A review of homelessness among veterans: Policy and practice implications for prevention and intervention efforts

Blake Barrett, B.A.
Colleen Clark, Ph.D.
Roger Peters, Ph.D.
Michael Caudy, M.A.

Department of Mental Health Law & Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida

Prepared for the National Center on Homelessness among Veterans
January 18, 2010
The goal of this report is to provide a comprehensive review of the individual and structural factors and interactions that contribute to homelessness; to describe different levels of interventions, promising practices, and policy recommendations with a focus on preventing homelessness among Veterans. Topics and areas covered in this report include, but are not limited to: individual factors (socioeconomic status, gender/family issues, mental health and substance use disorders, criminal justice interactions); structural factors (housing availability/affordability, job security/unemployment/underemployment, health insurance, current recession and healthcare crisis); and Veterans issues (maintaining housing/employment after combat deployments, trauma experiences, PTSD and other clinical issues, need for continuity of care with VA services, factors that facilitate/interfere with benefit receipt).

Due to these authors areas of expertise there special recommendations focusing on gender issues, co-occurring disorders; integrated treatment (including substance use disorders, psychiatric disorders, trauma disorders, and criminal justice issues); discharge planning and an extensive discussion of criminal justice system issues for Veterans.

A prevention-oriented model for homelessness assistance policies and services

Incorporated into this report is the public health model of primary, secondary, and tertiary prevention of homelessness (Shinn, Baumohl & Hopper, 2001; Burt, Pearson & Montgomery, 2005; Culhane & Metraux, 2008). Supported by recent legislation (i.e., the American Recovery and Reinvestment Act of 2009 and its “Homelessness Prevention and Rapid Rehousing Program”), a prevention-oriented service system model represents a paradigm shift in the provision of homelessness assistance policies and services. Specifically, by providing preventative services and supports to a larger number of people before they become homeless, and providing increasingly intensive services to fewer numbers of individuals and families with more intensive needs, this preventative model seeks to offer the greatest amount of aid to the greatest amount of people in the most effective and efficient manner. Additionally, primary features of this preventative model focus on “attaining housing stability and maintaining ties with community-based social and health services delivery networks” (Culhane, Metraux, & Byrne, 2010).

This prevention-oriented discussion is consistent with the great variability in the patterns of homelessness as well as for the creation and provision of the best services for specific populations (Burt, Aron, Lee, & Valente, 2001). Studies employing cross-sectional or point-in-time methodologies often over represent the proportion of homeless persons with long and/or continuous histories of homelessness (Burt et al. 2001). Results from a study by Culhane and Kuhn (1998) utilizing shelter tracking databases in New York and Philadelphia found that only around 10 percent of the shelter-using homeless population could be considered long-term or chronically homeless; further, the study found that the vast majority of shelter-users (~80%) were individuals experiencing first-time/crisis or transitional homelessness. Beyond those experiencing first-time/crisis or transitional and long-term/chronic homelessness, there are also individuals who experience periodic spells of homelessness across many years which require additional, specific interventions and services (Burt et al. 2001).

Those individuals experiencing their first episode of homelessness, as well as individuals who experience short terms of homelessness, may only need simple emergency assistance to help alleviate the immediate crisis which triggered their literal state of homelessness (e.g., loss of a
job, death of an income-earning spouse, loss of transportation). However, given the extreme rise in both housing costs and poverty levels the probability that a very poor person/family will experience one such emergency event within a year is very high; with these precarious conditions, 1 out of every 10 poor households has a strong possibility of experiencing a spell of homelessness over the course of a year (Burt et al. 2001, pg. 322). As such, policy efforts should focus resources on providing both comprehensive and continuous support (as necessary) to poor and very poor families and individuals to prevent their fall into homelessness.

Those individuals who experience periodic spells of homelessness over many years benefit from policy and intervention efforts that: assist in finding more affordable housing; develop or increase social networks; help manage limited financial resources; continue treatment for behavioral health needs; and provide subsidize housing, with and without supportive services, to those who otherwise would not achieve housing stability on their own (Burt et al. 2001). These services are also appropriate for individuals who are chronically homeless, however, this population also benefits from and often requires: basic life-skills training; remedial education and basic job training; longer-term behavioral health services; as well as subsidized housing with supportive services. These supportive services must be provided in an prescribed fashion that recognizes the specific needs of individuals and does not waste limited resources on services that are unneeded (Burt et al. 2001).

