Demystifying a Social Pandemic: Homelessness within the Veteran Population

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Similar to the general population of homeless adult males, about 45% of homeless veterans suffer from mental illness and slightly more than 70% suffer from alcohol or other drug abuse problems. Approximately 56% are African American or Hispanic. While the federal, state, and local government provides support to homeless veterans, there is still a lack of affordable housing programs. The theory of reciprocal determinism supports this case by highlighting how individuals' behavior influences and is influenced by personal factors and the social environment. This case scenario explores why certain homeless veterans have not been able to overcome obstacles of poverty, find affordable housing, and reenter mainstream society.

Keywords: *homelessness, incarcerated veterans, mentally-ill homeless veterans, outreach, transitional housing, veterans*

Introduction

Counting the number of homeless veterans is a difficult task. Convergent sources estimate that between 23 and 40% of homeless adults are veterans (Rosenheck, 1996). A recent estimate calculated by the U.S Department of Veterans Affairs (VA) found that on any given night in 2005,approximately194,000 veterans were homeless; this estimate is lower than numbers reported in early 2000 (Government Accountability Office [GAO], 2006). However, it is unclear if recent estimates represent real declines in homelessness among veterans or if the data were not as reliable in early 2000. In 2004, the VA improved data collection by using point-in-time data exclusively, relying on more standardized methods, and increasingly using data from the U.S. Department of Housing and Urban Development's (HUD's) Continuum of Care (GAO, 2006).Although homeless veterans have served in different wars, including World War II, Korean War, Cold War, Vietnam War, Grenada, Panama, and Lebanon, earlier research indicated that those serving in the late Vietnam and post-Vietnam era had the highest representation in the homeless population (Burt, 1999). Recent media accounts highlight a small but growing number of veterans from the Iraq war showing up in shelters.

Background

The causes of homelessness among veterans are difficult to untangle. Despite common perceptions that homeless veterans are more likely to be mentally ill or suffer from high rates of posttraumatic stress disorder (PTSD), the characteristics of homeless veterans actually look similar to other homeless adults. Rosenheck (1996) wrote,"Homelessness among veterans is not clearly related to military experience. Rather, it is the result of the same interrelated economic and personal factors that cause homelessness in the civilian population." In other words, the same things that predict homelessness among the general population—poverty, lack of affordable housing, poor access to support networks and personal characteristics—also predict homelessness among veterans.

Most homeless veterans are male; the VA estimates that as few as 3% of homeless veterans are female. However, this number has the potential to increase over time as the number of women veterans increases. The National Survey of Homeless Assistance Providers and Clients (NSHAPC), conducted in 1996, found that almost 46% of homeless veterans were White males and 46%were 45 or over; more than half (56%) had completed high school or a GED program. The number of veterans who reported problems

with drugs (40%) and alcohol (58%) did not differ significantly from nonveteran homeless males. Similarly, the reported rates of mental health problems were the same for veteran and nonveteran homeless males: approximately 10% of each group reported having a mental health problem in the past year. Homeless veterans reported they needed help finding a job (45%) and finding housing (37%; Burt, 1999).

In addition to overseeing the distribution of veterans' benefits and healthcare services, the VA has primary responsibility for overseeing programs targeted to homeless veterans. The VA operates several programs; the largest is the homeless providers Grant and Per Diem (GPD) program. The program provides transitional housing (available for 3 to 24 months with an average stay of 4months) to veterans who need the most assistance, including those whohave problems with mental illness and substance abuse. The GPD program is operated by local nonprofit and public agencies that compete for grants—capital cost grants, which can pay for a percentage of housing acquisition, and Per Diem grants, a fixed reimbursement rate to cover the cost of beds. A GAO report (2006) showed that the program spent approximately$67 million in fiscal year 2005 and has the capacity to house 8,000 veterans on any given night. In 2005, the program served 16,000 veterans. Although data are limited, the VA reported that 81% of veterans had housing when they left the GPD program (GAO, 2006). Some veterans, those who experience chronic homelessness (that is, are homeless for long periods, have repeated episodes of homelessness, or have a disability) may need additional housing and services. Approximately 63,000 veterans were chronically homeless in 2005 (GAO, 2006).

A survey conducted by the National Coalition for Homeless Veterans (NCHV) in Washington, DC, showed combat veterans from Iraq and Afghanistan are beginning to request help from homeless veterans service providers. The survey was in response to a growing number of inquiries by media and government officials involved in veterans and budgetary affairs. The sign of a crisis is seen in the VA's own numbers. Under considerable pressure to stretch dollars, the VA estimated it couldassist approximately 100,000 homeless veterans each year, which is only 20% of the more than 500,000 who will need supportive services. Hundreds of community-based organizations nationwide struggle to provide assistance to as many of the other 80% as possible, but the need far exceeds available resources. The subject of providing adequate funding for additional supportive services to help a new generation of wartime veterans has become a significant battleground as the administration maneuvers to limit spending on domestic assistance initiatives across the board, including funds for homeless programs and the Veterans Health Administration (VHA), the principal provider of grants to support community-based homeless veterans programs.

The Problem: Behavioral and Environmental Factors and Lack of Affordable Housing Affect Transition for Homeless Veterans

Burt and Pearson (2005) contended that "strong evidence is still lacking that homelessness prevention efforts are effective" and that measuring effectiveness is a critical but difficult and expensive component of prevention. Their study of six prevention programs found that although the prevention programs were innovative, there was no functional evaluation of the effectiveness of targeting those most at risk or of the housing outcomes. This sheds light on the problem concerning the lack of affordable housing programs for homeless veterans. The intrinsic and extrinsic factors supporting the efforts of homeless veterans toward successful transitioning into mainstream society needs to be examined further. Successful transitioning into mainstream society includes having access to comprehensive health, mental health, social resources, planning strategies, and affordable housing.

