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A Systematic Review of Rural Veteran Homelessness

Jonathan Fasse
jxf16b@acu.edu

ABSTRACT

This study is a systematic review to examine homeless veterans identified to be most at risk of unsuccessfully completing the VA's housing program (HUD-VASH), which promotes the use of Housing First (HF) as it's model for treating homelessness. The literature review identified those who were rural and experiencing comorbid substance use disorders (SUD) and mental health issues to likely be those who were most at risk. There were multiple reasons why this subgroup was most vulnerable including limited access to resources, higher levels of substance use and more serious mental health diagnoses, and chronic health needs. Both the literature review and systematic review in this study indicate a lack of evidence supporting Housing First especially its long-term effectiveness in the HUD-VASH program. The lack of evidence is due in part to the question of whether or not the programs examined in the literature are true HF models, which utilize all the core principles of HF. Further, the literature regarding HF predominantly measures the length of time to acquire permanent housing with little to no regard to harm reduction or rehabilitation of SUD and mental health needs. Further research is also needed to examine HUD-VASH effectiveness in treating rural veterans with comorbid SUD and mental health illnesses.

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Thesis Committee,

Dr. Wayne Paris, Chair

Dr. Tom Winter

This work is dedicated to my amazing wife Alicia. Thank you for all the sacrifices you've made to get us here. We did this together. I love you!

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CHAPTER I

INTRODUCTION

This program evaluation seeks to accomplish three main goals: 1) Identify those who are most likely to not positively graduate from the HUD-VASH program, 2) attempt to explain why this has happened within the program, and 3) identify strategies which may improve how HUD-VASH aids those who have the most difficulty in graduating from the program. In order to accomplish these goals, first a contextual basis for concepts such as homelessness, Housing First, and the prevalence and treatment interventions for mental health and substance abuse had to be established. For this reason, a literature review has been included in this report to provide context for the conclusions and recommendations.

CHAPTER II

LITERATURE REVIEW

Homelessness

Homelessness has become increasingly prioritized both politically and socially over the last decade. With effective and increasing governmental policy implementation and research, homelessness has slowly but steadily declined. According to the National Alliance to End Homelessness, on any given night in 2013 there were 600,000 homeless in the U.S. (as cited in (Polcin, 2016). The Housing and Urban Development's point-in-time survey, which seeks to identify the number of homeless on one single night, identified 567,708 homeless in 2015 (National Alliance to End Homelessness, 2016). The latest 2016 Annual Homeless Assessment Report (AHAR), conducted by Housing and Urban Development HUD, reported that there were at least 548,928 people experiencing homelessness on a single night (The U.S. Department of Housing and Urban Development, 2016). Although overall homelessness has dropped by 10% over the last three years, we still have a long way to go. There were fewer than 40,000 veterans and overall veteran homelessness has dropped by 47 percent since 2010 (The U.S. Department of Housing and Urban Development, 2016). However, veterans are still disproportionately represented in the homeless population. They now account for 9.5% of the overall population but 12% of the homeless population (Peterson et al., 2015).

Texas has the third largest veteran homeless population. However, Texas experienced a 26.1% decrease of veteran homelessness from 2015 to 2016 and a 55.4%

decrease in chronically homeless since 2007 (The U.S. Department of Housing and Urban Development, 2016). Winter, Slaymaker, Fasse, McCabe, and Paris, 2017, conducted a homelessness needs assessment of Abilene Texas—the geographical focal point of the data collected for this study—and they found that there were between 329 and 350 homeless in the city of Abilene in 2016 when including the often underrepresented unaccompanied youth, which accounted for 217 of that total (Winter, Slaymaker, Fasse, McCabe, & Paris, 2017).

Because "homeless" can have very different meanings for people and organizations, it is important to clarify what this study means when it refers to individuals whom are "homeless." According to the McKinney-Vento Act, homelessness "means individuals who lack a fixed, regular, and adequate nighttime residence" (U. S. Department of Education, 2005). This definition is used by Housing and Urban Development (HUD), Department of Veterans Affairs (VA), Department of Homeland Security (DHS), and the Department of Labor (DOL). This definition is fairly broad and can account for those who are at risk if they do not have a "fixed" or "regular" nighttime residence. Furthermore, in accordance with the HEARTH Act of 2009, an amendment to the McKinney-Vento Act, anyone at immanent risk of homelessness (14 days) and lacking the resources to acquire permanent housing, also meets the definition (as cited in Peterson, et al., 2015). Therefore, even if the individual is sleeping under a roof, if their situation is not stable, they are classified as homeless. For example, the VA's HUD-VASH program also sets out to house and provide case management for those at-risk veterans who have unstable living conditions.

Homeless Risk Factors

Studies have found many different issues have an association to homelessness. For instance, some studies have found that sensation seeking, risky sexual behaviors, aggression/domestic violence, and medical or mental illness, to be predominate correlations, while substance use is recognized in almost all studies as a strong correlation to homelessness (Bassuk, Olivet, & Olivet, 2012; Harris, Kintzle, Wenzel, & Castro, 2017; O'Connell, Kasprow, & Rosenheck, 2013; Schinka, Schinka, Casey, Kasprow, & Bossarte, 2012; Tsai & Rosenheck, 2013). The strongest three of those correlations are medical and mental illness, domestic violence, and substance abuse (Bassuk et al., 2012; O'Connell et al., 2013; Schinka et al., 2012; Tsai & Rosenheck, 2013).

