

Understanding and Treating Veterans Experiencing Homelessness

**Quantum Units
Education**

Affordable. Dependable. Accredited.

www.quantumunitsed.com

HEALING HANDS



James Crawford, 61, of Baltimore, Maryland, served in Vietnam 1970-73. He became homeless after a serious injury, but found help from VA services.

A Troubled Homecoming: Understanding and Treating Veterans Experiencing Homelessness

According to the January 2014 Point-in-Time count, there are 49,933 homeless veterans in the United States on any given night. For the U.S. Department of Housing and Urban Development (HUD), U.S. Department of Veterans Affairs (VA), and U.S. Interagency Council on Homelessness (USICH), the number marks a decline of 33% (or 24,837 people) from the 2010 count, and an advance toward the organizations' goal of ending veteran homelessness by 2015.

However, even as numbers decrease, veterans still make up 12% of the

There are 49,933 homeless veterans in the United States on any given night.

U.S. Department of Housing and Urban Development
Point-in-Time Count, January 2014

homeless population. Of these, 8% are female, and homeless veterans are younger on average than the overall veteran population. Veterans are at greater risk of becoming homeless than the general population, and they display a unique constellation of health risks and conditions that can both lead to and be seriously complicated by homelessness.

While the VA provides a large array of social and medical services, only 25% of veterans ever take advantage of those services due to confusion about eligibility, difficulty of access, and the perception that the VA is a charity organization. Some veterans experiencing homelessness prefer to seek care at Health Care for the Homeless (HCH) clinics because of the ease of seeing providers and a desire to avoid a military environment. Many homeless veterans are either not aware of the scope of their VA health benefits, unwilling or unable to confront the administrative and bureaucratic details involved in accessing that care, or barred from receiving benefits due to the character of their discharge (other than

Continuing Medical Education credit is available at www.nhchc.org/resources/publications/newsletters/healing-hands.

honorable, dishonorable, etc.). Only veterans who left military service under honorable or general conditions are eligible to receive health care from the VA, leaving a wide swath of former military servicemen and -women who are not considered to be "veterans" by the VA, but who have been deployed – sometimes multiple times – and share the same health concerns as veterans with honorable discharges.

For the purposes of this article, anyone who served in the United States military, regardless of the character of discharge, is counted as a veteran. More than 260,000 veterans left military service with Other Than Honorable (OTH) discharges after serving in Vietnam. Between 2006 and 2012, 76,165 soldiers received OTH discharges, most as a result of minor offenses related to the stresses of war. These servicemen and -women came home with the same traumatic experiences and injuries as their honorably discharged counterparts. In fact, these traumatic experiences and injuries are often directly related to the infractions that led to the OTH discharge, especially substance abuse and possession.

Veterans who seek care at HCH clinics may have questions about how to access VA care, how to appeal or address an OTH discharge (or, "bad paper"), or how to access other VA services. Many veterans hesitate to identify themselves as veterans, especially those who served during the Vietnam era, or those with OTH discharges who have been told they may not identify as veterans. It is important for HCH clinicians and staff to question patients about their military history in order to address the particular health needs of veterans and to help direct them, whenever possible, to the wide variety of health services available through the VA.

Veteran Stories

When **James Crawford**, 61, came home from Vietnam in 1973, he



faced a world that was hostile to veterans. "I couldn't get a job," he remembers. "People would call us baby killers. Or an interview would be going great, and then they look and see I was in the military and I don't hear back."

Crawford started his own business and swore he would never use any services from the VA because of how he was treated. Over the years he went to college, had a family,

and worked in the insurance industry. In 1998, everything changed when Crawford was struck by a tractor-trailer while riding his bicycle.

As a result of his injuries, he lost his job, his insurance, his savings, his marriage, and ultimately his home due to mounting medical bills. As things got worse, he turned to alcohol and became dependent. "I was ashamed and embarrassed," he says. "My self-esteem was down on the floor. I was out on the streets and trying to figure out how this happened."

After three years of homelessness in Reading, Pennsylvania, Crawford landed in a shelter in severe alcohol withdrawal with dangerously high blood pressure. Shelter staff connected him with VA services. "My life changed that day," he recalls. "When I got hooked up with the VA things started happening very rapidly for me: primary care, psychiatrist, psychologist, dental – they worked on everything. The VA is the best thing that ever happened to me."

For Crawford, finally being diagnosed with Post-Traumatic Stress Disorder (PTSD) and depression helped him frame his past experiences and better understand how to deal with present circumstances. He was able to get sober, secure housing, and take advantage of the full spectrum of VA services. "I didn't know I had disorders until they told me," he says. "Now I look back on my life and understand why things were the way they were."

Rebekah Sneed, 48, left the service in 2013 and found herself couch-surfing and then completely homeless. "Everything is provided in the military," she describes. "Beds, meals, everything. And then it's hardest to admit to yourself that you don't have a place to stay." Being homeless led to exacerbated symptoms of PTSD for Sneed: hyper-vigilance, reluctance to trust, irritability, and, ultimately, drug addiction.

