



# **A REVIEW OF THE LITERATURE RELATED TO HOMELESS VETERAN REINTEGRATION**

## **Final Report**

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**Table of Acronyms**

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<b>CEO</b>	Chief Evaluation Office
<b>CHALENG</b>	Community Homelessness Assessment Local Education and Networking Group
<b>COC</b>	Continuum of Care
<b>CLEAR</b>	DOL Clearinghouse for Labor Evaluation and Research
<b>DOL</b>	U.S. Department of Labor
<b>GAO</b>	Government Accountability Office
<b>GPD</b>	Grant and Per Diem
<b>HFV/HVFP</b>	Homeless Female Veterans/Homeless Veterans with Families Program
<b>HUD</b>	U.S. Department of Housing and Urban Development
<b>HUD-VASH</b>	Housing and Urban Development-Veterans Affairs Supported Housing
<b>HVRP</b>	Homeless Veterans' Reintegration Program
<b>IVTP</b>	Incarcerated Veterans' Transition Program
<b>MOU</b>	Memorandums of Understanding
<b>MST</b>	Military Sexual Trauma
<b>NCHV</b>	National Coalition for Homeless Veterans
<b>OEF</b>	Operation Enduring Freedom
<b>OIF</b>	Operation Iraqi Freedom
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>PHA</b>	Public Housing Agencies
<b>TIP</b>	Transition in Place
<b>SSVF</b>	Supportive Services for Veteran Families
<b>USICH</b>	United States Interagency Council on Homelessness
<b>VA</b>	U.S. Department of Veterans Affairs
<b>VETS</b>	Veterans' Employment and Training Services

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## ***Abstract***

The U.S. Department of Labor (DOL)'s Office and Chief Evaluation Office (CEO) and the Veterans' Employment and Training Services (VETS) requested a literature review in support of a 2015 assessment of DOL's Homeless Veterans' Reintegration Program (HVRP). This review synthesizes evidence from studies and reports related to homeless veterans, published by the end of 2014 and with a central focus to identify the risk factors for homelessness among veterans. A secondary aim of the review was to identify the promising practices in services and training that help ensure homeless veterans successfully reintegrate into meaningful employment. The nature of the literature and past studies related to homelessness among veterans is mostly qualitative, with few rigorous quantitative studies demonstrating causal evidence either between risk factors and homelessness, or between program interventions and states of homelessness. This current inventory of literature focuses on identifying the risk factors associated with veteran homelessness, providing a foundation for future research that can better establish cause-and-effect relationships.

The literature on homelessness among veterans finds a set of risk factors, some of which are common among the broader homeless population and others that are unique to veterans. Veterans and non-veterans share the common risk factors associated with homelessness, such as childhood instability, mental illness, substance abuse, insufficient social supports as adults, and low or unstable income. Veterans, however, bring with them a set of additional factors that appear to compound or exacerbate the risk for homelessness, including Post-Traumatic Stress Disorder (PTSD), and for women veterans, an increased risk of PTSD related to Military Sexual Trauma (MST). Beyond individual risk factors, structural issues also appear to contribute to the persistence of homelessness among veterans, including lack of access to stable housing and employment opportunities. Studies show that services that combine transitional housing support with employment and training opportunities lead to promising outcomes for homeless veterans over the longer term. Further, the literature provides insight into how veteran assistance programs can effectively braid these services for homeless veterans, by navigating incongruent eligibility criteria, sequencing of services requirements, and funding mechanisms.

# A REVIEW OF THE LITERATURE RELATED TO HOMELESS VETERAN REINTEGRATION

## ***Background***

### **Purpose and Objective of this Review**

This literature review contributed to an assessment of the U.S. Department of Labor (DOL) Veterans' Employment and Training Services' (VETS) Homeless Veterans Reintegration Program (HVRP). The assessment, overseen by DOL's Chief Evaluation Office (CEO), involved an in-depth analysis of HVRP sites across the United States during 2015. A review of existing literature supported this analysis by synthesizing existing evidence on risk factors for homelessness among veterans and promising practices related to services, including housing assistance, training and up-skilling, supported employment, and program-level partnerships to ensure veterans receive a comprehensive continuum of support. The intended goal of these service programs, including the HVRP, is to position veterans with long-term stability in housing and to successfully reintegrate them into meaningful employment. The HVRP is the only federal program wholly dedicated to providing employment assistance to homeless veterans, serving over 16,000 veterans annually.

### **Background on Homelessness among Veterans**

In November 2009, President Barack Obama and then-Veterans Affairs Secretary Eric Shinseki announced a goal of ending homelessness among U.S. veterans within five years. To realize this ambitious goal, the United States Interagency Council on Homelessness (USICH) created *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness 2010*. These efforts turned attention to the disproportionately high rates of homelessness among U.S. veterans. At the end of the five years the rate of veteran homelessness was not zero, but progress was evident. In August 2014, the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Veterans Affairs (VA), and USICH announced a decline in veteran homelessness of 33 percent, or 24,837 people, since 2010 (Henry, Cortes, Shivji, & Buck 2014). Between 2013 and 2014 veteran homelessness declined by 11 percent, or 5,846 people (Henry et al., 2014). Despite this progress, the Department of Housing and Urban Development reported that more than 49,000 veterans were homeless in January 2014. Further, the rate of homelessness among veterans remains nearly double the rate of homelessness among non-veterans (Henry et al., 2014).

The definition of the key term "veteran" varies between programs and sources. However, most programs serving homeless veterans define "veteran" as an individual who has served in the military, regardless of active duty or discharge status (Perl 2013). Regarding the term "homeless individual," the HVRP defines it to include persons who lack a fixed, regular, and adequate nighttime residence. It includes persons whose primary nighttime residence is either a supervised public or private shelter designed to provide temporary living accommodations; an institution that provides a temporary residence for individuals intended to be institutionalized; or a private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

There are three data sources widely relied on for estimating the number of homeless veterans (Balslem, Christensen, Tuepker, & Kansagara 2011): (1) the Department of Housing and Urban Development's (HUD) Point-in-Time (PIT) estimate (an approximate count of homelessness during a single night in January); (2) the Homeless Management Information System (HMIS) estimate (a count of sheltered homeless populations during a calendar year); and (3) the Department of Veterans Affairs' (VA) Community Homelessness Assessment, Local Education, and Networking Group (CHALENG) Report Data. HUD and the VA annually collaborate to produce and release a veteran-specific supplement to the Annual Homeless Assessment Report (AHAR) to Congress, which incorporates data from multiple sources and is credited with being the most accurate. As the only federally funded program wholly dedicated to serving homeless veterans, the HVRP sites and services are unique and important because they serve veterans who may be ineligible for other veteran programs and services because of co-occurring disorders such as severe Post-Traumatic Stress Disorder (PTSD), long histories of substance abuse, serious psychosocial problems, and legal issues. In particular, chronically homeless veterans require more time-consuming, specialized, intensive assessment, referrals, and counseling than is possible in other programs that work with veterans seeking employment. The employment focus of HVRP distinguishes it from most other programs for the homeless, which concentrate on more immediate needs such as emergency shelter, food, and substance abuse treatment. HVRP is also concerned with these aspects of aid, but emphasizes these supports in the context of securing stable long-term employment and housing. In September 2007, the Government Accountability Office (GAO) cited the HVRP as one of the most effective and efficient federal homeless assistance programs in the nation (GAO 2007).