Desired Outcomes

The desired outcomes consist of federal, state, and local political officials introducing bills, creating initiatives, and providing funding to support the expansion of affordable housing programs for homeless veterans. McGuire et al. (2003) posited that outreach to homeless veterans in the community that included making contact and building credibility; engaging clients; identifying mental illness, substance abuse, housing, and employment needs through assessment; and providing ongoing case management are associated with successful transition.

To avoid losing sight of the goal of preventing homelessness, Leginski and Randolph (1999) noted, “Careful conceptualization and relevant data are the best analytic defenses” (p.1257) in implementing large systems initiatives. Others have demonstrated the utility of logic modeling for implementing evaluation, which is a technique that structures review of links between program assumptions, client needs and outcomes, program resources, and data collection (Morzinskis &Montagnini, 2002; Mulroy & Lauber, 2004). If the VA’s system-wide initiative is carefully implemented and evaluated, veterans are likely to have a higher probability of successful community readjustment housing outcomes, and the VA will be able to provide the widest possible prevention coverage to those most in need of the appropriate elements of the VA’s service package.

Support for This Case Scenario: Theory of Reciprocal Determinism

Bandura (1986) advanced a view of human functioning that accords a central role to cognitive, vicarious, self-regulatory, and self-reflective processes in human adaptation and change. People are viewed as self-organizing, proactive, self-reflecting, and self-regulating, rather than as reactive organisms shaped and shepherded by environmental forces or driven by concealed inner impulses. From this theoretical perspective, human functioning is viewed as the product of a dynamic interplay of personal, behavioral, and environmental influences. For example, how homeless veterans interpret the results of their own behavior informs and alters their environments and the personal factors they possess which, in turn, inform and alter subsequent behavior. This is the foundation of Bandura's (1986) conception of reciprocal determinism, the view that (a) personal factors in the form of cognition, affect, and biological events; (b) behavior; and (c) environmental influences create interactions that result in a triadic reciprocality. Bandura altered the label of his theory from social learning to social cognitive to both distance it from prevalent social learning theories of the day and to emphasize that cognition plays a critical role in people’s capability to construct reality, self-regulate, encode information, and perform behaviors.

According to Bandura (1986), the reciprocal nature of the determinants of human functioning in social cognitive theory makes it possible to direct therapeutic and counseling efforts at personal, environmental, or behavioral factors. Strategies for increasing well-being can be aimed at improving emotional, cognitive, or motivational processes; increasing behavioral competencies; or altering the social conditions under which people live and work. For example, in homeless shelters, case managers have the challenge of improving the confidence of the homeless residents in their charge. Using social cognitive theory as a framework, case managers can work to improve the homeless residents’ emotional states and to correct their faulty self-beliefs and habits of thinking (personal factors), improve their self-regulatory practices (behavior), and alter the homeless shelter structures that may work to undermine homeless resident success (environmental factors). The more confident a person is, the more likely that person will succeed and accomplish a task. Beliefs of reciprocal determinism are gained through individual experiences.

The theory of reciprocal determinism supports this case scenario because homeless veterans’ environments are influenced by their behavior, and their behavior is influenced by the environment. For example, if homeless veterans have been chronically homeless for an extended period of time, they can become complacent with the environment in which they live, and their behavior may become

lackadaisical toward transitioning back into mainstream society. This type of behavior can impact the environment as homeless veterans causing them to embrace homelessness as their new state of normalcy.

Homelessness the Pandemic

About half of the people who experience homelessness over the course of a year are single adults (Burt et al., 1999). Most enter and exit the homeless system quickly. The remainder lives in the homeless assistance system, in a combination of shelters, hospitals, jails, and prisons, or on the streets. Overwhelming majorities (80%) of single adult shelter users enter the homeless system only once or twice, stay just over a month, and do not return. Approximately 9% enter nearly five times a year and stay nearly 2months each time. This group uses18% of the system's resources (National Alliance to End Homelessness, 2007).

The remaining 10% enter the system just over twice a year and spend an average of 280 days per stay—virtually living in the system and using nearly half its resources (Kuhn & Culhane, 1998). HUD defined many of these individuals as chronically homeless. They often cycle between homelessness, hospitals, jails, and other institutional care and often have a complex medical problem, a serious mental illness such asschizophrenia, and alcohol or drug addiction. According to the National Alliance to End Homelessness (2005), there are approximately 150,000 to 200,000 chronically homeless individuals nationwide. Although chronic homelessness represents a small share of the overall homeless population, chronically homeless people use up more than 50% of the services (Kuhn & Culhane, 1998).

Despite the difficulties in serving chronically homeless people, several cities have launched initiatives to end chronic homelessness, and many are showing results. In some cases, the results represent reductions in the number of people living on the streets. Cities with more advanced data systems are able to track reductions in chronic homelessness for people living in shelters. In most cases, these initiatives are part of larger efforts to end all types of homelessness.

- Denver, Colorado, reduced homelessness by 11.5% in the metro region, including a reduction in street homelessness from 100 – 600 people since January 2005 (Metro Denver Homeless Initiative, 2006).
- Over many years, Philadelphia, Pennsylvania, has reduced street homelessness by more than half (Eckholm, 2006).
- When they released their plan to end homelessness in December 2004, Portland, Oregon, had an estimated 1,600 chronically homeless individuals (Citizen's Commission on Homelessness, 2006). During 2005, they housed 660 (Multnomah County, 2006).
- Over a 3-year period, San Francisco, California, reduced homelessness by 28%, reduced street homelessness by 40%, and reduced the number of people who died while living on the streets by 40% from the prior year (National Alliance to End Homelessness, 2005).

