




Original Article

Social, Health and Mental Health Barriers for Care: The Perspective of Providers of Homeless Veterans

Barreras Sociales, de Salud y de Salud Mental para el Cuidado: La Perspectiva de los Proveedores de Veteranos Sin Hogar

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ABSTRACT

Most veteran homelessness literature focused on homelessness predictors, services provision, housing security, and homelessness experiences. One scarcely studied aspect is the perceptions of service providers in the Veterans Health Administration. Using two Focus Group Interviews in 2016 and 2021 as part of a Plan-Do-Study-Act Quality Improvement Process, the scope of homelessness and issues related to health, mental health, social services use, and recovery were assessed with 22 providers of homeless veterans at the VA Caribbean Healthcare System. Narratives indicated 2 major themes (homeless veteran care and factors limiting successful reintegration) and seven minor themes (first approach, OIF/OEF homeless veterans, Stigma, VA and non-VA communication, mental health and substance use, legal problems, and social and life skills). Results highlighted the presence of institutional stigma towards this population that extended to the providers. There is also a shortage of gender appropriate shelters on the island. Providers remarked on providing resources beyond housing to ensure quality of life. Implications of results call for a more integrated view of the Homeless Program with occupational, recreative, health and mental health services, institutional education initiatives to reduce stigma, and a more effective VA and non-VA service coordination.

Keywords: homeless persons, psychosocial care, veterans

RESUMEN

Literatura sobre veteranos sin hogar se ha centrado en predictores, provisión de servicios, seguridad de vivienda y experiencias sin hogar. Un aspecto poco estudiado es la percepción de los proveedores de servicios en la Administración de Salud de Veteranos. Mediante dos grupos focales como parte de un Planea-Haz-Estudia-Actúa, se evaluó en 2016 y 2021 el alcance de la falta de vivienda y problemas relacionados con salud y salud mental, uso de servicios

y recuperación con 22 proveedores de veteranos sin hogar en el Sistema de Salud de Veteranos del Caribe. Las narrativas indicaron 2 temas principales (cuidado de veteranos sin hogar y factores que limitan reintegración) y siete temas menores (primer enfoque, veteranos sin hogar, OLI/OLD, estigma, comunicación entre hospital y otras instituciones, salud mental y uso de sustancias, problemas legales y habilidades para vivir). Los resultados destacaron estigma institucional extendida a proveedores. También, escasez de refugios apropiados por género. Los proveedores comentaron sobre provisión de recursos más allá de vivienda para garantizar calidad de vida. Implicaciones promueven una visión más integrada del Programa con servicios de salud mental, ocupacional, recreativa y de salud, iniciativas de educación institucional para reducir estigma y coordinación más eficaz de servicios entre hospital y otras instituciones.

Palabras Claves: personas sin hogar, cuidado psicosocial, veteranos

INTRODUCTION

According to the latest Annual Homeless Assessment Report (AHAR) there are 326, 000 homeless sheltered persons on a single night. From those, Hispanics or Latinos represent 8.6% and veterans 6% (Henry et al., 2022). Since the national campaign to end veteran homelessness started in 2009, there has been a 55% reduction on homelessness (Henry et al., 2022). However, these findings do not represent the entirety of the homeless population. This report does not include data collected in Puerto Rico and U.S. Virgin Islands, and due to COVID-19, the latest report only collected data on sheltered individuals (Rivera-Rivera & Villarreal, 2021). As a result, the Caribbean region is underrepresented in the ongoing fight to end veteran homelessness. Furthermore, the effects of this pandemic on the numbers of homeless individuals who have been chronically affected by the lack of resources, including veterans, are yet to be quantified. Still, in a recent literature review, it was documented how homelessness is a risk factor for Covid-19 (Martínez-Taboas, 2020).