A report by HUD in 2009 concluded that 40% of homeless have some disability (Bassuk et al., 2012). If someone is incapable of working due to a disability, it can be a slippery slope into homelessness. For veterans, risk factors include sensation seeking, substance use, risky sexual behaviors, and aggression (Harris et al., 2017). Burke, Johnson, Bourgault, Borgia, & O'Toole, 2013 and Washington et al., 2010, indicate socioeconomic factors such as health, lack of employment, and disability have strong associations to homelessness among veterans (as cited in Creech et al., 2015).

In a meta-analysis study of Western countries, the prevalence of alcohol dependence in the homeless population was found to be 37.9% and drug dependence 24.4% (Fazel, Khosla, Doll, & Geddes, 2008). Of the 112 identified homeless adults in Abilene, Texas in 2016, 22% reported mental illness or substance use were the cause of their homelessness (Winter et al., 2017).

Like veterans, minorities are also disproportionately affected by homelessness. African-Americans make up 13% of the general population but 39% of the homeless population (Lynsen, 2014). In 2016 the veteran population consisted of 58% white, 33% black, 5% multiracial, and the last 5% were Native American, Pacific Islander, or Asian (The U.S. Department of Housing and Urban Development, 2016). One in ten were Hispanic. Veterans are less likely to take advantage of VA homeless care if they are white or live in rural areas (Tsai, Link, Rosenheck, & Pietrzak, 2016). However, in Abilene, Texas, minority homeless only make up 17% of the total for adult homeless (Winter et al., 2017).

The Department of Urban Development's latest 2016 point-in-time survey found that 89% of homeless were above age 24. In the Abilene homeless assessment, the authors found that the average age for those surveyed was age 40. However, the mean age for when they first became homeless was 33. The youngest age reported for first episode of homelessness was age 12 and the oldest was age 61 (Winter et al., 2017).

The most influential factor for becoming homeless reported in the Abilene assessment was financial reasons (Winter et al., 2017). This includes issues such as loss of work, lack of affordable housing, and lack of available jobs. All of these issues can quickly turn into a serious struggle for people, resulting in the loss of safe and stable living conditions. Furthermore, which is more often the case than not, individuals and families that fall into homelessness also have comorbid mental health and/or physical health conditions which only serve to exacerbate financial crises.

The second highest reported cause was domestic abuse. Domestic abuse is a significant factor in veteran homeless with 64% reporting a need for domestic abuse

intervention (Schaffer, 2012). The majority of women with children seeking help with homelessness have experienced domestic violence driving them from their home (Spinney, 2013). This reaffirms the McKinney-Vento definition of homelessness when it refers to stability. If it is not safe for someone to go home, even though they technically have a home to go to, they can qualify for serves from a multitude of agencies as someone who is homeless. The West Texas Homeless Network 2016 Point-In-Time survey found that 48.5% of those surveyed reported experiencing child abuse or neglect (West Texas Homeless Network, 2016). The Abilene homeless assessment found that domestic abuse was most prevalent in those between age 25 and 50 (Winter et al., 2017).

In rural environments, such as West Texas, these risks are exacerbated by limited access to resources, poverty, and isolation. Furthermore, rural homeless veterans have been shown to have higher rates of substance use (57%), unemployment (53%), and mental illness (45%) (Adler, Pritchett, Kauth, & Mott, 2015). Moreover, there is a shortage of providers for the various mental and behavioral health needs of veterans that are often only found in VA hospitals or clinics that can sometimes be hours from their home (Rishel & Hartnett, 2015). The VA has attempted to combat these issues with the development of programs such as Telehealth that allows doctors and mental health counselors to perform treatments through a video chat system. This allows the veteran to receive services from their home without having to travel to the VA clinic or hospital. However, there is still a very real and increased need and gap for services for those living in rural locations.

Substance Abuse and Mental Health

Substance Abuse

Active duty military and combat veterans have a higher risk of substance use than same age civilians (Larson, Wooten, Adams, & Merrick, 2012). The application of a "zero tolerance" policy in the military in 1981—including mandatory random urinalysis and the administrative discharge of military personnel who "pop" positive for illegal drugs—has reduced overall illegal drug use in the military. Active duty personnel turned to more acceptable forms of drugs instead; including an increase in heavy alcohol use and prescription medication (Gale, 2016).

It is interesting to note that although veterans are often stereotyped alcoholics, a study by Golub et al., 2013 found that veterans did not have a higher prevalence of alcohol use disorder than nonveterans (Golub et al., 2013). Those veterans at the highest risk for abusing alcohol are those who are younger, white, those who have experienced more and longer deployments, those who have experienced combat, Marines, and those who smoke (Gale, 2016).

Conversely, other studies indicate disproportionate drinking by military with numbers as high as 62% for binge drinking and 43% heavy drinking, which is very high compared to the general population of 36% for binge drinking and 16% heavy drinking (Vazan, Golub, & Bennett, 2013). Moreover, veterans are at a higher risk of alcohol use following combat and when veterans transition to civilian life (Larson, Wooten, Adams, & Merrick, 2012). For this reason, and the increased risk of mental illness, veterans are often screened for whether they have experienced combat.

