Homelessness and Veterans:

Social Policies Critique

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Abstract

With anywhere from one-quarter to one-third of the homeless population being reported as veterans of the armed services it is necessary to review why this is the case and the policies that have been developed to provide prevention and intervention services. Demographics, definitions, and a short history of policy development in relation to homeless veterans will be discussed. A review of the literature will provide an overview of the correlations between homelessness and mental health and substance abuse issues among veterans and how combat tours have affected various war cohorts. Also addressed are various policies from housing first to outreach services and the social theories that have lead to the formulation of such policies. Implications with regards to social work and services will be drawn and additional suggestions to help ameliorate homelessness among veterans will be given.
Introduction

Veterans have provided a service to the nation that the general population has not. In recent years veterans have endured multiple deployments to combat zones in two different wars. Kline, Callahan, Butler, St. Hill, Losonczy and Smelson (2009) write that Vietnam and Middle East veterans have a higher rate of homelessness than other war era cohorts. Further research indicates that this may be due to the unidentified psychological trauma and mental health issues associated with these two cohorts. A review of the literature in regards to homelessness among veterans will indicate that there has been research done in this area. Further, there are many policies and legislative acts that cover veterans once discharged from service. These policies are formulated based on a variety of foundations and models that have been proven to work in the field. From this review one can determine that there are a variety of implications that affect those working in the field that may improve services to this population.

In recent years homeless veterans have become a concern among those working at the highest levels of government. In a recent report, released by the White House the National Security Staff (2011), several measures that need to be taken in order to reduce the number of homeless veterans have been outlined. Many of these policies are not in place yet while other policies need to be reviewed to determine in they are helping or hindering veterans as they navigate the transition from the military to the civilian world. Programs that help to increase outreach to veterans, provide housing first services, work on substance abuse and mental health issues, provide linkages to employment, and help veterans develop social support networks are all key to ending
homelessness among veterans. Many may feel that it is an obligation that the United States has to those who have volunteered to defend her borders and fight her wars.

**Importance of Homeless Veterans**

With approximately one-fourth of the homeless population belonging to the veteran population (Burt, Aron, Douglas, Valente, Lee & Iwen, 1999), there is a need to determine how this particular group can be assisted. By doing so, there is a chance that individuals from the general population that are homeless can be helped as well. Cunningham (Aug 2009) asserts that working to end homelessness in veterans may be part of the solution to ending homelessness in the Untied States. Being a large group veterans take away resources from others that are homeless that do not have the same support systems in place, through the VA. Indirectly affected are the programs that operate the emergency shelters, food pantries, and other such programs designed to support the homeless as their resources have to cover more individuals when including the veteran population, meaning more funding, more fund raising, more volunteers; there is a monetary and human capital consequence that is affected by homeless veterans. Due to the resources that exist for veterans it makes sense to focus on this group to help ameliorate the social problems associated with homelessness. The government should be able to find a better way to screen veterans for at risk homelessness prior to exiting the military, and ensuring that service-members are connected to the VA and other programs that can help to assist them make the transition from service-member to civilian.

Many shelters also have conditions attached to an overnight stay, as do many homeless programs, these conditions include not abusing substances, which
disqualifies many veterans from being able to utilize their services. This leads to veterans who have no shelter. Burt et. al., (1999) indicate that men are more likely to live on the streets rather than utilizing emergency shelter; considering that most veterans are men this means they are more likely to live on the street and be open to victimization such as violent attacks, robbery, and other forms of abuse. Addressing homelessness among veterans will help to remove those men living on the streets from this environment, as approximately one-third of homeless men are veterans (Burt et. al., 1999) this would significantly decrease this population. By decreasing this population of homeless individuals one would expect to see a decrease in crime and victimization against those living on the streets as they are no longer there.

On the positive side, Burt, et. al., (1999) indicates that approximately thirty-three percent of all homeless veterans receive some form of government medical coverage. For those receiving medical assistance not meeting the conditions of shelters and other homeless agencies is not as critical as those who do not; at a minimum their physical health is checked on a somewhat regular basis, and for those who have mental health issues and medical coverage there is a chance that they are being assessed. If all veterans that qualify for medical coverage through government agencies can be identified this would free up public health care for other homeless who fall in the general population.

Target Populations

The National Security Staff report that there are currently more than 2.2 million service members that make up the all-volunteer force (p. 1). Over two million have deployed in support of the Global War on Terror (GWOT) to Iraq and Afghanistan
(National Security Staff, 2011). This does not include all of the veterans who make up the war cohorts for Vietnam, Korea and World War II. In order to begin to understand the scope of veterans and homelessness one must understand who is affected. Further, it is important to look at the demographics associated with homelessness and veterans.

**Definitions**

Homeless is defined in Public Law 100-77 as, “an individual who lacks a fixed, regular, and adequate nighttime residence” (Love, 2010, 4). Further, a person can be classified as homeless if they utilize a shelter, an institution on a temporary basis or a public or private place that is not designated as an accommodation (Love, 2010, 4). In order to be classified as homeless, by law, an individual cannot have a permanent location in which to sleep on a nightly basis. Many individuals are homeless on any given night, but are not classified as chronically homeless. These are individuals that are temporarily without accommodation for a short period of time; in order to be chronically homeless an individual must be without nighttime accommodation on a regular basis over a period of time.

A veteran is an individual that has served in the Armed Forces. Veterans may or may not have served in combat, and have given a minimum of two years of service to over twenty years of service. Veterans are made up of individuals, who have served in the Army, Marine Corps, Air Force, Navy, Coast Guard, National Guard or Reserves. There are federal laws that oversee benefits and entitlements for veterans based upon their time in service, disability rating, and other determinants as defined by Veteran’s Affairs (VA).
Demographics

Understanding who makes up the population of homeless veterans is important to understanding the effects of homelessness among veterans. This knowledge can help those in field determine the best way to reach out to veterans and the services that they need. Not only are numbers important, but also the war cohorts and types of medical and mental health issues play a role in understanding the demographic.

Counting the number of homeless is a difficult task as there is no permanent residence for these individuals. Numbers come from emergency shelters, food pantries, transitional housing, and other such programs, as well as physically counting individuals that are living on the streets (Burt, et. al., 1999). The National Survey of Homeless Assistance Providers and Clients (NSHAPC), conducted from 1996-1997 and published in 1999 is, to date, the most comprehensive study of homelessness in the United States. According to Burt et. al., (1999) “twenty-three percent of homeless clients are veterans” (p 18). Also of interest is that one percent of homeless women are veterans while thirty-three percent of homeless males are veteran’s (Burt, et. al., 1999, p 18). Numbers from recent reports indicate there are approximately 131,000 veterans who are homeless on any given night and close to double that number who have been homeless during the course of the year (Cunningham, 2009).

