

Integrated Holistic Care: A Service Model for the Veterans of South Carolina

Report of the Joint Committee to Study Certain Issues Affecting Veterans

Representative Bobby J. Cox, Chairman
Senator Ronnie Cromer, Vice Chairman
Senator Tom Davis
Senator Thomas McElveen

Representative Lonnie Hosey
Representative Michael F. Rivers, Sr.
Secretary Will Grimsley

31 January, 2021
Final

Contents

Executive Summary	3
Introduction.....	4
Methodology	7
Understanding Risk	7
Common Risk Factors.....	10
Post-Traumatic Stress Disorder (PTSD)	10
Traumatic Brain Injury (TBI)	17
Homelessness.....	17
Substance Use	20
Traumatic Brain Injury.....	21
Adverse Childhood Experiences	22
Employment and Income	22
Incarceration	22
Combat Exposure and PTSD	23
Unique Challenges of the Female Veteran.....	24
A Service Model for Veterans.....	26
Findings: Our Current Service Model	28
Recommendations	45
Reference List.....	47
Homeless Veteran Data Figures	53
Military Service Inmates in Institutional Count Figures	63
County Veterans Affairs Offices' Telephonic Interview- Data Figures	68
Appendix	

Executive Summary

Beginning on 17 November 2020, this Joint Committee conducted a formal study of Veteran homelessness, unemployment, job placement, incidence of post-traumatic stress disorder, access to basic human services, and other issues affecting South Carolina Veterans. Using a research team provided by the SC Department of Veterans' Affairs (SCDVA), we examined data from four sources: 1) peer-reviewed academic research in the field of Veterans care; 2) expert testimony from persons with extensive experience in serving Veterans within the state; 3) raw data collected from Veteran service providers within the state; and 4) the results of a telephonic survey of County Veterans' Affairs Offices.

The fundamental insight of this study is that today's Veteran does not face a small number of individual risks, but a complex environment in which multiple risk factors interact to produce a cumulative level of risk greater than the sum of the individual factors. Successfully mitigating the risks to our Veteran population requires a holistic, integrated approach that spans the entire state. Because each Veteran's situation is unique, a unique combination of mitigating measures will be required for each Veteran. This dictates that the state system has enough centralized control to ensure a standard level of service across the state, tempered with decentralized execution to allow for unique solutions at the local level.

We found the current state model of service to Veterans to fall short in several areas, all of which are well within the means of the state to address. We therefore make the following recommendations to the Governor and the General Assembly (with additional details in the Recommendations section of this report):

1. Expand South Carolina's vision for Veteran care to encompass the social determinants of health.
 - Develop a state-wide network of organizations that provide services to Veterans
 - Expand and standardize the scope of services provided at County Veterans' Affairs Offices
 - Expand the use of Veteran Treatment Courts
 - Reorganize the Veteran Trust Fund as a resource for non-governmental efforts
2. Integrate the efforts to aid Veterans across the state.
 - Develop a collaborative coalition of organizations serving Veterans
 - Assign overall responsibility for this coalition to the SC Department of Veterans' affairs
 - Establish a State Veteran Engagement Board
 - Make County Veteran Affairs Offices part of the SC Department of Veterans' affairs
3. Objectively measure the effectiveness of efforts to serve Veterans.
 - Identify, measure, and report specific measures of performance and measures of effectiveness
 - Establish a long-term, annual study to monitor and report the condition of the South Carolina Veteran population along all social determinants of health

Introduction

On 28 September, 2020, the Governor signed a joint resolution directing the establishment of a Joint Committee to study “Veteran homelessness, unemployment, job placement, incidence of post-traumatic stress disorder, access to basic human services, and other issues affecting South Carolina Veterans,” and to provide a written report to the General Assembly and the Governor no later than 31 January, 2021. This study fulfills the reporting requirement of the Joint Committee and is intended to provide its recipients with a robust understanding of the challenges facing today’s South Carolina Veterans and specific recommendations for improving the manner in which the state supports our Veterans.

We should begin by noting the timing of this study is particularly fortuitous. Based on a commonly shared perception that South Carolina’s service to her Veterans, though genuine, falls short of what Veterans deserve and the citizens of the state intend, the General Assembly established the South Carolina Department of Veterans’ Affairs on 1 July 2019. Beginning with the confirmation of the inaugural Secretary of Veterans’ Affairs in March 2020, the Department conducted a formal analysis of its assigned duties and responsibilities, developed an initial campaign plan, and took a number of intermediate steps to begin the execution of that plan. Ambiguity concerning lines of authority and responsibility, wide variances in both the resourcing and scope of services at the county level, and a Department budget that is inadequate to support the expanded role defined in legislation, however, continue to limit the Department’s progress. This study provides an opportunity for the General Assembly and Governor to more precisely define the intended role of the Department and align authority and resources accordingly.

The fundamental insight of this study is that today's Veteran does not face a small number of individual risks, but a complex environment in which multiple risk factors interact to produce a cumulative level of risk greater than the sum of the individual factors.

Unemployment, as an example, often drives a Veteran into homelessness; being homeless creates insurmountable barriers to employment. In the same manner, substance abuse can lead to incarceration; incarceration, in turn, increases the risk of unemployment, homelessness, and suicide. Risk factors reinforce one another, potentially producing a downward spiral of unemployment, homelessness, substance abuse, and other challenges that all too often lead to a tragic conclusion. See Figure 1 for a graphic representation of the complex interaction of Veteran risk factors.

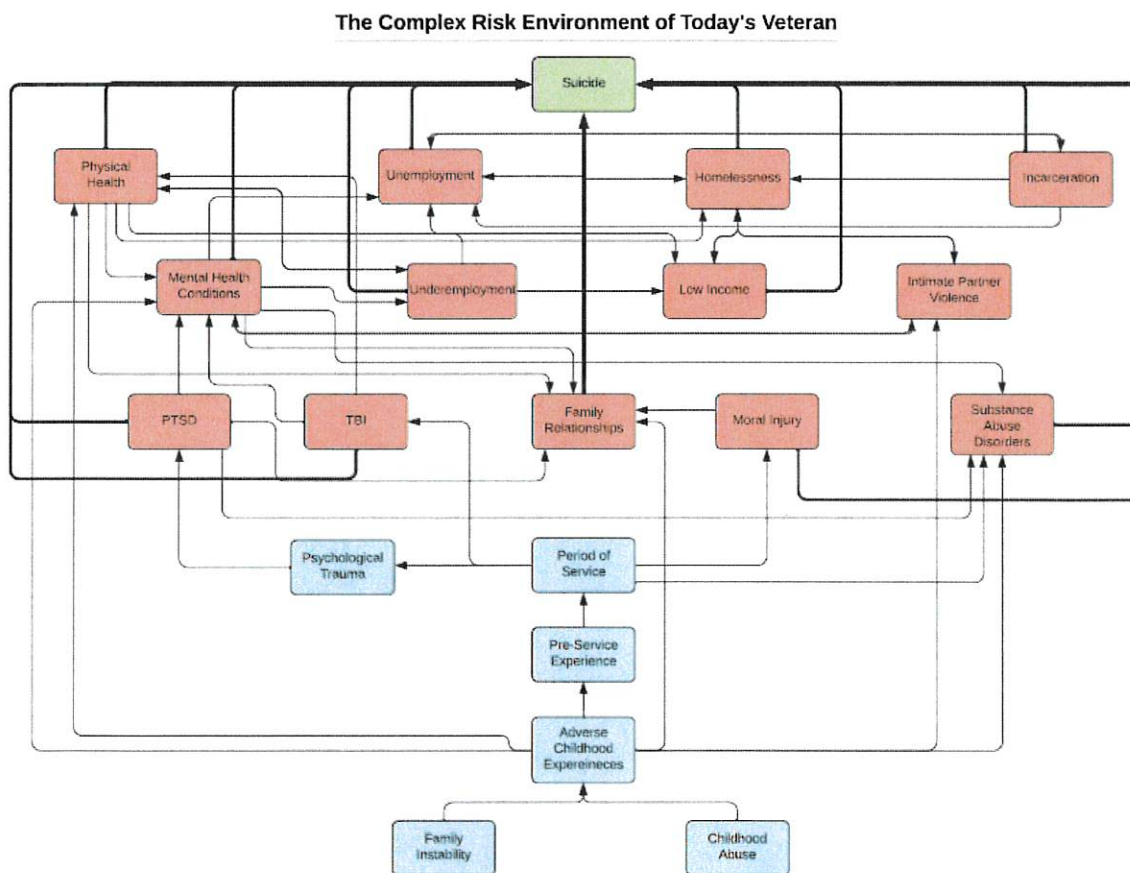


Figure 1. The Complex Risk Environment of Today's Veteran

More importantly, the evidence is clear that reducing the collective risk factors in the life of a Veteran can produce an upward spiral, with factors such as steady employment, secure housing, and substance abuse counseling reinforcing one another to produce a Veteran who is excited about her future, contributing to her community, and serving as a role model for those around her. Understanding, addressing, and reducing holistic risk factors for Veterans offers the most promising approach, not simply to prevent tragedy, but to produce thriving Veterans who live fulfilled lives and serve as pillars of their communities.

Achieving this outcome, however, requires at least two changes to our current approach to serving Veterans. First, we need to expand our vision of Veteran services. Defeating the complex network of risks facing our Veterans demands a holistic approach – one that addresses risks collectively rather than individually, and that includes prevention, mitigation, and recovery from the negative effects these risks can produce. Second, we need to integrate the efforts of the myriad agencies, organizations, and individuals who provide any service to Veterans in South Carolina. By working together in voluntary cooperation, this collective can provide a level of support to Veterans that no state could afford to fund on its own. The key, however, is to build a coalition that allows a more effective and efficient alignment of resources to Veteran needs.

In the pages that follow, we will examine in detail the risk factors which face today's South Carolina Veteran, and what is known about how to mitigate those risks. We will then examine our current system for addressing Veteran risk, detailing its strengths and its considerable weaknesses. We will then examine a more promising framework for providing Veterans with the services they need. While adopting such a framework will not guarantee success for every Veteran in South Carolina – no approach will meet that lofty goal – it will

produce an environment in which our Veterans can thrive as valued and contributing members of the South Carolina community.

Methodology

This study rests on four primary sources of data. First, the research team supporting the Joint Committee conducted an extensive literature review of the most current academic findings in the fields of Veteran care and the social determinants of health. The review incorporated multiple peer-reviewed and professionally published academic studies on all aspects of the challenges facing today's Veterans. Second, the Committee heard testimony from a variety of subject matter experts from the US Department of Veteran Affairs, the state government, and multiple non-profit organizations currently serving Veterans in South Carolina. This testimony included a question and answer period with each speaker. Third, the research team collected raw data on the current status of the Veteran population from a variety of Veteran service providers from across the state. Finally, the research team conducted a telephonic survey of the forty-six County Veterans' Affairs Offices to gather accurate data on the current scale and scope of the services provided at the county level.

The research team combined and analyzed the data from these four sources to develop draft findings and recommendations, then presented the draft to the Joint Committee for refinement and approval.

Understanding Risk

Nearly all Veterans face challenges resulting from their service in the military, but only a minority of Veterans are affected by these challenges to a degree that lowers their quality of life. Most Veterans successfully navigate life's challenges in a manner that helps them to grow and

become more productive citizens; many Veterans are at least as successful as their civilian counterparts. For the exceptions, however, recognizing the risk factors and responding to them can prevent Veterans from crossing over the threshold where a Veteran's ability to function is impaired or quality of life is degraded. As demonstrated in the research that follows, the number of Veterans with risk factors for negative life circumstances is much higher than the number of Veterans experiencing those negative life circumstances. Nevertheless, Veterans are much more likely than their civilian counterparts to experience a variety of negative outcomes, to include homelessness, PTSD, and suicide.

A majority of Veterans experience events during military service that have the potential to negatively impact their course of life. However, there are just as many factors in the lives of Veterans that protect them from the harmful effects of these events - the factors that promote and cultivate resilience. Recognizing and building upon the positive factors while acknowledging and intervening on the negative is key to cultivating resilience. There is no single, universally applicable solution to Veteran risks. The challenges that Veterans face are the result of a combination of circumstances specific to each Veteran. These challenges, when weighed against positive factors, will produce a unique outcome for each Veteran so that every Veteran must be approached with a solution tailored to the specific conditions of the local community in which the Veteran resides. This study is a comprehensive overview of the many individual risk factors present, those Veterans most likely to experience risk factors, when risk factors are most likely to emerge, the best responses for Veterans in the midst of negative life circumstances, and the ways in which the state and its partners can collaborate to intervene and mitigate the risks to our Veterans.

Mitigating risk factors in a way that addresses the complexity of the situation requires a responsive framework to guide practice and service delivery. A commonly used framework is the social determinants of health, and we will use it throughout this report. This framework informs decision making through a holistic lens. Rather than addressing medical challenges solely from a medical standpoint, this framework also considers the social aspects of a person's life which can negatively affect recovery. For the purpose of this study and the work done by the South Carolina Department of Veterans' Affairs, the social determinants of health include income, social support, education, employment, personal health practices, coping skills, addiction, food, and early life. In partnership with the many healthcare professionals already dedicated to improving the outcomes of Veterans, the South Carolina Department of Veterans' Affairs seeks to integrate the effects of efforts across all social determinants of health to assist Veterans in South Carolina to prevent the development of adverse outcomes.

Before we turn to a detailed examination of the individual risk factors facing South Carolina Veterans today, a word of caution is appropriate. A persistent challenge in seeking a full understanding of Veteran risk is the absence of current, complete, and reliable statistical data concerning Veterans, particularly Veterans in South Carolina. In the absence of a state-wide intake and tracking system for Veterans, we are reliant on multiple sources of partial data. While some data is available, and will be used extensively in the discussion below, small sample spaces, inconsistent research methodologies, and even differences in how key terms are defined make it very difficult to combine the available data and produce a comprehensive view of the Veteran population and its challenges. Nevertheless, the available data does allow for an understanding of broad trendlines, as we will demonstrate below. As we make use of the available data, we will attempt to explain how it affects our understanding of the problem while

recognizing its limitations. As an example, much of the data for Veterans in South Carolina is provided solely by the U.S. Department of Veterans' affairs (USDVA). Such data includes only those Veterans seeking care at the U.S. Department of Veterans' affairs facilities in South Carolina. Since Veterans seeking care at U.S. Department of Veterans' affairs facilities are, by definition, facing at least one risk factor, the U.S. Department of Veterans' affairs population is not representative of the Veteran population as a whole. Veterans not registered for care with the U.S. Department of Veterans' affairs are not represented in the U.S. Department of Veterans' affairs data, regardless of the number of risk factors those Veterans may be facing. According to Averill et al. (2015), only about 60% of the members discharging from military service are seeking care at U.S. Department of Veterans' affairs facilities, which means that as many as 4 in 10 Veterans are not represented by data provided by the U.S. Department of Veterans' affairs. While it may be reasonable to assume most Veterans who do not seek care from the U.S. Department of Veterans' affairs are able to manage their risk factors without assistance, this is not an established fact.

Common Risk Factors

Properly understanding the risk factors in the lives of Veterans is a critical prerequisite for developing methods for effectively mitigating those risks. In this section, we will examine major risk factors in detail, exploring the latest research on each.

Post-Traumatic Stress Disorder (PTSD)

Given recent interest in PTSD and its portrayal in the news and entertainment industries, it is important to understand what the term means from a medical perspective. Not surprisingly, the term is often used in daily life in ways that conflict with the actual definition of the disorder.

According to the Diagnostic and Statistical Manual V (DSM-V) (2013), Post-traumatic stress disorder is defined by the following:

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
 5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
 5. Markedly diminished interest or participation in significant activities.
 6. Feelings of detachment or estrangement from others.
 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
 2. Reckless or self-destructive behavior.
 3. Hypervigilance.

4. Exaggerated startle response.
 5. Problems with concentration.
 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

There are three generally recognized categories of trauma exposure resulting from military service: military combat trauma, non-combat trauma (i.e. hazing, training accidents, etc.), and military sexual trauma. Research to date predominantly focuses on military combat trauma and military sexual trauma. Military sexual trauma, as defined by the US Department of Veterans' affairs, refers to experiences of sexual assault or repeated, threatening sexual harassment experienced during military service. Although in the clinical setting the goal is to avoid diminishing the experiences of any one individual based on the event resulting in their trauma, it is important to note that outcomes vary depending on the event. For example, military members experiencing military sexual trauma are at a higher risk for post-traumatic stress disorder than those experiencing trauma from other sources (Sexton et al., 2017). Military sexual trauma is also associated with "more severe physical health outcomes and lower quality of life than civilian sexual trauma" (Suris et al., 2007). While women experience military sexual trauma at a higher rate than men do, for men the severity of PTSD associated with military sexual trauma far exceeds that of women with similar histories (Sexton et al., 2017). Additionally, male Veterans

tended to report military sexual trauma that was repetitive, involved multiple assailants, and including simultaneous physical battery (Sexton et al., 2017). While the severity of PTSD for both military combat trauma and military sexual trauma are similar, those with military sexual trauma are more likely to suffer from symptoms of depression and dissociation, as well as anxiety and thought disorders (Sexton et al., 2017).

Often associated with PTSD, although differing in important ways, is the developing concept of moral injury. Not addressed in the DSM-V, moral injury is defined in Doehring (2019) as the emotional, spiritual, and psychological wounds that stem from the “ethical and moral challenges that warriors face in combat, especially nontraditional forms of combat, such as guerilla war in urban environments” (Drescher et al., 2011, p. 8). It is most commonly associated with an act the Veteran perceives as fundamentally unethical, whether that act was performed by the Veteran himself or by those the Veteran trusted. Common examples include the killing or abuse of a non-combatant by the Veteran, or the issuance of an unlawful order by a trusted leader. Although the basic idea of moral injury is widely accepted, the concept has not yet undergone sufficient research to allow for a clinical definition. In the absence of formal research, it is telling that many Veterans of both Vietnam and Iraq/Afghanistan appear to accept moral injury as an established fact, and one that occurs at a disturbingly high frequency in combat.

