Curriculum Vitae

Brenda J. Jorden, MSW, LCSW-C
bjjorden17@gmail.com

EDUCATION

Ph.D.	2018 School of Social Work, University of Maryland, Baltimore Dissertation title: "Rural Veterans: Pathways to Homelessness"
MSW	2003 Salisbury University, Department of Social Work
BASW	2002 Salisbury University, Department of Social Work

TEACHING INTERESTS

Social Work Practice, Human Behavior, Social Work Policy, Research Methodology

AWARDS

University of Maryland Social Work Ph.D. Program Dissertation Award ($2998) Fall 2016
• Competitive award to fund expenses related to conducting dissertation research

The Nikki R. Wooten Dissertation Award for Research with Military, Veterans, and Vulnerable Populations ($1000) Fall 2016
• Competitive award to fund expenses related to conducting dissertation research

RESEARCH INTERESTS

Homelessness, Veteran Issues, Rural Populations, Poverty, Qualitative Methods, Social Work Education

UNIVERSITY TEACHING EXPERIENCE

1/18---5/18 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
BASW Course: Field Instruction II
Lead Instructor for 9 sections of the course
Designed online course component

8/17---12/17 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
BASW Course: Field Instruction I

Lead Instructor for 9 sections of the course
Designed online course component

1/17---5/17 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
BASW Course: Human Behavior and the Social Environment II
BASW Course: Field Instruction I
Lead Instructor for 6 sections of the course
Designed online course component

8/16---12/16 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
BASW Course: Human Behavior and the Social Environment I
BASW Course: Field Instruction I
Lead Instructor for 6 sections of the course
Designed online course component

1/16---5/16 Instructor
Salisbury University
Supervisor: Batya Hyman, Ph.D.
BASW Course: Human Behavior and the Social Environment I
BASW Course: Field Instruction II
Lead Instructor for 6 sections of the course
Designed online course component

8/15---12/15 Instructor
Salisbury University
Supervisor: Batya Hyman, Ph.D.
BASW Course: Human Behavior and the Social Environment I--2 sections
Lead instructor for 5 sections
MSW Course: Field Instruction I
BASW Course: Field Instruction I
Lead Instructor for 6 sections of the course
Designed online course component

1/15---5/15 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
BASW Course: Human Behavior and the Social Environment I
BASW Course: Field Instruction II
Lead Instructor for 6 sections of the course
Designed online course component

8/14---12/14 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
MSW Course: Human Behavior and the Social Environment I
MSW Course: Field Instruction I
BASW Course: Basic Interviewing Skills
Lead Instructor for 5 sections of the course
Member of design team for course content
BASW Course: Field Instruction I
Lead Instructor for 6 sections of the course
Designed online course component

1/14---5/14 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
MSW Course: Practice I
BASW Course: Practice I
BASW Course: Field Instruction II
Lead Instructor for 6 sections of the course
Designed online course component

1/13---5/13 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
BASW Course: Human Behavior and the Social Environment II
BASW Course: Field Instruction I
Lead Instructor for 6 sections of the course
Designed online course component

8/12---12/12 Instructor
Salisbury University
Supervisor: Deborah Mathews, Ph.D.
BASW Course: Human Behavior and the Social Environment I
BASW Course: Field Instruction I—2 Sections
Lead Instructor for 6 sections of the course
Designed online course component

1/12---5/12 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
MSW Course: Human Behavior and the Social Environment I
BASW Course: Human Behavior and the Social Environment I
BASW Course: Field Instruction II
Lead Instructor for 6 sections of the course
Designed online course component

8/11---12/11 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
MSW Course: Field Instruction III
BASW Course: Basic Interviewing Skills
BASW Course: Field Instruction I
Lead Instructor for 6 sections of the course
Designed online course component

1/11---5/11 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Human Behavior and the Social Environment I
BASW Course: Field Instruction II
Lead Instructor for 6 sections of the course
Designed online course component

8/10---12/10 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Basic Interviewing Skills
BASW Course: Field Instruction I
Lead Instructor for 6 sections of the course
Designed online course component

1/10---5/10 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction II—2 Sections

8/09---12/09 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
MSW Course: Field Instruction II
BASW Course: Field Instruction II

1/09---5/09 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
MSW Course: Field Instruction II
BASW Course: Field Instruction II

8/08---12/08 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.

MSW Course: Field Instruction I
BASW Course: Field Instruction I—2 Sections

1/08---5/08 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction II—2 Sections

8/07---12/07 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction I—2 Sections

1/07---5/07 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction II—2 Sections

8/06---12/06 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction I—2 Sections

1/06---5/06 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction II—2 Sections

8/05---12/05 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction I—2 Sections

1/05---5/05 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction II—2 Sections

8/04---12/04 Instructor
Salisbury University
Supervisor: Marvin Tossey, Ph.D.
BASW Course: Field Instruction I-- 2 Sections

RESEARCH EXPERIENCE

10/15---4/16 Assisted in the development of a comprehensive community plan to determine prioritized areas of need and the approach to addressing identified needs in Dorchester, Caroline, and Talbot Counties in the State of Maryland. Data collection and analysis included surveys, focus groups, and community forums.

7/15---4/16 Co-PI for Substandard Housing Study encompassing Somerset County, MD. Windshield Survey of all housing units. Interviewed residents of targeted households and prepared final report for the Somerset County Government. This study included a follow-up study with residents identified as having damage as a result of Hurricane Sandy.

7/15---4/16 Co-PI for Substandard Housing Study encompassing Dorchester County, MD. Windshield Survey of all housing units. Interviewed residents of targeted households and prepared final report for the Dorchester County Government.

5/03---8/10 Research Assistant
Salisbury University Center for Family and Community Life
Supervisor: Marvin Tossey, Ph.D.
Research Support for the following reports:

2010 Mathews, D., & Jorden, B. "Worcester County 21st Century Learning Center Project: Fourth and Fifth Grade After School and Summer School Academies, School Year 2009-2010"

2010 Mathews, D., & Jorden, B. "Worcester County 21st Century Learning Center Project: High School After School Academies, School Year 2009-2010"

2010 Tossey, M., & Jorden, B. "Somerset County Needs Assessment"

2010 Mathews, D., & Jorden, B. "Somerset County Evaluation of 21st Century Learning Centers"

2010 Mathews, D., & Jorden, B. "Worcester County 21st Century Learning Center Project: Fourth and Fifth Grade After School and Summer School Academies, School Year 2008-2009"

2010 Mathews, D., & Jorden, B. "Worcester County 21st Century Learning Center Project: High School After School Academies, School Year 2008-2009"

2009 Mathews, D., & Jorden, B. “Worcester County Evaluation of 21st Century Learning Centers: School Year 2007-2008"

2009 Tossey, M., & Jorden, B. “Cecil County Needs Assessment”

2009 Mathews, D., & Jorden, B. “Worcester County 21st Century Learning Center Project: High School After School Academies, School Year 2007-2008"

2008 Tossey, M., & Jorden, B. “Kent County Needs Assessment”

2008 Jorden, B. "An Evaluation of the Worcester County Court-Based Mediation

2007 Mathews, D., & Jorden, B. “Somerset County Evaluation of 21st Century Learning Centers"

2007 Tossey, M., & Jorden, B. "City of Cambridge Substandard Housing Study"

2006 Mathews, D., & Jorden, B. “Worcester County Expanded Community Partnership: An Annual Program Evaluation”

2006 Tossey, M., Mathews, D., & Jorden, B. “Somerset County Needs Assessment”

2006 Mathews, D., Tossey, M, & Jorden, B. “Dorchester County Needs Assessment”

2006 Mathews, D., Tossey, M, & Jorden, B. “Worcester County Needs Assessment”

2006 Tossey, M., & Jorden, B. "Wicomico County Substandard Housing Study"

2006 Mathews, D., & Jorden, B. “Somerset County Evaluation of 21st Century Learning Centers"

2005 Tossey, M., Mathews, D., & Jorden, B. “Somerset County Housing Study”

2005 Mathews, D., Tossey, M. & Jorden, B. “A Survey and Analysis of Homelessness in Cecil County”

2004 Tossey, M., & Jorden, B. "Worcester County Substandard Housing Study"

2004 Tossey, M., & Jorden, B. "Caroline County Substandard Housing 15 Years Later: A Follow-Up Study"

2003 Tossey, M., Soule, M., & Jorden, B. "An Evaluation of the Worcester County Court-Based Mediation Program"

PROFESSIONAL EXPERIENCE

8/10—7/18 Salisbury University Social Work Department Clinical Faculty
Promoted to Clinical Associate Faculty 7/15
Designated Interim Director of Undergraduate Field Education 7/17
Supervisor: Dr. Deborah Mathews Ph.D.
*Teaching responsibilities for MSW and BASW Program
* Confirm 90-100 quality field education placements for BASW students
* Development and implementation of orientation and training for field supervisors, field liaisons, and students in the BASW program
*Resolution of field problems in the BASW program
*Staffing field seminars for the BASW program
*Academic advising
*Monitor delivery of the BASW field seminar curriculum to ensure consistency with curriculum design

