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Swords to Plowshares

Iraq Veteran Project

Risk and Protective Factors for Homelessness among OIF/OEF Veterans

Prepared by Swords to Plowshares' Iraq Veteran Project

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Risk and Protective Factors for Homelessness among OIF/OEF Veterans

Introduction

The following preliminary report briefly outlines the risk factors and transitional responses which will contribute to chronic homelessness among veterans of Iraq (Operation Iraqi Freedom or OIF) and Afghanistan (Operation Enduring Freedom or OEF). This paper presents some of the findings of Swords to Plowshares' Iraq Veteran Project – an effort to gather information about the issues facing new veterans and their families, to identify gaps in services and to make recommendations to improve policies and programs for this population.

OIF/OEF veterans are at significant risk for homelessness and chronic homelessness and are becoming homeless sooner than their predecessors. After Vietnam, it generally took 9 to 12 years for veterans' circumstances to deteriorate to the point of homelessness. OIF/OEF veterans, though, are already seeking housing services, some just months after returning from Iraq. New veterans are falling through the cracks, and they are shocked and angry at the lack of care afforded them. They stand at the precipice of chronic homelessness unless there is a concerted effort to address their needs.

Approximately 600 Iraq veterans have sought homeless healthcare services from the Department of Veterans Affairs (VA).[1] Knowing that veterans, particularly recent veterans are loath to seek help, we can safely assume that the number of Iraq veterans with unstable housing is much higher. Further, the high incidence of PTSD and traumatic brain injury will contribute to increased chronic homelessness unless proactive measures are taken to mitigate the trend.The following material outlines areas of particular concern which demand attention, data collection, increased funding and aggressive policy and program responses. Veteran service providers and advocates are struggling to improve access to benefits and services, but the conditions of the Iraq war and limited capacity and resources present considerable challenges.

Risk and Protective Factors as Predictors of Homelessness

Troops and new veterans continue to be exposed to every significant risk factor known to contribute to homelessness. Transitional services are insufficient, and the resources of the VA and community-based organizations were already operating at or beyond capacity before Iraq veterans began seeking services. Materials prepared for the VA Advisory Committee on Homeless Veterans identify risk and protective factors for chronic homeless and economically secure outcomes.

The risk factors during service are extended deployment, combat exposure, unit transfers, disrupted family status, injury and diminished function. The risk factors during civilian

[1] NEPEC, VA Homeless Program Assessment 2006.

adjustment are unstable network, under/unemployment, mental illness and dropping out of the workforce.

Protective factors include training success, choice of military, continuity of tours of duty, Department of Defense (DOD) housing and rehabilitation. Civilian adjustment protective factors listed by the VA include employment assistance, transition assistance, rehabilitation, medical care, commensurate employment, compensation award and work therapy.

Risk Factors Related to the Nature of OEF/OIF

Repeated Deployments Urban Combat

One and half million service members have been deployed in the wars in Iraq and Afghanistan. At present 50% of the approximately 140,000 troops are enduring their second tour of duty, another 25% are on their third and even fourth tour. These repeated deployments and extended deployments are themselves a risk factor for homelessness. Further, while we have a "volunteer" military, the unprecedented reliance on National Guard and Reservists, Individual Ready Reservists, and the extension of service contracts through stop loss[2] all are contrary to the choice of military and continuity of tours indicated as protective factors. Indeed, service members are enduring repeated extended deployments, combat exposure and continual family disruptions, all risk factors for homelessness.

National Guard and Reserve Deployment

Approximately 40% of OIF/OEF troops and veterans are National Guard and Reserve. Risk factors are exacerbated for Guard and Reserve and their families who tend to be more geographically diverse than regular service members, and they have less access to support networks and services before, during, after and between deployments. National Guard organizations' efforts to inform members of available services vary greatly. The programs in place are largely dependant on the volunteer efforts of family members. Guard and Reserve are almost half as likely to file VA claims as their regular forces counterparts and half as likely to have their claims approved.[3] This may be attributed to lack of knowledge about earned benefits, difficulty navigating the claims process, barriers to legal guidance and service records split between state and federal entities.

Regular Forces

Many of the new homeless veterans who were in the regular forces are very young. These individuals entered the service as teenagers leaving their homes for the first time, never having been responsible for their own housing. Upon their return, the family home may not be available or available only in the short term. In addition, young veterans who were exposed to childhood risks, unstable housing and marginal family status are returning to the same unstable environments, with the added stress of combat experience.