Housing assistance is one of the most important parts of the interventions homeless providers do. Among housing provision initiatives, research has determined that housing first is one of the best methods because it addresses mental health, substance abuse, and other health issues (Forchuk et al., 2021). Even when specific programs have been identified as successful, providers still face difficulties in assisting homeless veterans. For example, the National Alliance to End Homelessness (2022) have highlighted the fact that homelessness assistance systems in the U.S. often do not have the resources needed to meet the needs of homeless persons. Among those, the lack

of appropriate housing has been recognized as one of the most challenging aspects of aiding homeless veterans (Hutt et al., 2015). In Puerto Rico, for example, there is a shortage of 1,705 year-round beds for individuals and 15 year-round beds for households with children (National Alliance to End Homelessness, 2022). Furthermore, readmission to the Homeless Program in the VA Caribbean Healthcare System has been found to be 25% (Rivera-Rivera & Villarreal, 2021). Other issues providers have identified in the service provision of homeless veterans include VA and non-VA service coordination, access to services, patient willingness to accept services, affordability, and patient goals matching those of the providers (Hutt et al., 2015; Crone et al., 2021; LaCoursiere Zuccherro et al., 2016).

Furthermore, a range of studies have explored stigmatization aspects of service provision. A study in the UK identified 5 common themes (employment, housing, skills and experience, physical/psychological wellbeing, and addictions/antisocial behavior) in which stigmatization was made based on erroneous stereotypes that exacerbated the difficulties toward social reintegration (Phillips, 2020). Intersectionality aspects may also be considered in the case of homeless veterans who are also sexual offenders because they experience higher stigmatization rates and difficulties towards social reintegration (Sreenivasan et al., 2022). Beyond this, race and sex also play a role in the stigmatization process from a blameworthiness, dangerousness, and social distance perspective. A study found that people tend to practice social distance of homeless veterans when perceptions of dangerousness and blameworthiness are present (Markowitz & Syverson, 2019). These experiences of stigma and discrimination not only affect social reintegration

but also have been identified as barriers for healthcare provision and use (Schreiter et al., 2021).

In this Plan-Do-Study-Act Quality Improvement Process project, we used data from two focus groups to assess homeless providers perspectives. The aims of the project were to 1) identify the current needs of the Homeless Program according to the providers, 2) learn about the most salient problems veterans face when requesting the services of the Homeless Program, and 3) identify the factors involved in veterans being readmitted to the Homeless Program.

METHOD

Participants and Procedure

Following Institutional approval, we conducted an official Plan-Do-Study-Act Quality Improvement Process. This method is iterative and includes four steps used to improve processes or carry out changes. As part of the planning-stage, we identified what were our aims, which population and which intervention would give us the desired outcomes. Then, as part of the do-stage, we carried out the two Focus Groups to obtain emic data or “insiders’ perspectives”, from providers of homeless veterans at the VA Caribbean Healthcare System. A total of 22 participants from the Homeless Program, Social Work and Behavioral Health Services shared their thoughts regarding the problems and barriers faced by homeless veterans seeking social services and the limitations of the program. All participants filled out and signed VA Form 10-3203 for consent for production and use of verbal or written statements, photographs, digital images, and/or video or audio recordings at the VA. Both sessions were examined using content analysis, which involved coding, categorization, and clustering of data. The semi-structured focus groups included the following questions:

1. Currently, what are the needs of the Homeless Program? On what needs is it necessary to investigate more? How has been the collaboration with other services at the hospital and non-VA institutions?
2. What issues did homeless veterans experienced when they requested the Program’s services? Specifically, have there been issues with substance abuse, mental health, difficulties with leisure, and recreational activities?

Does the program teach skills training in some areas such as budgeting, for example?

3. What factors limit the stability and social reintegration of the homeless veterans? Is there a mental health diagnosis that you deem important in this process? Do you see a lot of readmissions to the program? Can you identify factors in the readmission process?

As part of the study-stage, we analyzed the data and determined if the collected data was sufficient to reach our aims. Finally, as part of the act-stage we determined if the plan resulted in success and disseminated the results.

Data Analysis

The process of developing the content categories entailed three phases. First, the Focus Group was recorded in an audio format and then transcribed into written form by one of the study authors. Transcripts were proof-read by two members of the study team. As no discrepancies were identified the second phase started. In this second phase, the transcribed interview was divided into meaning units to allow for a detailed analysis of their content by the study team. As a third phase, meaning units were organized into descriptive content categories via an inductive, iterative process that involved comparing and differentiating each meaning unit with the other meaning units.