Although a large portion of the contemporary military force has been exposed to combat, and 1 in 3 women and 1 in 50 men experience military sexual trauma (Military Sexual Trauma, 2020), the exact prevalence of PTSD within the Veteran community is surprisingly difficult to determine. What is reasonably certain, however, is that Veterans suffer from PTSD at a rate significantly higher than that of the general population. According to research by the U.S. Department of Veterans’ affairs, the lifetime prevalence of PTSD among adults in the total US

population is estimated to be 6.8%. The lifetime prevalence of PTSD among Veterans is not firmly established, but multiple efforts to determine it have consistently found rates well above that of the general population. A study conducted in 1986-1988 estimated a 30.9% prevalence rate for Vietnam Veterans; a 1995-1997 study estimated a 12.1% prevalence rate for Gulf War Veterans; and a 2008 study estimated a 13.8% rate among Veterans of Operation Enduring Freedom and Operation Iraqi Freedom (Gradus, n.d.). Because both sampling methods and the criteria for diagnosing PTSD changed from study to study, and the research was done at different points in the life cycle of the Veteran population, it is impossible to draw any conclusions about how PTSD prevalence rates really differ between Veterans of different conflicts. Even within a single cohort of Veterans, estimates of the PTSD prevalence rate can vary markedly. As an example, Fulton et al. (2015) estimates, based on a meta-analysis of 33 studies involving over 4.9 million Veterans, that the PTSD prevalence rate was approximately 23% for Operation Enduring Freedom/Operation Iraqi Freedom Veterans, almost twice the rate estimated in 2008. This disparity is indicative of the limitations mentioned early in the paper. The data used by Fulton et al. (2015) came exclusively from the U.S. Department of Veterans' affairs, and did not include those Veterans not seeking care from the U.S. Department of Veterans' affairs.

PTSD in Veterans may be as rare as 1 in 10, or as common as 1 in 3; we simply do not have a precise and reliable figure. Despite the uncertainty over the exact prevalence rate, however, what remains clear is that PTSD is a significant risk factor in the lives of many Veterans, a risk factor with the potential to directly affect mental health and indirectly influence such critical aspects of Veteran life as employment, homelessness, and personal relationships.

Traumatic Brain Injury (TBI)

Traumatic Brain Injury is the result of impact or injury with the head that causes damage to the brain, interrupting normal function. According to U.S. Department of Veterans' affairs data, there have been a reported 414,000 traumatic brain injuries between 2000-2019. The most common cause of traumatic brain injury in military and Veterans is explosions. The effects of traumatic brain injury effects can range from being dazed to losing consciousness to memory loss, and those with TBI can suffer no symptoms, mild symptoms, or severe symptoms. Examples of common symptoms include headaches, irritability, sleep disorders, memory problems, slower thinking, and depression. TBI, not managed, has the potential to impair a Veteran's employment, reintegration, and relationships. Because TBI has low stigma and is managed in large part by the United States Department of Veterans' affairs, individuals with TBI generally are not at greater risks for adverse outcomes because they are often treated in Warrior Transition Units while still in service and become embedded in U.S. Department of Veterans' affairs services soon after discharge. Although the direct risk associated with TBI is generally low, it can, like PTSD, have a direct effect on mental health leading to increased risk in other Social Determinants of Health.

Homelessness

Homelessness plays a key role in the popular perception of Veterans among the general population in the US. The image of a disheveled and desperate Veteran living in a makeshift shelter in a city park may be the first thing to come to mind when the average American hears the term "Veteran." The risk of homelessness, and its consequent effects on all other aspects of a Veteran's life, however, are far more complex than commonly understood. A true grasp of

Veteran homelessness requires an understanding of the complex interconnections among the many risk factors in the life of a Veteran. As the legislation directing this study focused heavily on Veteran homelessness, we will use the discussion below to address both homelessness and its connection to other risk factors that interact with homelessness to drive a Veteran’s cumulative risk to ever higher levels.

According to Tsai and Rosenheck (2018) and Cusack et al. (2020), homelessness can be defined as not having a nighttime residence that is regular, fixed, and adequate and includes moving frequently between different types of accommodations, risk of losing housing within 14 days, and staying in homeless shelters and places not meant for human habitants (e.g. vehicles, abandoned buildings). Housing instability can be classified by three types: transitional, episodic, and chronic. Transitional housing instability is characterized by having a small number of brief episodes over a multi-year period. Episodic housing instability is categorized by having more episodes alternating between shelters, hospitals, and other institutions. Chronic housing instability is categorized by having long periods of homeless episodes. It is important to distinguish the classification of housing instability because it determines the type and level of prescribed intervention. See Figure 2.

Housing Instability	
Transitional	Small number of brief episodes of homelessness over a multi-year period
Episodic	More frequent episodes of homelessness and use of shelters, hospitals, and other institutions on an alternating basis
Chronic	Long periods without a nighttime residence that is regular, fixed, and adequate

Figure 2. Categories of Housing Instability

A Veteran's risk of homelessness is significantly affected by both when the Veteran served and when he transitioned to civilian life. Veterans who served in the All-Volunteer Force (beginning in 1973 and extending to today), are generally at greater risk than those generations who served during the period of the draft. According to Tsai and Rosenheck (2018), those who served in the period from 1973-1983, in the first decade of the All-Volunteer Force, are at the greatest risk for homelessness. The commonly accepted explanation for this is referred to as the social selection effect, meaning that individuals voluntarily electing to serve in the military are more likely to be escaping poor economic conditions, poor family conditions, lack of family support, etc. (Tsai & Rosenheck, 2015, 2018). Although its influence was less pronounced after the first decade of the All-Volunteer Force, the social selection effect appears to have affected the risk of homelessness for Veterans up to the events of 9/11. Since 9/11, factors other than economic concerns appear to be driving decisions to enter military service, and the risk of homelessness for Veterans of this period is again shifting. According to a study conducted by Tsai and Rosenheck (2015), Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) war-zone Veterans are not at greater risk of homelessness than Veterans of other eras. This runs counter to the common assumption that the extended period of war and longer, more frequent deployments that post-9/11 service members have endured would increase the risk of homelessness. Metraux et al. (2013) noted that Reserve and National Guard Veterans, many with multiple combat deployments, had an even lower risk of homelessness than their OEF/OIF active duty counterparts. While the risk of homelessness among our most recent Veterans has not disappeared, its relative decline is indicative of an important truth: the risks and needs of our Veterans differ from era to era, as well as from individual to individual. The risk of homelessness varies from generation to generation and individual to individual.

This is further demonstrated by the wide variation in the timing of homelessness risk. Not surprisingly, a Veteran's risk for homelessness increases the moment she transitions to civilian life. That risk changes over time, however. For the average Veteran, Tsai et al. (2020) found the greatest risk of homelessness comes at six to ten years after discharge (often expressed as "Discharge to Homelessness" or "DTH" of six-ten). Again, however, there are generational differences. Vietnam Veterans have the longest DTH. Veterans of Iraq and Afghanistan, while less at risk for homelessness as a group, have the shortest DTH. Since Iraq and Afghanistan Veterans still have decades of life expectancy ahead of them, the lower DTH may not yet tell the story. There could be cohorts of younger Veterans that will become homeless in the future (Zoroya, 2014).

Setting time of service aside, factors that increase the risk of homelessness for Veterans tend to be the same as for non-Veterans (Cusack et al., 2020; Tsai & Rosenheck, 2018). These include mental health conditions, substance use disorders, chronic illness, low-income and other income-related factors, intimate partner violence, experiences related to military service, (such as military sexual trauma, and post-traumatic stress disorder), difficulties in childhood, low social support, and history of incarceration (Tsai & Rosenheck, 2015, 2018). Substance use disorders and mental illness are the two most common risk factors for homelessness, with substance use disorder having the greatest magnitude of effect and schizophrenia being a major risk factor. Although homelessness can exacerbate mental health disorders and substance use disorders, Tsai and Rosenheck (2015) showed that "these problems preceded homelessness" in most if not all cases.

Substance Use. Although substance use is typically tied to alcohol and illegal drugs in the popular imagination, a major substance use concern among Veterans is opioid use. Opioids

have been commonly prescribed to service members and Veterans for pain management (Hoggatt et al., 2017), and to address “injuries sustained during combat, chronic pain, and/or psychological and physical ailments that can arise while readjusting to civilian life” (Golub & Bennett, 2013). Prior to revised Centers for Disease Control guidelines on opioid prescribing, the Veterans Health Administration and military health facilities prescribed opioids at a high rate, often leading to dependence. According to a study by Hoggatt et al. (2017), “one in five young Veteran men and one in seven young Veteran women reported past year prescription drug misuse”. The misuse of prescription drug use raises concerns beyond the immediate negative effects as there is a strong correlation between non-medical use of prescription opioids and heroin addiction across literature (Banerjee et al., 2016). A recent study found 15% of Veterans using opioids reported taking them for non-medical purposes (Barry et al., 2018). The potential for opioids to have a significant long-term negative effect on the risk of Veteran homelessness, and other aspects of Veteran health, is obvious.

Again, in contrast to popular opinion, Veterans with persistent pain issues, not PTSD, seem to be most at risk for substance use and subsequent homelessness. Even so, mental health conditions can increase the risk of substance use. The highest rates of substance use disorders are not associated with PTSD, however, but with bipolar disorder and schizophrenia (Petrakis et al., 2011). In fact, those with PTSD have a relatively low rate of substance use disorder when compared to other mental health disorders (Petrakis et al., 2011). Similarly, Bowe and Rosenheck (2015) showed that Veterans who had a “dual diagnosis of PTSD and substance use disorders” also had “higher rates of bipolar diagnoses, liver problems, HIV infection, and homelessness.”

Traumatic Brain Injury. As one would expect, traumatic brain injury can increase the risk of homelessness, but there is an interesting, and encouraging, contemporary twist to this long-standing risk. Unlike all previous generations, Veterans of Iraq and Afghanistan do not experience increased risk of homelessness with TBI. Metraux et al. (2013) reports that “TBI and anxiety disorders (excluding PTSD) significantly increased, though modestly, the risk of becoming homeless only for the male non OEF/OIF subpopulations.” While this likely indicates the military’s efforts to counter TBI are producing results, more research is required to establish a firm causal relationship.

Adverse Childhood Experiences. Not a consequence of military service, but nevertheless common among homeless Veterans is a history of family instability and childhood abuse. More than half of homeless Veterans surveyed in the study said they had a parent missing in their household and nearly 40% reported some childhood physical, sexual, or emotional abuse (Tsai & Rosenheck, 2013). This risk factor is particularly troubling because of the difficulty in developing a feasible intervention to mitigate it.

Employment and Income. Two other particularly preventable risk factors for Veteran homelessness are employment and income. Although recent data indicates Veteran unemployment to be at or below that for the population at large, underemployment of Veterans appears to be a persistent issue. A recent *Wall Street Journal* article by Fuhrmans (2017) reported the high turn-over rate among Veterans reflects underemployment or a sense of being insufficiently challenged. Underemployment and low income both increase the risk of homelessness among Veterans.

Incarceration. Legal problems and incarceration increase the risk of homelessness in ways that are particularly difficult to overcome. Incarceration has the potential to lead to residential displacement, stigma, disrupted personal relationships, and limited employment prospects (Tsai & Rosenheck, 2015). When a Veteran falls into legal trouble and is ultimately incarcerated, the risk of homelessness increases immediately (because existing housing arrangements are lost) and in the future (because the record of incarceration will make it more difficult to obtain housing upon release). This effect is exacerbated by the negative impact of an incarceration record on the future employability of the Veteran; preventing homelessness requires employment to pay for housing. For Veterans facing legal challenges, early intervention is critical. Most Veterans in the criminal justice system are eligible for rehabilitation when their offenses are associated with the effects of military service. Early intervention not only prevents unnecessary homelessness, it reintegrates productive citizens of society into the workforce. One relatively new but very promising intervention for Veterans in the justice system are Veterans Treatment Courts, to which we will return later.

Combat Exposure and PTSD. Within this lengthy discussion of factors that increase the risk of homelessness, it is worth recognizing that two common explanations for homelessness, combat exposure and PTSD, do not play a meaningful role. Research consistently finds weak or non-existent connections between these two factors and the risk of homelessness. Combat exposure does not increase risk for homelessness (Tsai & Rosenheck, 2015). While PTSD does have some effect on the risk of homelessness, it is considerably less pronounced than the effect of other mental health conditions. While Veterans with combat exposure and PTSD are not more likely to be homeless, they are more likely than other Veterans to receive a U.S. Department of Veterans' affairs pension, compensation, and health benefits. These provide Veterans with

direct, consistent, and early intervention for many potential risk factors for homelessness (Tsai & Rosenheck, 2015).

Unique Challenges of the Female Veteran. Before concluding the discussion of factors that increase the risk of homelessness, we must examine the challenges that significantly complicate this issue among our female Veterans. Although there are less homeless female Veterans than homeless male Veterans, women Veterans tend to be overrepresented in the homeless population. This reflects an unpleasant reality: our women Veterans are more at risk for a number of other factors that affect the risk of homelessness.

Women Veterans are 10% more likely to experience interpersonal violence (IPV) than their civilian counterparts (Kimerling et al., 2016; Dichter et al., 2015; Yu et al., 2020). According to a survey conducted by Dichter et al. (2015), 40.5% of women reported experiencing interpersonal violence prior to military service, 58.9% reported experiencing interpersonal violence while serving in the military, and 67.2% experienced interpersonal violence after leaving service. More than a third of respondents reported experiencing interpersonal violence at all three time points. Similarly, “less than 5% experienced interpersonal violence only before entering service, 14.2% only during military service, 22.7% only after separating from military service” (Dichter et al., 2015). It is important to note that the small rate at which women Veterans report experiencing interpersonal violence prior to entering the military “indicates that higher rates of interpersonal violence exposure among women Veteran compared with civilian women cannot be explained exclusively by women entering the military to escape prior interpersonal violence” (Dichter et al., 2015). Among women most at risk for interpersonal violence are those that identified as lesbian or bisexual, served during the Vietnam and Post-Vietnam Era, and served for less than 10 years (Kimerling et al., 2016).

According to Yu, et al. (2020), interpersonal violence can lead to increases in the risk of homelessness and housing instability both indirectly and directly. Indirectly, interpersonal violence leads to potential mental health problems which, in turn, produce homelessness. Interpersonal violence leads directly to homeless as a woman loses her home when separating from an abusive partner. Thomas et al. (2015) highlight “women seeking safety from partner violence often face difficult ‘trade-offs’ and multiple losses, including loss of stable housing.”

Once a woman experiences housing instability due to interpersonal violence, it becomes more difficult for her to find housing because her experiences affect both her definition of housing safety and security and her perception of what constitutes suitable housing (Yu et al., 2020). Yu et al. (2020) describes a tragic cycle in which women accept homelessness and housing instability in order to escape from interpersonal violence, only to find that accepting unsafe housing exposes them to “additional and continuing episodes of physical or sexual abuse.”

While interpersonal violence undoubtedly increases the risk of homelessness, other more common factors have a similar effect. As discussed previously, unemployment, economic hardship, low-income, substance abuse, and military sexual trauma all increase the risk of homelessness (Lovine et al., 2019; Kimerling et al., 2016).

As we conclude this lengthy discussion of the factors which increase the risk of Veteran homelessness, it bears repeating that risk factors define probability, not destiny. Cusack et al. (2020) reported that homeless Veterans consistently reported not a single cause of their condition, but a combination of factors that cumulatively proved to be overwhelming. Many Veterans experience one or more risk factors but remain securely housed throughout their lives.

The critical task, it would seem, is to detect in advance when risk factors begin to reinforce one another and intervene early enough to prevent a tragic outcome and return the Veteran to full functionality.

And there is reason for optimism if we commit to this task. Homeless Veterans tend to be more educated than their non-Veteran counterparts, more likely to have been married, more likely to have health coverage, and, due to military service, more likely to have extensive work experience and leadership skills (Tsai & Rosenheck, 2018). Veterans, as a subpopulation of the overall homeless population, have greater skillsets and abilities than their non-Veteran counterparts. Considering these conditions, there is no reason that a combination of proper outreach, early intervention, coaching, and guidance cannot drive the homelessness rate within the South Carolina Veteran population to functional zero.

A Service Model for Veterans

No model of service provides a perfect solution to the challenges of helping Veterans mitigate risk factors and thrive in the civilian world. The research we have discussed in this report, however, clearly points to three key characteristics of any model that genuinely seeks to aid Veterans.

First, and most importantly, an effective service model must address the social determinants of health across the entire life cycle of the Veteran population. Any model that focuses exclusively on physical health, financial benefits, employment, or any other single Veteran risk factor will produce disappointing results. In the same manner, a model built to target the needs of only one segment of the Veteran population may enjoy some local success, but only at the expense of the Veterans who fall outside the targeted group. The scope of an

effective service model will address the risk factors of all Veterans, at all points in their life cycle. In an optimal world, services provided to a Veteran in his 40s should be designed to meet his current needs and reduce the risk factors he will face in his 80s.

Second, an effective service model should integrate all efforts to serve Veterans, regardless of the source of such efforts. No model can provide each Veteran all possible services at all times in his immediate vicinity. The resource requirements of such a model would be prohibitive. Instead, an effective service model must include a cooperative coalition of service providers that collectively meet the needs of Veterans. Such a coalition must, by its nature, be voluntary; this, in turn, means the model must include adequate incentives for cooperation among federal and state government agencies, non-profit organization, and private sector businesses.

Third, an effective service model should have clear goals and objectives for the Veteran population, and regularly assessed measures of performance and measures of effectiveness to determine how the services provided are or are not affecting Veterans. Optimally, a disinterested third party would measure and report on both performance and effectiveness, enabling rational decisions about which services are provided and in what manner.

A service model with these three characteristics offers the best chance of meeting the greatest number of Veteran needs in as cost-effective a manner as possible. The central idea of such a service model would not be a massive increase in the resources committed to Veteran issues, but a concentrated effort to optimize the use of the available resources, the subsequent analysis of the entire system to identify any remaining gaps, and then the targeted application of additional resources to achieve full functionality.

Findings: Our Current Service Model

When we compare our current model for serving Veterans to the characteristics above, we find both encouraging signs of potential and significant room for improvement. This should not be surprising. Today's service model is less a deliberate state-wide plan and more a collection of state, county, non-profit, and private sector initiatives that were largely developed independently with the best of intentions but little or no awareness of the efforts of others. Predictably, this results in a patchwork of Veteran services that differs remarkably from location to location within the state. A broad recognition of this reality was the impetus for both the creation of this Joint Committee and the establishment of the South Carolina Department of Veterans' Affairs.

A close examination of the current situation in South Carolina leads us to the findings below.

1. ***Our current approach to Veteran service does not adequately address the social determinants of health.*** According to Braveman and Gottlieb (2014), "the World Health Organization's Commission on the Social Determinants of Health has defined Social Determinants of Health as "the conditions in which people are born, grow, live, work and age" and "the fundamental drivers of these conditions." Although we have several areas of the state where Veteran services address most of the key determinants, throughout most of the state this is not remotely true. While assistance with submitting a claim for federal benefits is reasonably available in most, but not all, counties, the availability of assistance in dealing with risk factors such as physical health, unemployment and under employment, homelessness, incarceration,

mental health conditions, low income, and intimate partner violence varies radically across the state. As a rule, the closer a Veteran is to a major urban center, the broader the array of resources available. Both the scope and scale of available service typically diminish rapidly as one moves into the more rural portions of the state.