## ***Methodology***

### **Key Research Areas Addressed by Literature Review**

This literature review focused on answering eight specific questions organized into three areas of focus: (1) foundational knowledge (pathways to homelessness and veteran-specific risk factors); (2) key data and correlations that illustrate the critical junctions in the individual homeless veteran's experience where intervention and assistance are critical (i.e., pre-conditions for homelessness, risk factors for chronic homeless, differences between generations of veterans, characteristics of women veterans, risk factors relating to military policy involving duration of deployment, and redeployment and recruitment standards); and (3) homelessness intervention efforts and common approaches in serving homeless veterans, including housing interventions, transitional housing programs, skills training, supported employment programs, and streamlining and alignment among veteran assistance programs.

As discussed in further detail below, the literature available to address these areas of inquiry varies considerably – and there are few experimental studies to provide impact-type findings to address these questions. The U.S. DOL Clearinghouse for Labor Evaluation and Research (CLEAR) establishes guidelines and ratings for causal evidence, with the highest rating assigned to randomized controlled trials, mid-level ratings for comparison group studies, and lowest ratings for non-experimental assessments and studies (DOL 2014). The literature used in this review reflects the significant gap in high-rigor causal evidence related to homeless veterans,

with the vast majority of research on this subject meeting the guidelines only for the lowest tier of evidence.

### **Literature Search Strategy and Selection of Studies and References**

The search strategy began with a scan of academic journals, newspaper articles, federally funded reports and agency websites referencing studies related to homelessness and veterans. No initial limitations were placed on publication year. Two sources were particularly relevant to the focus questions of this review: the research briefs highlighted by the National Coalition for Homeless Veterans (NCHV)<sup>1</sup>, and a literature review completed in April 2011 by the Department of Veterans Affairs, entitled *A Critical Review of Literature Regarding Homelessness Among Veterans* (Balshem et al., 2011). These resources effectively inventoried relevant findings up to 2011. Additional scans were conducted independently to identify more recent research from 2012, 2013, and 2014.

This literature review process drew on a total of 45 research reports highlighted by NCHV related to employment and training, supportive services, housing, women veterans, Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF), aging veterans, and other topics most critical for HVRP grantees. Their catalog of research draws on articles from the National Institutes of Health, the Government Accountability Office, the Pew Research Center, various medical and science journals, and federal agencies such as the Department of Veterans Affairs, the Department of Labor, and the Department of Defense. A chain-referral sampling technique was utilized to build out the full list of references, making use of referenced studies and cited research in each reviewed article. This technique allowed for layers of evidence to be collected on the specific topics and focus questions of the review.

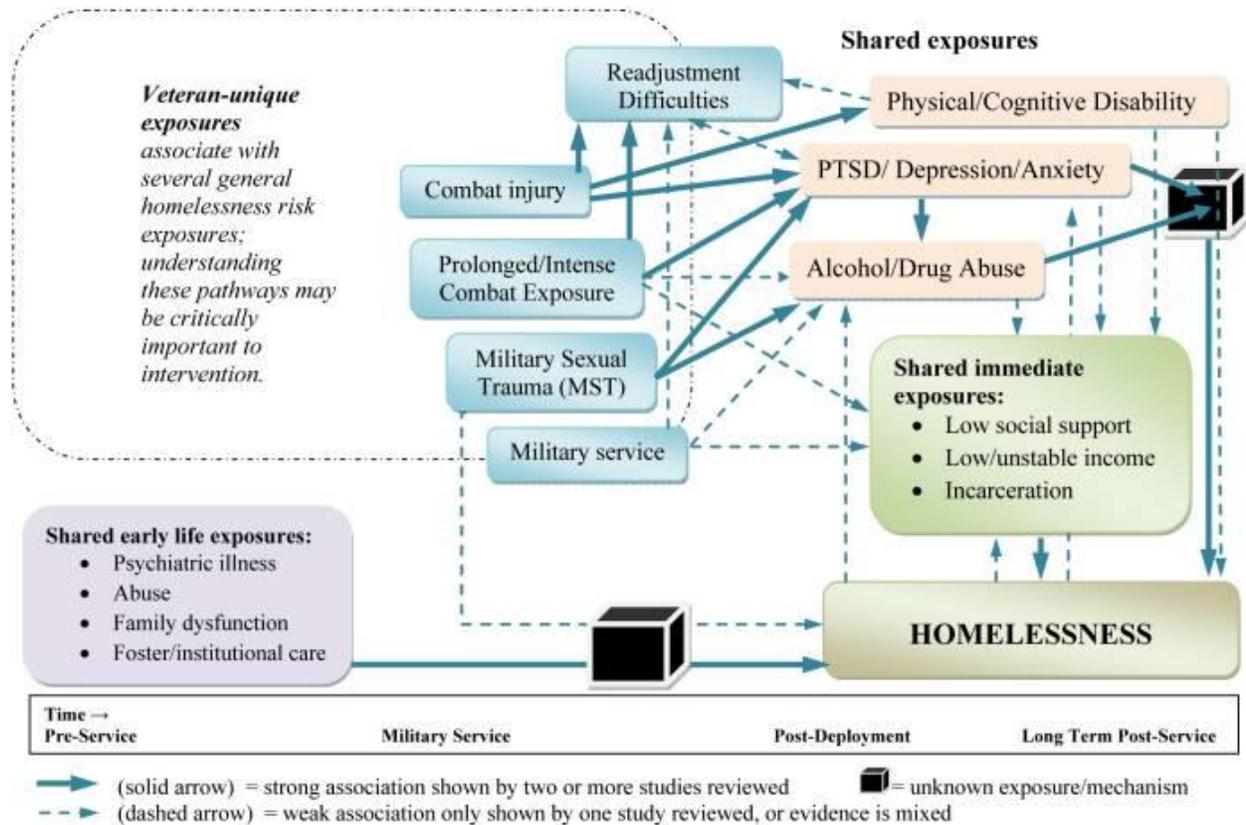
An important source of information related to housing interventions and transitional housing programs, skill training, supported employment programs, and alignment of efforts across multiple agencies were promising practice reviews of veteran-focused programs. The promising practice compendiums, assembled by NCHV (NCHV 2007, 2011, and 2012), detailed a collection of successful HVRP profiles from across the country, including a wide range of market models. NCHV used questionnaires and interviews to compile the information presented in the profiles of the compendiums and made an effort to ensure the inclusion of programs representing the full range of program types: urban, rural, faith-based and community-based organizations, local projects, regional networks, and public agency homeless veteran service providers. While the practices in these compendiums have not undergone rigorous evaluations or studies that provide CLEAR correlations between promising practices and improved homeless veteran outcomes, the findings in these profiles identify sites that demonstrate higher than average outcomes (such as completion of training, employment, retention in housing, and job retention) for the client base. This literature review summarizes repeated practices and