These numbers, reported in 1999, match closely with the current numbers from the National Coalition for Homeless Veterans (2010). They assert that approximately thirty three percent of homeless individuals are veterans. Considering the small percentage of the American population that serves in the military, it appears that veterans are overrepresented in the homeless population; the VA projects that thirteen
percent of all adults are homeless (Burt, et.al., 1999, p. 44). Further, the homeless have served in World War II, the Korean War, the Cold War, the Vietnam War, Grenada, Panama, Lebanon, Afghanistan and Iraq; about half of homeless veteran’s served during Vietnam (National Coalition for Homeless Veterans, 2010, FAQ page). An aging homeless population among veterans, considering that half are from the Vietnam era, will bring with it new problems and concerns that need to be addressed as these individuals begin to develop age-related illnesses and disabilities. African-Americans are overrepresented, making up fifty-six percent of the homeless veteran population (National Coalition for Homeless Veterans, 2010, FAQ page). Not yet counted, in full, within the homeless veteran population are the OIF/OEF veterans that are transitioning from the military into civilian life. Society has yet to see how these young men and women will make the transition and how many will need additional support in order to overcome the challenges that veterans in the past have faced that have led to homelessness.

**History**

In the early days of United States homelessness was a community problem that was addressed through private organizations and community members, such as church groups and food pantries. Pearson (2002) outlines the historical support of veterans in the United States indicating that veteran compensation was one of the first acts of federal legislation, providing compensation to veterans injured during the Revolutionary War; homeless veterans were not addressed through this legislation, but providing for those who had been injured would seem to support those who might be at risk for homelessness. The New Deal would refocus social welfare policies and homelessness
would eventually become a part of the federal as well as the state budgets. Today, both private, non-profit and government resources are directed towards ending homelessness in the United States.

Interestingly, homelessness among veterans did not become a recognizable problem until the Vietnam cohort returned from combat (Kline, et. al., 2009). This became the first group of veterans to become homeless in large numbers. Programs such as the GI Bill that had helped thousands of veterans from World War II did not help Vietnam War veterans escape homelessness. Maybe it was because social sentiment towards the war was negative and those returning from combat were not received as heroes, as had their predecessors. Maybe it was the way combat unfolded, with stories of young Vietnam children offering to light a GI’s cigarette, only to sacrifice themselves in an explosion; this would certainly affect a GI’s trust in humanity, affecting their ability to maintain attachments. Current research indicates that attachments are affected by PTSD (Zulueta, 2006), which may, in turn, affect the ability for some individuals to reestablish social support systems upon return from the war zone.

While programs and policies directed towards veterans have existed since the United States was a colony, to include disability and widow’s compensation, it was not until the New Deal that homelessness among veterans was identified as an area of concern. The VA continued to focus on its main mission of providing disability and compensation benefits (Vandenberg, Bergofsky, & Burris, 2010). The hope that education programs such as the GI Bill and other rehabilitation programs would help to keep veterans from becoming homeless was not to be seen. Programs such as the HUD-Veteran’s Affairs Supportive Housing (HUD-VASH) program did not come into
existence until 1992 (Cunningham, 2009, p 5). Within the past twenty years there has been a greater focus from the federal government and the VA with regards to homelessness and veterans. Today the VA assists in providing support to homeless veterans and implementing policy set forth by the government. Many of the programs and policies reviewed in this paper are rather new as agencies try to find a solution to housing our nation’s veterans.

The goal of the federal government is to eliminate homelessness among veterans by 2015 (National Security Staff, 2011). In the latest report, put out by the White House, the National Security Staff (2011) outlines new initiatives and policies that will address homeless among veterans in the United States. These initiatives include an increase in mental health care access, developing early intervention strategies, and developing help for homeless veterans find employment (p 11). These policies are new and have yet to be implemented, and therefore will not be covered within the literature review. However, it is important to include, within this analysis, the future actions that will affect homelessness among veterans.

**Literature Review**

Homeless veterans are one demographic of the overall homeless population. While many attributes between a veteran and another homeless individual may be similar in nature there are differences between the two. A review of the literature associated with the homeless veteran population provides a wealth of knowledge in (a) the homeless veteran population as a social problem, (b) the theories related to homelessness and veterans, and (c) policies and programs that exist in order to
address homelessness among veterans. Through these areas of study one can begin to determine the implications in practice when working with homeless veterans.

**Homeless Veterans as a Social Problem**

Homelessness, in general, is considered a social problem, to the extent that the McKinney Act was signed into law in 1987 (Love, 2010). This law identifies who is homeless and the funding streams from the federal and state levels that will be appropriated in order to address homelessness. In 1999 one of the most comprehensive reviews of homelessness was published; this review compiled two years worth of research on homelessness, consisting of observation, review of policies and programs, and interviews with both the homeless and those who provide for the homeless. Unfortunately, this data is over ten years old at this time and a new report has yet to be published. While it provides quality information regarding homelessness in the 1990’s it does not capture what has been happening to the veteran population since the Global War on Terror (GWOT) was declared. Published reports on the veteran population since GWOT indicate that there is anticipated growth in the veteran homeless population unless additional policies and practices are put into place that will help to ameliorate the problem. However, it will be years before research will tell the total effect of the Iraq and Afghanistan campaigns and repeated deployments will have on the veteran population.

Individuals that are homeless tend to be socially isolated, lack attachments in relationships, are more at risk for illness, and are more likely to be targets of crime (Cunningham, 2009). Further, the homeless population tends to have a higher percentage of individuals that abuse substances and are mentally ill. Many more will
face legal problems and incarceration. The veteran population is disproportionately represented in the homeless population and reflects all of the above-mentioned social problems. Approximately twenty-three percent of the homeless population is comprised of veterans; ninety-eight percent of these are men (Burt, et. al., 1999, xxi). Most of these men do not qualify for services under Temporary Aid to Needy Families because they have no family, and thus do not qualify for services that are geared to ensuring children are cared for and have a home. Instead, they fall to the care of the VA.

Unfortunately, the VA is unable to help every veteran that has fallen into, or is at risk, for poverty and homelessness. Instead, their focus is on the veteran who has been diagnosed with a service-connected disability (Vandenberg, et. al., 2010). This leaves many honorably discharged veteran’s who are haunted by their experiences in combat, unable to relate to the civilian population, and unable to hold a job without support. These individuals are at risk for falling into the homeless population, especially if their social support networks are weak or non-existent.

**Why are Veterans Homeless? Theories and Models**

Social problems surrounding homeless veterans, such as substance abuse and mental illness can contribute to the risk for homelessness among veterans. Add to that a military culture that chooses to ignore the psychological ramifications of war, increasing the stigma of seeking help for psychological trauma (Savitsky, Illingworth, & DuLaney, 2009), and one has a recipe for social problems as the military member begins to exit the military. Several different theories and models try to answer the question: why are veteran’s homeless?

**Social exclusion.**
One theory looks at social exclusion. Savitsky, et. al. (2009) write of the military culture, which can contribute to social isolation over time. Military members are made to move every two to three years, leaving behind family and social networks. Overtime, this can leave the service-member isolated and without social attachments. Members of the military develop a camaraderie with one another as they go through training exercises and combat experiences where they literally depend on one another to keep them alive. Bowling and Sherman (2008) assert that a positive reintegration is critical to the success of the military member and the family. An unsuccessful reintegration can leave the family in pieces and the military member alone. If the military member returns with post traumatic stress syndrome (PTSD) and is unable to receive support from their spouse chances are that the marriage will end in divorce (Renshaw, Rodrigues, & Jones, 2008). Conclusions by the research conducted by Renshaw et. al. (2008) supports the importance of social inclusion and relationships for veterans that are experiencing PTSD and other mental illnesses that are a result of combat. These unsuccessful relationships increase the chances that the military member will have difficulty forming attachments in other relationships further isolating them and creating social exclusion.