**General causes and phenomena related to homelessness**

Homelessness is caused by and related to a variety of individual and structural factors, characteristics, and systemic interactions. In this report, these factors, characteristics, and systemic interactions will first be discussed in the context of the general population and then focused specifically to the needs and experiences of Veterans. Speaking broadly, Veterans are subject to the same risk factors for homelessness as those in the general population – e.g., lack of affordable, available housing, employment issues, mental health and substance abuse problems, criminal justice interactions. However, Veterans are also subject to a variety of other risk factors for homelessness – e.g., maintaining housing and employment during and after deployment, the effects of combat exposure and related conditions such as post-traumatic stress disorder (PTSD) - as well as protective factors such as access to VA healthcare and other services. The following sections will describe the structural and individual factors, characteristics, and systemic interactions related to homelessness, as well as risk and protective factors related to homelessness specifically for Veterans and Veterans’ issues.

**Individual factors**

Prior research has identified many individual characteristics associated with homelessness (e.g., male gender, lack of a high school education, physical or mental illness, substance use disorders, previous criminal incarceration, adverse childhood experiences, foster care or out-of-home placement, etc). However, these characteristics are much better understood as descriptive information rather than predictors of homelessness. These characteristics describe *who* will become homeless, but only in the context of significant structural stress wherein “*some* among the very poorest will become homeless at a particular time in a particular place
Accordingly, policy and preventative efforts should interpret research findings regarding who is homeless as indicators of at-risk populations and focus resources accordingly to address the larger structural conditions which enable people to fall into homelessness (e.g., lack of education, job training, sufficient wages, affordable and available housing). A recent case-control study of all Veterans who used VA services in 2008 compared those who did and did not recently experience homelessness, finding several characteristics of at-risk populations (National Center on Homelessness among Veterans: December 23, 2009). Results from this study found that having a diagnosis of a mental health or substance use disorder, being black, and being male (except among Operation Enduring Freedom/Operation Iraqi Freedom [OEF/OIF] Veterans), increased the risk of a recent experience of homelessness. However, these findings only generalize to Veterans who have access to and have utilized VA services; risk factors for homelessness may differ when compared to Veterans without access to VA services.

Demographic factors related to homelessness
Younger Veterans are at increased risk of homelessness following their military service for a variety of reasons (Fairweather, 2006). For those entering into military service at a younger age, many have not yet had the opportunity to develop life skills necessary for independent living and often have difficulty transferring military training to employment opportunities (this issue is further exacerbated by civilian employment which may trigger PTSD symptoms). Additionally, young Veterans exposed to earlier adverse childhood experiences (e.g., unstable housing and marginal family status) often return to similar unstable environments following military service, which serves as an additional risk factor for homelessness.

Women Veterans are at a higher risk for experiencing homelessness when compared to other women. Gamache, Rosenheck, and Tessler (2003) conducted a study examining the likelihood of homelessness among women Veterans, utilizing data from a clinical sample of homeless persons with mental illness treated in the ACCESS program as well as a nationally representative sample of persons who used homeless assistance services in 1996 (NSHAPC). Data from a joint project of the Bureau of Labor Statistics and Bureau of the Census (CPS) provided estimates of homelessness among the domiciled general population and in subsample of low-income domiciled women. Results from this study that, when compared to both the domiciled and low-income domiciled populations, women Veterans are 2 – 4 times more likely to be homeless when compared to non-veteran women.

