

**Reintegration of Homeless Veterans into Society**

**BY**

**STEPHANIE BUTLER**

A thesis submitted

in partial fulfillment of the requirements for the degree of

Master of Arts in Forensic Psychology

California Baptist University

School of Behavioral Sciences

2017

© 2017  
Stephanie Butler  
All Rights Reserved

**DEDICATION**

I would like to dedicate this thesis to my family and friends for always supporting me through all my life's adventures. Without their love and support all these years I would not have come this far. To my uncle, KC Blake, for always loving me and taking pride in my accomplishments. To my grandma, Audrey Blake, for being my first teacher and instilling in me a thirst for knowledge. To my grandpa, Bruce Blake, for igniting a fire in me to help others and being my model of joy. And to my mother, Polly Butler, for being the greatest mother alive and sacrificing so much to help me be successful. It is only through my mother's love and devotion that I have been able to reach my goals.

To Cynthia Keating, Megan Crandell, and Amanda Wells, who are more like sisters than friends. All the love, support, and laughs have kept me going through the trials and tribulations I have faced.

### **ACKNOWLEDGMENTS**

First, I would like to acknowledge California Baptist University for my acceptance into the Forensic Psychology Graduate program and allowing me to further explore my career interests.

Next, I would like to acknowledge the amazing professors that guided and shaped my thesis and goals for my future. I would like to specifically mention Dr. Jenny Aguilar, Dr. Ana Gamez, Dr. Anne-Marie Larsen, and Professor Troy Hinrichs. The kindness and guidance provided by all, exceeded my every expectation. I am so grateful to have been given the opportunity to learn from these incredible individuals.

Lastly, I would like to acknowledge fellow graduate students Morgan Crater, Elisabeth Knopp, and Anyssa Llerena for their advice, friendship, and guidance during this process.

**ABSTRACT OF THE THESIS**

Reintegration of Homeless Veterans into Society

by

Stephanie Butler

School of Behavioral Sciences

Anne-Marie Larsen, Ph.D.

Thesis Committee Chairperson

2017

Due to the nature of military culture and combat exposure homeless veterans experience a unique set of obstacles when reintegrating into society. A historical analysis was used, to test the theory that Iraq and Afghanistan veterans face inter-related problems with regards to mental disorders and societal functioning. As expected, Post-Traumatic Stress Disorder (PTSD) and Substance use were reported within the homeless veteran population. The experience of Military Sexual Trauma has been found to be a cause of PTSD. These disorders have an effect on the employment possibilities and potential for crime in homeless veterans.

## Table of Contents

DEDICATION.....	iii
ACKNOWLEDGMENTS.....	iv
ABSTRACT OF THE THESIS.....	v
Table of Contents.....	vi
Chapter 1.....	1
The Problem Statement.....	1
Problem Statement.....	1
Purpose of the Study.....	2
Research Questions/ Objectives.....	2
Delimitations.....	3
Assumptions.....	3
Definition of Key Terms.....	3
Military Sexual Trauma.....	3
Post-Traumatic Stress Disorder.....	3
Substance Use.....	4
Supported Employment.....	4
Theater of War.....	4
U.S. Department of Veteran Affairs.....	4

Chapter 2.....	5
Review of the Literature .....	5
Disorders .....	6
Substance Use .....	7
Post-Traumatic Stress Disorder .....	8
Military Sexual Trauma .....	9
Gender Differences in MST .....	12
MST and Disorders .....	14
Employment .....	16
Supported Employment Programs .....	16
Employment and Disorders .....	19
Crime .....	20
Incarceration .....	21
Incarceration and Disorders .....	23
Veterans Court .....	24
Iraq/Afghanistan Veterans .....	26
Disorders .....	27
MST .....	29
Employment .....	29
Crime .....	30

Subject Biographies .....	31
Tom Woods .....	31
Nathan .....	32
Gena Smith .....	32
Chapter 3.....	33
Method .....	33
Participants .....	33
Design .....	33
Procedure .....	33
Chapter 4.....	35
Results .....	35
Post-Traumatic Stress Disorder .....	36
Alcohol Use Disorder .....	46
Tom Woods .....	46
Nathan .....	47
Gena Smith .....	48
MST .....	48
Tom Woods .....	48
Nathan .....	48
Gena Smith .....	48



Employment Problems .....	49
Tom Woods .....	49
Nathan .....	49
Gena Smith .....	49
Crime and Arrests .....	50
Tom Woods .....	50
Nathan .....	51
Gena Smith .....	51
Summary .....	51
Chapter 5.....	53
Discussion .....	53
Limitations .....	55
Future Research .....	55
References.....	57
APPENDICES.....	69
APPENDIX A .....	70
APPENDIX B .....	79

## Chapter 1

### **The Problem Statement**

In recent years, the U.S. Department of Veteran Affairs (VA) has prioritized ending homelessness among veterans as the top goal of the department (Tsai, Kaspro, Rosenheck, 2013). However, there still remains a large population of homeless veterans, in the 2015 Annual Homelessness Assessment Report (AHAR) to Congress the point-in-time estimate of homeless veterans was 11% of homeless individuals were veterans. Although this number may seem low, the U.S. Department of Housing and Urban Development suggests that veterans are at a greater risk for homelessness than their civilian counterparts (Tsai, Link, Rosenheck, & Pietrzak, 2015). Many military veterans have been exposed to the risk of mental health disorders due to the experience of war. This risk only heightens, when returning to society is mixed with the experience of homelessness, as homelessness has its own risk factors. Previous studies have been done showing the presences of mental disorders and their effects on reintegrating into society with homeless military veterans.

### **Problem Statement**

Homeless United States veterans from the Iraq and Afghanistan wars face a unique set of factors when integrating

back into society due to traumatic events experienced during active military duty.

### **Purpose of the Study**

This study examines what mental disorders are more prominent in homeless United States military veterans. Due to the nature of war and the experience of being homeless, many mental health issues may be comorbid. It is important to discover the type of mental health issues this population faces and the effects these disorders have on all aspects of life in order to understand the problems homeless veterans face. These findings may help researchers formulate a way in which to prevent these mental health problems from occurring and to create programs to assist homeless veterans in multiple aspects of life.

### **Research Questions/ Objectives**

This research assesses the prevalence of mental disorders within the homeless veteran population. A high rate of Post-Traumatic Stress Disorder (PTSD), and Substance Use are expected to be found. It is expected for these mental disorders to affect employment and incarceration rates. These disorders are also expected to be comorbid with Military Sexual Trauma (MST).

**Delimitations**

This study covers research from multiple states, due to the nature of the government documents available. The research will only cover homeless military veterans and not non-homeless military veterans or nonveteran homeless. Only Iraq and Afghanistan veterans will be subjects. Substance Use and PTSD are the only mental disorder categories that will be covered.

**Assumptions**

All previous research on mental health issues in the homeless veteran population will be assumed as accurate. The anecdotal archived data on the subjects used will be assumed as truthful and accurate.

**Definition of Key Terms**

**Military Sexual Trauma.** This term is used by the Veteran Affairs and U.S. government to refer to trauma associated with "sexual harassment and/or sexual assault experienced by military personnel during active duty service" (Mondragon et al., 2015, p. 402). This term encompasses unwanted sexual attention, sexual coercion, sexual assault, and gender harassment (U.S. Code, Title 38, §1720D).

**Post-Traumatic Stress Disorder.** A pervasive pattern of psychological disturbance that lasts longer than a month and impairs social, occupational, and other important areas of

functioning due to a traumatic experience happening to the self, or a loved one (American Psychiatric Association [APA], 2013).

**Substance Use.** A problematic pattern of behavior related to the use of substances leading to significant impairment with social, occupational, or other important functioning due to the dependence on a substance (APA, 2013).

**Supported Employment.** This model of assisted employment was created to facilitate "individuals with severe mental illnesses obtain employment beyond transitional work, in permanent jobs in the competitive economy" (Resnick & Rosenheck, 2007, p. 868).

**Theater of War.** An area of air, land, or water "that is, or may become, directly involved in the conduct of major operations and campaigns involving combat" (U.S. Department of Veteran Affairs [VA], 2016, para. 41).

**U.S. Department of Veteran Affairs.** The VA is a governmental department created:

to serve America's Veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive medical care, benefits, social support, and lasting memorials promoting the health, welfare, and dignity of all Veterans in recognition of their service to this Nation (VA, 2016a, para. 10).

## Chapter 2

### Review of the Literature

Military veterans often face a risk of homelessness when returning from duty. Veterans are more likely to experience chronic homelessness compared to civilians due to the greater frequency of disabling physical or psychological conditions, due to experiences within the military (Woolsey & Naumann, 2015). Veterans face a unique set of risk factors when reintegrating into society, most notably is the presences of mental disorders including PTSD (Woolsey & Naumann, 2015). In the 2009 AHAR 53% of homeless veterans were experiencing some type of physical or psychological disability (Balshem, Christensen, & Tuepker, 2011). Disabilities can include physical problems, mental disorders, and substance use.

These disabilities are not uncommon in the civilian population, however the unique experience as a veteran may alter the pathway to which they develop the risks of becoming homeless (Balshem et al., 2011). Due to the All-Volunteer Force (AVF) structure of the current military, more individuals are exposed to combat. Intense and prolonged combat exposure or Military Sexual Trauma (MST) have been found to be comorbid with PTSD (Balshem et al., 2011; Rosenheck & Fontana, 1994). As a result of psychological trauma, many individuals will turn to substance

abuse. Within the veteran homeless population these disorders may cause problems with employment and incarceration or crime.

### **Disorders**

Mental disorders are characterized by causing severe impairment in functioning in social, occupational, or cognitive abilities. Mental disorders are a common component seen within the generalized homeless population. It is even more prevalent in the veteran homeless population, due to exposure to war or other stressful experiences, which can lead to trauma and subsequent mental disorders. The most common disorders seen within both Veterans and their homeless counterparts are PTSD and Substance use (Balshem et al., 2011). These disorders are inter-connected as potential risk factors for homeless status of United States Veterans. There is an association between combat stress, PTSD, and substance use (Rosenheck & Mares, 2007). When looking at the reintegration of homeless veterans into society, it is important to look at the mental health disorders that they may face. Veterans that have been deployed experience many stressful situations which have shown to "increase risk for post deployment mental health morbidity" (Horton et al., 2013). Mental disorders directly affect all aspects of the reintegration process.