In a study conducted in 1996 by Hurlburt, Hough, and Wood, nonveterans who were provided permanent housing and were documented over a two-year period were found to have a 5% greater risk of homelessness if they reported using (total of 26% likelihood of homelessness within the two-year period) at the time of program entry than those not suffering from addiction (21% risk of homelessness). Moreover, those with comorbid drug and alcohol use had a vastly increased risk (63% likelihood) of becoming homeless within that same two-period (as cited in Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). Moreover, regarding veterans, a history of substance use has been shown to have a significant association of greater risk for chronic homelessness (Creech et al., 2015). These statistics indicates substance use is a significant factor and focus for this study in identifying the most at risk population of homeless within the HUD-VASH program.

With regard to age, generally within the veteran population substance use disorders decrease with age while dementias increase with age (Kerfoot, Petrakis, & Rosenheck, 2011). In fact, in veteran men under age 30 such as those referred to as Operation Enduring Freedom OEF and Operation Iraqi Freedom OIF, the rates of alcohol misuse was double that of older non-OEF/OIF veterans (Hawkins, Lapham, Kivlahan, & Bradley, 2010).

Mental Health

Veterans also have a higher risk of mental illness than nonveterans. Veterans have a 2% higher prevalence of serious psychological distress and 3% higher likelihood of experiencing a major depressive episode than the general public (Golub A et al., 2013). As with substance use, experiencing combat can greatly increase the risk for

mental illness. In 2010 the rate of PTSD and depression in Army and National Guard personnel who served in positions likely experiencing combat was reportedly between 26% and 33.2% (Gale & Therivel, 2016).

Active duty military may encounter barriers to treatment due to the nature of their insurance. TRICARE, the standard military health insurance, does not cover office-based outpatient services, intensive inpatient treatment, and some evidence-based pharmacological therapies (Gale, 2016).

In a study by R. B. Trivedi et al., 2015, of the 4.4 million veterans seen by VA PACT, 1.15 million were diagnosed with some form of mental illness. The most prevalent was depression (13.5%), followed by PTSD (9.3%), anxiety disorder (4.8%), and serious mental illness SMI (3.7%). What's more, of those diagnosed with depression, 33.2% had comorbid PTSD, 19.4% had an anxiety disorder, and 23.3% had a substance use disorder. Moreover, a fifth of those diagnosed with any mental illness had comorbid SUD (Trivedi et al., 2015). These statistics indicate the high risk of comorbidity in regards to SUD and other mental health diagnoses and these are also correlated to homelessness as indicated above. However, unlike substance use, mental health has been shown to have a significant association with a decrease in falling into chronic and repeated homelessness (Creech et al., 2015).

Sorrell and Durham (2011) asserted the country is not prepared for the special needs of older veterans (as cited in (Rishel & Hartnett, 2015). Moreover, studies consistently indicate older adults have low rates of treatment utilization; some indicate as much as three times less than younger mental health patients (Karlin, Duffy, & Gleaves, 2008; Karlin & Zeiss, 2010).

Housing First

Background

Housing First was developed in the 1990s and it was initially referred to as "Choices," a program that focused on the positive clinical outcomes when patients have some form of agency and self-determination when being treated. The Tsemberis et al., 2003 and Shern et al., 2000 studies are often hailed the pioneers of the model. In these studies, patients were treated on the streets of New York City applying components of the experimental Choice program. The authors hypothesized that by using integrated health and individualized approaches—which made available and streamlined the use of a multitude of health and social services—the participants would have greater access to resources needed for community living, greater improvements in housing status, higher reported quality of life, and greater reduction in psychiatric symptoms (Shern et al., 2000). These studies found that ironically, even though previous models emphasized self-reliance, this Choices program, by applying aspects of a self-determination and client-centered goal-oriented approach, developed in patients their own sense of self-reliance and motivation with the assistance of program staff. The experiment indicated higher rates of quality of life, service utilization, and reduced depression and anxiety in the experiment group as compared to the treatment as usual control group (Shern et al., 2000). These findings have motivated the development of what we now refer to today as Housing First.

This experiment was motivated by the fact that approaching individuals on the streets struggling with homelessness and likely comorbid psychological and substance use disorders as well as a history of domestic abuse is difficult for physicians and social

services let alone effectively treating a population that often had a history of refusing treatment (Asmussen, Romano, Beatty, Gasarch, & Shaughnessy, 1994; Osher & Drake, 1996; Rowe, Hoge, & Fisk, 1998). They also noted that previous studies (Drake, Osher, & Wallach, 1991; Koegel et al., 1996; and Toro, 1998) indicated a disproportionate prevalence of mental illness in the homeless ranging from 20 to 37% and those with substance use disorders at least 50% (as cited in Tsemberis et al., 2003). The homeless with these issues were often the hardest to treat and often fell through the gaps developing systemic and chronic homelessness. The authors recognized that a new approach to treating chronic homeless with serious mental illness and substance use disorders was needed. In fact, housing homeless with serious mental illness and substance use disorders is precisely what they set out to do. All of this, along with a serious lack of affordable housing in New York, motivated the researchers to attempt an experimental study.

