

DECEMBER 2013

Needs Assessment *Veterans in the Western United States*

POLICY BRIEF



By Phillip Carter and Katherine Kidder

Veterans in the 12 western states account for nearly one-third of all veterans nationwide, including a mix of large, dense veterans communities in urban areas and veterans dispersed across vast rural and mountainous areas.

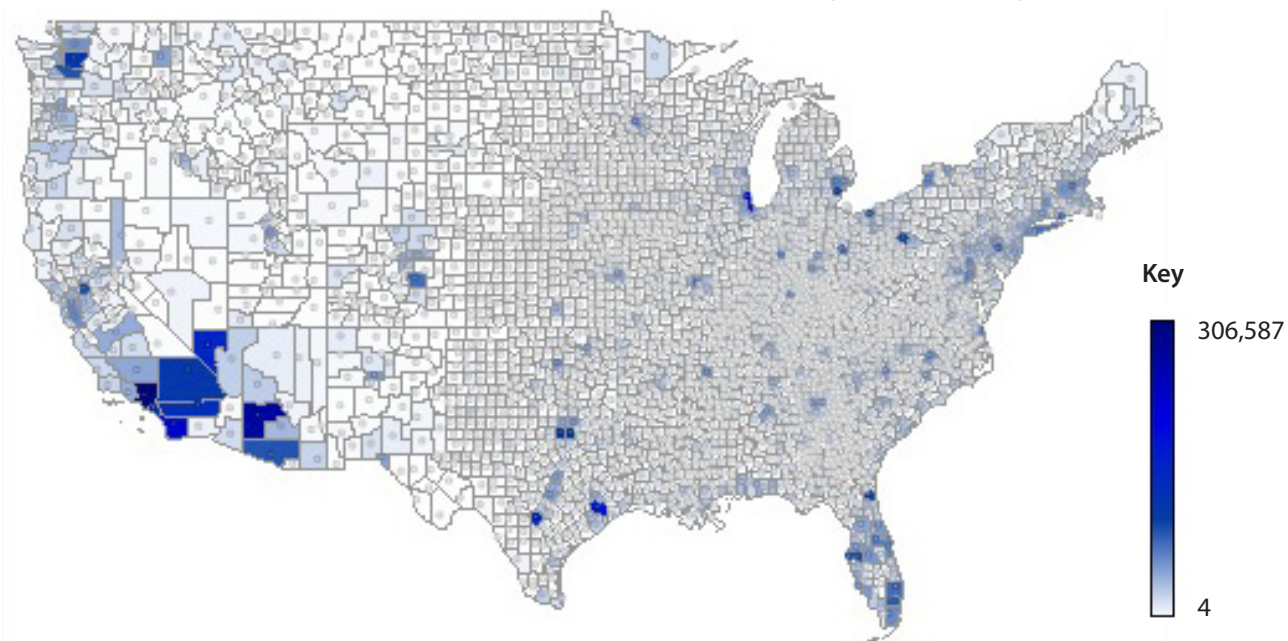
The overwhelming majority of veterans in the western United States do well after they leave the military, with higher than average employment and income and better results for other socioeconomic indicators than their nonveteran peers. However, some veterans struggle to adjust to civilian life or suffer later in life with issues relating to their service. In the western states, our research found that these veterans' struggles often relate to broader community issues where they reside, such as the shortage of affordable housing in high-cost areas like the San Francisco Bay Area.

This policy brief summarizes the results of a needs assessment conducted by the Center for a New American Security (CNAS) between August and November 2013, focusing on veterans in the

western United States. Research involved extensive qualitative research on trends in the region, quantitative research using data made public by the Department of Veterans Affairs (VA), the Department of Defense (DOD), and other agencies, and interviews and working groups with participants from more than 90 leading organizations serving veterans in the western United States.

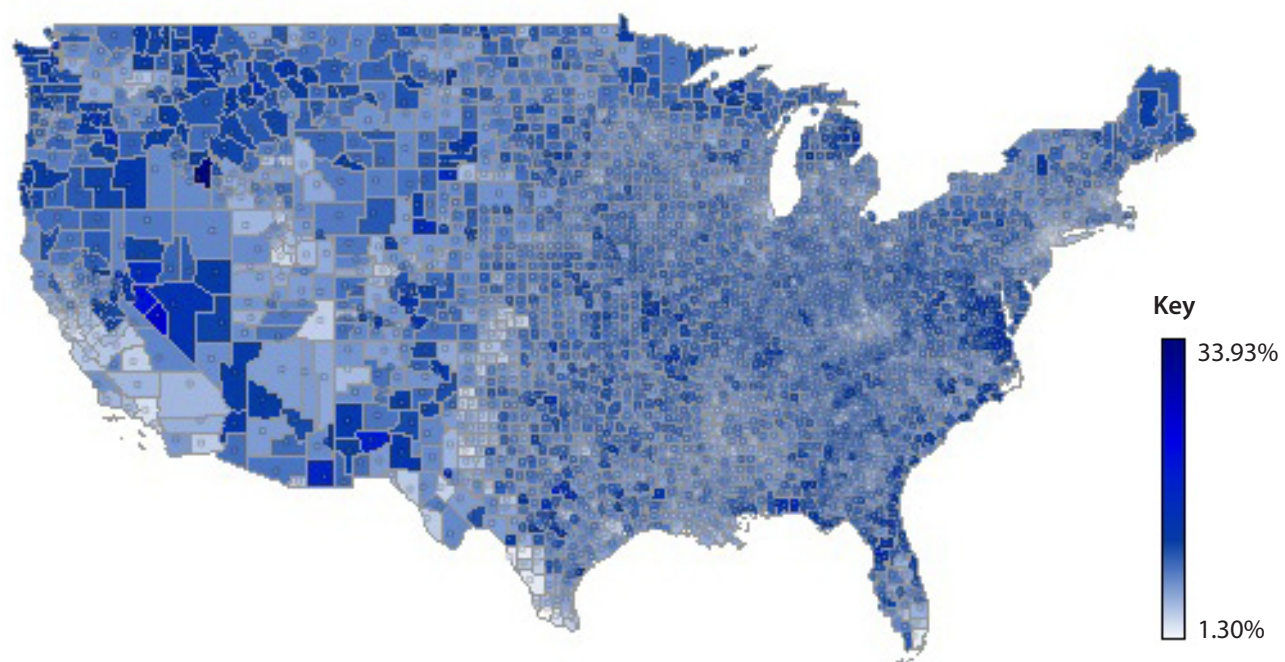
In addition to observations and findings relating to specific communities in the Western United States, the report also reached some general conclusions relating to support to veterans. Where possible, philanthropy (and public funders too) should encourage communities to build collaboration and coordination mechanisms that allocate increasingly scarce resources efficiently and effectively. Philanthropy should also seek to identify policy gaps that lead to shortfalls in assistance – such as the drop in resources available to veterans after they are discharged, the VA's narrow scope of authority for supporting families or the lack of resources available to veterans with unfavorable discharges – and should aim to fill those gaps. The private and philanthropic sector can also provide far more assistance to help veterans navigate the “sea of goodwill,” as the field of more than 40,000 charitable organizations serving veterans has been

FIGURE 1: VETERAN POPULATION BY COUNTY (2012 ESTIMATE)