Women attribute their experience(s) of homelessness to different causes when compared to men, offering opportunities for targeted interventions among women and women Veterans to prevent homelessness. Tessler, Rosenheck, and Gamache (2001) conducted a study examining gender differences in self-reported reasons for homelessness among a homeless sample with mental illness treated through the ACCESS program. Self-reported reasons for homelessness were described in three categories: 1) those related to alcohol, drugs, and mental health problems; 2) those related to problems in interpersonal relationships; and 3) those related to poverty. Analyses focused on gender differences as well as gender by veteran interactions for self-reported reasons for homelessness. Results indicated that men were more likely to report problems related to alcohol, drugs, or mental health as their reason for experiencing homelessness while women were more likely to report interpersonal reasons and eviction as causes for homelessness. Women may be more likely to report interpersonal reasons as the
cause of their homelessness as many “find themselves in interpersonal relationships in which they are dependent on another person or persons for their (and their children’s) survival” (Tessler, Rosenheck, & Gamache, 2001, p. 251). Additionally, a significant gender by veteran status interaction was found, wherein female Veterans were more likely than male Veterans to self-report eviction as the reason for their experience of homelessness. Findings from this study suggest that women Veterans would benefit from homelessness prevention efforts that focus on addressing relationship issues, as well as housing subsidies or assistance efforts to prevent eviction and a subsequent experience of homelessness.

**Behavioral health issues**

There is a strong tendency in America to perceive those with alcohol/drug and mental health issues (ADM) as “less deserving” when it comes to assistance and the allocation of scarce resources for homeless populations (despite the prevalence of ADM issues in homeless populations). Around half of all homeless adults will report a problem with ADM at any given point; additionally, four out of five homeless persons will report some ADM problem(s) at some point in their life. However, around 25% of homeless persons will report having no problems with ADM in the past year. The relationship between homelessness and ADM is complicated and not necessarily a causal one. The existence of ADM problems is strongly related to adverse experiences during childhood and adolescence which are strongly associated with the probability that a person will “experience a spell of homelessness, experience it early, and experience it often or for a long duration” (Burt et al. 2001, pg. 320). The *policy question* is then why does the existence of ADM problems lead to homelessness (Burt et al. 2001, pg. 99).

Amongst those experiencing homelessness, there are several delineations concerning behavioral health issues (no ADM, alcohol/drug only, mental health only, co-occurring disorders) which profoundly shape their need for services, experiences across service sectors (including barriers to service access/provision), as well as the ideal service types and provision for specific populations. Individuals who report no ADM problems experience the fewest negative experiences and circumstances, those with either alcohol/drug or mental health problems only experience more negative experiences and circumstances, and those with co-occurring disorders experience the most (Burt et al. 2001, pg. 137). Individuals with only mental health problems are more likely to have experienced childhood mental health problems, receive cash benefits from disability programs (e.g. SSDI) which often serves as a barrier to employment and self-sufficiency, as well as utilize specifically designed transitional housing services for homeless persons with disabilities. Individuals with only substance use disorders are likely to have histories of heavy alcohol/potential drug use during early adolescence as well histories of criminal justice interaction and incarceration (which often serves as a barrier to employment and access to services to prevent/transition out of homelessness). Those with co-occurring disorders experience the highest level of negative experiences and vulnerability (e.g., hunger, criminal victimization, and health problems) compared to those with only one type of disorder as well as those with no ADM problems (Burt et al. 2001).

The effects of ADM problems on the “likelihood of homelessness [indicates a] broad failure of formal care systems to adequately treat their clients and to develop effective support mechanisms that will prevent their descent into homelessness” (Burt et al., 2001, p. 236). Policy and preventative efforts should focus on integrating behavioral healthcare with housing supports in the community, as well as measures to prevent acute episodes of care that jeopardize
residential stability (e.g. psychiatric and substance abuse residential treatment), to increase and facility the community tenure of those with ADM problems. It has also been recommended that supplying housing vouchers along with intensive case management supports range of positive outcomes among formerly homeless Veterans with behavioral health issues (O’Connell, Kasprow, Rosenheck, 2008).

The frequency of co-occurring substance use and other mental health disorders not only increases the severity of each disorders but suggests the need for systems serving Veterans to become “co-occurring competent”. These includes increasing knowledge and responsiveness to one of the emerging issues for Veterans, dependency on opioids including prescription painkillers.

Alcohol use disorders play a pervasive and complex role in the experience of homelessness (Clark & Rich, 2005). Alcohol use disorders play a predisposing, precipitating, mediating and moderating, and maintaining and perpetuating role in homelessness. In addition, alcoholism is often comorbid with mental health and physical disorders, causing and making these disorders worse. The risk of comorbidity with trauma-related disorders including PTSD is also very high. These relationships highlight the importance of integrated treatment at multiple intervention sites. For example, that includes screening for alcohol use disorders at medical clinics, housing outreach with harm-reduction models. Further, due to the nature of the disease and its insidious relationship to homelessness, alcoholism should be treated in a continuing and long term manner, rather than one time episodes of treatments (McKay, 2009).