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<sup>1</sup> NCHV is a nonprofit organization that acts as the resource and technical assistance center for a national network of community-based service providers and local, state, and federal agencies that provide emergency and supportive housing, food, health services, job training and placement assistance, legal aid, and case management support for hundreds of thousands of homeless veterans each year. Based on this review, NCHV is the most comprehensive known source of information about veteran service program development, administration, governance, and funding to all of the nation's homeless veteran service providers.

approaches from the higher performing HVRP sites, as well as Homeless Female Veterans/Homeless Veterans with Families Program and Incarcerated Veterans Transition Program higher-performing grantees, as potential critical success factors in serving homeless veterans.

**FIGURE 1: RISK FACTORS FOR VETERAN HOMELESSNESS: CONCEPTUAL MODEL**



**Source:** Balshem, H., Christensen, V., Tuepker, A., and Kansagara, D. (2011). A Critical Review of the Literature Regarding Homelessness Among Veterans. Department of Veterans Affairs, Washington D.C.

### Key Findings from Literature

#### Conceptual Framework

Based on an analysis of the individual pathways to homelessness, Balshem and colleagues designed a comprehensive conceptual framework to depict the relationship between veterans’ pre-service, service, and post-service experiences and homelessness (Balshem et al., 2011). Reproduced in Figure 1 above, the graphic highlights certain risk factors for veteran homelessness based on the number of times each factor appeared in studies. The model assigns a

value in terms of weak or strong correlation of risk factor to veteran homelessness. The graphic is consistent with the latest available literature and illuminates the complexity and unknowns of an individual's pathway leading to homelessness or chronic homelessness.

## Specific Focus Question Findings

### Research Area 1: Foundational Knowledge of Risk Factors and Pathways to Homelessness

#### I. What factors lead to disproportionate veteran homelessness?

**Summary:** The literature on veteran homelessness converges on at least three risk factors that increase veteran propensity toward homelessness, but fails to find consistent protective factors mitigating homelessness among veterans. The three risk factors are: (1) overall mental health status (correlated with Post-Traumatic Stress Disorder, or PTSD), (2) co-occurring substance abuse issues, and (3) chronic illness (Shelton 2009, Johnson 1997, O'Toole 2003). Among the protective factors that mitigate homelessness within the general population, including education, marital status and family cohesion, the available literature is conflicting in its findings as they related to the veteran population.

**Discussion:** The literature on risk factors associated with veteran homelessness relies predominantly on self-reported data, rather than the more rigorous comparison studies, which means that validity of these findings is contingent on the willingness and accuracy of study participants' self-disclosure (Fischer 1991). Among this evidence, however, there is significant agreement that mental health status, co-occurring substance abuse issues, and chronic illness heavily contribute to veteran homelessness (Shelton 2009, Johnson 1997, O'Toole 2003). In particular, exposure to intense or prolonged combat, combat injury, and Military Sexual Trauma (MST), all of which have an impact on a veteran's mental health (particularly PTSD), appear to directly affect an individual's ability to secure a stable income (Shelton 2009). Additionally, the prevalence of mental health, substance abuse, and chronic medical problems among homeless veterans is higher than among housed veterans (Shelton 2009), suggesting that there may be pre-existing variables among certain veterans that make them more vulnerable to PTSD, such as aforementioned military-related trauma, but also pre-existing traumas or conditions that occurred or existed before joining the military (Hamilton 2014). In Hamilton's study, which included a study group of homeless women veterans and a control group of housed women veterans, it was noted that there was a possible confounding factor in these data's statistical validity. Many of the women in the housed group shared the risk factors of the homeless group, but also had been homeless in the near past and were at risk for becoming homeless again in the near future. It is important to note the fluidity of these two defined sub-groups in order to fully understand the data in many of these comparative studies (Hamilton 2014).

In addition to risk factors, literature on this topic also discusses protective characteristics that should be *expected* to shield veterans from becoming homeless, based on non-veteran

homelessness studies. These characteristics include higher levels of education and historic family cohesion. Yet some studies reviewed found that, among homeless veterans, these predicted protections appear not to have the associated, expected influence (Balslem et al. 2011). Despite higher than average levels of education compared to their non-veteran homeless peers, and a higher rate of past family cohesion (including a higher likelihood to be or have been married), rates of homelessness among veterans are twice that of non-veteran individuals. Reasons for this in the literature are based on conjecture: it may be that unique veteran experiences associated with combat, trauma, and post-deployment readjustment outweigh or cancel out the expected protections associated with a strong family support and history of support (Tessler 2002). Some literature offers further conjecture that, in fact, individuals with a stronger and more stable family experience are actually more likely to be negatively affected by the trauma of deployment (Washington 2010). A similar argument has been made for National Guard veterans, who are often older and more established in their civilian lives, and therefore tend to be less connected to social supports offered by the military in post-deployment. At least anecdotally, National Guard veterans are considered to have more serious post-deployment readjustment difficulties (DOD Taskforce 2007).

Only a couple of studies relating to veterans have found marital status and education level to be protective factors among their populations of interest (Lee 2013, Hamilton 2014). However, both studies focused on specific sub-groups among the larger homeless veteran population; homeless and domiciled veterans seeking urgent care at a VA psychiatric unit, and women veterans. Both authors hypothesize that it could be that the positive correlation between marital status and education level can be explained by the context or gender specific factors of the study that was conducted. Regardless, further research is needed, particularly when comparing homeless veterans and non-homeless veterans (as opposed to comparison studies of homeless veterans and their non-veteran homeless peers).

