

## VETERANS VOICES

# Homeless Veterans: It Takes a Community

Joseph M. Moranda

Seton Hall University, US

[jmoranda77@yahoo.com](mailto:jmoranda77@yahoo.com)

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Veterans' Voices is a unique space for the contributions of veterans, active military, and military family members to voice their perspectives and experiences with areas of military or veteran life of interest to *Journal of Veterans Studies* readership and veterans studies scholars. Authors connect their experiences or perspectives with issues (explored or not yet explored) in applicable research, academic, or teaching fields. Veterans' Voices submissions are vetted by members of the *Journal of Veterans Studies* editorial board.

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### Introduction

Across these great United States stretches an ongoing and growing issue of homelessness. In most towns, a person does not have to go far to find members of a population that are without proper housing, protection from the elements, self-safety, secure sources of sustenance, or access to preventative health care. It is described by those who suffer from it as an "incurable virus" (personal communication, 2018). The homeless population is susceptible to horrible situational exploitations such as murder, forced prostitution, and a myriad of other crimes. Lack of any sense of safety and or security leaves this cohort struggling to simply survive. Maslow's hierarchy of needs would have this group cemented to the bottom one and two tiers. This would explain why many within the population have lost touch with a world that flashes by each day. The homeless population's primary aim is to simply obtain the essentials for life from moment to moment, in turn, preventing them from interacting in society in other more relatable and productive ways (NAEH, 2019). Case managers that work with the homeless population battle to place permanent structure that will allow the homeless to stop treading and start moving forward with other areas of their lives and relationships (Finkelman, 2011).

The United States Department of Housing and Urban Development (HUD), among other things, is an agency that collects data pertaining to the homeless population census. HUD uses a point in time (PIT) count system that is divided into two broad categories of sheltered and unsheltered homeless. Counts are taken from the street homeless, homeless shelters, emergency shelters, and transitional housing units. PIT count results demonstrated that an average of 552,830 people suffered from homelessness on any given

night in January of 2018 (HUD, 2018). This number does not include the 4.4 million of working poor in doubled households who are at the greatest risk of becoming homeless (NAEH, 2019). It is feared that shortcomings in the HUD counting procedure may result in a homeless count grossly underrepresenting the actual number of homeless across the United States.

Each homeless person has a story as to why or what led them down the path of homelessness, and each story is as unique as the respective homeless person's own fingerprints. If you spend any amount of time volunteering at a homeless shelter this fact will become apparent. Homelessness does not discriminate by race, religion, or sexual orientation. There is no mercy for one-time heroes, the college educated, or veterans of military service. HUD breaks down the PIT count into several demographic variables such as race, chronic homeless individuals, youth, homeless families, individuals, and veterans (NAEH, 2019).

The statistics regarding race are broken into the following five categories: American Indian and Alaskan Native; Asian; Black or African American; Multiracial; White (NAEH, 2019). Among the homeless census for January 2018, 70% of the homeless population were men. The white race represented a larger portion of the U.S. population and, in turn, a larger portion of the homeless population. The more alarming statistic is that of minority representation within the homeless community compared to the much smaller representation in the U.S. population. For instance, Native American and Native Alaskans only represent 1% of the U.S. population, yet they make up 3% of the homeless population. According to the HUD (2019) census, African Americans represent only 13% of the American population but make up close to half of the homeless population. This represents

a serious dichotomy that should not be ignored as research on how case managers can help homeless subpopulations moves forward (NAEH, 2019).

### Multi-factorial Reasons for Homelessness

An overview of the literature on the homeless population reveals some common qualities that are prevalent within the homeless communities: Broken homes, unemployment, lack of access to affordable housing, substance abuse, mental illness, and post-traumatic stress disorder (NAEH, 2019). The focus of this commentary on homelessness is meant to drill down into the interactions of case management with the homeless veteran subpopulation that exists in this country. All of the aforementioned demographics and characteristics are represented in a population that at one time or another was involved in military service for the United States of America. The veterans, like all other subgroups, have multi-factorial rationalities for either choosing homelessness or ending up homeless.

Carol Malte, Koriann Cox, and Andrew Saxon (2017) researched the effects of advanced case management for homeless veterans with noted substance abuse issues. For each author, homeless and addicted veterans were a part of their everyday lives while working for the Veteran Affairs Center in Washington state, and all three worked for large healthcare systems in the greater Seattle area. This means that all three have had personal experience as to the large-scale damage and correlation that exists between homelessness and substance use disorder (SUD). In fact, substance abuse remains the primary causative factor for homelessness (Malte, Cox, & Saxon, 2017).