Even though Sneed had been honorably discharged from military service, she had no idea the range and type of medical services offered by the VA. "It never occurred to me that I could get help for my addiction as a veteran," she says. "I called a crisis line, and they got me to a safe place and into a rehab program. Now I am four months clean."



Josh Smart, 32, was deployed to Iraq in 2003 for a full year. After a combat injury, Smart developed a dependency on narcotics, and since he was a medic with access to drugs, he could secretly keep his addiction going. Once he was back in the United States, he had no way to access the medication he needed, so he began forging prescriptions. Once he was caught, he took an OTH discharge in order to avoid court martial.

"I served a year in Iraq at the beginning of the war, and look at me now," he reflects. "I can't get the VA to help me, not with PTSD, or mental health. They won't even talk to me."

"I feel like I've been kicked to the side," he says. "In my eyes I served honorably. I know I messed up, but I expected to be taken care of for the service I did and it takes the life out of me to know that I'm no different than any other homeless person on the road."

After years of addiction, he became homeless in 2013 on the streets of Denver. Currently Smart lives at Fort Lyon, a transitional housing and addiction treatment center in Colorado. Connected to the Colorado Coalition for the Homeless, Fort Lyon favors veterans but makes



no rules about character of discharge. Smart is halfway through a two-year stay at Fort Lyon, where he receives job training and addiction counseling. He is working to appeal his OTH discharge, but he is not optimistic.

"The VA is all paperwork, and if you don't send it in the way they want to see it they're not even going to work it," he says. "How motivated should I be to wrestle with the VA and paperwork when I have problems like alcohol and homelessness? My mental health is screwed and I'm in no shape to get the VA to listen to me."



Jeffrey W. Sternberg, 50, is also living at Fort Lyon. He served 1980-83, first at Fort Benning in Georgia, and then in Germany. After three years, he went home on leave and never returned. "They had us sitting outside guarding barracks in a tank," he recalls. "We only had blanks in our guns, but they would shoot at us and I felt like a sitting target. We were over there in a bad time."

Sternberg turned himself in six months after abandoning his position. He received a

Dishonorable Discharge under General Conditions. "If I really wanted to push," he says, "I could probably get some veterans benefits. But I don't. In my mind I kind of think, well, I deserted so I don't deserve them."

After he became homeless, Sternberg found himself in dangerous situations on the street. At one point he fought with a drug dealer and was bludgeoned with a pipe and nearly killed. Not long after that, he learned about Fort Lyon.

"When you're on the street as a veteran, it's worse than other people," he says. "Regular homeless folks could go to the food bank or get coins for the bus, but if you're a vet you'd have to go someplace with VA and people didn't really want to help us, even not knowing about the discharge. There are so many vets on the streets. I have hundreds of friends who've seen war, and they're so screwed up and can't get the help they need."

Sternberg works in maintenance for Fort Lyon, gathering job experience, saving money, and staying sober in a two-year program like Josh Smart. "This place is a godsend," he says. "This place has given me opportunities. I can go to school, get job training, put some money in the bank. I just got a nice hat, nice shirt, nice boots. I'm looking ahead at the future now. I want to be clean and sober for my daughter to come see me when she's older. I've got the rest of her life."

Nearly 70% of all homeless veterans experience substance abuse issues, with many of those resorting to drugs in an effort to self-medicate and cope with the traumas of war. More than 250,000 have mental health issues from combat service, and veterans ages 18-30 are twice as likely as the general population to become homeless; this risk increases if veterans also experience poverty. While there are health risks and conditions that affect all veterans, Vietnam veterans and veterans of the recent conflicts in Iraq and Afghanistan (OIF/OEF/OND) also carry health risks specific to those contexts.

Fort Lyon Supportive Residential Community



The Fort Lyon Supportive Residential Community provides recovery-oriented transitional housing to people experiencing homelessness. The program combines housing with counseling along with educational, vocational, and employment services for up to 300 homeless and formerly homeless individuals from across Colorado with a preferential option for homeless veterans.

The program at Fort Lyon allows homeless persons to stay for up to two years in order to achieve sobriety and stable health. As a result, residents gain the necessary resources to maintain long-term recovery, employment, and overall self-sufficiency. The Colorado Coalition for the Homeless provides the transitional housing and recovery-oriented supportive services. The program gives priority to homeless veterans regardless of character of discharge. While not officially affiliated, Fort Lyon receives referrals from the VA and often patients are discharged directly to Fort Lyon.

"Patients have to be homeless with a substance-use disorder they want to address," explains **James Ginsberg, MNM, CAC III,** Director of Veteran and Native American Services for the Colorado Coalition for the Homeless and the Director of Fort Lyon. "They can have a co-occurring mental health disorder, and we collaborate with a mental health clinic. We are trauma informed, strength based, and person centered. It has to be safe, and if people want to get clean and sober, people have to know that they are safe."