Women

More women are engaging in combat roles in Iraq where there are no traditional front lines. Women veterans are 2 to 4 times more likely than non-veteran women to be homeless.[4] Until recently, the VA's research and treatment of PTSD was focused predominantly on men. In

[2] Involuntary extension of service contract.

[3] Veterans for America FOIA request http://www.veteransforamerica.org/files/vcs/CPGWOT.pdf

[4] Overrepresentation of Women Veteran Among Homeless Women, G. Gamache, R. Rosenheck , R. Tessler. J. Amer. Public Health, July 2003, Vol. 93 No. 7. http://www.ajph.org/cgi/content/abstract/93/7/1132

2002, prior to the Iraq war, the VA began a study of women and PTSD. The study includes subjects whose PTSD resulted from stressors that were both military and non-military in nature. Preliminary research shows that women currently serving have much higher exposure to traumatic experiences, rape and assault prior to joining the military (13% among American women, 36% among women in the navy). Other reports show extremely high rates of sexual trauma while women are in the service (20-40%). Repeated exposure to traumatic stressors increases the likelihood of PTSD. Researchers also suspect that many women join the military, at least in part, to get away from abusive environments. Like the young veterans, these women may have no safe supportive environment to return to, adding yet more risk of homeless outcomes.[5]

Homeless veteran service providers' past and current clients have been almost exclusively male. That is changing as more women veterans and women veterans with young children have sought help with National Coalition for Homeless Veteran member agencies who have few options for women. Additionally, the approximately 150,000 female Iraq veterans are isolated during and after deployment making it difficult to find gender-specific peer-based support. Access to gender-appropriate care for these veterans is essential.

Risk Factors Related to Injury and Diminished Function

These materials do not consider poly-traumatic injuries such as amputations and severe burns. Instead, the injuries highlighted are those more insidious—invisible injuries that may easily go undiagnosed and untreated, and may be difficult to prove for disability claims purposes.

PTSD and Mental Health Needs

PTSD has a debilitating effect on veterans' ability to maintain employment and family relationships and to engage in reckless behavior and substance abuse—all risk factors for homelessness.

According to studies by Colonel Charles W. Hoge, published in the *Journal of the American Medical Association*, over one third of troops returning from Iraq have screened at risk for PTSD and other mental health needs on their Post Deployment Health Assessment (PDHA).[6] This is no doubt an undercount, as veterans tell us that they routinely avoid positive responses on the PDHA survey because of the stigma associated with mental health needs, fear of impact to their military or civilian careers and because they are told that if they admit need they will be placed on medical hold and not allowed to return home after deployment.

The conditions of the Iraq war are a recipe for PTSD. Troops are serving repeated deployments in urban war zones. They are exposed to extremely hostile conditions, in constant 360-degree danger of drawing fire, coming under mortar attack and falling prey to improvised explosive devices (IEDs). The repeated exposure to trauma and the fact that just being in Iraq is itself a traumatic stressor is resulting in unprecedented numbers of veterans experiencing mental health issues, from difficult transition to full blown PTSD requiring

[5] Researchers study PTSD in Women, Deployment Link, 12-02 http://deploymentlink.osd.mil/news/feb03/news_020303_001.shtml

[6] All returning troops are required to fill out form DD 2796 Post Deployment Heath Assessment which includes questions regarding exposure to traumatic events, experiencing nightmares and depression and desire to seek mental health counseling. http://deploymentlink.osd.mil/pdfs/dd2796postdepha.pdf

crisis intervention. Over 35% of OIF/OEF veterans who have sought VA healthcare have been diagnosed with mental disorders.[7]

The Department of Defense (DOD) is failing to follow up with treatment for troops, referring just one in five troops to treatment who report risk factors for PTSD.[8] The DOD is returning troops to combat who have been diagnosed with PTSD, this despite the fact that repeated exposure to trauma can worsen psychiatric symptoms.[9] In addition, veterans tell us that service members—even NCOs—who do seek mental health services while on active duty are ostracized by their peers. Service providers and OIF veterans report a high level of dangerous and illegal behavior consistent with combat-related mental health problems: domestic violence, substance abuse, DUIs and reckless driving, bar fights and other anti-social actions.[10]

An alarming number of Iraq veterans are receiving inappropriate less-than-honorable discharges for engaging in behavior symptomatic of PTSD and traumatic brain injury. Less-than-honorable discharges are attributed to pre-existing personality disorders, substance abuse and bad conduct. These high numbers coupled with the symptomology of PTSD suggest that these veterans have been discharged because of psychological injuries sustained during services, yet they will be forever barred from VA mental health care.[11]

Traumatic Brain Injury

Traumatic Brain Injury (TBI) is the signature wound of the Iraq war. TBI is caused by blunt force injury to the head and/or the concussive force of explosions which cause the brain to slam against the skull. Recent screening of returning troops shows that 20% of infantry and 10% of other troops have at least mild brain injury. Many troops are experiencing multiple concussions throughout their tours of duty which increase the impact of the brain injury.

