By Sunita Patel, Maya Chaudhuri, and Will Ostrander*

I. INTRODUCTION

U.S. Department of Veterans Affairs (VA) hospitals and campuses were originally designed to meet the needs of veterans returning home from war, including medical care and community integration. In recent years, we have seen that there are barriers to achieving this goal. The VA has taken steps to address concerns with health care service delivery, particularly for unhoused and mentally ill veterans. However, harmful and unnecessary interactions with the VA Police Force, including police violence against veterans and medical staff, are a potentially significant barrier to veterans seeking healthcare and refuge on VA campuses. Without comprehensive data collection or policy transparency, the scope of the problem is largely unknown and appropriate solutions are difficult to develop.

In recent years, the federal government has responded to national outrage over the deadly delays some veterans face when seeking medical care from the VA. The VA and Congress have also expressed concern over mismanagement and inadequate governance of the VA Police Force. Both issues resulted in reports issued by the VA Office of the Inspector General (OIG) and Congressional Oversight Hearings. The OIG report on the VA Police Force focused on understaffing, lack of oversight, and a lack of centralized management. Despite the depth and breadth of these reports and hearings, there was minimal discussion of VA police officer practices, such as investigations, arrests, and use of force involving veterans on VA campuses. These prior investigations focused on increasing resources for the VA Police Force rather than interactions between VA police officers and veterans or medical staff. The comments and questions on these interactions interjected throughout the Congressional Oversight Hearing on the VA Police Force management indicate that this is a growing concern for legislators and their constituents. Interactions with VA police officers create a barrier to healthcare for many veterans and have been largely unexplored up to this point.

The advisory’s authors are concerned that harmful interactions with VA police across the country disproportionally impact minority and unhoused veterans because of the biased and potentially violent experiences they might have had with the VA Police Force. As a non-profit focused on serving minority veterans, the National Association of Minority Veterans (NAMVETS) is dedicated to ensuring that all veterans receive equal access to VA healthcare and benefits. The UCLA Veterans Legal Clinic provides legal services and advocates on behalf of particularly vulnerable veterans in Los Angeles. Similarly, these missions are consistent with the U.S. Department of Veterans Affairs’ mission to serve and honor our veterans. Veterans’ advocates and community providers understand that interactions with VA police officers can create barriers to healthcare for veterans, including access to life-saving suicide prevention resources. These experiences are corroborated by media reports and individual reports to NAMVETS and the UCLA Veterans Legal Clinic.
As the U.S. Department of Veterans Affairs considers how to improve the VA Police Force, it should seek to transform VA campuses, including medical facilities, into sanctuaries where veterans can seek refuge from the challenges they face after serving our country. The VA Police Force was created and expanded to protect populations on the VA campuses, including medical staff and other VA employees, in addition to veterans. But VA campuses can only be true places of refuge if they manage to increase security without sacrificing anyone’s safety. To further this goal, ending harmful or unnecessary interactions between VA police officers and veterans, as well as medical staff, should be a priority. As the VA Police Force undergoes reforms, including management changes and increased staffing, it would be perilous to our veterans to implement these changes without simultaneously prioritizing their safety.

Significant concerns with current VA Police Force practices merit further inquiry before steps are taken to grow the VA Police Force in size or to implement greater police surveillance systems on VA campuses. The OIG of the VA and the Congressional Committees on Veterans Affairs should immediately begin investigations into the policy, practices, and conduct of the VA Police Force. Any expansion of the VA Police Force should be halted during the investigatory period, and a focal point of the investigation should be the feasibility of reducing the size and statutory authority of the VA Police Force. As they consider changes to the VA Police Force, lawmakers and VA leadership will need to balance staff safety and veteran needs, though investigation might reveal that these priorities are not necessarily at odds. These investigations should aggregate data, as there currently is no centralized repository or reporting system for data on VA police officer interactions or subsequent criminal legal system consequences of these interactions, and provide recommendations in line with the mission of the VA.