## **II. What characteristics are unique to women veterans that contribute to homelessness?**

**Summary:** Data from the VA suggest that as greater numbers of women in the military return to their communities after their service ends, the rate of homelessness among women veterans is likely to rise. This projection is based on interrelated factors: first, the increased enrollment by females in the military will likely increase incidents of Military Sexual Trauma (MST), which is strongly correlated to PTSD, a risk factor for veteran homelessness; and secondly, women veterans experience higher rates of unemployment compared to male veterans.

**Discussion:** There are currently 2.2 million women veterans in the United States. The VA projects that the number of women veterans will continue to grow to 2.5 million within the next 10 years. Quantitative data tell us that women veterans are four times more likely to experience homelessness than non-veteran women and that women veterans are disproportionately more at risk for homelessness than their male peers (Hamilton 2014). While homeless veterans are predominantly men (90.2 percent), women veteran rates are at 9.8 percent compared to their 7.2 percent share of the total veteran population (Perl 2013). Women veterans also have worse employment rates than their male counterparts. Recent Bureau of Labor Statistics data show an increase in overall rates of women veteran unemployment from 4.6 percent in January 2014 to

6.2 percent in January 2015 (compared to decreases for male veterans from 5.7 percent in January 2014 to 5.1 percent in January 2015).

In a study among homeless women veterans in 2010 who received VA services, 39.1 percent of them were victims of MST (Perl 2013). The VA uses the term Military Sexual Trauma (MST), specifically defined by public law, to refer to sexual assault and to repeated, threatening sexual harassment occurring during military service. MST is conceptualized within an occupational exposure framework as a duty-related hazard and, therefore, sexual assault and sexual harassment are grouped together. The survey also found that women were the victims of 95 percent of sex crimes reported in the military, and female victims of MST are nine times more likely to suffer from PTSD than non-MST victims (Perl 2013). Perl suggests that as greater numbers of women in the military return to their communities after their service ends, the rate of homelessness among women veterans is likely to rise. This is based on a chain of correlations: increased enrollment by females in the military, high current and past rates of MST (reported by one in every five women veterans), correlations between MST and PTSD, and correlations between PTSD and veteran homelessness.

In 2013 and 2014, Hamilton conducted a rigorous structured qualitative ethnographic study, which compared homeless and housed women veterans. Hamilton argues that “gender and the military are both social institutions that may act in combination to create gendered social roots of homelessness that are particular to women” (Hamilton 2014). The study data identified characteristics that are specifically associated with homelessness among women veterans: unemployment, disability, poor overall health, screening for an anxiety disorder or PTSD, and a history of MST. Hamilton reported that the number of homeless women veterans doubled between 2006 and 2010 (Hamilton 2014).

Evidence suggests that sexual assault from before and during military service is associated with women veteran homelessness (Washington 2010, Hamilton 2014). In a study of 581 homeless women veterans, Tsai et Al. (2012) found that 67 percent of the women reported having experienced rape (32 percent of the trauma was inflicted by a family member, and 42 percent occurred while in the military). Multiple studies report an association of sexual abuse with increased risk of anxiety, depression, and poorer general health, all of which are considered risk factors for PTSD, substance abuse, disrupted social networks, and employment difficulties—all of which, in turn, are risk factors for homelessness (Hankin 1999, Murdoch 1995, Kimerling 2010, Suffoletta-Maierle 2003, Benda 2006). Awareness of MST has significantly increased over the past decade, but the evidence on MST prevalence varies dramatically across sources. Two studies in the 1990s cite 14 percent (Murdoch 1995) and 23 percent (Hankin 1999) of women veterans in study samples reporting attempted rape, while a 2003 study (Murdoch 1995) reports that 90 percent of women veterans in a sample reported sexual harassment while in the military. Inconsistencies in study inquiry questions explain some of this variation (“rape” vs. “attempted rape” vs. “sexual harassment”). Willingness to self-report based on increased public awareness of the problem may also explain the variation (Hamilton 2014). Sexual and physical abuse are typically underreported both inside and outside of military settings, and given the fact that non-military-related sexual abuse cannot be technically connected to service in the way it’s reported, there is an especially high risk that it remains underreported among veterans (Suffoletta-Maierle 2003).

The likely cumulative effects of abuse on an individual's resiliency, coupled with the underreporting of sexual abuse, make it difficult to determine the magnitude and nature of MST's relationship to homelessness. Further, given the range of associated outcomes, it may be that MST, like combat exposure, exerts greater influence on intermediate outcomes, such as PTSD, than on homelessness itself.

Protective factors mitigating risk of homelessness for women veterans include being a college graduate and being married. While the correlation between these protective factors and homelessness among male veterans is debatable, women veterans who have received a degree or are married are less prone to homelessness (Hamilton 2014). A likely reason for the strong protective effects of marriage for women veterans is because they are so much more likely to be the sole caregiver to their children, if unmarried or divorced. According to the Department of Defense, in 2010 more than 30,000 single mothers had been deployed to Iraq and Afghanistan, and more than 40 percent of active duty women had children. In the 2010 CHALENG report, the VA and community providers indicated accessible and affordable childcare as the most necessary and yet unmet need of veterans. Unstable childcare may also be related to unemployment for women veterans as well, especially among single mothers who have a reduced support network. Rigorous study is necessary to explain the interactions between marital status, parental status, unemployment, and homelessness for women veterans.

It is important to note, as a confounding factor, that women who have served in the military may be less likely to self-identify as veterans, and may have concerns for their safety and security that outweigh the potential benefits of services offered specifically to veterans. A GAO study in 2010 highlighted the failure of VA medical centers to consistently provide safe and private spaces and gender-specific care to women (GAO 10-287). VA's Homeless Providers Grant and Per Diem Program (GPD) is offered annually (as funding permits) by the Department of Veterans Affairs Health Care for Homeless Veterans Programs to fund community agencies providing services to homeless veterans. The purpose of the GPD Program is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. GPD-funded organizations are reimbursed for the daily cost of housing a homeless veteran. According to a 2012 audit by the VA Office of Inspector General, 31 percent of GPD facilities did not address specific services or safety needs of women clients, including secure, separate living spaces, and a staff competent in handling trauma issues (VHA OIG 2012). If transitional programs for veterans cannot accommodate the unique needs of women veterans, women veterans may be less likely to access or even attempt to access services geared specifically to veterans, which may in turn increase their risk for homelessness. Also, if women who are veterans chose not to self-identify as veterans, important data may be missing from analysis.