RESULTS

We conducted two focus groups to assess homeless providers perspectives. Upon analysis of both transcripts, we identified themes relevant to the Homeless Program needs, homeless veterans most salient problems when requesting services, and readmission factors. This process yielded 2 major themes and 7 minor themes (see Figure 1). Minor themes were first identified and then clustered under the major themes. The major themes were: Homeless Veteran Care and Factors Limiting Successful Reintegration. On Homeless Veteran Care, participants described difficulties related to the Homeless Program resources, limited knowledge that affected referrals from other VA services, health and mental health problems, Homeless Program requirements and expectations, stigma, changes in the veteran profile and social support issues. These resulted in the following

minor themes: First Approach, OEF/OIF Homeless Veterans, Stigma, and VA and non-VA Collaboration. As for the other major theme we named it Factors Limiting Successful Reintegration. There participants discussed issues related to social reintegration obstacles such as limited resources, health, and mental

health issues, limited social support, legal history, and daily living skills. These resulted in the following minor themes: Mental Health & Substance Use, Legal Problems, and Social & Life Skills. Representative quotations of all minor themes are displayed in Table 1.

Figure 1

Major and Minor themes from focus groups

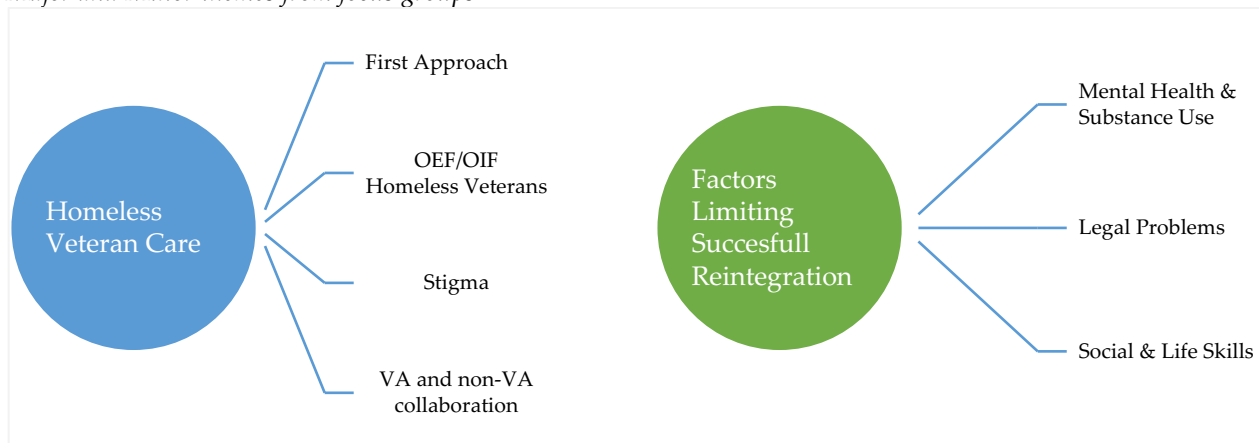


Table 1

Representative quotations from providers on minor themes.

| Minor Theme | Participant Quotation |
|------------------|---|
| First Approach | <p>“A lot of the veterans that get into the program don’t receive any other service in the hospital, so the first approach is really from our program”.</p> <p>“Many times, the only service the veteran wants is the one from homeless; that’s why we identify other needs they have. Medical needs, mental health needs and we facilitate access and fulfill that needs, but the veteran many times don’t want to; is apathetic. Thus, we are restricted, we know they have those needs, but they don’t access services and then we try to assume those other hospital roles to better channel the veterans’ needs”.</p> <p>“Once they get to us, we find the veteran has a series of untreated medical complications because cognitively he doesn’t have that capacity to go and make appointments or make a phone call and schedule an appointment, so we are getting these very decayed patients”.</p> <p>“Many of the problems we identified when they come into the program are that they have expectations of what VA is going to provide. We don’t have all the resources. We have a warehouse, canned foods which run out real fast, but we don’t have furniture and basic items for them to have quality of life and when we get donations, we don’t have transportation and we lack people who can load and help bring the furniture to them. <i>Sometimes it makes me think and feel that maybe we provide a roof, but they don’t have the quality of life we would want... They lack some items and basic things for you to say: “I have an apartment where I want to be and stay there all the time”.</i>”</p> |
| OIF/OEF Veterans | <p>“I understand that veterans... have particular characteristics by war period. The veterans we are receiving, younger, from Iraq and Afghanistan, they are unemployed. Many times, that’s the reason they become homeless. Prepared people struggling with reintegration from military to civilian life. The family doesn’t know what’s happening because it feels like another person returned home. How the family receives those veterans, the lack of knowledge, stereotypes in the streets...”.</p> |