In addition to documenting their success atreducing chronic homelessness, many cities are also documenting the cost effectiveness of their efforts. Portland found that prior to entering the Community Engagement Program, 35 chronically homeless individuals each used over $42,000 in public resources per year. After entering permanent supportive housing, those individuals each used less than $26,000, which included the cost of housing (Moore, 2007). While making progress toward ending chronic homelessness, Portland, Oregon, has saved the public over $16,000 per chronically homeless person.

The successes in these communities provide insight to effective strategies in ending chronic homelessness. Ending chronic homelessness requires permanent housing with supportive services, and implementing policies to prevent high-risk people from becoming chronically homeless. The most successful model for housing people who experience chronic homelessness is permanent supportive housing using a Housing First approach. Permanent supportive housing combines affordable rental housing with supportive services such as case management, mental health and substance abuse services, health care, and employment. The Housing First approach is a client-driven strategy that provides immediate access to an apartment without requiring participation in psychiatric treatment or treatment for sobriety. After settling into new apartments, clients receive a wide range of supportive services that focus primarily on helping them maintain their housing. The vast majority of people who become chronically homeless interact with multiple service systems, which provides an opportunity to prevent their homelessness in the first place. Promising strategies focus on people who are leaving hospitals, psychiatric facilities, substance abuse treatment programs, prisons, and jails.

Although chronic homelessness represents a small share of the overall homeless population, its effects on the homeless system and on communities are considerable. Chronically homeless people are inefficiently served by the systems they interact with, including emergency shelters, emergency rooms, hospitals, and police departments. These systems in turn are adversely affected by chronic homelessness. A landmark study of homeless people with serious mental illness in New York City found that, on average, each homeless person usedover $40,000 annually in publicly funded shelters, hospitals (including VA hospitals), emergency rooms, prisons, jails, and outpatient health care. Much of the cost was for psychiatric hospitalization, which accounted for an average of over 57 days and nearly $13,000 (Culhane, Metraux, &Hadley, 2002). When people were placed in permanent supportive housing, the public cost to these systems declined dramatically.

The documented cost reductions—$16,282 per unit of permanent supportive housing—were nearly enough to pay for the permanent supportive housing. If other costs, such as the costs of police and court resources and homeless services, were included, the cost savings of permanent supportive housing would likely have been higher. In other words, the study found that it cost about the same or less to provide permanent supportive housing as it did for people with serious mental illness to remain homeless. However, while the costs were the same, the outcomes were much different. Permanent supportive housing results in better mental and physical health, greater income (including income from employment), fewer arrests, better progress toward recovery and self-sufficiency, and less homelessness.

Guided by research, Congress has taken several steps to encourage the development of permanent supportive housing. Beginning in the late 1990s, appropriations bills have increased funding for HUD's homeless assistance programs and targeted at least 30% of funding to permanent supportive housing. Congress has also provided funding to ensure that permanent supportive housing funding by one of HUD's programs (Shelter Plus Care) would be renewed noncompetitively, helping to ensure chronically homeless people could remain in their housing.

The Bush Administration included a funding incentive called the Samaritan Housing Initiative to help spur the development of more permanent supportive housing. Congress considered other measures, including a $209 million increase in HUD homeless assistance funding in Fiscal Year (FY) 2007 and the Services for Ending Long Term Homelessness. The Obama administration has worked on pilot programs with not-for-profit organizations to ensure veterans at risk of losing their homes have a roof over their heads. Although a considerable amount of resources and programs has been implemented to prevent veterans from losing

their homes, there is still a lack of resources such as affordable housing for veterans who have been experiencing chronic homelessness longterm.

Factors

Exploring the factors that may affect the outcome can help federal, state, and local political officials develop preventative strategies to reduce or end homelessness in the veteran population. In this section, I summarize research that provides the background necessary for understanding the key aspects of characteristics and lived experiences and environmental factors as they relate to homelessness. Additionally, I highlight the historical context of homelessness, obstacles faced by veterans, and support services for homeless veterans. Lastly, I summarize homeless outreach and the plan to end homelessness among veterans.

Homelessness Risks Among Incarcerated Veterans

Considering the attention that the relationship between incarceration and homelessness has received, it is surprising how little research exists on inmates reentering communities and the subsequent rates of homelessness. Homelessness and incarceration are common among VA patients with bipolar disorder and share many risk factors. Homelessness and incarceration have a bidirectional relationship: homelessness can lead to loitering or criminal acts and then to arrest, and release from incarceration can turn someone out onto the street with nowhere to go. Among VA patients with bipolar disorder, Copeland et al. (2009) found that 12% reported having been homeless in the previous 4 weeks, which is comparable to the homelessness rates of 13% to 17% reported among personswith chronic mental illness. Slightly more than half of their sample reported ever having been homeless (55%) or incarcerated (55%), which indicated that this group was at high risk of having unstable treatment courses andpoor outcomes. Copeland et al. also found that lifetime experience of homelessness was associated with 4-fold increasedodds of lifetime experience of incarceration and that recent homelessness was strongly related to recentincarceration.

Metraux and Culhane (2004) examined the postprison experience of released New York State prison inmates, finding that 11.4% had a homeless shelter episode within 2 years of release. Other studies have documented the legal and homelessness status of either parole or homeless populations. For example, the California Department of Corrections reported that up to 10% of the state's parolees were homeless (California Department of Corrections, 1997), and a Baltimore study indicated that onehalf of people sleeping on the streets have a history of incarceration (Fischer, 1988). In general, researchers who study homeless people have found that prior incarceration, particularly for males, is an important risk factor associated with homelessness (Burt, 2001).Homeless veterans essentially have the same homelessness risk factors as other homeless Americans: poverty, joblessness, mental illness, and substance abuse (Rosenheck &Koegal, 1993). Within age and service era cohorts, younger veterans and veterans of the post-Vietnam All Volunteer Force era have a higher risk of homelessness compared to other veterans, yet less than onethird of veterans in one study reported that military service increased their risk for homelessness (Mares & Rosenheck, 2004).