## Research Area 2: Correlations and Trends

### I. What trends or correlations can we identify related to chronic homelessness in the veteran population?

**Summary:** Veterans are more likely than non-veterans to experience chronic homelessness because with greater frequency they experience disabling physical and psychological conditions, often incurred or exacerbated by their time in the military, all of which are linked to continued homelessness. Further, this cycle contributing to chronic homelessness has increased over time because of the extensive recent military conflicts and deployment strategies and Military Sexual Trauma (MST) among a growing women veteran population.

**Discussion:** A chronically homeless individual is defined federally as “either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, or (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years” (HUD 2007, p.3).

Childhood risk factors such as inadequate care from parents, experience with the foster care system, and prolonged periods of being a runaway youth are typically and consistently associated with adult chronic homelessness (Shelton 2009, Koegel 1995, Susser 1991). For veterans these factors also contribute to risk of homelessness but, as highlighted above, veterans demonstrate unique risk factors that make them even more vulnerable to homelessness, most notably the presence of PTSD. In other words, the variable that is most commonly cited as a strong predictor of homelessness (childhood neglect and lack of a consistent guardian relationship) is not as strong of a predictor for veteran homelessness. Additionally, by definition a “chronically homeless” individual has a “disabling condition” that implies that homeless veterans are more likely than their non-veteran homeless peers to receive the title “chronically homeless” because of injury (psychological and physical) sustained while in the military.

Homeless veterans and non-veterans tend to have similar rates of alcohol and substance abuse (Winkleby 1993, O’Toole 2003). While drug and alcohol abuse are widely assumed to be a high risk factor for homelessness, research is inconclusive on the subject. Inherent challenges to studies on the topic are that they rely on self-reported data and do not consistently or accurately distinguish between current and chronic/lifetime hazardous drinking practices (Erbes 2007). Among the veteran population, studies do not typically distinguish between veterans’ predisposition to substance abuse problems (i.e., exhibiting tendencies prior to military service) and veterans that dramatically increase their substance use during or after military service (Erbes 2007).

The relationship between homeless veteran status and veteran incarceration is significant. Metraux et al. (2008) found in their review of the literature that inmates of local jails, as opposed to state or federal prison inmates, had a cyclical pattern of intermittent homelessness and incarceration leading to prolonged residential instability, but not “chronic homelessness” because they are often not labeled as having a “disabling condition.” In contrast, because state and federal prisons are often located remotely from inmates’ local communities, social ties that may be

necessary to support successful integration upon release are often disrupted. Inmates of prison, therefore, are more likely to become homeless within 30 days of release and remain homeless over longer periods of time (Metreaux 2008). In addition to factors that put prisoners at risk for subsequent and/or chronic homelessness, the review points to the “criminalization” of many of the activities of the homeless as factors increasing their risk for incarceration. This leads to what the review describes as an “institutional circuit,’ where a series of institutions provide sequential stints of housing in place of a stable, community-based living situation” (Metreaux 2008).

The literature suggests that risk factors for chronic homelessness have not changed over time, but that certain risk factors have become more important. Military trauma has always been a risk factor for the development of mental illness, which also contributes to veteran chronic homelessness. Historically, the intermediary effect of exposure to trauma has been PTSD, but more recently MST has become an important and prevalent risk factor associated with homeless women veterans. Evidence also exists suggesting that repeated tours of duty negatively affect an individual’s ability to successfully readjust to civilian life. Recent combat wars in Iraq and Afghanistan are characterized as “high-redeployment” wars whereby individuals are deployed repeatedly to combat areas over a lengthy period of time. Correlations between geography and veteran homelessness also exist, and while the data is not specific to “chronically” homeless veterans it could be informative for future research models. Homeless veterans (similar to the overall homeless population, and probably chronically homeless populations) are concentrated in certain parts of the country. Almost half of homeless veterans on a given night are located in four states: Florida, New York, California, and Texas. Meanwhile only 28 percent of all veterans reside in those same states. The share of homeless veterans located in the densest urban areas (or principal cities) is more than twice that of all veterans (72 percent compared to 31 percent) (HUD Supplemental 2009).

## **II. What are the differences in duration of homelessness and identifiable causes/contributing factors of homelessness across generations of veterans (Vietnam vs. Iraq/Afghanistan)?**

**Summary:** The literature suggests that the Iraq/Afghanistan-era veterans are at a higher risk for homelessness than previous generations of veterans. Because of the deployment conditions and recruitment strategies of the recent conflicts, the returning veterans are at higher risk for sustaining the mental health problems correlated with homelessness compared to prior war generations. Between 15 and 17 percent of veterans returning from Iraq and Afghanistan are screening positive for mental health-related trauma, including PTSD, and veterans returning from Iraq are seeking mental health services at higher rates than veterans returning from prior conflicts. If these predictive factors are accurate in predicting homelessness, then it is anticipated that there will be proportional increases of homelessness among the recently separated veterans.

**Discussion:** If the experiences of the Vietnam War are any indication, the risk of becoming homeless continues for many years after service. One study found that after the Vietnam War, 76 percent of Vietnam-era combat troops and 50 percent of non-combat troops who eventually became homeless reported that at least 10 years passed between the time they left military service and when they became homeless (Perl 2013). Currently, about 47 percent of homeless veterans are Vietnam-era.

A contributing factor to homelessness, mental health status has been a concern for troops returning from Iraq and Afghanistan. According to one study, between 15 and 17 percent of returning troops screened positive for depression, generalized anxiety, and PTSD (Tanielian & Jaycox 2008). Veterans returning from Iraq are seeking mental health services at higher rates than veterans returning from prior conflicts (Tanielian & Jaycox 2008). Research also found that the length and number of deployments of troops in Iraq result in greater risk of mental health problems (Tanielian & Jaycox 2008). Access to VA health services could be a critical component of reintegration into the community for some veterans, and there is concern that returning veterans might not be aware of the VA health programs and services available to them (VHA OIG 2012).

According to research, factors that predate military service also play a role in homelessness among veterans. A study by Rosenheck and Fontana (1994) found that three pre-service variables present in the lives of Vietnam-era veterans had a significant direct relationship to their subsequent homelessness: (1) exposure to physical or sexual abuse prior to age 18, (2) exposure to other traumatic experiences, such as experiencing a serious accident or natural disaster, or seeing someone killed, and (3) placement in foster care prior to age 16. Further research is needed to correlate these pre-enrollment factors with a predisposition or proclivity to join the military, or whether Armed Forces recruitment standards in times of war surges draw more heavily on individuals with high risk pre-enrollment characteristics. Qualitative data suggest that women veterans frequently join the military as a means of “escape” from abusive situations or as a means for upward mobility in society (Hamilton 2014). So far, quantitative data are too sparse to test these conjectures.