5/07---8/10 Admissions Coordinator and Research Assistant
Salisbury University Social Work Department
Supervisor: Dr. Marvin Tossey, Ph.D.
* Initial contact for students entering the BASW and MSW programs
*Coordinate student admission process to the BASW program
* Serve as liaison with the SU/UMES Dual Degree Program
*Research duties for the Center for Family and Community Life Projects

1/06---12/08 Therapist
Arrow Project Ministries, Salisbury, MD
Supervisor: Susan Gray, LCSW-C
* Provide Individual Therapy to youth in Arrow Ministries foster care placements
*Assessment and evaluation of Foster Care youth participants
*Formulate and implement individual treatment Plans

5/03---5/07 Research Assistant
Salisbury University Social Work Department
Supervisor: Dr. Marvin Tossey, Ph.D.
*Research duties for the Center for Family and Community Life Projects

PRACTICUM INTERNSHIPS

8/02---5/03 Advanced Standing MSW Social Work Intern
Eastern Shore Hospital Center, Cambridge, MD
Supervisor: Andrew Karten, LCSW-C
*700 clinical hours completed
* Worked individually with patients toward stabilization, treatment goals and discharge. Learned to identify symptoms, medications and treatments relevant to individuals with mental illness.
*Planned and facilitated goals groups and therapeutic groups
*Completed assessments and social histories and progress notes

8/01---5/02 BASW Social Work Intern
Dove Pointe, Salisbury, MD
*440 hours completed
*Case management with developmental disability population

COMMUNITY SERVICE

5/03---Present
Developed and implemented the Community Emergency Shelter Project(CESP) to fill a gap in homeless services in he lower three counties of the Eastern Shore of Maryland. CESP is a community-based effort using local churches to provide safe, temporary, emergency, overnight shelter and hospitality to adult homeless males.

1/09---Present
Homeless Outreach Point of Entry (HOPE) Board of Director Member
*Chairperson 1/17-present

PRESENTATIONS

2012---2018 Salisbury University's Social Work Department Field Supervisors Orientation

2012---2018 Salisbury University's Social Work Department Field Students Orientation

2012---2018 Salisbury University's Social Work Department Field Liaisons Orientation

2012 Keynote speaker at Salisbury District United Methodist Women Conference

2012---2014	Rural Homelessness, guest lecturer in Introduction to Social Work Course at Salisbury University.
2011	Jorden & van Vulpen, Secondary Trauma at Salisbury University's Field Appreciation Event
2011	Depressive Symptoms and Fear of Crime Poster Presentation at University of Maryland School of Social Work.
2010---2011	Salisbury University's Social Work Department Field Supervisors Orientation
2010---2011	Salisbury University's Social Work Department Field Students Orientation
2010---2011	Salisbury University's Social Work Department Field Liaisons Orientation
2007	Jorden & Clark, Homeless Awareness Workshop presented at Christ United Methodist Church, Salisbury, Maryland.
2005	Jorden & Clark, Homeless Awareness Workshop presented at Christ United Methodist Church, Salisbury, Maryland.
2005	Jorden, Housing the Homeless using Congregational Care presented at St. Peters Church, Salisbury, Maryland

HONORS

2011 Honored and Recognized by the American Association of University Women (AAUW) as an "Outstanding Women Who Are Charting the Course" for service to the community with CESP.

2010 Participated and contributed to earning the National Civic League's All America City designation for the City of Salisbury representing CESP. CESP was presented as a program making Salisbury an All America City.

2008 Recognized for the time and assistance devoted to the Communities Mobilizing for Change on Alcohol Coalition by the Somerset Health Department.

2005 Received Homeless Organization of the Year Award for Community Emergency Shelter Project by the Tri-County Alliance for the Homeless Continuum of Care Committee.

Abstract

Title of Dissertation: Rural Veterans: Pathways to Homelessness

Brenda J. Jorden, Doctor of Philosophy, 2018

Dissertation Directed by: John Belcher, Ph.D., Full Professor, School of Social Work, University of Maryland, Baltimore and Bruce DeForge, Ph.D., Associate Professor, School of Social Work, University of Maryland, Baltimore.

Veterans are overrepresented in homeless populations compared to non-veterans (Gamache, Rosenheck, & Tessler, 2001; Perl, 2015). Most homeless individuals live in urban centers and as a result most research studies have focused on urban homelessness leaving the rural homeless less studied and understood (Knopf-Amelung, 2013). The purpose of the current qualitative study was to explore the pathways to homelessness for a sample of rural homeless veterans.

Fifteen veterans and 16 staff/administrators were interviewed to determine the causes of homelessness for veterans living in a rural area. A limited grounded theory approach was used to develop themes identified as causing homelessness. The primary pathway according to both groups was chronic substance abuse. Mental health and economic problems, and adverse childhood events were also major factors in veterans experiencing homelessness. Social support appeared to delay the onset of homelessness for some individuals. Not all veterans qualify for VA services, which leaves a segment of the population without access to VA services. Overcoming barriers to substance abuse

and mental health services for rural homeless veterans is an area to focus research efforts. Creative ways to provide outreach to the hidden homeless are needed.

Rural Veterans: Pathways to Homelessness

by
Brenda J. Jorden

Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, Baltimore in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2018

Acknowledgements

I am grateful to the veterans and staff/administrators who agreed to participate in this study. Thank you for your willingness to share your thoughts, and your stories. Your insight into the problem of homelessness taught me so much.

I would like to thank my family and friends for their support and encouragement while earning this degree. A special thankyou goes out to my husband Dave, the love of my life, who kept things going around the house when I couldn't. I could not have done it without you sweetheart. Dave Jr, Mike, Ben, Brittany, Hayden, Jim and Lisa and Jeff and Lisa, thanks for your interest and understanding during this process, I love you all. Special thanks go out to my mom and dad and brother Bob whom offered encouragement along the way but are not alive to see the completion. I miss you all so much.

I appreciate my colleagues at Salisbury University whom were supportive and shared wisdom through the process. Debbie and Marvin, working with you both on research projects sparked my interest in becoming a trained researcher and Debbie, you were the first one to suggest earning a PhD. Thanks to both of you for allowing me the flexibility to complete the requirements of this degree. Kim, you are a special friend and role model and you have been helpful in so many ways. Thanks for all your help. Jen thanks for taking on more than your share at times in the field office so I could work on this project.

I would like to thank my committee members, John Belcher, Bruce DeForge, Debbie Gioia, Carolyn Tice, and Vicki Root for their time, guidance, and leadership throughout this process. I would like to thank Donna Harrington and Charlotte Bright for the wisdom, support, and leadership they provided and to Jen Canapp for everything she

did during my time at UMB. Funding was generously provided by the University of Maryland Social Work Ph.D. Program Grant and The Nikki R. Wooten Dissertation Award for Research with Military, Veterans, and Vulnerable Populations. This funding allowed me to compensate veteran participants for their time and to use a transcription service to transcribe the interviews.

Most importantly, I would like to thank my Lord and savior Jesus Christ, who is with me always providing comfort, encouragement, wisdom, and purpose.