Previous continuum model programs often frustrated patients by setting contingencies for treatment based on requirements such as abstinence from alcohol and drugs and the stabilization of prescription medication before the program would provide services. In other words, patients must be treated for their substance use and mental health disorders before being treated for homelessness. As these treatments saw progress in the individual's self-reliance and responsibility, the individual moved up a continuum scale to transitional housing, and eventually to permanent housing. However, Tsemberis et al. (2003) argued that these individuals' mental illness and substance abuse were not as debilitating as previously believed by other professionals. They also hypothesized that

these homeless individuals would be more compliant with treatment if they had a choice and agency over their living situation first and foremost (Tsemberis et al., 2003).

The Choices Unlimited program was designed to help patients breach the barriers to services of previous care models and provide patients with an environment that would motivate the patient to actively engage in treatment. The Choices Center offered a wealth of resources for homeless individuals with no strings attached, such as showers, lockers, telephones, library and computers, laundry, and television. Moreover, the center managed to develop rapport between staff and patients, and these staff acted as informal case managers assisting individuals in finding medical, psychiatric, and social service resources (Tsemberis et al., 2003).

Core Principles and Fundamentals

Many of the core principles of the Choices experiment were grandfathered into what we now refer to as Housing First. The five core principles include:

- immediate access to permanent housing with no continuum requirements,
- patients have the right to self-determination and choice regarding resources and services including where they want to live,
- focusing on recovery from mental illness, homelessness, and substance use,
- individualized and client-centered care,
- and social and community integration (Canadian Observatory on Homelessness, 2017).

Traditionally, housing programs would prioritize treatment for mental health and substance abuse before providing housing. Their rationale for this approach was that individuals could not sustain housing if they were not stabilized mentally and emotionally

requiring compliance with medication and sobriety from drugs and alcohol. Housing First programs have set out to debunk this rational by providing evidence that homeless individuals, when provided immediate access to permanent housing without treatment requirements, have been able to sustain their housing. However, it is important to note that many of these studies do not provide long-term and post-treatment evidence. Furthermore, there is evidence that those who report using during the time of their housing placement have lower outcomes than those who report no substance use (Kertesz et al., 2009; O'Connell et al., 2013).

It is very important to note that when many professionals discuss the effectiveness of Housing First, they often only contribute the effectiveness of the approach to its namesake "housing first" and fail to recognize the importance of the other aspects to Housing First, such as using case management within an integrated healthcare model. Case management is a quintessential fundamental of Housing First and its effectiveness in treating chronically homeless and their multitude of needs such as comorbid mental health and substance use disorders. These disorders would not be treated as effectively without the case management component.

Today the literature regarding Housing First has almost unanimously asserted Housing First as the best practice for housing due to its effectiveness in housing chronically homeless individuals with comorbid mental health and substance use disorders (Canadian Observatory on Homelessness, 2017). However, there are still critics of the efficacy of Housing First. Some think that there is still not enough evidence to praise Housing First as many do.

Kertesz, Crouch, Milby, Cusiman, and Schumacher, concluded in their 2009 study that there just simply was not enough evidence to support Housing First for those with active addiction when they enter a Housing First program. They also argued that we shouldn't necessarily compare Housing First to its linear model predecessors because they serve to treat two different issues: Housing First is simply a method for providing permanent housing whereas traditional linear models focused on treating the underlying issues which led to the homelessness, i.e., mental health and addiction (Kertesz et al., 2009)

Watson, Shuman, Kowalsky, Golembiewski, and Brown (2017) concluded in their study that the literature on Housing First had gaps in the way they were studying and presenting the model. Their primary concern was lack of focus on harm reduction. They argue that the discourse surrounding Housing First is harmful and politicized because harm reduction which was previously a focus of traditional housing models has been replaced with terms such as low-demand, and that these terms should not be used interchangeably because they mean very different things. They are concerned that Housing First promotes the lowering of initial treatment barriers and access without acknowledging what exactly should be done once they are in (Watson, Shuman, Kowalsky, Golembiewski, & Brown, 2017).

HUD-VASH

The VA has paved the way for health and mental health services for decades with some of the largest and most comprehensive programs in the nation (Karlin & Zeiss, 2010; R. Trivedi, 2016). As indicated by studies such as Katon et al. (2002), Rollman (2005), and Roy-Byrne (2001), integrated health care models, such as the VA's PACT

primary care integrated health program, have been shown to have increased treatment adherence, clinical outcomes, patient satisfaction, and cost-effectiveness (as cited in Karlin & Zeiss, 2010). The process of care is certainly streamlined. For instance, if the patient, who is consistently screened for mental health needs such as depression, shows signs of mental health needs, the patient could, after his primary care appointment, go back to the front desk and schedule a mental health appointment within the same clinic, and might even get in to see a mental health provider later that same day. Moreover, all the practitioners that work with that client can see the documentation for the patient. This makes the process of diagnosis and case management more effective and more efficient.