### **Research Area 3: Review of Current Intervention and Support Programs and Practices**

#### **I. What is the evidence on promising practices in supported housing, such as Housing First approaches?**

**Summary:** Literature on the promising practices and pitfalls of supported housing approaches, such as Housing First, suggests that adding vouchers to intensive case management reduces the risk of returning to homelessness, enhances quality of life, and may contribute to reduced alcohol and drug use. The studies suggest that simply securing housing is not enough to ensure successful community tenure for a population of homeless people with psychiatric problems, addictive problems, or both. Rather, the housing support must be embedded within a structure of wraparound resources to ensure veterans’ long-term housing stability.

**Discussion:** An important study on interventions for homeless veterans involved an experimental evaluation of the collaborative Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) initiative. Over a three-year period, intensive case management without vouchers was compared against immediate access to rent subsidies through housing vouchers in combination with intensive case management. The latter was shown to significantly reduce days of homelessness by 36 percent (O’Connell 2008). The results of this study suggest that adding vouchers to intensive case management, in addition to increasing the likelihood of obtaining housing, can help significantly reduce the risk of returning to homelessness, enhance quality of life, and may provide a buffer to increased alcohol and drug use and expenditures on substances

over time. The study suggests that simply obtaining housing is not enough to ensure successful community tenure for a population of homeless people with psychiatric problems, addictive problems, or both—resources must be in place to help ensure that housing is maintained (O’Connell 2008). Future research is needed to explore whether vouchers alone (without intensive case management) would achieve similar results.

This study helped inform the HUD-VASH Housing First pilot program, which between 2010 and 2013 helped 339,000 veterans and their children to secure housing (Fischer 2013). Between 2010 and 2013, the number of veterans experiencing homelessness dropped by 24 percent, and for veterans stably housed, there was an overall decrease in VA healthcare costs of 32 percent. The HUD-VASH pilot (2010-2013) enlisted 14 VA Medical Centers to participate in distributing 700 HUD-VASH vouchers in a “Housing First” approach to help chronically homeless veterans.

In the 2010-2013 HUD-VASH Housing First pilot, more than 90 percent of voucher recipients were male, and most were Vietnam or post-Vietnam veterans aged 45-64 years. Many (78 percent) were diagnosed or previously diagnosed with a mental illness or substance abuse condition. Upon admission, it took an average of 136 days for veterans to move into permanent housing, with lack of a security deposit and negative credit history presenting as the most persistent common barriers to veterans securing housing independently. In the 12 months following receipt of a housing voucher as part of the pilot, 84 percent of recipients were still living in permanent housing. Among the 115 who left the program: 37 percent moved on to more “independent living arrangements”; 20 percent were discharged to an institutional setting; 30 percent disengaged and returned to homelessness; and 13 percent died, most of natural causes. Among the 700 served, the number of emergency room visits decreased by 27 percent; acute inpatient hospitalizations decreased by 33 percent; and total number of hospital bed days declined by 71 percent. Overall, the VA realized a 32 percent decrease in healthcare costs once veterans became stabilized in permanent housing. Based on this data, the VA has officially adopted the “Housing First” approach for its homeless programs (Montgomery 2014).

A 2011 study (Tsai & Kaspro) used data from the HUD-VASH program to examine if individuals can obtain housing without a voucher and whether greater employment earnings or better clinical outcomes were associated with such housing success. Data were used for an observational study that compared participants who, at 3 months, were: (1) independently housed without a voucher (n = 96), (2) independently housed with a voucher (n = 93), (3) housed in another individual’s place (n = 60), or (4) not yet housed (n = 170). Participants who obtained independent housing without a voucher worked more days and had higher employment income than those who did use a voucher. Based on these results, the authors suggest that housing vouchers may act as a disincentive to finding employment. About one-third of participants who lived in independent housing without a voucher had others living with them. While it is possible that living with others could inhibit an individual’s motivation to find independent housing, the authors argue that some elements of cohabitation (including sharing rent and living amidst peers) could be beneficial. While very few homeless services directly encourage veterans to live together, shared housing is often more affordable and has not been associated with negative effects on health or employment. The study suggests that clients should be offered various modes of access to supported housing, including the possibility of sharing housing with other veterans.

Beyond the HUD-VASH program, community organizations such as DOL's HVRP grantees can tap into the U.S. Department of Veterans Affairs Grant and Per Diem (GPD) program, which encourages a Transition in Place (TIP) model of support for homeless veterans. The TIP housing model offers residents housing in which support services transition out of the residence over time, rather than the resident. This leaves the resident in place at the residence and not forced to find other housing in 24 months or less. The concept of TIP is for each service agency to convert existing suitable apartment-style housing where homeless veteran participants would receive time-limited supportive services, optimally for a period of 6-12 months but not to exceed 24 months, into a permanent housing outcome for the participant. Upon transition housing/program completion the veteran must be able to "transition in place" by assuming the lease or other long-term agreement that enables the unit in which he or she resides to be considered the veteran's permanent housing (TIP Guide 2012). The TIP model is not appropriate for every homeless veteran, particularly those in need of specialized and comprehensive case management (NCHV Best Practices for HVRP Grantees: Housing Services).

For veterans with comprehensive needs, HUD-VASH funding can be more appropriate because it is inclusive of wide-ranging supports in addition to housing. However, in many cases, veterans who receive a HUD-VASH voucher are not eligible to enroll in HVRP because they are no longer considered chronically homeless. Under the 2009 Hearth Act, veterans are no longer considered chronically homeless after 90 days in a transitional housing program. If a veteran is enrolled in HUD-VASH without consideration of their need for job training and employment (a main focus of HVRP), that individual veteran may not receive needed services. As a result, HVRP and HUD-VASH programs must quickly and effectively understand the initial needs of a homeless veteran before making decisions about where to initially enroll them. HVRP grantee organizations, according to the NCHV Best Practice guide, must maintain strong relationships with HUD-VASH liaisons within their VA Medical Center and transitional and permanent housing contacts within the broader community to ensure their clients receive the most appropriate sequence of programming and services.