Ginsberg notes that the demand for the program is high due to the lack of available services for those with Other Than Honorable (OTH) discharges. Fort Lyon also has a HRSA-funded HCH clinic on site, so every resident – 25% are veterans – has access to primary and integrated behavioral health care. In addition, staff members work with OTH veterans on appealing their character of discharge to gain access to VA services.

Source: Fort Lyon website, http://www.coloradocoalition.org/what_we_do/what_we_do_housing/fortlyon.aspx

Allow your patient to give you permission to ask these questions. Ask all military service members and all Veterans. Gain trust.

General Questions

- *Would it be ok if I talked with you about your military experience?*
- When and where do you/did you serve?
- What do you/did you do while in the service?
- How has military service affected you?

If your patient answers "Yes" to any of the following questions, ask:
"Can you tell me more about that?"

- Did you see combat, enemy fire, or casualties?
- Were you or a buddy wounded, injured, or hospitalized?
- Did you have a head injury with loss of consciousness, loss of memory, "seeing stars" or being temporarily disoriented?
- Did you ever become ill while you were in the service?
- Were you a prisoner of war?

Compensation & Benefits

- Do you have a service-connected condition?
- Would you like assistance in filing for compensation for injuries/illnesses related to your service?

Call VBA at 1-800-827-1000

Sexual Harassment, Assault, and Trauma

- *Would it be ok to talk about sexual harassment or trauma that you might have experienced while serving in the military?*
- Have you ever experienced physical, emotional, or sexual harassment or trauma?
- Is this past experience causing you problems now?
- Do you want a referral?

Living Situation

- *Would it be ok to talk about your living situation?*
- Where do you live? • Is your housing safe?
- Are you in any danger of losing your housing?
- Do you need assistance in caring for dependents?

Exposure Concerns

Would it be ok if I asked about some things you may have been exposed to during your service?

- **What...** were you exposed to?
 - **Chemical** (pollution, solvents, etc.)
 - **Biological** (infectious disease)
 - **Physical**

Blast or explosion	Noise	Vehicular crash
Bullet wound	Radiation	Vibration
Heat	Shell fragment	Other injury

What... precautions were taken? (Avoidance, PPE, Treatment)

How... long was the exposure?

How... concerned are you about the exposure?

Where... were you exposed?

When... were you exposed?

Who... else may have been affected? Unit name, etc.

Blood Borne Viruses (Hepatitis, HIV...)

- Have you ever had a blood transfusion?
- Have you ever injected drugs such as heroin or cocaine?

Stress Reactions/Adjustment Problems

- *Would it be ok to talk about stress?*
In your life, have you ever had an experience so horrible, frightening, or upsetting that, in the past month you...
- Have had nightmares about it or thought about it when you did not want to?
- Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detached from others, activities, or your surroundings?

Veterans Crisis Line 1-800-273-8255 (Press 1)

Caring for veterans' health requires a unique understanding of the complexities of such issues as PTSD and TBI. Health care systems will need to work together to provide this specialized care because as the number of veterans in need of care increases and becomes more complicated, the more it will require all of us to stand together."

Sharon Morrison, RN, MAT

 <p>Tell your patient about VA's Gateway to Veteran Health Benefits and Services</p>	<p>Personal Health Journal Online Rx refill</p>	<p>VA benefits & resources Manage your health</p>
<p>www.myhealth.va.gov</p>		

Military Health History Pocket Card for Clinicians

Screening Tools for Clinicians

There are multiple assessment tools available that can help HCH providers identify veterans, evaluate their health conditions (both veteran- and non-veteran-specific), provide them with a thoroughgoing regimen of care, and direct them to VA services where appropriate.

- » **Primary Care PTSD Screen.** Four-item screen designed for use in primary care and other medical settings. It is currently used to screen for PTSD in veterans at the VA. <http://www.integration.samhsa.gov/clinical-practice/pe-ptsd.pdf>
- » **HELPS Brain Injury Screening Tool.** Contains five questions that can help providers determine the possibility of a traumatic brain injury. <http://www.ncdhhs.gov/mhddsas/providers/TBI/helps-screeningtool.pdf>
- » **The Patient Health Questionnaire (PHQ-9).** This tool aids in screening, diagnosing, monitoring, and measuring the severity of depression. <http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>
- » **Military Health History Pocket Card for Clinicians** (above). This set of questions was designed by the VA to help providers gain information about a patient's medical problems and concerns while establishing rapport with military service members and veterans. Answers may also provide a basis for referrals to specialized services. Careful questioning and asking permission to inquire about military service allows the patient to feel safe and in control of the conversation. For example, asking, "Have you ever served in the United States military?" rather than, "Are you a veteran?" may yield a more accurate result. Asking, "Would it be okay to ask you about your military experience?" gives the patient the option to go forward or decline to talk about it. <http://www.va.gov/oa/pocketcard/military-health-history-card-for-print.pdf>

Vietnam Veterans

Veterans returning from Vietnam suffered a range of medical conditions, including impaired fertility, hearing loss, depression, anxiety, combat-related PTSD, exposure to Agent Orange, and substance abuse. As a result of the negative cultural climate with regard to the war in Vietnam, veterans also returned home to a hostile environment that held them responsible for what some perceived to be a baseless conflict and senseless loss of life.