Although not comprehensive, the three examples below give some indication of the current efforts to address needs across the social determinants of health.

Military to Civilian Transitions. Transition to civilian life after separation or inactivation creates a potentially critical time for intervention and a stressful period for Veterans, one in which they are particularly vulnerable to adverse outcomes (Williams et al., 2015). Services that proactively provide support and facilitate the transition process are important to ensure a successful transition for Veterans and reduce adverse outcomes resulting from challenges during this period. The military provides some transition services to service members prior to exit, but these are often limited in scope and differ in organization and composition from one South Carolina installation to another. Veterans and their families often struggle to navigate the move to a new phase in life, frequently lacking both knowledge of and access to existing community resources when such resources are available.

It is surprisingly difficult to identify service members who are approaching transition while in South Carolina, or transitioning from elsewhere with the intention of relocating to our state. While the South Carolina Department of Veteran's Affairs has several efforts underway to improve visibility of transitioning Veterans, to date progress has been very limited.

Even when we can identify a transitioning Veteran in advance, connecting her to the existing structure of their new community remains challenging. To be effective, this connection

should include a “warm handover” from the military transition office to a local sponsor who can help the Veteran connect to the civilian community, navigate the processes of the US Department of Veterans’ affairs, and identify and address any risk factors the new Veteran faces immediately. While the SC Department of Veteran Affairs is working with a number of agencies to make this a reality, today a service member transitioning from a military base in South Carolina is likely to find himself largely on his own unless he actively seeks out assistance. History teaches us he is unlikely to do so before the risk factors in his life have combined to create a crisis. We need a model of transition assistance that intervenes before, and optimally prevents, such a crisis.

Transportation. While South Carolina is blessed with a robust system of US Department of Veterans’ Affairs medical facilities, a persistent challenge has been adequate transportation to get Veterans in rural areas to medical facilities that are, of necessity, centrally located in urban areas. Many rural counties attempt to address this with local assets, but the result typically meets only a portion of the need. Increased reliance on telemedicine as part of the US Department of Veterans’ Affairs’ response to the global pandemic has provided some assistance, but the rural population most in need of transportation is also the least likely to have access to the broadband internet needed for telemedicine.

Employment. Although multiple federal and state agencies seek to assist Veterans in finding employment, our research revealed consistent underlying weaknesses in our approach to addressing this need. First, employment assistance efforts tend to be conducted in isolation, with little communication or cooperation between agencies involved. The SC Department of Veterans’ Affairs has recently created a Veteran Employment Working Group to encourage and aid in cooperative efforts. Second, while South Carolina has both a large number of businesses

that want to hire Veterans and a large number of Veterans who are seeking jobs, efforts to connect them have not attained consistently positive results. On-going collaborative efforts, such as the partnership between the South Carolina Manufacturing Alliance and Veterans Ascend which aims to bring advanced technology to connect employers with potential Veteran employees, offer a glimpse of what may be possible through greater cooperation and collaboration. Finally, most efforts in this field focus almost exclusively on addressing Veteran unemployment, when Veteran underemployment appears to be the more relevant issue. In the absence of a common definition of underemployment and any reliable method for measuring its prevalence in the Veteran community, most service providers have opted to largely ignore it. This amounts to solving the problem that we know how to solve rather than the problem that Veterans face.

a. Although many agencies, organizations and individuals provide services to Veterans in South Carolina, they are not connected in a network that allows continuous collaboration and the efficient use of resources. Of all the Joint Committee learned throughout this process, the most encouraging aspect was the realization that literally hundreds of organizations and thousands of people commit themselves daily to meeting the needs of Veterans in South Carolina. From federal and state agencies charged with service to Veterans, to a myriad of non-profit and private section efforts to address specific needs, to individual volunteers who are committed to turning “Thank you for your service” into action, South Carolina is quite literally blessed with an abundance of riches in the field of Veteran services.

Unfortunately, most of these efforts to assist Veterans are performed in isolation, without knowledge of or cooperation with other people and agencies doing complementary work. A

Veteran who approaches a service provider with an array of needs is likely to find assistance with only one or two, and may have to search for other providers to address the remaining issues.

In the absence of a state-level entity to oversee the development of a state-wide network that would enable multiple service providers to collectively address the holistic needs of a Veteran, many of those involved in serving Veterans have attempted to “fill the vacuum” themselves, at least at a county or regional level. A prime example of this is the role Upstate Warrior Solution, a non-profit organization, has filled and continues to fill in the Upstate. Adopting the mantra of a “quarterbacking organization,” Upstate Warrior Solution built and maintains a regional network of providers that allows all participants to gain access to the capabilities of all other participants, enabling the effective and efficient use of the resources of all. A Veteran visiting one of these providers gains immediate access to the others, as appropriate to meet his needs. This model is, however, the exception. Throughout most of the state, organizations providing services to Veterans do so with limited insight into the totality of Veteran needs within their area and an incomplete understanding of the resources available through other service providers.

b. Most County Veteran Affairs Offices are not trained or equipped to address Veteran needs across the social determinants of health. County Offices were originally created to assist Veterans in filing claims of federal benefits, a role that most continue to fulfill with competence. As the Veteran population and its needs have changed, however, only a relatively small number of County Offices have adapted accordingly. While most organizations that serve Veterans have recognized the importance of addressing Veteran needs across the social determinants of health, a significant portion of our County Offices remain focused almost exclusively on claims

management. (For a detailed look at which basic services are provided at County Offices across the state, see the enclosed results of the telephone survey conducted by the research team.)

The degree to which a County Office addresses the social determinants of health is largely driven by the level of resourcing provided by the county. Generally speaking, poorer counties fund their County Office solely to manage claims, while more affluent counties expand the scope of services to address other Veteran needs. This rule of thumb is not universally true, however, as some rural County Offices have combined the available county resources with a network of partners to address many key risk factors in the local Veteran population.

Unfortunately, we also have County Offices that categorically refuse to expand their role beyond that of claims management. The majority of county offices fall between these extremes, partially addressing at least some of the social determinants of health by stretching their available dollars and cooperating with outside organizations that can provide additional resources.

In the same manner, many of our County Offices are focused on a narrow band of the Veteran population. During our phone survey of the County Offices, a majority of the counties reported serving only older male Veterans. All County Offices emphasized their positive relationships with traditional Veteran service organizations such as the Veterans of Foreign Wars and American Legion. Most use input from these organizations as their primary indicator of Veteran opinion, despite the almost total absence of younger Veterans in these organizations. The majority indicated they have no relationship with such contemporary service organizations as Team Rubicon and Iraq and Afghanistan Veterans of America, the organizations that are attracting the younger generation of Veterans, and many County Officers indicated they were not even familiar with these organizations. In discussing the Veterans they serve, County Officers routinely characterized them as unfamiliar with cell phone technology and uncomfortable with

modern communications. This perception persists although 55.26% of the South Carolina Veteran population is under the age of 65. Taken together, these indicators point to the likelihood that our County Offices are optimized to serve Veterans from the Vietnam era, and may not be meeting the needs of a substantial portion of the Veteran population.

Similarly, a significant portion of our County Offices expressed little interest in the unique challenges facing women Veterans, and several expressed the opinion that women Veterans do not require special resources. Only 13 of 46 County Office have an acceptable response plan for a Veteran reporting interpersonal violence, despite the prevalence of such incidents among women Veterans.

Perhaps most troubling is the fact that most County Offices may miss critical Veteran issues for the simple reason that they do not ask. Only 8 of 46 County Offices reported having a comprehensive screening process designed to identify a Veteran's issues as part of the intake process. Such a screening process identifies risk factors associated with suicidal ideation, homelessness, interpersonal violence, food, employment, income, etc., and is critical to mitigating risks before they grow into crises. The fact that only 17.4% of our County Offices ask Veterans about these risk factors is perhaps the most convincing evidence that we are not currently addressing the social determinants of health in a systemic manner.

c. Veteran Treatment Courts offer an opportunity to mitigate one of the most difficult risk factors for Veterans, but are not employed across the state in a standard manner.

Veterans treatment courts are diversionary programs that offer intervention in the form of treatment, counseling, and rehabilitation to Veterans that become involved in the justice system. Most commonly, Veterans that are facing time in prison or jail are given the option or request to

participate in Veterans Treatment Court. According to an inventory by Flatley et al. (2017) there were approximately 461 Veteran treatment courts in the United States at the time of their report in 2017. As of 2020, there were six known Veteran treatment courts in South Carolina.

Veteran treatment courts have varying criteria for participation across the nation (Clark & Flatley, 2019) and across South Carolina. The most common criteria that varies between courts is U.S. Department of Veterans' affairs eligibility and offense severity. In areas that are well resourced, such as Greenville County, Veterans are not required to have access to U.S. Department of Veterans' affairs health care for services because they can rely on services provided in the community. In areas not as well resourced, Veterans must have U.S. Department of Veterans' affairs health care or be prepared to pay out of pocket. Another variation between courts is in offense severity. According to national data reported by Clark and Flatley (2019), "over 60% of courts will consider all violent offenses, including domestic violence (in many jurisdictions, Veterans facing violent charges are admitted only with the consent of the alleged victim)." Many of the South Carolina Veterans treatment courts admit Veterans not based on established policy but on a case-by-case basis.

Admittedly, there are challenges in creating and maintaining Veteran Treatment Courts. The most prominent is identifying Veterans when they come into the justice system. There is currently no standardized system in place to identify Veterans as they come into the justice system in South Carolina. Most jurisdictions rely on Veterans to self-report, which becomes a challenge when considering the hesitance of some Veterans to disclose status for fear of a loss or reduction of benefits (Clark & Flatley, 2019). Another challenge is finding and retaining mentors - volunteers who serve as near-peer guides on an individual basis through what can often be an extended and intense process (McCall & Pomerance, 2019). There is a cost in

resources, especially in time and personal expenses to mentors. These factors exacerbate challenges when trying to find mentors, especially for younger mentors in full-time working age groups, the preferred source of mentors for younger Veterans.

One last challenge faced in South Carolina is the lack of data on the utilization and impact of these courts. Because there is no centralized system for collecting information on Veterans involved and Veteran treatment courts are fairly new in South Carolina, this is the perfect opportunity to build and implement a system that will help track data on the impact of such programs on recidivism and overall well-being of the Veterans that participate.

d. The Veterans Trust Fund is not organized to serve as an incentive for non-governmental cooperation. Despite having been in existence for decades, the Veterans Trust Fund contains such a small amount of available grant money that its effect on South Carolina's efforts to provide services to Veterans has been negligible. For each of the past two years, the Fund has disbursed less than \$20,000 in grants, an amount that makes the Fund irrelevant to all but the smallest and most narrowly focused of service providers. This is not because of some defect in the Trust Fund itself, but in the legislated composition of the Fund's Board. As currently comprised, the Board is comprised of members who lack access to the major donors that would enable the Fund to grow large enough to become a tool for encouraging cooperation among the non-governmental organizations serving Veterans in South Carolina. A change in composition allowing a greater number of At Large members would open the door for Board members with greater access to major donors.

2. The many efforts to serve Veterans across the state are not adequately integrated. As discussed earlier, South Carolina is fortunate to have a wide variety of organizations and people

committed to meeting the needs of Veterans. The efforts of these organizations and individuals, however, are not organized in a way to allow for the efficient use of available resources. Each organization operates largely independently, perhaps aware of a few other organizations in the same field but lacking an understanding of the full scope of resources available through the service organizations collectively.

Many involved in serving Veterans are aware of this shortfall in coordination, and have come together in various committees, council, boards, etc., in an effort to bridge the gap. An excellent example of this effort is the Community Veterans Engagement Board (CVEB), a US Department of Veterans' Affairs initiative that aims to bring everyone within a specific region into a recurring forum for information sharing. At least four major CVEBs are functional in South Carolina today, and all attempt to align needs with resources through voluntary cooperation among the participating organizations. The level of success varies from Board to Board, but even the most mature Board has a limited geographic reach and does not include all organizations serving Veterans within the prescribed area. Even with these shortfalls, however, CVEBs are demonstrative of the potential for improving Veteran services by establishing a volunteer state-wide coalition within which regional, county, and even local coalitions can organize.

A word of caution is necessary, however. While a voluntary state-wide coalition of those serving Veterans could significantly improve the efficiency and effectiveness of that service, it would do so only through voluntary cooperation, not top-down directives. To be effective, a state-wide coalition would require enough central structure to allow for information and resource sharing, but would of necessity leave the particulars of Veteran service to the local organizations actually providing services. This follows directly from the recognition that each Veteran's

situation is unique, requiring a unique set of solutions. In the same way, local conditions will influence how an organization applies resources to assist Veterans. Wide differences in both Veterans and local conditions preclude “standard solutions” to be applied uniformly across the state. Instead, the purpose of a state-wide coalition is to foster cooperation that enables each organization to fit its unique approach to service within a larger framework of services, reaching out to others when a Veteran’s needs exceed its capabilities. In a mature coalition, each Veteran has access to the services of the entire community, regardless of the organization that he first approaches for help.

The value of a state-wide coalition has been repeatedly recognized in the past, and repeated efforts have been made to create one. Most have experienced some initial success, but none has been sustained over time. We believe this reflects the absence of a state-level entity tasked with building and sustaining an effective coalition. The newly created SC Department of Veterans’ Affairs is clearly the most appropriate organization for this role, and has already begun the process of establishing a coalition. Much remains to be done, however.

a. In the absence of a state-wide coalition, cooperation among service providers has been limited to local and occasionally regional scales. Some counties have created coalitions at the local or county level, and the most mature of these are effective at addressing Veteran needs across the social determinants of health. These are in a decided minority, however. In the average South Carolina county, ad hoc coalitions of a small number of organizations have informal cooperative agreements based largely on personal relationships, but no formal venue for enabling cooperation across all organizations with an interest in Veterans.

At the regional level, the Community Veteran Engagement Board in the Upstate is by far the most mature effort at establishing a broader coalition. Led by Upstate Warrior Solution, this Board uses voluntary cooperation to greatly expand both the scope and scale of services available to any Veteran who seeks assistance from any participating organization. In many ways, the Upstate offers a model of what a coalition is capable of doing for Veterans, even as it continues its efforts to expand across the entire Upstate region.

A state-level coalition is the missing component. A State Veteran Engagement Board would serve as the venue allowing local and regional coalition to expand their networks beyond current boundaries, enabling a broader and more effective sharing of information and resources possible.

b. No state organization is tasked with building the necessary coalition or resourced to do so. Although the SC Department of Veterans' Affairs has recognized the need for a state-wide coalition and has already taken initial steps to create one, it is currently doing so without a clear mandate and in the absence of adequate resourcing. Although the Department was formally created in July, 2019, it continues to operate with the same level of funding assigned to the previous Division of Veterans' Affairs, an organization focused solely on benefit claims with no responsibility for other Veteran needs.

The reality is that South Carolina significantly underfunds its state-level efforts to care for Veterans. Today, according to the July, 2019, report of the Institute for Veterans and Military Families, South Carolina ranks last in the nation in the amount of State dollars spent on Veterans on a per capita basis. We spend, on average, \$4 per year per Veteran. By way of comparison, Tennessee spends \$17 per Veteran, Georgia spends \$59 per Veteran, and North

Carolina spends \$82 per Veteran. But to be clear, we do not simply lag behind our nearest neighbors. We are dead last in the nation – 50th of 50.

A coalition of federal, state, non-profit, and private sector partners offers the potential to significantly improve services to Veterans without a major influx of state dollars, but funding adequate to build a capable Department of Veterans' Affairs is necessary to make such a coalition a realistic possibility.

c. An effective coalition needs an established structure that allows for effective cooperation across the entire state. Over the past decades, several efforts have been made to establish a state-level venue for cooperation across all organizations serving Veterans. These well-intentioned efforts have typically resulted in the establishment of an ad hoc board or committee that came into existence, enjoyed some short-term success, and then faded into irrelevance.

What is needed is an enduring, state-sponsored venue for the voluntary sharing of information and resources, a central clearing house for all issues pertaining to Veterans. A State Veteran Engagement Board would allow local and regional coalitions to expand their networks across the state, enable a state-wide understanding of both Veteran needs and available resources, and foster a cooperative rather than competitive relationship among those serving Veterans. By replacing the multiple competing ad hoc boards and committees currently in existence, it would also reduce confusion and duplicative efforts.

d. Our current approach to County Veteran Affairs Offices undermines cooperation and reduces both the effectiveness and the efficiency of our Veteran services. Although the legislation establishing the SC Department of Veterans' Affairs made County Veterans' Affairs

Officers state employees, the reality is the Department's authority is not aligned with its responsibility. Today, County Offices continue to operate as 46 independent agencies, answering to an ambiguous mix of the Department, their respective county councils, and their respective county delegations. As a result, County Offices vary widely in both what services they offer to Veterans and the way they deliver those services.

In our best County Offices, Veterans will find professional assistance in filing a claim for federal benefits, a service officer who takes the time to understand the full scope of a Veteran's needs, and an array of resources adequate to address needs across the social determinants of health. In other County Offices, a Veteran may have difficulty even getting competent help with his benefit claim.

While by law the SC Department of Veterans' Affairs has responsibility for the services Veterans receive in County Offices, the current authority of the Department to establish and enforce standards of service is ambiguous at best. In light of this ambiguity, most County Offices are understandably more responsive to the desires of their county administrators than to the Secretary of Veterans' Affairs. The fact that counties continue to fund County Offices, with only a very small state supplement, only reinforces this tendency.

The current ambiguity about lines of authority and responsibility complicates even the most basic functions of the Veteran service symptom. Since mid-August, 2020, the SC Department of Veterans' Affairs has asked County Offices to submit a weekly status report indicating whether services to Veterans are being provided remotely or in-person. Since then, an average of 63% of counties have submitted the report in any given week. Fifteen counties have submitted their report less than half the time, and five counties have never submitted a report.

Given the difficulty in answering the straight-forward question of “Are the county offices open this week?”, one can imagine the obstacles to achieving a standardized scope and scale of services to Veterans.

Under our current system, the level of service a Veteran receives from a County Office differs wildly from Office to Office, and the authority of the Department to address this is not clearly established.