TBI results in a broad range of physical, cognitive, behavioral, emotional and social challenges. Diagnosis can be difficult because there need be no obvious injury or penetration of the skull, and the symptoms are diffuse and mimic those of PTSD. Survivors may appear normal but their memory is diminished; they act irrationally, lose their temper, and have difficulty maintaining concentration, family relationships and employment. Anti-social and dangerous behavior are common symptoms leading troops with TBI to get in trouble with the law and engage in behavior which leads to bad conduct less-than-honorable discharge when service-connected TBI is the appropriate diagnosis.[12]

The DOD and the VA should screen all OIF/OEF veterans for TBI and ensure that supportive services, including cognitive, behavioral and vocational therapy are available to assist the veteran in managing TBI and maintaining employment and relationships. Bad conduct

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[7] Analysis of VA Health Care Utilization Among US Southwest Asian War Veterans, OIF/OEF, VHA Office of Public Health and Environmental Hazards, Nov. 2006.

[8] Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers, GAO-06-397, May 11, 2006, http://www.gao.gov/new.items/d06397.pdf

[9] Mentally Unfit, Forced to Fight, Hartford Courant, May 17, 2006, http://www.courant.com/news/specials/hc-mental4.artmay17,0,3447385,print.story

[10] See PTSD Timeline http://scoop.epluribusmedia.org/story/2006/12/3/231421/666

[11] Soldiers say Army Ignores, Punishes Mental Anguish, NPR All Things Considered, Dec. 4, 2006 http://www.npr.org/templates/story/story.php?storyId=6576505

[12] Troops risk undetected brain injury, USA Today, 6/7/2006, http://www.usatoday.com/news/health/2006-06-06-brain-damage-main_x.htm

discharges should be scrutinized to ensure that the veteran is not suffering from service-connected brain injury, therefore protecting access to the medical care TBI survivors require. Those who cannot function independently must be afforded permanent supportive housing.

Risk Factors Related to Employment and Finances

Unemployment

The unemployment rate among veterans ages 20-24 is 15%, three times the national average for this age group. Recent GAO reports have been critical of state-based veterans' employment and training services.

Younger veterans who may have joined the service immediately after high school express difficulty transferring their military skills to the civilian work force. These veterans may have limited education and no civilian work experience. Newly discharged veterans and demobilized Guard and Reserve may have difficulty maintaining their composure and self-control throughout the work day, especially in positions of high stress or high public exposure. Some veterans are re-enlisting because they are discouraged by the lack of opportunity in their local job markets.

National Guard and Reserve Job Protection

Federal Law (USERRA) requires employers of any size to re-employ Guard and Reserve veterans after their discharge from active duty. However, the law fails on several levels. Many Guard and Reserve troops are returning to find their jobs no longer exist. In their absence their employers have folded, down-sized, merged or relocated.

Deployment interferes with income and career development in other ways. For example, a veteran we spoke with was a project manager deriving approximately 30% of his income from bonuses and commissions. While his employer retained him, he could not manage projects because of his extended and unpredictable absences during three deployments. This not only impacts the veteran's income but also his/her career growth. This particular veteran had to sell his home due to the income loss.

These veterans have no recourse under USERRA.

Veterans cannot afford to pursue legal remedies or wait until their claims are processed by the Department of Labor. Guard and Reserve veterans also report that employers are hesitant to employ them because of the possibility of future deployments. In addition USERRA also does nothing to assist small business owners and the self employed.

Vocational Rehabilitation

Anecdotal accounts suggest that securing appropriate services and benefits from VA Vocational Rehabilitation can be a challenge. It appears that services vary widely, and approval of certain vocational education or training program requests can be difficult.