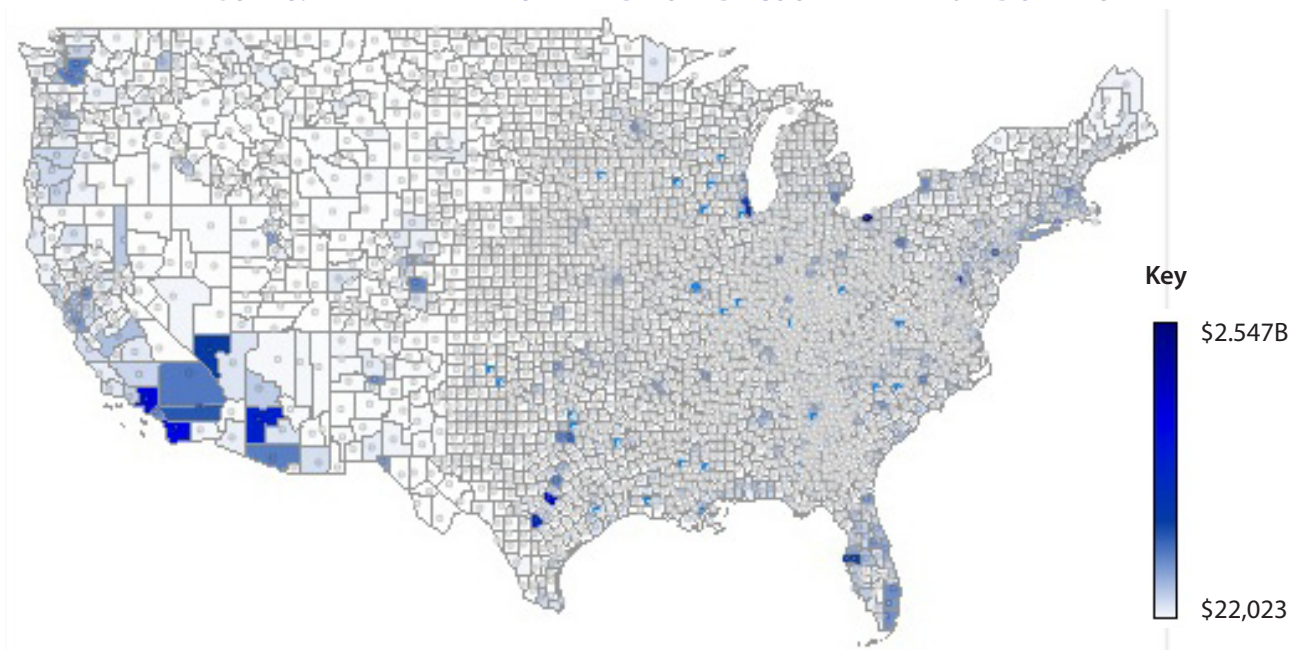
Source: Department of Veterans Affairs VetPop2011 County Level Veteran Population by State. Graphics developed with support from Palantir Technologies.

FIGURE 2: VETERANS AS PERCENTAGE OF THE POPULATION BY COUNTY IN FY 2012



Source: Department of Veterans Affairs VetPop 2011 County Level Veteran Population by State; United States Census Bureau Population Estimate 2012. Graphics developed with support from Palantir Technologies.

FIGURE 3: VETERAN AFFAIRS EXPENDITURE BY COUNTY IN FY 2012 DOLLARS



Source: Department of Veterans Affairs Expenditures for Fiscal Year 2012. Graphics developed with support from Palantir Technologies.

described. Through these and other strategic choices, described more fully below, philanthropy can achieve maximum impact for every dollar invested in the veterans community.

Background and Methodology

BACKGROUND

As of September 30, 2013, the VA estimated there were 21.2 million veterans living in the United States. Of these, approximately 6.1 million live in the West, which was defined for this needs assessment as the states to the west of the Rocky Mountains plus Texas.¹ The May and Stanley Smith Charitable Trust commissioned CNAS to conduct a needs assessment of the veterans in this region, in order to inform a series of future planned investments by the Trust.

The veterans population in the West generally mirrors the overall population, although this diversity is not represented evenly among veterans in the region. Large military bases in southern California,

Colorado, Washington state, and Texas attract and retain large numbers of younger veterans; larger cities such as Los Angeles and San Francisco have a veterans population more consistent with the national profile, which is to say, older and more predominantly white and male.

Similarly, the geography of need varies considerably across the region, suggesting an investment strategy that focuses on individual communities rather than the region as a whole. High real estate prices in urban areas such as San Francisco and Los Angeles create acute need for housing and other forms of economic assistance. Historically large homeless communities, driven in part by favorable climate, animate the need for homelessness services in Los Angeles, San Diego, and Phoenix, among others. Large active-duty populations and young veterans populations create need for employment and transition-related services in locations such as San Antonio. This policy brief

describes these needs across the region, based on CNAS' research as well as interactions with more than 90 leading organizations serving the veterans community in the West.

METHODOLOGY

This needs assessment built on a foundation of earlier studies done by CNAS on the subject of veteran wellness. That previous research defined wellness in the veterans context as "the dynamic and multi-dimensional quality of one's existence overall, as informed by both civilian and military experiences and circumstances," incorporating four dimensions: social/personal relationships, health, fulfillment of material needs, and purpose.² This broad definition articulates a normative goal for the community of practice that serves veterans and also integrates the traditional areas (medical and mental health, employment, education, and housing) that are the focus of most research on the veterans community.

Based on this body of work and the priorities for the Trust commissioning this study, CNAS further focused our assessment on the following four clusters of issues, with the parenthetical elements indicating the corresponding component of wellness:

- Mental Health (a component of health)
- Employment and Career Assistance (fulfillment of material needs)
- Housing Stability (fulfillment of material needs)
- Family Support and Community Reintegration (relationships and purpose)

Within these areas, the study sought to identify the most disadvantaged populations within the veterans community and those at greater risk of poor outcomes, such as veterans who had discharges that preclude care or support provided by the VA and those experiencing chronic

homelessness. Within the community of practice serving veterans, it looked for opportunities to leverage existing investments and successes as well as gaps where targeted investments could address significant unmet need.

To assess the needs of veterans in the western United States, CNAS developed a mixed-methods approach involving qualitative research, quantitative data collection and analysis and interviews and working group discussions with leading scholars and practitioners in the field. Qualitative research consisted of review of prior needs assessments in the field, including the CalVet needs assessment of California veterans and the RAND needs assessment focused on New York State.³ The research looked at work by the Congressional Budget Office (CBO), the Government Accountability Office (GAO), the DOD, and the VA as well. CNAS also researched local trends and issues as reported by press organizations and veterans groups in the region. Additionally, CNAS gathered publicly available data on veterans from the VA, the DOD, the U.S. Department of Housing and Urban Development (HUD), the Bureau of Labor Statistics (BLS), and the Census Bureau (with particular emphasis on the American Community Survey dataset [ACS]), as well as state and local agencies where such data were available.

Based on this qualitative and quantitative research, CNAS identified seven cities in the western states to be the focus for this assessment, based on the size or density of their veterans populations: Seattle, San Francisco, Los Angeles, San Diego, Phoenix, San Antonio and Denver/Colorado Springs. In each of these areas, CNAS convened working groups to conduct detailed discussions of the issues facing veterans locally. These working groups included, among others, county veterans service officials, veterans employment specialists, local VA service providers, community college and university

Who is a Veteran?