The VA is also becoming a leader in tackling the issue of homelessness. The United States Department of Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) program was established in 1992 as a collaboration between HUD and the VA in order to develop a permanent housing program with case management. This program was developed with a specific goal of adequately and effectively housing chronic homeless veterans with mental illness and substance use disorders (O'Connell et al., 2013). It is also important to note that the VA's homeless program (HUD-VASH) policy has been driven by the Housing First model since approximately 2011 after the reported success of an experimental study conducted in 2010 (Kane, 2014). Prior to the application of the Housing First evidence-based practice, veterans in the HUD-VASH program waited an average 108 days before being housed (O'Connell, Kasprow, & Rosenheck, 2010). Although the program was designed to house those who are traditionally the most vulnerable and difficult to treat, the program

also houses homeless or at-risk individuals who have a need for case management and qualify according to the other program requirements.

To qualify for the program, the participant must be a veteran who is eligible for VA health services. The veteran does not have to be retired or service connected to be eligible to receive services from the VA. The veteran must require ongoing case management. Often this means the veteran has serious mental illness, a history of substance use, and/or a physical disability. The veteran is expected to participate in case management and the available resources provided by the HUD-VASH case manager. The HUD-VASH case manager screens for eligibility using an acuity matrix that measures veteran's income, clinical need, social support, physical and mental health, substance use, and current living status (i.e., whether the individual is living with family or under a bridge). The veteran is also screened for when he or she served in the military and for how long and whether or not the individual is a registered sex offender. If the potential participant did not serve an acceptable length of time in the military (which is determined by when the veteran was in the military), is a registered sex offender, or has an income that is too high, he or she is disqualified from the program (va.gov).

Once the participant is screened, and if they are accepted, they will receive case management after their first meeting with a HUD-VASH case worker and the consent to treat form has been read and signed by the participating veteran. From this point on the veteran is both obligated and entitled to case management service so long as he is in the HUD-VASH program. However, participation in other various resources presented by the case worker are entirely voluntary. Case managers can assist with obtaining Public Housing Authority documentation, locating an apartment that accepts HUD-VASH

housing vouchers, managing money, connecting with community resources, monitoring health and mental health needs, and providing psychoeducation, counseling, and referrals to other resources as needed (Smith, Gilkey, Milliorn, & Ozuna, 2017).

In order to acquire a housing voucher, the veteran has to complete a lengthy HUD voucher application; the HUD-VASH case manager can assist with the completion of this application and acquiring the needed documentation. After the application is complete, the veteran has to attend a voucher briefing where the HUD staff explain the rules and regulations regarding the use of a HUD housing voucher and then the veteran has six months to find a place to live where the owner accepts HUD vouchers. If the veteran requires help, the HUD-VASH case manager should have a working knowledge and relationship with apartment managers to assist the veteran in the process of choosing a place to live. Once the lease is signed, the veteran is responsible to uphold the rules of the lease as any other resident at the apartment complex (Smith, Gilkey, Milliorn, & Ozuna, 2017).

The goal of the program, once the veteran has found permanent housing, is to help the veteran attain self-sustainability and self-reliance so that he can stabilize his housing status. Every participant has a different set of needs, whether that is health, mental health, substance use, social support, etc., and the case worker attempts to improve each need so that the veteran can eventually graduate from the program and no longer be at-risk of homelessness should case management be terminated. Because compliance with mental health and substance use treatment is entirely voluntary, this process may take a very long time, or it may never be fully achieved.

CHAPTER III

METHODOLOGY

Design

This will be an exploratory descriptive study analyzing existing data provided by the Veteran's Affairs. The data to be analyzed is from the HUD-VASH program as it was operating in the West Texas region during the year 2016. No identifiable information will be collected or analyzed and there will be no direct interaction with patients or human subjects for which this data was collected for the purposes of this study.

Participants

All data will be collected from existing data collected by participants within the West Texas HUD-VASH program. Participants are those who qualified and entered the HUD-VASH program requiring case management and documentation. These participants range from those who are at-risk of homelessness to those who are chronically homeless requiring intensive case management. The population size is estimated between 100 and 175 total veteran patients.

Procedure

The writer of this study followed proper procedures for documentation and fully informing the Veterans Affairs of the intentions and goals of this project and was in negotiations for several months. This study intended to collect and analyze nonidentifiable current HUD-VASH participant data. This study intended to only analyze recent 2016 patient record data regarding demographics, treatments, and

outcomes to accomplish the identified goals to: identify those at most risk, identify possible causalities or correlations to explain their identified risk, and in doing so identify strategies to improve HUD-VASH program fidelity. The author hypothesized, as informed by the literature, that it is likely those most at risk from not graduating from the program and relapsing into housing instability and homelessness are those who continue to use substances without seeking treatment or those who relapse into heavy use (O'Connell et al., 2013).

Although formal IRB approval provided by the Abilene Christian University Institutional Review Board was acquired for the proposed study, this project was changed from that study due to several limitations including but not limited to the lengthy process to receive approval from the Veterans Affairs Privacy Office to collect nonidentifiable patient record information, and time requirements for this project. For this reason, this study was changed to a systematic review, which meant this study no longer required IRB approval because no participants or patient data was collected, and only existing literature was analyzed.