Rates of criminal involvement by homeless veterans are also similar to rates of nonveterans. In describing special populations of homeless Americans, Rosenheck et al. (1999) noted the special national concern afforded homeless veterans, yet pointed out that boundaries between homelessness and criminal justice status among veterans are not as clear as the public might think. In one sample of 10,000 veterans seen in a national VA program, onethird of whom had served in combat, over 50% had significant criminal histories. Studies that capture data on legal status, and have included or focused on veterans, have found the following types of criminal justice involvement to be associated with homelessness: (a) history of

arrests (Caton et al., 2005), (b) having been jailed (Rosenheck & Koegal, 1993), and (c) criminal behavior (Douyon et al., 1998). Duration of homelessness was associated with criminal history in one of two samples of veterans surveyed in a VA domiciliary program (Wenzel et al., 1993). Viewed from the institutional perspective, the Mumola (2000) study of incarcerated veterans documented a cluster of factors that indicated a substantial risk for homelessness at the point of their reentry to the community. Prior to incarceration, 81% reported drug-use problems, 31% in prison (35% in jail) reported CAGE-assessed current alcohol dependency, and 19% in prison (23% in jail) had been homeless for some period during the 12 months before incarceration.

Incarceration can also have severe negative effects on persons with mental illness by reducing employability, impeding personal relationships, and interrupting the continuity of health care. Mental health services are often minimal in correctional facilities, so there is a great need to intervene with patients at risk for incarceration. In a recent study by Copeland et al. (2009), homelessness was the factor most strongly associated with incarceration among veterans withbipolar disorder.The study also found that, among potentially treatable factors, current substance use was associated with lifetime incarceration history (after the authors controlled for other factors, including homelessness), which indicated that persons with incarceration histories have a special need for preventive services and proactive assessmentfor possible substance use.

Failure to assess and treat comorbid substance use undercuts treatment of bipolardisorder.
In recognition of the many issues faced by veterans with mental illness, the VA has initiated a number of programs to assist this group. In many communities, the VA is already working with local police to divertveterans into VA mental health care in lieu of incarceration, which may increase intervention opportunities. In addition, the VA is currently developing a transition assistance program for incarcerated veterans that are intended to prevent homelessness by giving information about health care, housing assistance, andemployment services to veterans nearing release from jail or prison (McGuire, 2007).Although no single strategy can improvequality of life for all veterans with bipolar disorder, the many factors identified in this case scenario and in other studiesrepresent numerous opportunities to address a complex problem.

Contacting incarcerated veterans also built on a VA tradition of viewing mental health and substance abuse issues that resulted in incarceration as being related to experiences encountered while in the military. VA clinical staff members who were veterans themselves had a particularly strong commitment to provide mental health and substance abuse services to their fellow veterans. By 2000, an informal review of the VA's 22 Veteran Integrated Service Networks (VISNs) revealedthat 20 conducted some form of outreach, health, or benefit service directed to reentering veterans. Since FY 2002, when the VHA's Northeast Program Evaluation Center began tracking data on jails or prisons as locations of outreach activities, 6,493 veterans had received outreach services while incarcerated, which is a substantial number (Kasprow et al., 2003, 2004, 2005, 2006).

Early prevention outreach efforts by individual VA clinicians and some VA medical centers were augmented in 2003 by a U.S. Department of Labor (DOL) VA program named the Incarcerated Veterans Transition Program (IVTP). With leadership on the VA side from the director of VA's homeless programs, IVTP is a seven-site DOL-funded pilot project mandated by Congress under Public Law 107-95 (Homeless Veterans Comprehensive Assistance Act, 2001) to carry out a demonstration program to provide services to assist eligible veterans in transition from institutional living, including jails and prisons. As the lead agency, DOL's role has been to provide employment services to incarcerated veterans making the transition to community living. The role of the VA in IVTP has been to assist with access to VA benefits

and healthcare, including VA-funded transitional housing. By the end of its second year in 2006, IVTP had provided employment services to 1,448 incarcerated veterans. IVTP staff also coordinates with VA outreach staff to link veterans to VA healthcare or benefits directly or through referral.

VA has learned four important lessons from these beginning efforts. First, a collaborative partnership with the corrections system must be established and nurtured over time to gain access to veterans and to ensure coordination of reentry planning. Second, practical planning is essential to ensure veterans leaving prison or jail are actually connected to the VA for follow-up services. Without such arrangements in place, barriers at the time of releasesuch as lack of transportation or money 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 reentering veterans. Finally, veterans 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.

Posttraumatic Stress Disorder

It was not until World War I that specific clinical syndromes came to be associated with combat duty. In prior wars, it was assumed that such casualties were merely manifestations of poor discipline and cowardice. However, with the protracted artillery barrages commonplace during The Great War, the concept evolved that the high air pressure of the exploding shells caused actual physiological damage, precipitating the numerous symptoms that were subsequently labeled *shell shock*. By the end of the war, further evolution accounted for the syndrome being labeled a *war neurosis* (Glass, 1969).

During the Korean War, the approach to combat stress became even more pragmatic. Clinicians provided immediate onsite treatment to affected individuals, always with the expectation that the combatant would return to duty as soon as possible. The results were gratifying. During World War II, 23% of the evacuations were for psychiatric reasons. However, in Korea, psychiatric evaluations dropped to only 6% (Bourne, 1970). It finally became clear that the situational stresses of the combatant were the primary factors leading to psychological casualty.