The U.S. Code (38 USC § 101) defines a veteran as “a person who served in the active military, naval, or air service, and who was discharged or released there from under conditions other than dishonorable.” For the purposes of this report, a veteran is defined as anyone who has served on active duty, in any job capacity, while a member of the Army, Navy, Air Force, Marines or Coast Guard active components or of the National Guard or Reserves, regardless of discharge status.

veterans service officers, veterans mental health care researchers, veterans mental health care practitioners, veterans housing providers, academics, congressional office staff, business owners and representatives from the health care industry providing private care to veterans. The groups also incorporated a number of veterans, men and women who served during the Vietnam War, the Cold War, the first Gulf War or the post-9/11 era. In addition to these working groups, CNAS conducted semi-structured interviews with a number of scholars and practitioners serving veterans in the West who were not able to attend these working group sessions, adding their input to the findings in the needs assessment.

Regional Assessment

This section describes the report’s findings for the veterans community in the seven areas on which it concentrated during this assessment.

SEATTLE

Background

Seattle is a city of approximately 608,660 residents,⁴ and it is also the seat of King County, Washington, home to 1,931,249 persons. The VA and Census Bureau estimate that 31,164 veterans live in the city of Seattle, and 122,163 veterans live in King County overall.⁵ The city is located about 50 miles

from Joint Base Lewis-McChord (JBLM) and approximately 75 miles from Naval Base Kitsap. Area veterans also access a number of services in neighboring Pierce County, which includes Tacoma and the JBLM military complex. The Seattle area falls within Veterans Integrated Service Network (VISN) 20,⁶ the VA health care system’s Northwest Health Network. The cost of living in Seattle is 21.4 percent higher than the national average.⁷

Observations and Conclusions

Geography plays a critical role in veteran service delivery in the Seattle area. While there are no active-duty bases in the city, the two large bases in the region draw active-duty service members and veterans. Southern King County – bordering Pierce County, home to JBLM – has a large number of veterans. A number of social and economic dynamics are spurring rapid economic and population growth in the Seattle area but also population dispersion, with the result that “people are getting pushed north and south” because of the cost of living in the city, according to one of the working group participants.

The Seattle region has a robust Regional Veterans Initiative overseen by the King County Department of Community and Human Services. Because of the region’s geography and the somewhat arbitrary drawing of county boundaries, county officials say they also work closely with Spokane, Fairchild, Pierce and Snohomish counties to ensure that veterans have access to care “without feeling like a pinball in a machine.” The primary reason for the county’s leadership role is the existence of the Veterans and Human Services Levy, a countywide property tax passed several years ago with overwhelming voter support that provides up to \$6 million annually for services to support the veterans community.⁸ Backed by this tax revenue, the King County government has developed a strategic plan and coordination mechanism for the region,

including goals, objectives and performance metrics for all county and nonprofit entities funded by the levy. The county also conducts monitoring and evaluation of those entities, partners with the VA to leverage the VA's enormous investments in the area and matches county investments to both areas where VA investments exist and those where there are gaps in VA funding and services.

The research conducted for this assessment suggests that the Seattle veterans community might be well served by increased resource navigation assistance, thus making fuller use of existing support structures, particularly in the areas of housing, mental health and employment. Transportation services may also improve veterans' ability to access available services as well as jobs and other community offerings. Acute needs appear to center on the adequacy of transitional housing.⁹ Utilization rates for county-level transitional housing services – two to three times greater than projected – indicate significant demand within the veterans community.

SAN FRANCISCO

Background

San Francisco is a city and coterminous county of approximately 825,863 individuals, with an estimated 32,007 veterans.¹⁰ The broader San Francisco Bay Area includes several counties – San Francisco, Marin, Alameda, San Mateo, Napa and Santa Clara – that have a total veterans population of 199,691. This area falls within VISN 21 of the VA health care system, which covers northern California and northern Nevada.

The San Francisco Bay Area is characterized by its high-technology clusters around the University of California (UC) Berkeley, UC San Francisco, Stanford University and several national research laboratories; a dense urban area in San Francisco itself; a multifarious population and a diversified regional economy. The Bay Area is also known for

having a very high cost of living; the cost of living index for San Francisco is 64 percent higher than the national average.¹¹ The San Francisco Bay Area veterans population tilts heavily toward older cohorts, likely reflecting the fact that there are no longer any major active military bases in Northern California.

Observations and Conclusions

In the course of the study's working group and interviews, Bay Area participants and respondents repeatedly described the diversity of the region's veterans population as a challenge facing the community. Government, private and nonprofit entities must contend with a broad array of needs, ranging from those of older, chronically homeless veterans to those of younger veterans struggling to transition from the military in an extremely expensive region. Similarly, the geographic and demographic diversity of the region contributes to a balkanization of efforts in the Bay Area, with little coordination or collaboration between public agencies and private and nonprofit organizations.

Within the San Francisco region, the most acute need appears to be serving the homeless veterans population. Despite the best efforts of some extraordinary organizations (like Swords to Plowshares), the demand for supportive housing, affordable housing and transitional housing exceeds the available supply. This imbalance reflects the extremely high cost of housing in the Bay Area, as well as the limited resources available to the VA and nonprofits in the area. Note that this problem does not relate particularly to veterans but rather arises out of a much larger issue with housing affordability in the Bay Area. However, because veterans are over-represented in the Bay Area homeless population, the problem disproportionately affects the veterans community.

The other significant need in the Bay Area relates to veterans employment. There appear to be a large

number of veterans stuck as they try to match their military experience with the employment opportunities available in the Bay Area. The region's educational institutions are playing the most significant role in bridging this gap, with some efforts by labor unions, large employers and others to help veterans retool themselves for the 21st century Bay Area job market. However, more can be done in this field, through such partners as Vets in Tech and the Bay Area's numerous community colleges.

LOS ANGELES

Background

According to the 2010 Census and American Community Survey data, Los Angeles County had 9.8 million residents, of whom 319,623 were veterans. The county is home to 88 incorporated cities and a number of unincorporated areas as well. The largest of these, the city of Los Angeles, has 2,990,493 residents, with approximately 107,952 veterans.¹² The city has a VA regional office in West Los Angeles, a large VA medical center located nearby and several other major VA health care facilities scattered throughout the area. The VA's health care facilities in Los Angeles fall into VISN 22, which includes southern California and southern Nevada. The cost of living index for Los Angeles is 36.4 percent higher than the national average.¹³ Several significant active military bases ring the L.A. metropolitan area – including Camp Pendleton to the south, Fort Irwin and Twentynine Palms to the east in the Mojave Desert and Vandenberg Air Force Base and Edwards Air Force Base to the north. The L.A. veterans population reflects the national average in terms of age distribution and does not feature a large component of military retirees.

Observations and Conclusions

The expansive geography and large number of political subdivisions contributes to an extremely diffuse and fragmented political environment.

Furthermore, no single private-sector organization or nonprofit foundation has the leverage or influence to play a significant coordinating or convening role in this vast region. Over the past few years, a new model of cooperation has emerged in the L.A. region through the creation of the University of Southern California's Center for Innovation and Research on Veterans and Military Families (USC CIR). Each month, USC CIR convenes a veterans collaborative with five focus groups, using this forum to bring together many of the leading public, private and nonprofit agencies serving veterans in the region.¹⁴

The city of Los Angeles, has 2,990,493 residents, with approximately 107,952 veterans.