The COVID-19 pandemic makes our inquiry more important than ever. Veterans have higher rates of co-morbidities than the general population, making them more vulnerable to the virus and at a higher risk of death when infected. There will be increased need for healthcare on VA campuses, and the VA is working to maintain services during the pandemic despite the challenges of virtual or remote healthcare. And there will simultaneously be increased populations living on VA campuses. For example, to address the challenges unhoused persons experience with practicing social distancing, the West LA VA is implementing new and innovative policies to provide mental health and social services while allowing veterans to reside on the campus. As more veterans stay on the campus, there will be more interactions between these residents and the VA police stationed near those areas on the campus. An investigation into VA Police Force practices is particularly urgent at this moment.

This advisory will (1) briefly describe the VA Police Force, (2) note four major concerns with the current state of the VA Police Force, and (3) call for data transparency and an investigation into VA police misconduct.

II. BACKGROUND

1. THE VA POLICE DEPARTMENT’S SCOPE AND AUTHORITY

The Department of Veterans Affairs Police Force provides security and law enforcement services to individuals on VA owned property throughout the United States. Approximately 4,000 VA police officers operate on about 1,200 VA healthcare facility and clinic properties, serving seven million patients and more than 388,000 employees. The size of the VA Police Force’s operations makes it one of “the 10 largest law enforcement workforces in the federal government.” While VA police officers also operate on the grounds of VA national cemeteries, they primarily patrol Veteran Health Administration (VHA) facilities and Veterans Benefits Administration offices associated with the VHA.

Federal law authorizes VA police officers to engage in a wide variety of security duties. Under 38 U.S.C. § 902, officers are empowered to enforce federal law as well as state and local traffic laws while on VA owned property. They may also conduct investigations on and off VA property into criminal activity originally occurring on VA property and effect arrests for the violation of any federal law. Additionally, they are authorized to carry firearms any time and any place they are acting in their official capacity. Section 902 also directs the VA Secretary to create regulations for the use of firearms, the exercise of enforcement and arrest authority, and the degree of training engaged in by VA police officers.

The VHA is primarily responsible for overseeing the daily activity of VA police officers. Under the VHA, the Deputy Under Secretary for Health for Operations and Management is responsible for “maintaining [a] sufficient number[] of officers on duty with proper equipment and supervision.” Through the Undersecretary’s...
oversight, VA police units have been established at 139 of the VA’s 141 medical facilities, with each facility’s unit being managed by its own police chief. Each police chief, in turn, reports to the director of the medical facility at which their unit operates. Responsibility for the VA police operations are then shared between the police chief and medical facility director. The VA police chief is tasked with “implementing legally and technically correct law enforcement practices and physical security operations,” while the medical director is tasked with “ensuring that law enforcement activities are accomplished in a legally and technically correct manner.”

2. A BRIEF HISTORY OF THE VA POLICE FORCE

While the current VA Police Force is a significant presence on and around VA facilities, this was not always so. When the Veterans Administration was established in 1930, security personnel had no delegated police power. Rather, their role was cabined to checking veterans in and out of VA properties and transferring those who had committed criminal offenses over to state and federal authorities.

That limited role began to change in the 1970s, when Congress awarded the VA Police Force full police power. Increased authority coincided with increased weaponization as officers began to carry batons and mace for their protection, though VA police officers were not authorized to carry firearms at this time.

In the 1990s, the VA Police Force saw a second wave of expansion. For the first time, officers were issued firearms, and their footprint in VA communities became significantly larger. Physical police offices were established on VA campuses, and officers increased their foot and bicycle patrols. Specialized police training programs were developed, and canine units were introduced to the repertoire of VA policing procedures.

Although some members of Congress expressed concerns over the introduction of new weaponry to the VA Police Force’s arsenal, their concerns were largely ignored. By 2003, the entire VA Police Force was fully armed with firearms.

III. CONCERNS AROUND CURRENT PRACTICES

The VA Police Departments, like many police departments throughout the United States, implement a number of practices designed to maximize their presence within their jurisdictional reach. VA police officers are peculiar, however, with respect to where that jurisdictional reach typically extends. Because the VA Police Department almost invariably operates on and around VA owned medical facilities, their presence (and the procedures that come with it) imposes unique burdens on veterans seeking medical care. These burdens, several of which are explored below, can put to veterans a difficult and unfair choice: potentially expose oneself to undue police scrutiny or forgo high quality VA provided medical care altogether.