( $n = 181$ ) Veterans who were already entering a Veterans Affairs (VA) substance use program agreed to participate in a randomized study testing the control group, housing support group (HSG), against the intervention group which was rightfully titled abuse/homeless case management group (AHCM). HSG would provide the existing homeless housing services, which would include access to a medical social worker and finding adequate and affordable housing solutions within the community. Each week control participants would receive a drop-in housing support group visit. The test group would receive the intervention of both addiction case management services and housing case management services. Each would work together to follow each participant within the substance abuse program and help to transition the veteran to appropriate housing with continued support by both entities (Malte, Cox, & Saxon, 2017a).

Results were mixed within this study. The HSG group showed more of an improvement in decreased emergency room visits than did the intervention AHCM group. The HSG group had reduced alcohol composite scores (ACS) compared to the AHCM group. The AHCM group did have a longer average stay in the treatment program with a 52.7 days average. The AHCM group was also noted to show more participation within the group than did the HSG control group (Malte, Cox, & Saxon, 2017a). The overall conclusion

of this study was mixed and failed to disprove the null hypothesis that HSG was superior to the AHCM approach to homelessness and substance abuse (Malte, Cox, & Saxon, 2017a). Research will have to be expanded in order to justify moving away from the HSG program, which has equally modest results as AHCM.

Malte, Cox, & Saxon (2017b) was an expansion on an earlier 2017 article that explored the utilization of a substance use program and the overall effects of case management. Their goal for this branch of study was to identify common patterns of homeless veterans entering the substance use program in the first place. In turn, this research might result in a better hypothesis of how to help this population within advanced case management. Results concluded that a large majority entering into a substance use program was first identified in the emergency department. Second to that, the mental health division was also crucial in identification of addicted and homeless veterans. The fact that the vast majority of these veterans are identified through the emergency department shows lack of continuity within the community to provide consistent veteran support (Malte, Cox, & Saxon, 2017b).

Another drawback of substance use is that the demand for services is far larger than the capacity of those organizations offering services. Upwards of 50% of homeless veterans identified as needing services are never admitted after they are placed on a waiting list (Winn et al., 2013). This leads to the following question: What pieces are missing in order to bridge the gap between treatment and sound, substance-free community living?

Mental health is another major consideration with respect to the veteran homeless population. Gabrielian et al. (2019) set out to identify how best to support homeless veterans, with severe mental illness, to better manage problem solving and other noted deficits. The primary focus was on decision making within a structured housing environment. Two broad categories were formed within the participants. Stayers, identified as those veterans who stayed one year or more in VA provided housing, and Exiters, which were those veterans who did not stay the length of a year. Gabrielian et al. (2019) concluded that stayers were more likely to develop a more complex decision-making skill set within the home than those who left prior to a year stay. In-house training from case management has an overall positive effect with homeless veterans with severe mental illness. Gabrielian et al. (2019) noted that success was the result of supportive housing treatment, assertive community treatment, and substance use disorder treatment. Again, research notes the use of multidisciplinary and multi-service approaches to homeless veterans as a plausible solution to long-term housing and mental well-being (Gabrielian et al., 2019). This study was in relation to another study attempting to identify why homeless veterans were leaving the VA program that provided secure housing.

Veteran Affairs Secure Housing Program (VASH) is a program that offers subsidized housing and other services

meant to support once street homeless veterans with obtaining a stable housing situation in which they could stay indefinitely. Gabrielian et al.'s (2016) study took place in Los Angeles during a 2011–2012 timeframe. Multiple factors were noted to be associated with early exit from VASH. Substance use, emergency department visits, chronic pain, poor compliance with outpatient care, and hepatitis C among others (Gabrielian, 2016). Whatever the motivation or reason behind leaving VASH, it is important to note that 50% of Exiters were subsequently “street homeless” or incarcerated following their exit from VASH (Gabrielian, 2016). The authors did base future research studies on the outcomes noted in the VASH study. It seems intuitive that a mixture of VASH, HSG, and community resources begin to make a positive impact on our homeless veterans.