Surprisingly, with American involvement in the Vietnam War, psychological battlefield casualties evolved in a new direction. What was expected from past war experiences—and what was prepared for—did not materialize. Battlefield psychological breakdown was at an all-time low: 12 per 1,000 (Bourne, 1970). It was decided that use of preventive measures learned in Korea and some added situational manipulation had solved the age-old problem of psychological breakdown in combat.

Also during the 1970s, many other people were experiencing varying traumatic episodes other than combat. There were large numbers of plane crashes, natural disasters, fires, acts of terrorism on civilian populations, and other catastrophic events. The picture presented ofmany mental health professionals working with victims of these events, helping them adjust after traumatic experiences, was quite similar to the phenomenon of troubled Vietnam veterans. The symptoms were almost identical. Finally, after much research (Figley, 1978) by various veterans' task forces and recommendations by those involved in treatment of civilian posttrauma clients, the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., 1980) was published with a new category: PTSD, acute, chronic, or delayed.

Evidence to date suggests that demobilization and return home after combat can be challenging for militaryservice members. Numerous reintegration problems have been reported among veterans from

the Gulf War andmore recent conflicts in Iraq and Afghanistan, including marital difficulties, financial difficulties, problems withalcohol or substance abuse, medical problems, behavioral problems such as depression or anxiety, homelessness, and motor vehicle accidents (Doyle & Peterson, 2005). Readjustment to community living is likely to be especiallychallenging for servicemembers who are injured, as readjustment may be complicated by the co-occurrence ofphysical injuries and postwar adjustment difficulties such as PTSD, depression,substance abuse, and severe mental illness.

Although the survival rate for servicemembersinjured in recent conflicts is far greater than that of previousconflicts, the improved survivability is associated with an increased rate of servicemembers with severe injuriesthat include head injuries, burns, and extensive injuries to the limbs. Improvised explosive devices arethe cause of a majority of these injuries (Fischer, 2009). As of May 2010, over 31,800 U.S. servicemembers had beenwounded in Operation Iraqi Freedom and Operation Enduring Freedom (Brookings, 2010).Injuries caused by improvised explosive devices are associated with anunusually high prevalence of traumatic brain injury and PTSD among the injured, which are conditions likely to present substantial challenges in reintegrating into community roles.

Data indicatethat Operation Iraqi Freedom and Operation Enduring Freedom service will negatively affect a far greater number of persons beyond thosecounted in the combat casualty statistics, with more than 790,000 veterans expected to seek disability benefitsfor service-related health problems (Committee on the Initial Assessment of Readjustment Needs of Military Personnel, Veterans, and TheirFamilies, 2010).Society’s understanding of the effects of poor post-deploymentreintegration stems largely from the experience of Vietnam War veterans, a disproportionate number of whomsuffer from chronic PTSD and pervasive difficulties in their everyday lives, including marital and work difficulties,poor parenting skills, violent behavior, alcohol and drug abuse, involvement with the criminal justice system,suicide attempts, and homelessness. More than onethird of homeless men in the United States are veterans, with an estimated 250,000 veterans homeless on a given night and more than 500,000 homelessover the course of a year (Resnik & Allen, 2007).

Given what is known about the experiences of veterans from previous wars, it isimperative to find ways to assess the community reintegration of today’s combat veterans and that early intervention is applied to prevent long-term consequences for returning servicemembers, their families, and society.To date, no systematic efforts have estimated the scope of these problems. At present, neither VA nor U.S. Department of Defense electronic medical records contain standardized dataelements related to community reintegration. Enhanced clinical information systems are a key component ofimproving care delivery for patients with chronic and complex conditions (Resnik, Plow,& Jette, 2009).Routine assessment of communityreintegration would enhance patient assessment and referral targeting to mental health, social services, andbenefit programs, as well as drive interventions that address underlying factors related to poor community reintegration.

Mental Illness and Suicide

It is well established that homeless people, especially those with mental health problems, require diverse services that include housing and income supports; medical, psychiatric, and substance abuse treatment; and social and vocational rehabilitation. It is also widely believed that access to these services is impeded by the fragmentation of most service systems and that fostering service system integration by improving communication and cooperation between service agencies can enhance the accessibility of services and ultimately improve client outcomes (Interagency Council on the Homeless, 1992). When services are not accessible, homeless people pose a huge health risk.

From the standpoint of health risk, the homeless population comprises a particularly vulnerable group of veterans.According to Khadduri, Culhane, andCortes(2010), the most recent estimates indicate that approximately one seventh of the adult homeless population consists of veterans. Veteran status is associated with increased risk for homelessness; a larger percentage of veterans ishomeless than in either the general population or the population living in poverty. Studies of homeless veterans revealed exceptionally high rates of significant psychiatric disorders, alcohol and drug abuse, and chronic medical conditions (Kushel, Vittinghoff, &Haas, 2001).These factors are potentiated by the impact of aging in the veteran population.

According to Khadduri, Culhane, and Cortes (2010), current estimates show that more than 20% of homeless veterans are aged 55 years or older.Cognitive decline because of aging and possible early onset of degenerative dementias add to the cumulative impact of health risks in older homeless veterans. Although it is anticipated that the increasing health vulnerability produced by these risk factors increases morbidity and reduces life expectancies because of all-cause mortality, few studies have approached these issues, including suicide, in a programmatic manner (Khadduri, Culhane, and Cortes (2010).