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Chapter 1: Introduction and Theory

Background

The homeless experience may be cruel to any human experiencing it but it is even more of an atrocity when that human is a veteran that has served in the United States (US) military. Homelessness is a serious social problem in the United States (US) with 553,742 individuals estimated to be homeless during the 2017 Point-in-Time (PIT) count completed nationally (US Department of Housing and Urban Development [HUD], 2017. Seven percent or 40,056 individuals self-reported veteran status (HUD, 2017). Both male and female veterans are overrepresented in homeless populations. Male veterans were 1.4 times more likely than nonveterans to be homeless (Gamache, Rosenheck, & Tessler, 2001) and female veterans were three to four times more likely to experience homelessness than non-veteran women (Gamache, Rosenheck, & Tessler, 2003; Hamilton, Poza, & Washington, 2011).

Veteran homelessness is receiving constant attention in the US and ending veteran homeless was one of the primary goals of the Opening Doors, Federal Strategic Plan to Prevent and End Homelessness (U.S. Interagency Council on Homelessness [USICH], 2010). The Department of Veterans Affairs (VA) Five-Year Plan to Prevent and End Homelessness among Veterans paralleled the Opening Doors plan (USICH, 2012). This coordinated effort to eliminate veteran homeless by 2015 demonstrated the importance of this issue in the US. The 2015 goal was not met but progress was made as veteran homelessness dropped 45% between 2009 and 2016. The downward trend was interrupted due to a two percent increase in veteran homelessness between 2016 and 2017 (HUD, 2017). Ending veteran homeless continues to be a primary focus for the VA.

Geographic location of veterans is an important consideration when studying veteran homelessness. Almost a third (28%) or 6.1 million veterans live in rural areas (Rural Assistance Center [RAC], 2013). The homeless veterans living in rural areas are difficult to identify because many do not participate in services available to them (USICH, 2014). This may be due to geographic isolation or lack of transportation alternatives; however it may also be due to the stigma and mistrust attached to seeking help by poor people living in rural areas (Smalley, Warner, & Rainer, 2012).

Rural areas provide barriers to helping homeless veterans for multiple reasons. Generally speaking there are less helping agencies to serve rural populations when compared to urban areas. There are more people living in poverty in rural areas and there are fewer resources available to help. Residents in rural areas may experience geographic isolation and may find it difficult to access available resources. Transportation is limited making it difficult to explore employment opportunities, health care and other services. The average driving distances to a VA medical facility for veterans living in rural areas is 24 miles and veterans living far from VA medical facilities have been shown to be less likely to use VA outpatient services (USICH, 2012). Barriers to health care can be a problem for all categories of homeless people. Veterans as well as nonveterans living in sheltered or unsheltered locations may experience physical, psychiatric, and emotional health stressors.

The problems faced by the homeless can be exacerbated in rural areas due to high rates of poverty, unemployment, limited affordable housing stock and geographic isolation (National Health Care for the Homeless Council, 2013). Declining industries located in these rural areas, such as farming, mining, timber or fishing often leads to

higher poverty and unemployment rates in some regions. The chances for living in poverty are 1.2 to 2.3 times higher in nonmetropolitan areas, than in metropolitan areas (USICH, 2014). The poverty rate is 15.3% for rural Americans which is higher than the national average, which stands at 13.2% (US Census Bureau, 2010).

The US Department of Agriculture (USDA) Economic Research Service defines counties as persistently poor if 20 percent or more of the county residents were living in poverty over the last 30 years (2014). There are 353 persistently poor counties in the US, and 85.3% of these are located in nonmetropolitan counties (USDA, 2014). Pervasive and consistent poverty in rural areas is a major concern, since it contributes to poor housing and health circumstances and limited employment opportunities. Poverty is related to poor mental and physical health, however, people living in poverty tend to be less trusting of formal helping agencies and worry about the stigma attached to asking for help (Smalley, Warren, & Rainer, 2012). This may help explain why some homeless people do not use services that are available to them.

The rural homeless are somewhat invisible compared to the homeless in urban areas and are often overlooked as part of the homeless population. In a recent synthesis of literature on rural homelessness, one of the limitations reported was the use of outdated references because of the lack of recent literature pertaining to rural homelessness (Knopf-Amelung, 2013). The Homeless Evidence and Research Synthesis (HERS) Roundtable Series stressed the need for additional research specific to the needs of homeless veterans living in rural areas (VA National Center on Homelessness Among Veterans, 2017). The Office of Rural Health Policy cited several reasons that rural homelessness is underrepresented in homeless research: lack of rural service sites,

difficulty including individuals that do not use services, a limited number of homeless researchers working in rural communities and a lack of incentive for providers, many whom are small and/or faith based organizations to collect data (2014). The less attention given to problems like homelessness in rural places allows public policy to continue to focus on urban problems.

Study Purpose

The purpose of this research study was to answer two research questions, "What are the pathways to homelessness for rural veterans?" and "What are the self-identified contributing factors to homelessness for a sample of rural homeless veterans?" This study used the information provided by homeless veterans to gain a deeper understanding of the context in which veterans become homeless when living in a rural area. Homeless veterans are overrepresented in the homeless population yet little is known about the contextual factors associated with pathways to homelessness for rural veterans. There are many pathways that lead into homelessness including poverty, lack of affordable housing, unemployment, medical bankruptcy, mental illness, trauma, substance abuse and domestic violence. Compared to urban homelessness little attention has focused on the pathways into homelessness for rural residents and more specifically rural veterans. Missing in the research literature is the voice of the rural veteran describing their experience of becoming homeless.

This qualitative research study targeted rural veterans whom have experienced homelessness to help address this gap in the research literature. In depth interviews were used to gather information on homelessness from the veteran's perspective. Staff/administrators at agencies providing services for the homeless were also

interviewed to provide contextual information from the stand point of a service provider for this population. The research incorporated limited grounded theory concepts using in-depth interviews to study the problem of rural veteran homelessness. The voice of veterans experiencing homelessness and staff/administrators informed the content of this study to learn more about pathways into homelessness for this population.

Relevance

Three-fourths of veterans in the United States can be found living in urban areas, which means about five million or one-fourth reside in rural areas (US Census Bureau, 2017). Obstacles to veterans receiving health care in rural areas may include high poverty rates, less hospitals and doctors to meet the need, greater distance to VA healthcare services and limited transportation options (Office of Rural Health, 2015). Homeless veterans living in rural areas may have limited access to services because VA health care centers are generally located in urban areas (Gordon, Haas, Luther, Hilton, & Goldstein, 2010). Health status of homeless veterans living in rural areas has been found to be poorer than the health status of homeless veterans living in urban areas (Gordon, Haas, Luther, Hilton, & Goldstein, 2010; Tsai, Ramaswamy, Bhatia, & Rosenheck, 2015)

Researchers agree that little empirical data exist surrounding the study of rural homeless veterans (Adler, Pritchett, Kauth, & Mott 2015; Tsai, Ramaswamy, Bhatia, & Rosenheck, 2015). Often only those homeless veterans enrolled in VA services are included in research (Tsai, Ramaswamy, Bhatia, & Rosenheck, 2015). Tsai et al. suggest that more creative methods are needed to provide clinical outreach services and more studies are needed in rural areas (2015). Adler, Pritchett, Kauth, and Mott (2015) suggest

that researchers identify the needs of rural homeless veterans and determine how services are being delivered to help address the sparseness of research with this population.

Hearing from two perspectives (homeless veterans and agency staff) the pathways into homelessness experienced by rural veterans will begin filling a void of information regarding the circumstances of veterans living in rural areas. Understanding the pathways as revealed by people living through homeless experiences can guide the design and provision of services to meet the needs of this homeless population. Exploring the pathways into homelessness for rural veterans provides a richer understanding of the stressors that lead to homelessness for this population and provides further insight into preventive measures that could be used to keep veterans from becoming homeless. Hearing firsthand concerning the barriers to service delivery for these individuals provides a better understanding of alternative approaches that may be necessary to help these individuals. Barriers to receiving help may be a combination of individual, family, community, systems, and policy factors. Resources can be used more prudently to achieve housing for this group if we understand what the barriers are. The findings allow for transferability to other regions similar in composition to the geographic location of this study.