Once the individual leaves the military the sense of camaraderie is gone; the individual is no longer a part of this group. If they cannot figure out how to fit into the civilian population there is a chance that the veteran will become increasingly isolated socially. While military leadership takes an active interest in the family and social life of the service member, protecting them from isolation and social exclusion, the civilian employer is not as concerned about these aspects of their employee. Thus, the service-
member who is transitioning from military service to civilian employment may find it
difficult to fit into the civilian workforce that may create unemployment, which can then
lead to homelessness if not remedied.

**Medical model – mental health and substance abuse.**

The medical model must also be looked at when determining why homelessness
occurs among the ranks of veterans. Vietnam era veterans make up a majority of the
homeless veteran population (Love, 2010). This can be attributed, in part, to the lack of
mental health care these individuals received upon return from Vietnam. The
combination of the horrors of combat mixed with an ill received reception at home left
many Vietnam veterans with nowhere to go, no hope, and untreated PTSD. Many
turned to alcohol and other substances to relieve the pain associated with their mental
illness and to escape the nightmares that haunted them while they slept (Kline, et. al.,
2009). As technology has decreased the mortality rate associated with war it has
increased the psychological traumas as individuals now live through trauma that would
once kill them.

Today the signature injury of Operation Iraqi Freedom (OIF) and Operation
Enduring Freedom (OEF) is traumatic brain injury followed closely by PSTD (Savitsky
et. al., 2009). Over 25,000 service members have been injured in combat operations
(Savitsky et. al., 2009) while the VA has indicated that 35,000 soldiers have sought
assistance for PTSD through VA hospitals since June of 2006 (Bowling & Sherman,
2008, p. 451) and Wales (2009) estimates 391,000 of the 1.79 million deployed
veterans since 9/11 will have mental disorders associated with combat (p. 373). These
are only the individuals that actually seek assistance and help; it is estimated that there
are thousands more service-members who self-medicate or ignore the psychological effects of war and do not report them. While some of these injuries, such as the loss of limbs and other physical injuries, are easily identifiable many more, such as the psychological injuries, are not easily identified. The unidentified injuries are of concern and can contribute the homeless veteran population, as these individuals do not receive compensation for their unidentified and unclaimed injuries.

Cunningham (2009) reports that twenty-nine percent of homeless veterans are tri-morbid, meaning that they report mental health problems, serious medical conditions, and substance abuse (p 2). The high rate of multiple medical issues would appear to create an increased risk for homelessness as research has indicated a strong correlation between mental illness, substance abuse and homelessness in the general population. Kline, et. al. (2009) found, in their study with veterans from different service eras, that mental health problems were prevalent across cohorts with the following being reported most often: depressive disorder, PTSD, antisocial personality disorder, and anxiety disorder (p 363). One of the problems facing many veterans is that the mental illness was not reported while still in service; it may not have presented or it may not have been reported. Therefore, trying to prove a service-connected disability becomes increasingly difficult. The rules regarding timelines for claims with the VA also work against veterans with mental illness that presents after they have left the service. Wales (2009) writes of the difficulty veterans have with proving that the mental illness is service-connected. Also of concern is how many veterans will utilize substances to self medicate for psychological trauma. Military policies make it difficult for an individual to receive support if discharged under other than honorable conditions; Wales (2009)
explores the difficulties in receiving benefits when substance abuse occurs as part of
the epidemiology of the mental illness.

**Policies and Programs**

compensation available to veterans that are injured while in service. A review of this
legislation indicates a desire, on the part of the federal government to provide for
service members who are injured in connection with their service. While disability
compensation can help to decrease the overall numbers of veterans who are homeless,
it cannot prevent homelessness completely. The Veteran’s Disability Benefits
Commission (2007) outlines how policies and legislation came into effect based on the
needs of veterans and the disabilities that were presenting due to service connection.
This includes acts to provide for those affected by Agent Orange and radiation
experiments. A review of such legislation indicates that there has been little attempt to
compensate veterans for psychological trauma. Not only is this the case, but if injury or
death is caused by substance abuse the individual or widow will not receive any
compensation (Economic Systems, Inc., 2004); this is a concern when one considers
the literature indicating that veterans self-medicate through substance use for
psychological trauma rather than reporting it (Savitsky, et. al., 2009). The VA has a
majority of the responsibility for providing veteran specific programs and implementing
veteran directed policies. They have done so through a variety of methods.

**HUD-veterans affairs supportive housing (HUD-VASH).**

Cunningham, the Senior Research Associate for Metropolitan Housing and
Communities Center, testified to Congress the importance of the HUD-VASH program
in decreasing homelessness among veterans. The program is designed to assist homeless veterans in obtaining housing through a partnership between the Public Housing Administration (PHA) and the VA. The VA provides vouchers and the PHA provides assistance in finding the housing. Cunningham (2009) describes the program in detail to include federal funding streams, assessments for qualification, and whom the program has helped.

The approach of the HUD-VA program is to provide vouchers for qualifying veterans while providing them with case management. Rather than placing stipulations on the vouchers, such as negative drug and substance abuse tests, the program provides housing to the individuals and then works with them to decrease substance abuse problems. The premise of the program is that if individuals have a home then care will follow. The utilization of case managers appears to help the veterans decrease substance abuse and maintain treatment for mental illness (O’Connell, Kasprow, & Rosenheck, 2009).

Originally implemented in 1992 the program only provided a small number of vouchers to veterans. According to Cunningham (2009), in 2008 funding was increased by congress and the VA began providing the vouchers. The initial intent of the policy was to provide housing to those who were chronically homeless and had mental illness diagnosis; today the eligibility for the program has expanded to include a variety of veterans, thus diminishing the original intent of the program (Cunningham, 2009).

The HUD-VASH program has utilized a social inclusion framework to provide housing for veterans. Such social inclusion policies have proven to help homeless individuals to become more successful in the mainstream (Till, 2008). Housing is not
limited to a project base, but instead incorporated into the public housing population providing role models in neighbors and utilizing already constructed social supports in these neighborhoods.

While O'Connor et. al.'s (2008) study indicates that such a program has been beneficial to homeless veterans more research needs to be done on the housing first programs. Cunningham (2009) indicates that there may be project-based programs derived from HUD-VASH; of interest would be the success of social inclusion versus social exclusion housing programs for veterans. Veterans may benefit from a social exclusion program, as they would have the sense of camaraderie and understanding from the veteran population that does not exist in the civilian population, but if the goal is to have the veteran transition to civilian living this may not be the desired framework. Ultimately more study in this area needs to be done to determine the best course of action for housing first programs and where to place them in the community to best benefit the veteran. Also, because the program was revitalized so recently follow-up studies need to be done to determine if it does help to decrease the homeless population of its intended target and, thus, the claim that it will help to decrease homelessness in the general population as well.