### Women Veterans

Another subpopulation that cannot be ignored is women veterans. It is true that women are the minority when it comes to homeless veterans, but nonetheless they too make up a sub-cohort that deserves help. Homeless women veterans can have all of the same aforementioned psychosocial and physical problems as men. Tsai, Rosenheck, & Kane (2014) took notice of the increased role that women were filling in the U.S. Military and therefore wanted to study the difference between homeless veteran women and homeless veteran men.

Homeless veteran women were noted to be younger in age and have less of a criminal record than that of their male counterparts. Tsai, Rosenheck, & Kane (2014) noted that women were less likely to report traumatic events but more likely to suffer from those traumatic events. Homeless veteran women had a higher rate of Post-Traumatic Stress Disorder (PTSD) than veteran men. The authors warn that women veterans are more likely to have experienced non-combat trauma such as sexual or physical abuse and are more likely to not report family dysfunction. For these reasons, the 10% of homeless veterans that are women may have reasons outside of those most commonly referenced (Tsai, Rosenheck, & Kane, 2019). It is important to note that women veterans are more likely to have homeless children who also need support from advanced case management.

A 2013 study by Decker, Rosenheck, Tsai, Hoff, & Harpaz-Rotem supported further research into the after effects of military sexual assault (MSA) on homeless female veterans. Per Decker et al. (2013), women are more prone to PTSD and less likely to report the trauma. This echoes the previous study mentioned pertaining to women and traumatic events. MSA can be the source of trauma or it can be the exacerbating factor for another traumatic event. Case managers and practitioners alike can support women veterans by establishing a complete history and physical to include physical/sexual abuse history. Decker et al. (2013) note a lack of corroborating evidence was a limitation to their study. After having the luxury of looking forward, future studies in this area would corroborate their initial evidence.

It is important to note that Decker et al. (2013) did not find any significant correlation between MSA and sexual abuse as a child. According to women that have experienced MSA, the most effective treatment is providing a safe and caring environment for veteran women to effectively heal (Decker et al., 2013).

Suicide is another aspect of homeless veteran care that case managers must be cognizant of when advanced care planning is taking place. Goldstein, Luther, & Haas (2012) worked with 3,595 veterans from the North Eastern United States to identify the mental and physical factors that predisposed homeless veterans to suicidal actions. An elevated rate of suicide in the homeless veteran population was the basis for this research study. Goldstein, Luther, & Haas (2012) hypothesized that risk for suicide increases in the veteran population related to “significant life stress and degraded quality typically associated with homelessness (p. 37).” If case managers are educated over a propensity for suicidal ideations or actions in their homeless veterans, they can adjust a care plan to involve social workers and counseling in a prophylactic manner (Goldstein, Luther, & Haas, 2012). It is imperative that case managers working with homeless veterans receive specific trauma-informed training. Case managers should have an idea of treatment plans that have been approved for military veterans suffering from PTSD. Trauma-informed care is case managing from a perspective that is informed of a traumatic patient history. Three important suggestions noted for case managers providing care to homeless veterans are as follows: develop a base knowledge of trauma, create a physically and emotionally safe environment, and identify/promote/support each individuals’ strengths (Dinnen, Kane, & Cook, 2014).

### It Takes a Community

The literature pertaining to indigent veterans suggests that multiple entities coming together are necessary to care for our U.S veteran homeless population. Studies have shown minimal gains when one or two interventions are put into place for people that have multi-level psychiatric disorders, traumatic events, substance use, and no safe place to heal or even live. Caring for even just one of these patients takes the commitment of several interdisciplinary resources to include case management, providers, social workers, and community resources who are all willing to help with continuity of care.

The purpose of this commentary is to review literature regarding homeless veterans and how case management can better help solve this ongoing social issue. Case management with respect to the homeless veteran population comes in the form of multiple entities locking arms and working together to ensure ongoing support for the homeless veteran. In fact, community efforts in this area has already started to create a positive effect on reducing the number of homeless veterans according to HUD PIT decreasing counts across the nation (NAEH, 2019). According to the National Alliance to End Homelessness (NAEH), homeless

rates have been in decline in certain subpopulations and states with concerted efforts to comprehensively involve the community as a whole.