## **Substance Use**

In the American homeless population, the rates of alcohol and substance use are similar between veterans and non-veterans (Woolsey & Naumann, 2015). It is widely assumed that substance use is highly correlated with homeless status. As many veterans face combat and stressful situations, substances can be used to alter the perception of reality. There is evidence to suggest that military culture increases the likelihood for drug and alcohol use (Balshem, Christensen, Tuepker, & Kansagara, 2011). This is reflected in the statistics showing that there is higher prevalence of alcohol use in Veterans compared to general populations. Woolsey and Naumann (2015) found that 59.68% of the total sample had a substance use disorder and within that 59.68%, 53.76% had both a drug and alcohol use disorder. Another study found that 40% of male Veterans had used alcohol compared to 25% of male civilians (Balshem et al., 2011). It has also been reported that more than one in six active duty personnel is likely to be a heavy drinker (Balshem et al., 2011).

Although the military does not condone illicit drug use, the use of alcohol is still permitted during active duty. The service members can use alcohol as a way of bonding with others or as a coping strategy for the stress they may endure. The influence of this military drinking culture can shape post-service behavior. It was found that younger service members that



have been deployed to combat are more likely to develop new alcohol use problems post-deployment. Further analysis found that this risk is even greater among the veterans diagnosed with PTSD (Balshem et al., 2011).

### **Post-Traumatic Stress Disorder**

One of the risk factors that is almost completely unique to homeless veterans is the presence of Post-Traumatic Stress Disorder (PTSD). Historically the type of trauma that is most closely related to military service has been PTSD. There has been extensive research that has "consistently found an association between prolonged or intense combat exposure and an increased risk of a PTSD diagnosis" (Balshem et al., 2011, p. 29). Not all military service includes combat exposure, however, in times of conflict exposure to traumatic events is more likely, which can cause both mental and bodily injuries. The advancement in military medicine has increased the survival rate of physical injuries due to battle, which in turn has caused a high rate of service members coping with "serious physical impairments along with the psychological consequences of injury and combat exposure" (Schnurr, Lunney, Bovin, & Marx, 2009, p. 728). Rosenheck and Fontana (1994) found that individuals that had served in longer tours of duty reported higher stress as a direct result of various traumatic experiences. The effects of PTSD vary across many domains in an individual's life including

social, marital, family, occupational, and interpersonal functioning. The changes in a single aspect of one's life can result in corresponding changes in another aspect of life, making this disorder highly debilitating. Due to the crippling nature of the disorder, many homeless veterans have low quality of life satisfaction. The National Vietnam Veterans Readjustment Survey found PTSD to be correlated with "extreme isolation and extreme unhappiness" (Balshem et al., 2011, p.31). Emotional well-being is directly affected by the experience of PTSD.

### **Military Sexual Trauma**

MST is used to describe physical and emotional trauma due to sexual assault or harassment during the time of active duty. Characteristics that are unique to MST is the loss of identity and military structure's impact on retraumatization (Northcut & Kienow, 2014). MST differs from other types of trauma because the survivor's mind and body are violated. It is important to understand the framework of military culture when considering the loss of identity associated with MST. Military culture is predominately dominated by rank structure, camaraderie, and paternalistic beliefs of higher ranking individuals protect those beneath them (Northcut & Kienow, 2014). While one is in the military, complete obedience and a sense of collective responsibility is expected. The individual is to diminish their individuality and personal identity, in order to form a new

personal identity of based off squadron, branch of service, and rank. MST may leave an individual feeling betrayed by their environment, and rejected by their organization, leaving them without a personal identity (Northcut & Kienow, 2014).

The military culture not only can cause a lack of personal identity, but also retraumatization and stigma for MST survivors. MST survivors commonly live or work with their perpetrators after their trauma, some may even be dependent on or report to their perpetrator (Foster & Vince, 2009). This power dynamic may cause the individual to fear reporting their superior or comrade. The structure of the military may keep the service member that experienced MST powerless or susceptible because their perpetrator may be near them due to housing or work arrangements (Eckerlin, Kovalesky, & Jakupcak, 2016). If an individual does report the assault or harassment they may be "accused of breaking unit cohesion" (Foster & Vince, 2009, p. 34), or not believed or trusted by other personnel. The stigma attached to MST can may hurt an individual's military career (Foster & Vince, 2009; Northcut & Kienow, 2014). MST is significantly correlated with separation or retirement from the military (Eckerlin et al., 2016).

Due to the trauma occurring during active duty, any further encounters with the military may cause retraumatization. This can include the contact with the VA for assistance with

health care, housing, and any other benefits offered. In these circumstances the "survivors are surrounded by representatives of the perpetrators and the military personnel who did not support them in their time of need" (Nortcut & Kienow, 2014).

The United States Government has seen an increase in military personnel that were sexually assaulted, with a rise of 7,000 more cases in 2012 than in 2011 (Northcut & Kienow, 2014). The VA (2016b) reported about one-in-four women, and one-in-one hundred men report experiencing MST when screened by the VA. Although more women report MST than men, the rates of men in the military are higher. When considering the actual percent of men and women that report MST the two genders are about equal (Suris & Lind, 2008; VA, 2016b). The numbers reported by the VA are only give a glance into the problem, because these are veterans that have reported it when seeking VA health care. Not all veterans will seek VA support and many MST cases may go unreported. The Department of Defense estimates that 81% of men and 67% of women do not report their experience with MST (O'Brien, Keith, & Shoemaker, 2015). Although this is an experience that may occur to both genders, the bulk of the research has been on the effect of MST on women (O'Brien et al., 2015; Schry et al., 2015).

### **Gender Differences in MST**

The reports regarding the number of women military personnel that have experienced MST vary, however not by much. The VA (2016b) reported one-in-four women, while Suris and Lind (2008) reported one-in-three female veterans. These rates are still higher than the civilian population, which is reported to be one-in-six women that face sexual assault (Foster & Vince, 2009). Women entering the military at a young age, or without a collegiate education, or that have experienced assault (physical or sexual) prior to entry of service have been found to be more likely a victim of MST (Foster & Vince, 2009; Suris & Lind, 2008). Recent research has identified MST as a risk factor for homelessness among women veterans (Gunter-Hunt, Feldman, Gendron, Bonney, & Unger, 2013). Hamilton, Poza, and Washington (2011) found in a survey of homeless women that all the women in the study believed homelessness and MST "go hand-in-hand" (p. 206). Pavao et al. (2013) found that 53.3% of homeless women veterans reported sexual assault during active duty. The rates of lifetime sexual trauma are higher among homeless individuals than those that are not homeless (Pavao et al., 2013). Overall women veterans are four times more likely to be homeless than civilian women (Gunter-Hunt et al., 2013).

As said before, most research regarding MST has focused on women service members and even the VA screened for only women

with MST until recently. The law now specifies that the report to Congress by the VA must include the number of individuals receiving care for MST, not just women (Eckerlin et al., 2016). The 1% (Suris & Lind, 2008), or 1.6% (Pavao et al., 2013) of men with MST experience may look low, however when adjusted for the amount of men in the military the actual amount of men compared to women with MST experience is about equal (Suris & Lind, 2008). Approximately 54% of all MST positive VA screens are men (Suris & Lind, 2008). The literature regarding men and MST focuses on the barriers involved in reporting MST due to military culture and gender. Researchers have found barriers related masculinity, sexual orientation, gender role expectations, and type of report (Eckerlin et al., 2016; Turchik et al., 2013). In the military, there are two types of reports for MST: restricted and unrestricted (Eckerlin et al., 2016). A restricted report allows the victim to receive treatment and counseling while remaining anonymous. However, if a member would like adjudication along with treatment, an unrestricted report must be filed. With an unrestricted report the possibility of facing the perpetrator in court or the investigation becoming public is common. This may deter male victims from reporting due to the stigma attached with MST.

Men in the military are expected to be hyper-masculine, heterosexual, and physically strong (Eckerlin et al., 2016;

Mondragon et al.,2015). It is within this stereotype that rape myths and stigma are born. Rape myths such as "men don't get raped"; "male on male rape is about homosexuality"; and "strong men don't get raped" often are reported by those men who have experienced MST (O'Brien et al., 2015). Due to these myths, many men fear that they will not be believed when reporting sexual assault to others (O'Brien et al., 2015; Turchik et al., 2013). Male's may experience shame or self-blame due to the myth that only weak men get raped (Mondragon et al., 2015). The experience of MST may leave members feeling stripped of their masculinity and further stripped of their masculine military identity. This shame and embarrassment can lead to fear that the report will not stay confidential (Turchik et al., 2013). Men seeking services for MST may have more concerns regarding stigma than women. Turchik et al. (2013), found that 100% of the male participants were concerned with at least one stigma-related barrier.

### **MST and Disorders**

Unlike PTSD and substance use, MST is not a diagnosis, it is an experience. However, MST is a significant traumatic event that precedes the development of mental health disorders and is related to poorer post-deployment adjustment to civilian life (Mondragon et al., 2015). Mental disorders such as PTSD, substance use, and depression are often reported in individuals

that have experienced MST (Gunter-Hunt et al., 2013; Hamilton et al., 2011; Pavao et al., 2013; Suris & Lind, 2008). Military sexual harassment has been found to be significantly associated with PTSD symptoms within women (Gunter-Hunt et al., 2013; Pavao et al., 2013; Suris & Lind, 2008). Pavao et al., (2013) found that MST increased the odds of a PTSD diagnosis six-fold for women and four-fold amongst men. However, in a Gilmore et al. (2016) found men with MST experience were more likely to have a diagnosis of PTSD than women with MST. MST is considered to be a greater contributing factor to the development of PTSD symptoms than other stress related active duty experiences (Mondragon et al., 2015). The effect of sexual harassment on mental health was found to be greater in men than in women (O'Brien et al., 2015). Turchik et al., (2013) found male veterans with PTSD were most concerned about stigma in regards to barriers of reporting.

Women veterans that are victims of MST are more likely to report substance use disorders (Gunter-Hunt et al., 2013). Participants in the study by Hamilton et al., (2011) stated that substance abuse was a way to cope with the trauma from day to day. Suris and Lind (2008) found that women with MST were twice as likely to have substance abuse problems than women with no MST experience. In comparison to women, men are more likely to report alcohol abuse associated with MST (Suris & Lind, 2008).



Gilmore et al. (2016) found that men had greater odds of having only substance use disorder or only PTSD in comparison to women.