The evidence presented in this study describes those most at risk of experiencing homelessness and behaviors during homelessness rather than the overall efficacy of the HUD-VASH program. In an effort to examine a subpopulation of veterans most at risk of not successfully responding to homeless treatment, rural veterans were chosen as the population to study due to their limited access to resources. Furthermore, due to the reduced outcome of those with substance use during program entry and especially for those with comorbid mental health issues (Kertesz et al., 2009; O'Connell et al., 2013), these were also chosen characteristics for examination in this study. Most studies found

regarding the utilization of Housing First only measured outcomes based on length of time from initial program entry to housing. There is little evidence regarding the long-term effectiveness of the HUD-VASH program; and therefore, it is difficult to determine suggestions for program improvement. This will be discussed in further detail in the discussion section below.

CHAPTER IV

RESULTS

Identifying Literature

A total of five articles were collected and included in this systematic review. The table below provides a description of the basic characteristics of each article including the author, date, title, purpose, and results. Few articles could be found which examined the effects living in rural locations has on homelessness given parameters that provide samples comparable to the sample that would have initially been analyzed by this study.

The articles used in this systematic review were all found in the EBSCOhost electronic database using "OneSearch" through the ACU library webpage. The following inclusion criteria was used to identify the articles included in this review: (1) empirical (peer-reviewed), (2) the following key words: veteran, HUD-VASH, homeless, substance use, mental health, rural, (3) 2011 and later, and (4) only studies conducted in the United States. The initial study proposed included gathering data from a West Texas VA CBOC to examine correlates of homeless veterans. The inclusion criteria were designed to provide evidence from similar samples. For instance, rural was used in the inclusion criteria because the intended study sample would have been retrieved from rural West Texas. Furthermore, substance use and mental health were also identified due the impact on homelessness indicated by the literature. Studies were excluded if they did not: meet the inclusion criteria, provide results to evaluate, or if full text copies could not be collected.

Systematic Review

All studies examined in this review gathered data from different sources. Each article had varying characteristics of their sample; however, all studies included only veterans with the Adler et al. (2015) study being the only exception. The Adler et al. (2015) was a qualitative study that surveyed 296 multidisciplinary VA staff from 30 community-based outpatient clinics (CBOCs) located in states across the country. The Byrne et al. (2016) article collected existing data from VHA electronic medical records and Edens et al. (2011) collected administrative VA data. Tsai et al. (2016) analyzed data used in the Pietrzak and Cook (2013) Psychological resilience in older US veteran study. The Tsai et al. (2015) study had a total sample size of 151 homeless veterans living in both rural and metropolitan areas within the state of Nebraska in order to examine the correlations between the different living areas and their effects on homeless veterans.

Results regarding those living in rural locations were contradictory. The Byrne et al. (2016) and Edens et al. (2011) articles indicated reduced risk of homelessness for those who live in rural locations whereas all other articles indicated higher risk for rural veterans. Specifically, the Byrne et al. (2016) article found that those in rural locations were less likely to be unsheltered than those in urban locations. The Edens et al. (2011) article concluded that those who were female, over 65, Hispanic, rural-dwelling, higher income, and those with a service connection were less likely to experience homelessness. Conversely, the Tsai et al. (2016) study found that those who had experienced homelessness were more likely rural. According to the Tsai et al. (2015) article, those living in micropolitans, or smaller cities as compared to metropolitans, experienced a gamut of issues including mental illness, health problems, and alcohol abuse; all of which

were worse than their metropolitan counterparts. Those in micropolitans were also more transient. Interestingly however, this study also found that those in micropolitans reported higher rates of social support, alcohol treatment utilization, and housing satisfaction than those in metropolitans. The qualitative staff perception article reported higher risks and a lack of resources for those who are homeless in rural localities including increased problems with transportation, treatment utilization, and limited access to health and mental health services (Adler et al., 2015). Another theme from the Adler et al. (2015) study were their concerns of what they perceived as cultural ideals of greater self-reliance. They believe these ideals can be a barrier for individuals to actively pursue help as it would be a sign of weakness and reduced self-esteem and social support. These ideas however, conflict with the results of the Tsai et al. (2015) study which reported higher levels of social support and treatment utilization for those in rural locations than their urban counterparts.

Four of the five articles describe substance use as a significant factor, if not the most significant factor, in predicting homelessness. The only outlier, Tsai et al. (2016), did not provide data or results for substance use and only provided Audit-C scores for alcohol use. However, even though they predicted that substance use would play a large role in their results, they never presented substance use data in their results. The Adler et al. (2015) study found that staff perceived substance use as the most common cause of homelessness among their patients at the VA. In the most at-risk subgroup presented in the Byrne et al. (2016) article, two-thirds of tri-morbid subgroup had SUD. In the Edens et al. (2011) study, substance use was the single strongest predictor of homelessness. Substance use was found to increase odds of homelessness by eight times followed by

alcohol use, which increased risk by five times. SUD was such a strong indicator of homelessness that their findings indicated that when they controlled for demographical and substance use characteristics, serious mental illness including schizophrenia and bipolar were not predictors of homelessness independently of a comorbid diagnosis of SUD. They concluded that the reasons why some mental illnesses score higher for predictability of homelessness is due to their high comorbidity of substance use disorders and the effects of those disorders overshadow the mental illness. The comparative study Tsai et al. (2015), found much higher rates of alcohol use in micropolitans (90.3%) as compared to metropolitan homeless (53.6%). Drug dependency rates were also higher for those in micropolitans than metropolitans with rates of (84.2%) and (56.2%) respectively.