1. THE USE OF BIASED POLICING PRACTICES BY THE VA POLICE FORCE

The goal of transforming VHA facilities into sanctuaries for veterans seeking healthcare is undermined by the profiling that minority and unhoused veterans experience when engaged with VA police officers. NAMVETS has documented examples from its membership in which VA police have targeted Black veterans. First, VHA staffers are more likely to perceive Black veterans seeking medical care as “intimidating” and initiate internal security protocols that increase interactions with the VA police at subsequent visits to medical facilities. Second, NAMVETS members report that the VA police more heavily scrutinize and surveil Black veterans, drawing a greater number of traffic violations than white veterans and, thus, incurring greater economic costs when visiting VA property. Finally, when these interactions with VA police occur, Black veterans are more likely to experience force than white veterans.

Unhoused veterans are also at risk of biased policing practices when on VA property. For example, VA police officers are authorized to question the occupants of vehicles parked on VHA campuses “during non-visitation hours” and to direct their removal when occupants “cannot present a valid reason for their presence.” As a result of such policies, veterans who live in their vehicles may be required to justify their presence on VA property in a manner the general public is not. This would expose unhoused veterans to a higher number of police interactions than the general public. And it potentially exacerbates the over-policing that unhoused communities already experience.
Despite clear evidence of a problem, however, current VA record keeping obscures the degree to which profiling is employed at VHA sites. Nor is there any publicly available data regarding the socioeconomic and racial composition of veterans arrested, ticketed, or otherwise engaged by the VA Police Force. Indeed, it is uncertain whether the VA Police Force even documents the race or housing status of the veterans with whom they interact on a daily basis. This data gap presents challenges when attempting to identify the precise nature of profiling on VHA campuses and blocks the path toward solutions.

2. THE USE OF EXCESSIVE FORCE AT VA FACILITIES

VA police excessive force cases raise concerns about the safety of veterans seeking healthcare on VHA campuses. Those cases have sporadically entered public consciousness, garnering national attention in some instances. For veterans subjected to this force, the consequences have been severe, ranging from serious injury to PTSD to even death. Interactions with law enforcement occasionally become violent when officers use force despite the lack of any underlying criminal behavior. These encounters sometimes generate “cover charges”: accusations by an officer that an arrestee engaged in some illegal behavior – such as disorderly conduct – as a post-hoc rationalization for the force they employed. Examples of cover charging have been observed on VA campuses, and they raise concerns that veterans may arbitrarily be exposed to excessive police power even when engaged in perfectly legal activities.

The concerns raised by the use of excessive force against veterans are particularly acute when a veteran is experiencing a mental health crisis. The VA Handbook recognizes the need to treat mental illness with special care, directing officers to use only a “minimum of force” and to “consult[] with the appropriate physician” before making an arrest. Policies like these are encouraging, but they must be implemented reliably in order to protect veterans unable to fully appreciate the nature of a police encounter. Officers who fail to recognize that a veteran exhibits mental illness, for instance, will not initiate these procedures and will not reduce the danger posed by an excessive use of force. And even when officers have notice of mental illness, they sometimes fail to adequately implement the VA Handbook’s guidelines to the detriment of veterans.

There is little publicly available data regarding the use of force by VA police officers toward veteran patients. And the VA does not appear to track how often force is used against veterans exhibiting mental illness, despite policies that recognize a greater need for care during these encounters. This absence of data frustrates our understanding of the magnitude of risk that policing might pose to veterans who seek healthcare on VA property. It also prevents the development of reforms that might adequately address such risk.

3. THE USE OF SURVEILLANCE TECHNOLOGY

For veterans seeking healthcare, the extensive police surveillance systems operating at VHA facilities raise concerns about the potential for misuse of police authority. For instance, the VA Handbook on Security and Law Enforcement authorizes the VA Police Force to secretly record the conversations and activities of veterans in certain cases. It, furthermore, encourages the use of monitoring systems so extensive as “to ensure [a] maximum probability of observation” of activity on VA grounds. Implemented to their fullest, these systems enable the VA Police Force to penetrate virtually every corner of each VHA facility for law enforcement purposes. That capability should be viewed with skepticism, particularly when it has the potential to conflict with the role of VHA facilities as sanctuaries for our veterans by subjecting anyone on VA property to extensive police scrutiny.