Much of what isknown about homeless suicidal behavior is based on data from the Access to Community Care and Effective Services and Supports (ACCESS) program. The ACCESS program provided clinical mental health services to 7,224 individuals in 15 cities across the country (Randolph, Blasinsky, Leginsky, Parker,&Goldman, 1997).All participants were homeless adults with evidence of serious mental illness who self-reported a suicide attempt in the 30 days before admission to the program or a 2-week period of persistent serious thoughts of suicide in the same 30-day period. In theACCESS group comprised of individuals aged 55 years and older, 3.5% of participants reported a suicide attempt and19% reported persistent suicidal ideation in the30-day period (Desai, Liu-Mares, Dausey, &Rosenheck, 2003).Approximatelyequivalent estimates were obtained in studies of veterans. In a sample of 34,245 veterans (mean age = 46.6 years) who sought treatment of substance abuse or psychiatric disorders, 3.4% of the veterans reported an attempted suicide in the month before seeking services (Tiet, Finney, &Moos, 2006).A similar study of 600 veterans (mean age = 56.3 years) who sought treatment of substance abuse at a Midwestern VA revealed that 40% reported current suicidal ideation as determined by an established cutoff score on a suicidal ideation self-report scale (Benda, 2003).The limited research to date indicatesthat older homeless veterans may be at substantively greater risk forsuicidal behavior than are individuals in the general population.

Because U.S. veterans are predominantly older individuals with substantial medical morbidities, high levels of substance abuse and mental illness, and increased knowledge of and access to firearms, it is not surprising that some research reported that male veterans were at approximately twice the risk for suicide than male nonveterans (Bossarte, Claassen, &Knox, 2010).However, the associations between history of military service and risk for suicide are not clear.For example, subsequent studies of male veterans in the general population failed to identify increased risk among middle-aged and elderly males (Kaplan, Huguet, McFarland, &Newsom, 2007).Among veterans receiving care from the VHA, suicide risk for men and women combined across all age groups was estimated to be 66% higher than that observed in the general population (McCarthy et al., 2009).For male veterans, the risk in age groups 50 to 70 years was 56% to 108% greater than the risk in the general male population. The frequency of suicidal ideation also appeared to be higher in veterans receiving VHA health services. In a study of older veterans receiving services in VA primary care clinics, Ayalon et al.(2007) found that 5% of veterans reported suicidal ideation in the 2 weeks before assessment. Notably, Ayalon et al. found that poorer cognitive functioning contributed to the occurrence of suicidal ideation.

Veteran's Affairs and Support Services for Homeless Veterans

Answering the question about how much the federal government spends on homelessness should be as simple as summing the total expenditures for homeless assistance programs. Homeless programs, however, do not fit into one federal agency; instead, they are spread across several, including HUD, the U.S. Department of Health and Human Services, the Social Security Administration, the U.S. Department of Education, and the DOL. These federal agencies administer programs dedicated to serving homeless people—meaning that the goals and eligibility requirements target homeless people—and mainstream programs that serve homeless people as well as other low-income people, for example, Medicaid or mainstream housing and community development programs (i.e., Section 8, public housing).

According to the National Alliance to End Homelessness (2006), the federal government spent $1,928 billion dollars on dedicated homelessness programs in 2006. HUD's McKinney-Vento Homeless Assistance Grant is the primary source of funding for homeless people. McKinney-Vento funds support emergency shelters, transitional housing, permanent housing, and supportive services. Since 2001, McKinney-Vento Homeless Assistance funding has increased slightly, with a dip in 2005. In 2001, the McKinney-Vento Homeless Assistance Grant was funded at $1.286 billion; by 2006, it had increased slightly to $1.327, after adjusting for inflation. Althoughthese homeless programs are funded, it is still difficult to get the homeless to engage in the programs.

Homeless mentally ill individuals can be difficult to engage in treatment and are at high risk for dropping out of treatment (Park et al., 2002: Rosenheck & Gallup, 1991). Difficulties associated with engaging homeless mentally ill individuals living on the streets or in transient shelters are well known. It is equally challenging to maintain engagement when individuals transition from living in institutional settings such as shelters to independent community living. Programs such as the Critical Time Intervention (CITI), aimed at preventing recurrent homelessness, target this critical crossroads (Susser et al., 1997). Individuals moving into independent housing often lose ongoing daily support from professional staff.

For homeless veterans leaving VA short-term residential treatment programs, moving may also mean losing informal camaraderie and support from fellow veterans. As individuals face the increased responsibilities and expectations of independent living, they may feel overwhelmed and may subsequently miss appointments for mental health care and other rehabilitation services. Dropping out of treatment, disruption of personal relationships and environmental stresses can lead to exacerbated psychiatric symptoms and a cycle back into homelessness.Although mental health professionals can help ease the transition, formerly homeless mentally ill peers are uniquely able to understand what the transition to housing entails and what supports are needed to ensure community tenure. Formerly homeless peers can serve as role models and help homeless individuals look beyond immediate housing acquisition to the ongoing tasks of maintaining treatment connections, avoiding substance use, and developing appropriate social contacts in the community.

Studies show that peer involvement can have a positive impact on quality of life for patients with severe mental illness (Bedell, Choen, & Sullivan, 2000; Felton et al., 1995) and that consumer advocates can make valuable contributions to Assertive Community Treatment teams treating homeless mentally ill patients "by virtue of their street smarts, engagement skills, peer support, positive role modeling, fighting stigma, and education of co-workers" (Dixon, Krauss, & Lehman, 1994, p. 615). Based on this research, program leadership at Project TORCH (The Outreach and Rehabilitation Center for Homeless Veterans), and part of the VA New York Harbor Health Care system, and the Mental Illness Research Education and Clinical Center developed a pilot peer-assisted case management program. The program developers

hypothesized that peers—veterans with severe mental illness who had been homeless previously, graduated from a homeless veteran's treatment program, and subsequently maintained sobriety in independent, stable housing—could help other veterans make the transition to independent living.