3. *We do not have the means to objectively assess the effectiveness of our efforts to serve our Veterans.* One of the more surprising facts to emerge during this study is the difficulty in understanding the current state of the South Carolina Veteran population and assessing the degree to which state and county efforts are affecting that population.

a. *We do not have established goals and objectives relative to the Veteran population in South Carolina.* A significant contributor to the confusion is the absence of clearly defined goals and objectives for the Veteran community in South Carolina. While almost everyone agrees we want better Veteran services and less Veteran hardship, specific objectives are surprisingly rare, and objective metrics to assess progress even more so.

As an example, the latest employment data (which pre-dates the disruption caused by the global pandemic) indicates unemployment among Veterans in South Carolina is below that general unemployment rate. Is that good enough? How much below the general unemployment rate does the Veteran rate need to be? How do we measure underemployment? Is a Veteran who is bored with her job underemployed, or is underemployment tied to the difference in compensation between a Veteran’s current job and their most recent military assignment? Should our goal be that Veterans earn at least as much in their civilian jobs as they did in the

military, or is that even realistic, or necessary, or appropriate? These questions have, for the most part, not been answered in any definitive way, although the SC Department of Veterans' Affairs is already devoting considerable energy to developing answers.

Once we have established goals and objectives, however, finding reliable indicators of progress is likely to prove equally challenging. The natural human and organizational tendency is to measure things that are relatively easy to measure, not necessary those things that actually provide meaningful data. As an example of how easy it is to fall into this trap, both state and county level agencies responsible for Veteran services routinely use the annual US Department of Veterans' Affairs *Summary of Expenditures by State* (commonly referred to as "GDX Data") to demonstrate how effective their efforts are at bringing federal dollars into the state or county. This is more than a little misleading, as the *Summary of Expenditures* includes all U.S. Department of Veterans' affairs expenditures within the designated area, and most of those dollars were not influenced in any way by the actions of the state or county governments. As a simple example, the *Summary of Expenditures* includes compensation and pension awarded to each county resident regardless of whether the County Office played any role in filing the claim that generated the compensation and pension.

Long-term improvement in how we serve Veterans in South Carolina requires clearly established goals and objectives, tied to reliable measures of performance and measures of effectiveness.

b. We lack a disinterested third party, with expertise in Veteran issues, to provide an audit function to our Veteran service efforts. Our current understanding of the state of Veteran services within South Carolina is heavily dependent upon self-reporting by the agencies charged

with providing those services. Perhaps unsurprisingly, this had led to the common misperception that an absence of complaints against an agency equates to good performance. We can do better.

A robust and timely understanding of the state of the South Carolina Veteran population is of interest to both policymakers and the academic community. This suggests the possibility of a long-term, state-wide study of that population by one or more of the state's institutions of higher learning. Such a study, built around the state's goals and objectives for the Veteran population, would serve two critical functions. First, it would provide policymakers with reliable indicators of progress from an unbiased third party, significantly reducing reliance on self-reporting. Second, it would position South Carolina as a leader in Veteran studies, a growing field of research across the nation.

Simply establishing goals and objectives for our Veteran population is unlikely to produce the results we want unless we find an unbiased third party to measure progress.

Recommendations

Based on the findings of this study, the Joint Committee offers the following recommendations to the Governor and the General Assembly:

1. Expand South Carolina's vision for Veteran care to encompass the social determinants of health.
 - Task the South Carolina Department of Veterans' Affairs to develop a state-wide network of organizations that provide any service to Veterans that collectively address Veteran needs across all social determinants of health.
 - Task the South Carolina Department of Veterans' Affairs to expand and standardize the scope of services provided at County Offices to address the full range of Veteran needs using a combination of government resources and a network of non-government partners.
 - Expand the use of Veteran Treatment Courts, and standardize their practices across the state.
 - Reorganize the Veteran Trust Fund to enable it to serve as a viable resource for non-governmental efforts to address the social determinant of health needs for Veterans.
2. Integrate the efforts to aid Veterans across the state.
 - Develop a collaborative coalition of organizations (federal, state, non-profit, and private sector) with an interest in serving Veterans, operating with enough central direction to allow for the efficient use of resource and enough decentralized control to allow for local solutions to the unique challenges facing Veterans.

- Assign overall responsibility for the development and operation of this coalition to the South Carolina Department of Veterans' Affairs, and resource the Department accordingly.
 - Establish a State Veteran Engagement Board, chaired by the Secretary of Veterans' Affairs, to serve as the central agency for coordinating goals and objectives for Veteran care in South Carolina.
 - Make County Veteran Affairs Offices part of the South Carolina Department of Veterans' Affairs.
 - Assign responsibility for operation and oversight of County Offices to the Secretary of Veterans' Affairs.
 - Make all County Office employees state employees.
 - Incrementally transfer funding responsibility for County Offices from the counties to the State.
3. Objectively measure the effectiveness of efforts to serve Veterans.
- Task the South Carolina Department of Veterans' Affairs to identify, measure, and report specific measures of performance and measures of effectiveness that can be used to determine and track trendlines within the South Carolina Veteran population along all social determinants of health.
 - Task the South Carolina Department of Veterans' Affairs, in conjunction with South Carolina's institutions of higher learning, to establish a long-term, annual study to monitor and report the condition of the South Carolina Veteran population along all social determinants of health.

Reference List

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)
- Ammerman, B. A., & Reger, M. A. (2020). Evaluation of prevention efforts and risk factors among veteran suicide decedents who died by firearm. *Suicide and Life-Threatening Behavior*
- Averill, L. A., Eubanks Fleming, C. J., Holens, P. L., & Larsen, S. E. (2015). Research on PTSD prevalence in OEF/OIF Veterans: expanding investigation of demographic variables. *European journal of psychotraumatology*, 6, 27322.
<https://doi.org/10.3402/ejpt.v6.27322>
- Banerjee, G., Edelman, E. J., Barry, D. T., Becker, W. C., Cerdá, M., Crystal, S., Gaither, J. R., Gordon, A. J., Gordon, K. S., Kerns, R. D., Martins, S. S., Fiellin, D. A., & Marshall, B. D. (2016). Non-medical use of prescription opioids is associated with heroin initiation among US veterans: a prospective cohort study. *Addiction*, 111(11), 2021–2031
- Bowe, A., & Rosenheck, R. (2015). PTSD and substance use disorder among veterans: Characteristics, service utilization and pharmacotherapy. *Journal of dual diagnosis*, 11(1), 22–32. <https://doi.org/10.1080/15504263.2014.989653>
- Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, 129, (pp. 19-31. <https://doi.org/10.1177/00333549141291S206>

- Clark, S., & Flatley, B. (2019). VA programs for justice-involved veterans. In *Intersections between Mental Health and Law among Veterans* (pp. 45-58). Springer, Cham
- Cusack, M., Montgomery, A. E., Sorrentino, A. E., Dichter, M. E., Chhabra, M., & True, G. (2020). Journey to home: development of a conceptual model to describe Veterans' experiences with resolving housing instability. *Housing Studies*, *35*(2), 310-332
- Dichter, M. E., Wagner, C., & True, G. (2015). Timing of intimate partner violence in relationship to military service among women veterans. *Military medicine*, *180*(11), 1124-1127
- Doehring, C. (2019). Military Moral Injury: An evidence-based and intercultural approach to spiritual care. *Pastoral Psychology* *68*, 15–30. <https://doi.org/10.1007/s11089-018-0813-5>
- Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Schutz, K., & Litz, B. (2011). An exploration of the viability and usefulness of the construct of moral injury in war Veterans. *Traumatology*, *17*(1), 8–13. <https://doi.org/10.1177/1534765610395615>
- Flatley, B., Clark, S., Rosenthal, J., & Blue-Howells, J. (2017). Veterans court inventory 2016 update: Characteristics of and VA involvement in Veterans treatment courts and other Veteran-focused court programs from the Veterans justice outreach specialist perspective. Washington, DC, US Department of Veterans' affairs, Veterans Health Administration, March 2017
- Fuhrmans, V. (2017, March 28). Hiring Veterans is easy. Keeping them is hard. *The Wallstreet Journal*. <https://www.wsj.com/articles/the-battle-to-keep-veterans-from-quitting-corporate-jobs-1490702401>

Fulton, J. J., Calhoun, P. S., Wagner, H. R., Schry, A. R., Hair, L. P., Feeling, N., Elbogen, E., & Beckham, J. C. (2015). The prevalence of posttraumatic stress disorder in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans: a meta-analysis. *Journal of anxiety disorders, 31*, 98–107.
<https://doi.org/10.1016/j.janxdis.2015.02.003>

Golub, A., & Bennett, A. S. (2013). Prescription opioid initiation, correlates, and consequences among a sample of OEF/OIF military personnel. *Substance use & misuse, 48*(10), 811–820

Golub, A., Vazan, P., Bennett, A. S., & Liberty, H. J. (2013). Unmet need for treatment of substance use disorders and serious psychological distress among veterans: a nationwide analysis using the NSDUH. *Military medicine, 178*(1), 107–114.
<https://doi.org/10.7205/milmed-d-12-00131>

Gradus, J. (n.d.). Epidemiology of PTSD. *US Department of Veterans' affairs*.
[https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp#:~:text=The%20NCS%2DR%20estimated%20the,%25%20among%20women%20\(3\).](https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp#:~:text=The%20NCS%2DR%20estimated%20the,%25%20among%20women%20(3).)

Hoggatt, K. J., Lehavot, K., Krenek, M., Schweizer, C. A., & Simpson, T. (2017). Prevalence of substance misuse among US veterans in the general population. *The American journal on addictions, 26*(4), 357–365

Iovine-Wong, P. E., Nichols-Hadeed, C., Thompson Stone, J., Gamble, S., Cross, W., Cerulli, C., & Levandowski, B. A. (2019). Intimate partner violence, suicide, and their overlapping risk in women Veterans: A review of the literature. *Military medicine, 184*(5-6), e201–e210

Kimerling, R., Iverson, K. M., Dichter, M. E., Rodriguez, A. L., Wong, A., & Pavao, J. (2016).

Prevalence of intimate partner violence among women veterans who utilize Veterans Health Administration primary care. *Journal of General Internal Medicine*, 31(8), 888-894

McCall, J. D., & Pomerance, B. (2019). Veterans Treatment Courts. In *Intersections between Mental Health and Law among Veterans* (pp. 89-110). Springer, Cham

Metraux, S., Clegg, L. X., Daigh, J. D., Culhane, D. P., & Kane, V. (2013). Risk factors for becoming homeless among a cohort of veterans who served in the era of the Iraq and Afghanistan conflicts. *American Journal of Public Health*, 103(S2), S255-S261

Military Sexual Trauma. (2020, November). Retrieved from:

https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

Muhuri, P. K., Gfroerer, J. C., Davies, M. C. (2013). Associations of nonmedical pain reliever use and initiation of heroin use in the United States. *National Institute on Drug Abuse*

Petrakis, I. L., Rosenheck, R., & Desai, R. (2011). Substance use comorbidity among veterans with posttraumatic stress disorder and other psychiatric illness. *The American journal on addictions*, 20, 185–189

Sexton, M. B., Raggio, G. A., McSweeney, L. B., Authier, C. C., & Rauch, S. A. (2017).

Contrasting gender and combat versus military sexual traumas: Psychiatric symptom severity and morbidities in treatment-seeking veterans. *Journal of Women's Health*, 26(9), 933-940

- Suris, A., Lind, L., Kashner, T. M., & Borman, P. D., (2007). Mental health, quality of life, and health functioning in women veterans: Differential outcomes associated with military and civilian sexual assault. *Journal of Interpersonal Violence*; 22: 179-197
<https://doi.org/10.1177/0886260506295347>
- Thomas, K. A., Goodman, L., & Putnins, S. (2015). "I have lost everything": Trade-offs of seeking safety from intimate partner violence. *American Journal of Orthopsychiatry*, 85(2), 170–180. <https://doi.org/10.1037/ort0000044>
- Tsai, J. & Rosenheck, R. A. (2015). Risk factors for homelessness among U.S. Veterans. *Epidemiological Review*, 37(1), pp. 177-195
- Tsai, J., & Rosenheck, R. A. (2013). Conduct disorder behaviors, childhood family instability, and childhood abuse as predictors of severity of adult homelessness among American veterans. *Social psychiatry and psychiatric epidemiology*, 48(3), 477-486
- Tsai, J., & Rosenheck, R. A. (2013). Examination of Veterans' affairs disability compensation as a disincentive for employment in a population-based sample of veterans under age 65. *Journal of Occupational Rehabilitation*, 23(4), 529-546
- Tsai, J., & Rosenheck, R. A. (2018). Risk factors, service delivery, and prevention of Veteran homelessness. In *Military and Veteran Mental Health*, 183-195. Springer, New York, NY
- Tsai, J., Szymkowiak, D., & Pietrzak, R. H. (2020). Delayed homelessness after military discharge: Examination of a sleeper effect. *American Journal of Preventive Medicine*
- Williams, E. C., Frasco, M. A., Jacobson, I. G., Maynard, C., Littman, A. J., Seelig, A. D., Crum-Cianflone, N. F., Nagel, A., & Boyko, E. J. (2015). Risk factors for relapse to

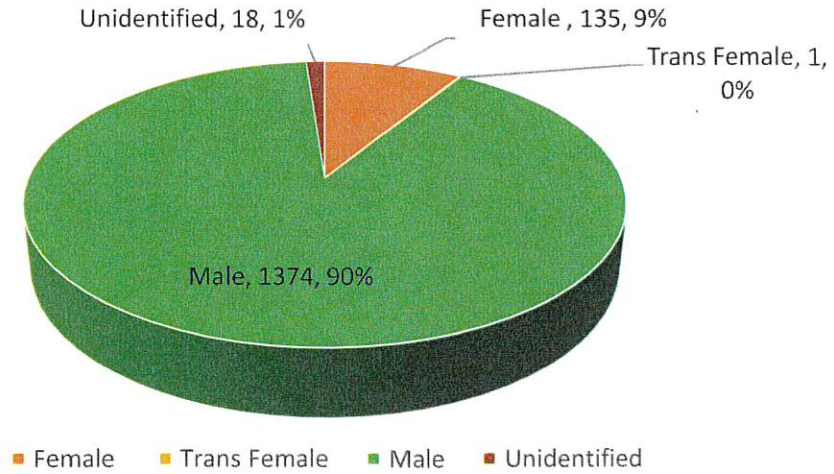
problem drinking among current and former US military personnel: A prospective study of the Millennium Cohort. *Drug and alcohol dependence*, 148, 93–101

Yu, B., Montgomery, A. E., True, G., Cusack, M., Sorrentino, A., Chhabra, M., & Dichter, M. E. (2020). The intersection of interpersonal violence and housing instability: Perspectives from women veterans. *American journal of orthopsychiatry*, 90(1), 63

Zoroya, G. (2014). Up to 48,000 Afghan, Iraq vets at risk for homelessness. *USA Today*. January 17, 2014; (Accessed March 11, 2020)
<https://www.usatoday.com/story/news/nation/2014/01/16/veterans-homeless-afghanistan-iraqwars/4526343/#:~:text=Nearly%2050%2C000%20Iraq%20and%20Afghanistan,the%20Department%20of%20Veterans%20Affairs.>

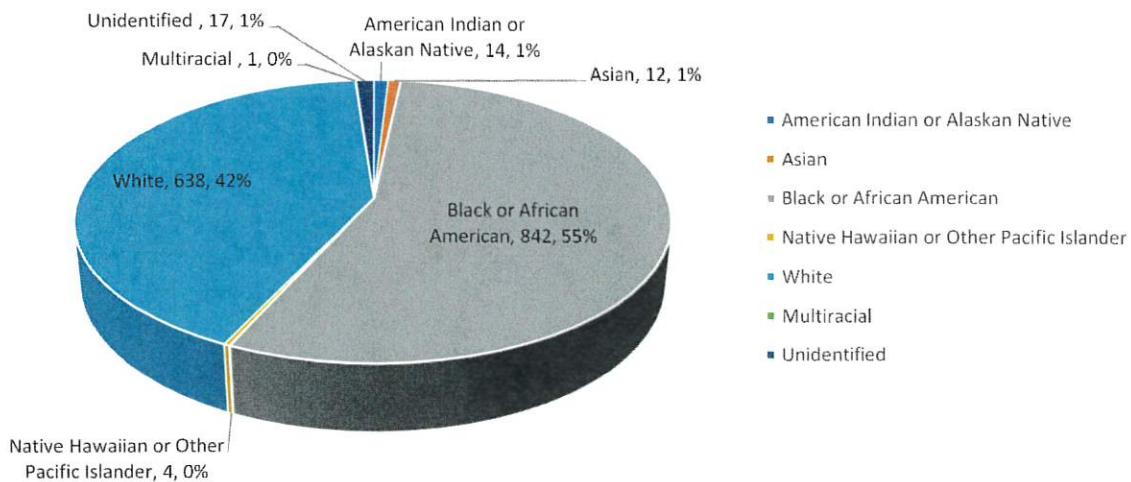
Homeless Veteran Data Figures

Homeless Veteran Gender Breakdown



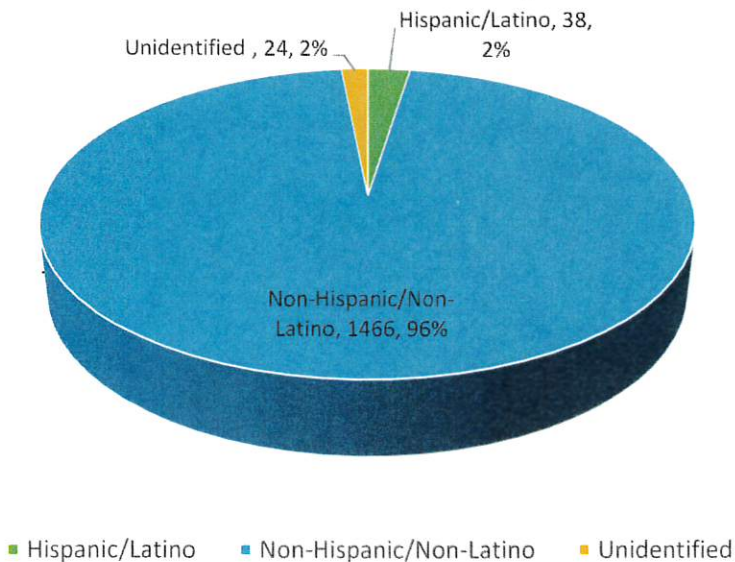
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Homeless Veteran Racial Breakdown