Theory

Introduction

Homelessness is a complex issue studied using different theoretical perspectives. Some theoretical approaches focus on the entire homeless population (Christian & Armitage, 2002; Christian &Abrams, 2003; Clapham, 2003), whereas others focus on subgroups like homeless women (Davis & Shuler, 2000), homeless families (Morris &

Strong, 2004), homeless youth (Gaetz, 2004), and homeless children (Menke, 1998). Trauma-informed care (TIC) is used in treatment of homeless veterans (Dinnen, Kane, & Cook, 2014). Theory has also been used to study characteristics of homeless individuals such as the use of health services (Christian & Armitage, 2002), victimization (Gaetz, 2004), and health issues including mental health (Calsyn & Winter, 2002) and substance abuse (Sosin & Grossman, 2003). The homeless research literature is extensive; however most of the research literature has focused on homelessness in urban areas.

Themes in the homeless research literature related to the causes of homelessness generally focus on individual or structural reasons for becoming homeless. Common individual reasons are mental health issues or severe substance abuse. The structural causes are related to how our society is organized and its resources are distributed, as well as reflecting how social policy and legislative decisions are made that have led to an increase in homelessness (Rossi, 1989). A structural explanation of homelessness puts the reasons for homelessness beyond the individual, in wider social and economic factors (Neale, 1997). Examples are urban renewal and deinstitutionalization (Rossi, 1989). Wright and Lam (1987) used the concept of homeless structural theory in their study to show that there is not enough low income housing for the number of people living in poverty regardless of individual pathology. Housing and labor market theories were used to explain the lack of low-cost housing, unemployment rates and the lack of unskilled and semi-skilled jobs (Elliot & Krivo, 1991). Bohanon (1991) theorized that homelessness was a housing and economic problem and found that rents and unemployment rates were statistically significant. The causes of homelessness are complex and appear to be linked to both structural and personal issues. Human development theory and symbolic

interactionism will allow for consideration of both structural and personal issues to study the problem of homelessness and will form the theoretical framework for this study.

Human Development Theory

Ecology of human development theory provides a scientific lens in which to consider the changing environments or the contexts in which a person lives and interacts with others as a factor in human development (Bronfenbrenner's, 1977). The premise of the theory was that humans do not exist in isolation but in the context in which they live and this interconnection with the environment impacts personal development (Bronfenbrenner, 1977). The definition provided by Bronfenbrenner was:

> The ecology of human development is the scientific study of the progressive, mutual accommodations, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these immediate settings, as well as the larger social contexts, both formal and informal in which the settings are embedded (Bronfenbrenner, 1977, p. 514).

The ecology of human development theory was modified through the years to include biological aspects of the person in addition to environmental contexts only and became known as bioecological systems theory (Rosa & Tudge, 2013). In the final stage of the theory, the four elements of process, person, context, and time were said to simultaneously influence human development across the lifespan (Rosa & Tudge, 2013).

The environmental context of the individual includes five layers of systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The influences between the systems are bi-directional (Bronfenbrenner, 1977). The microsystem

includes the direct interactions that the individual has with their family, peers, neighbors, school or work. These are the daily interactions that an individual has within the environmental context in which they live. Mesosystems are the interactions between two or more microsystems. The interactions between a family and the neighbors or the family and church members, or parents and school staff are examples of mesosystems. The exosytem is an extension of the mesosystem and contain the major structural institutions of a society (Bronfenbrenner, 1977). The exosystem is comprised of laws, regulations, economic policies, transportation systems, mass media, and community resources. The individual does not directly participate with the exosytem but the exosystem has an indirect influence on the individual.

The macrosytem is abstract and includes the institutional systems of a culture including economic, social, education, legal, and political systems (Bronfenbrenner, 1977). The influence of the microsystems on the individual's environmental context has an effect on the individual. The institutional systems impact individuals differently based on socioeconomic status, ethnicity, heritage, customs, traditions, and religion. The chronosystem incorporates the element of time and refers to the environmental events in a person's life that changes over the lifetime and influences human development. The birth of a sibling, going through puberty, divorce of parents, a major illness or death are examples of events which can occur and have an effect on development (Bronfenbrenner & Morris, 1998).

The microsystem is considered the most important because most of the proximal processes that shapes an individual's development occur in this setting (Bronfenbrenner & Morris, 1998). Proximal processes are the reciprocal interactions that occur over time

in an individual's environment. Physical and cognitive development occurs primarily during childhood and adolescence and the complexity of interactions increase as a person grows and matures. The elements of process, person, context, and time as influences of human development across the lifespan were key components of the bioecological systems theory (Rosa & Tudge, 2013). The two propositions describing the properties of proximal processes are:

> Proposition 1 states that, especially in its early phases, and to a great extent throughout the life course, human development takes place through processes of progressively more complex reciprocal interaction between an active evolving biopsychological human organism and the persons, objects, and symbols in its immediate environment. To be effective, the interaction must occur on a fairly regular basis over extended periods of time. Such enduring forms of interaction in the immediate environment are referred to henceforth as proximal processes. . . . Proposition 2 [states that] the form, power, content, and direction of the proximal processes that affect development vary systematically as a joint function of the characteristics of the developing person and the environment (both immediate and more remote) in which the processes are taking place and the nature of the developmental outcomes under consideration and the social continuities and changes occurring over time through the life course and the historical period during which the person has lived (Bronfenbrenner & Ceci, 1993, p. 317).

Bronfenbrenner's theory supports using a research design that explores the interactions between proximal processes and the developing person (Bronfenbrenner & Morris, 1998). Veteran participants were asked about the chain of events that led to the

decision of joining military service and the age in which they joined. They were asked about their family growing up to provide insight into their childhood and adolescent development and the environment they were raised in. The answer to these questions provided information about the stability or lack of stability in their pre-military environment. Veteran participants were asked about the transition from military life to civilian life and the process of becoming homeless for them. The response to these questions allows the researcher to consider the theory of human development conceptually to consider the systems and contexts that have influenced the participants in this study.

Symbolic Interaction Theory

The framework of symbolic interaction was used to explore the shared meanings of participants and the journey to homelessness for them. Symbolic interaction is a relevant framework to develop theory and to inform social work practice (Forte, 2004) and can be used to integrate research and practice (Forte, 2001). This theory can be used to explore the shared meanings of marginalized groups (Forte, 2004). The homeless population which is the focus of this research project would fall into the theme of a marginalized group.

Symbolic interactionism has been used in qualitative research with homeless people. Snow and Anderson (1987) used an ethnography approach to study the processes used by urban homeless people in forming a meaningful personal identity. They studied the concept of identity and how it connects to role and self. Homeless people generally do not hold social roles that provide dignity and establish self-worth. Snow and Anderson (1987) operationally defined the concept of identity as consisting of social identities,

personal identities, and self-concept. Social identities are assigned by others and are based on appearance, behavior, and the setting one is in whereas personal identities are self-assigned. Self-concept emerges based on the meaning given to social identity and personal identity by the individual. Snow and Anderson (1987, p.43) used the term, "identity talk" to describe how homeless people construct personal identities that contain dignity and self-respect. They found that the homeless participants improved self-concept through distancing, embracement, and fictive storytelling. Some participants were found to distance themselves from other homeless individuals because they saw themselves as different and not like other homeless people. Others demonstrated embracement when the individual accepted the social identity assigned to them, such as "bum." Fictive storytelling involved embellishing the individual's homeless experiences.

Morris and Strong (2004) used symbolic interactionism as a framework for studying the impact of homelessness on the health of female headed homeless families. They used grounded theory methods and in-depth interviews to understand the perceived health problems and barriers to care that homeless families face. Using semi-structured interviews and open ended questions; patterns emerged from the narratives shared by homeless participants. Many of the participants described experiences of abuse and violence in their lives. Coming from a dysfunctional family that did not provide support was frequently a theme among participants. Blaming others for their problems and not taking responsibility for their current circumstances was voiced.