### **Employment**

The relationship between the status of homelessness and employment is a multidimensional issue, lack of employment can lead to homelessness, but it is difficult to obtain a job once homeless due to lack of resources. Dunne et al. (2015) reported that 64.4% of nonveterans and 45.8% of veterans credited unemployment for their status as homeless. In the veteran population, combat exposure may increase the possibility of unemployment when returning to civilian life. In comparison to non-combat veterans, the military service members that experience combat are more likely to have increased rates of unemployment when initially returning to society and throughout their lives (Balshem et al., 2011). This may be due to the increased likelihood of mental disorders within combat veterans as discussed earlier. To assess the unemployment problem within the homeless population, supported employment programs have been created to assist veterans with finding and maintaining employment.

### **Supported Employment Programs**

The VA has provided compensated work therapy programs since the 1970s (Leddy, Stefanovics, & Rosenheck, 2014). At the beginning of the implementation of these employment

opportunities the veterans were offered jobs within sheltered workshops. The programs evolved to emphasize the transitional work experience which includes noncompetitive employment in both therapeutically managed VA jobs and community employers (Leddy et al., 2014). In these programs the employers establish a contract with the VA, which then pays the veterans an hourly wage. There is no actual contract between the employee and the employer (Resnick & Rosenheck, 2007). An expansion of the VA employment program occurred when Veterans Health Care, Capital Asset and Business Improvement Act of 2003 was signed into law. This act supported employment programs as a routine part of VA compensated work therapy programs. A few months later in 2004, the Secretary of Veterans Affairs allocated 6 million dollars to the implementation of supported employment as an endorsement of the President's New Freedom Commission on Mental Health (Resnick & Rosenheck, 2007).

The key component to supported employment is the integration of mental health services and the search for competitive employment. Competitive employment can be defined as a job that pays at least minimum wage and is in a community setting which is not reserved for people with disabilities (Marshall et al., 2014). The supported employment programs differ from traditional compensated work therapy programs, because the worker is directly paid by the employer and is

considered to *own the job* (Resnick & Rosenheck, 2007). Rather than the VA filling the position with veterans as needed, the veteran is directly employed. The model of this type of program comes from individual placement and support, which is used to help veterans obtain a position in competitive employment. The program's structure "...ensures that the link between work performance (productivity and presentation) and health behaviors (sobriety and use of addiction services) to job rewards (wages, hours, and responsibilities) are not undermined by the vicissitudes of labor markets" (Kashner et al., 2002, p. 938). Another main difference includes the individual's desire and self-determination to work in a competitive setting, where the traditional programs look at work readiness instead of desire (Pagoda, Cramer, Rosenheck, & Resnick, 2011).

These programs focus on reintegrating homeless veterans into society, through use of competitive employment and mental health services, as well as the individual's desire to work. These key components of the program have shown there is a higher rate of success with employment rates of homeless veterans (Leddy et al., 2014; Marshall et al., 2014; Resnick & Rosenheck, 2007). The focus on the individual has been shown to increase the likelihood in the individual engaging in work with a greater number of hours worked, as well as, higher income (Leddy et al., 2014). Individuals participating in these programs show "...

improved self-esteem, quality of life, social inclusion, and psychiatric symptoms" (Leddy et al., 2014, p.162).

### **Employment and Disorders**

Supported employment programs are developed to assist individuals with mental disorders maintain competitive employment. The majority of research regarding employment and disorders focuses on the impact of supported employment on mentally ill individuals. In the homeless veteran population, combat-veterans with PTSD are significantly less likely to be employed (Resnick & Rosenheck, 2008). The more severe a case of PTSD the less likely an individual is to have full time employment. Individuals with disorders may still express interest in working in a competitive market. Mares and Rosenheck (2006) found that individuals with mental disorders that desire to work and made an effort to find work were significantly more likely to be employed one to two years after initial hiring. In individuals with substance disorders, the employment by a Compensated Work Therapy program was associated with a higher use of addiction services (Kashner et al., 2002). Rosenheck & Mares (2007) found, that veterans with substance use disorders that did not have comorbid psychiatric illnesses showed significant employment gains from supported employment. It was also found that the same magnitude of significance of employment gains was found for those with mental disorders (2007). Davis et

al. (2012) found individuals with PTSD that participated in individual placement and support employment were 2.7 times more likely to gain competitive employment.

### **Crime**

As previously noted, substance abuse is replete within the homeless veteran population. Due to the nature of substance use, crime can be present within the population due to the possession or use of illegal substances. Outside of substance use, prior psychiatric hospitalizations are significantly associated with committing a crime (Balshem et al., 2011; Benda, Rodell & Rodell, 2003). Not only are these risk factors, but public policy such as the Sacramento City No-Camping Ordinance, which makes it unlawful for an individual to camp on public property not determined for camping (Sacramento City Code, § 12.52.030.), increase the risk of a homeless individual committing a crime, due to the criminalization of activities necessary to survive while homeless (Woolsey & Naumann, 2015). This criminalization of activities associated with being homeless increases the risk of being incarcerated leading to a cyclical pattern of incarceration and homelessness. The amount of risks that may lead to crime within the homeless population is large and has resulted in a portion of the homeless veteran population being incarcerated.

**Incarceration**

Homeless individuals have an increased risk of incarceration, due to the negative outcomes associated with release and the lack of social support (Balshem et al., 2011; Tsai, Rosenheck, Kaspro, & McGuire, 2013). There is a bidirectional relationship between the risk factor of homelessness and incarceration, suggesting that there may be a cyclical pattern present among individuals that have been homeless or incarcerated (Woolsey & Naumann, 2015). Tsai et al. (2013) found in their sample of incarcerated veterans, that 30% were homeless or had a history of being homeless. This is "five times the 6% rate of past homelessness" among the general population (p. 360). Research on the type of crime committed by homeless veterans has mixed results. In some studies, homeless incarcerated veterans are less likely to become incarcerated for a violent offense, more often for misdemeanors such as drug offense, parole violation, or a property offense (Benda et al., 2003; Tsai et al., 2013). These studies have found arrests of homeless veterans also correlated with substance abuse offense, such as public intoxication. Rather than committing crimes with intent, homeless veterans are presumed to be more likely to commit crimes due to psychological problems. However, other studies report homeless veterans as committing more violent crimes (Brown, 2008; Greenberg, Rosenheck, & Desai, 2007; Noonan

& Mumola, 2007). Noonan and Mumola (2007) found that compared to an incarcerated non-veteran population, incarcerated veterans were more likely to have committed violent offenses. In the veteran population 57% had committed a violent crime, with 15% incarcerated for homicide, and 23% serving sentences for rape (Noonan & Mumola, 2007). Greenberg et al. (2007) found that the exposure to combat during tour of duty is correlated with high expression of hostility and antisocial behavior, including violence or crimes.

Arrests among the homeless veterans can be common, because many people can get treatment of disorders in prison when the individual may not be able to get help outside of the prison system. Once released from prison, Creech et al. (2015) found that "first time homelessness was significantly associated" (p. 624), suggesting that homeless veterans may have difficulty re-entering society. The difficulty in reintegration may stem from the amount of time a veteran is away from civilian life and the lack of social support for veterans and incarcerated individuals. Vietnam veterans, overtime, have had higher incarceration or criminal justice system involvement in comparison to other theaters of combat (Greenberg et al., 2007). One explanation for this is the lack of social support when the soldiers returned from war. The Vietnam War was controversial and the soldier's homecoming was negative and hostile (Greenberg

et al., 2007). Inmates are typically not released into their local communities, because of transfer within the state and federal prison system. This leads to a lack of social support when released, causing released veterans to be more likely to become homeless within a month of release (Woolsey & Naumann, 2015).

### **Incarceration and Disorders**

It has been observed that homeless persons have higher rates of contact or involvement with the criminal justice system. The deinstitutionalization processes that ended in the 1980s left a gap in available treatment for persons with mental disorders or disabilities. As a result, jails and prisons are now housing mentally ill people due to a lack of alternate options. These institutions are not trained to treat the substance use and PTSD seen in homeless veterans and the environment of these institutions may exacerbate the mental problems further (Benda et al., 2003). Within incarcerated populations substance use is highly prevalent and within the incarcerated veteran populations PTSD is prevalent (Saxon et al., 2001). It has been reported that substance abuse and PTSD commonly co-occur (Balshem et al., 2011; Woolsey & Naumann, 2015). This may be due to the use of substances to cope with the symptoms of PTSD. Saxon et al. (2001) found, "veterans who screened positive for PTSD had greater lifetime use of



alcohol...of heroin, and cocaine" (p. 961). This study further found that veterans with PTSD consistently had a higher rate of involvement with the criminal justice system stating, "the rate of positive PTSD screenings observed among jailed veterans in this study (39%) was much higher than the lifetime PTSD rate of 7.8% reported in the general population" (2001, p. 962). This is not the only time that this has been found, research found in 2003 that, alcohol and drug abuse, as well as, prior psychiatric hospitalizations were significantly associated with committing a crime within the past year (Balshem et al., 2011). Benda et al. (2003) found, "for every one standard deviation on the alcohol abuse scale, the odds of crime doubles" and "the odds of crime rise 3.5 times with each increase of one standard deviation in the drug abuse scores" (p. 339). With these odds in place, more homeless people will encounter the criminal justice system due to the lack of adequate services for homeless persons, substance abusers, and individuals with psychiatric disorders.

### **Veterans Court**

Incarceration is viewed in the justice system as being inappropriate for homeless substance abusers with mental illness that commit only nuisance offenses (Benda et al., 2003). As a result of many veterans with mental health issues and substance abuse disorders appearing on court dockets, the first specialized veteran treatment court was established. Although

there had been attempts at a process similar to this in Alaska, the first official court began January 2008 in Buffalo, New York by Honorable Robert Russell (Cartwright, 2011). The veteran court follows similar structure to drug and mental health treatment courts. The veteran court integrates mental health services, justice system case processing, and substance treatment to promote sobriety, recovery, and stability. Judge Russel states that veterans need a specialized court because they are "a niche population with unique needs" (Russell, 2009, p. 357).

Many stressors involved in military service are unique to military life and are not experienced by civilians, which is why traditional community services may not meet the treatment needs of a veteran. One key component in the processes of these courts is the involvement of veterans to help veterans. The veteran on the court docket is typically referred to a Veteran Service Representative that is also a veteran. This individual assists the veteran with developing a treatment plan (Hawkins, 2010). Veterans tend to respond favorably to working with the VSR because of shared military experiences (Hawkins, 2010). The structure of these courts integrates multiple individuals to create a complete treatment and program plan.