In addition, PTSD was not formally recognized as a psychological disorder until the publication of the Diagnostic and Statistical Manual of Mental Disorders III in 1980. The modern understanding of PTSD stems from attempts to describe the disorder afflicting returning soldiers from Vietnam. First described as “shell-shock,” “combat fatigue,” “post-Vietnam syndrome,” or “post-combat disorder,” the experience of soldiers returning from Vietnam helped define PTSD even if that definition came too late to diagnose and help many of them. Thirty percent of today’s Vietnam veterans suffer from PTSD, a rate higher than returning veterans from any other theater.

Vietnam veterans may also struggle with the effects of exposure to Agent Orange, a highly toxic chemical agent used by the United States in Vietnam to thin heavily forested areas, often resulting in increased rates of cancer and nervous-system disorders for veterans exposed to the toxic herbicide. Veterans exposed to Agent Orange report a variety of serious health problems, including skin lesions, liver damage, changes in skin pigmentation and sensitivity to light, numbing or tingling extremities, sore joints, cancers, and birth defects in their children.

According to the VA, veterans (likely those with honorable or general discharges) who were exposed to Agent Orange may be eligible for VA benefits including disability compensation. The VA employs a “presumptive policy” with regard to Agent Orange exposure. Veterans are not required to prove exposure; certain diseases including Parkinson’s disease and Type II Diabetes are simply “presumed” to be the result of exposure to these herbicides. All Vietnam veterans and certain military personnel who served in Korea are presumed to have been exposed, but eligibility for medical treatment may still depend on the character of a soldier’s discharge.

Nearly half of all veterans counted as homeless served in the Vietnam era. This is an aging population with increasing health needs and conditions related to trauma and environmental exposure. Some Vietnam veterans may not even realize that they are eligible for VA services, especially services for addiction and recovery. Veterans with other than honorable discharges also may not realize that they are eligible for at least limited social services or housing support. For this reason, a thoroughgoing military-history questionnaire for new patients about past military service may open doors to services yet unrealized.

“Many Vietnam-era veterans are coming to the VA for the first time,” says **Jack Tsai, PhD**, Clinical Psychologist at the VA Connecticut and Professor of Psychiatry at Yale University. “It was a different climate back then, an unpopular war, people spitting on soldiers, and many returning vets didn’t want to identify as veterans. Since the VA is the institution for veterans, they kept a distance.”

Iraq and Afghanistan Veterans

Homeless veterans from the recent conflicts in Iraq (Operation Iraqi Freedom – OIF [2003-2010]; Operation New Dawn – OND [2010-present]) and Afghanistan (Operation Enduring Freedom – OEF) were twice as likely to be diagnosed with mental illness and/or Traumatic Brain Injury (TBI) at the time of discharge. During the OEF/OIF conflicts, 22% of soldiers wounded in combat suffered wounds to the face, head or neck, which gives a rough estimate of TBI incidence, with most of these veterans also likely to show symptoms of PTSD. Veterans returning from Iraq and Afghanistan are younger than the overall veteran population.

Character of Discharge

When a soldier leaves military service, he or she is assigned a “character of discharge.” These are the most common types of discharge from the United States military:

- » **Administrative Discharges**
 - » **Honorable.** A soldier’s service must be rated from good to excellent, exceeding standards for performance and personal conduct.
 - » **General.** The service is satisfactory but does not meet all expectations of conduct for military members.
 - » **Other Than Honorable Conditions.** The soldier’s service is unsatisfactory and he or she may not enlist again in the United States military. Examples include discharges as a result of a crime, security breach, or other infraction that does not warrant a court martial, or the discharge is offered in exchange for the court martial.
- » **Punitive Discharges**
 - » **Bad Conduct.** Sometimes preceded by a military prison sentence, a bad conduct discharge is delivered as punishment by a court martial.
 - » **Dishonorable.** This discharge can only be given by a general court martial for what the military considers to be the most reprehensible conduct. In some states, a dishonorable discharge is the equivalent of a felony conviction.

In order to receive VA benefits and services, a veteran’s character of discharge must be under other than dishonorable conditions (e.g., honorable, general). With the exception of the dishonorable discharge, soldiers who have a prior honorable discharge from the military before OTH discharges may still be eligible for VA services based on the earlier service.

In addition, many soldiers with OTH discharges are not aware that **they may request another Character of Service Determination (CSD) directly from the VA.** Requesting a CSD is an alternative to the lengthy and complicated process of formally appealing the character of discharge and requesting an upgrade. Instead, veterans with OTH discharges may apply for the VA to make a new CSD. In many cases, the VA will review the service history and opt to give the veteran a better character of service for the purpose of accessing health and other benefits.