**Structural factors**

Veterans are subject to the same larger structural factors that increase the risk of homelessness among the general population, including: the lack of available and affordable housing; unemployment, underemployment, and job security issues; difficulties in accessing needed health care services; as well as systemic interactions which increase the risk of homelessness (e.g., incarceration, acute psychiatric hospitalization).

*Institutions and the public system of care*

Those who are homeless, or at-risk of homelessness, often cycle through many public systems of care (e.g., psychiatric and substance abuse treatment facilities, jails/prisons, emergency departments, etc.) which perpetuate or leave them further at-risk for experiencing homelessness. Despite the magnitude of interaction between those who are homeless/at-risk of homeless and the public systems of care cited above, there is a pervasive lack of planning and coordination amongst these systems. Individuals discharged from these systems of care are often left in situations “where they immediately, or at least very quickly, fall into homelessness (Burt et al. 2001, pg. 183). Those mainstream programs which serve populations who are homeless or are at-risk of homelessness must hold greater accountability for “their most vulnerable clients and wards” (National Alliance to End Homelessness, 2000, p. 10); this applies especially to institutions that discharge individuals who are currently homeless or at-risk of homelessness. The Department of Veterans Affairs has opportunities to prevent homelessness institutional commitment to their residential stability in the community at time of discharge. Policy and prevention efforts should focus on: 1) promoting a culture of communication and relationships across public systems of care that recognizes the cyclical nature of homeless interactions with
adult public systems of care; 2) providing resources to and incentivizing public systems of care to facilitate community tenure for homeless persons who interact with the public systems of care; and 3) forming partnerships amongst the public systems of care and housing authorities to help those who cannot maintain housing on their own secure adequate permanent housing (Burt et al. 2001).

To prevent homelessness there will have to be improvement in all adult systems of care

- Mental health, substance abuse
- Invest in improving and coordinate homeless systems of care
- Structure and invest in services for high-risk populations
- Cost-effective if consider all public systems of care and support (health, mental health, SUD, corrections, housing) (pg. 332 for citations that support cost savings)*
- Commit societal resources to eliminating conditions in which people grow up that increase their vulnerability to homelessness
- Some populations need long-term support (e.g., those with SMI); those systems with official responsibility should structure housing as additional resources to their comprehensive services offered to meet individuals need

*Taken from Burt and colleagues (2001).

As an example, a recent report by the LA County Department of Public Social Services says that the County will realize significant savings by investing in a housing subsidy program for homeless general relief recipients who are either employable or eligible to receive SSI benefits.

*Criminal justice system interactions as a risk factor for homelessness

Those incarcerated in jails and prisons experience rates of homelessness much higher than those of the general population (Greenberg & Rosenheck, 2008a, 2008b). A secondary analysis of a 2002 national survey of jail inmates conducted by the Bureau of Justice Statistics found that 12.4% of inmates had been homeless in the year prior to their incarceration, and 2.9% were homeless at the time of their arrest (Greenberg & Rosenheck, 2008a). Further, results from this study found the rate of homelessness among jail inmates to be 7.5 to 11.3 times the annual rate of homelessness when compared to the general population. Past criminal justice system involvement, mental illness and substance abuse, and the lack of sociodemographic assets were found to be the largest contributors to the high rate of homelessness among jail inmates. The authors suggest that a bidirectional association between homelessness and incarceration may exist in part due to the detrimental effects of prior incarceration on family and community ties, as well as employment and public housing opportunities. However, while mental illness and substance abuse indicators were both associated with greater risk of homelessness among jail inmates, substance abuse appeared to be “the stronger risk factor for incarceration among both homeless and nonhomeless inmates” (Greenberg & Rosenheck, 2008a, p. 176).