These courts are structured for veterans, typically with misdemeanors showing signs of mental health issues or substance

abuse, to attend court sessions, probation meetings, and work with VA representatives (Knudsen & Wingenfeld, 2016). The eligibility for a veteran to participate within the court varies by jurisdiction. The court aims to develop programs for each veteran that will address all issues and needs adequately.

Once the program requirements have been met the veteran then graduates from the program (Russell, 2009). According to the National Institute of Corrections in 2016 there were over 300 veterans courts within the United States. Preliminary findings and current research suggest that graduation from the veteran courts results in lower recidivism rates (Erickson, 2016; Knudsen & Wingenfeld, 2016; Lucas & Hanrahan, 2016; McCormick-Goodhart, 2013).

### **Iraq/Afghanistan Veterans**

After the Vietnam War in 1973 the draft was abolished and a new military structure, the AVF was established (Brown, Stanulis, Theis, Farnsworth, & Daniels, 2013). The most recent theaters of war under the AVF structure are Operation Enduring Freedom (OEF), which began when the United States invaded Afghanistan on October 7<sup>th</sup>, 2001 and Operation Iraqi Freedom (OIF), which began in Iraq on March 20<sup>th</sup>, 2003 when the United States invaded (Seal et al., 2009). The AVF structure of the military requires soldiers to serve longer deployments and they are often redeployed with very short breaks between the

deployments (Cartwright, 2011). It is estimated that at least one-third of the troops involved in OEF and OIF have been deployed more than once (Cartwright, 2011). More active duty members have been called from the Reserves and National Guard to fight in these conflicts (Cartwright, 2011). In 2008 approximately 20,000 military personnel had been deployed in OEF and OIF missions five or more times (Brown, 2008). Not only have there been more deployments in these two wars, but 70,000 military personnel have been kept beyond their scheduled discharge date (Brown, 2008). The inability to draft members into the military has caused a strain on the current military structure. Members within the AVF are not a volunteer in the typical sense of the word. The members are unable to leave their duty stations without permission, and will be court-martialed if they attempt to leave (Suris & Lind, 2008). OIF and OEF veterans are facing more combat exposure than service members of past theaters. This exposure and inability to leave their duty station may lead to higher rates of mental disturbances.

### **Disorders**

The structure of an AVF military may have effects on the mental stability of the soldiers. The advance in medicine has increased the survival rate from war wounds and blast injuries, which as a result leaves many service members to return to civilian life having to cope with physical and psychological

problems (Schnurr et al., 2009). The VA suggests that 40% of Iraq veterans will face psychological problems most closely related to PTSD (Brown, 2008). Since the beginning of the Iraq war the VA has seen a tenfold increase in veterans screening positive for PTSD (Brown, 2008). Veterans of OEF and OIF that are under 25 years of age are twice as likely to develop PTSD symptomology leading to diagnosis (Seal et al., 2009). In comparison PTSD rates were higher among reserve and National Guard veterans over 40 years of age (Seal et al., 2009). In 2008 five of the top discharge diagnoses in the VA were for psychological disorders or substance use (Horton et al., 2013).

Military veterans are more likely to report substance abuse and PTSD six months following their return to civilian life, which is significantly higher than the initial post-deployment health screenings (Brown, 2008). Seal et al. (2009) found that veterans of OEF and OIF under the age of 25 are twice as likely to develop alcohol use disorder symptomology and 5 times as likely to develop drug use disorder symptomology. This study further found that men had a significantly greater risk for drug use disorders than their female counterparts (Seal et al., 2009). Veterans with multiple deployments reported higher alcohol abuse than veterans with no deployments (Godfrey et al., 2015).

**MST**

Although MST is not a new experience within the military, the bulk of the research regarding MST and the legal components of MST screening reports began during OIF and OEF theaters of war (Foster & Vince, 2009). VA medical records of OIF and OEF female veterans indicate that 20% screened positive for MST (Foster & Vince, 2009). It is reported that 1% of men in the military screen positive for MST (Mondragon et al., 2015). However, due to the amount of men in the military this percentage seems low, but men equal approximately half of all MST screenings and reports (Mondragon et al., 2015). The rate of actual MST may be much higher given that in a 2008 Government Accounting Office report only 51 out of 103 OIF and OEF veterans reported MST to proper authorities (Foster & Vince, 2009). Stigma and fear have been reported by both gender as reasons for not reporting MST (Gunter-Hunt et al., 2013; Mondragon et al., 2015).

**Employment**

As previously stated the AVF military structure calls for service members to have multiple deployments during OIF and OEF theaters of war. Multiple deployments have been linked to disruption in family life, leading to reduced financial well-being and financial strain (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012). After years spent in the military, new veterans

may require retraining for civilian work, making it more difficult to find civilian employment (Elbogen et al., 2012). In regards to younger veterans that entered the military after high school graduation and lived on base, where basic needs are always met, may not have learned the skills needed for money management or financial independence (Elbogen, Sullivan, Wolfe, Wagner, & Beckham, 2013). Elbogen et al. (2012), found that veterans with poor money management skills had the most problems with reintegrating into society. This study also revealed a correlation between lower rates of employment and individuals with PTSD (Elbogen et al., 2012). They further found that homelessness was associated with lower income as were criminal arrests (Elbogen et al., 2012).

### **Crime**

The most recent data regarding OEF and OIF veterans in prison was collected in 2004 and reported that 4% of the state and federal prison population was made up of OEF and OIF veterans (Noonan & Mumola, 2007). This data collected did not include post September 11<sup>th</sup> attack veterans, and therefore, does not include the possibility of the effect of multiple deployments on veterans and crime (Brown et al., 2013). A study by Tsai et al. (2013) attempted to record data regarding OEF and OIF veterans and incarceration rates. This study found that the most common reason for an incarceration offense was a violent

offense (Tsai et al., 2013). Although the actual amount of veterans incarcerated or arrested is not widely reported, it has been found that alcohol related crimes increased between 2005 and 2006 (Cartwright, 2011). Veterans involved in alcohol-related offenses like "drunk driving, reckless driving, and disorderly conduct increased from 1.73 per 1000 soldiers to 5.71 per 1000 soldiers" (Cartwright, 2011, p. 302). Although drug and alcohol courts already exist, the development of veteran courts has been greatly influential on OEF and OIF veterans. These courts allow for individuals with lower offenses to gain treatment for their mental health and substance use problems. Given that these courts began in 2008, the majority of veterans using them come from OIF and OEF theaters of war (Cartwright, 2011).

### **Subject Biographies**

#### **Tom Woods**

Tom Woods was an Army sergeant that served in the Iraq conflict with the 1-4 Cavalry Regiment (Goffard, 2013). He spent 14 months in Baghdad between 2007 and 2008. His time was spent performing night raids and looking for insurgents. During his time in the military he was deployed on two tours of duty. After returning home from Iraq, Woods continued to drink heavily as he did in the military. During his time, home he showed symptoms of PTSD. Due to his drinking problem and erratic behavior his



family struggled to stay in proper housing and pay bills (Goffard, 2013).

### **Nathan**

Nathan was a homeless veteran that chose to have his last name protected due to his ongoing legal issues (Steele, 2013). He was a Navy SEAL in the Afghanistan conflict in 2005. He was a part of the single largest loss of lives for the Navy SEALs up to that point since World War II. After returning home to America, he had trouble with alcohol. His behavior changed due to symptoms of PTSD. As a result, he was arrested due to a bar fight and in the time before his court date became homeless (Steele, 2013).

### **Gena Smith**

Gena Smith was an Army intelligence specialist deployed for 15 months to Iraq in 2006 (Lasker, 2014). While deployed, she was sexually harassed and assaulted by her squad members. Upon returning home to America, she struggled with homelessness and symptoms of PTSD. She struggled with addiction to painkillers, however, her use of pain killers was not detailed enough for her to be coded in the results with a potential substance abuse diagnosis (Lasker, 2014).

## Chapter 3

### Method

#### Participants

This study utilized archival data from various sources about homeless military veterans. The sources included newspaper interviews and a personal blog.

#### Design

A historical analysis was used for this study to test hypotheses regarding homeless veterans. Historical research assists in the development of a narrative about a specific topic based on the evidence that is present (Salkind, 2012). This analysis was chosen to assess the previous research detailing the factors associated with reintegration of homeless veterans including the presence of Post-Traumatic Stress Disorder, Substance Use, military sexual trauma, employment struggles, and crime or arrests. It was hypothesized that PTSD and Substance Use would be prevalent within the population. It was hypothesized that PTSD or Substance Use would have an effect on employment. It was hypothesized that military sexual trauma would be comorbid with Post-Traumatic Stress Disorder. Lastly, it was hypothesized that Post-Traumatic Stress Disorder would have an effect on possible crime or arrests.

#### Procedure

Two checklists were created: one for PTSD, and one for Alcohol Use Disorder symptomology. An extensive search for

archival data, such as, stories, blogs, and interviews about homeless military veterans was conducted. The inclusion criteria for the subjects included military experience within the Iraq and Afghanistan conflicts, and a period of homelessness after discharge from the military. The archival data of homeless military veterans was then analyzed by entering into the checklist and coding for themes, then further placing the themes into categories of diagnostic criteria for PTSD and Alcohol Use Disorder. The anecdotal data was then analyzed for themes and coded into categories of employment problems, MST experience, and crime or arrests.

## Chapter 4

### **Results**

It was hypothesized that homeless individuals with military combat exposure would present with symptoms and potentially meet the full criteria for PTSD. It was further hypothesized that homeless individuals with military combat exposure would present with symptoms and potentially meet the full criteria for Alcohol Use Disorder. It was hypothesized that an individual with MST would present symptoms and potentially meet the full criteria of PTSD. It was hypothesized that PTSD or Substance Use would have an effect on employment. Lastly, it was hypothesized that PTSD would have an effect on possible crime or arrests.

Three subjects were used with each individual was checked against both PTSD and Alcohol Use Disorder. The archival data of all three subjects supported the hypothesis that individuals with combat exposure would show symptomology and potentially meet the criteria of PTSD. The archival data of the three subjects partially supported the hypothesis that individuals with combat exposure would show symptomology and potentially meet the criteria for Alcohol Use Disorder. The archival data of the one subject with MST supported the hypothesis that individuals with MST would present symptomology and potentially meet the criteria of PTSD. The archival data with all three subjects supported the hypotheses that PTSD or Substance Use

would have an effect on employment. Lastly, the hypothesis regarding PTSD resulting in crime or arrests was partially supported by two subjects.

