%. In the same time period, the rate of suicide among women veterans who use VA services increased 4.6% while the rate of suicide increased 98% among women veterans who do not use VA services.

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APPENDIX C

OLDER VETERANS: FACTS ON VA UTILIZATION + SUICIDE

INSTITUTE FOR VETERAN POLICY AT SWORDS TO PLOWSHARES
AUGUST 2016

DEMOGRAPHICS OF OLDER VETERANS

- Veterans ages 55 and older represent 66% (13.9 million) of the veteran population in the U.S. 22% are over 75 years old.
- Over the next 10 years, mean age will increase and the population will have a higher proportion of older veterans.
- Older veterans (age 51 or older) represent 50% of all homeless veterans, compared to 19% homeless non-veterans. The number of homeless veterans over the age of 55 is projected to increase dramatically over the next 10 – 15 years. And among that age group, there is significant early onset health issues and age adjusted mortality.

OLDER VETERANS AND VA UTILIZATION

- According to data Swords to Plowshares obtained on San Francisco Department of Veterans Affairs (SFVAHCS) patients ages 55 and older, the top 5 most frequent medical diagnostic categories are circulatory (56%), vision loss (46%), pain (42%), hyper-lipidemia (35%), and diabetes (22%). The top four mental health diagnostic categories are substance abuse (17%), depression (16%), PTSD (9%), and anxiety (8%).
- A large portion (71%) of San Francisco senior veterans are not enrolled in VA healthcare. Additionally, 61% of SFVAHCS patients ages 55+ also have non-VA insurance coverage, and seek care outside of VA services.[10]
- There is a shortage of specialized geriatric care across the country, with private sector systems and VHA having similar challenges.[11] At present, there is no health system with as many care teams, known in VHA as Geri-PACTS, dedicated to the geriatric population.

OLDER VETERANS AND SUICIDE RISK

- 11% of veterans aged 65 years and older have a diagnosis of major depressive disorder, a rate more than twice that found in the general population of adults aged 65 and older.[12]
- PTSD is associated with high rates of morbidity and mortality and is one of the most common sequelae in older veterans.[13] The deterioration of physical health can exacerbate or even trigger the onset of PTSD symptoms as the veteran ages.[14]
- There is continued evidence of a high burden of suicide among middle-aged and older veterans. In 2014, about 65% of all veterans who died by suicide were age 50 or older.[15]

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[10] FY 2014 data obtained by Swords to Plowshares from SFVAHCS by Freedom of Information Act, July 2015.
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APPENDIX D

LGBTQ VETERANS: FACTS ON VA UTILIZATION + SUICIDE

INSTITUTE FOR VETERAN POLICY AT SWORDS TO PLOWSHARES
AUGUST 2016

DEMOGRAPHICS OF LGBTQ VETERANS

- There are over one million veterans who identify as lesbian, gay and bisexual (LGB).
- The military is the largest employer of transgender veterans: 20% of the U.S. transgender population are veterans.
- On July 1, 2016 the Pentagon announced the repeal of its ban on open service for transgender service members, which will affect at least 15,500 actively serving Trans members of the U.S. military.
- Women were only 15% of the Armed Forces during Don't Ask, Don't Tell (DADT), the military's previous policy against open LGB service, but 38% of those discharged under DADT. 29.4% of Armed Forces are people of color, but were 45% of DADT discharges.

LGBTQ VETERANS AND VA UTILIZATION

- Some challenges LGBT veterans face include the following:[16]
  - Lower overall health status
  - Lower rates of routine and preventive care
  - Higher rates of smoking, alcohol, and substance abuse
  - Higher rates of discrimination, stigma, and trauma experiences
  - Higher risk for mental health illnesses, such as anxiety and depression
  - Increased incidence of some cancers

LGBTQ VETERANS AND SUICIDE RISK

- Lesbian women veterans have higher rates of mental distress than heterosexual women veterans.[17]
- More lesbian, gay and bisexual veterans report suicidal ideation compared with heterosexual veterans.[18]

[16] http://www.diversity.va.gov/programs/files/lgbt/Veteran-hc-fs.pdf
[17] John Blosnich, Melissa Ming Foynes, and Jillian C. Shipherd. Journal of Women's Health. 22(7): 631-636. doi:10.1089/jwh.2012.4214. July 2013.
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