Housing was out of reach for the participants due to high rent and eviction histories. Many were unemployed and lacked basic job skills resulting in the ability to secure housing. Without a permanent address is was difficult for a potential employer to

contact them about a job. Some that found jobs did not retain them long enough to help overcome homelessness. Shelter conditions and living in close proximity to others generated frequent illness for the women and their children. Sleeping poorly, eating poorly and substance use led to health problems for some of the participants. Some participants had healthcare benefits but they did not know how to access the services or the provider they went to did not accept the insurance. Faced with the hardships of homelessness health care became a low priority for the participants unless there was an emergency or crisis situation. Eventually some would quit trying to improve their living conditions and health issues and this sometimes led to involvement with Child Protective Services. Symbolic interaction and grounded theory methods provided the framework to collect data from the perspective of the homeless individual relating the lived experience of being homeless and the barriers they faced in procuring housing and healthcare.

The structural conditions of homelessness and gender inequality were studied using symbolic interactionism (Wesley, 2009). Individual biographies were constructed from in-depth interviews capturing the lived experience of the female participants staying in a homeless shelter. Some of the participants experienced sexual abuse in their childhood homes without receiving assistance in ending the abuse. The participants described their childhood experiences as degrading and devaluing to their sense of self-worth. The women had few role models and limited support while growing up. Some of the participants reported learning from their mother how to get what they want in life by using and selling their bodies. The childhood abuse and experiences became part of their female identity. Wesley (2009) found that being sexualized at a young age created vulnerability and fear and low self-worth in adulthood. Fears from childhood became a

reality when living on the street as a female. Participants reported that living literally homeless was a coed experience and some homeless males expected sexual favors. Many of the participants reported being sexually assaulted while being homeless. Symbolic interaction theory was used to connect low self-worth in childhood resulting from forced sexuality to how living homeless provided circumstances for sexual assault occurrences and low self-worth as an adult.

Symbolic interaction theory has been used successfully as a framework for qualitative studies with the homeless population. The term symbolic interactionism was coined by Herbert Blumer, and George Herbert Mead is given credit for establishing the foundation for this theory (Blumer, 1969). Blumer (1969, p.2) identified three principles that guide the symbolic interactionist approach:

1. Human beings act toward things on the basis of the meanings that the things have for them.
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.
3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters.

The basic ideas of symbolic interactionism will be used to steer this research project. Blumer (1969) identifies these ideas as: human groups or societies, social interaction, objects, the human being as an actor, human action, and the interconnection of the lines of action (1969, p. 6).

Identifying and interpreting social interactions among rural homeless veterans is included in this study. The application of the symbolic interactionism approach proposes that individuals use the process of interpretation of the social interaction with others to guide behavior decisions. Blumer (1969) describes the interpretative process as the individual communicating with him or herself to interpret the meanings attached to the current situation they are in to direct their behavior. Blumer (1969) gives credit to Mead for defining two levels of social interaction. The first level occurs when an individual responds to an action automatically or by reflex without interpreting the action. The second type of social interaction is not automatic and takes place when significant symbols are used and the action is interpreted by the person receiving the gesture or symbol.

Communication involving gestures or symbols includes the person making the gesture and the intended message that is being conveyed to the person that is given the gesture. Also involved in the interaction process is the meaning attached by the person receiving the gesture (Blumer, 1969). Successful communication results if the person receiving the message accurately interprets and puts into the action the intended meaning of the person making the gesture. Uncertainty in the interpretation of the intended meaning of the gesture may result in miscommunication. Symbolic interactionism provides the framework to explore and interpret the social interaction between homeless veterans and the others in their lives with whom they interact to construct meaning regarding their homeless experience. In-depth interviews provided the forum to ask participants about their social relationships and support systems. Social interactions with other veterans is included.

Symbolic interactionism views human society as people participating in action. The actions of individuals can be solitary or collective in nature. This research study collected empirical data related to the social action of homeless veterans. The symbolic interactionist approach allows for identifying the objects in the lives of homeless veterans. Objects may be physical (bicycle, knapsack or tent), social (friend, relative, or neighbor) or abstract (morals or spirituality) in nature. Identifying the objects in a participant's life and the meaning attached to the objects provides insight into their world and the context in which they live and the actions they take.

Related to the concept of objects is the meaning given to "self" and the roles that a person gives to themselves (Blumer, 1969). Participant self-images, self-conversations and interpretive definitions of themselves will shed light into the situation of homelessness and how they function within this situation for veterans living in a rural area. Interpretation of the process of becoming homeless will be important in analyzing causes of homelessness for the participants. When using symbolic interaction processes are essential to causal analysis, because they form definitions of situations, which help define causes of action (Athens, 1993). Limited empirical research has been completed with this population to find out how veterans become homeless in rural America and how they manage it. Symbolic interactionism will be utilized to explore the roles that the participants identify in their lives and the meaning they give to "self."

Symbolic interaction is used as a conceptual framework in this study to enable researchers to attempt to understand the unique existence of homeless veterans living in rural areas. This framework allows the researcher to understand their world and the

meanings they attach to themselves, the physical space around them, and the social interaction of others with whom they interact.

Chapter 2: Literature Review

Ending veteran homelessness is a priority for the White House, the VA, HUD, and the American people. This research study focused on the pathways into homelessness for veterans living in rural areas of the US. The research literature regarding the rural homeless is very outdated. Few researchers have focused on the problem of rural homelessness in recent years. The literature on rural veteran homelessness is limited as well and generally includes individuals whom seek services through the VA. This review of the literature includes a discussion of homelessness in the United States including risk factors associated with homelessness. Homelessness in rural areas is included in the review of literature with both quantitative and qualitative research studies represented. A definition of what constitutes a rural area is included and the concept of rural culture is discussed. Gaps in knowledge are identified regarding rural veteran homelessness.

Homelessness in the United States

Counting the homeless in the United States is a daunting task and researchers and policy makers have used varying definitions in their studies of the homeless (Toro & Warren, 1999). Defining whom is homeless is paramount to the task of counting the homeless and is worthy of inclusion in this review of the homeless literature. The first major legislation to address homelessness was the McKinney-Vento Homeless Assistance Act of 1987. This legislation allowed federal money to go to state and local jurisdictions through Continuum of Care (CoC) Programs under HUD. The purpose of the CoCs was to gain community-wide commitments to ending homelessness. The funds could be used for emergency shelter, transitional housing, job training, health care,

education and some permanent housing. People experiencing homelessness could be rehoused while receiving services to become more self-sufficient. This allowed for collaboration between homeless service provider agencies in CoCs to work together toward serving the needs of the homeless in their communities. Duplication of services could be minimized and gaps in services could be identified and addressed through the CoCs. Communities were required to work together to submit a single application to receive the McKinney-Vento funds. Returning to permanent housing within 30 days became a goal for families whom became homeless.

The McKinney-Vento legislation was amended by the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act) of 2009. Under the HEARTH Act, CoC Programs were consolidated to better serve the homeless population. Permanent supportive housing for the chronically homeless was still funded; however, a focus on homeless prevention through rapid rehousing programs were implemented. The definition of what constitutes being homeless was extended under the HEARTH Act to include people living in shelters or in public or private places not intended for living. Also included were people leaving institutions, victims of domestic violence, people losing housing in 14 days with no resources to purchase housing and people frequently moving because of a disability or other barriers. The HEARTH Act does not include the individuals and families that are living doubled-up with relatives or friends.

The HEARTH Act of 2009 was amended in 2012 to include four categories of homeless individuals:

> (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency

shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided;

(2) individuals and families who will imminently lose their primary nighttime residence;

(3) unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and

(4) individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member. (The McKinney-Vento Homeless Assistance Act as amended by S.896 HEARTH Act of 2009 SED.103. [42 USC 11302]).