Within the large L.A. veterans population, mental health is a major concern for thousands. According to the VA's latest report on health care utilization for post-9/11 veterans, VISN 22 serving the Southern California region has treated 21,861 post-9/11 veterans for post-traumatic stress disorder (PTSD) since 2002. A majority of these veterans live in the Los Angeles area, with nearly 10,000 diagnosed with PTSD in the VA's Los Angeles and Long Beach health care systems (including VA hospitals and clinics). Post-9/11 veterans getting care for PTSD make up 27.1 percent of all post-9/11 veterans seeking care from the VA in the region.

The second most pressing concern in Los Angeles is homelessness, part of a large homelessness problem for the city in general. The region leads the country in the number of homeless veterans. According to the most current government point-in-time count from January 2013, the Los Angeles area had 53,798 homeless persons, of whom 6,291 were veterans,

TABLE 1: CONTINUUMS OF CARE WITH THE LARGEST NUMBER OF HOMELESS VETERANS IN 2013

MAJOR CITY COCS		SMALLER CITY, COUNTY AND REGIONAL COCS		BALANCE OF STATE OR STATEWIDE COCS	
COC	Total Homeless Veterans	COC	Total Homeless Veterans	COC	Total Homeless Veterans
Los Angeles City and County, CA	6,291	St. Petersburg/Clearwater/Largo/Pinellas County, FL	618	Texas Balance of State	1,698
New York City, NY	3,547	Orlando/Orange, Osceola, Seminole Counties, FL	611	Georgia Balance of State	496
San Diego City and County, CA	1,486	Santa Ana/Anaheim/Orange County, CA	446	Oregon Balance of State	459
Houston/Harris County, TX	877	Santa Rosa/Petaluma/Sonoma County, CA	400	Arizona Balance of State	389
Las Vegas/Clark County, NV	866	Honolulu, HI	398	Indiana Balance of State	365
San Jose/Santa Clara City and County, CA	718	Watsonville/Santa Cruz City and County, CA	395	Montana Statewide	309
San Francisco, CA	716	Daytona Beach/Daytona/Volusia, Flagler Counties, FL	380	Washington Balance of State	271
Chicago, IL	712	Pasco County, FL	368	West Virginia Balance of State	257
Seattle/King County, WA	682	Gainesville/Alachua, Putnam Counties, FL	300	Wisconsin Balance of State	247
Long Beach, CA	527	Nassau, Suffolk Counties/Babylon/Islip/Huntington, NY	286	Kentucky Balance of State	245

Source: Department of Housing & Urban Development 2013 Annual Homeless Assessment Report.

and 77 percent of those homeless veterans were unsheltered.¹⁵ More than 32,000 veterans will experience homelessness at some point this year in Los Angeles, according to government and private-sector studies.¹⁶ However, the Los Angeles area has

made significant headway in resolving veterans' homelessness since 2009. Prior to 2009, all populations of homeless individuals were rising; since then, homeless population rates have continued to rise except for the homeless veterans population.¹⁷

Although California experienced a 4.5 percent overall increase in the size of the homeless population this past year, California's homeless population decreased by 14.3 percent between 2007 and 2013, leading the country in homelessness reduction.¹⁸ Most of this reduction took place in Los Angeles, and government data suggests much of the improvement owes to efforts focused on the homeless veterans population.

SAN DIEGO

Background

San Diego has a population of approximately 1,028,845, with a veterans population estimated at 96,267. The city stands out because it is home to both big active-duty bases and a large veterans community. The San Diego area is home to seven major military bases and around 95,000 active-duty personnel.¹⁹ According to a regional assessment of military families, "although less than 1 percent of the entire U.S. population lives in San Diego County, the region is home to more than 8 percent of the Active Duty military population."²⁰ This large active-duty population skews the demographic profile of the San Diego veterans community, making it younger and more diverse, with a higher percentage of post-9/11 veterans than most other large veterans communities studied here.²¹ The cost of living index for San Diego is 32.3 percent higher than the national average.²² San Diego, like Los Angeles, is located in the VA's VISN 22 region. Within VISN 22, the VA San Diego Healthcare System (VASDHS) serves approximately 232,441 San Diego and Imperial Valley veterans annually while providing support to six community-based outpatient clinics in Chula Vista, Escondido, Imperial Valley, Mission Valley, Oceanside and Mission Gorge.²³

Observations and Conclusions

The CNAS research found a vibrant community assisting veterans in San Diego, including

prominent organizations like the Veterans Village of San Diego and a constellation of nonprofits and foundations, with many focused on the active-duty population. The activities serving the veterans community in San Diego are loosely coordinated at the grassroots level by a trio of convening groups, each of which perform different functions, and the San Diego Grantmakers, which convenes and coordinates philanthropic activities in this space. The San Diego Veterans Coalition has about 130 members, bringing together many stakeholders in this area.²⁴ San Diego County also has a Regional Vet/Fam Forum for veterans and their families, described by one participant as the "brain trust" of ideas within the veterans community.²⁵ In addition to these two, there is also a United Veterans Council of San Diego County, which brings together traditional veterans service organizations and others on a monthly basis. These organizations meet frequently with nonprofit organizations and foundations and often coordinate events, such as the area's annual "Stand Down" Day.²⁶ Such grassroots efforts to coordinate services supplement the region's lack of a formal, government-led collaboration mechanism. For example, the San Diego Grantmakers' Military Transition Support Working Group has made tremendous strides coordinating local government agency representatives, Navy personnel, veterans service organization executive staff and funders in support of military personnel as they transition from service.

There are a substantial number of veterans in the San Diego with mental health concerns. According to the VA's latest report on health care utilization for post-9/11 veterans, the VA health care region serving the San Diego has treated 21,861 post-9/11 veterans for PTSD since 2002, with 6,592 of those going to VA health care facilities in the San Diego area. Veterans diagnosed with PTSD in the VA Desert Pacific Healthcare

Network (VISN 22) make up 27.1 percent of the 80,538 post-9/11 veterans seeking care from the VA in this region. This appears to reflect a communitywide problem, with one report indicating that 25 percent of San Diego's adults and 20 percent of San Diego's children suffer from either a diagnosable mental disorder or some degree of emotional or behavioral difficulty.²⁷

San Diego County has the third-largest veteran resident population in the country for all veterans and is the top destination for Iraq and Afghanistan veterans when they leave the service.

According to the San Diego Regional Chamber of Commerce, San Diego County has the third-largest veteran resident population in the country for all veterans and is the top destination for Iraq and Afghanistan veterans when they leave the service. San Diego veterans constitute 8.3 percent of the total labor force and own or jointly own 13.5 percent of San Diego firms. The reported veterans median income is nearly \$20,000 higher than that of nonveterans.²⁸ This indicates that when veterans are employed in the San Diego area, they are entering the workforce at high levels. However, unemployment is still an issue for San Diego's veterans community, which faces a 9.7 percent employment rate, above the national average.²⁹

Military and veterans' families present significant needs of their own. In addition to the 56,096 active-duty personnel in the region, there are 118,296 family members.³⁰ It is the general sense among interviewees and working groups that the effects of deployment on children and families are a pressing

concern in the San Diego community. However, more research is necessary to understand the impacts of military life on military families, as well as the best approaches for serving these members of the community.