The finding that substance abuse emerged as a stronger risk factor for homelessness among jail inmates as compared to mental illness is mirrored by another study predicting incarceration among homeless Veterans leaving VA inpatient units (Erickson, Rosenheck, Trestman, Ford, & Desai, 2008). The study by Erickson and colleagues examined factors predicting arrest among all male Veterans treated in inpatient units in the VA Connecticut Healthcare System between 1993 and 1997, merging these data with the Department of Corrections database for the same period. Descriptive information revealed that those Veterans
experiencing an incarceration episode were more likely to have mental health, substance abuse, and co-occurring disorders. However, in multivariate models predicting incarceration, having a diagnosis of a severe and persistent mental illness (i.e., bipolar or schizophrenia disorder), as well as co-occurring mental health and substance abuse disorders, were no longer independent predictors of incarceration. In multivariate models, only substance abuse disorders remained an independent predictor of incarceration. The authors note that these results are consistent with criminological theories which suggest substance abuse is largely responsible for incarceration risk (Andrews & Bonta, 2006; Bonta, Law, & Hanson, 1998; Lamberti, 2007). These models view substance abuse as a problematic behavior (rather than a secondary consequence of mental illness), and support interventions using legal leverage to maintain community tenure.

Investments in such interventions should be increased and promulgated to help prevent homelessness among those arrested/incarcerated in jails.

Those in prison experience much greater rates of homelessness when compared to that of the general population. Greenberg and Rosenheck (2008b) conducted a secondary analysis of a national sample of adult state and federal prison inmates who completed the 2004 Survey of Inmates in State and Federal Correctional Facilities. Results from this study found that 9.2% of prison inmates had been homeless in the year prior to their arrest with 1.7% homeless at the time of their arrest. Further, the rate of homelessness among prison inmates was found to be 4 to 6 times the annual rate of homelessness in the general population. While mental illness and substance abuse were common among all prison inmates, those who were homeless had significantly higher rates of behavioral health needs. When compared to other prison inmates, those who were homeless were more likely to have past criminal justice system involvement, mental illness and substance abuse problems, histories of trauma, as well as to be poor.

Research conducted by Metraux and Culhane (2004, 2006) suggests that different trajectories exist between homelessness/jail and homelessness/prison for those utilizing shelter services. Findings from these studies indicate that there is a much more immediate link between prison release and shelter utilization (with an episode of homelessness most likely to incur within 30 days of release); this suggests that homelessness among those released from prisons is more an issue of reentry into the community. For those leaving jails, a different relationship exists between incarceration and shelter utilization (Metraux & Culhane, 2006). This relationship is characterized by a “more sequential pattern featuring multiple stays in each system and a more prolonged pattern of residential instability” (Metraux, Roman, & Cho, 2007, p. 8).

Taken together, current research supports the concept of the “institutional circuit” between shelters, jails, prison and other institutions experienced by homelessness proposed by Hopper and colleagues (1997). While most of the existing evidence linking homelessness and criminal justice interaction is correlational, this research provides factors which may be amenable to intervention to prevent homelessness among those leaving carceral institutions (Metraux, Roman, & Cho, 2007). Interventions to prevent homelessness among those leaving carceral institutions should focus on: adequate discharge planning and other support services available to those incarcerated prior to their release; the provision of a continuum of housing options for those who have been incarcerated, specific to the needs of persons released from carceral institutions and including supported housing; integrating services and treatment with housing services (permanent or transitional); the use of case management models for service delivery; the “front-loading” of services whereby more intensive services are provided during a critical time period where persons are thought to be at high risk for subsequent re-incarceration and/or homeless (Nelson, Deess, & Allen, 1999).
Criminal justice system interactions as a risk factor for homelessness among Veterans

Approximately 9% of U.S. jail and prison populations consist of Veterans, amounting to well over 200,000 who are incarcerated nationwide (Greenberg & Rosenheck, 2008; National GAINS Center, 2008; Noonan & Mumola, 2007). These numbers are likely to rise with the large number of returning Veterans from Afghanistan and Iraq, who are at elevated risk for incarceration due to high rates of substance use disorders, mental disorders (e.g., trauma/PTSD, depression), and domestic violence. Most Veterans in jail are there for non-violent offenses (McGuire, 2009). However, Veterans face longer sentences than other arrestees for some types of offenses (Bureau of Justice Statistics, 2007). From 15-16% of jail inmates are homeless (Greenberg & Rosenheck, 2008; McNiel, Binder, & Robinson, 2005), including significant numbers of Veterans. Veterans who are released from custody are at particular risk for homelessness (McGuire, 2007).