PTSD may require Guard and Reserve veterans to completely redirect their career path. The skill sets used in Iraq (and in prior careers) are themselves a trigger for the veterans' symptoms. This has been the case for the transportation field, such as the truck driver who returns with an unmanageable fear of improvised explosive devices (IEDs) on U.S. roads. The same can happen to National Guard forces who used their communications, information technology (IT), language or paramedic skills in Iraq.

These activities, while not traumatic in and of themselves, are associated with duties and memories that may trigger traumatic stress. In these cases, a complete change in career path may be needed in order for the veteran to maintain civilian work.

Financial Instability and Debt

Too many service members and their families are enduring financial hardship associated with deployment. This includes Guard and Reserve whose civilian incomes were higher than active duty income, troops whose income depended on bonuses and commissions lost due to absence, delays and mistakes in military pay, and to debt. Payday loan stores around military bases contribute to a spiraling cycle of extremely high interest debt. One in four military families has taken out such loans which can carry interest rates exceeding 400%. Other financial pitfalls identified by the DOD include car title lending, rent-to-own arrangements, fee-based overdraft programs and tax refund anticipation loans. Such financial difficulties put tremendous strain on families and can jeopardize security clearances and military careers.[13]

Risk Factors Related to Access to Services and Benefits

VA Eligibility OEF/OIF Combat Veterans

Combat veterans are eligible for free health care for conditions possibly related to combat for two years after separation. They are assigned to Priority Group 6 unless otherwise qualified for higher enrollment status. PTSD can begin long after the occurrence of traumatic events, yet new veterans are granted presumptive eligibility for VA health care for just two years. Considering the delayed onset of PTSD, the presumptive eligibility should be extended to five years.[14]

VA Outreach

The VA has established its Seamless Transition Program specifically for OEF/OEF veterans (http://www.seamlesstransition.va.gov/). This program is intended to create a partnership between the DOD and VA to ease post-deployment adjustment. As part of the program, social work staff is directed to engage in outreach. More resources need to be directed to this effort. It appears the increase in access to information is not adequately benefiting new veterans seeking or receiving VA health care and other services. Bureaucratic obstacles and delays serve to discourage these veterans from seeking out the care they need and exacerbate depression and combat-related stress.

Enrollment in VA healthcare should be automatic for returning troops. More full-time staff devoted to outreach, continued follow-up, and streamlining and accelerating services are necessary to provide assistance to OIF/OEF veterans immediately upon request.

Vet Centers

According to a review of Vet Center capacity prepared for the House Committee on Veterans' Affairs, Vet Centers do not have the capacity to meet the current increase in OIF/OEF veterans seeking readjustment counseling and PTSD treatment. Forty percent of Vet Centers surveyed reported directing veterans who need individualized therapy to group

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[13] Pentagon Finds Predatory Lending Harms Troops, enter for Responsible Lending, August 11, 2006 http://www.responsiblelending.org/issues/payday/briefs/page.jsp?itemID=29862357

[14] See Testimony of Paul Sullivan, Dir. Of Programs, Veterans for America, Institute of Medicine Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans, Oct. 4, 2006. http://www.veteransforamerica.org/files/vcs/Sullivan_testimony_Oct_2006.pdf

therapy, and 25% have had to limit services and establish waiting lists. The number of OIF/OEF veterans seen for PTSD has doubled and the number of OIF/OEF veterans seen for readjustment problems tripled from October 2005 to June 2006. The Vet Centers have hired 100 OEF/OIF veterans to provide outreach to their peers but only eight counseling and administrative staff has been added since 2002.[15]

Vet Center staffing—particularly licensed mental health staff—needs to keep pace with the increased demand of OIF/OEF veterans seeking readjustment and PTSD counseling. In addition, there should be a review of the training given to OIF/OEF outreach specialists and if it is not available, recommend that curriculum related to homelessness prevention be established.

Family Services

VA medical and clinical services are limited to the veteran. Some Vet Centers have implemented services for family members such as couples therapy and group therapy for spouses of veterans with PTSD. However, increased demand is forcing Vet Centers to reduce rather than expand family services. The value of providing family services and trying to prevent family dissolution is undeniable. It is often family members who recognize the veteran's need for services and encourage treatment. However, the veteran must be enrolled and act as the conduit for family services. In cases where the veteran is reticent to address their own need for care, or where there is family violence, spousal and family resources are limited.

Family services need to be expanded and the VA, DOD Guard and Reserve should contract with community based organizations to increase capacity and access.