PHOENIX

Background

Phoenix is a city of 1,084,104 residents, with an estimated 78,738 veterans. Phoenix sits within Maricopa County, Arizona, home to 60 percent of the state's total population and approximately 276,000 veterans, out of a statewide total of 531,910 veterans in Arizona.³¹ Approximately 55,000 of the veterans in Arizona are military retirees.³² Phoenix falls within the VA's VISN 18 region, which serves Arizona, New Mexico, and western Texas. The cost of living index for Phoenix falls roughly around the national average.³³ The moderate cost of living and pleasant climate draw veterans to the Phoenix area. The median sales price for Phoenix homes in the third quarter of 2013 was \$163,000,³⁴ while the estimated median household income for 2011 was \$43,960³⁵ – making Phoenix a relatively affordable place to live. Statewide efforts at enabling “Veterans Supportive Campuses” appear to draw younger veterans using G.I. Bill benefits at the region's community colleges and universities.

Observations and Conclusions

Phoenix has made significant strides in solving the problem of chronic veteran homelessness, aligning with the VA's five-year plan to end homelessness. The state of Arizona developed an ambitious strategic framework for tackling the issue and put into operation the framework's priorities.³⁶ Periodic active street surveys monitor the homeless population. As of November 13, 2013, there are 56 chronically homeless veterans in the city. The Phoenix City Council recently voted to commit \$100,000 toward housing the remaining homeless veterans, seeking to realize

the city's ambitious goal of housing every single chronically homeless veteran by January 1, 2014.³⁷ This distinguishes Phoenix among the communities studied here as the one area with a realistic chance of ending veteran homelessness by the VA's target date of 2015.

Among Arizona's rural population are 22 sovereign Native American communities, inhabiting reservation lands covering more than a quarter of the state.³⁸ From the perspective of those interviewed, there is a need for greater cultural competency among service providers within the VA, the Indian Health Service (IHS) and local tribes, all of which are charged with meeting the needs of Arizona's estimated 10,943 Native American veterans.³⁹ As of December 2012, the VA is supplementing Phoenix-area IHS facilities through a program that reimburses clients for medical care provided through those facilities, increasing IHS capacity and expanding the VA's reach to meet Native American veterans' treatment needs in the region.⁴⁰

SAN ANTONIO

Background

San Antonio is a city of approximately 1,016,840 residents, with an estimated 106,233 veterans. The greater San Antonio area of Bexar County, Texas, has a population of nearly 2 million, of whom about 154,000 are veterans. The Department of Defense estimates there are around 296,000 active and reserve military personnel, civilian DOD employees and government contractors affiliated with the military in San Antonio.⁴¹ The large active military population in San Antonio affects the demographic profile of the city's veterans community, with post-9/11 veterans making up nearly a quarter of them. The city is home to Fort Sam Houston and Lackland Air Force Base, with Randolph Air Force Base nearby as well. San Antonio falls under VISN 17, the VA Heart of

Texas Health Care Network, which extends from Dallas in the north to the Gulf of Mexico in the south. The cost of living index for San Antonio is 6 percent lower than the national average,⁴² making it a reasonably affordable place to live.

Rural areas south of San Antonio, particularly those in the Rio Grande Valley, lack many of the resources available in the city. Rio Grande Valley veterans leaders estimate that around 115,000 veterans reside in the "24 counties south of San Antonio," yet the nearest VA hospital (the Audie L. Murphy Memorial Hospital in San Antonio) can require up to 300 miles of travel. Participants in the CNAS working group note that veterans in the Rio Grande Valley feel isolated from services and other veterans and think that there is an unmet need for transportation services for rural veterans to facilitate access to the VA health care system and, potentially, social and recreational programming.

Observations and Conclusions

San Antonio's unique intersection of military and urban cultures presents opportunities for, and challenges to, meeting the needs of the region's veterans. Drawing on the vast resources of the DOD, the VA, the employment sector and local service providers, the city offers a thriving atmosphere for veteran relocation. Like many other cities in the West, the city lacks a centralized, government hub for coordination and allocation of resources serving veterans. Instead, the San Antonio Area Foundation plays a more informal role in convening and coordinating resources for the veterans community, alongside organizations such as the Texas Workforce Commission and various veterans and military service organizations in the area.

Within the San Antonio community, the most acute need appears to be veteran employment. While the overall unemployment rate for San

Antonio is 6.5 percent, area veterans experience an unemployment rate of 8.9 percent – nearly two and a half percentage points higher. The relatively large cohort of post-9/11 veterans in the area (23.8 percent of San Antonio’s veterans – approximately 25,000 individuals) indicates that a substantial number of young, working-age veterans seek employment in and around San Antonio. While the city is home to a number of corporate headquarters (including financial services and energy-sector companies) and regional employers (notably, the three area military bases, which employ 80,165 collectively), the disparity in veterans’ unemployment rates as compared with their civilian counterparts indicates room for improvement.

DENVER AND COLORADO SPRINGS

Background

Denver has a total population of approximately 496,210, with an estimated 35,112 veterans. It is the county seat of Denver County. Its environs are home to Buckley Air Force Base, and it is situated around 60–75 miles from the United States Air Force Academy and Fort Carson, each located near Colorado Springs to the south. Denver is located within the VA’s VISN 19 region, which expands north to Montana and west to Utah and parts of northeastern Nevada. The cost of living index for Denver is 21 percent above the national average.⁴³

A large active-duty military presence characterizes Colorado Springs, which sits within El Paso County, Colorado. Further, a substantial number of veterans inhabit the rural counties (Adams, Weld, Morgan and Larimer) north of Denver, all the way up to Cheyenne, Wyoming. Area veterans access the VA’s Eastern Colorado Health Care System in Denver and the VA Medical Center in Cheyenne. Vietnam-era veterans make up the largest segment of the Denver veteran population.

Observations and Conclusions

Like many cities in the West, Denver lacks a formal mechanism to coordinate the delivery of services to veterans. The Denver Metro Chamber of Commerce, local universities and community colleges and the Veterans Health Administration interact on an ad hoc basis. The United Veterans Committee of Colorado convenes more than 50 veterans organizations and service providers from across the state several times per year (but not on a regular basis) and conducts some legislative and policy advocacy on behalf of veterans, but it does not take an active role in assessing need, allocating resources or coordinating the provision of services to veterans.⁴⁴ The local VA medical centers serve as a community hub, often collaborating with local organizations in the context of individual veteran cases, but those medical centers also do not play a central coordinating role.