**Co-location of services.**

The co-location of services started in 1930 when the different agencies that support veterans came under one organization, the Veteran's Administration (Haigh, 2008). Before that time different agencies handled disability compensation, insurance, vocational rehabilitation, and education benefits. Today the VA handles all veterans’
claims. However, until recently veterans still had to travel to different locations in order to receive care.

In 2001 the Greater Los Angeles Community Care director proposed an integrated program of services for homeless veterans (Blue-Howells, McGuire, & Nakashima, 2008). The director, a social worker, proposed to co-locate health and claims services in one building in order to increase the efficiency and quality of care provided by the VA to homeless veterans. The program utilized a primary care/mental health model and followed the framework of Rosenheck’s synthesized multiple organizational theories (Blue-Howells et. al., 2008, p. 222). This framework follows a four-step process: the decision to implement, initial implementation, sustained maintenance, and termination of transformation (Blue-Howells, et. al., 2008, p. 222). In so doing the program increased care for homeless veterans and decreased fragmented services. Ultimately, their goal in helping the homeless to increase the utilization of services available was met. While this program does not ameliorate homelessness among veterans it does increase the care veterans are receiving, thus decreasing the number of homeless veterans with medical care issues. By insuring that the veteran’s basic and medical needs are met the hope is that they become healthy enough to be eligible for sustained employment, thus decreasing the homeless population.

The Greater Los Angeles project met with such success that it became a model for the VA and has since been replicated across the country. As the program is new further research and studies will need to be done to determine the success rate of the program and its policies. Such success stories have lead to a transformation within the VA as integrated regional service networks, eligibility reform, and capitation based
resource allocation become the new basis for how the VA is organized (Vandenberg, et. al., 2010). Blue-Howells et. al., (2008) indicate that the program has served thousands more veterans than the fragmented services did. Once again, though, veterans who do not meet qualifying criteria are not served through this program, leaving many veterans who are unable to establish a service-connected disability without care under this system.

**Outreach programs**

The VA has undergone transformation in recent years, in part to the success of programs such as the one conducted by the Greater Los Angeles area (Vandenberg, et. al., 2010). A shift from a primary care model to a case management model is part of this transformation, as is increasing outreach services to homeless veterans who may qualify for care, but have not filed claims.

Chen, Rosenheck, Greenberg, & Seibyl (2006) reviewed the utilization of outreach services in their article. The outreach services took place through the VA Health Care for Homeless Veterans (HCHV) programs and provided outreach, benefits counseling, referral and other assistance to eligible veterans (Chen, et. al., 2006, p. 64). Outreach through the VA is conducted through mobile vet centers that are able to go into the neighborhoods to provide care to homeless veterans and to help them to file claims. These services increased the number of veterans who received both compensation and pension benefits. Review of the outcomes of the outreach program indicated that far more veterans were able to qualify for compensation benefits, which are designed to compensate veterans for service-related disabilities than those that qualified for pension benefits, which are designed to provide a pension for qualifying
low-income veterans over the age of 65, (Greenberg, Chen, Rosenheck, & Kasprow, 2007).

The VA provides mobile vet centers to provide basic medical care to veterans rather than having the veterans come to the VA hospitals (Veteran’s Administration, 2010). These outreach services are intended to provide basic medical care in lieu of more traditional health care. The hope is that by providing such care veterans will not deteriorate physically as they live on the street, but remain physically healthy. Such programs cannot address chronic mental and physical health issues. The VA time limits for claims to be filed upon discharge from service can hinder qualifying for care, and while any veteran can receive medical care through the VA if there is not a service-connected disability the veteran falls to the bottom of the priority list (Vandenberg, et. al., 2010).

As outreach services become more commonplace it will be necessary to further the studies in this area to determine their effectiveness. Innovation in services is still new to the VA and outreach services are in their infancy. As the OIF/OEF veterans leave service more studies will need to be done on how outreach can help individuals qualify for services who were not presenting with psychological disabilities upon discharge, but are now affected by combat related psychological trauma.

**Strengths of the Literature**

Documentation of homelessness among veterans is very thorough; it is an obvious problem that has been recognized by the federal government as well as scholars in the field. Literature has focused on existing and emerging programs and policies that affect homeless veterans. Research on the effectiveness of the medical
model and the VA’s effectiveness is well documented. Understanding the needs of the homeless that utilize the VA is well documented and provides an understanding of the overall veteran population. Such access to individuals can provide researchers with first hand knowledge as to why veterans fall into homelessness. There is research-based literature that has focused on determining the success rates of various policies and programs that follow research methodology in order to prove a hypothesis correct. This research utilizes real programs that are designed to help the homeless. The literature further evaluates areas that need more research and study, identifying areas that are in need of more attention.

The published study on homelessness completed by Burt et. al., (1999) is comprehensive in nature, looking at all aspects of homelessness and it’s impact. There are sections in the study that target the veteran population specifically as well as the benefits and supports that are available to veterans. The National Coalition for Homeless Veterans (2010) focuses specifically on the veteran population among the homeless. Both of these reports include actual interviews from the homeless population, which provides a first hand view to the problem.

Weaknesses of the Literature

While there are many strengths associated with the literature available on homelessness and veterans there are still areas that need to be improved. Most of the literature focuses on veterans that are utilizing the VA for medical purposes or to collect benefits. Doing so excludes many veterans who do not meet the VA’s criterion for support, or who fall as secondary priorities. Because the VA provides basic medical care and provides cash benefits to veterans the group included in the literature does not
provide a full picture of the problem of homeless veterans. There are veterans that do not utilize VA services, either because they do not know they exist, they never filed for compensation, missed the deadlines for filing, or they do not qualify for services; these veteran’s are underrepresented in the literature and may be utilizing resources through other programs designed to help the general homeless population. More information is needed on what happens to those who do not have service-connected disabilities and do not qualify for VA pensions, which are many veterans. With such a large portion of the homeless population being veterans it would be prudent for the VA and the military to review transitional services for veterans that are being discharged from active duty status. Knowing how many additional veterans that are receiving either no support or support through other programs is an important piece of understanding the total problem that is not well represented in the literature.

Another area of weakness is the lack of information on homelessness and veterans of OIF and OEF. Much of the literature uses figures from prior to 2001. The last comprehensive report on homelessness, conducted by Burt, et. al. (1999) is over ten years old. There have been many changes that have taken place within the military over the past ten years that need to be captured in the literature to a greater extent. While there are associations between psychological trauma and homelessness, and there are assumptions that the increase in such trauma from OIF and OEF will affect those transitioning out of the military there is little research on this topic. More needs to be done to understand the consequences of the past ten years of combat and the affects on homelessness and veterans. More studies need to be done with veterans in terms of the correlation between substance abuse and combat tours; this may shed light
on those who have been discharged under other than honorable circumstances who are now homeless.