In order to request a CSD from the VA, veterans must first apply for disability compensation or pension. The VA will respond with a letter that flags the soldier’s character of discharge and includes instructions on how to request a favorable CSD.

Forty-four percent of these veterans return from deployment with complex health conditions and find that readjusting to life at home, reestablishing relationships with family, finding employment, or going back to school is a continual struggle.

Returning veterans from Iraq and Afghanistan were likely to have more than one deployment, and thus suffer multiple layers of trauma. Forty-seven percent of current active duty soldiers have been deployed more than two times, and 16% have completed three or more deployments. Homeless OIF/OEF/OND veterans are likely to suffer from TBI, amputated limbs, burns, internal injuries, PTSD, and also to find themselves in a downward spiral involving substance abuse (often in an attempt to address PTSD or TBI symptoms), depression, and ultimately, suicide. Further complicating the traumatic experience is the likelihood that Iraq and Afghanistan veterans suffer from “polytrauma,” or multiple severe injuries from the same incident.

“Caring for veterans’ health requires a unique understanding of the complexities of such issues as PTSD and TBI,” says **Sharon Morrison, RN, MAT**, of the Boston Health Care for the Homeless Program’s clinic at the New England Center for Homeless Veterans. “Clinicians need to keep vigilant about how these issues impact veterans’ day-to-day ability to care for themselves. Health care systems will need to work together to provide this specialized care because as the number of veterans in need of care increases and becomes more complicated, the more it will require all of us to stand together.”

By a rough estimate, around 22% of OIF/OEF/OND veterans

Resources for Engaging Veterans

- » **Funding for Veteran-Specific Services.** This guide outlines funding opportunities available from federal agencies to assist HCH clinics in their efforts to serve veterans. <http://www.nhchc.org/wp-content/uploads/2014/04/nhchc-vet-services-funding-quick-guide.pdf>
- » **HCH-VA Collaboration Quick Guide.** Joining Forces to Coordinate Care for Unstably Housed Veterans. This guide assists HCH grantees with their efforts to establish and strengthen collaborations with local Veterans Affairs Medical Centers (VAMCs). <http://www.nhchc.org/wp-content/uploads/2011/10/HCH-VA-Collaboration-Quick-Guide.pdf>

suffer from TBI. This is due in part to the extensive use of improvised explosive devices (IEDs) by insurgents in Iraq and Afghanistan. These injuries are defined as “a traumatically induced structural injury and/or physiological disruption of brain function as a result of external force.” Classified as severe, moderate, or mild, TBI symptoms include ringing in the ears (tinnitus), difficulty sleeping, amnesia, chronic pain, and other indications similar to PTSD – such as irritability, insomnia, mood and anxiety disorders, headaches, and memory loss – at least partly because so many TBI patients also suffer from PTSD.

Trauma is a critical issue for all homeless veterans, but for OIF/OEF/OND veterans returning after repeated deployments, the compounded effects of PTSD have a profound effect on their ability to reintegrate into society. For veterans with OTH discharges, PTSD has likely been a direct or indirect cause of the offending behavior. This was the case with Josh Smart, who became addicted to drugs as a way to cope with military trauma and ultimately led him to forge prescriptions and be discharged under Other Than Honorable conditions.

Female Veterans

As the number of women in the military has increased in recent years, so has the number of women veterans. Homelessness among female veterans is also increasing. Eight percent of all homeless veterans are female. From 2006 to 2010, the number of female veterans identified as homeless by the VA increased by 141% (1,380 to 3,328). In addition, female veterans are three-to-four times more likely to be homeless than non-veteran women, and much less likely to access VA health services than their male counterparts.

“Homeless female veterans have different needs compared to homeless male veterans,” explains **Terri LaCoursiere Zuccherro, PhD, RN, FNP-BC**, Assistant Professor of Nursing, University of Massachusetts Worcester. “In addition to gender-related care needs including reproductive health, homeless female vets may require treatment for physical and sexual trauma, as well as care for dependent children.”

Female veterans are far more likely than male vets to be raising a child alone, making securing housing and employment even more complicated. Homeless female veterans with other-than-dishonorable discharges may still be eligible to receive housing through programs such as HUD-Veterans Affairs Supportive Housing (HUD-VASH), which combines rental assistance with case management and clinical services provided by the VA. The VA’s Homeless Providers Grant and Per Diem Program is offered annually by the VA’s Health Care for

Veteran Resources



- » VA National Call Center for Homeless Veterans: (877) 424-3838
- » National Coalition for Homeless Veterans: (800) 838-4357
- » Veteran Combat Call Center (to talk to a combat veteran): (877) 927-8387
- » Military Sexual Trauma (Department of Defense Safe Helpline): (877) 995-5247
- » Health Care for Homeless Veterans (HCHV) Program: (877) 4AID-VET (424-3838)



Homeless Veterans (HCHV) Program and funds community agencies to provide services to homeless veterans. These programs promote the development of supportive housing and supportive services with the goal of helping homeless veterans achieve stable housing, increase their skill levels and income, and become more autonomous.