| | |
|---------------------------------|--|
| Stigma | <p>“Working with stigmatization, the perception of providers that provide services to the homeless population, sometimes is a barrier. Yes, we are encountering barriers, not only with primary care, but with mental health. We do not have points of contact to, for example, speed up. It is not that it is preferred, but that we must speed up some processes, I can specifically tell you, I work with those who are leaving institution and need to reintegrate into the community. Those cases can’t comply with the sensitivity of the bureaucratic system that wants the veteran to be present to coordinate an appointment; he is in prison, I have to coordinate the appointment for when he leaves. So the perception, the stigma ... we have to sometimes beg for services and it is very complicated and when we knock on doors, many times that perception and that stigma is a barrier in the services we provide.”</p> |
| VA and non-VA Communication | <p>“There are times when the veteran needs laboratories, medical orders, x-rays, and we don’t have those available. Communication with other clinics, even though when we knock on doors, and they open maybe isn’t as agile as we would need to because that veteran is on the streets today”.</p> <p>“We have a lot of situations... the perception in the hospital [sometimes is, this] is not a place for homeless veterans.”</p> <p>“I have veterans stagnant in my program because they don’t have income, they are homeless without family support, and they have medical conditions that require assisted living. Now, we call the Family Department of Puerto Rico and ASSMCA and the ball keeps rolling back to VA...There is no real housing permanent plan because the veteran doesn’t have the resources... The government says they don’t have funds. There is no money to care for them.”</p> |
| Mental Health and Substance Use | <p>“You help them with the apartment, you ease their way into hospital services, and they really see you as a resource... but when we say “enough” ... a hospitalization is medically and clinically adequate. They don’t want to go. One has to fill a 408 and you have to change providers or try to ease things to continue with the veteran”.</p> |
| Legal Problems | <p>“When they are looking for a job, they are requested their criminal record and even when looking for housing because some sexual offenders are disqualified from housing, but if you are 60 years old you can qualify for an elderly home without being sexual offender, but they limit them because they ask for a clean criminal record. You are limiting housing options to people who don’t have any income because of legal status”.</p> |
| Social & Life Skills | <p>“Of the problems I have encountered with these veterans one is the capacity of living independently... like maintaining a clean house, cook, grocery shopping, do a budget... when HUD VASH gives them an apartment; its 4 walls and no plates, cups, bed, personal hygiene items, toothpaste, and they are almost a month depending 100% of what the homeless program can supply...and there you encounter some veterans that decide to stay or go back to what they know; which is the streets and opt out or you get veterans who continue their dependence on the program”.</p> <p>“Living independently requires the veteran to assume roles, for example, responsibilities as maintaining a clean apartment, pay utility fees, and when they were in the streets, they didn’t have that”.</p> <p>“They don’t know what a healthy recreation is and in a lot of cases, I could say 80% recreation is going to the doctor or being with the social worker”.</p> |

DISCUSSION

Homeless providers perspectives provide us with an insight on the barriers and limitations the veteran homeless community face in their road to social reintegration, quality of life, and housing security. Results from the focus groups highlighted difficulties

not only related to when veterans first request services at the VA Caribbean Healthcare System Homeless Program, but while receiving services how difficult it is to maintain housing security and socially reintegrate to society. It is important to draw attention to the fact that for some homeless veterans the Homeless Program represents the primary source of direct

support, and they may have untreated medical complications. Therefore, the availability of services beyond housing is crucial. Both physical and mental health conditions may be exacerbated by living conditions, lack of healthcare services, violence, trauma, nutrition deficiencies, among other factors. If we add experiences regarding stigma, discrimination, and mistreatment when approaching healthcare services, the Homeless Program is then the most seeming option for veterans to feel secure, understood, and served.