Moreover, the VA Police Force is authorized to use national crime databases to conduct criminal history and arrest record checks. These databases raise concerns around the privacy and accuracy of such identity information, and they present the potential for further profiling based on the assumed criminality of certain individuals. The dangers posed by criminal checks are compounded by the existence of hidden holding rooms at some VA police campuses where veterans are detained without public knowledge or oversight. Lack of oversight could lead to VA Police Force misconduct, exacerbating the perception by veterans (particularly those belonging to overpoliced communities) that VHA facilities are unwelcoming and even dangerous.

The VA Police Force does not make public the full extent to which surveillance technologies and practices are utilized at VHA facilities. Little is known about how these systems operate in practice or what oversight exists to manage them. The lack of information makes it difficult to assess the efficacy of these policies as well as understand the impact they have on veterans accessing their healthcare.
4. THE USE OF “RED FLAG” POLICIES AT VHA FACILITIES

“Red flag” policies enable VHA staff to designate certain veterans as “disruptive,” potentially limiting the care they are entitled to receive on subsequent visits to VHA facilities and disrupting the unfettered access veterans should enjoy when seeking healthcare.48 Each VHA facility decides what behavior is disruptive enough to warrant a flag49 and how flags affect a veteran’s access to VHA staff and resources in the future.50 The VA Police Force plays a significant role in this process. A 2013 OIG Report found that representatives of the Force were routinely involved in setting “red flag” policies for VHA campuses and that they were “a primary source of referrals” for who should be flagged.51

While VHA “red flag” policies are designed to ensure that VA healthcare workers are safe, lack of oversight and inconsistencies raise concerns about their impact on veteran communities seeking care. Because each VHA campus designs its own “red flag” policies, there are “significant differences in how [various] VHA facilities define disruptive behavior.”52 As a result, a wide variety of conduct can raise flags depending on which VHA site a veteran visits. Red flags have been raised for behavior as severe as physical violence and as moderate as threatening a lawsuit,53 with both flags prompting interventions by VHA staff that restrict the manner of care a veteran receives on subsequent visits.

How a flagged veteran’s subsequent care is restricted also appears to be inconsistent across VHA facilities. Each facility evaluates a veteran’s access based on the severity of their individually flagged conduct,54 but no uniform standard seems to exist for governing how those decisions are made.55 Flagged veterans may have the time in which they are eligible to receive care restricted to designated hours in the day56 or, in more severe cases, be barred from returning to a particular VHA site altogether.57 In a 2013 survey of veterans flagged for disruption, 25 percent could not receive patient care at a VHA facility without first checking in with a VA police officer and 12 percent required a “police escorts or standby for appointments.”58

Although “red flag” policies have the potential to seriously disrupt a veteran’s expectation of care, VA data policy, again, obscures the impact of these programs. With no uniform standards governing how to record “red flags,” “VHA facilities do not consistently collect and analyze data on disruptive incidents” or aggregate data across facilities.59 Absent that data, it is difficult to draw conclusions about how severely “red flag” policies impact a veteran’s access to healthcare, how the care of veterans flagged at one institution with a more lenient definition of “disruption” are impacted when visiting VHA facilities that employ a more rigorous definition, and how effective these programs truly are at protecting VHA staff.

IV. INVESTIGATION OF VA POLICE FORCE PRACTICES

The need for investigation is clear given the concerns raised in this advisory and the lack of data. Investigation would allow the VA and the federal government to better understand the magnitude of barriers to healthcare faced by veterans. The OIG and the House Veterans Affairs Subcommittee on Oversight and Investigations are well-positioned to lead these investigations because they have recently conducted investigations into the management of the VA Police Force.60 Though these investigations did not delve into the interactions between veterans and VA police officers, or their impact on health outcomes for veterans, members of the U.S. House of Representatives raised questions and concerns about negative and potentially harmful interactions. The systemic concerns and constituent stories they shared are serious and indicate a deeper problem that cannot be addressed without an accurate and complete understanding of current VA police practices. As a result of prior investigations, there are ongoing plans to increase the size of the VA Police Force, which could unintentionally exacerbate the concerns identified in this advisory because they were not studied in prior investigations.