However, there are barriers to accessing these services such as limited housing for women with dependent children and concerns for personal safety, especially for female veterans who are victims of Military Sexual Trauma (MST). The VA defines Military Sexual Trauma as “sexual harassment that is threatening in character or physical assault of a sexual nature that occurred while the victim was in the military, regardless of geographic location of the trauma, gender of the victim, or the relationship to the perpetrator.” Recent data show that 23% of servicewomen have experienced MST, and 55% report being victims of sexual harassment. Research also shows that female veterans who suffered MST are at greater risk of becoming homeless. For this reason, it is important for health care providers to employ trauma-informed care when working with veterans in general, but especially female veterans.

In the general population, about 8% of men and 20% of women who are exposed to a traumatic event will develop PTSD. Female veterans are at greater risk for PTSD because of the likelihood that they experienced not only combat trauma while deployed, but also MST. There are a number of reasons that female veterans have a hard time readjusting to life as civilians, but the experience of MST should be of special concern to health care providers.

However, health care providers may have a difficult time identifying these veterans because of a general reluctance of female veterans to self-identify. Some may think that “veteran” is a term that refers only to men, or that their military service doesn’t count because they were not deployed. Others do not want to identify as veterans because the military was the site of their traumatic experiences, from either combat, MST, or both. Some female veterans do not want to be referred back to the VA, where services are perceived to be male-centric and similar to the military service environment that caused the original trauma. Careful questioning and the use of military service screening tools can help providers uncover military experience and offer more thorough treatment, including trauma-informed care.

Trauma-Informed Care

Many homeless female veterans have suffered traumatic events earlier in life, and then experienced combat trauma and MST while in the service. The loss of place, stability, and safety that comes with homelessness only compounds the traumatic experience. While female veterans are especially vulnerable, the experience of trauma is likely

Trauma-informed care changes the question, “What’s wrong with you?” to, “What happened to you?”

Julia Dobbins, MSSW

true for all homeless veterans. “Veterans experiencing homelessness have often experienced trauma, such as combat exposure, wartime trauma, post-traumatic stress disorder, and military sexual trauma,” says **Laura Zeilinger**, Executive Director of the U.S. Interagency Council on Homelessness. “It is critical to care for our veterans in a trauma-informed way, supporting them to break through the trauma cycle and achieve safety and stability in a home of their own.”

Trauma-informed care is “a health care system whose primary mission

Essentials of Trauma-Informed Care

- » A trauma is an incident or event that is, or is perceived to be, threatening to one’s own life or bodily integrity. It is a subjective experience of terror and helplessness.
- » A trauma overwhelms normal coping mechanisms and affects two parts of the brain: the limbic system (the center of survival functions), and the amygdala (signals alarm in the brain when danger is perceived). In the aftermath of trauma, the broken down system tries to bring itself back to stability. As a result, stories and narratives may be jumbled, the ability to orient to safety and danger may be compromised, and the body may have trouble regulating emotions.
- » Survivors of trauma can be triggered into re-traumatization by things in their environment that make them feel as though they are re-experiencing the original trauma. For some veterans, especially victims of MST, simply trying to access care through a military system can be overwhelming.
- » Trauma-informed care is a framework that involves an understanding of the effects of trauma on the body and the brain. This understanding is applied to the ways in which the agency recognizes and responds to the needs of its clients. The cornerstone of trauma-informed care is prioritizing the physical, emotional, and psychological safety of their clients in an effort to rebuild a sense of safety, control, and empowerment while avoiding re-traumatization.
- » Trauma-informed care changes the question, “What’s wrong with you?” to, “What happened to you?”
- » Trauma-informed care asserts that a provider who understands how trauma has impacted a client’s life is better able to provide effective and long lasting care.
- » The core principles of a trauma-informed culture include safety, trustworthiness, choice, collaboration, and empowerment

*Source: Julia Dobbins, MSSW, Project Coordinator,
National Health Care for the Homeless Council*

is altered by virtue of knowledge about trauma and the impact it has on the lives of consumers receiving services.” Such care involves an emphasis on safety in the health center or shelter environment, a welcoming and supportive attitude of staff and providers, careful and sensitive questioning about military experience, cultural competence, privacy and confidentiality, open communication, and consistency and predictability. For example, a veteran who approaches a health care setting that is perceived to be chaotic, abrasive, dangerous, insensitive, or unpredictable may find herself reacting defensively or even unwilling to receive care in that environment because it reenacts the traumatic experience. The practice of trauma-informed care ensures that the health care setting itself does not serve as yet another site of uncertainty, injury, and trauma for veterans in need of care.

HEALTH & HOMELESSNESS AMONG WOMEN VETERANS

RESEARCH UPDATE

AUGUST 2012

This Research Update provides a focused literature review on health and homelessness among women veterans in the United States. This topic is gaining increasing attention in research, public policy, and the media due to rising levels of deployment and an elevated risk of homelessness among women veterans.