Peer case management can be a useful adjunct to standard treatment for homeless mentally ill individuals during the transition to independent housing, but implementation can be challenging. Staff education is a key component to making a peer advisor program work. Staff must be able to voice their concerns and become comfortable with the intended role the peer advisor is to play. Establishing broad-based staff support can provide stability in the face of turnover in management and clinical staff, as can training extra staff for each role. Peer advisors may also have a high turnover rate, which may reflect a positive outcome because peers may move on to school or higher paying jobs in the private sector. Future studies should systematically collect data from peer advisors to quantify potential benefits and liabilities associated with their work. Larger studies with budgets that allow tracking of participants independent of the treatment system are needed to determine the most effective practice styles and the outcome domains most likely to improve due to peer interventions.

Disability Benefits and Clinical Outcomes

Although disability payments are intended to provide income support to people who are unable to work due to illness or injury, some critics have expressed concern that such payments create perverse financial incentives for over reporting or falsely reporting illness or injury among people who are capable of working (Frueh et al., 2003). One critic asserted that the government pays people to be sick (Mossman, 1996), whereas another suggested that the payment of benefits to addicts with severe mental illness results in a process of "social pathogenesis"(Satel, 1995, p. 794), which is the exacerbation of disease by an economic policy intended to promote well-being.Empirical findings from studies onthe effects of disability benefits on substance use outcomes have been mixed. One study involving 105 veterans with schizophrenia and histories of long-term dependence upon cocaine found that cocaine use peaked shortly after the arrival of disability payments around the first day of the month (Shaner et al., 1995). In contrast, a longitudinal study involving 655 homeless veterans with alcohol or drug problems found no significant relationship between receipt of public support payments and substance use (Rosenheck & Frisman, 1996). A third study of 2,474 homeless veterans dually diagnosed with schizophrenia and a substance abuse disorder also showed no significant relationship between receipt of disability payments and substance use, even among users of alcohol and drugs (Frisman & Rosenheck, 1997).

Previous studies examining the relationship between disability status and mental health outcomes have generally found more mental health problems and greater subjective distress or burden from psychiatric symptoms among individuals seeking or receiving disability compensation as compared to those not interested in receiving disability (Fontana & Rosenheck, 1998; Frueh et al., 2003). However, one longitudinal study found no significant differences in rates of clinical improvement between those receiving or seeking benefits and those expressing no interest in such benefits (Fontana & Rosenheck, 1998).Persons receiving disability payments have shown considerably less favorable longitudinal outcomes in employment than have non-receivers. While statistically significant, the effect sizes of such differences have been small, except at high levels of payment. Among 1,634 veterans with or without psychiatric disorders assessed by the national Vietnam Veterans Readjustment Survey (1987-1988), those receiving disability payments of less than $500 a month were no less likely to work than were rejected applicants. Each additional $100 a month in monthly payments was associated with an additional 2% decline in the proportion of veterans who worked (Rosenheck, Frisman, & Sindelar, 1995).

In a more recent study involving 22,515 veterans with physical or psychiatric diagnosis participating in a transitional employment program, Drew et al. (2011) found that subjects receiving disability benefits worked fewer hours per week, earned less income, were more likely to leave the program, and were less likely to be competitively employed at discharge than veterans who did not receive disability benefits. In contrast to these negative effects on employment, a longitudinal outcome study of 406 homeless veteran patients with psychiatric and substance use disorders found that increased public support payments were associated with increased housing tenure (Rosenheck, Frisman,& Gallup, 1995). Further empirical study of the relationship between disability payments and various health outcomes is needed.

Homeless Outreach

During the 1980s, homelessness among persons with mental illness emerged as a serious problem, as more than half of all homeless Americans were found to suffer from psychiatric or substance abuse disorders (Tessler, 1989). A number of studies have shown that a major difference between homeless persons with mental illness and non-homeless persons with mental illness is their access to public support payments (Rossi, 1989). One longitudinal study of homeless mentally ill veterans showed that increased public support payments are significantly associated with exiting homelessness, but not with increased alcohol or drug use (Rosenheck, 1995).

Few studies exist on outcomes associated with coordinated interagency benefits outreach, in which agencies responsible for administering public support programs join with clinicians to reach out to underserved homeless persons in the community to provide them with the benefits to which they are entitled. In 1992, the Social Security Administration and the VA initiated a Joint Outreach Initiative designed to improve access to Social Security benefits, including Social Security Disability Insurance and Supplemental Security Income among homeless veterans with mental illness served by the VA's Health Care for Homeless Veterans program(Rosenheck, 1995).An evaluation of that initiative showed that a concerted co-location approach to benefits outreach modestly increased the proportion of homeless veterans whoapplied for Security Disability Insurance and Supplemental Security Income from 11% to 19%, and the proportion awarded benefits had a higher quality of life 3 months after receiving benefits than those who were not and had higher total income and expenditures on transportation, necessities, and tobacco, but not on alcohol or drug use(Rosenheck, 1995).

In 1994, as authorized by Public Law 102-590, a joint Veterans Benefits Administration (VBA)/VHA Homeless Outreach Initiative was implemented to expand the VBA's efforts to assist homeless veterans through collaboration and sharing of resources. The goal of this national, multisite benefits outreach effort was to create an ongoing, working partnership that would join VBA and VHA staff to make the benefits claim process more accessible, responsive, timely, and efficient for eligible homeless veterans. Similar to the Social Security Administration/VA Joint Outreach Initiative, the VBA/VHA Homeless Outreach Initiative focused on improving the interaction between two agencies (an agency-specific approach) rather than on the entire system (a system-wide approach; Rosenheck, 1999).

Comparing Homeless Veterans With Other Homeless Men in Clinical Outreach Programs

Since the dramatic increase in urban homelessness in the United States in the late 1970s, large numbers of veterans have been observed among the homeless. For many years, it was assumed that this was a reflection of the hardships incurred during the Vietnam conflict. However, recent research has shown that the risk of homelessness was lower than expected among Vietnam era veterans and that, unexpectedly, veterans of the All-Volunteer Force were at a dramatically higher risk of homelessness (Rosenheck, 1994).