It is essential that the VA halt plans to reform the VA Police Force before conducting a thorough investigation into policing practices and the feasibility of reducing the size and authority of the VA Police Force. The VA should also refrain from increasing surveillance before gaining a full understanding of the impact of the current state of surveillance and assessing the needs for such pervasive surveillance in a medical facility.61 The investigation should produce recommendations that seek to turn VA campuses into sanctuaries for veterans, where their basic needs can be met.
1. DATA TRANSPARENCY

Data transparency is a necessary part of evaluating and improving policing practices. This data should be collected and analyzed as part of initial investigations. The investigations should also evaluate the best method for continued data transparency. There is currently no central repository for data on the VA Police Force. The federal government has significant experience collecting data from local agencies and publishing the data. One possible home for this data is the Bureau of Justice Statistics, which regularly publishes data on local policing.

2. FOCAL POINTS OF THE INVESTIGATION

While the investigation should be broad and provide a deep understanding of the current practices of regional VA Police Forces, there will inevitably be certain focal points. Based on preliminary research, we recommend that the investigations evaluate:

- The feasibility of reducing police presence, including VA police officers and local police agencies, at VHA facilities.
- The potential to increase non-police staff, such as social workers and behavioral health specialists, focused on intake and patient management at VHA facilities.
- The efficacy of current training models, especially for interacting with individuals seeking medical care.
- The potential to implement regional trainings, targeted to support the needs of the local veteran community.
- The necessity to question and ticket veterans living in cars or temporarily parked on VA campuses in light of the VA’s larger housing and healthcare goals and any increased population of unhoused veterans on VA campuses in response to the pandemic.
- The feasibility of removing or limiting criminal charging authority.
- Whether weapons and force are being used proportionately to the need.
- The feasibility of removing or limiting authority to carry and deploy weapons and study whether de-weaponizing inhibits or promotes safety of veterans and medical staff.
- The efficacy of current oversight of police officer conduct, including use of force and arrests.
- The efficacy of the complaint process, and investigations into complaints.
- The potential to increase oversight of individual facilities’ red flag procedures and limit the types of conduct that can be included as a red flag.

While this is not a comprehensive list, it is a starting point that will likely lead to information that can be used to improve the experiences of veterans on VA campuses and at VHA facilities. Each of these points should be evaluated with respect to medical outcomes, in addition to safety concerns.

3. VETERAN INVOLVEMENT IN THE INVESTIGATION

Transforming VA campuses into the sanctuaries that they were originally intended as requires veterans having a voice in identifying barriers to healthcare and safety on VA campuses. The investigations should also survey veterans on their interactions with the VA Police Force, as police interactions can often go unreported. Veterans’ advocates and veterans’ advocacy groups, such as NAMVETS, could also be useful sources of information during this investigation, as well as conduits between investigators and impacted veterans. The investigation will be more reflective of the experiences of veterans with a complete understanding of VA Police Force practices.

Regional medical directors are another important voice. They should have an opportunity to provide input as part of the investigation, as they are uniquely situated to understand both staff safety needs and veteran healthcare needs. Involving medical directors, veterans, and veterans’ advocates in the process will create opportunities to strengthen relationships between veterans and their healthcare providers.

V. CONCLUSION

Veterans’ access to healthcare should be a national priority. Veterans have specific health needs often due to their service, many of which last for the rest of their lives. This will be particularly urgent in the next few years as the COVID-19 pandemic continues to unfold. As this advisory has emphasized, access to healthcare on VA campuses is about more than ending long wait times and improving management. Congress and the Department of Veterans Affairs should begin to investigate and take steps to end VA police practices that create barriers to healthcare. They should use the investigations to formulate recommendations that will begin to make VA campuses and medical facilities safer places for all veterans and staff.
Endnotes


5  OIG II, supra note 3, at ii–v.

6  Id.

7  Veterans are more likely to be unhoused than the general population, and minority veterans make up nearly half of the unhoused veteran population but only one-fifth of the overall veteran population. Nat’l Center for Veterans Analysis and Statistics, Military Service History and VA Benefit Utilization Statistics (March 2017), 55.

8  About VA, U.S. Dept. of VA, https://www.va.gov/about_va/mission.asp (quoting President Abraham Lincoln, ”To care for him who shall have borne the battle, and for his widow, and his orphan”).