In addition to navigating between HUD-VASH and GPD program funds, the HVRP grantees must also coordinate among funds related to Continuum of Care (CoC) services and Supportive Services for Veteran Families (SSVF) programming. The CoC program (created by the HEARTH Act) consolidates several formerly separate programs into one large program in an effort to streamline eligibility and access. Funds from the CoC program can cover the costs of permanent housing supports for persons with disabilities, rapid re-housing or relocation services, transitional housing and supports for up to 24 months, supportive and referral services to sheltered and unsheltered individuals, homeless information management systems, and homeless prevention services (HUD Exchange CoC Program Eligibility). SSVF funds are intended to help very low-income veteran families to maintain housing stability. According to the Best Practice guide, coordinating eligibility between HVRP and SSVF funding takes dedicated program staffs that are cognizant of the limitations and spending restrictions on both programs.

## **II. What evidence exists on promising practices related to skills training?**

**Summary:** HVRP grantees with the most successful outcomes for their clients, in terms of job attachment and retention, effectively deliver case management, career counseling, and job

development activities alongside support services. Job retention over the longer term improves when individuals are provided work experience during the program. Also, post-employment support is an important factor, including regular check-ins with employed veterans to troubleshoot the first week on the job, the first 90 days on the job, and to coach individuals on communication, motivation, and retention/advancement goals.

**Discussion:** NCHV's three rounds of HVRP best practice reviews, covering 2007, 2011, and 2012, describe a package of employment supports as part of the service menu for homeless veterans. HVRP grantees with the highest rates of job attachment and retention for their clients combine case management, career counseling, and job development activities with support services such as access to clothing, transportation, life skills training, assistance with legal issues, and transitional housing. These promising practice reviews profile the HVRP programs and their service components, and as noted previously, selected HVRP sites for profiling based on highest program outcomes on key measures of performance (e.g., job attachment and job retention). Effective HVRP grantees immediately engage clients with a "job coach," and use an individualized service delivery approach to job preparation to ensure that effective job development occurs that benefits the client as well as fits the need of a prospective employer. This requires staff members with two sets of skills: case management and client coaching, as well as employer outreach and ability to assess a "best job fit." Client services include "soft skill" training and preparation (punctuality, appearance, responsibility, etc.), as well as occupational skills training contingent on the job opportunities and best fit of a client to a potential job. Some HVRP grantees integrate military-style social and leadership structures into a college campus environment. Individual training plans seem to be a common tool among HVRP sites. These tools help the case manager and client co-develop a plan for career building, which cultivates a client's sense of ownership of his or her pathway to reintegration.

Early assessment of client abilities and preferences for certain types of jobs also seem important to the success of employment services. Various assessment tools are used across the cohort of best practice grantees, but all seem to cover vocational assessment as well as interest assessments. Early intensive job search training is also common across sites, including search techniques, resume-building workshops, coaching on talking points related to unique homeless veteran gaps in employment records, and mock interviews.

Many HVRP sites specifically focus on short-term, specialized training and occupational certificates, and, in the best cases, regularly cross-check labor market information with employer feedback to ensure trainings meet actual demand. Special work-based projects within the community (such as housing restoration or retrofitting for energy efficiency), or often within the HVRP program itself (such as working in retail at a Goodwill organization or in the cafeteria onsite) also seem to be a common strategy for immediately engaging veterans in work experience while allowing hands-on coaching around work skills and soft skills. These work-based projects also immediately provide veterans with earning capacity and are correlated with longer-term job retention, based on self-reports by HVRP grantees.

Finally, there is strong association between job retention and post-employment supports including regular check-ins with employed veterans to troubleshoot the first week on the job, the

first 90 days on the job, and to coach individuals on communication, motivation, and retention/advancement goals.

### **III. What evidence exists on promising practice related to supported employment programs?**

**Summary:** No evidence-based studies on supported employment programs for homeless veterans were identified during the time of this review. However, researchers have identified a theoretical model for effective supported employment programs, including a discrete set of critical components to improve employment status, employment compensation and employment retention.

**Discussion:** The term “supported employment” traditionally refers to a service provision used to assist persons with disabilities participate in the labor market, helping them find meaningful jobs, and offering ongoing professional supports that help them maintain gainful employment. No research-based studies were located during this literature review that directly assessed supported employment for homeless veterans. A 2001 report “Implementing Supported Employment as an Evidence-based Practice” (Bond et al. 2001) may present some useful findings, but it should be noted that this summary of evidence-based practice is based on supported employment for individuals with severe mental illness, not veterans or homeless individuals. It is therefore used in this literature review as indirect evidence for the model. According to Bond et al.:

Supported employment for people with severe mental illness is an evidence-based practice, based on converging findings from eight randomized controlled trials and three quasi-experimental studies. The critical ingredients of supported employment have been well described, and a fidelity scale differentiates supported employment programs from other types of vocational services. The effectiveness of supported employment appears to be generalizable across a broad range of client characteristics and community settings.

This literature review does not summarize any detail on the eight randomized control studies and three quasi-experimental studies referenced by Bond et al., but instead suggests that based on Bond’s research there is a set of critical components that makes supported employment an effective approach to improved employment status, employment compensation, and employment retention. These criteria include:

- Commitment by program staff to competitive employment as an attainable goal for clients, rather than placing them in non-competitive work-like activities (sheltered workshops, or similar activities);
- Rapid and immediate job search, as opposed to lengthy pre-assessment and training before beginning the job search activity;
- Strong assessments of client preferences, strengths, and work experiences in order to inform job fit and placement;
- Follow-along supports that are maintained indefinitely; and
- Integration with full mental health and case management supports.

These criteria may be similar to some of the same defining criteria of high-performing HVRP grantees. The HVRP grantees with higher-than-average outcomes have adopted a job development approach for their homeless veteran clients with staff resources dedicated to: understand the competitive labor market; customize training and preparation accordingly for each homeless veteran client based on the labor market demand; approach employers directly to identify and deeply understand job openings and the skills, abilities and characteristics needed in a job applicant; client assessment of interests, strengths, and skills; and following up regularly with employers and veteran hires to ensure longer-term retention in the job.

Another study included here represents one of the most recent studies focusing on the efficacy question of supported employment outcomes (Ottomanelli, et al. 2013). Like the Bond et al. study, this study did not focus on homeless veterans explicitly. It examined the impact of participation in a supported employment program on employment and health-related quality of life for veterans with spinal cord injury. Ottomanelli et al. found that employment had a positive effect on an individual's ability to participate in social relationships, move about in their home and community, and spend time in productive and normal roles, among 157 veterans with spinal cord injuries. While the results indicated positive impact of supported employment, the authors concluded that these findings did not reflect a statistically significant difference between supported employment intervention and "treatment as usual."