Denver’s veterans manifest a substantial need for mental health services. Within the VA’s regional health care system, which extends throughout the northern Rocky Mountains region, Denver’s veterans account for nearly 50 percent of all post-9/11 veterans seen for potential PTSD (7,173 cases out of VISN 19’s 14,936). Homelessness poses another significant challenge for Denver’s veterans. The 2011 point-in-time count estimates that 1,322 of the city of 4,809 homeless individuals are veterans, representing 24.5 percent of Denver’s homeless population, a group that experiences particular vulnerabilities owing to Denver’s extreme low temperatures and precipitation during the winter months.⁴⁵

Beyond the city center, the Veterans Health Administration Office of Rural Health (ORH) notes that rural veterans tend to be at higher risk for physical illness than urban veterans, yet they experience obstacles to care because of their remoteness from VA facilities. For example, veterans in the Longmont, Colorado, area face challenges attending

their VA appointments in large part owing to distance and transportation costs. The ORH includes significant travel as a barrier to rural veteran health care access.⁴⁶ For veterans in western Colorado, such barriers increased significantly with the reduction of surgical services at the Grand Junction VA Medical Center, where some procedures (e.g., complex cardiovascular surgeries) have been suspended by the VA following reports indicating adverse patient outcomes.⁴⁷ Not only did the change result in significant barriers to individuals in need of surgery, it placed added pressure on the Denver and Salt Lake City VA medical centers.⁴⁸

Findings and Recommendations

GENERAL OBSERVATIONS

Balanced Approaches. As in other regions of America, veterans in the West run the gamut from complete self-sufficiency to chronic need. Government entities, service providers and nonprofits alike face the challenge of balancing preventive action and interventions with long-term supportive care and services for those with chronic need. High-impact investments in prevention today can produce long-term savings in the future. Based on dollars spent and numbers served, the VA (with its massive resources) shoulders the largest share of the burden for long-term care and services. Philanthropy and nonprofits can achieve maximum impact by acting earlier in the life cycle of veterans, long before veterans' needs develop into crises. Philanthropic dollars can also maximize effectiveness by bridging gaps between services, such as between the short-term crisis interventions provided by county and municipal agencies and the long-term housing or care funded by the VA. This approach can increase the national capacity for veteran care, minimizing long-term costs and improving the individual quality of life for veterans.

Transition. The DOD, the VA, and other federal agencies offer a number of programs to support

the transition needs of veterans and their families, particularly in the realms of employment and career assistance, family support and community reintegration.⁴⁹ However, the scheduling and availability of these otherwise robust programs fail to produce optimal results for veterans. For example, participants in multiple working groups reported that Transition Assistance Programs (TAP)⁵⁰ currently run by the military services provide useful information and training, especially in their new and improved form. However, the timing of the programs – offered at the end of a service member's career in the armed forces – serve more as a “box to check” than an effective tool for re-entry into society and the civilian working world. It is only after the point of separation that veterans realize how necessary some of the TAP resources, such as employment-related training, are.

Upon service members' separation – frequently, at the time when families need the most support – they lose a number of networks and services previously offered to them.

Family Support. Working group members in several cities highlight the disconnect between military family-focused support prior to discharge and individually focused support to reintegrate the veteran into the family and community after leaving military service. For many military families, the period of transition from service member to veteran is stressful. Exacerbating the stress is the near total disappearance of the extraordinary level of community support offered to military families as the service member becomes a veteran. While DOD systems and programs embrace the

family unit, the VA is focused almost solely on the veteran himself or herself. Therefore, upon service members' separation – frequently, at the time when families need the most support – they lose a number of networks and services previously offered to them.

Navigating the “Sea of Goodwill.” Participants in several cities cite the absence of resource navigation tools. Their recommendations fall into two categories: 1) the need for a “Yelp”-like service⁵¹ and 2) the need for peer-to-peer resources that can provide valuable feedback and assistance. Effective resource navigation tools would make use of existing resources; rather than creating new services (i.e., access to health care, housing and employment programs), such tools would simply point veterans to the services in place that most closely meet their requirements.

Strategic Investments for Veterans Employment. While much support can be channeled to the level of the individual veteran, strategic investments can also be made at the institutional level, particularly in the realms of employment and career assistance. In a number of the cities, participants emphasize that human resources and hiring managers need to be better informed where veterans issues are concerned. Many companies are eager to hire veterans and have articulated major commitments to do so,⁵² but, notwithstanding large gains in veterans hiring, these companies struggle to find, engage, and assimilate qualified candidates. A large number of participants and organizations interviewed by CNAS also express concern about retaining veterans in the workforce, as distinct from hiring them, as well as the phenomenon of underemployment, whereby veterans take jobs at a lower skill or compensation level because of difficulty translating military experience into the civilian labor market, or the pressing need to take a job or other concerns.

Collaboration and Coordination. The most efficient and effective veterans services are those offered within the context of a collaborative community. Collaborative communities serve a number of functions. First, they create a united voice for communal needs to be conveyed to government agencies and philanthropic organizations. Second, they help to allocate resources effectively and efficiently, identifying areas of concern and, ideally, avoiding redundancy. Third, they encourage innovative and comprehensive thinking by convening stakeholders attending to the multifaceted requirements of veterans in their community. Philanthropic investments can therefore best be leveraged by organizations that operate within a collaborative environment. Where such environments are lacking,⁵³ efforts can be directed toward encouraging collaboration.

While variations can be tailored to unique local environments, effective collaboratives across the western states possess five essential components: funding, staffing and oversight, regular convening, written strategic plans, and a feedback loop supported by rigorous monitoring and evaluation. By establishing a funding stream, whether through grants, taxes or donations, collaboratives are able to incentivize participation through strategic investment in projects and the leverage that comes from being a funding source. Staffing a collaborative with at least one individual to coordinate efforts and handle administrative tasks streamlines processes. Advisory boards can provide oversight, guidance and direction. Regular convening informs the community of service providers on current trends and challenges and allows for integrated service delivery coordination (for example, between service providers focused on mental health and housing, or between those concerned with job placement and legal/justice issues). A successful annual strategy for program inclusion and implementation, written

and developed with the input of all collaborative members, furnishes outcome-based goals for the community of providers with explicit indicators and metrics for evaluation. Rigorous monitoring and evaluation, using the indicators and metrics set forth in the program strategy, measures the effectiveness of the collaborative in meeting its established goals and allows for changes in prioritization as concerns shift over time.

In CNAS' research, three models stand out. The King County, Washington, model serves as a best practice in terms of public-sector coordination and collaboration, leveraging public resources. The collaborative led by the University of Southern California's Center for Innovation and Research on Veterans and Military Families in Los Angeles is exemplary in showing how a community organization, in this case a university research and teaching center, can effectively create a forum for coordination, even without control over funding. A third leading example can be seen in San Diego and San Antonio, in the ways that the San Diego Grantmakers and San Antonio Area Foundation play a role in convening veterans organizations and service providers and also in coordinating the efforts of philanthropy to allocate resources efficiently and effectively.

VULNERABLE POPULATIONS

Over the course of the assessment, CNAS identified three populations that were frequently characterized as vulnerable or underserved by those interviewed or convened in working groups: veterans with less than honorable discharges; Native American veterans; and children of military families.

Other than honorable and dishonorable discharges

Interviewees and working group attendees in nearly every city discussed the difficulty of service provision for individuals with other than honorable and dishonorable discharges. Service members discharged "under conditions other than

honorable" do not qualify as veterans under federal law.⁵⁴ Consequently, their "bad paper" makes them statutorily ineligible for the health care, employment, housing and education benefits offered by the Department of Veterans Affairs. Many of these veterans struggle upon leaving the military. When they falter, the burden for supporting them falls heavily on communities because the VA and other federal agencies cannot help them.