### **Post-Traumatic Stress Disorder**

Symptomology of PTSD begins with an exposure to a traumatic event regarding death, injury, or sexual violence. These experiences can happen directly to the individual, be witnessed by the individual, or happen to a family member.

#### **Tom Woods**

"As a cavalry scout in Baghdad, he had crashed through countless doors on nighttime raids. The "hard knock," he called it" (Goffard, 2013, para. 1).

"As part of the "surge," the 1-4 Cavalry patrolled bomb-laden roads and went door-to-door hunting insurgents" (Goffard, 2013, His Painful Return section, para. 10).

"He told her about a pile of dogs, killed by his men and left on a corner – the barking had been giving away their presence on nighttime raids..." (Goffard, 2013, His Painful Return section, para. 13).

"They were in their 20s, most of them killed by roadside bombs. "Rushing you to the hospital was the worst day of my life," he told one" (Goffard, 2013, Then He Vanished section, para. 20).

"We lost a lot of friends, he said. When the blasted Humvees were towed back to base, Tom had to scrub the blood off the radios and ammo boxes" (Goffard, 2013, His Painful Return section, para. 14).

### **Nathan**

His mind still carries the image of 11 buddies whose remains he had to gather after a disastrous June 2005 mission in Afghanistan's Hindu Kush mountains. It was the single largest loss of life for Navy SEALs at that point since World War II: Operation Red Wings.

Three SEALs were killed in a firefight, and eight SEALs died when a rescue helicopter went down. Nathan was one of the remaining team members sent to collect the bodies and put them into bags (Steele, 2013, para. 10/11).

### **Gena Smith**

I remember these moments were the most terrifying of all of the moments I had during a long 15 month deployment. And as it turns out, when the mortars stopped, there were no enemy in Old Baqubah that night. I remember the firefights. I remember the IED's. I remember the sound of bullets flying a little too close coming from nowhere. I remember the silent wounded. I remember the corpses lying dead in the street. In the night animals, would come and eat from the dead. No family came to claim their dead while we were

there. I remember I really never wanted to know what the inside of the human body looks like (Smith, 2010, April 12, para. 5).

"I remember after the battles, in the dark, fighting dirty hands. I remember the silence. I remember choking on tears and screams when I couldn't get away, when I was cornered. I remember being raped" (Smith, 2010, April 12, para. 8).

"By that time I had been raped, assaulted, and humiliated by several soldiers, while rumors about my supposed promiscuity and other insults were heaped on my head" (Smith, 2010, September 23, para. 3).

One of the men who raped me told me once that he loved manipulating women into situations to force them to have sex with him. He loved making women do things they didn't want to do. He smiled as he described some of the things he'd done to women. Control.

Another of the men who raped me, waited until I was unconscious from my migraine medications to rape me. I briefly regained consciousness during the rape and he was telling me "You have wanted this for so long." The only way he could control me enough to get what he wanted was to wait for me to be unconscious. (Smith, 2015, March 30, para. 5/6).

Individuals will experience either recurrent, involuntary, flashbacks or memories, recurrent distressing dreams regarding the event, or dissociative flashbacks.

**Tom Woods**

"One night her husband thought he was back in Iraq and tried to kick down the door of their home on Garden Gate Lane. He shouted something in Arabic she didn't understand" (Goffard, 2013, para. 1).

**Nathan**

"...came home from Afghanistan with haunted thoughts" (Steele, 2013, para. 9).

**Gena Smith**

"It's like a flashback and my worst nightmares all rolled up into one" (Lasker, 2014).

"...intrusive memories of combat and nightmares about being raped by a fellow soldier" (Lasker, 2014).

"Also I have been having horrible nightmares. Sometimes they wake me up, and other times I can't wake up..." (Smith, 2010, December 10, para. 3).

Individuals will avoid internal and external reminders of the traumatic event. This includes avoiding people, places, conversations, or thoughts that are reminders of the event. These avoidance techniques can be carried out through physical avoidance or substance use.



**Tom Woods**

"He'd mix liquor with antidepressants and forget how many pills he'd swallowed" (Goffard, 2013, People Who Loved section, para. 11).

"He needed alcohol to...forget" (Goffard, 2013, People Who Loved section, para. 11).

"But the other parts – the details behind the bracelets with the names of his dead friends – he didn't talk about" (Goffard, 2013, His Painful Return section, para. 12).

**Nathan**

"So he numbed up" (Steele, 2013, para. 12).

"...Nathan holed up in his brother's house...He came out once a day to find food ...Otherwise he stayed in his room, with the whiskey" (Steele, 2013, para. 27).

**Gena Smith**

So its pretty chaotic in my head these days. I'm constantly reminded of what I didn't or couldn't or should've done, which leads to feelings of being a failure, which leads to depression blah blah blah. So I avoid. I curl up on the couch with my book or laptop and proceed to not move except to smoke or pee all day. Sometimes all this avoidance makes me tired and I take a nap (Smith, 2011, February 18, para. 2).

Symptomology of PTSD further includes negative thoughts or emotions associated with the trauma that worsen after the event.

### **Tom Woods**

"More than once, he remarked that she would be better off with him dead" (Goffard, 2013, A Wife's Lonely Struggle section, para. 3).

"After a long silence he said, "How can you possibly love somebody like me?" ((Goffard, 2013, Then He Vanished section, para. 11).

"I feel ashamed, guilty, selfish, and pathetic for not being a stronger and more supportive man" (Goffard, 2013, Three Days section, para. 2).

"I don't know what it feels like to be happy anymore," he told his wife" (Goffard, 2013, para. 6).

### **Nathan**

I was on the way out. I've put a gun in my mouth. I've felt it in my mouth. I've not known if there was a round in the chamber because I've been so drunk. And I've pulled the trigger,... (Steele, 2013, para. 7).

"He carried the guilt of surviving while they had not" (Steele, 2013, para. 12)

"...he didn't want to be around people anymore," said his mother..." (Steele, 2013, para. 18).

**Gena Smith**

"After all, they can't fix me, so I will never have a life anyway" (Lasker, 2014).

"I also had a humiliating tendency to burst into tears around my team" (Smith, 2010, September 23, para. 3)

"I don't want to do anything. I start reading a book and can't finish it. I start watching a movie and turn it off halfway through. I just lose interest in things so quickly" (Smith, 2011, January 16, para. 1).

Changes in arousal and responsiveness characterized by irritability, recklessness, hypervigilance, startle response, concentration issues, or sleep disturbance will occur.

**Tom Woods**

"...he drove his Jeep Wrangler around the base with an open bottle of Jack Daniels in the cup holder" (Goffard, 2013, His Painful Return section, para. 9).

"...discovered whiskey bottles and beer in the duffel bag Tom brought to the maternity ward" (Goffard, 2013, When Tom Talked section, para. 4).

"...they attended a concert at the House of Blues in Anaheim, and the crowd made him panic. He raced away, breathing hard, saying, "I need it quiet, I need it quiet" (Goffard, 2013, People Who Loved section, para. 7).

"He needed alcohol to sleep, he insisted..." (Goffard, 2013, People Who Loved section, para. 11).

### **Nathan**

"Outside a bar, he had a heated exchange with a group of guys who saw it as a threat" (Steele, 2013, para. 22).

It was very hard to go in public when I first got out. I froze up in the airport. I remember the first time I came back from combat, this is after I lost all my buddies, I just froze. I didn't even move," he said. "I would sweat, sweat, sweat – booze. OK, I feel good now. (Steele, 2013, para. 9).

"Now he wouldn't sleep on a bed, only the floor. They were afraid to do anything that might spook him" (Steele, 2013, para. 13).

### **Gena Smith**

"The entire rest of the deployment is literally a blur of blind rage. I fought with EVERYONE about ANYTHING. I argued with every order" (Smith, 2010, September 23, para. 3).

"I lashed out at friends, commanders, anyone who dared to come close" (Smith, 2010, September 23, para. 3).

I'm having serious problems with anxiety and paranoia. I went shopping with one of my friends and some guys pointed at us and started walking our way, and I immediately started conducting counter-surveillance maneuvers. Then I

had a massive panic attack (Smith, 2010, December, para. 1).

The duration of the individual's disturbance in functioning lasts more than a month.

**Tom Woods**

"...during his 14 months in Baghdad in 2007 and 2008" (Goffard, 2013, His Painful Return section, para. 10).

"April 24, 2012, Candy sat on a wooden bench in Judge Lindley's courtroom next to the glassed-in cage where Tom waited among other inmates..." (Goffard, 2013, Maybe This is My Lesson section, para. 14).

**Nathan**

"Four years after discharge, the downward spiral turned into a frenzy" (Steele, 2013, para. 17).

**Gena Smith**

"Seven years later, "they are still telling me that my prognosis is good and I am going to be fine" (Lasker, 2014).

The disturbance causes clinical distress, or impairment in functioning socially or occupationally or in any other major area of life.

**Tom Woods**

"With Tom unable to work..." (Goffard, 2013, A Wife's Lonely Struggle section, para. 4).

"She stopped inviting him to get-togethers. She made

him sleep in the living room. Once, she came home from work and found him on the couch, out cold, clutching a loaded gun under his ear" ((Goffard, 2013, People Who Loved section, para. 11).

"...after being evicted over the wrecked door" (Goffard, 2013, Then He Vanished section, para. 4).

### **Nathan**

"Unable to work as before, Nathan holed up in his brother's house. His savings dwindled. He came out once a day to find food. Otherwise he stayed in his room, with the whiskey. He didn't call anyone" (Steele, 2013, para. 27).

"...had finally collapsed, ending in a dust-up outside a bar and a criminal charge" (Steele, 2013, para. 3).

"But look where I'm living. I'm a homeless veteran" (Steele, 2013, para. 47).

### **Gena Smith**

Here I am (in Wyoming) with a bag full of clothes living out of a hotel, going through two traumatic withdrawals from medications that I should have had but the VA screwed me," she says. "The VA has turned me into a junkie and they don't care (Lasker, 2014).

"Smith...homeless and living in a hotel in Wyoming near her parent's home" (Lasker, 2014).

"I quit school to deal with the all the things that were

driving me into a constant state of terror, and that's what I've been doing" (Smith, 2011, February 18, para. 2).

### **Alcohol Use Disorder**

Individuals will experience problematic pattern of alcohol use that causes impairment within social, occupational, or other important functioning.