#### **IV. What evidence exists on promising practices related to aligning and streamlining services available to veterans across multiple programs (with different federal funding, performance criteria, eligibility requirements, and sequence of service requirements)?**

**Summary:** According to the literature, favorable outcomes for homeless veterans, in terms of employment and stability, are correlated with formal organizational collaboration mechanisms between veteran assistance programs and community-based organizations, such as Memorandums of Understanding (MOUs). Success also depends on program staff continually scanning, assessing, and cultivating relationships with the organizations in their community that can provide very specific needed services of their clients. Best practice programs reference calculated decision-making around what to provide in-house versus when to refer clients to outside partners.

**Discussion:** Best practices across HVRP grantees and a small sample of Homeless Female Veterans/Homeless Veterans with Families Program (HFV/VF) and Incarcerated Veterans Transition Program (IVTP) grantees reveal a wide array of strategies to align and streamline services available to veterans across multiple programs within a community. The HVRP grantees with the strongest outcomes for homeless veterans in terms of employment and stability highlight formal collaborative mechanisms such as MOUs between programs and community-based organizations. Perhaps more importantly, success depends on HVRP program staff continually scanning, assessing, and cultivating relationships with the organizations in their community that can provide very specific needed services of their clients. Across the approximately 60 best practice reviews, among all the best practice HVRP grantees, they each partnered with between 6 and 24 different service providers to cover the array of needs across

their client base. Examples of essential program partners include (names of these programs may not be the same across all grantee sites):

- VA Homeless Program's Compensated Work Therapy Programs
- State Departments of Labor
- State Workforce Agencies (WIA/soon to be WIOA funded)
- Departments of Vocational Rehabilitation
- Departments of Criminal Justice
- Veterans Service Organizations
- State Housing Agencies
- State and local disability agencies
- U.S. Department of Housing and Urban Development programs
- U.S. Department of Labor programs
- Local vet centers
- State or local legal service providers or centers
- National Guard bases and organizations
- Community-based training organizations (such as Goodwill International)
- Other education and training institutions
- Mayors' offices
- Opportunity Industrialization Centers (OICs)
- Operation Stand Downs
- Community organizations such as The Salvation Army

Best practice profiles suggest that the level of understanding of distinct roles and responsibilities across partner programs is quite sophisticated, and that clarity in roles and responsibilities results from years of partnership development, often pre-dating HVRP funds. Best practice compendiums suggest that high-performing HVRP grantees require high levels of cross-program trust and shared credibility in order to respond quickly to client needs, work around or through complex program eligibility rules (and therefore funding mechanisms), and understand how to navigate complex, often restrictive, sequence of service requirements of each program.

Most HVRP best practice profiles reference some decision-making process or turning points in their decision-making process around what to provide in-house versus when to refer clients to outside partners. As an organization evolves in this arena, in-house services tend to consist of daily behavioral case management, financial literacy, self-determination counseling, peer support meetings, job training, and job development activities. In some cases, mental health counseling and addiction therapy are provided in-house, but this varies greatly. HVRP organizations tend to play strong oversight and connecting roles for transitional housing placement and needed legal services. Access to healthcare is contracted and referred out to VA hospitals and other veteran related healthcare providers.

## **Conclusions**

This literature review confirms that a set of risk factors for homelessness is associated with veteran status. A core set of these factors is the same for non-veteran homeless individuals,

including childhood family abuse, neglect and/or dysfunction; having lived in foster care; and the presence of mental illness. For veterans however, these factors may be exacerbated by combat exposure and/or MST, both of which increase the risk of PTSD. These factors combined with any combat-related disabilities increase the overall chance of veterans of entering a state of homelessness. Structural barriers, such as lack of access to transitional and permanent housing and a stable income, further heighten the risk of homelessness. The strength of any of these associations remains unsubstantiated by scientifically rigorous standards, such as U.S. DOL's CLEAR guidelines.

**Specific recommended areas for further research include:**

**1. Establishing causal relationships between veterans' pre-existing risk factors and homelessness:**

- Additional studies are needed that distinguish between veterans' predispositions, such as a predisposition to substance abuse problems (i.e., exhibiting tendencies prior to military service) and veterans manifesting issues during service.
- Deeper analysis is warranted that examines military recruitment standards beyond high school diploma status and aptitude test scores that might indicate predispositions for becoming homeless post-deployment.

**2. Explaining women veterans' disproportionately high rates of homelessness:**

- Comparison studies are needed of women veteran homelessness to male veteran homelessness, as well as female non-veteran homelessness to assess like and unique variables.
- More rigorous study needs to be conducted on risk factors unique to women veterans, with an effort to catch the part of the population who chooses not to self-identify as a veteran.

**3. Identifying evidence-based veteran support services:**

- Rigorous studies and analyses are necessary to establish credible and evidence-based definitions of "best practices" related to supported employment, training and education, Housing First and other housing assistance initiatives, and coordination of services (including funding and eligibility standards) across programs.
- Examination of how the definition of "veteran" (which sometimes excludes those that have not served active duty or been honorably discharged) is recommended and how these parameters may exclude a key population from study or resources.
- Evaluation is needed of the implications of labeling someone as "chronically homeless" and veterans' predisposition for falling in this category as a population that is more likely to have documented "disabling conditions."

**4. Identifying evidence-based veteran-specific risk factors for homelessness:**

- Further research is needed that compares homeless veterans and non-homeless veterans, as well as comparison studies of homeless veterans and their non-veteran homeless peers.
- Exploration is needed of how policy change could have preventative qualities, such as deployment strategies that minimize PTSD and on-the-ground management that addresses MST.
- Critical junctions should be identified in the homeless pathway where intervention is effective.
- Further examination of how military service not only predisposes individuals for homelessness because of inflicted mental trauma (PTSD/MST), but also potentially because of “disabling conditions” and chronic physical pain associated with injury sustained during combat is recommended.
- Further study is warranted on whether marital status (current, past) and/or family cohesion are protective factors for veterans against homelessness.
- Further study is needed on whether higher education is a protective factor against homelessness (e.g., including attendance in two- and four-year programs, attendance in trade schools and certificate-based programs, and if a degree or certificate earned makes a difference) and how educational status correlates with historic family wealth and class distinctions as a co-protective factor.
- Further rigorous study is necessary in order to examine the nature of veteran substance abuse and its correlation to homelessness and chronic homelessness.
- Further rigorous study that compares generations of homeless veterans to each other to determine specific risk factors and support needs of different sub-populations of veterans is recommended.

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