Mental health is continually found to have a disproportionately high prevalence among the homeless. Of all veterans sampled in the Edens et al. (2011) study, 10% (9.7%) of those who utilize VA mental health services had been homeless in the last year. This statistic was cited in the Tsai et al. (2016) study, which also cited a statistic from a Access to Community Care and Effective Services and Supports (ACCESS) program study that found that 56% of mentally ill veterans had used VA homeless services at some point in their lives. The qualitative study found that staff perception of the need for substance use treatment and mental health services were both very high for the veteran homeless population (Adler et al., 2015). The most at-risk subgroup presented by the Bryen et al. (2016) study indicated complex needs and high comorbidity of SUD and SMI as well as health issues and high utilization of both outpatient and inpatient care. Interestingly, in the Tsai et al. (2015) article, they found that those in micropolitan areas reported higher VA mental health services utilization and less travel time. However, they

had a much higher prevalence of several mental illnesses including major depression, bipolar, PTSD, and anxiety and personality disorder.

Table 1

Articles Reviewed

Author(s)	Article/ Study Title	Purpose of Study	Methodology	Results
Adler et al.	Staff perceptions of homeless veterans' needs and available services at community-based outpatient clinics (2015).	VHA staff were surveyed to analyze their experiences and perspectives on rural veteran homeless needs.	Qualitative study, which surveyed 254 VHA staff members from 30 rural community-based outpatient clinics (CBOCs).	Of those surveyed, 63% reported having contact with a homeless at least once a month; 37% reported working with 3 veterans a month. Respondents reported substance use (57%), unemployment (53%), and mental illness (45%) to be the most influential factors in homelessness. 34% of those surveyed reported growing numbers of homeless at their CBOC. Dental care (80%), substance-use treatment (71%), and mental health care (63%) were reported as the most significant of unmet needs. Lack of available resources, transportation, access to healthcare, and rural cultural ideals such as self-reliance were all considered significant problems for rural homeless as compared to urban homeless.

Byrne et al.	Unsheltered Homelessness Among Veterans: Correlates and Profiles (2016).	This study characterized unsheltered veterans into subgroups in order to analyze the differences between those with the greatest needs and those who are sheltered.	Quantitative with a sample size of over 35,000 veterans who screened positive for homelessness between 2012 and 2013. The researchers collected existing data from veteran electronic medical records. The data was analyzed with consideration for a number of characteristics including income, disability, geographical location, age, race, and treatment utilization.	Of the 35,897 veterans who screened positive for homelessness 4,034 (11.2%) reported unsheltered homelessness. Of these unsheltered veterans, they were more likely to be white, male, between the ages of 50 and 69, and did not have a service connected disability. Surprisingly, veterans screened in rural locations were less likely be unsheltered. The subgroup identified most at risk of unsheltered homelessness was the tri-morbid subgroup consisting of 14.5% of unsheltered veterans sampled. Two out of three had co-occurring SUD and SMI and eight of ten had chronic health needs. This group frequently utilized both VA outpatient and inpatient treatment.
Edens et al.	Association of substance use and VA service-connected disability benefits with risk of homelessness among veterans (2011).	To determine risk factors and predictors of homelessness for those utilizing mental health services through the VA. The authors identified	Quantitative case-control study using VA electronic medical record data for FY2009. Of the 1,120,424 sampled, 109,056 were	The demographical characteristics of those most at risk of homelessness were those who were between the ages of 40-64 years of age, male, urban-dwelling, and an income of less than $7,000. Diagnoses that

		targetable and modifiable correlates of homeless in order to promote practices which would prevent rather than treat homelessness.	classified as homeless and were compared to nonhomeless. Multiple factors were analyzed including type of mental health disorder, substance use, location, disability, and income.	indicated a risk of homelessness was pathological gambling, bipolar, schizophrenia, personality disorders, alcohol use, and illicit drug use. SUD increased risk for homelessness by eight times and alcohol use five times. Blacks were four times more likely to experience homelessness than whites. The next largest predictors of homelessness were those who were pathological gamblers, ages 40-49, and those with personality disorders. Those who were female, over 65, Hispanic, rural-dwelling, higher income, and those with a service connection were less likely to experience homelessness.
Tsai et al.	Homelessness among a nationally representative sample of US veterans: prevalence, service utilization, and correlates (2016).	The purpose of this study was to examine life-time homelessness for veterans who have utilized VA housing programs and their demographic and clinical characteristics.	Quantitative study utilizing data collected from the National Health and Resilience in Veterans Study (2013). The 1,533 sample included those who have previously been homeless but are not currently homeless.	Of the 1,533 sampled, 8.5% reported experiencing homelessness with an average cumulative of 2 years. Of those only 17.5% reported utilizing VA homeless services. Those with lifetime homelessness were more likely to be non-White, low-income or unemployed, rurally located, and served during the Persian Gulf War. Clinically,