#### **Tom Woods**

When Tom talked about life in the 1-4 Cavalry, he made it sound as if drinking was inseparable from a cavalry scout's identity. At parties, every "true cavalry scout" would dip his Stetson into the grog bowl- a plugged-up sink mixed with whatever mad combination of liquor was on hand- and swig right from the brim. "Everybody drinks," Tom would say. She told herself the Army was the problem that he'd sober up once he got out. (Goffard, 2013, When Tom Talked section, para 1.)

"He needed alcohol to sleep, he insisted, and to forget. She would discover him sitting by himself, his eyes vacant, his speech slurred. He'd mix liquor with antidepressants and forget how many pills he'd swallowed" (Goffard, 2013, People Who Loved section, para. 11).

"By the time he returned home, past dark, Candy had discovered his stash of beer and was throwing it away. He insisted that she give it back, or he would go buy more" (Goffard, 2013, Then He Vanished section, para. 22).

"He picked up two DUIs in rapid succession" (Goffard, 2013, A Wife's Lonely Struggle section, para. 5).

"Even after she learned that Tom had been caught drunk on duty, and was being stripped of his sergeant's stripes and forced out early with a general discharge" (Goffard, 2013, When Tom Talked section, para. 7).

Then he pulled up in the moving truck that day in January 2012. He had been drinking. The Jeep he was supposed to be towing was missing. He hadn't realized that it had broken loose over a bump, somewhere in San Bernardino (Goffard, 2013, When Tom Talked section, para. 10).

### **Nathan**

I was on the way out. I've put a gun in my mouth. I've felt it in my mouth. I've not known if there was a round in the chamber because I've been so drunk. And I've pulled the trigger... (Steele, 2013, para. 7).

"I would sweat, sweat, sweat – booze. OK, I feel good now" (Steele, 2013, para. 9).

"What people didn't see was the darkened room, the bottle of Jameson whiskey..." (Steele, 2013, para. 11).

"For a guy like me – any operator who's been to combat – if you have idle time and money in your pocket, nine times out of 10 you're going to go booze. Because you don't want to be alone" (Steele, 2013, para. 12).



"Unable to work as before, Nathan holed up in his brother's house. His savings dwindled. He came out once a day to find food. Otherwise he stayed in his room, with the whiskey. He didn't call anyone" (Steele, 2013, para. 27).

**Gena Smith**

There is no evidence to meet this criterion.

**MST**

MST is an unwanted sexual assault or sexual harassment that occurs during active duty. MST can be the traumatic event that is the first criterion for PTSD, therefore, MST and PTSD can be comorbid.

**Tom Woods**

No evidence of MST.

**Nathan**

No evidence of MST.

**Gena Smith**

"By that time I had been raped, assaulted, and humiliated by several soldiers, while rumors about my supposed promiscuity and other insults were heaped on my head" (Smith, 2010, September 23, para. 3).

"I just got overwhelmed by everything ...and the sense of futility of trying to deal with PTSD..." (Smith, 2012, May 12, para. 2).

### **Employment Problems**

PTSD and Substance Use Disorder cause an impairment in functioning. It is possible that these disorders can cause an impairment in occupational functioning.

#### **Tom Woods**

"Doctors diagnosed him with post-traumatic stress disorder, though he didn't believe it... With Tom unable to work..."  
(Goffard, 2013, A Wife's Lonely Struggle section, para. 4).

#### **Nathan**

When you start adding substance abuse, it turns that PTSD into something that is uncontrollable. It literally is uncontrollable," Nathan said during two days of interviews at Veterans Village of San Diego, where he received court-ordered treatment for PTSD...

He agreed to tell his story because he wants people to know it happens, even to former Navy SEALs. Unable to work as before... (Steele, 2013, para. 25-27).

#### **Gena Smith**

"I filed an appeal of my initial disability award of 30% for PTSD. I've been living on around \$500 a month for the last two years or so, and unable to work due to my disabilities"  
(Smith, 2012, February 1, para. 1).

### **Crime and Arrests**

Substance use can often lead to criminal activity, due to the use of illegal substances or impairment in judgment and behavior that substances can cause.

#### **Tom Woods**

"He picked up two DUIs in rapid succession" (Goffard, 2013, A Wife's Lonely Struggle section, para. 5).

"Even after she learned that Tom had been caught drunk on duty, and was being stripped of his sergeant's stripes and forced out early with a general discharge" (Goffard, 2013, When Tom Talked section, para. 7).

Then he pulled up in the moving truck that day in January 2012. He had been drinking. The Jeep he was supposed to be towing was missing. He hadn't realized that it had broken loose over a bump, somewhere in San Bernardino (Goffard, 2013, When Tom Talked section, para. 10).

He asked his VA social worker for a referral to Combat Veterans Court in Santa Ana, a program designed to divert former war fighters from lockup and into treatment.

The presiding judge, Wendy Lindley, sent him to county jail while lawyers weighed the charges. She made it clear that he was either going to stay in lockup or enroll at Beacon House, a last-resort rehab program.. (Goffard, 2013, Maybe This is My Lesson section, para. 9-10).

"The judge told him he was endangering the people of Orange County by driving drunk, and was out of chances" (Goffard, 2013, Maybe This is My Lesson section, para. 15).

### **Nathan**

"Outside a bar, he had a heated exchange with a group of guys who saw it as a threat. It led to a criminal charge" (Steele, 2013, para. 22).

Nathan elected for his case to go through San Diego County veterans court. The court, which opened in early 2011 and is one of several in the state, allows former service members with mental-health problems to get probation for their charges if they seek treatment. Some convictions are even dismissed (Steele, 2012, para. 31).

The former SEAL's rehab came through Veterans Village, the Pacific Highway nonprofit organization that offers a 120-day residential program. But the court first made him appear at this summer's "Stand Down," a military term for a pause in the action (Steele, 2013, para. 35).

### **Gena Smith**

There is no evidence of crime or arrests.

### **Summary**

The findings of this study supported the hypothesis that homeless individuals with military combat exposure would present with symptoms and potentially meet the full criteria for PTSD.

Combat exposure revealed a negative effect on the psychological functioning of all the subjects.

The findings of this study partially supported the hypothesis that homeless individuals with military combat exposure would present with symptoms and potentially meet the full criteria for Alcohol Use Disorder. To cope with combat exposure, it was revealed that two of the three subjects had an alcohol disorder.

The findings of this study supported that an individual with MST would present symptoms and potentially meet the full criteria of PTSD. MST revealed to have a direct impact on the psychological functioning of the subject with MST experience.

The findings of this study supported the hypothesis that PTSD or Substance Use would have an effect on employment. It was revealed that PTSD or Substance Use had an effect on the ability to maintain employment.

The findings of this study partially supported that PTSD or Substance Use would have an effect on possible crime or arrests. It was revealed that two of the subjects with PTSD and substance use committed crimes related to their PTSD and alcohol use.

## Chapter 5

### **Discussion**

The primary purpose of the current study was to assess which mental disorders are more prominent in the homeless veteran population and to identify how these mental disorders may affect areas of functioning. Overall, several findings of this study were consistent with prior research. First, homeless individuals with military combat exposure potentially presented with symptoms fitting full criteria of PTSD. This is consistent with research stating that there is a consistent association between combat exposure and PTSD (Balshem et al., 2011; Schnurr et al., 2009).

Second, the findings of this study partially supported that homeless individuals with military combat exposure present with symptoms and potentially met the full criteria for Alcohol Use Disorder. Balshem et al. (2011) found individuals deployed to combat zones are more likely to develop alcohol use problems post-deployment. A possible explanation for the increase use of substances post-deployment comes from the research that individuals use substances as a coping method for PTSD. This was present in the archival data used within this study. All three individuals used substances as a method for coping with PTSD.

Third, the individual with MST experience presented with symptoms and potentially met the full criteria of PTSD. This is

consistent within the literature, that MST is often comorbid with mental disorders such as PTSD, Substance Use, and depression (Gunter-Hunt et al., 2013; Hamilton et al., 2011; Pavao et al., 2013; Suris & Lind, 2008).

Fourth, findings suggest that PTSD or Substance Use have a potential effect on employment. This is consistent with prior research findings, such as, homeless veterans with PTSD are significantly less likely to be employed (Resnick & Rosenheck, 2008). One possibility that is that the symptoms of PTSD can cause an issue in functioning at an occupational level. Individuals with flashbacks may not be able to work with others without struggles, or individuals with negative persistent emotions may not be able to see the value in doing their job.

Lastly, the findings partially supported that PTSD or Substance Use would have a potential effect on crime or arrests. Prior research has also shown that incarcerated veterans have a high prevalence of Substance Use and PTSD (Saxon et al., 2001). These findings could possibly be due to the behavior associated with substance use. Depending on the substance the acquisition and use of the substance may be illegal in itself. Further, the behavior that substances may induce, such as driving while drunk, could be a criminal act.

**Limitations**

Although this study contributes to the current research on homeless veterans and the problems they may face, due to service in the military, it is not without limitations. This study relied on archival data, and thus, we do not have control of the questions asked. Due to this method of collection we were unable to assess body language and behavior during the interview process. This design limited the ability to code for disorders fully. Additionally, the sample size of this study was small and therefore a larger sample size would give more generalizable and comprehensive results.

**Future Research**

The present findings in this research have many implications for further studies. As seen in the literature OEF and OIF veterans in jail and incarcerated has not been documented since 2004. Given that many veterans returning from these conflicts have a high chance of developing PTSD and PTSD has a potential effect on crime it would be beneficial for the military and VA to assess how many OEF and OIF veterans are incarcerated. Additionally, further research should document the relationship between PTSD and Substance Use, due to both being highly reported in the homeless veteran population. This type of study would be beneficial to both the VA and other civilian



counseling programs to determine the best way to treat both disorders in conjunction.

## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Arlington, VA: American Psychiatric Publishing.
- Balshem, H., Christensen, V., Tuepker, A., & Kansagara, D. (2011). A Critical Review of the Literature Regarding Homelessness Among Veterans. Department of Veterans Affairs, Washington DC.
- Benda, B. B., Rodell, D. E., & Rodell, L. (2003). Crime among homeless military veterans who abuse substances. *Psychiatric Rehabilitation Journal*, 26(4), 332-345.
- Brown, W. (2008). Another Emerging "Storm": Iraq and Afghanistan Veterans with PTSD in The Criminal Justice System. *Justice Policy Journal*, 5(2), 4-37.
- Brown, W. B., Stanulis, R., Theis, B., Farnsworth, J., & Daniels, D. (2013). The Perfect Storm: Veterans, culture and the criminal justice system. *Justice Policy Journal*, 10(2), 1.
- Cartwright, T. (2011). "TO CARE FOR HIM WHO SHALL HAVE BORNE THE BATTLE": THE RECENT DEVELOPMENT OF VETERANS TREATMENT COURTS IN AMERICA. *Stanford Law & Policy Review*, 22(1), 295-316.
- Counseling and Treatment for Sexual Trauma, 38 USC §1720D.
- Creech, S., Johnson, E., Borgia, M., Bourgault, C., Redihan, S.,

- & O'toole, T. (2015). Identifying Mental and Physical Health Correlates of Homelessness Among First-Time and Chronically Homeless Veterans. *Journal of Community Psychology, 43*(5), 619-627.
- Davis, L. L., Leon, A. C., Toscano, R., Drebing, C. E., Ward, L. C., Parker, P. E., ... & Drake, R. E. (2012). A randomized controlled trial of supported employment among veterans with posttraumatic stress disorder. *Psychiatric Services, 63*(5), 464-470.
- Dunne, E. M., Burrell, L. E., Diggins, A. D., Whitehead, N. E., Latimer, W. W., & Burrell, L. 2.(2015). Increased risk for substance use and health-related problems among homeless veterans. *American Journal On Addictions, 24*(7), 676-680.  
doi:10.1111/ajad.12289
- Eckerlin, D. M., Kovalsky, A., & Jakupcak, M. (2016). Military Sexual Trauma in Male Service Members. *American Journal Of Nursing, 116*(9), 34-45.
- Elbogen, E., Johnson, S., Wagner, R., Newton, V., & Beckham, J. (2012). Financial Well-Being and Postdeployment Adjustment among Iraq and Afghanistan War Veterans. *Military Medicine, 177*(6), 669-675. doi:10.7205/MILMED-D-11-00388
- Elbogen, E. B., Sullivan, C. P., Wolfe, J., Wagner, H. R., & Beckham, J. C. (2013). Homelessness and Money Mismanagement in Iraq and Afghanistan Veterans. *American Journal Of*

*Public Health*, 103(S2), S248-54.

doi:10.2105/AJPH.2013.301335

Erickson, J. W. (2016). Veterans treatment courts: A case study of their efficacy for Veterans' needs. *International Journal Of Law And Psychiatry*, 49(Part B), 221-225.

doi:10.1016/j.ijlp.2016.10.009

Foster, L. K., & Vince, S. (2009). *California's women veterans: The challenges and needs of those who served* (p. 34).

California: California Research Bureau.

Gilmore, A. K., Brignone, E., Painter, J. M., Lehavot, K., Fargo, J., Suo, Y., & ... Gundlapalli, A. V. (2016). Women Veterans' Health: Military Sexual Trauma and Co-occurring Posttraumatic Stress Disorder, Depressive Disorders, and Substance Use Disorders among Returning Afghanistan and Iraq Veterans. *Women's Health Issues*, 26, 546-554.

doi:10.1016/j.whi.2016.07.001

Godfrey, K. M., Mostoufi, S., Rodgers, C., Backhaus, A., Floto, E., Pittman, J., & Afari, N. (2015). Associations of military sexual trauma, combat exposure, and number of deployments with physical and mental health indicators in Iraq and Afghanistan veterans. *Psychological Services*, 12(4), 366-377.

doi:10.1037/ser0000059

Goffard, C. (2013, September 8) A Soldier's Wife: Her husband

- came home, and the war came with him. *Los Angeles Times*. Retrieved from <http://graphics.latimes.com/soldiers-wife/>
- Greenberg, G. A., Rosenheck, R. A., & Desai, R. A. (2007). Risk of Incarceration among Male Veterans and Nonveterans: Are Veterans of the All-Volunteer Force at Greater Risk?. *Armed Forces & Society, 33*(3), 337-350.
- Gunter-Hunt, G., Feldman, J., Gendron, J., Bonney, A., & Unger, J. (2013). Outreach to women veterans of Iraq and Afghanistan: A VA and National Guard collaboration. *Federal Practitioner, 30*(2), 25-31.
- Hamilton, A., Poza, I., & Washington, D. (2011). Homelessness and Trauma Go Hand-in-Hand: Pathways to Homelessness among Women Veterans. *Women's Health Issues, 21*(4), 203-209.
- Hawkins, M. D. (2010). Coming Home: Accommodating the Special Needs of Military Veterans to the Criminal Justice System. *Ohio State Journal Of Criminal Law, 7*(2), 563-573.
- Henry, M., Shivji, A., de Sousa, T., Cohen, R., Khadduri, J., & Culhane, D. P. (2015). The 2015 Annual Homelessness Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness.
- Horton, J., Jacobson, I., Wong, C., Wells, T., Boyko, E., Smith, B., ...Smith, T. (2013). The Impact of Prior Deployment Experience on Civilian Employment After Military Service. *Occupational and Environmental Medicine, 70*(6), 408-17.

- Kashner, T. M., Rosenheck, R., Campinell, A. B., Suris, A., Crandall, R., Garfield, N. J., ... & Wicker, A. (2002). Impact of work therapy on health status among homeless, substance-dependent veterans: A randomized controlled trial. *Archives of General Psychiatry*, 59(10), 938-944.
- Knudsen, K., & Wingenfeld, S. (2016). A Specialized Treatment Court for Veterans with Trauma Exposure: Implications for the Field. *Community Mental Health Journal*, 52(2), 127-135. doi:10.1007/s10597-015-9845-9
- Lasker, J. (2014, October 22). A Female Veteran's Cautionary Tale. *Columbus Free Press*. Retrieved from <http://columbusfreepress.com/article/female-veteran's-cautionary-tale...>
- Leddy, M., Stefanovics, E. & Rosenheck, R. (2014). Health and Well-being of Homeless Veterans Participating in Transitional and Supported Employment: Six-month outcomes. *Journal of Rehabilitation Research and Development*, 51(1), 161-175. doi:10.1682/JRRD.2013.01.0011
- Lucas, P. A., & Hanrahan, K. J. (2016). No Soldier Left Behind: The Veterans Court Solution. *International Journal Of Law & Psychiatry*, 4552-59. doi:10.1016/j.ijlp.2016.02.010
- Mares, A., & Rosenheck, R. (2006). Attitudes towards employment

- and employment outcomes among homeless veterans with substance abuse and/or psychiatric problems. *American Journal Of Psychiatric Rehabilitation*, 9(3), 145-166.
- Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., ... & Delphin-Rittmon, M. E. (2014). Supported employment: assessing the evidence. *Psychiatric Services*, 65(1), 16-23.
- McCormick-Goodhart, M. A. (2013). Leaving No Veteran Behind: Policies and Perspectives on Combat Trauma, Veterans Courts, and the Rehabilitative Approach to Criminal Behavior. *Penn State Law Review*, 117, 895-926.
- Mondragon, S. A., Wang, D., Pritchett, L., Graham, D. P., Plasencia, M. L., & Teng, E. J. (2015). The influence of military sexual trauma on returning OEF/OIF male veterans. *Psychological Services*, 12(4), 402-411.  
doi:10.1037/ser0000050
- National Institute of Corrections. (2016, May 17). *Veterans Treatment Court*. Retrieved from <https://nicic.gov/veteranscourts>
- Noonan, M. E., & Mumola, C. J. (2007). *Veterans in state and federal prison, 2004*. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Northcut, T. T., & Kienow, A. K. (2014). The Trauma Trifecta of

- Military Sexual Trauma: A Case Study Illustrating the Integration of Mind and Body in Clinical Work with Survivors of MST. *Clinical Social Work Journal*, 42(3), 247-259.
- O'Brien, C., Keith, J., & Shoemaker, L. (2015). Don't tell: Military culture and male rape. *Psychological Services*, 12(4), 357-365. doi:10.1037/ser0000049
- Pagoda, T. K., Cramer, I. E., Rosenheck, R. A., & Resnick, S. G. (2011). Qualitative Analysis of Barriers to Implementation of Supported Employment in the Department of Veterans Affairs. *Psychiatric Services*, 62(11), 1289-1294.
- Pavao, J., Turchik, J. A., Hyun, J. K., Karpenko, J., Saweikis, M., McCutcheon, S., ... Kimerling, R. (2013). Military sexual trauma among homeless veterans. *Journal Of General Internal Medicine*, 28(2), 536-541. doi:10.1007/s11606-013-2341-4
- Resnick, S. G., & Rosenheck, R. (2007). Dissemination of supported employment in Department of Veterans Affairs. *Journal Of Rehabilitation Research & Development*, 44(6), 867-877.
- Resnick, S.G. & Rosenheck, R.A. (2008). Posttraumatic Stress Disorder and Employment in Veterans Participating in Veterans Health Administration Compensated Work Therapy.



*Journal of Rehabilitation Research and Development*, 45(3), 427-35.

Fontana, A., & Rosenheck, R. (1994). Traumatic war stressors and psychiatric symptoms among World War II, Korean, and Vietnam War veterans. *Psychology And Aging*, 9(1), 27-33. doi:10.1037/0882-7974.9.1.27

Rosenheck, R. & Mares, A. (2007). Implementation of Supported Employment for Homeless Veterans With Psychiatric or Addiction Disorders: Two-Year Outcomes. *Psychiatric Services*, 58(3), 325-333. doi:10.1176/appi.ps.58.3.325

Russell, J. T. (2009). Veterans Treatment Court: A Proactive Approach. *New England Journal On Criminal And Civil Confinement*, 35,357-372.

Salkind, N.J. (2012). *Exploring research* (8th ed.). Essex, England: Pearson.

Saxon, A. J., Davis, T. M., Sloan, K. L., McKnight, K. M., McFall, M. E., & Kivlahan, D. R. (2001). Trauma, Symptoms of Posttraumatic Stress Disorder, and Associated Problems Among Incarcerated Veterans. *Psychiatric Services*, 52(7), 959-964.

Schnurr, P., Lunney, C., Bovin, M., & Marx, B. (2009). Posttraumatic Stress Disorder and Quality of Life: Extension of Findings to Veterans of the Wars in Iraq and

Afghanistan. *Clinical Psychology Review*, 29 (8), 727-735.

doi:10.1016/j.cpr.2009.08.006

Schry, A. R., Hibberd, R., Wagner, H. R., Turchik, J. A.,

Kimbrel, N. A., Wong, M., & ... Brancu, M. (2015).

Functional correlates of military sexual assault in male veterans. *Psychological Services*, 12(4), 384-393.

doi:10.1037/ser0000053

Seal, K., Metzler, T., Gima, K., Bertenthal, D., Maguen, S.,

Marmar, C. (2009). Trends and Risk Factors for Mental

Health Diagnoses Among Iraq and Afghanistan Veterans Using

Department of Veterans Affairs Health Care, 2002-2008.