VA PTSD Treatment Capacity

The VA failed to anticipate the increased demand for mental health services resulting from the wars in Iraq and Afghanistan. The VA expected to treat only 2,900 war veterans for PTSD; however, as of June, they had seen 34,000.[16] This number is growing daily and will continue to grow, particularly as the symptoms of PTSD are often delayed and stigma of acknowledging mental health problems keeps many veterans from seeking care until they have no choice.

Several GAO and internal VA studies outline the VA's lack of capacity to continue to serve its current enrollees and the new veterans returning from Iraq. According to the VA Mental Health Task Force "a newly returning veteran, who suffers from suicidal ideation related to deployment, will find the availability of appropriate evidence-based care is haphazard and spotty." Despite spikes in the need for PTSD treatment, the VA has failed to develop performance measures for PTSD treatment, coordinate adequate PTSD care with community-based outpatient clinics, or develop treatment settings and effective approaches for veterans with PTSD and co-existing substance abuse, psychiatric or medical conditions.[17]

Mental heath care varies widely within and among the VA regional networks (VISNs). News reports and personal accounts suggest delays in receiving mental health care and spotty

[15] Review of Capacity of Department of Veterans Affairs Readjustment Counseling Service Vet Centers, US House of Representatives Democratic Staff, October 2006.

[16] VA response letter to Rep. Lane Evans pre- House Veterans Affairs Committee Hearing. On file with House VAC Democratic staff.

[17] "Availability and Access to Mental Health and Substance Abuse Services for Veterans: Review and Recommendations", Dept. of VA 3/11/2004.

treatment once diagnosed. Veterans report receiving less one-on-one professional therapy than they (or their doctors) deem necessary and a high reliance on antidepressants and group therapy. Those who do seek care report having to wait months for an initial VA mental health appointment.

The most recent GAO reports indicate that the VA has failed to spend money allocated to mental health through the Mental Health Strategic Plan. In FY 2005, the VA spent just $53 million of $100 million intended for Mental Health Strategic Plan initiatives. In addition, it distributed $35 million to medical centers but did not inform officials that these funds were to be used for mental health. There is no accounting of what programs these dollars actually funded. An additional $12 million went unspent. In FY 2006, the VA allocated $158 million of the $200 million intended for Mental Health Strategic Plan initiatives. The VA has failed to adequately track spending for the mental health plan. In 2005 it did not track spending at all. In 2006, "it tracked aspects of plan initiatives but not dollars spent."[18]

In addition, barriers to seeking care include, lack of knowledge regarding VA services, lack of capacity within nearby VA mental health facilities, distrust of government, inability to navigate bureaucracies, long waiting times for appointments and prohibitive distances to VA health care providers.

The VA must expedite the funding of improved mental health services for OIF/OEF veterans. The period of presumptive service-connected eligibility should be extended from two to at least five years.

VA Disability Claims

Claims for VA disability benefits have increased 36% since 2000 and the backlog has never been greater.[19] New veterans are struggling to maintain stability without income while they wait for claims to be resolved. Considering the number of troops deployed in Iraq and Afghanistan, over 1.1 million, and the rates of physical and psychological injury, the coming wave of claims will easily run into the hundreds of thousands. Already over a half million claims are pending before the VA and will take years to resolve. Even if these veterans ultimately prevail and receive annual benefits, this period of financial instability remains a risk factor for homelessness.

In 2004, the Veterans' Disability Benefits Commission was chartered to conduct a study of benefits and determine the "the appropriate standard or standards for determining whether a veteran's disability or death should be compensated." This scope-of-work language is very disturbing, especially as it appears that newly disabled veterans will face increased hurdles to secure the benefits they have earned and which could be the difference between a life of dignified, modest financial security and a life of chronic homelessness.

Conclusion

This material is not an exhaustive accounting of the issues new veterans must overcome to achieve stability in their civilian lives. It is a starting point for homeless veteran service providers and others to engage these issues and to develop programs and policies to mitigate the risk factors for OIF/OEF veterans.

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[18] VA Health Care: Spending for Mental Health Strategic Plan Initiatives was Substantially Less than Planned http://www.gao.gov/new.items/d0766.pdf , November 2006

[19] http://www.va.gov/OCA/testimony/hvac/051207RA.asp, Statement by Ronald R. Aument Deputy under secretary for Benefits Dept. Of Veterans Affairs before the House Committee on Veterans' Affairs. Dec. 7 2005

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