One piece of literature stands out as an overwhelming successful tool for case managers to develop when working with the homeless veteran population. Weismann, Covell, Kushner, Irwin, & Essock (2005) developed a research article titled "Implementing peer-assisted case management to help homeless veterans with mental illness transition to independent housing." The project set out to show how veterans that have successfully managed recovery are able to then turn around and take another veteran with similar issues under their guidance while transitioning from homelessness to transitional housing. Weismann et al. (2005) offers that case managers and mental health professionals can help monitor the transition, but veterans tend to bond with fellow veterans that have already gone through the same transition. Fellow veterans can better understand each other's particular situation(s). Veterans helping veterans appears to create positive care environments and situations. Weismann et al. (2005) goes on to note that homeless veterans that have successfully navigated housing are positive role models for those homeless veterans just getting acclimated to changes that come with transitional housing. The results of this study showed that a peer-case management program is useful in adjunct to already established care models (Weismann et al., 2005). Peer-case management shows the level of resources needed to provide care that combats rates of homeless recidivism.

Group-intensive peer support is another model of care that utilizes veteran peers to supplement intensive one-on-one case management. Case managers using this model will provide support to a group of veterans in a group setting. Individual treatment plans include support from other homeless veteran peers who have shown to be able to successfully navigate the program. One program that has had some recent success is a hybrid program called HUD-VASH. Both of these programs alone have been academically proven to have some success with homeless veterans. The combination of the two programs and the adoption of an element of peer case management as part of the care plan provide a more holistic continuation of care (Tsai & Rosenheck, 2012). Group-intensive peer support (GIPS) is a model that shows potential in the area of homeless veterans transitioning back to the safety and security of a structured home (Tsai & Rosenheck, 2012).

Case management of homeless veteran populations is not an easy task by any stretch of the imagination. Homeless veterans suffer from a host of complicated mental and physical diagnosis that may or may not be service related. PTSD from traumatic events can only add to the unpredictable nature of mental illness or military sexual assault. Service-related disabilities can result in chronic pain or permanent disability such as a traumatic brain injury, which can then have long lasting effects on the success of a nursing care plan.

Creating a mentally and physically safe environment where the veteran feels comfortable discussing the more sensitive aspects of his or her homelessness is of utmost importance. Collecting data in the form of a true and thorough history that includes more than just military service will prepare the case manager for an informed approach to care. The case manager must have a sound idea of what factors play into the veteran's positive or negative experience in order to effectively treat him or her (Tsai & Rosenheck, 2012).

Case managers must then decide on which model or collection of nursing models will work best for the individual veteran in their care. Czerwin & Halley-Boyce (2018) note that multi-variant cases must have a multi-discipline approach. A homeless veteran may possibly need management from many different perspectives to have an overall positive outcome.

What our homeless community, as a population, needs is a case management model that is dynamic in its function. Case management should transcend nursing alone. Let us form a new case management model called intercommunity homeless management (ICHM). This model would ideally be an organization that would account for our homeless veterans from the street through transitional housing and substance use programs, and onto a stable individual home environment with acclimation back into society. The interdisciplinary team will consist of health care professionals such as nurse case managers, providers, social workers, community members, volunteers, church members, and fellow veterans that have already been successful and active in recovery. This patient-centered community will be able to provide a much-needed safe space and foothold so that our homeless and homeless veteran heroes can march up Maslow's hierarchy toward self-actualization.

### Final Words

As a veteran of the United States Air Force, hospice nurse of several years, and volunteer for end-of-life veterans, personal experience has provided empirical evidence supporting a community approach to treat a wide variety of veteran needs. In many cases, homeless veterans suffer from acute and chronic mental illnesses that have led to estrangement from primary and secondary family members. Without the mental capacity to help themselves, or family members to assist veterans in seeking help, it is up to a community of health professionals and caring volunteers to create an inner circle of trust for homeless veterans.

As a volunteer for No Veteran Dies Alone, I have met many homeless veterans transitioning into end-of-life without any family members at their bedside. Volunteers stepped in around the clock to let veterans know they are cared for and not alone. After a veteran moves on from life, each is draped with an American flag during a ceremony performed by medical staff and veteran volunteers. This is just one positive example of individuals coming together as a caring community for our vulnerable veterans. Imagine what could be done if that same dedication was put into continuity of

care for homeless veterans. The overarching purpose for this manuscript is to create an ongoing community dialog regarding how we, as a nation, can holistically improve quality of life for our homeless veteran population.

### Competing Interests

The author has no competing interests to declare.

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