Neither the Department of Defense nor the Department of Veterans Affairs publishes an authoritative count for this subpopulation. However, research suggests that there are hundreds of thousands of veterans with "bad paper." Some 3 percent (roughly 260,000) of the 8.7 million who served during the Vietnam War were discharged on less than honorable terms. More recently, according to documents separately obtained by the *Colorado Springs Gazette* and *Stars and Stripes*, the Army alone discharged 76,165 personnel from 2006 to 2012 on a variety of grounds for misconduct, a figure that represents approximately 16 percent of all Army discharges during that period. Only 13 percent of recent Army misconduct discharges resulted from courts-martial for serious crimes. The remainder arose out of lesser offenses or failures to perform, including many cases in which the misconduct at issue bore some relation to the stresses of war. One investigation at Fort Carson, Colorado, found scores of cases for which discharges over incidents like driving while intoxicated or barracks misconduct ultimately resulted from post-traumatic stress disorder.⁵⁵

Native American veterans

There are currently 383,000 Native American and Alaska Native veterans nationwide.⁵⁶ In the desert Southwest and in Colorado, both the data and conversations with participants highlight the particular challenges facing the Native American veteran population. The Native American veteran

Federal, state, local and private funding can all contribute to and enable collaborative environments through incentive structures, rewarding organizations that participate in the broader veterans service spectrum within their community.

cohort is unique in its composition. According to the VA, Native American veterans are “younger as a cohort” than all other service members; they have “lower incomes, lower educational attainment, and higher unemployment than Veterans of other races” and are “more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other races.”⁵⁷ Efforts to bridge the gap in services are currently under way. In 2010, the Veterans Health Administration and the Indian Health Service signed a memorandum of understanding with the intent to increase collaboration, outlining PTSD-related training as a specific area of emphasis.⁵⁸ Tribal health systems provide a fundamental cultural component, while the VA supplies clinical knowledge of post-traumatic stress and traumatic brain injury.⁵⁹

Children of Military Families

More than two million children with active-duty parents experienced at least one parental combat deployment over the past twelve years.^{60, 61} Associated risk factors for children include exposure to a parent with “post-traumatic stress disorder, traumatic brain injury, substance use, and major depression,” as well as “increased marital conflict and domestic violence ... [and] increased risk of parental maltreatment or neglect of children.”⁶² Trauma from deployment separation “pulls on the fabric of the family.” Such stressors affect child development, as children

internalize anxiety, knowing their parent is in a dangerous environment. Further, deployments often put significant pressure on the caregiving parent during deployment, heightening the stress on children. Reintegration with parents who have experienced a traumatic brain injury or other significant change further exacerbates the impact on the child. After deployment, there is a greater potential for impaired parenting and worsening couple relationships. Early intervention to address the needs of children of active-duty personnel and veterans offers an opportunity to interrupt the intergenerational transfer of trauma and otherwise attenuate or mitigate some of the impacts of military service on children, such as frequent and extended parental absences, parental illness or disability, frequent moves, isolation from civil society and others.

Recommendations

Federal, state and local funding, supplemented with private philanthropy, can create incentives for collaboration. Collaboration increases communication, reduces redundancy and best matches resources to needs. Federal, state, local and private funding can all contribute to and enable collaborative environments through incentive structures, rewarding organizations that participate in the broader veterans service spectrum within their community. Such initiatives offer a higher return on investment, as service providers take advantage of strengths specific to the locale and are exposed to more comprehensive data on the need profile within their community.

Federal, state and local funding, supplemented with private philanthropy, can increase resource navigation capacity. Many robust veterans services already exist in the public and private sectors, and many veterans are eligible for those services. However, as expressed by participants in several of the cities examined, veterans are largely unaware

of the services available to them and which services are effective and appropriate to their needs. Increased resource navigation capacity – whether in the form of virtual or peer-to-peer assistance – enables philanthropic dollars to go further; instead of making large investments in new resources that will prove to be redundant, small improvements in resource navigation can result in more efficient exploitation of the current veterans service market. The technology sector should develop better resource navigation tools – including some kind of crowd-sourced, Yelp-like ratings system that provides qualitative feedback – for veterans and military families to enhance their understanding of the more than 40,000 organizations serving veterans.

Private philanthropy can best reach veterans and families in transition at the point of maximum impact. Arguably the most difficult transitional period for veterans – that period stretching from just before to several months after discharge – coincides with the moment when federal resources decline based on departure from service. This transition gap affects both veterans and families, with the latter suffering most acutely because few VA resources are available to serve family members at all. Philanthropic commitments to employment and family resources within the first year to eighteen months of transition may help the individual to negotiate the transformation from service member to well-adjusted civilian. Additionally, support for services provided during this period function in a preventive capacity – meeting the needs of veterans and families before they face larger crises such as chronic unemployment and homelessness or domestic violence and divorce.

Private philanthropy can best reach vulnerable populations. Innovative, supplemental services for vulnerable populations may best be provided in the nonprofit sector. Programs targeting those

with “bad paper” – particularly veterans of recent wars – may arrest the downward spiral and ultimately decrease the cost of care for this vulnerable subpopulation. Likewise, philanthropy can assist in the development of services for Native American veterans, to include alternative medicine, cultural competency training and outcomes-based peer mentorship training. Further, the nonprofit sector can help fill the gaps in service provision for military and veterans’ children at the community level, engaging in the needs of families within the local context.

Strategic investments can yield institution-level change for the employment of veterans. Even as the corporate world increasingly recognizes the value in and business case for hiring veterans, many hiring managers and human resources professionals still lack adequate training and the resources necessary to recognize and manage the unique skill sets of veteran employees. Training programs can tap into existing professional organizations and networks, such as the Society for Human Resource Management. Large corporations can integrate such training into their annual meetings. The Small Business Administration can be further equipped to train local small business managers. Modest investments in training and education for human resources and hiring managers may yield exponential results for individual veterans seeking employment.

Conclusion

Veterans in the western states confront challenges in the realms of mental health care, employment, housing, family support, reintegration and legal issues. As the post-9/11 wars are brought to a close and the services draw down, the western states will likely see an increase in the number of veterans struggling with these challenges.

Strategic investments in prevention and early intervention can stave off the looming bow wave

of need. Federal, state and local governments will reap savings from reduced long-term costs. Service providers and nonprofits will gain from greater collaboration, leveraging shared resources and data to meet the needs within their community. Most important, individual veterans will benefit from comprehensive, outcomes-based collaboration and support.