9  Id.


14  OIG II, supra note 3, at 1.

15  OIG II, supra note 3, at 2.

16  OIG II, supra note 3, at 1.

17  OIG II, supra note 3, at 2.

18  OIG II, supra note 3, at 1.

19  OIG II, supra note 3, at 4.

20  Id.

21  Id.

22  Id.

23  Id.


25  Id. at para. 3h (3).


27  Future research could delve into the underlying reasons for this shift in policing. One source attributes the shift to an increase in crime on VA campuses. Darlene Richardson, VA Pittsburgh Healthcare System, U.S. Dep’t of Veterans Affairs, https://web.archive.org/web/20170510062132/https://www.pittsburgh.va.gov/about/va-history/va-guards-police.asp. But other possible factors merit further study. During the 1970s, there were changes across society and within the military, including the racial composition of veterans—increasingly black and brown—and the deinstitutionalization of veterans with mental illness, that might be correlated with increased discriminatory responses in VA policing. See, e.g., Nat’l Center For Veterans Analysis and Statistics, supra note 8, at 20.

28  Id.

29  Id.

30  Safety and Security in the VA: Hearing before the Subcommittee Oversight and Investigations of the Committee on Veterans’ Affairs, 105th Cong. at 2 (1997) (statement of Rep. James E. Clyburn, Ranking Member, H. Comm. on Veterans’ Affairs) (“Very few private hospitals even in some of the dangerous crime-ridden areas of our country allow the officers who guard their facilities to carry guns. I believe there is a reason for this. As the written testimony of the Nurse’s Association suggests, hospitals are for making sick people healthy; guns are for killing people.”).

31  Richardson, supra note 26.
32 Email from Horace Walker Jr., National Director of the National Claims Center for the National Association of Minority Veterans, (Apr. 22, 2020) (on file with author).
33 VA Directive 0730, supra note 24, at para. 5r. The Clinic aims to continue to collect data on this point, and others made throughout the advisory, at the West LA campus in the future.
35 Craven, supra note 1.
36 Id.
40 See Craven, supra note 1. Juan Victoria, a Navy Veteran and nursing supervisor at the Fayetteville VA Hospital, advised a VA police officer that he was breaking the law by interfering with the patient's access to emergency medical treatment. Id. The officer pushed Victoria to the ground while another pushed their knee into Victoria's neck and back. Id. Victoria was charged with disorderly conduct, but the charge was dropped after intervention by Congressman Steve Womack. Id.
41 VA Directive 0730, supra note 24, at para. 7e (5).
42 Craven, supra note 1. Derek Hathaway, a veteran with mental illness, experienced excessive force when visiting a VA hospital in Phoenix. Id. Mr. Hathaway was forced to the ground by one officer after VHA staff identified him as a trespasser. Id. The officer did not consult with medical professionals before effecting the arrest, although they do seem to realize Mr. Hathaway's mental condition at the time. Id.
43 See, e.g., Oversight Hearing, supra note 4, (statement of Rep. Kathleen Rice, Member, H. Subcomm. on Oversight and Investigation at 39:18) (describing the story of a disabled veteran who was body slammed soon after spinal surgery and criminally cited by VA police officers who failed to properly deescalate an interaction, preventing him from receiving scheduled medical care).
45 Id. at 22.
46 Id. at 54.
49 Id. at 7.
50 Id. at 12.
51 Id. at 6.
52 Id. at 1.
53 Id. at 9.
54 Id. at 12–13.
55 See id. at 12 ("VHA Facilities Use a Variety of Interventions for Patients Referred to DBCs").
56 Id.
57 Id. at 14.
58 Id. at 13–14.
59 Id. at 16–17.
60 Sources cited, supra note 4.
61 There will likely be increased conversations around surveillance in response to the COVID-19 pandemic. Nicole Turner Lee & Jordan Roberts, Managing Health Privacy and Bias in COVID-19 Public Surveillance, Brookings (Apr. 21, 2020), https://www.brookings.edu/blog/techtank/2020/04/21/managing-health-privacy-and-bias-in-covid-19-public-surveyance/. The legal and ethical concerns associated with current VA police practices are distinct from concerns around medical surveillance that will likely increase in response to the pandemic, and they should be treated as such.
63 Id.
64 See, e.g., U.S. Dep't of Justice Civil Rights Div., Investigation of the Ferguson Police Department 1 (2015) (describing the methodology, which included interviews with dozens of people, meeting with neighborhood associations and other community courts, observing court, and participating in ride-alongs).