Many of these programs and policies are new and need follow-up studies to be completed to determine how successful they will be into the future. Programs such as the HUD-VASH have only been in existence for twenty years, and during this time the program did not run continuously (Cunningham, 2009). As such, it will be necessary to continue to study the effectiveness of this program as well as outreach programs and the co-location of services. Longitudinal studies are lacking in the literature and need to be considered in order to get a full feel for the effectiveness of existing programs.

Most policies and programs that have been included in the literature are intervention measures. By the time that individuals are utilizing these services they are already homeless. More attention needs to be given to prevention policies, such as transition programs within the military, employment programs, mental health services, exit procedures and screenings. Such studies would provide insight as to what tools and resources are being given to veterans prior to exiting from the military regardless the reason. While this is addressed by Savitsky et. al. (2009) and Bowling and Sherman’s (2008) articles little of the literature on homeless veterans address the transitional issues associated with moving from the military to the civilian population. Anecdotal reports on this transition, interviews with veterans, and a review of the military transition program would be helpful to further this theory.

**Social Policies Analysis**

The theoretical frameworks utilized to build social policy are important to understand when looking at social policy. Within the scope of homelessness and
veterans there are two theoretical frameworks that play an integral role in how social policy is being developed. The medical model and the social exclusion or social attachment theories both play a role in how systems are set up to assist homeless veterans. Both theories have strengths and weakness, and both theories have the ability to work with one another to create well-rounded policy that will benefit the homeless veteran.

**Medical Model**

Medical models are based in the realm of diagnosis and treatment of an illness. Swarbrick (2006) states that the “medical model narrowly focuses on symptom reduction, rapid stabilization, and interventions focused on the deficiencies and incapacity” (p. 312). An analysis of homeless veterans found that twenty-nine percent of homeless veterans were tri-morbid, meaning they had mental health problems, serious medical conditions and substance abuse issues (Cunningham, 2009, p. 2), which would indicate that a medical approach to caring for veterans would be a necessity. This medical approach can be seen through the structure of the Veteran’s Affairs (VA) office and the primary eligibility for care being based on disability. In order to have a disability one must have a medical diagnosis, thus inducing the medical model for treatment.

Treatment, under a medical model, focuses on the pathological illness and treatment of said illness (Boyle, 2006). A focus on the biological systems of the individual plays a large role in treatment under this model. Medication and focused treatment are keys to success; illness and disease management become the primary focus for the practitioner and patient. The thought process is that if the disability or
illness can be treated then the individual will be healthy enough to begin to make repairs to other quality of life issues, such as maintaining employment and housing.

**Strengths of the medical model.**

Treatment of illness is key to ensuring the overall health of an individual. If one is sick or disabled one can hardly be expected to thrive. A focused treatment plan that works on the presenting pathologies allows the veteran to ensure that they are medically cared for. By focusing on disability the VA office has a way to prioritize care and ensure that the veteran is cared for based on medical need. A focus on the cause of the disability allows for treatment that will directly affect the individual’s functioning. Medications and other such interventions allow for a reduction in pain, and a return to health. Utilization of the medical model makes it easier to care for numerous veterans, as it is focused and efficient in nature.

A long history in the use of the medical model also makes it comfortable for practitioners. Often, it is easier to apply an approach that is well researched and appears to have qualitative and quantitative results that are positive. A focus on pathology allows for the practitioner to treat the diagnosis and move the patient along, allowing for a multitude of patients to receive care. This model also allows for the prevention of infectious and contagious disease, thus prioritizing public health. With new studies indicating that PTSD is connected with specific brain functions the medical model may prove beneficial for treating the immediate affects of psychological trauma. For physical disabilities the medical model makes sense, however, psychological trauma, such as PTSD, depression, etc. and substance abuse and other disabilities that
have long term emotional consequences, may need policies that incorporate other models beyond the medical model for complete recovery.

**Weaknesses of the medical model.**

While a high success rate in mitigating physical symptoms of disability can be attributed to the medical model there are many instances where the medical model falls short. The specific focus on diagnosis and rapid treatment of the pathology limits the practitioner to the physical realm of the disability and discounts other avenues for treatment including the exploration of social and environmental factors that can be associated with the disability. As so many veterans are faced with the psychological wounds of combat it may behoove practitioners to go beyond the medical model; this would allow them to answer the why behind the disability, thus providing the patient with a causative relation to the disability. Boyle (2006) asserts that “life experiences and traumas are very important in causing emotional distress and even psychotic experience, but their importance is mediated through an individual’s prior biological vulnerability” (p. 192) when utilizing a medical model. Such an approach takes away from experiences of combat trauma, indicating that some individuals will be more predisposed to psychological trauma than others. While this may be the case, what good does it do to evaluate biological vulnerability after the fact? Instead, would it not make more sense to help the individual make sense of the experiences and traumas? This however does not fall within the realm of the medical model. One does not make sense of the experiences, but rather treats the disability that comes from the experiences. For example, anxiety medication may be utilized to help reduce anxiety in
social situations for one with PTSD, but the cause of the anxiety is not evaluated or dealt with.

Swarbrick (2006) asserts that rather than a medical model a wellness model should be utilized. A wellness model approaches all aspects of one’s life rather than the narrow focus of the disability that the medical model employs. This approach requires the individual to be actively involved in all aspects of recovery, whereas the medical model has the individual taking a passive role in recovery. In taking on a more active role in their recovery the patient has a greater sense of control over treatment. The wellness model pays attention to a well rounded treatment plan that includes an interconnectedness between the different dimensions of health, to include spiritual health, with is often missing from the medical model, but has seen to play an important part in recovery (Swarbrick, 2006). The medical model’s narrow focus makes interconnected treatment difficult as the focus is on the pathology of the disability rather than on the overall health of the individual.

**Social Exclusion or Attachment Theories**

Social inclusion is a key part of being involved in society. Inclusion provides individuals with protection, a sense of being, a sense of purpose, and a connectedness with society in general. Positive relationships play a key role in successful social inclusion. The social exclusion or attachment theories build on the principal that those who are social excluded or have social attachment issues are less likely to have prosocial behaviors, thus ostracizing them, over time from successful social relationships (Twenge, Ciarocco, Baumeister, DeWall, & Bartels, 2007). MacDonald and Leary (2005) make a connection between social exclusion and social pain, stating that
someone who endures social exclusion experiences true pain. Over time, if the individual is repeatedly excluded socially their ability to empathize with others and can create a level of emotional numbness that exists in order to protect the individual from the physical pain associated with exclusion (MacDonald & Leary, 2005; Twenge et. al., 2007). This evaluation of social exclusion may help to explain why substance abuse is so high among homeless veterans, as alcohol is a numbing agent against pain both physical and emotional.

Social exclusion and lack of social attachment can also lead to antisocial behaviors such as aggression; the hypothesis being that aggression becomes a defense mechanism for individuals who are social excluded (Twenge, et. al., 2007). Other symptoms include: anxiety, self-defeating thoughts, intellectual impairment, impulsive and under controlled behaviors, decreased social supports, and lack of trust (MacDonald & Leary, 2005; Twenge et. al., 2007). These sorts of behaviors could quickly lead to lack of employment thus putting an individual into a downward spiral towards homelessness.