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ENDNOTES

1. In the context of this study, the "western states" were defined to include California, Oregon, Washington, Colorado, Arizona, Nevada, Wyoming, Utah, Idaho, New Mexico, Montana and Texas. Statistics calculated using the U.S. Census Bureau's American Community Survey (ACS) 1-year projections for California (1,857,748), Nevada (228,936), Arizona (526,292), New Mexico (178,510), Wyoming (48,328), Colorado (406,624), Oregon (325,534), Washington (587,266), Utah (145,078), Idaho (123,594), Montana (99,396) and Texas (1,607,667), totaling 6,134,973 of the total U.S. veteran projected population of 21,230,865.
2. Nancy Berglass and Margaret C. Harrell, "Well After Service," (Center for a New American Security, 2012), 14.
3. Other assessments include the Promises2Kids needs assessment of military families in San Diego County and the Central Connecticut State University needs assessment on Operation Enduring Freedom/Operation Iraqi Freedom veterans in the state of Connecticut. While the RAND and CCSU needs assessments focused on states outside the scope of the western states emphasized in this needs assessment, they provided useful insights into national trends and regional trends affecting veterans elsewhere, as well as assistance with the development of this needs assessment's methodology.
4. U.S. Census Bureau, 2010 Demographic Profile, <http://www.census.gov/popfinder/?fl=53:5363000>.
5. Throughout this report, we use ACS data because it provides a common data set enabling comparisons across cities and counties, as well as visibility on veterans' demographic characteristics. Conducted by the U.S. Census Bureau, the ACS is "a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data every year." Using a rigorous weighting system for sample populations, the ACS projects estimates at the city, county, state and national levels. The ACS also serves as the basis for U.S. Department of Veterans affairs estimates to "evaluate the need for health care, education, and employment programs for those who served in the military." For more information, see the United States Census Bureau, "American Community Survey Information Guide," Census.gov, https://www.census.gov/acs/www/about_the_survey/acs_information_guide/ and U.S. Census Bureau, Design and Methodology: American Community Survey (2009) 11-1 – 11-20.
6. The Veterans Health Administration divides its healthcare system into 23 "Veterans Integrated Service Networks" (VISN). These networks' boundaries do not neatly follow state or county boundaries, nor do they evenly map to the veterans population. Within each VISN, the VA maintains a number of VA Medical Centers, community-based outpatient clinics (CBOC), Vet Centers, and other healthcare facilities. A map of the VA VISN structure is available online at <http://www2.va.gov/DIRECTORY/guide/division.asp?dnum=1>.
7. The Bureau of Labor Statistics provides the Cost of Living Index for selected urban areas. According to the BLS, "Data are for a selected urban area within the larger metropolitan area shown. Measures relative price levels for consumer goods and services in participating areas for a mid-management standard of living. The nationwide average equals 100 and each index is read as

a percent of the national average." See Bureau of Labor Statistics, Cost of Living Index—Selected Urban Areas, Annual Average: 2010 (hereafter referred to as "Cost of Living Index 2010"), <http://www.census.gov/compendia/statab/2012/tables/12s0728.pdf>.

8. King County Department of Community and Human Services, "Status of Veterans and Veterans Services in King County" (February 2013), 3.

9. In this context, CNAS uses HUD's definition of transitional housing: "Transitional Housing Program is housing where homeless people may stay and receive supportive services for up to 24 months, and which are designed to enable them to move into permanent housing." See U.S. Department of Housing and Urban Development, *The 2013 Annual Homeless Assessment Report (AHAR) to Congress* (hereafter "2013 AHAR Report") (November 2013), 2.

10. U.S. Census Bureau, San Francisco Quick Facts, <http://quickfacts.census.gov/qfd/states/06/06075.html>.

11. Bureau of Labor Statistics, Cost of Living Index 2010.

12. U.S. Census Bureau, American Community Survey, http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_S2101&prodType=table.

13. Bureau of Labor Statistics, Cost of Living Index 2010.

14. The collaborative, "composed of community stakeholders and representatives from organizations serving veterans and military families in the L.A. area," has five working groups on the following topics: behavioral health, career advancement, families and children, housing and homelessness, and legal and re-entry. The collaborative meets on a monthly basis. For more information, agendas and meeting minutes, see <http://cir.usc.edu/community-engagement/la-vet-collaborative>.

15. See U.S. Department of Housing and Urban Development, *2013 AHAR Report*, 10 and 43–44.

16. See "Slow March to VA Housing" (editorial), *Los Angeles Times*, September 27, 2013.

17. According to the government's latest counts, the number of homeless veterans in the L.A. area declined from approximately 8,000 in 2011 to 6,300 in 2012. See Jessica Ogilvie, "Homeless Vets' Tough L.A. Winter," *LA Weekly*, January 24, 2013.

18. *2013 AHAR Report*, 9.

19. San Diego Regional Chamber of Commerce, "Military Employment in San Diego" (January 2013), 2, http://www.sdchamber.org/assets/files/Website%20Resource%20Docs/Military%20Veterans%20in%20the%20San%20Diego%20Labor%20Market_JAN%202013.pdf.

20. Promises2Kids, "2010 Promises2Kids Military Families Support Initiative: Needs Assessment" (2010), <http://promises2kids.org/sites/default/files/ExecSummary2010Dec23.pdf>.

21. Keegan Kyle, "Fact Check: Where the Most New Veterans Live," *Voice of San Diego*, February 22, 2011.

22. Bureau of Labor Statistics, Cost of Living Index 2010.

23. U.S. Department of Veterans Affairs, VA San Diego Healthcare System, "About the VA San Diego Healthcare System," <http://www.sandiego.va.gov/about/index.asp>.

24. San Diego Veterans Coalition, http://sdvetscoalition.org/?q=user%2Flogin&destination=comment%2Freply%2F106%23comment-form&eo_month=2013-07.

25. "This forum is run by veterans and veteran programs. [The County of San Diego] provides administrative support. Presentations are made to the Forum by organizations that serve the military and their families to educate them on what is available. Discussions occur on current issues affecting the military, families, veterans, National Guard and reservists." County of San Diego Health and Human Services Agency, Behavioral Health Division, "Overview of Services for Military, Veterans, and Families" (December 2012), <http://www.sdcounty.ca.gov/hhsa/programs/bhs/documents/VetsServ.pdf>.

26. The San Diego "Stand Down" Day traces its lineage to the late 1980s, when a group of Vietnam veterans developed this concept based on their experience with "stand down" days in the service, which facilitated training, refit, rest and other restorative activities. It now involves a large community gathering whereby scores of service providers, government agencies and others participate in a public event that offers services, information and support to homeless and other at-risk veterans in San Diego. For more information, see http://www.vvds.net/standdown_meaning.htm.

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28. San Diego Regional Chamber of Commerce, "Military Employment in San Diego," 1.

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30. Promises2Kids, "2010 Promises2Kids Military Families Support Initiative: Needs Assessment," 1.

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32. Department of Defense, Office of the Actuary, Military Retirees and Survivors by Congressional District, as of January 31, 2013.

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41. See U.S. Department of Defense, Military Installations, "Joint Base San Antonio (Lackland, Randolph, Sam Houston), Texas: Fast Facts," http://www.militaryinstallations.dod.mil/pls/psgprod/f?p=132:CONTENT:0::NO::P4_INST_ID,P4_INST_TYPE:4450,INSTALLATION.
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49. These areas align with Goals 2 and 4 of the May and Stanley Smith Charitable Trust's Proposed Strategic Planning Framework for Veterans.
50. The Transition Assistance Program (TAP) is a joint DOD, VA, Department of Education, Small Business Administration, and Department of Labor program mandated by statute to support separating service members as they transition from the military to civilian life. The law establishing TAP requires these agencies to establish programs to provide employment and training information to separating soon-to-be veterans within 180 days of discharge or retirement. In 2012, these agencies launched a new TAP program known as "Transition Goals Plans Success" or "Transition GPS," which is currently being implemented for separating troops across the services.
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52. See, e.g., corporate commitments from JPMorgan Chase, Walmart, Home Depot, Bank of America, Bristol-Myers Squibb, and more than 100 others as part of the 100,000 Jobs Mission, <https://www.veteranjobsmission.com/>; see also Starbucks Newsroom, "Starbucks Focuses Hiring Strategy on Veterans and Military Spouses," press release, November 6, 2013, <http://news.starbucks.com/news/starbucks-focuses-hiring-strategy-on-veterans-and-military-spouses>.
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