Even when the Homeless Program has resources, they are limited within the scope of what the program was design to do which is to provide housing assistance. During the focus group, the examination of expectations homeless veterans had of the program, the resources the program has, and the difficulties contacting services inside and outside the hospital was brought into discussion. VA facilities are known to have limited ability to attend non-healthcare related needs (transportation, job training, and clothing) compared to non-VA facilities (Adler et al., 2015). As veterans resort to the Homeless Program for their primary source of assistance they sometimes expect the Program to provide services related to physical and mental health, nutrition, recreation, and occupational opportunities outside the scope of the Program. These discussions sometimes bring disappointment, in part due to negative previous experiences in the hospital and the community. When providers try to contact services within the VA or in the community the experience becomes an extension of the stigma veterans face. Building on how the Homeless Program is designed to help the person develop a permanent plan for obtaining and maintaining housing these coordination difficulties exacerbate program re-admission. Providers reflected on how they the lack of urgency and overall assistance sometimes does not consider that these veterans are currently living on the streets and in potential unsafe conditions.

To increase public alliances and address that lack of collaboration, Michelle Obama and leaders from HUD, VA, USICH and the National League of Cities launched the Mayors Challenge, a commitment between them and mayors, governors and county and city officials to end veteran homelessness in their cities through a series of resources and homeless assistance programs (US Department of Housing and

Urban Development, 2015). Out of the 883 leaders who decided to be involved in the initiative, less than 5 were from Puerto Rico. Initiatives like those which provides information, guidelines and provisions for communication and action are extremely important in the road toward ending veteran homelessness and have city officials committed to action. This is particularly important in cases where bureaucratic processes limit and hinder service provision (e.g., justice system, housing assistance, health, and mental health). In the case of the justice system is important to highlight how the homeless population is highly stigmatized and associated with violence; often facing “negative circumstances that have an impact on eligibility for and the retention of permanent housing” (Semeah, et al., 2017). Therefore, the ways in which processes may be hindered for the lack of understanding and bureaucratic inflexibility can directly impact housing security. Moreover, some of those restrictions for housing refer to previous criminal history and type of crime committed like in the case of sexual offenders where zones in which they can live are restricted and background checks may influence the consideration of prospective landlords.

Another of the service provisions affected by the lack of fluency is mental health. HUD-VASH often serves homeless veterans with medical and mental health vulnerabilities and/or substance use disorders (Chinchilla, et al., 2019). In Puerto Rico, 79% of homeless veterans have been diagnosed with psychiatric disorders and 55% with substance use disorders (Rivera-Rivera & Villarreal, 2021). The most common diagnosis affecting these veterans are major depression disorder (50.4%), drug-induced disorders (14.5%), generalized anxiety disorder (15.3%), and post-traumatic stress disorder (PTSD) (12.5%) (Rivera-Rivera & Villarreal, 2021). PTSD has become predominant after Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF)/Operation New Dawn (OND) conflicts and it can be further developed by traumatic events after military service (Carlson, et al., 2013). Homeless veterans are also twice more likely than their counterparts to attempt suicide in their lifetimes (Benda, 2005; Kline, et al., 2009). Most common substances used by homeless veterans in Puerto Rico are alcohol (41.4%), and drugs such as cocaine (35.1%) and cannabis (21.6%) (Rivera-Rivera & Villarreal, 2021). Independent living or abstinence plans

becomes difficult to the homeless veteran due to their deteriorating health, nonetheless, some housing programs regularly require that the veteran is functionally independent and sober (Hutt, et al., 2017). Furthermore, providers also remarked on how service provision and therapeutic alliances may suffer due to involuntary hospitalizations to psychiatric hospitals.