What is important to understand in the realm of homeless veterans and this theory is that the veteran returning from combat is already dealing with some sense of social exclusion, especially if they are being released from duty. There is a large loss of the military culture and the lack of understanding regarding the experiences of the combat veteran in the civilian world. This disconnect can quickly lead to social exclusion especially if the veteran exhibits antisocial behavior. Also of importance is the connection between social attachment and PTSD. Zulueta (2006) asserts that when the traumatic event occurs there is an immediate effect on the individual’s ability to create
social attachments. Further, previous social attachments may be severed. Other studies have indicated that veteran’s that return from combat with PTSD and other psychological traumas recover more quickly and are less likely to abuse substances if they have a strong social support network and relationships where the individuals believe their symptoms and stay with them (Renshaw et. al., 2008).

**Strengths of the social exclusion/attachment theory.**

The social exclusion theory allows the social worker to focus on ways to provide for social inclusion for the homeless veteran. Identifying that social exclusion can be the cause of antisocial behaviors gives the individual a partial answer as to why they are reacting in a certain manner. Such a theory also gives the caregiver a root for the behavior and a place to start in terms of treatment. If the premise of the social exclusion theory is the more an individual is excluded on a social level the more they withdraw and pick up antisocial behaviors then it would make sense that policies focused on social inclusion would be beneficial. Social inclusion, it would seem, would help to decrease the antisocial behaviors found in homeless veterans and increase the pro social behaviors that will help them to be successful.

This theory also plays well for those that are working with the reintegration of soldiers upon return from combat. Rather than allowing for isolation, applying this theory would help to create policies that provide for social gatherings and other socially inclusive activities to help keep combat veterans involved and social included. Such a theory may also help those that are working with veterans with psychological trauma or spouses of veterans that have returned and seem distance and isolated. Veterans returning from combat may have lost trust in their social ties, depending on their combat
experiences and the failure of long distance relationships during lengthy deployments, thus creating a lack of trust in relationships leading to social exclusion and a severing of social attachments. Understanding this may allow the practitioner or the spouse to begin to build those relationships and find ways to provide for social inclusion that would increase trust and, thus, decrease the desire to isolate oneself leading to further social exclusion.

**Weaknesses of the social exclusion/attachment theory.**

Understanding that social exclusion may occur in combat veterans, in turn creating antisocial behaviors that can lead to the dissolution of relationships and social support systems is only half the battle. The other half is figuring out how to work with this knowledge. Simply creating situations in which the veteran is social included does not mitigate the anxiety, depression, aggression and other symptoms related to social exclusion. Twenge et. al. (2007) indicate that negating social exclusion with taught prosocial behaviors does not appear to provide progress towards social inclusion because, “pro social behavior is not a strategy that rejected people use to find friends. The reduced ability to empathize with others undercuts the inclination to provide help, and reduced trust may also hamper any willingness to make the first move” (p. 64).

Acknowledgement of the affects of social exclusion and social attachment are not enough, policies must find a way to address the affects of social exclusion in such a manner that antisocial behavior is decreased and the veteran is able to feel comfortable in socially inclusive environments.

This model also does not take into consideration the loss of military culture that exists for the veteran who is leaving the military. Such a loss can be devastating if the
veteran has little outside support. At this time the only support they may have is through the VA or other military affiliated programs such as Veteran’s of Foreign Wars (VFW). The inability to connect outside the military may be detrimental for many of those leaving the service, and more so for those with undiagnosed psychological traumas that have yet to be addressed.

**Comparison of the Medical and Social Exclusion/Attachment Models**

Both models provide stepping-stones for those that are involved in policy development for veterans. The medical model provides a focused method to treatment and disability management while the social exclusion/attachment model provides a better understanding as to why certain behaviors may occur within the veteran population leading to homelessness. Neither model is the answer unto itself, but rather pieces in the puzzle for caring for those who served our country and are now affected by unseen or seen wounds. The medical model allows for treatment of disability through medical intervention, medication, and treatment of infectious disease, focusing on the physical health of the veteran. In the meantime, the social exclusion/attachment theory focuses on antisocial behaviors that may have lead to joblessness and homelessness and looks at methods for providing a social inclusive environment for the veteran where they do not feel threatened in their environment.

Each model has it's own benefits, and by putting the two of them together it seems as though practitioners may have a better approach to the overall health of the veteran. Understanding the social exclusion/attachment theory may help those utilizing the medical model to look at underlying causes that may need treatment. On the other hand, those utilizing the social exclusion/attachment theory may need to utilize the
medical model to treat a specific ailment associated with social exclusion, such as anxiety, in order to remove the symptom so that the individual can function and work through the underlying cause associated with the social exclusion.

**Analysis of Social Policies**

Understanding the theoretical frameworks for policy is not enough, one must them take these frameworks and determine how they are applied within the current policies. Both the medical model and the social exclusion/attachment theory have been applied to various policies and programs that have been developed to help homeless veterans. The medical model appears to be the model of choice by the Veteran’s Affairs office, but social exclusion/attachment is prevalent in policy as well.

**HUD-Veterans Affairs supportive housing (HUD-VASH) policy**

The HUD-VASH program is a housing first program, meaning that any medical, substance abuse or employment issues the veteran is facing are not as critical as getting housing. Once housing is established then treatment for the rest of the issues will be taken care of. This program is run through a partnership between the PHA and the VA. The PHA provides the links to housing while the VA provides the case managers and vouchers necessary to facilitate the program.

This policy focuses on the social exclusion/attachment theory. Here, the focus is on inclusive housing that is of fair market value in neighborhoods that are not in ghetto environments (Cunningham, 2009). The thought is that if the veteran can be included in the neighborhood, feel comfortable in their home they will be more able to begin to heal from physical and psychological wounds, deal with their substance abuse issues, and become involved in employment training programs, leading to employment. The veteran
becomes a part of the social fabric rather than being excluded from it simply by being able to maintain housing.

The housing first approach is socially inclusive, but does present some barriers for the veteran that has been social excluded either by their own volition or by their social support networks that could not understand the psychological wounds the veteran was dealing with. By placing a homeless veteran into a social inclusive environment and away from those who understand their experiences (other veterans) the program fails to address the reasons why the veteran became socially excluded in the first place. Cunningham (2006) states that there is a current push to create project based housing in which vouchers would stay with the housing rather than with the veteran possibly creating communities where veterans would be each other's neighbors and neighborhood programs could run and outreach to the veterans in the HUD-VASH housing. This approach may be more beneficial based on the knowledge of the social exclusion/attachment theory; veterans may do better first being including within their own peer group in a neighborhood setting, where they can learn to trust again, and then slowly to be included with society at large.

**Co-location of services**

The co-location of services as done by the Greater Los Angeles area, which later became a model for care across the VA can be seen as taking the medical model approach. The co-location of mental health and physical health services does not take away from the main mission of these practitioners, to treat and manage disabilities. Rather, it puts all the practitioners under one roof so that it is not difficult for the veteran to receive and maintain services. As this is simply a restructuring of how the VA does
business it continues to prioritize those needing care based on disability and focuses on pathology.