Increased Deployment and Risk of Homelessness

The deployment of women rose from 41,000 in the Gulf War to 200,000 in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), with women totaling 12% of OEF/OIF veterans; combat-related roles have also increased for women service members, a shift from their historically back line duties.^[1, 2]

Between October 1, 2008, and September 30, 2009, women veterans accounted for 10,214 of the 136,334 sheltered veterans.^[3] Following military service, women veterans are at three to four times greater risk of homelessness than non-veterans; this risk is increasing for those who served in Iraq and/or Afghanistan.^[4, 5, 6] According to Fargo et al., women veterans who were African American or between the ages of 18 to 24 years were at an even higher risk of homelessness.^[7] According to Washington et al., other characteristics found to be associated with homelessness were sexual assault during military service, being unemployed, being disabled, having worse overall health, and screening positive for an anxiety disorder or Post-Traumatic Stress Disorder (PTSD); meanwhile, protective factors were being a college graduate or married.^[6]

Distinct Experiences Influencing Health and Homelessness

Women veterans often encounter distinct experiences, which influence their health status. Stress resulting from motherhood and deployment can affect women veterans uniquely. A report by Iraq and Afghanistan Veterans for America stated that 40% of women veterans have children and 30,000 of them are single mothers.^[5] Vogt et al. found that women report higher levels of stress over their deployment's effect on their family than their male counterparts.^[8]

Hamilton et al. studied women veterans' pathways into homelessness through focus groups and identified prevalent precipitating experiences and contextual factors—collectively forming a “web of vulnerability” that could lead to homelessness.^[9] The five precipitating experiences that initiated homelessness included: 1) childhood adversity; 2) trauma and/or substance abuse during military service; 3) post-military abuse, adversity, and/or relationship termination; 4) post-military mental health, substance abuse, and/or medical problems; and 5) unemployment. The common contextual factors included the “survivor instinct” among women veterans, a lack of social support and resources, sense of isolation, sense of independence, and barriers to care.

Zinzow et al.'s study revealed that experiences of trauma affect 81-93% of women veterans, with more than half experiencing trauma or abuse prior to military service.^[10] Military Sexual Trauma (MST) — defined by the VA as “sexual harassment that is threatening in character or physical assault of a sexual nature that occurred while the victim was in the military, regardless of geographic location of the trauma, gender of victim, or the relationship to the perpetrator”—affects between 20-48% of women veterans in the form of sexual assault and 80% in the form of sexual harassment.^[11] According to listening sessions conducted by the U.S. Department of Labor (DOL) Women's Bureau (WB), women veterans experienced a breadth of traumatic experiences, including childhood abuse, intimate partner violence, combat-related stress, MST, and the loss of social supports and stable housing; additionally, a common theme was the stress of being a woman in a male-oriented military culture.^[5]



81-93%
**of women veterans
experienced trauma**

NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
P. O. Box 60427 | Nashville, TN 37206 | www.nhchc.org | 615.226.2292
Health Care and Housing Are Human Rights

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

HEALTH & HOMELESSNESS AMONG WOMEN VETERANS

RESEARCH UPDATE

AUGUST 2012

Traumatic experiences before, during, and after military service can have major implications on health status and daily functioning, including increased substance abuse, mental health issues, trouble accessing and maintaining employment, and hesitance to utilize support services.^[5] Regardless of its source, trauma exposure can be a risk factor for homelessness and PTSD.^[12, 13]

Varied Accounts of Health Care Utilization and Perceptions

Literature regarding women veterans' health care utilization is largely concentrated in the Veterans Health Administration (VHA) setting and varies in frequency of utilization patterns. Blackstock et al. evaluated the sex-specific risk of using a VHA homeless program among the 443,419 OEF/OIF veterans with at least one VHA clinical visit between 2001 and 2009.^[2] Of the 7,431 veterans who utilized a VHA homeless program, 12.9% (961) were women. Women were as likely as men to utilize a VHA homeless program and their median time to first use was similar. Women veterans in the following sub-groups were at an increased risk for VHA homeless program use in comparison to men: ages 26-35 years, 100% service-connected disability rating, PTSD, and northeast location.

19%
had delayed health care or unmet need

Although not specific to homeless populations, Washington, Bean-Mayberry, Riopelle, and Yano found that women veterans underutilize the VHA system in comparison to their male counterparts.^[14] Of the 3,611 women veterans surveyed, 19% had delayed health care or unmet need. Several barriers – general and veteran-specific – predicted delaying or foregoing care, including unaffordable health care, inability to take off from work, transportation barriers, being uninsured, knowledge gaps about VA care, perception that VA providers were not gender-sensitive, and military sexual assault history.

Similar findings regarding gender-sensitive VA perceptions were identified by the Women's Bureau's Listening Sessions.^[5] Participants perceived a shortfall in health services tailored to their specific needs and were less likely to seek care in what they perceived to be male-oriented programs. Hesitance to identify as a veteran, sometimes triggered by avoidance of traumatic military experiences or a perceived lack of acknowledgement from society, also prevented some participants from utilizing veteran-specific services. Participants expressed a desire for more programs offering culturally competent, trauma-informed service provision and targeted outreach and communication regarding the VA system to ease their transition into civilian life. The Women's Bureau also drew upon the perspectives of community-based services providers, who noted a lack of communication with the VA regarding veteran-specific services and uncertainty over how to best support women veterans experiencing homelessness.