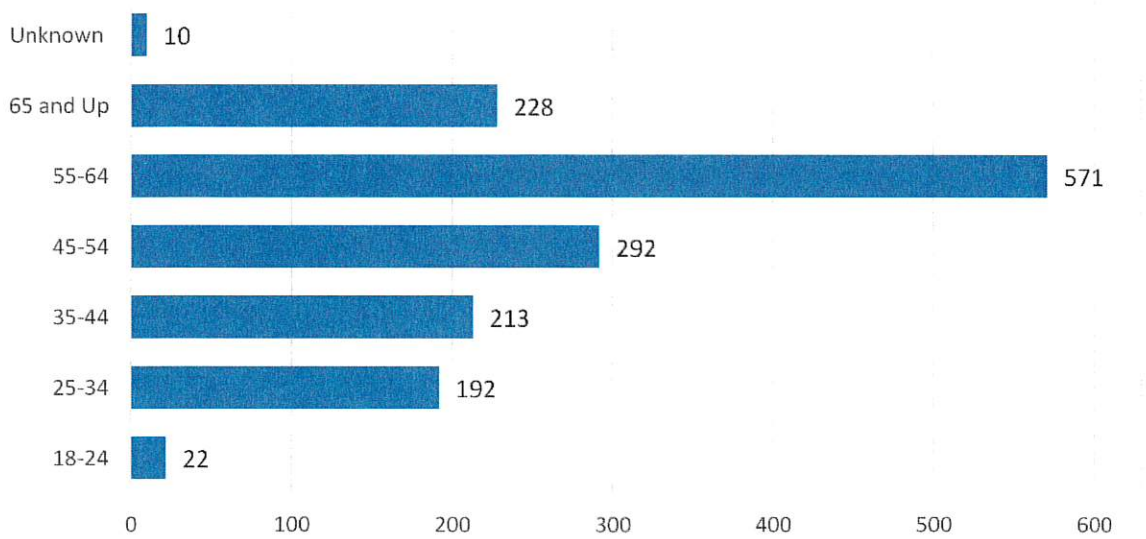
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Homeless Veteran Ethnicity Breakdown



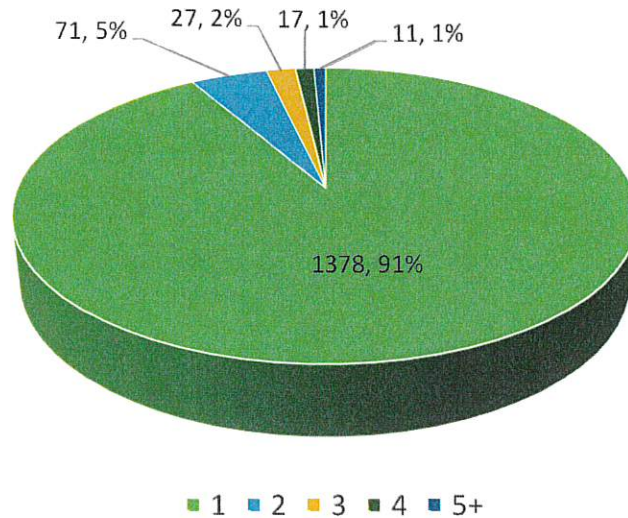
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Homeless Veteran Age Range



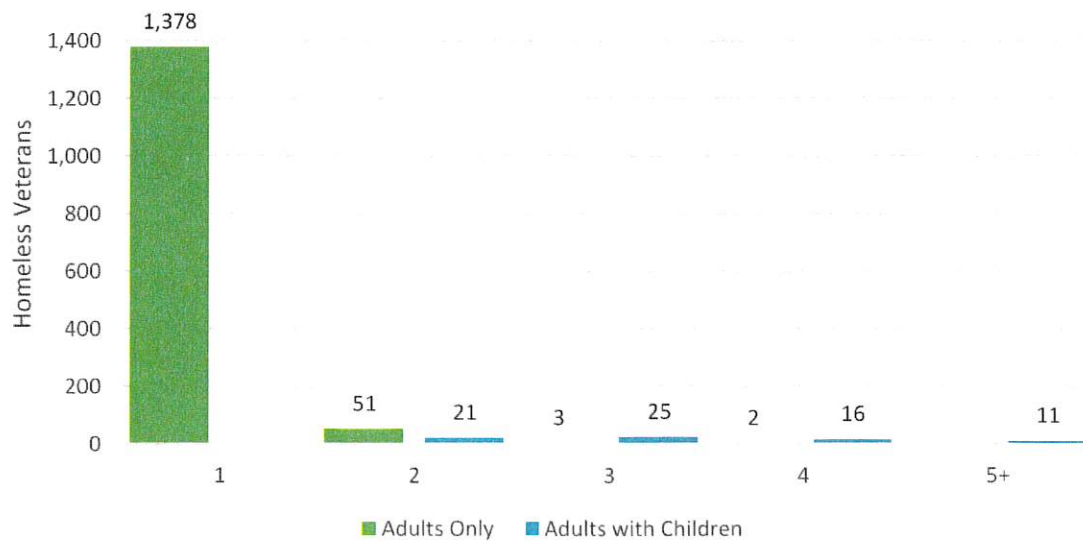
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Household size



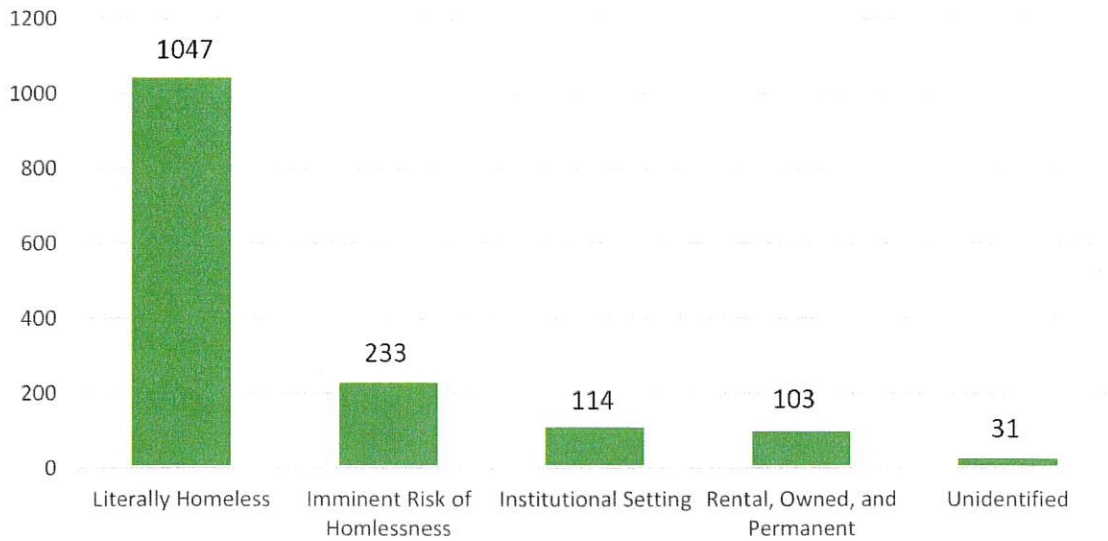
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Household Composition



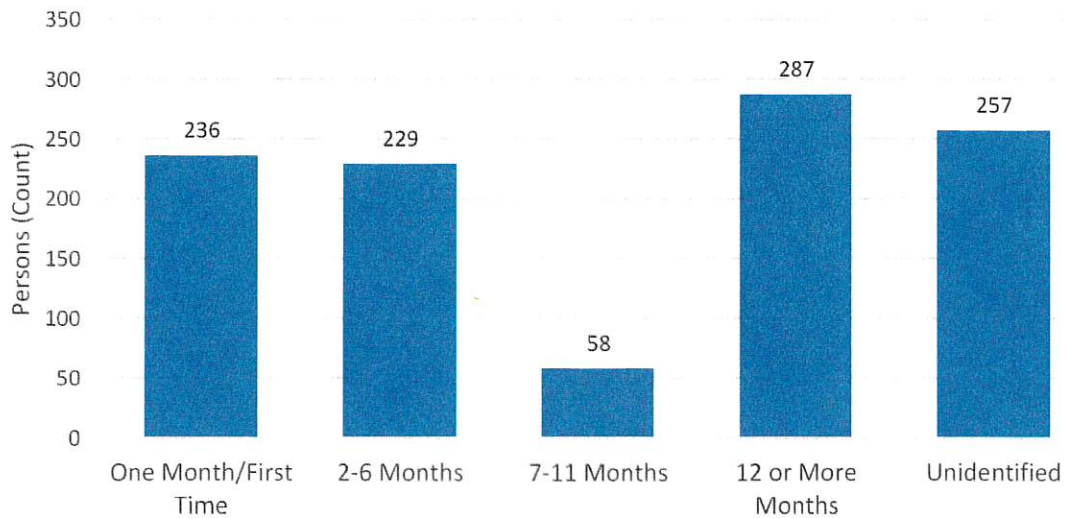
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Prior Living Situation



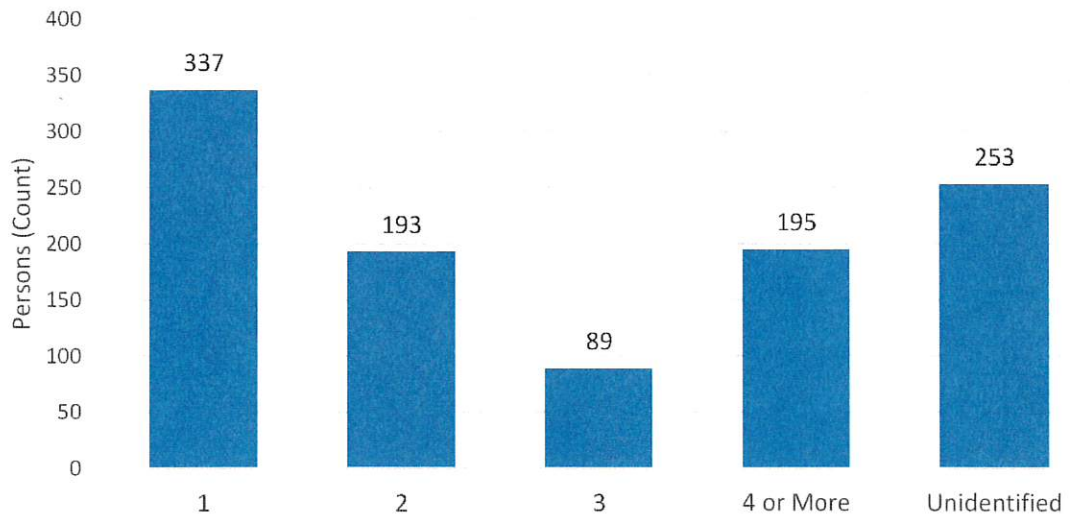
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Length of Time Experiencing Homelessness in Last 3 Years



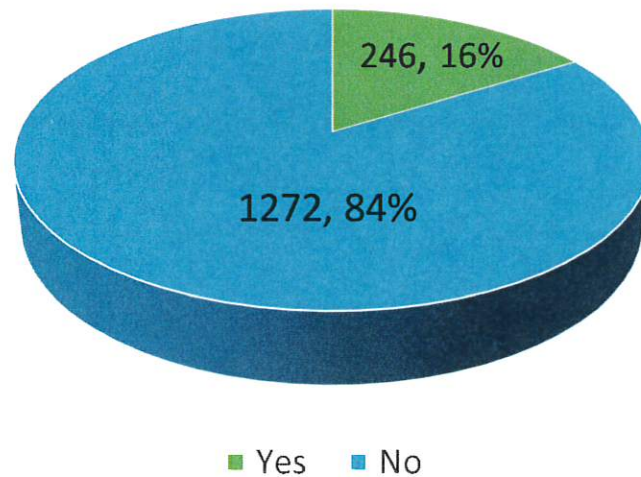
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Number of Homelessness Episodes in the Last 3 Years (Prior Living Situation Literally Homeless)



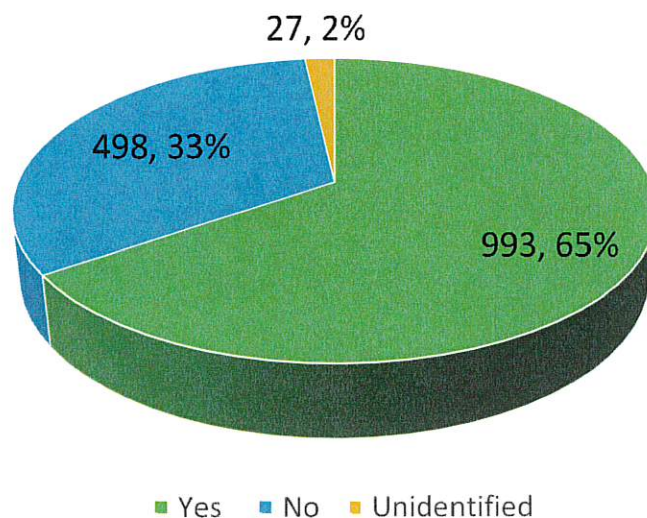
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Experienced Chronic Homelessness



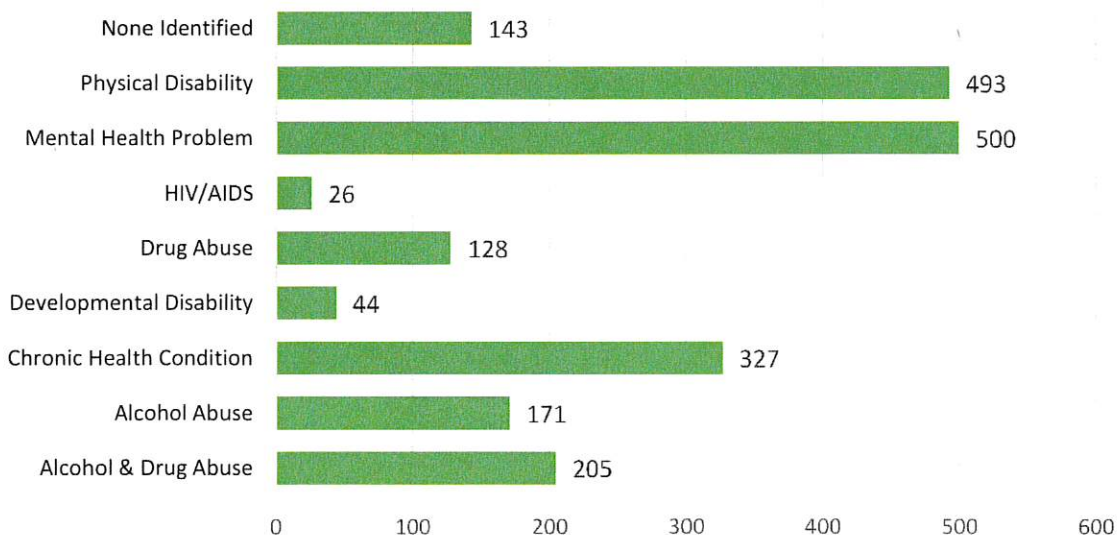
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Disabling Condition



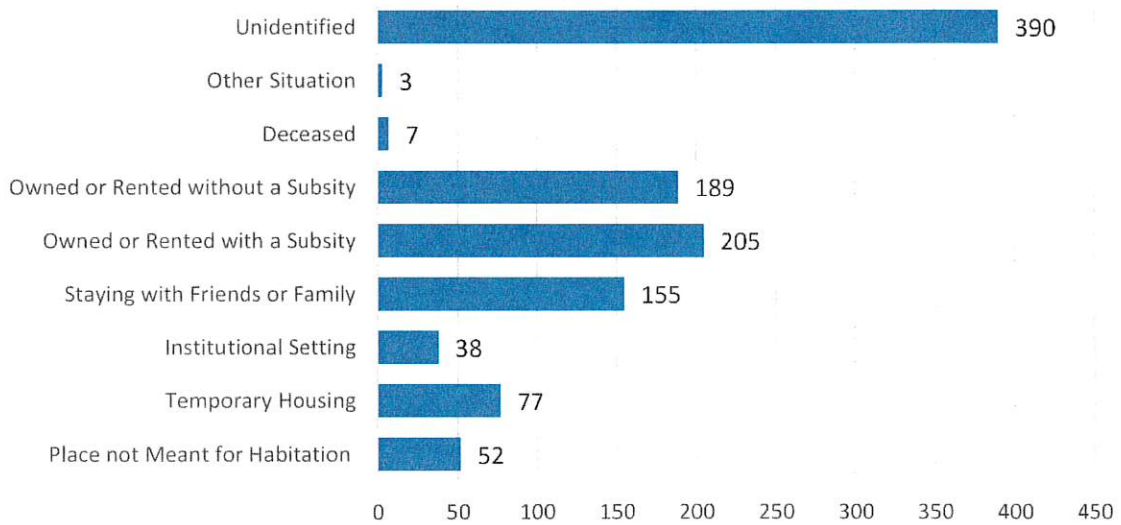
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Disabling Condition Types



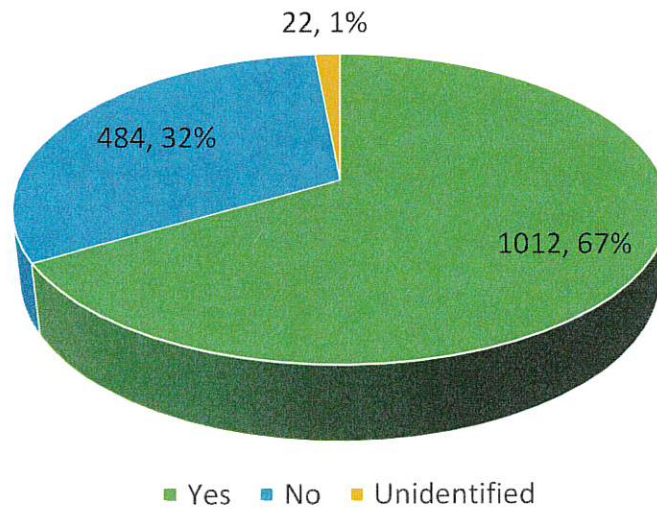
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Exit Destinations