One mission of the VA has been healthcare, and it has followed the medical model in providing care to veterans since it’s inception. The primary responsibility of the VA health care system is to, “provide quality healthcare services to veterans and to reduce their burden from illness, injury and disability, especially for those conditions that are related to their military service” (Vandenberg et. al., 2010, p. 13). Such a mission indicates a strong focus on medical care and attention to the pathology of the disability, the words “reduce their burden from illness…” does not indicate a full recovery on the holistic level, but rather management of disability, which falls within the realm of the narrowly focused medical model. The co-location of services does not change this mission, but rather makes it easier to execute the mission for practitioners, and for veterans to receive some level of medical care.

The integration of medical, mental health, and homeless services into one center does indicate a desire to move away from the medical model as all encompassing, but does not rid the VA of the medical model completely. As stated by Boyle (2006), even in the mental health field there is still a strong focus on pathology and medical terminology, and until the field moves away from this focus it will continue to fall under the medical model. The only level of services that would fall outside this model would be the homeless services, which may employ the social exclusion/attachment theory, in working with homeless veterans, especially if utilizing the HUD-VASH program.
Outreach services.

The one program that does employ both the medical and the social exclusion/attachment models is the outreach program. First, by going to where the veterans are, rather than expecting the veterans to come to them the outreach workers are building trust and developing relationships with homeless veterans. The program's desire to outreach is inclusive in nature; it shows those veterans that have had every social relationship broken that there is someone that is willing to extend a hand to them. By developing these relationships there is a hope that the veteran will eventually utilize services offered through the VA and other such agencies, and become more social included.

The other aspect of this program, which is it's main mission, is to ensure that those homeless veterans that are eligible for benefits are receiving them, and that basic health care needs are taken care of (Chen, et. al., 2007). Under this umbrella outreach services is utilizing the medical model, once again focusing narrowly on access to health care and the pathology of disability. Benefits are either pension or disability based, both with specific requirements, and health care is basic preventative care such as physicals and immediate treatment of contagious illness. All of this leans towards pathology, rapid treatment, and a narrow focus, all of which are a part of the medical model.

A combination of the two models through outreach services may help to provide access to more treatment for veterans who are currently homeless and may not realize that they have access to medical care. The program serves to develop relationships with homeless veterans who have been socially excluded, leading to antisocial
behaviors, making it harder for them to seek treatment, and the ability of the medical model to provide treatment to relieve those living on the streets from the “burdens of their illness or disability” (Vandenberg, et. al., 2010, p. 13).

Summary of Policies

Each approach has strengths and weakness associated with it and each is applied in different ways across the policies that are being developed in order to assist homeless veterans. Policy makers need to be aware of the different theoretical frameworks that exist and ensure that they are consciously applying theories to the policies in order to ensure that they have direction and purpose. One model is not better than another, and together they may compliment each other in such a way as to provide a service to homeless veterans that is better than when just one method is utilized. A move from a medical model approach to a wellness approach may be justified when looking at the number of psychological wounds combat veterans are returning with. Such an approach would allow for interconnectedness among life dimensions that would allow for a well-rounded recovery rather than the management of disability. Incorporating the knowledge associated with the social exclusion/attachment theories will also help to develop a well-rounded approach to working with homeless veterans.

Implications for Practice

With a focus on the veteran population and so many new programs and policies being implemented there will inevitably be implications for practice among professionals who work with this population. Each new policy brings with it changes in the field and how different agencies will work with one another. Programs such as the co-location of services and the HUD-VASH programs will require an integration of agencies as has not
been seen before. Employment programs and focus on mental health will require case management among social workers as they connect clients to various resources. The largest implication, however, is that if homelessness among veterans can be ameliorated by 2015, as the White House and the VA would like to see, one-third of the homeless population will no longer be homeless, opening resources to the general population that is homeless.

Integration of Agencies

Just as the Veteran’s Administration was required to integrate services at the bureaucratic level in 1930 agencies are going to be required to integrate in order to provide efficient and effective care for homeless veterans today. The success of co-locating medical agencies in Los Angeles indicates the way forward for care. Also important, will be what type of organizational systems model such programs will utilize; bureaucratic systems will run differently than cost/transactional systems. This will come with growing pains, funding issues, and leadership questions.

Funding.

Funding, as seen by the Greater Los Angeles program, can be key as far as co-location of services goes. This is because each agency is funded through different streams either privately or through taxpayer dollars. Each funding stream has certain requirements as to how money can be spent. This can create chaos within a program that is requiring agencies to co-locate. Which agency pays for the general receptionist? How are case managers funded as they work between agencies to support the client? Which agency is responsible for the facility and facility maintenance? Such a program may require a change to funding streams or an addition of funding that currently does
not exist. Ultimately, it may make sense, to relook funding among such programs and fund the program as one agency rather than several different agencies.

Without looking at funding with regards to the co-location of agencies and services a disservice to the client will exist. In the Greater Los Angeles project funding for a dental clinic never came to fruition due to funding issues on the medical agency side of the house (Blue-Howells, et. al., 2008). Other programs also suffered due to funding issues. Staffing among the different agencies would vary based on how each agency was funded; one agency may be fully staffed, but another understaffed. In such instances the fully staffed agency should be able to assist with the understaffed agency, but funding streams may make this difficult. Ultimately it is one program and should be viewed as such in regards to funding the program, however, as long as each agency is viewed as a distinctly separate agency from the others this will not happen, and fragmentation of services will continue.

**Case management**

Case management will have a larger role in caring for homeless veterans, as co-location and outreach policies become the standard when working with veterans. As shown through the Greater Los Angeles VA project, social workers and case management go hand in hand in the field and provide opportunities to support veterans through a holistic approach combining different frameworks and social work theories together. Social work case management can play a major role in the solutions to the homeless veteran population. The co-location of agencies will require case managers that will be able to help identify which services a veteran will need. Outreach programs will need case managers to oversee cases, chart histories and recommend additional
outreach services. Employment programs will require case management to ensure that veterans have the proper job training and to link them with employers.

Case management will also have a need to look at individual veterans based on their war era cohort. The study done by Kline et. al., (2009) has overreaching implications for case managers working with veterans from different war eras. The need to tailor programs and interventions based on war cohorts is important in helping veterans to better help themselves. Social workers working with this population will need to be educated in veteran issues to include: the effects of combat on mental health, substance abuse use among the veteran population, transition services, veteran’s benefits, VA rules for claims, and the culture of the military. One of the goals outlined by the National Security Staff in the 2011 report is to “leverage partnerships with professional associations and academic institutions to ensure military culture is included in core curricula and published standards” (p. 10) This includes implementing standards associated with military issues within the American Psychological Association ad the Council on Social Work Education. Such outreach indicates a recognized need for case managers and those working with veterans to have a better understanding of the culture veterans have lived within prior to becoming a civilian.