A result of the HEARTH Act was implementation of a Homeless Management Information System (HMIS) that is used to collect data about clients using homeless services. Using HMIS is a requirement of receiving money under the McKinney-Vento Act programs. HUD developed technical standards for using HMIS that CoCs adhere to. Beginning in 2007 HUD publishes the Annual Homeless Assessment Report (AHAR) using data submitted from CoCs. The AHAR provides relevant data on individuals using homeless services and provides an unduplicated count and identifies patterns of service use.

In January of 2017, 553,742 homeless people were counted in the United States (HUD, 2017). Sixty-five percent were living in emergency shelters or transitional housing and the remaining 35% were living in unsheltered locations (HUD, 2017). The

data available on the incidence of homelessness is usually taken from nightly counts of the literal homeless, emergency shelters and requests for emergency shelters. Using these methods is not an exact science and many homeless people are not included in homeless counts, so estimates of the prevalence of homelessness are used. Most (70%) of the homeless are over the age of 24; however, 10 % are between the ages of 18 and 24 and 20% are children under the age of 18, which is a statistic of concern (HUD, 2017). The estimated racial categories for the homeless population are: 47% white, 40% African American, and 13% other races (HUD, 2017). The National Survey of Homeless Assistance Providers and Clients (NSHAPC), a large-scale study found that homeless people were more likely to be members of minority groups. Results from NSHAPC found that 62% of families and 59% of individuals were members of minority groups, predominantly African American (Burt, Aron, Douglas, Valente, Lee, & Iwen, 1999). The NSHAPC data is outdated but is the most comprehensive national survey of homelessness prior to the implementation of HMIS by HUD (Perl, 2015).

When considering household type, 67% of all the homeless are individuals and 33% are families (HUD, 2017). One study categorized homeless adults into three categories: the transitional homeless whom are homeless for one or two brief periods; the episodic homeless whom have several homeless incidents that decrease in length between occurrences; and the chronically homeless (Kuhn & Cuhane, 1998). Government agencies commonly consider a homeless individual as chronically homeless if they have a disabling condition and have had four occurrences of homelessness in three years or if they have been homeless for at least a year. The disability commonly includes severe and persistent mental illness, substance abuse, or both and HIV/AIDS (Caton, Wilkins, &

Anderson, 2007). Twenty-five to 30% of homeless people have been found to have a serious mental illness (Folsom et al., 2005). One study matched characteristics on age, gender, and psychiatric disorder of 39 homeless individuals to 39 housed people and found that reasons given for homelessness were unaffordable housing options, criminal activity, alcohol and drug use and limited or no social support (Odell & Commander, 2000).

Homeless families are much more likely to be sheltered (89%) than living on the street (HUD, 2017). Homeless families are generally headed by non-white women (Rossi et al., 1987; Whaley, 2002). This held true in the 2017 AHAR report which found 53% of sheltered families to be African American and 28% to be Hispanic. In addition to low incomes and issues of poverty, interpersonal violence may be a cause of homelessness for families. Homeless mothers have been found to have high rates of childhood abuse and assault (Bassuk, Perloff, & Dawson, 2001) and partner or domestic violence has been shown to proceed homelessness for some individuals (Anderson & Rayens, 2004).

People fall into homelessness for both structural and personal reasons. Poverty, loss of employment or underemployment and the inability to find affordable housing are major contributors to homelessness (National Coalition for the Homeless, 2009). Personal reasons may include substance abuse, mental health issues, or victimization related to violence. The body of homeless research literature has focused on one or the other and is beginning to agree that it may be a combination of both (Christian, Clapham, & Abrams, 2011).

To be considered homeless under the HEARTH Act a person would need to be literally homeless, living in a shelter or hotel, leaving an institution, a victim of domestic

violence or in danger of losing housing in two weeks. Living doubled-up with a friend or relative does not constitute living homeless under the HEARTH Act. The implementation of the HMIS database is providing a picture of the people using homeless services. Homeless estimates tell us that most homeless people are utilizing shelters or transitional housing but a third of the population is living literally homeless. Homeless families comprise about a third of the homeless population and are more likely to be living in sheltered situations. Homeless experiences can be categorized by frequency and duration. Transitional homeless people are only homeless for one or two brief episodes whereas, the episodic homeless people have several shorter episodes of homelessness. The chronically homeless have many occurrences or have been homeless for over a year. Homeless causes have been shown to be related to poverty, unemployment, interpersonal violence, substance abuse and mental illness. A discussion on risk factors related to homelessness is next.

Risk Factors

Health stressors. Health problems can lead to homelessness or be a result of living homeless. Existing health problems, serious illness, injuries caused by accidents or a disability can lead to medical bankruptcy and eventual homelessness (National Health Care for the Homeless Council, 2014). Existing medical conditions can worsen without proper care and maintenance. For someone already experiencing homelessness, the stress of finding and maintaining shelter and finding enough food to eat may take priority over medical needs.

Homeless people are at high risk for health problems and are less likely to have health insurance, social support, steady income, and preventive health services (Forchuk,

Brown, Schofield, & Jensen, 2008). Proper nutrition and participation in primary or preventive health care are challenging for this population to achieve (National Alliance to End Homelessness {NAEH}, 2013). Most homeless people do not have a primary care physician and wait until a health concern becomes a crisis to seek emergency care (Schiff, 2015). Homeless individuals are five times more likely to use emergency room services than their housed counterparts (Frankish, Hwang, & Quantz, 2005).

Many individuals experiencing homelessness have chronic health issues. Homeless people are at a high risk for hypertension, asthma, diabetes, tuberculosis, and HIV/AIDS (National Health Care for the Homeless Council, 2014). High blood pressure, heart disease, diabetes, asthma, hepatitis, emphysema, and diseases of the skin are found at higher rates in homeless individuals than the general population (Schiff, 2015). Injuries, infections, and pneumonia are difficult to manage when living homeless in sheltered or unsheltered locations (National Health Care for the Homeless Council, 2014). Medications may be difficult to obtain and can be easily lost or stolen; routine supplies may not be available to manage diabetes or to keep wounds clean (Schiff, 2015). In addition to difficulties managing medical health issues, dental health may be difficult to maintain for this population. In a study of adults living in shelters, 88% needed fillings and 40% needed emergency treatment (Figueiredo, Hwang, & Quinonez, 2012). Lack of dental care may contribute to poor health and low self-esteem (Schiff, 2015).

Living sheltered may pose additional health risk to the homeless population. Living in a shelter can lead to exposure to conditions that come from living in close proximity to others. Specifically, living in shelters increases the risk of communicable diseases due to crowded living conditions (National Health Care for the Homeless

Council, 2014). Shelters provide a mechanism to keep homeless people out of the extremes of weather conditions, while at the same time they also increase the risk of illness. In addition to physical health concerns, some homeless individuals struggle with substance use and mental health issues.

Substance use and mental illness. Substance use and psychiatric difficulties have been linked to homelessness. Just over a quarter (26.2%) of the adults living in shelters during the 2010 PIT count had severe mental illness and 34.7% had a chronic substance use problem (HUD, 2010). Mental illness can lead to loss of housing because the symptoms of the illness do not allow the person to work or social support needed during extreme stress and disability are not available or do not provide the support needed (Schiff, 2015). Rates of alcohol and or drug dependence have been shown to be as high as 50-70% in homeless populations and some homeless individuals have both a major mental disorder and a substance abuse disorder (Schiff, 2015).

Trauma. Trauma may impact the mental health, substance abuse, and behavior of homeless people (Schiff, 2015). Trauma is associated with depression, anxiety, difficulty trusting others, and alcohol and substance abuse (Briere & Scott, 2006). Post-Traumatic Stress Disorder (PTSD) (Tsai, Pietrzak, & Rosenheck, 2013) and Traumatic Brain Injury (TBI) (Topolovec-Vranic et al., 2012) are associated with some homeless people. A diagnosis of PTSD can increase the risk of becoming homeless (Dinnen, Kane, & Cook, 2014). TBI is more prevalent in homeless people then the general public (Topolovec-Vranic et al., 2012). TBI can result in unstable behavior and cognitive deficits which may decrease social support and hinder employment which may result in eventual homelessness (Schiff, 2015). Homeless people are often the victim of violence

that may result in TBI and impact their coping behaviors (Schiff, 2015). Trauma information as it relates to veterans is included later in this review of literature.