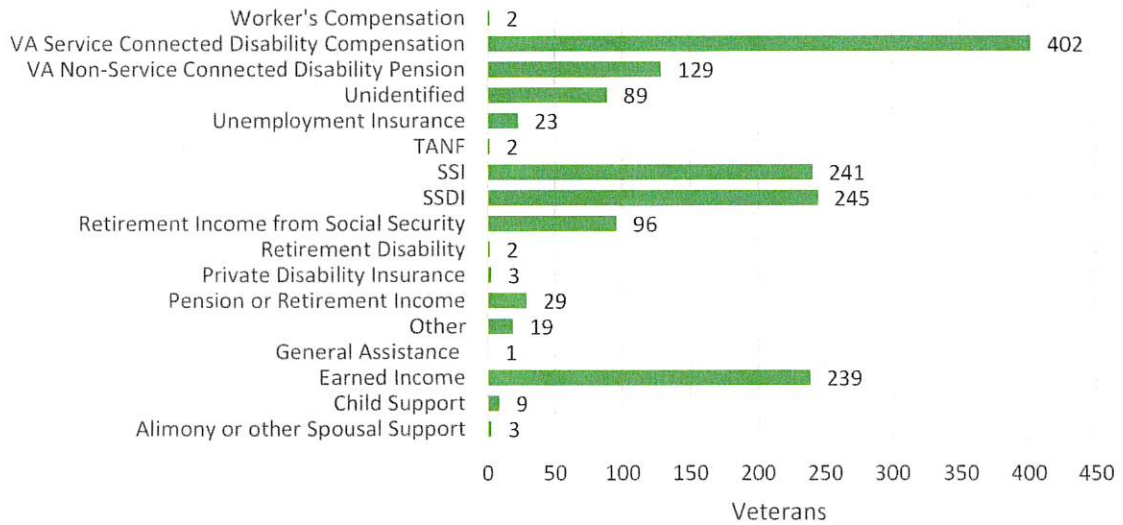
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Receiving Income (Adults Only)



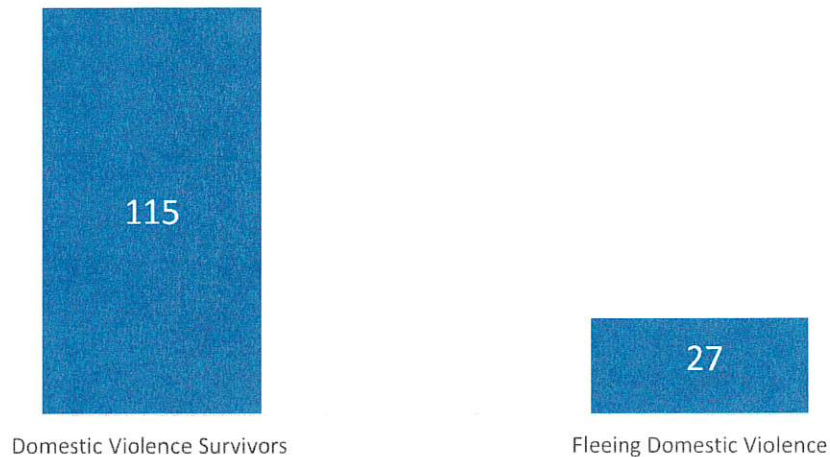
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Sources of Income



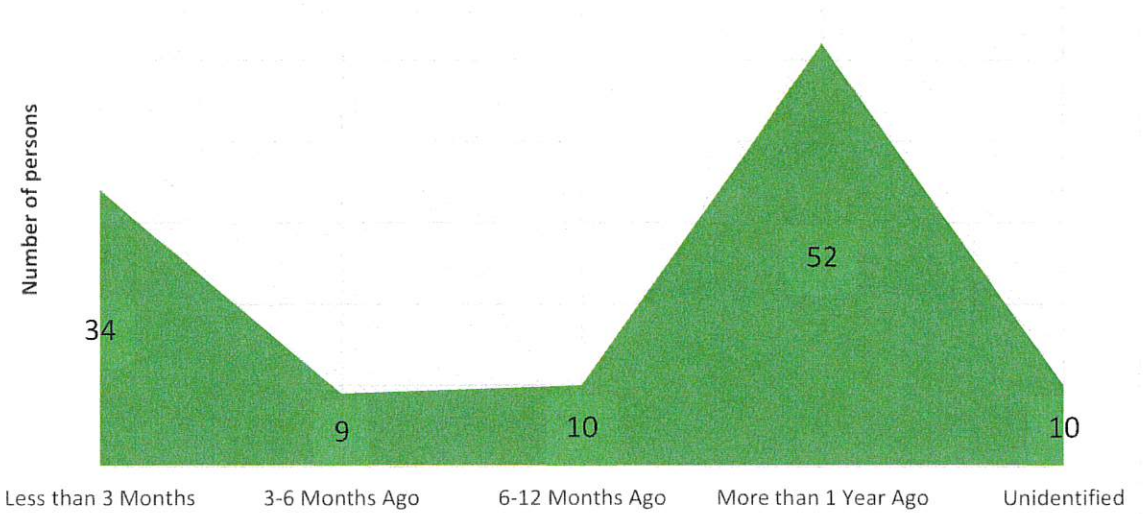
Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

Domestic Violence Experience



Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

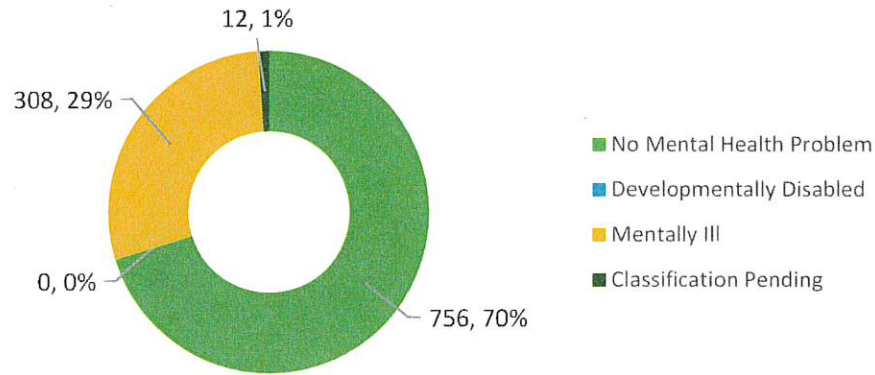
When Domestic Violence Occurred



Note: Data for this figure was gleaned from the 2020 SC HMIS data report; a compilation of data from the four continuums of care in South Carolina.

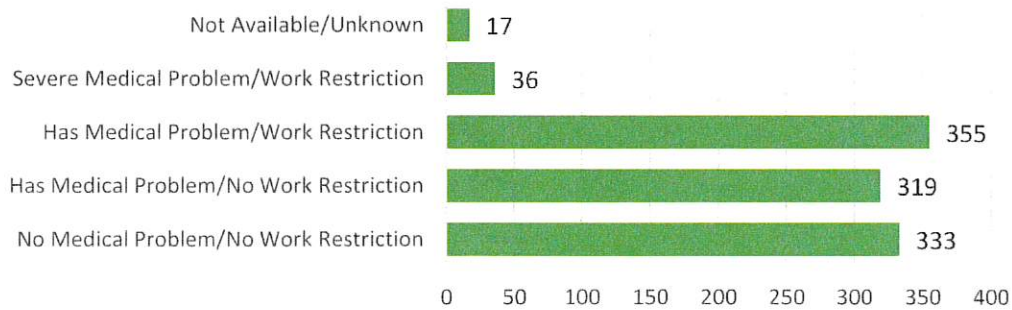
Military Service Inmates in Institutional Count Figures

Mental Health Classification



Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

Medical Classification



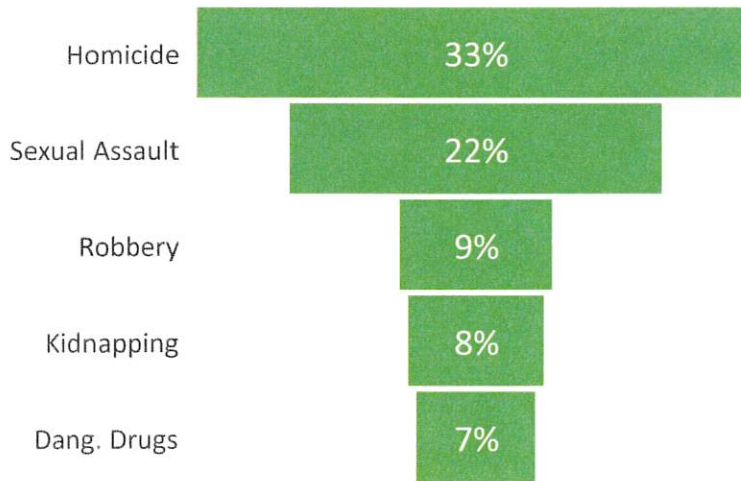
Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

Top 5 Comitting Counties



Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

Leading Most Serious Offense



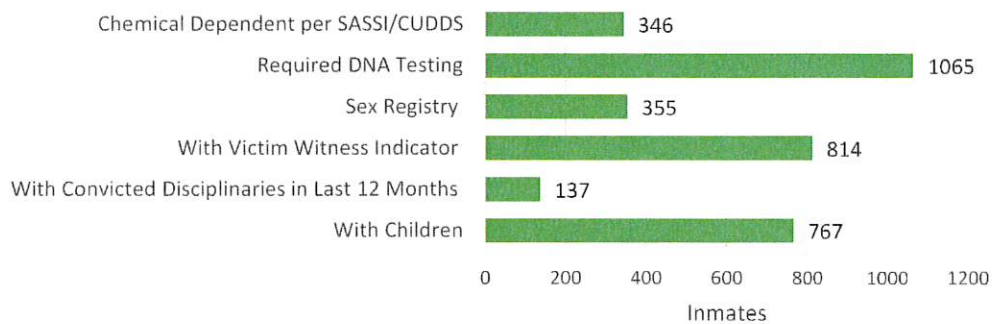
Note: To facilitate statistical reporting, SCDC determined a single "most serious offense" (MSO) for each inmate.. Effective August 2005, inmates' MSO is the offense with the highest severity level (i.e. offenses are classified between severity level 1 and 5, with 5 as the most severe). In cases where an inmate has multiple offenses at the same severity level, SCDC considers the category of each offense, where homicide offenses take precedence, followed by sex offenses and violent offenses. If multiple offenses exist within the same category, the offense with the longest sentence then determines MSO.

INMATE EDUCATION

Average Education Level at Intake	12.0
Without HS/GED	203, 19%

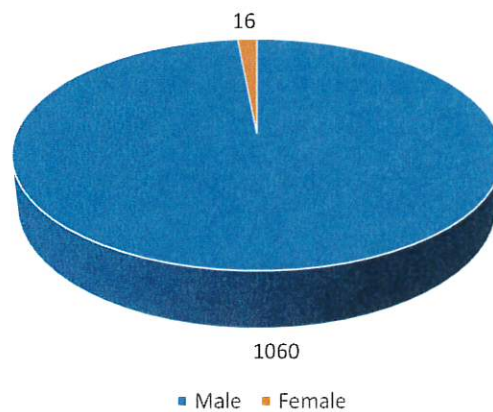
Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076. Education status is based on inmate self-reported information at intake.

Special Needs



Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

SC Total Veteran Inmate Population



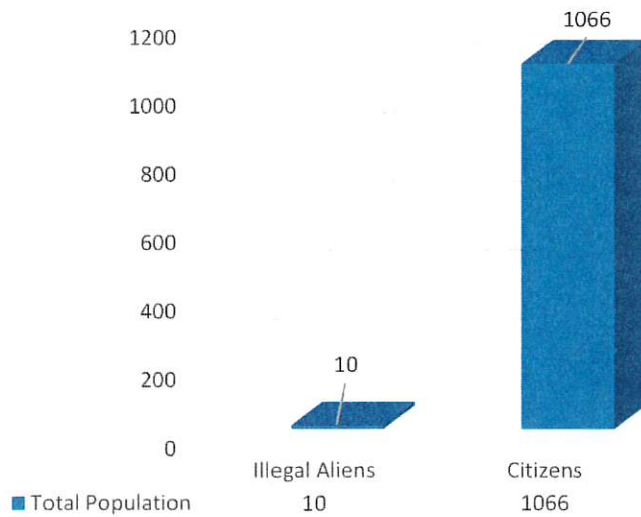
Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

SC Veteran Inmate Racial Breakdown



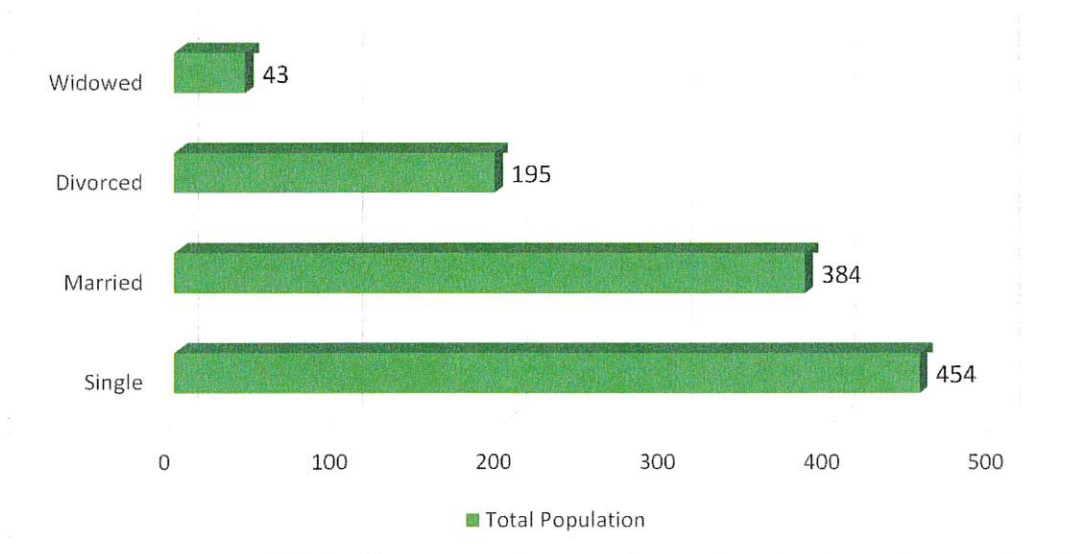
Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

US Veteran Inmate Citizenship Status



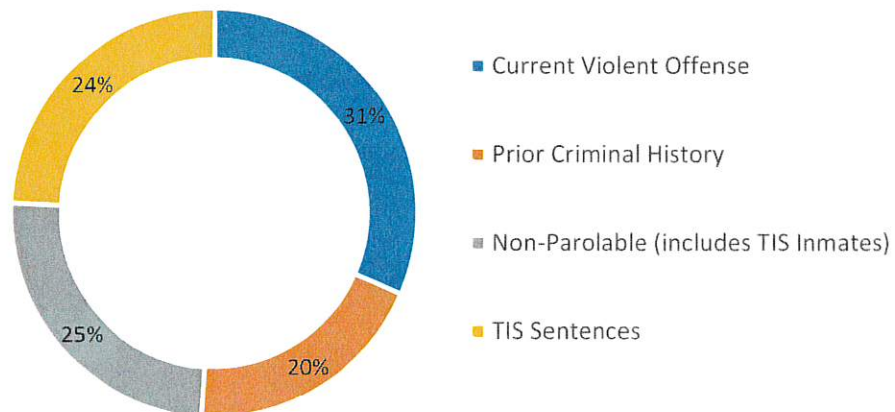
Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

Marital Status (Self-Reported)



Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

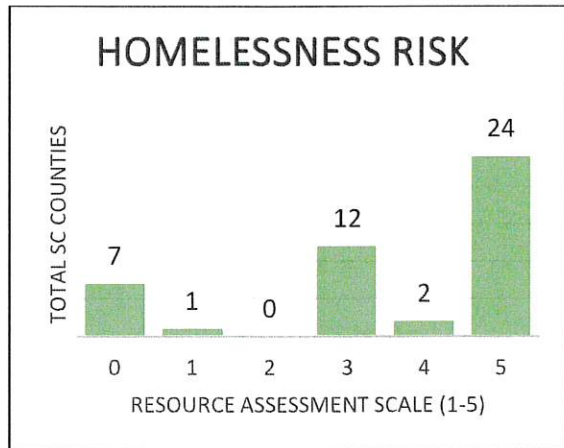
Sentencing Data/Criminal History



Note: Data Provided by South Carolina Department of Corrections. Profile of VA Verified and Self-Reported Military Service Inmates in Institutional Count as of December 14,2020. Total military service inmate population is 1,076.

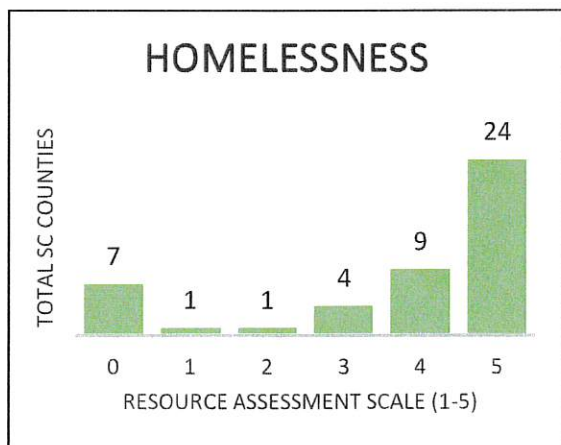
County Veterans' affairs Offices' Telephonic Interview- Data Figures

Q: What resources do you have available to you through your office or in your community to respond if Someone is at risk of losing their home?



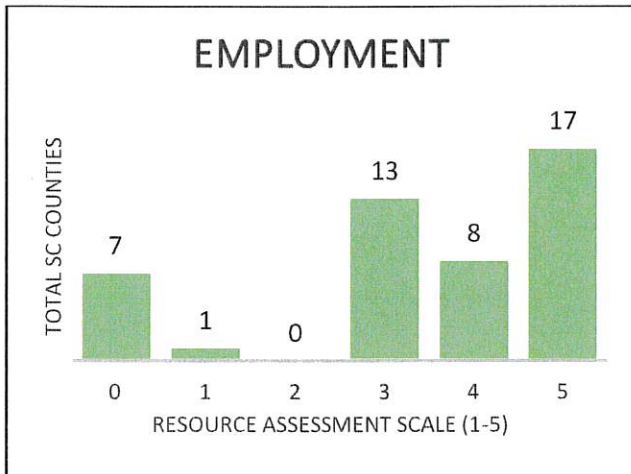
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Utilization of resources but bare minimum
4	Comprehensive – Utilization of a fair amount of resources
5	Extensive – Ample utilization of resources

Q: What resources do you have available to you through your office or in your community to respond If a client is homeless?



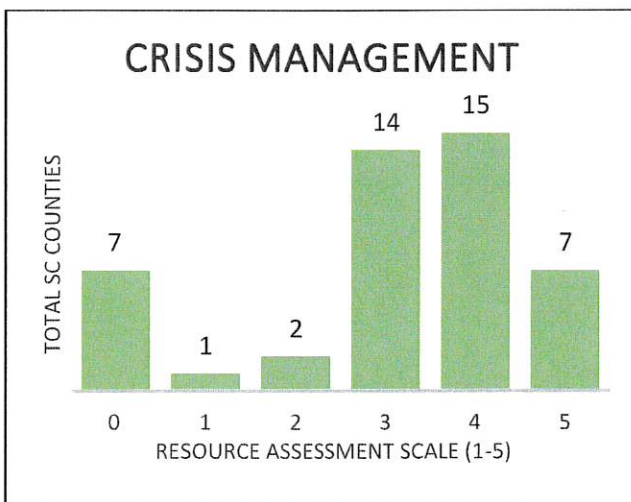
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Utilization of resources but bare minimum
4	Comprehensive – Utilization of a fair amount of resources
5	Extensive – Ample utilization of resources

Q: What employment resources do you have available either in your office or in your community?