**Impact on Overall Homelessness**

Cunningham (2009) asserts, in her testimony to Congress, that by focusing on the veterans that are homeless that the overall homeless population will be helped. As veterans leave the homeless rolls it opens up beds and resources, through private organizations for those homeless that are not veterans. As homeless veterans are removed from the streets and homeless shelters room is made for those in the general
population. Approximately one-third of the homeless population would not longer be homeless, opening resources to those who are left.

Not only will this relieve facilities designed to house homeless of part of the population, but identifying homeless individuals who are veterans will also open up mental health and medical facilities to the general population. Veterans have additional resources, through the VA for medical and mental health support that other homeless individuals do not have. However, many veterans are not utilizing VA services, as seen through Chen et. al's., (2007) study of the outreach services programs indicated. If veterans begin utilizing services that are designed for them then other services designed to support homeless individuals will open up for the general population. This is key to supporting those that are homeless as Cunningham (2009) reported that twenty-nine percent of homeless veterans are tri-morbid (p. 2) and Burt et. al. (1999) report that eight-six percent of all homeless individuals report alcohol, drug or mental health problems over their lifetime (p. 24). The identification of veterans among this population will allow resources to be freed for others needing assistance.

**Efficacy of Policies to Ameliorate Homelessness Among Veterans**

Many of the programs discussed are new in the scheme of social welfare programs and ending homelessness among veterans. They specifically target veterans who are homeless and utilize funds through the VA to address health and housing concerns. Funding is a major problem with these programs, Cunningham (2009) reports that the HUD-VASH program will not be able to meet the needs of every veteran that qualifies for the program, and Blue-Howells et. al. (2008) indicated that the Greater Los Angeles project ran into major funding problems affecting the overall program’s ability to
integrate services. Focus is currently on policies and programs that address homelessness after it has happened; there is a need to address preventative measures that help identify individuals at risk for homelessness prior to exiting the military. When this is done, and screening processes are taken seriously by leadership and service-members then the government will have moved forward to addressing homelessness among veterans in a well-rounded and thought out process.

**Transition from Military to Civilian Life**

The transition from military to civilian life can be difficult for many members of the military. They are leaving a culture that has protected, housed, fed, and paid them. Not only has the military provided for the service member’s basic needs, but they have also provided a camaraderie and common understanding of experiences to include the combat experience. An individual experiencing psychological trauma may not feel the full affects of it until they leave the military, and by the time they realize how the trauma is affecting their life it may be too late to file a benefits claim.

**Army career and alumni program (ACAP).**

Currently individuals leaving the military participate in a transition program that is designed to help them with employment options, writing resumes, and veteran’s benefits. The Army Career and Alumni Program (ACAP) is the transition program run by the Army in order to help soldiers transition from military life to civilian life. The website links individuals to a multitude of resources and tools, such as job fairs and ACAP centers that are designed to provide personal assistance to soldiers leaving the military. More emphasis in these programs needs to be made on filing for veteran’s benefits, and support post military.
Mental health considerations.

Mental health appears to be a contributing factor to homelessness. As such, the military needs to continue to screen accurately for psychological trauma, and to realize that substance abuse may be a symptom of mental health problems, rather than a separate issue. Savitsky et. al. (2009) state that substance abuse is reason for a discharge due to misconduct rendering the individual ineligible for VA benefits. However, many will cope with psychological trauma by abusing substances rather than seeking treatment due to the stigma of mental health care in the military. Better screenings for mental health issues would help to alleviate dishonorable discharge and allow for the individual to receive VA services. Wales (2009) writes of the legal battles those with substance abuse discharges face when trying to claim benefits for mental health issues. The correlation between substance abuse and mental health issues is great, and the military would do right by their service men and women to redress the policies in place with regards to mental health screenings upon discharge and dishonorable discharge due to substance abuse, particularly if the service member had served a combat tour.

To begin to ameliorate homelessness among veterans the military must relook policies associated with mental health and benefits claims. Wales (2009) indicates that a veteran has two years from the end of their service to file a compensation claim with the VA. Unfortunately, not all psychological trauma is diagnosed within two years of leaving the military (Satvisky et. al., 2009). As the VA focuses first on those with service-connected disability it becomes important for those with psychological trauma to be diagnosed as soon as possible in order to receive assistance from the VA. Outreach
programs and Vet Centers are beginning to address this issue, but more needs to be done to reach those veterans who are suffering mental illness.

**Social Support Systems**

As indicated by studies such as the one completed by Renshaw et. al., (2008) social support networks are critical to the success of the veteran as they transition from combat to home and from the military to the civilian world. Savitsky et. al., (2009) also indicate that support networks can assist veterans in transition providing them with other individuals who are compassionate to their situation. Veterans need to know that these support networks exist and how to access them. Spouses also need to know that there are support systems for them as they support the service member during transition. Renshaw et. al's., (2008) research indicates that those service members who have supportive spouses fair better, maintain relationships, and are more successful in their transition than those whose spouses are not supportive and do not believe their experiences in combat. This indicates that spouses must be educated and ready to support the service member during their reintegration from combat.

The HUD-VASH program has considered providing project-based housing (Cunningham, 2009), but it has yet to be approved. This may help those veterans transitioning from homelessness into the program to feel more supported. Such a program would allow veterans to be housed with other who would understand their experiences, because who better to understand a veteran than another veteran? Civilians who have never experienced combat may be able to empathize, but those who have been there will truly understand. Such a program would allow for a natural
camaraderie to occur, thus creating a social support system among veterans that can then be supported by educated social and mental health workers.

**Summary**

There is still much to be done to reach the VA’s goal to end homelessness by 2015. The most recent paper published by the National Security Staff (2011) indicates that more needs to be done and plans are in place to implement new policies and programs to assist veterans as they transition out of the military. There is a need to review existing policies and fund them properly. Also, as services are co-located there is a need to determine how best to fund them and how they should be structured so that agencies do not compete against one another for leadership. Housing first programs help to get veterans off the streets and into housing, but mental health and substance abuse treatment must also be addressed as does employment opportunities for those that are able.

The VA and other agencies need to find ways to outreach to those who are not eligible for services through the VA and determine how best to support them. Time limits on VA claims for service-connected mental health disabilities need to be relooked to determine how best to support veterans with psychological trauma that does not present immediately. As the OIF/OEF veterans leave the service it will be necessary to increase mental health screenings prior to discharge, and to follow these veterans to provide strong social support networks to provide preventative measures to homelessness. This will also need to include a review of the ACAP program and the other service’s transition programs to ensure that those leaving the military are fully supported and informed of support programs that exist for them as they enter the civilian world.
The education of social and mental health workers with regards to military culture, VA benefits, and the effects of combat are essential to providing support to veterans. Educating these individuals on veteran’s issues will ensure that those that fall outside of the VA purview will be assisted in the best possible manner, with consideration for their unique experiences that may affect their ability to make a successful transition. While much has been done, much more needs to be done to ensure that there are no homeless veterans. The people of the United States owe it to the one-percent of the nation (National Security Staff, 2011) that serves on its behalf. These individuals have seen combat, left their families for a year at a time, and literally put their life on the line in order to serve their country upon exit from the service they should be assured that they will not end up homeless, misunderstood and unsupported.
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