Mortality rates. Untreated chronic diseases, psychiatric illnesses, substance abuse and exposure to communicable disease may lead to premature death for homeless individuals when comparing mortality rates to the general population (Baggett et al., 2013). The National Coalition for the Homeless (2009) reports the life expectancy for a homeless person is 42-52; compared to age 78 for the general population (Schiff, 2015). In the Baggett et al. (2013) study, the mean age at death among homeless participants living in Boston was 51. Higher mortality rates were found in white homeless adult participants compared to nonwhite homeless adults (Baggett et al., 2013). Ahmed and Toro (2004) suggested previously that mortality rate differences may be due to the pathways into homelessness by individuals. Specifically, causes of homelessness for African American individuals are more likely to be poverty related, whereas, homelessness for white individuals are related to personal issues like substance abuse, mental illness, or family conflict (Ahmed & Toro, 2004).

Age was also a factor in comparing causes of death between study participants. Comparison of mortality rates between homeless and non-homeless individuals found mortality rates were nine times higher in the 25-44 homeless age group, and four and a half times greater in the 45-64 homeless age group (Baggett et al., 2013). The main cause of death for the 25-44 age group was drug overdose. Substance abuse is frequently linked to the problem of homelessness. Substance abuse has been identified both as a cause of homelessness and as a response to homeless stressors such as chronic diseases, assaults and accidents (National Healthcare for the Homeless Council, 2014). Cancer and

heart disease were found to be leading causes of death for homeless individuals over the age of 45 (Baggett et al., 2013). Many factors are related to high mortality rates in the homeless population and ending homelessness would help lower the rates of premature death (USICH, 2013).

Homelessness in Rural Areas of the United States

There is little empirical research literature on rural homelessness in the United States. Much of the research is outdated. The following paragraphs will provide a discussion of the current research literature available on this topic. Homelessness in rural areas may not be as visible as it is in urban areas, yet the experience of homelessness is just as difficult. Structural influences such as low numbers of affordable housing stock, high unemployment rates, and high poverty rates contribute to the problem. Personal problems like medical bankruptcy due to medical debt after a major illness, substance abuse, mental illness and victimization increase the risk of becoming homeless. Rural areas have less shelter options than urban centers and the homeless are less likely to live on the streets. Homeless individuals are more likely to live in an automobile, in substandard housing or doubled-up with friends or relatives, while some find places to camp. Rural homelessness is generally compared to urban homelessness so a discussion of what is rural is necessary for this study.

Rural area defined. The United States (US) government uses the US Census Bureau or the Office of Management and Budget (OMB) definitions to define what is rural, urban, and suburban areas. The US Census Bureau does not use city or county boundary lines in their definition but uses population density to define urbanized areas. An Urbanized area is defined as having 50,000 or more people, while urban clusters must

have at least 2,500 people but less than 50,000 (US Census, 2010). All other areas that are not defined with an urban area are considered rural. Unfortunately, using this definition allows some suburban areas to be designated as rural. The OMB defines a county as Metropolitan if the county contains an urban area population of 50,000 or more people. A Micropolitan county contains an urban area of less than 50,000 but has at least 10,000 people in its urban core. Under this definition Micropolitan counties and counties not designated as either Metropolitan or Micropolitan are considered rural (OMB, 2010).

Quantitative research studies. The research literature on rural homelessness is sparse and very outdated. Much of the literature dates back to the 1980's and 1990's. To a large extent, the research on homeless populations in rural areas has been cross-sectional involving structured surveys (Cummins, First, & Toomey, 1998; First, Rife, & Toomey, 1994; Gaber, 1996; Gaber & Cantarero, 1997; Hoover & Carter, 1991; Roth & Bean, 1986; Roth, Toomey, & First, 1987; Segal, 1989; Thrane, Hoyt, Whitback, & Yoder, 2006). During the late 1980's and early 1990's researchers in Ohio conducted studies with rural and nonurban homelessness populations using rigorous sampling strategies and robust sample sizes that allowed for data to be generalized to homeless adults in the state of Ohio with some confidence (Cummins et al., 1998; First et al., 1994; Roth & Bean, 1986; Roth et al., 1987).

The Roth and Bean (1986), the parent study, and Roth et al. (1987) were the first to publish generalizable findings pertaining to the rural homeless population. In the parent study by Roth and Bean (1986) a sampling strategy was utilized to count every homeless person in the 19 counties surveyed. The 19 counties included urban, non-urban, and rural areas in an effort to get a representative sample of homeless people in Ohio.

Major cities, small city areas and rural counties were included in the study. Nine of the counties were classified as rural with 20% of the interviews occurring in rural areas. Participants were considered homeless if they had limited or no shelter, were living in a shelter, mission, cheap hotel or motel or living with friends or relatives or in jail for less than 45 days. Under this definition of homelessness, people living doubled-up were considered homeless.

This study allowed comparisons between rural and urban homeless persons. Trained interviewers gathered data from 979 homeless individuals. Rural homeless participants tended to be younger than urban participants. The median age of a homeless person in a rural setting was 30 compared to 35 in an urban setting. A majority (92%) of the rural homeless individuals were white and twice as likely to be married as their urban counterparts. A higher proportion of homeless women (32%) were found in rural areas compared to urban areas (16%). Similar rates of community mental health center use and psychiatric hospitalizations were found; however, rural homeless persons had higher scores on the depression/anxiety scale than did urban homeless persons. Urban participants reported more behavioral disturbance severity symptoms than rural participants. Approximately one-third of the participants self-reported that they were veterans, including nine percent who were Vietnam veterans. Unfortunately, veteran status was not reported by geographic type in the findings, so it is unclear in which locations the veterans resided. Comparisons between rural and urban homeless veterans were not reported in this study. Over half of all the participants cited economic reasons as the cause for homelessness and 21% reported family conflict as the reason. Alcohol and drug abuse was reported as the reason for homelessness in 7.3% of the participants and

may have been contributing factors for the two main reasons of financial strain and family problems. Mental health problems were not identified as a self-reported reason for homelessness in this study.

Three homeless subtypes emerged from the Roth & Bean (1986) findings: street people who do not use shelter; shelter people; and resource people whom do not use shelter but have enough personal resources to stay in cheap hotels or with family and friends for short periods. The subtypes were not compared to veteran status, so no generalizations can be made regarding the subtype categories for veterans living in rural or nonurban locations. Of the homeless population living in rural areas of Ohio, a third were women and two thirds were born in the county they were living in or had lived there for over a year. This finding provided evidence that they were not a transient group of homeless persons. Half of these women were homeless for less than a month.

The Roth et al. (1987) study was based on the female subset (n=186) of Roth and Bean (1986) and compared gender differences. Females identifying as homeless were younger with a median age of 28 compared to males at 35. Almost two thirds did not graduate from high school compared to approximately half of the males in the study. Three quarters of the women were not married. Almost 40% of the homeless women in the study said that they had a medical problem that required treatment. Approximately a third of the women required some level of mental health services while two thirds had no measurable psychiatric problems. Economic factors and family conflict were almost equally cited as the cause for homelessness in this sample.

The Ohio studies, Roth and Bean (1986), and Roth et al. (1987) revealed differences in types of homeless people: street people, shelter people and resource people.

Street people were literally homeless and rarely used shelters. They were found to have more behavior problems than the shelter or resource group of homeless. Shelter people frequently used the shelter system and other homeless services available. Resource people did not use the shelter system and were more likely to have a job to pay for a cheap hotel or have friends or family that they could stay with. Resource people were found to be younger (half were under 30) and had been homeless the least amount of time compared to street people and shelter people. This study provided evidence that homeless people are not a homogenous group and use different methods to cope with homelessness.

The Ohio studies found differences between urban and rural homeless participants. Rural homeless people were younger and about twice as likely to be married as urban homeless people. The rural homeless were mostly white and mostly male. There were twice as many female homeless participants in rural areas than urban areas. The rural homeless were more likely to have income in the last month than the urban homeless and were less likely to use soup kitchens and shelters. The rural homeless had less behavioral disturbance symptoms than the urban participants but did have higher depression/anxiety scores suggesting that some members in both groups needed mental health services. This Ohio study provided relevant information about the populations of rural homeless and differences between rural and urban homelessness.