				those who experienced homelessness were more likely to report a suicide attempt, low social support, and higher scores for depression and anxiety.
Tsai et al.	A Comparison of Homeless Male Veterans in Metropolitan and Micropolitan Areas in Nebraska: A Methodological Caveat (2015).	This study examined the demographic, clinical, psychosocial, treatment utilization differences of veterans living in urban and rural localities.	Quantitative study consisting of a total sample of 151 veteran participants living in urban or rural locations in Nebraska.	Those in micropolitans were more transient, more likely to have diagnosed PTSD, anxiety disorders, personality disorders, and alcohol use disorder than those from metropolitans. The micropolitan group had a greater number of medical and behavior issues. There was no difference in reported medical utilization, but more of the micropolitan group reported utilizing mental health services with those from micropolitan locations having much higher rates of alcohol treatment utilization. However, the rural sample reported higher social support and satisfaction with housing assistance.

CHAPTER V

DISCUSSION

The contradictory results with regard to the effects of urban versus rural homelessness leaves much for speculation. It is worth considering why these results are almost diametrically antithetical. For instance, the Byrne et al. (2016) article found that those in rural locations were less likely to be unsheltered than those in urban locations. Also, the Edens et al. (2011) found that those living in rural locations were less likely to experience homelessness. Although it is possible to experience homelessness while being sheltered, the point is that these two articles indicate a reduced risk for rural homeless in comparison to those living in urban locations while the other articles indicate increased risk of homelessness and the effects of homelessness for those who are rurally located. A possible explanation for the outlying results in the Byrne et al. (2016) article could be that there is an adequate housing program coupled with less competition for housing when compared to urban populations and the rural locations studied in the other studies. Regardless, these results can result in additional questions: are rural homeless veterans at greater risk of homelessness and do they have an increased difficulty utilization housing services such as the VA's HUD-VASH, or is the issue far too contextualized to make such a general assessment?

Furthermore, of these studies, none provided evidence regarding the efficacy of the HUD-VASH program. They discuss service utilization, risks of homelessness, and correlations to various subpopulations of the homeless such as rural vs. urban, but none

describe the effectiveness of the homeless services they are utilizing. This study intended to examine the evidence regarding Housing First and its use with various subpopulations of the homeless, but the evidence was not found. With the very limited evidence on Housing First—especially in regard to its use in the HUD-VASH program for rural veterans with comorbid mental health and substance use—it appears difficult to establish Housing First as the best-practice method. Although there is undoubtedly limited evidence supporting Housing First within the HUD-VASH program for rural homeless, there is limited evidence supporting its effectiveness with active substance users as well, which should be alarming considering those with chronic SUD are the target population for the treatment. That is not to say that the alternatives to Housing First are better, but that we should think critically about why we support Housing First with limited evidence and why studies have presented the data they have instead of alternative data which would provide stronger evidence of the effectiveness of the Housing First model (Woodhall-Melnik & Dunn, 2016).

As mentioned in the literature review, some scholars have acknowledged that the evidence regarding Housing First has been politicized and can be dangerous for those they intend to serve. Studies no longer indicate reduced harm reduction or treatment effectiveness regarding substance use, mental health, and physical health beyond treatment utilization (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Watson, Shuman, Kowalsky, Golembiewski, & Brown, 2017). If studies began to evaluate the effects of Housing First on these critical issues, we could begin to examine what is and what is not effective for treating the correlated issues that often accompany homelessness. Moreover, if the literature only examines the reduced time from program

entry to housing placement and the patient's choice for housing, it is disingenuous to the overall Housing First model, which in its five core principles includes: focusing on recovery from mental illness, homelessness, and substance use, individualized and client-centered care, and social and community integration (Canadian Observatory on Homelessness, 2017). One of the quintessential components of the Choices Unlimited program often references as the original Housing First pilot study, was case management. However, the use of case management is rarely found in studies examining the effectiveness of Housing First.

Perhaps there is a larger question worth considering: If a housing program does not utilize all of these core principles is it still utilizing a Housing First model? If it is no longer a Housing First model without these core principles, then should we be examining whether programs claiming to be Housing First are truly Housing First? The assumption that current literature is evaluating true Housing First programs with the limited evidence that we have could be dangerous.

Limitations

This study was met with several limitations. The researcher spent approximately eight months attempting to acquire approval to collect chart review data to no avail. Due to time restrictions, this study was changed to a systematic review in an effort to evaluate articles with a sample population similar to the intended sample. Furthermore, very little literature was found which met the search criteria regarding said sample or regarding the effectiveness of Housing First and the implementation of Housing First within the HUD-VASH program.

Conclusion

Further research is needed regarding Housing First in general, but specifically as it is utilized by HUD-VASH. Research is also needed to indicate the long-term effects, the impact of SUD and mental health, and the impact of those in rural locations, for those using a Housing First model and specially for those in the HUD-VASH program. Current literature evaluates Housing First on the basis of housing alone with little regard for the other core principles that made Housing First so effective in its initial pilot study, such as case management, prioritizing substance use and mental health treatment, and the integration into the community at large to strengthen social support. With this in mind, we are left asking if those programs that do not consider the other core principles of the model are indeed Housing First. If not, then even the limited evidence we have is in question.

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