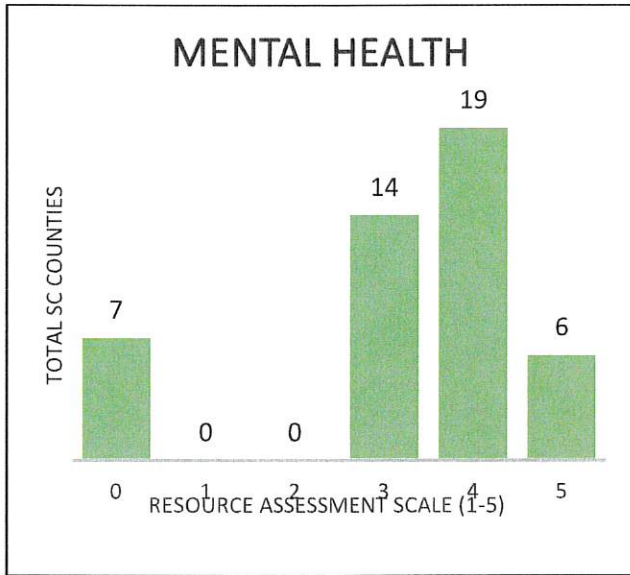
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Utilization of resources but bare minimum
4	Comprehensive – Utilization of a fair amount of resources
5	Extensive – Ample utilization of resources

Q: What crisis management interventions does your office have available through the community?



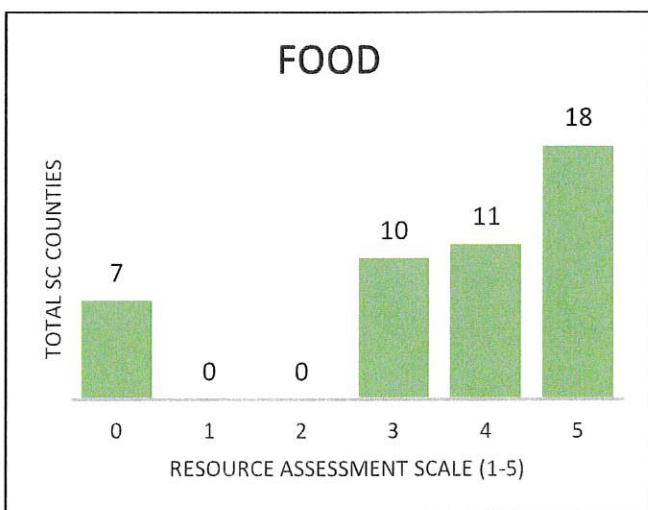
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Utilization of community connections but bare minimum
4	Comprehensive – Utilization of a fair amount of connections and resources
5	Extensive – Ample utilization of connections and resources

Q: How does your office hand and process mental health referrals for clients?



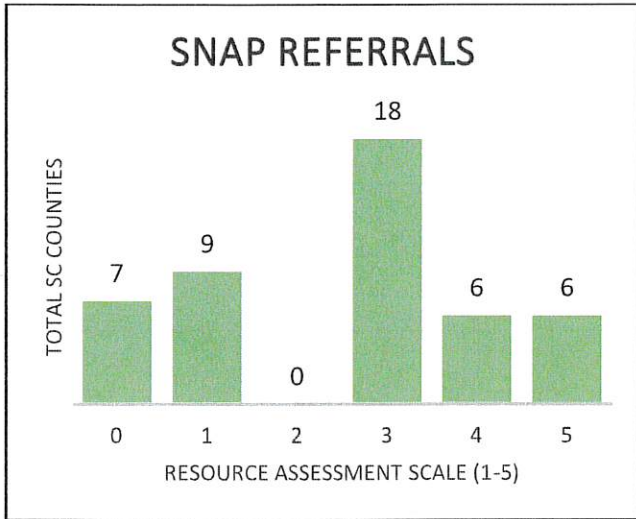
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Refer to VA Mental Health Program
4	Comprehensive – Use local Mental Facilities, Counselors, and the VA Mental Health Program
5	Extensive – Connections with and use of local Mental Health Counselors and Programs, as well as transportation to closest VA Mental Health Program

Q: What resources are available either through your office or in your community to provide food for clients not able to meet food resource needs?



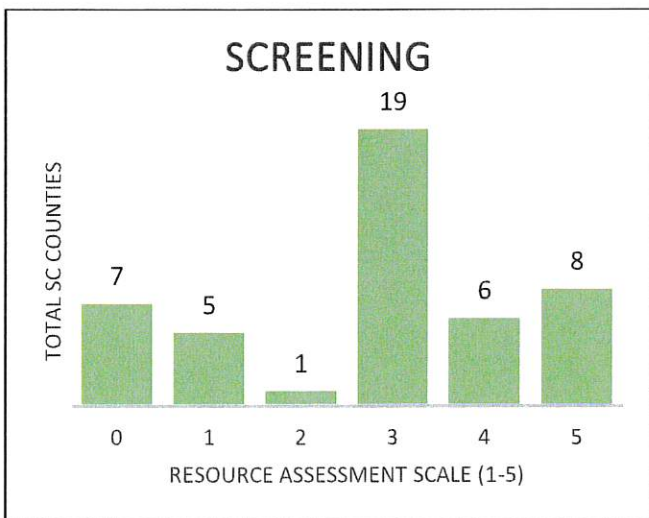
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Utilization of resources but bare minimum
4	Comprehensive – Utilization of a fair amount of resources
5	Extensive – Ample utilization of resources as well as resources in CVAO office

Q: How does your office handle SNAP referrals?



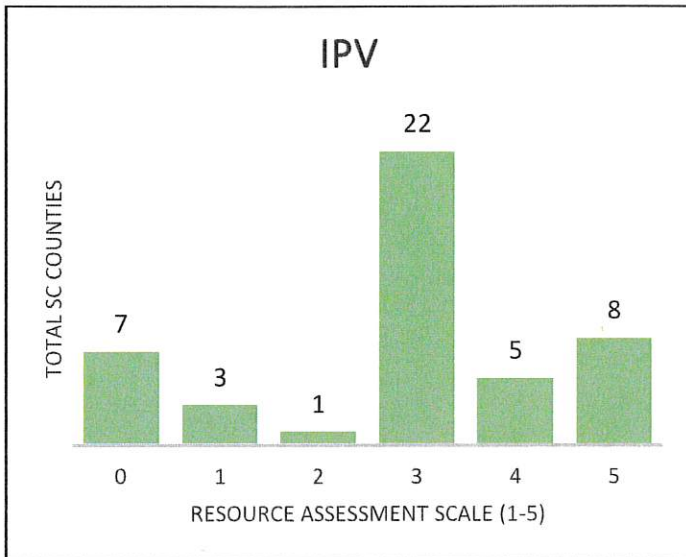
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Referral to DSS
4	Comprehensive – Have a direction connection with DSS
5	Extensive – Trained to do the paperwork, transport to DSS, and do a warm handoff to DSS

Q: What screening tools does your office have available for screening suicidality, homelessness, and exposure to intimate partner violence?



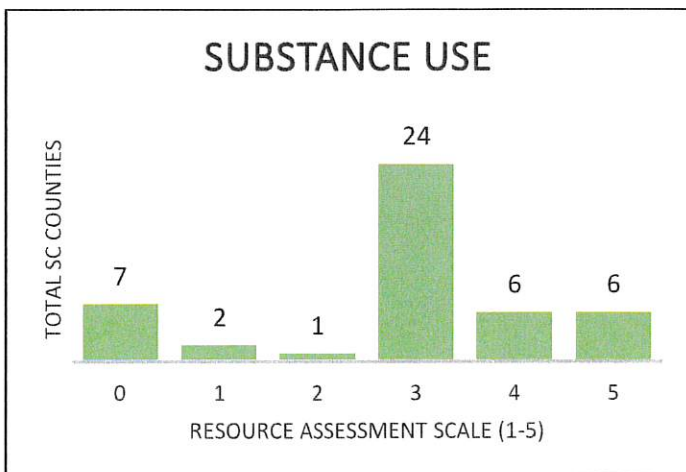
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have anything in place for screening
2	Limited – Referred to law enforcement or medical personnel
3	Adequate – CVAOs had a conversation with the individual
4	Comprehensive – CVAOs asked at least some intake questions of the individual
5	Extensive – CVAOs asked all necessary intake questions

Q: What resources does your office have available to refer clients to services for intimate partner violence?



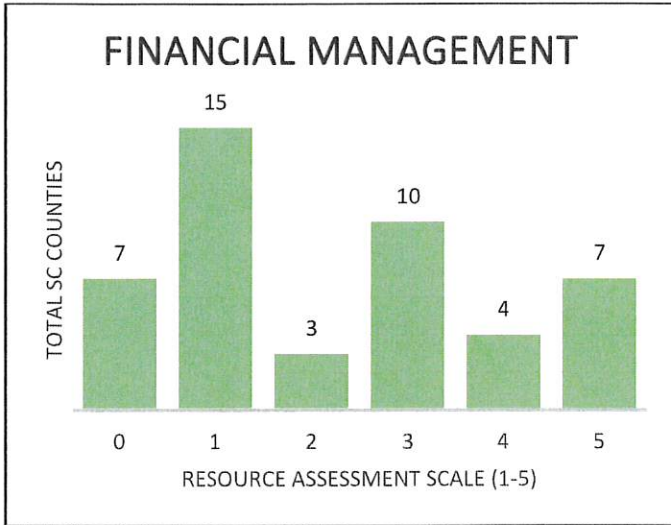
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have any resources
2	Limited – Referred to Law Enforcement
3	Adequate – Finding the individual a safe place to shelter
4	Comprehensive – Finding a safe place and referring the individual to appropriate agencies
5	Extensive – Transporting the individual to a safe place, contacting appropriate agencies for help, and conducting follow-up

Q: For clients requesting referrals for substance use what resources do you have available in your community?



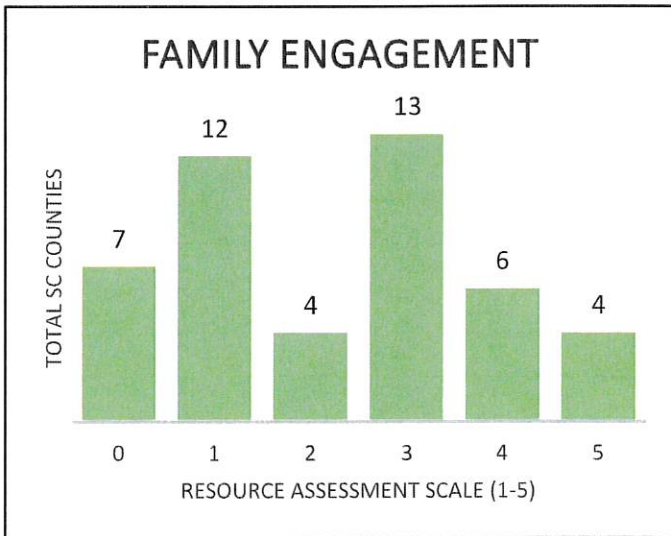
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – Have Resource but do not use it
3	Adequate – Utilization of resources but bare minimum
4	Comprehensive – Utilization of a fair amount of resources
5	Extensive – Ample utilization of resources

Q: What type of financial management resources does your office provide or have access to?



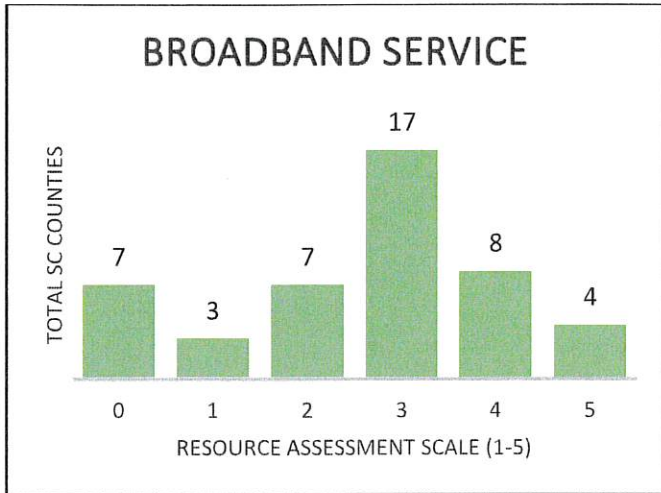
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have resources
2	Limited – CVAOs had a conversation with individual but had no one to refer to
3	Adequate – Referred to a local bank
4	Comprehensive – CVAOs have some training and a connection at a local bank
5	Extensive – CVAOs could provide counseling, classes, and referrals to organizations that could help

Q: What opportunities for veteran family engagement does your office offer?



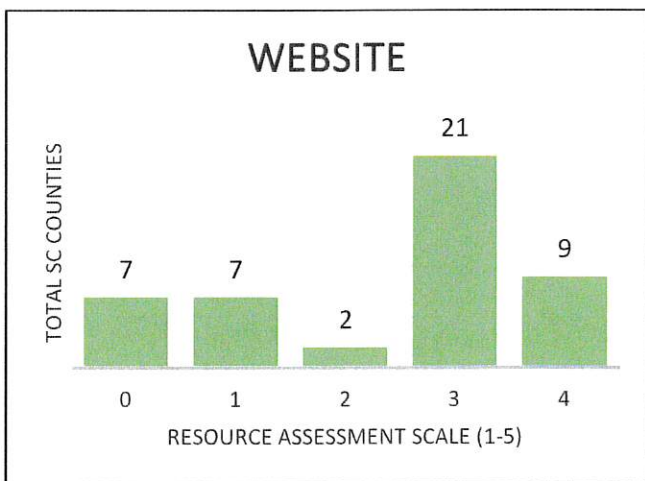
<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – No Veteran Family Engagement
2	Limited – Referred to Community Veteran Events
3	Adequate – Organized Veteran Family Engagement Events
4	Comprehensive – Organized Veteran Family Events, and provided resources specific to veteran families
5	Extensive – Create programs, events and resources for Veteran Families

Q: What are broadband services like in your area?



<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	None – Did not have Internet Connection
2	Limited – Had Very Poor Connection
3	Adequate – Good Connection in most of the County
4	Comprehensive – Good Connections and initiatives to improve areas with issues
5	Extensive – Great Coverage throughout the County

Q: Does your office have a website available where clients can access/find information on local community resources and VA resources available to them?



<u>Scale</u>	<u>Resources</u>
0	Non-Participant
1	No Website
2	Website – No list of resources
3	Website – A good amount of resources and links listed
4	Website – Extensive resources and links listed

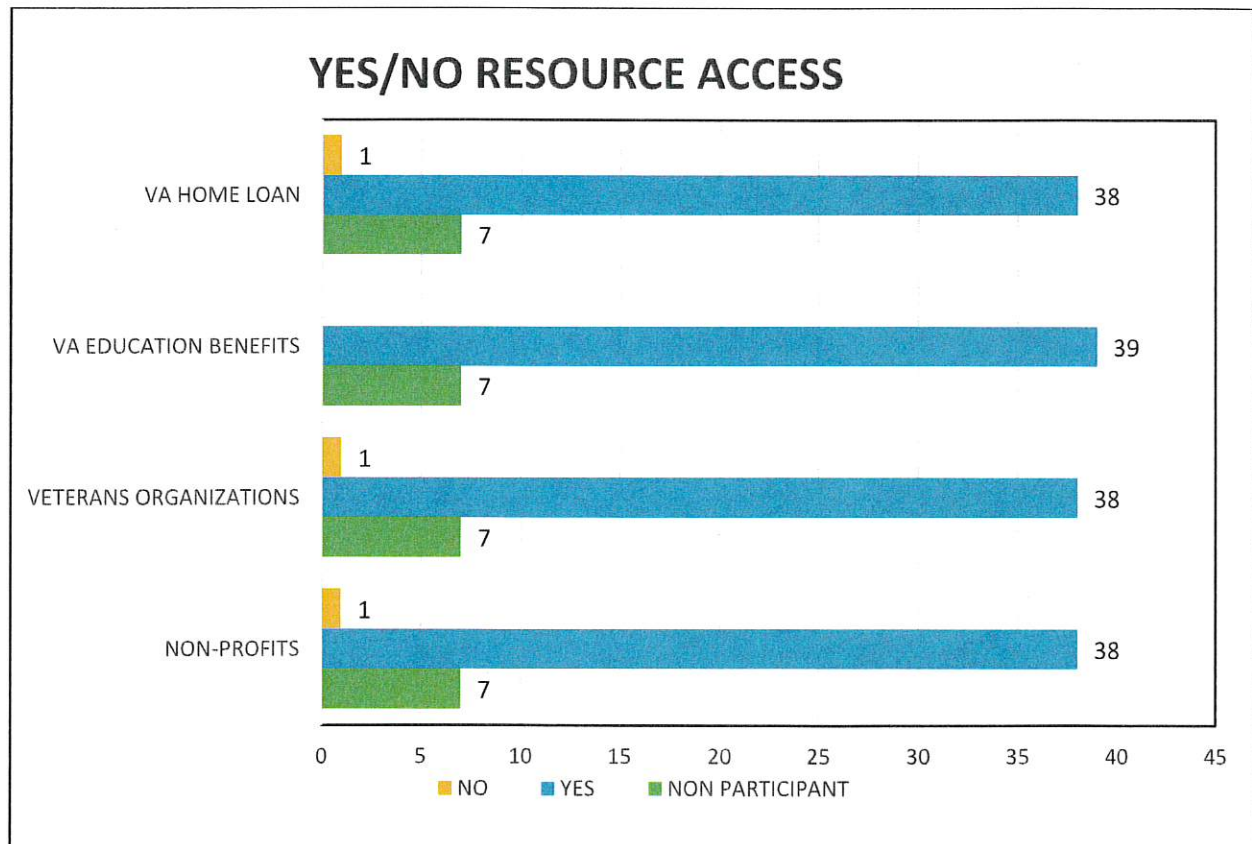
For this graph, four of the questions on the interview only required YES or NO answers. The questions will be listed in order from top of the graph to bottom.

Q1: Does your office have the ability to assist a veteran in getting appropriate documentation for a VA Home Loan?

Q2: Does your office have knowledge and ability to help a veteran apply for VA education benefits or know where to refer them for such help?