Recreational services were another of the provisions affected by the lack of support. Providers emphasized the difficulties these veterans faced by not having social and recreational skills and opportunities to develop them. This is particularly important because social impairment affects the ability of veterans to receive and maintain housing (Gabrielian et al., 2019). Research has found a positive correlation in the importance of treatment environment where patients that participate in more recreational and social activities have an increase in social support (LePage et al., 2006). Unfortunately, the lack of resources imposes a barrier to homeless veterans to achieve healthy behaviors and independence as reported by the providers. The incorporation of social skills training and the identification of recreational activities by psychologists and recreational therapists may be useful to this population. This may be particularly important because roles may be limited or different during homelessness experiences and reintegration demands and responsibilities may require skills they have not yet developed or practiced in some time. Sometimes this prolongs the dependence on the Homeless Program hindering independent living. As a result, the development of recreative, occupational and psychological interventions that directly target these skills may prove successful. Considerations of willingness and needs of the veterans may be taken into consideration using Trauma Informed Care and Motivational Interviewing which have been proven successful with this population (Dinnen, et al., 2014; Santa Ana, et al., 2016). These interventions may aid the veteran feeling more empowered and comfortable while making their new house their home.

One final aspect of the discussion these focus groups brought was the changes in the profile of the homeless veteran. Younger veterans from OIF/OEF/OND represent a 3% of the homeless veteran population referred to the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) Program (Tessler, et. al., 2002).

OEF/OIF/OND homeless veterans are mostly diagnosed with PTSD and/or mood disorder and substance use disorder (Kline, et al., 2009; Bennet, Elliot & Gollub, 2013). For Caribbean homeless veterans they are mostly unmarried, white, in their late 30s and without incarceration experience (Rivera-Rivera, Villarreal, 2021). Also, for OEF/OIF veterans there has been a prevalence of severe problems related to social functioning (Resnik, et al., 2012) and a risk factor for PO-related overdose and a barrier to accessing services is high degrees of social isolation (Bennet, Elliot & Gollub, 2013). This may represent an opportunity towards doing more client-centered interventions that include not only what we know about veteran homelessness, but what new generation of veterans display.

Strengths & Limitations

Our Plan-Do-Study-Act has several strengths. By taking a qualitative approach we were able to explore the richness of themes around barriers for care and readmission. By holding two separate focus groups composed of different providers we ascertain issues were still relevant after time. There are, however, several limitations. This was a single VA Quality Improvement Process and such generalizability to other Homeless Programs from the VA may be limited. Nonetheless, we believe that what our participants shared may represent what other studies have identified.

Interpretation within the context of the wider literature

Being a homeless veteran provider demands a compromise with social justice principles and trauma-sensitive interventions to avoid revictimization and further social oppression. Efforts have been made to recognize the cultural and interpersonal competency providers working with this population need and increase positive Primary Care experiences while lessening institutional stigma with the inclusion of the Homeless Patient Alignment Care Teams or H-PACTs in the VA (Jones, et al., 2019). However, not every VA meets the requirements for having this multidisciplinary team, which aggravates the institutional fragmentation the homeless veteran face. There are a multitude of limitations towards care for this population (e.g., institutional, legal, cognitive, social, recreational, financial, etc.) recognized in the

literature and Quality Improvement Projects are ways to lessen the difficulties this vulnerable population and its providers experience.

Implications for policy, practice, and research

Taken together these homeless providers perspectives suggest changes that could increase the effectiveness of the Homeless Program. These changes include institutional educational initiatives to reduce stigma and increase knowledge about the Homeless Program services and eligibility requirements. They also include the consideration of areas such as mental health, medical services, occupational health to provide a more comprehensive assistance to homeless veterans. Furthermore, there appears to be a need for better VA intra-services communication and collaboration alliances from non-VA parties. On the other hand, social skills, affordable housing, employment opportunities, family education and involvement are becoming crucial in the decisional process between social reintegration and readmission of homeless veterans. Research implications of this Plan-Do-Study-Act include stigma, mental health, resource related services and program evaluation. Future research should consider these areas to align efforts with the VA Homeless Program and directly benefit this population.

CONCLUSION

The problems and needs of homeless veterans are like those affecting the general homeless population, where care and limitations for a successful reintegration are common underlying themes. The presence of institutional stigma disrupts the effectiveness of service provision, alienating homeless veterans from much needed aid. For those who request services the lack of resources and the difficulties coordinating assistance from both VA and non-VA providers limits the successful road to quality of life and house security. No veteran should be homeless and improving service delivery within the VA should help us eradicate this social justice problem.

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