*American Journal of Public Health*, 99(9), 1651-1658.

doi:10.2105/AJPH.2008.150284

Smith, G. (2015, March 30). Regular Fury: Interview with an

abuser. [Web log comment]. Retrieved from

<http://regularfury.blogspot.com/2015/03/interview-with-abuser.html>

Smith, G. (2012, May 25). Regular Fury: No rest for the

wicked. [Web log comment]. Retrieved from

<http://regularfury.blogspot.com/2012/05/no-rest-for-wicked.html>

Smith, G. (2012, February 1). Regular Fury: Curious Furious. [Web

log comment]. Retrieved from  
<http://regularfury.blogspot.com/2012/02/curiously-furious.html>

Smith, G. (2011, February 18). Regular Fury: As of today.  
[Web log comment]. Retrieved from  
<http://regularfury.blogspot.com/2011/02/as-of-today.html>

Smith, G. (2011, January 16). Regular Fury: Depression.  
[Web log comment]. Retrieved from  
<http://regularfury.blogspot.com/2011/01/depression.html>

Smith, G. (2010, December 10). Regular Fury: Sleep and  
Prolonged exposure therapy. [Web log comment]. Retrieved  
from <http://regularfury.blogspot.com/2010/12/sleep-and-prolonged-exposure-therapy.html>

Smith, G. (2010, September 23). Regular Fury: Another betrayal  
of trust. [Web log comment]. Retrieved from  
<http://regularfury.blogspot.com/2010/09/another-betrayal-of-trust.html>

Smith, G. (2010, April 12). Regular Fury: A long story not so  
short. [Web log comment]. Retrieved from  
<http://regularfury.blogspot.com/2010/04/long-story-not-so-short.html>

Steele, J. (2013, February 2). Homeless Navy SEAL vet: 'A bad,

bad spot'. *The San Diego Union-Tribune*. Retrieved from  
[http://www.sandiegouniontribune.com/military/sdut-ptsd-  
 veterans-navy-seal-2013feb02-htm1story.html](http://www.sandiegouniontribune.com/military/sdut-ptsd-veterans-navy-seal-2013feb02-htm1story.html)

Streets, Sidewalks, and Public Places, Sacramento City Code  
 § 12.52.030

Suris, A., & Lind, L. (2008). Military sexual trauma: a review  
 of prevalence and associated health consequences in  
 veterans. *Trauma, Violence & Abuse, 9*(4), 250-269.

Tsai, J., KasproW, W. J., & Rosenheck, R. A. (2013). Latent  
 Homeless Risk Profiles of a National Sample of Homeless  
 Veterans and Their Relation to Program Referral and  
 Admission Patterns. *American Journal Of Public Health,*  
*103*(S2), S239-47. doi:10.2105/AJPH.2013.301322

Tsai, J., Link, B., Rosenheck, R. A., & Pietrzak, R. H. (2016).  
 Homelessness among a nationally representative sample of US  
 veterans: Prevalence, service utilization, and correlates.  
*Social Psychiatry And Psychiatric Epidemiology, 51*(6), 907-  
 916. doi:10.1007/s00127-016-1210-y

Tsai, J., Rosenheck, R., J KasproW, W., & McGuire, J. (2013).  
 Risk of incarceration and other characteristics of iraq and  
 afghanistan era veterans in state and federal prisons.  
*Psychiatric Services, 64*(1), 36-43.  
 doi:10.1176/appi.ps.201200188

Tsai, J., Rosenheck, R. A., KasproW, W. J., & McGuire, J.

- F. (2014). Homelessness in a national sample of incarcerated veterans in state and federal prisons. *Administration And Policy In Mental Health And Mental Health Services Research*, 41(3), 360-367. doi:10.1007/s10488-013-0483-7
- Turchik, J. A., McLean, C., Rafie, S., Hoyt, T., Rosen, C. S., & Kimerling, R. (2013). Perceived barriers to care and provider gender preferences among veteran men who have experienced military sexual trauma: A qualitative analysis. *Psychological Services*, 10(2), 213-222. doi:10.1037/a0029959
- U.S. Department of Veteran Affairs. (2016a). *Glossary*. Retrieved from <https://www.va.gov/vetdata/glossary.asp>
- U.S. Department of Veteran Affairs. (2016b). *Military Sexual Trauma*. Retrieved from [https://www.mentalhealth.va.gov/docs/mst\\_general\\_factsheet.pdf](https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf)
- Veterans Health Care, Capital Asset and Business Improvement Act of 2003, Pub. L. 108-170, 117 Stat. 2042, codified as amended at title 30, §USC 101 note.
- Woolsey, L. & Naumann, M. U.S. Department of Labor. (2015). *A Review of the Literature Related to Homeless Veteran Reintegration: Final Report*. Rockville, MD: Avar Consulting, Inc.

## APPENDICES

**APPENDIX A**

POST-TRAUMATIC STRESS DISORDER

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
  - a. Exposure to combat zones in war.
  - b. Fighting in war.
  - c. Being injured during active military duty.
  - d. Experiencing sexual harassment or unwanted sexual contact during active military duty.
  - e. Being a prisoner of war.
2. Witnessing, in person, the event(s) as it occurred to others.
  - a. Seeing military personnel injured during war.
  - b. Seeing military personnel killed during war.
  - c. Seeing civilians injured or killed during war.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - a. Learning squadron members have been injured or killed during war.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police



officers repeatedly exposed to details of child abuse)

- a. Deployment to a war combat zone.
- b. Fighting in a war combat zone.
- c. Repeated sexual harassment or assault during active duty.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s) , beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic events.
  - a. Flashback memories.
  - b. Memories involving sensory or emotional components to the event.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
  - a. Night terrors involving memories from the event.
3. Dissociative reactions in which the individual feels or acts as if the traumatic events were recurring.
  - a. Flashbacks memories causing the individual to feel as if the event is recurring.

- b. Visual or sensory intrusions causing the loss of reality orientation.
  - 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
    - a. Internalized fear at the presence of stimuli associated with the military.
  - 5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic events.
    - a. Sweating.
    - b. Visible fear at similar situations.
- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
  - 1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
    - a. Uses distraction techniques to deliberately avoid internal reminders about the event.
    - b. Use of alcohol to cope with internal feelings.
  - 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories,

thoughts, or feelings about or closely associated with the traumatic event(s),

- a. Avoids talking about the event with others.
- b. Avoids having contact with people involved in the event.
- c. Avoids environments that are similar to where the event occurred.

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
  - a. Inability to recall date, time, or specifics of the event.
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world.
  - a. Feeling as if the individual cannot trust anyone.
  - b. Feeling as if the individual has always been depressed or worthless.

- c. Feeling as if the individual could have saved others.
  - d. Feeling as if the individual is responsible for the traumatic event.
  - e. Feeling as if the individual deserved sexual assault or harassment.
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
- a. Blaming oneself for the events that occurred due to inaccurate thoughts of oneself.
  - b. Blaming others for the event, that did not have control of the event.
4. Persistent negative emotional state.
- a. Feeling prolonged guilt.
  - b. Feeling prolonged anger.
  - c. Feeling prolonged fear.
  - d. Feeling prolonged shame.
5. Markedly diminished interest or participation in significant activities.
- a. Individual no longer participates in activities once enjoyed.
6. Feeling of detachment or estrangement from others.
- a. Unable to talk to others.

- b. No longer spends time with family or friends.
- c. Feel cut off from others.
- d. Feels as if nothing is real.
- e. Sees friends and family as strangers.

7. Persistent inability to experience positive emotions.

- a. Cannot express or feel happiness or joy.
- b. Feeling on guard at all times.
- c. Constant feelings of panic.

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
  - a. Yelling at strangers.
  - b. Screaming in public.
  - c. Hitting another individual.
  - d. Destroying objects.
  - e. Always looking for threats.
2. Reckless or self-destructive behavior.
  - a. Alcohol or drug use.
  - b. Suicidal behavior.

c. Physical self-harm.

d. Reckless driving.

e. Cutting oneself.

3. Hypervigilance.

a. Heightened sensitivity to senses that cue memories of the trauma.

b. Always on high alert.

4. Exaggerated startle response.

a. Excessive jumpiness to small noises.

b. Panic after being startled.

5. Problems with concentration.

a. Difficulty remembering daily tasks or appointments.

b. Difficulty holding a conversation.

c. Difficulty finishing tasks at work.

6. Sleep disturbance

a. Waking up in the night screaming, crying, or distressed.

b. Trouble falling asleep.

c. Not being able to stay asleep.

d. Having night terrors.

F. Duration of the disturbance (Criteria B, C, D, and E) is more than a month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

a. Inability to go to work, or finish a work day without a disturbance.

b. Inability to keep in contact with friends or family.

c. Inability to keep up day to day tasks such as household chores, or feeding oneself.

H. **The disturbance** is not attributable to the physiological effects of a substance or another medical condition.

**APPENDIX B**

ALCOHOL USE DISORDER



A. A problematic pattern of alcohol use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
  - a. Blackouts from too much alcohol.
  - b. Drinks every day.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
  - a. Tries to become sober on their own, but cannot stop drinking.
  - b. Attempts to go to AA meetings, but continues drinking.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
  - a. Time is spent drinking.
  - b. Time is spent hungover.
  - c. Time is spent dealing with actions from the period the individual was drunk.
  - d. Time is spent purchasing or finding alcohol.
4. Craving, or a strong desire or urge to use alcohol.

- a. Feels the need to drink even at inappropriate times.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
  - a. Drinking causes problems attending work.
  - b. Drunk at work.
  - c. Inability to watch children.
  - d. Inability to be financially stable and pay bills.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
  - a. Drinking even though it affects marital relationship.
  - b. Drinking while working.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
  - a. Hours at work are lessened in order to drink.
  - b. Stop spending time with family in order to drink.
8. Recurrent alcohol use in situations in which it is physically hazardous.

- a. Driving while drunk.
  - b. Taking care of children while intoxicated.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- a. Drinking despite repeated altercations with others after being intoxicated.
  - b. Experiencing depression after drinking, yet continuing to consume alcohol.
10. Tolerance, as defined by either of the following:
- a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  - b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
- a. The characteristic withdrawal syndrome for alcohol.
    - i. Insomnia.
    - ii. Hand tremors.
    - iii. Vomiting.

b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.