Most published studies of homeless veterans are based on samples from the 1980s. While there are some inconsistencies, these studies tend to show that homeless veterans are older and better educated than homeless nonveterans are. In the groups studied, White men were also overrepresented among homeless veterans when compared to other homeless men who had not served in the armed forces (Rosenheck, 1996). However, with the advent of the All-Volunteer Force in 1973 and the introduction of younger veterans into the ranks of the homeless, it is timely to examine whether and in what ways the composition of the veteran homeless population is changing and how homeless veterans of the 1990s compare to homeless nonveterans. Differences between homeless veterans and homeless nonveterans may suggest different pathways into, and potentially out of, homelessness.Recent research has indicated a complex pattern of influences that predispose veterans to homelessness, including extreme poverty as well as post-military psychiatric disorders and social isolation. It appears that at least some of the problems that put veterans at risk of homelessness were not present when they were screened for military services, but instead developed later (Rosenheck, 1994).

From a life course perspective, military service occurs during a normative life stage in young adulthood in which a major goal is achieving independence. Thus, for many young adults, the decision to join the military represents a step toward separating from the family of origin, acquiring new skills, and developing an adult identity(Rosenheck, 1996). For some individuals, military service may also represent an effort to surmount childhood disadvantages and to set off on a new and more positive pathway in which induction into the service is the turning point.

Plan to End Homelessness Among Veterans

The problem of homelessness, many say, is unsolvable. Communities across the United Stateshave struggled with getting homeless people off the street by building shelters, transitional housing, and soup kitchens. Although these strategies help address the immediate needs of homeless people by providing food and temporary shelter, they have not been successful in decreasing homelessness, which has left communities frustrated and hopeless.

In 2000, the National Alliance to End Homelessness released *A Plan, Not a Dream: How to End Homelessness in Ten Years*. Drawing on research and innovative programs from around the country, the plan outlined key strategies to address the issue locally, which cumulatively can address the issue nationally. The plan outlined four key elements of a plan to end homelessness:

- Plan for outcomes: Every jurisdiction should collect data that allow it to identify the most effective strategy for each subgroup of the homeless population, and jurisdictions should bring those responsible for mainstream as well as homeless targeted resources to the planning table.
- Close the front door: Communities should prevent homelessness by making mainstream poverty programs more accountable for the outcomes of their clients.
- Open the back door: Communities should develop, and subsidize when needed, an adequate supply of affordable housing.
- Build the infrastructure: Ending homelessness can be a first step in addressing the systemic problems that lead to crisis poverty, including a shortage of affording housing, incomes that do not pay for basic needs, and a lack of appropriate services for those whoneed them.

Sixty-six percent of the community plans to end homelessness targethomeless people, and 34% focus on chronically homeless people. Many plans lay out strategies for specific subgroups of homeless people, including families, youth, veterans, and the elderly. Forty-one percent of the plans outline strategies to end family homelessness, 49% outline efforts to end youth homelessness, and 31% of plans address the housing needs of former prisoners to prevent them from becoming homeless. A wide range of stakeholders was involved in the community planning process, with the strongest representation from the nonprofit sector and the weakest representation from the private sector. Although some plans (28%) involve currently or formerly homeless people, their participation in the development of plans is lower than that of other stakeholders.

Communities outlined a wide range of strategies in the plans:

- Creating data systems: Almost all of the plans (91%) outline strategies to create Homeless Management Information Systems.
- Homelessness prevention: An overwhelming majority of the plans (79%) addresses emergency prevention, and 91% of the plans outline systems prevention activities, such as discharge planning for correctional facilities, foster care systems, or mental health facilities.
- Outreach: Outreach efforts to engage people living on the streets are outlined in 79% of the plans.
- Shortening time of homelessness: Shortening the time that people spend homeless by providing permanent housing to homeless people is included in 67% of the plans, and 57% call for rapid re-housing. In total, the plans call for creating approximately 196,000 units (or subsidies), of which 80,000 units are permanent supportive housing.
- Links to services: Afterindividuals or families are in housing, 81% of the plans outline strategies to link them with mainstream services so they can earn enough money to pay rent and avoid homelessness.

There is much more to be done, but despite these challenges, for the first timein two decades, communities have a plan and homelessness is a problem with a clear solution. The problem of what to do about homelessness is no longer viewed as an unanswerable question. Although community plans to end homelessness represent a collective effort, community plans need a stronger focus on families, shortening homelessness, and rapid re-housing strategies and implementation.

Conclusion

A review of the literature revealeda plethora of research concerning the problem of homelessness in the veteran population. Far too many veterans are homeless in the United States. Homeless veterans live in every state across the country and in rural, suburban, and urban communities. Many have lived on the streets for years, whereas others live on the edge of homelessness, struggling to pay their rent. Lack of affordable housing is the primary driver of homelessness. The 23.4 million U.S. veterans generally do not have trouble affording housing costs; veterans have high rates of home ownership and appear generally well housed. However, a subset of veterans hasa severe housing cost burden.

A considerable numberof resources and programs have been implemented to prevent veterans from being homeless, but for those veterans who have experienced chronic homelessness, affordable housing is necessary. Further research is needed to explore the tracking of homeless veterans and the treatment

needed to improve interventions related to posttraumatic stress disorder, mental illness, and suicide. Additional research is also needed to inform veteran affairs and public policy at the federal, state, and local government levels.

Millions of veterans have served and protected the United States. Althoughmost veterans are doing well and living in stable housing, a small subset are sleeping on streets, in shelters, or in other places that no one should have to endure. Americans are indebted to those who have served, and public policies should ensure veterans have access to stable housing and the necessary support needed to avoid homelessness.

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