Q3: Does your office have information available on veteran service organizations active in your state or area?

Q4: Does your office have information available to visiting veterans on the different veteran focused Non-profits available in your area or the state?



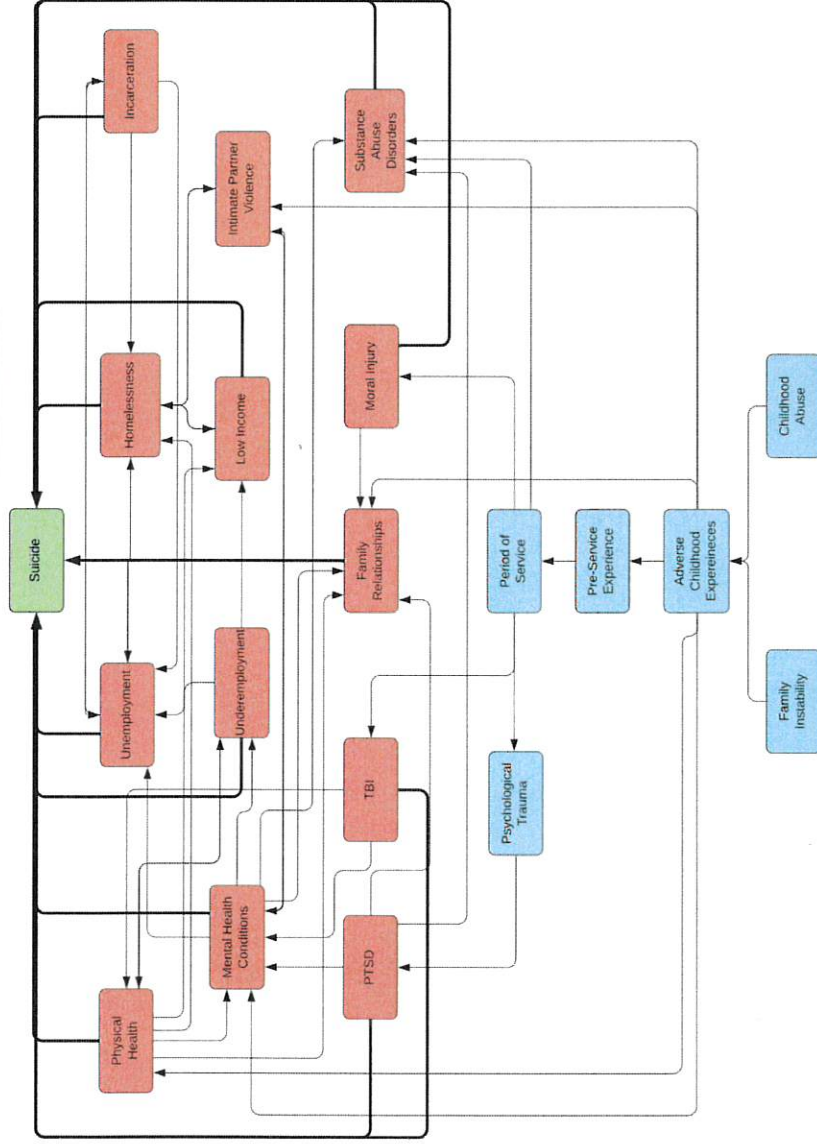
APPENDIX

Integrated Holistic Care:

A Service Model for the Veterans of South Carolina

Understanding the Core Challenge

The Complex Risk Environment of Today's Veteran



Key Concept: The Social Determinants of Health

This framework uses markers such as income, social support, education, employment, personal health practices, coping skills, addiction, food, and early life to practice and policy. Today, only 7-8 of 46 counties consistently respond to a majority of the social determinants of health to effectively mitigate risk and prevent adverse outcomes.

The Challenge:

The Complex Risk Environment

- There is no single root cause of Veteran issues; no “silver bullet” solution
- All Veterans have one or more risk factors in their lives
- All risk factors are interconnected and reinforcing
- Addressing any single risk factor in isolation offers little chance of success

The Solution:

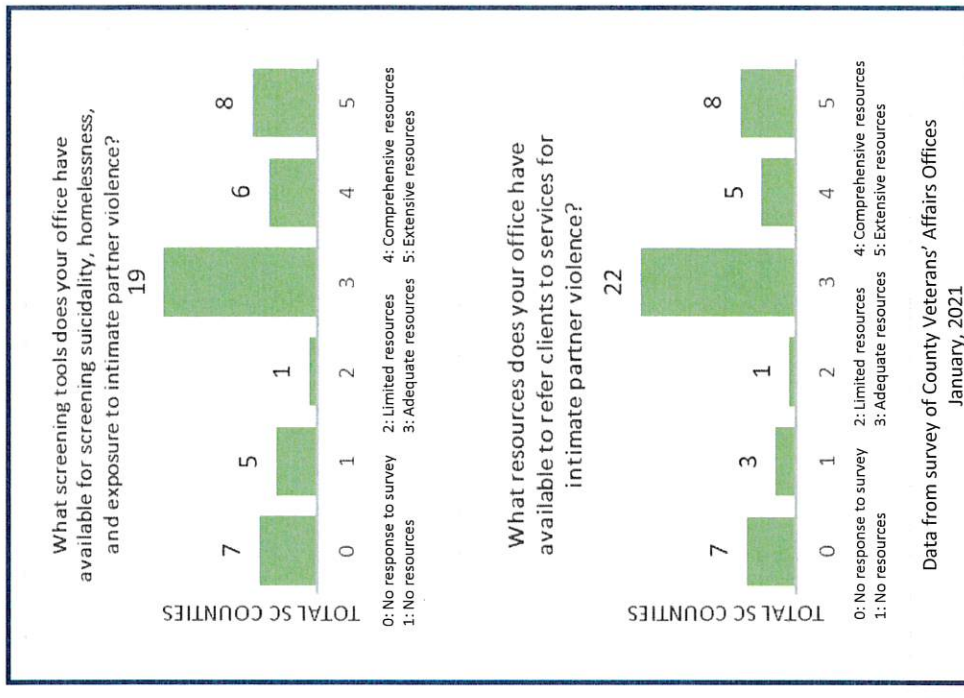
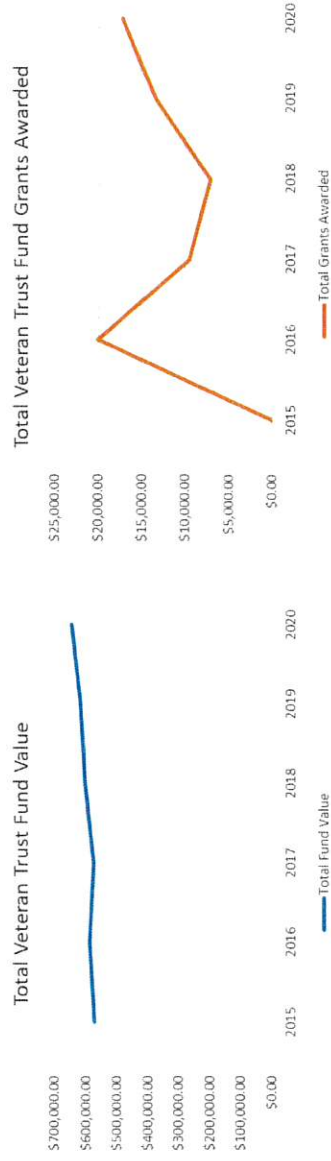
Holistic Risk Mitigation

- Address the social determinants of health across the entire life cycle of the Veteran population
- Integrate the efforts regardless of the source of such efforts
- Have clear goals and objectives for the Veteran population and regularly assess measures of performance and effectiveness to determine how services are affecting Veterans

Key Findings of the Study

1. Our current approach to Veteran service does not adequately address the social determinants of health.

- Although many agencies, organizations and individuals provide services to Veterans in South Carolina, they are not connected in a network that allows continuous collaboration and the efficient use of resources.
- Most County Veteran Affairs Offices are not trained or equipped to address Veteran needs across the social determinants of health.
- Veteran Treatment Courts offer an opportunity to mitigate one of the most difficult risk factors for Veterans, but are not employed across the state in a standard manner.
- The Veterans Trust Fund is not organized to serve as an incentive for non-governmental cooperation.



Recommendations

1. Expand South Carolina's Vision for Veteran care to encompass the Social Determinants of Health

- Task the SCDVA to develop a state-wide network of organizations that provide any service to Veterans that collectively address Veteran needs across all social determinants of health
- Task SCDVA to expand and standardize the scope of services provided at County Offices to address the full range of Veteran needs using a combination of government resources and a network of non-governmental partners
- Expand the use of Veteran Treatment Courts and standardize their practices across the state.
- Reorganize the Veteran Trust Fund to enable it to serve as a viable resource for non-governmental efforts to address the social determinants of health needs for Veterans

2. Integrate the efforts to aid Veterans across the state

- Develop a collaborative coalition of organizations (federal, state, non-profit, and private sector) with an interest in serving Veterans, operating with enough central direction to allow for the efficient use of resource and enough decentralized control to allow for local solutions to the unique challenges facing Veterans.
- Assign overall responsibility for the development and operation of this coalition to the SCDVA and resource the department accordingly.
- Establish a State Veteran Engagement Board, chaired by the Secretary of Veterans' Affairs, to serve as the central agency for coordinating goals and objectives for Veteran care in South Carolina
- Make County Veteran Affairs Offices part of the SCDVA
 - Assign responsibility for operation and oversight of County Offices to the Secretary of Veterans' Affairs
 - Make all County Office employees state employees
 - Incrementally transfer funding responsibility for County Offices from the counties to the State

Recommendations

3. Objectively measure Veteran service efforts

- Task SCDVA to identify, measure, and report specific measures of performance and measures of effectiveness that can be used to determine and track trends within the South Carolina Veteran population along all social determinants of health
- Task the SCDVA, in conjunction with the South Carolina's institutions of higher learning, to establish a long-term, annual study to monitor and report the condition of the South Carolina Veteran population along all social determinants of health

Post Traumatic Stress Disorder

Sources of Trauma During Military Service

- Military combat trauma: trauma originating from combat experiences
- Military sexual trauma: trauma originating from the experience of sexual assault or repeated, threatened sexual harassment experienced during military service
- Non-combat trauma: trauma originating from other sources during military service (examples include hazing, training accidents, etc.)

Prevalence of Post Traumatic Stress Disorder

- Healthcare professionals estimate 6.8% of the general population suffers from PTSD
- As much as 30% of the Veteran population may have PTSD
 - The exact prevalence for Veterans is unknown, but estimates range from as low as 10% to as high as 30%
 - Multiple studies have produced different results based on differences in sampling space and methodology
 - Because of differences in studies, it is impossible to compare PTSD prevalence by Veteran cohort

Military Sexual Trauma

- Produces a higher risk for the development of post traumatic stress disorder than other forms of military trauma (to include combat trauma) or even civilian sexual trauma
- Those experiencing military sexual trauma have more severe negative health outcomes and lower quality of life than those experiencing other forms of trauma, and are at greater risk for:
 - Depression
 - Dissociation
 - Anxiety
 - Thought disorders

Homelessness

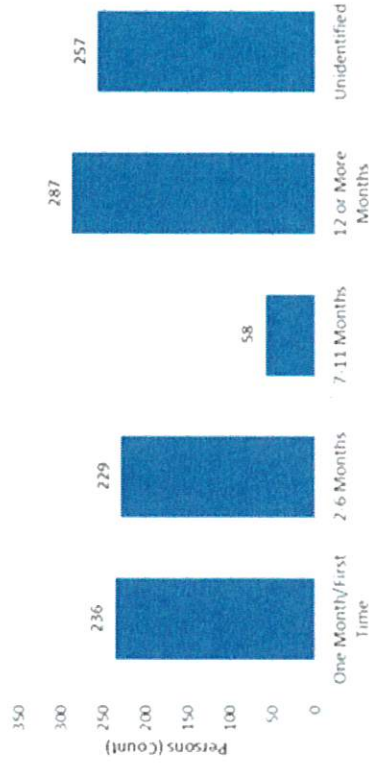
- Definition: Not having a nighttime residence that is regular, fixed, and adequate and includes moving frequently between different types of accommodations, risk of losing housing within 14 days, and staying in homeless shelters and places not meant for human inhabitants (e.g. vehicles, abandoned buildings)

	Housing Instability
Transitional	Small number of brief episodes of homelessness over a multi-year period
Episodic	More frequent episodes of homelessness and use of shelters, hospitals, and other institutions on an alternating basis
Chronic	Long periods without a nighttime residence that is regular, fixed, and adequate

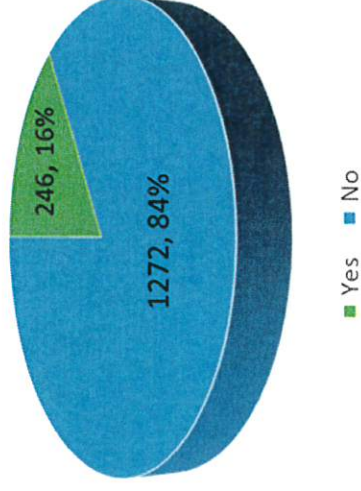
- Risk of homelessness varies by Veteran cohort

- Veterans of 1973-1983 are at highest risk
- Post-9/11 Veterans are at the lowest risk, but are likely to become homeless sooner after leaving service than any other cohort

Length of Homelessness Among Homeless Veterans



Prevalence of Chronic Homelessness Among Homeless Veterans

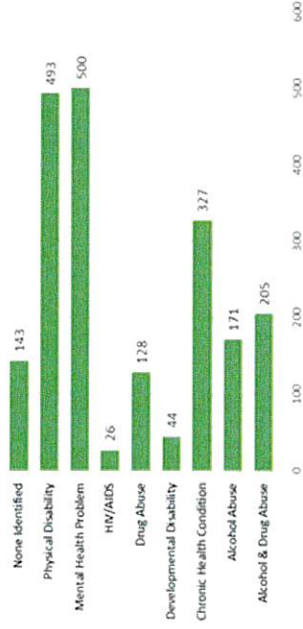


Common Risk Factors for Homelessness

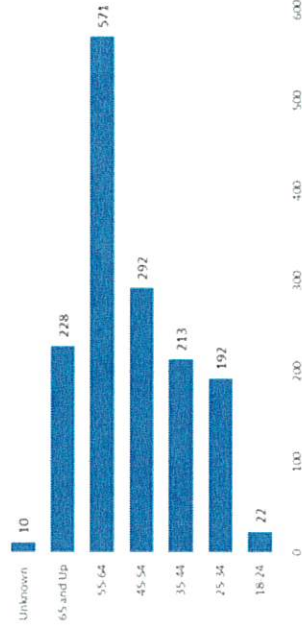
- Substance use disorders
 - Alcohol
 - Illegal drugs
 - Opiates
- Mental health conditions
 - Schizophrenia
 - Bi-polar disorder
- Chronic illness
- Employment and income
- Intimate partner violence
- Childhood experiences
- Low social support
- Incarceration

Contrary to common perception, combat exposure and post-traumatic stress disorder are not meaningful risk factors for homelessness.

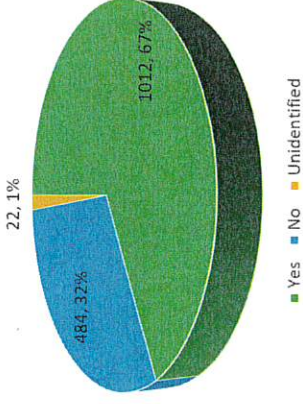
Disabling Conditions Among Homeless Veterans



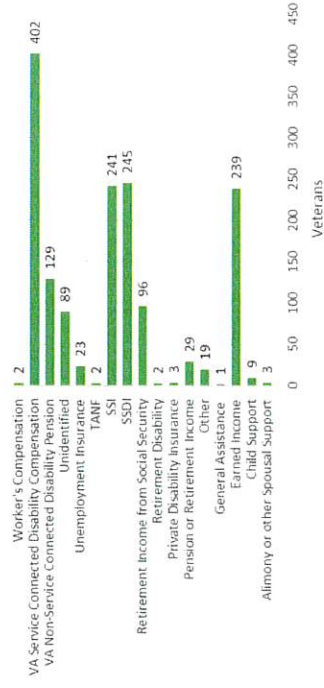
Age Range Among Homeless Veterans



Income Among Homeless Veterans

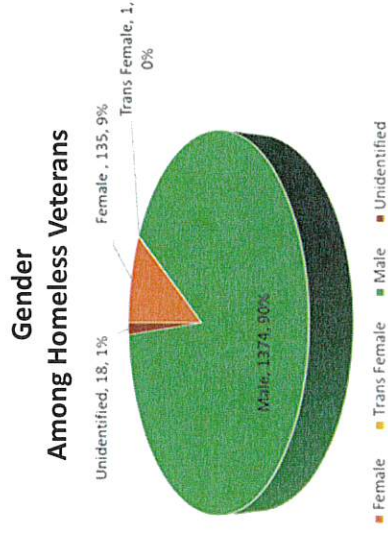
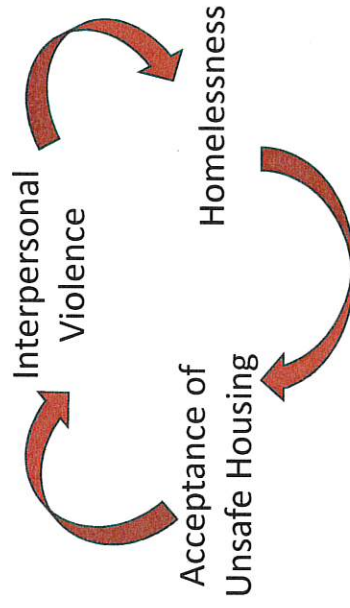


Sources of Income Among Homeless Veterans

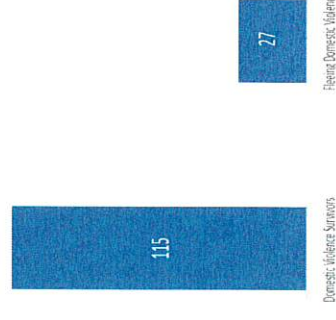


Unique Challenges of Female Veteran Homelessness

- There are fewer women in the Veteran homeless population, but women are overrepresented among homeless Veterans
- Women Veterans are 10% more likely to experience interpersonal violence than their civilian counterparts
 - 40.5% experienced IPV prior to military service
 - 58.9% experienced IPV during service
 - 67.2% experienced IPV after military service
- Interpersonal violence increases the risk of homelessness
 - Increases the risk of mental health issues
 - Increases the risk of losing a home (particularly to an abusive partner)



Experience in Interpersonal Violence Among Homeless Veterans



Data from continuum of care