Discussion

Literature on the health status and health services utilization of women veterans experiencing homelessness remains limited. However, the increasing role of women in the military has been documented. Women veterans are at three to four times greater risk of homelessness than non-veterans, are being deployed at faster rates than ever before, and are serving in more combat-related roles. Experiences of trauma, stemming from childhood to after military service, affect 81-93% of women veterans and can negatively impact health status, daily functioning, and willingness to access services. Numerous barriers prevent unstably housed women veterans from accessing veteran-specific services, leading to a pattern of under-utilization. These include the hesitance to identify as a veteran, lack of affordable health care, gaps in knowledge of available services, experiences of trauma, and

NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
P. O. Box 60427 | Nashville, TN 37206 | www.nhchc.org | 615.226.2292
Health Care and Housing Are Human Rights



HEALTH & HOMELESSNESS AMONG WOMEN VETERANS

RESEARCH UPDATE

AUGUST 2012

perceptions of male-oriented programs. These barriers must be rectified so that women veterans can utilize and benefit from the care and resources earned through their military service.

REFERENCES

- ¹ Women in Military Service for America Memorial Foundation, Inc. (2009). *Statistics on women in the military*. Retrieved from www.womensmemorial.org/PDFs/StatsonWIM.pdf
- ² Blackstock, O.J., Haskell, S.G., Brandt, C.A., & Desai, R.A. (2012). Gender and the use of Veterans Health Administration homeless services programs among Iraq/Afghanistan veterans. *Medical Care*, 50(4), 347-352.
- ³ U.S. Department of Housing and Urban Development, U.S. Department of Veterans Affairs, and National Center on Homelessness among Veterans. (2010). *Veteran homelessness: A supplemental report to the 2010 annual homeless assessment report to Congress*. Retrieved from <http://www.hudhre.info/documents/2010AHARVeteransReport.pdf>
- ⁴ Foster, L. (2010). *California's Women Veterans: Challenges and Needs*. CRB Briefly Stated. Retrieved from California Research Bureau, California State Library: www.library.ca.gov/crb/10/WomenVeteransBrieflyStated.pdf
- ⁵ U.S. Department of Labor, Women's Bureau. (2011). *Trauma-informed care for women veterans experiencing homelessness: A guide for service providers*. Retrieved from <http://www.dol.gov/wb/trauma/traumaguide.htm>
- ⁶ Washington, D.L., Yano, E.M., McGuire, J., Hines, V., Lee, M., & Gelberg, L. (2010). Risk factors for homelessness among women veterans. *Journal of Health Care for the Poor and Underserved*, 21(1), 82-91.
- ⁷ Fargo, J., Metraux, S., Byrne, T., Munley, E., Montgomery, A.E., Jones, H., Sheldon, G., Kane, V., & Culhane, D. Centers for Disease Control and Prevention. (2012). Prevalence and risk of homelessness among US veterans. *Preventing Chronic Disease*, 9, 1-9. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3337850/pdf/PCD-9-E45.pdf>
- ⁸ Vogt, D.S., Pless, A.P., King, L.A., & King, D.W. (2005). Deployment stressors, gender, and mental health outcomes among Gulf War I Veterans. *Journal of Traumatic Stress*, 18(2), 272-284.
- ⁹ Hamilton, A.B., Poza, I., & Washington, D.L. (2011). "Homelessness and trauma go hand-in-hand": Pathways to homelessness among women veterans. *Women's Health Issues*, 21(4), 203-209.
- ¹⁰ Zinzow, H., Grubaugh, A., Monnier, J., Suffoletta-Malerie, S., & Freuh, B. (2007). Trauma among female veterans: A critical review. *Trauma, Violence, & Abuse*, 8, 384-400.
- ¹¹ Foster, L., & Vince, S. (2009). *California's women veterans: The challenges and needs of those who served*. Retrieved from www.library.ca.gov/crb/09/09-009.pdf
- ¹² Perl, L. (2009). *Veterans and Homelessness*. Washington, DC: Congressional Research Service.
- ¹³ Gamache, G., Rosenheck, R.A., & Tessler, R. (2000). Factors predicting choice of provider among homeless veterans with mental illness. *Psychiatric Services*, 51(8), 1024-1028.
- ¹⁴ Washington, D.L., Bean-Mayberry, B., Riopelle, D., & Yano, E.M. (2011). Access to care for women veterans: Delayed healthcare and unmet need. *Journal of General Internal Medicine*, 26(2), S655-S661.

NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
P. O. Box 60427 | Nashville, TN 37206 | www.nhchc.org | 615.226.2292
Health Care and Housing Are Human Rights