A number of legislative and programmatic interventions have been developed for Veterans in the justice systems that are likely to address homelessness, including the Department of Veterans Affairs criminal justice outreach program. Several states (i.e., California, Minnesota) have enacted statutes which authorize diversion of Veterans from the criminal justice system who have service-related mental and substance use disorders, and other states are considering similar legislation. Veterans Courts have been established in several jurisdictions across the country to divert nonviolent Veterans who have substance use disorders to long-term drug treatment and community supervision, and provide linkages and coordination with VA services. SAMHSA has recently sponsored several pilot jail diversion programs for Veterans who have co-occurring mental and substance use disorders.

Several recent reports provide recommendations for improving services for Veterans in the criminal justice system, including those who are homeless or at risk for homelessness. These include a Consensus Report issued by the National GAINS Center’s Forum on Combat Veterans, Trauma, and the Justice System (2008); a white paper issued by the Drug Policy Alliance (“Healing a Broken System: Veterans Battling Addiction and Incarceration, 2009), and a review by McGuire (2007) entitled “Closing a Front Door to Homelessness among Veterans”. Key recommendations from these reports are relevant for homeless veteran populations, including the following:

- Provide routine screening at various points in the criminal justice system for military service, homelessness, and related issues (e.g., trauma, other mental disorders, substance use disorders). Key points include pre-trial screening, intake to probation and parole settings, jail booking, and prison reception.
- Encourage use of veteran peer specialists who can work in the criminal justice system, and who are knowledgeable about homeless and VA services.
- Homeless services for Veterans exiting the justice system (either from custody or post-sentence community dispositions) should address a comprehensive range of needs, including trauma, depression, and other mental disorders, substance abuse treatment needs, physical health issues, and employment.
- Law enforcement, court, community supervision, correctional, and other criminal justice professionals should receive training in identifying signs and symptoms of combat-related trauma, triage to VA and other community services (e.g., homeless, behavioral health services),
and to help respond effectively to Veterans who are experiencing mental health crises. For example, law enforcement Crisis Intervention Teams (CITs) would benefit from specialized training in deescalation techniques for combat Veterans who are experiencing PTSD.”

- Technical assistance should be offered to existing diversion programs (e.g., drug courts, mental health courts, jail diversion initiatives) to adapt and refine specialized programs for Veterans, and specialized approaches/interventions for Veterans who are homeless or at risk for homelessness.

- Policy initiatives at the county, state, and federal level should focus on: (1) encouraging legislation that authorizes diversion of non-violent Veterans from the criminal justice system to community dispositions that include linkage with homeless services and participation in mental health and substance abuse treatment services, (2) funding for development of innovative programs to divert this population from the justice system, (3) research to examine criminal justice and economic outcomes of these interventions, and (4) reducing barriers to community integration among Veterans with criminal justice involvement, homelessness, and related psychosocial problems. Initiatives in this latter area would address issues of engagement in VA services, eligibility for short and long-term housing, community outreach and case management, and reinstatement of SSI benefits.

- For homeless Veterans with substance abuse problems, community-based services should be expanded to include greater use of methadone and buprenorphine.

- Support should be provided to Veterans Justice Outreach specialists (VJOs) within the VA system to address the reentry needs of incarcerated Veterans, including housing. For example, reentry plans should be developed for all incarcerated Veterans that address homelessness and housing issues. Veterans in the justice system who are homeless or at risk for homelessness should receive priority among VJOs in receiving services.

In addition, McGuire (2007) proposes the following recommendations or lessons learned on preventing homelessness among incarcerated Veterans

- First, a collaborative partnership with the corrections system must be established and nurtured over time to gain access to Veterans and to insure coordination of re-entry planning.

- Second, practical planning to assure that Veterans leaving prison or jail are actually connected to the VA for follow-up services is essential. Without such arrangements in place, barriers (lack of transportation, money) at the time of release may prevent follow-through by the Veterans.

- Third, an array of both VA and non-VA community services is needed to provide the scope and intensity of services needed by re-entering Veterans.

- Finally, Veterans who have been incarcerated for long periods, usually in prison, benefit from an extended process of deinstitutionalization upon release during which considerable structure is initially provided that is gradually replaced by personal initiative; new coping skills are also developed to support adaptation to community living over time.

Preliminary planning for development of the model has incorporated five principles:

- encouraging voluntary participation by Veterans;
- coordinating with corrections and non-VA community providers;
- providing information on VA benefits, including healthcare;
- screening for medical, social, mental health, and substance abuse problems; and
- using outreach workers to serve as referral and linkage points of contact upon release as well as follow-up contact for re-entry crises and linkage problems.

Homelessness and Health Services

Homelessness and health care needs are interrelated in numerous ways with homeless persons facing a myriad of barriers which limit their access to and quality of health care services. Homeless individuals experience high rates of physical illness, mental illness, substance use disorders, and early mortality (Kushel, Vittinghoff, & Haas, 2001; National Coalition for the Homeless, 2009). Health problems may be exacerbated among homeless veteran populations due to increased rates of co-occurring substance use disorders and mental illness (Rosenheck, Leda, Frisman, Lam, & Chung, 1996). Barriers that limit the access to and quality of health care among homeless persons include their multiple and diverse health care needs, lack of health insurance and health benefits, lack of coordination between systems of care, as well as perceptions of uncompassionate care (Kushel, Vittinghoff, & Haas, 2001; National Coalition for the Homeless, 2009; Rosenheck, Resnick, & Morrissey, 2003).

The well-established relationship between homelessness and health care needs has led to a growing body of empirical research on the topic of improving access to and quality of health services among this population. Two suggested interventions that have received strong empirical support include the provision of and maintenance of health care benefits (Kushel, Vittinghoff, & Haas, 2001), as well as the improvement of communication and cooperation between systems of care to provide more uniform services for the diverse needs of homeless individuals (Rosenheck, Resnick, & Morrissey, 2003). Efforts may also be made to increase awareness of services among homeless populations and encourage individuals to seek available health care services.

Nature of OEF/OIF and implications for homelessness

While numerous studies document the increased risk of homeless between Veterans and non-Veterans, Veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) are becoming homeless sooner than earlier Veterans (Fairweather, 2006). The repeated and extended employments faced by OEF/OIF Veterans are themselves a risk factor for homelessness, related to combat exposure and the development of post-traumatic stress disorder (PTSD), as well as the inability to maintain continuity in civilian life (e.g., housing and employment) and social supports (Fairweather, 2006).

Difficulties in accessing VA services (both during and after service), as well as the difficulties of the meeting the mental health needs among OEF/OIF Veterans, increases the risk of homelessness among this population (Fairweather, 2006). Many OEF/OIF Veterans are National Guard or Reserve troops (approximately 40%); National Guard and Reserve troops are about as half as likely to file VA claims and about half as likely to have their claims approved when compared to regular forces. Additionally, the needs of Veterans experiencing PTSD as well as traumatic brain injuries (TBI), characterized by a broad range of physical, cognitive, behavioral, emotional, and social challenges, offer particular challenges to Veterans’ access and receipt of necessary services. Antisocial behaviors related to TBI may place our troops at further risk of homelessness due to legal issues and/or dishonorable discharges. Many Veterans are receiving inappropriate less-than-honorable discharges for relating to behavioral health needs symptomatic of PTSD and TBI. While OEF/OIF Veterans may be receiving less-than-honorable discharges due to psychological symptoms, the will be barred from receiving VA mental health services in the future.
Homelessness prevention efforts among OEF/OIF Veterans should focus on the proper diagnosis and provision of adequate care to Veterans during deployments, between deployments, and after military service. Many Veterans with mental health needs go undiagnosed, not receiving the proper services and/or being barred from ever again receiving mental health services from the VA which would greatly increase their ability to remain stably housed within the community. More resources should be devoted to: VA outreach efforts for OEF/OIF Veterans and limiting bureaucratic obstacles and delays to care and services; meeting the mental health needs of OEF/OIF Veterans seeking counseling and PTSD treatment; meeting VA disability claims (long waits for income increase the risk of homelessness); and providing family services and gender-specific care to Veterans.
References