Segal's (1989) study used a convenience sample of rural homeless individuals in Illinois. The research area was described as two neighboring towns with a combined population of approximately 95,000 people. A large state university and a military base were within the study area. The towns were surrounded by farmland. Using a cross-

sectional survey, trained interviewers collected data from 47 residents of five homeless shelters in Illinois. The sample may not have been representative of the homeless population and the findings can only be narrowly applied to those individuals who used the shelter. As we learned from the Roth and Bean (1986) study, people using shelters were only one category of homeless people identified. The street people and resource people categories were not represented in this study.

The average age of a rural homeless person utilizing a shelter was 34 in the Segal (1989) study. This finding is consistent with Roth and Bean (1986) if we consider that resource people tended to be younger (less than age 30) than street people and shelter people in their study. Almost three quarters of the sample were white and 17% were black. Nineteen percent of the sample were women, which is much lower than the 32% reported by Roth and Bean (1986). A consideration for the difference is that Roth and Bean (1986) included the literal homeless and homeless people doubled-up with friends and family and Segal only included homeless people staying at shelters. A third of the sample was born in the area in which they were living and another 26% had been born in the state. This finding supports that many homeless people living in rural areas are not transient but have roots in the area in which they are living. The needs of the participants were identified as adequate employment, affordable housing, and medical care. Due to the small sample and convenience sample the findings may not be generalizable to other homeless people living in rural areas although the identified needs are common to the rural homeless population.

Hoover and Carter (1991) used trained interviewers to administer a cross-sectional survey to 71 homeless individuals staying at two shelters located in two

counties. One of the shelters was located in a small town of about 5000 people and the other was located in a medium sized city with a population of approximately 30,000 people. Their findings supported prior studies in that two-thirds of the participants were from the local area and were not transient homeless people. Half of the sample had stayed with family or friends prior to coming to the shelter. A third cited economic reasons and another third cited family problems as the major causes of homelessness. Although the convenience sample was small and may not be generalizable, the two main reasons (economic causes and family conflict) identified for homelessness were the same as the two leading causes of homelessness found in Roth and Bean (1986).

In the early 1990's First et al. (1994) replicated the Roth and Bean (1986) study. Twenty-one rural counties were randomly selected to represent the five regions of the state of Ohio and a sample of 919 individuals was obtained. A county was considered rural if the population was less than 200,000 people. The 21 counties included in the study had populations ranging between 11,000 and 150,000 people. This study was the first study pertaining exclusively to rural homelessness using rigorous sampling strategies and robust sample sizes that allowed for data to be generalized to homeless adults in the state of Ohio with some confidence.

Homelessness was defined as having limited or no shelter or living in a shelter, mission, cheap hotel or motel. People doubled-up with friends and relatives were included in the study. Males and females were almost equally represented in the sample. The median age was 29 which was just one year below the earlier Ohio homeless rural sample. Over 85% of the rural homeless in the geographic locations studied were white. Just over half of the sample had completed a high school education and 70% were not

married. Female participants were younger and more likely to be married than male participants. Women were more likely to be heads of family with children and to be doubling up with family or friends. Men were more likely to have finished high school, were more mobile, homeless longer, and more likely to stay in shelters. Just over half (52.3%) were long term residents of the areas. Almost half of the participants cited economic factors as the cause of homelessness and another 30% said it was family problems. These findings support the two leading causes of rural homelessness found in earlier studies (Roth & Bean, 1986; Hoover & Carter, 1991).

First et al. (1994) had participants falling into the three homeless categories of street homeless, shelter homeless and resource homeless in their study. Almost half (46%) of the participants were living doubled-up with friends or family. The remainder of the participants were living in shelters or cheap hotels (39%) or on the street (15%). The findings in First et al. (1994) provided further descriptions of homeless participants and identified five major groups of rural homelessness. The identified groups were: young families, working individuals unable to afford housing, women in need of child care or with limited job skills, older men whom have been homeless longer and likely disabled with few social supports, and disabled people without social networks to live independently. Identifying the rural homeless in this way provided a more descriptive way to categorize homeless people living in rural and non-urban areas of the United States.

Using the female subset of the First et al. (1994) data, Cummins et al. (1998), made comparisons to urban homeless studies. Rural homeless women had cited family conflict and family separation as the primary reason for homelessness. This was

consistent with urban studies reporting high rates of physical or sexual violence among homeless women (Anderson, Boe, & Smith, 1988; Browne, 1993). Rates of mental illness, alcohol and drug use were found to be lower in these rural homeless participants than what was reported in prior urban homeless studies (Anderson et al., 1988; Fischer, 1991).

The second Ohio study by First et al. (1994) replicated the original Ohio study completed by Roth and Bean, (1986). It focused on rural homeless people only and gave us a better description of rural homeless people. Including the doubled-up homeless living in rural areas revealed that about half of the rural homeless participants were living with friends and relatives. Having ties in the area appears to help some people from becoming literally homeless and makes for a less transient group of homeless people.

Over half of the participants were female, many were found to be young families (27%) including women with children not able to afford housing on their own. Thirty percent of the participants cited family conflict as the reason they were homeless. Victims of interpersonal or domestic violence would fall into this category. Economic reasons for homelessness were reported by over 40% of the participants. Many of the participants (31%) had jobs but were not able to afford housing on their own. This study also provided information about homeless veterans living in rural areas of Ohio. The researchers asked about veteran status and found that 13.7% of the participants were veterans with 4.6% reporting as Vietnam veterans. Findings were not reported for homeless group type with regard to veteran status, so we don't know if the veterans were more likely to be working or more likely to have a disability that has contributed to being homeless. Generalizations to this subgroup could not be made.

To determine who the rural homeless were in Nebraska, Gaber (1996) used a cross-sectional telephone survey of 35 homeless service providers outside the two major cities of Omaha and Lincoln in Nebraska. The US Census Bureau definition of rural (areas with less than 2,500 population) areas was used. Gaber (1996) used snowball sampling to identify providers for the study. The Stewart B. McKinney Act of 1987 (PL 100-77) homeless definition was used as the criterion of a homeless person for this research. The definition included individuals lacking a fixed, regular, and adequate nighttime residence. The doubled-up homeless were not included.

Service providers identified four groups of homeless people unique to Nebraska and the Great Plains region: Native Americans, migrant agricultural workers, meat packing workers, and transients. Causes of homelessness for Native Americans living on reservations were high rates of poverty, substandard housing and living conditions, and overcrowding. The area included in the study attracted low-skilled, low-wage migrant or immigrant labor to perform seasonal agricultural work but was unable to meet the housing needs of this workforce. The meat packing industry in Nebraska also attracted low-skilled labor and was not able to meet the need for affordable housing. Major transportation routes cut through Nebraska which brings transient homeless people to the area.

This study in Nebraska did not survey homeless individuals but did provide a perspective of homelessness from agencies serving homeless populations. Poverty and lack of economic opportunities contribute to homelessness involving Native Americans living on reservations. Overcrowding living conditions suggest that family and friends may be willing to live temporarily doubled-up in these communities to help prevent

literal homelessness. The working poor that work for low wages but couldn't afford housing were represented in Nebraska's meat packing industry. Other low-wage jobs were available seasonally for the migrant workforce, which is a more transient group in nature. The findings in this study were specific to the rural homeless population in Nebraska and could not be generalized to other rural populations.

Approximately thirteen years ago, I was part of the research team that conducted a study of homelessness in Cecil County, Maryland using a cross-sectional survey instrument (Center for Family and Community Life, 2005). Cecil County is primarily rural and is one of the nine counties that make up the Eastern Shore of Maryland. Using the same homeless definition as found in the Ohio studies, homelessness was defined as having limited or no shelter or living in a shelter, mission, cheap hotel or motel. People doubled-up with friends and relatives were included in the study. Seventy-five homeless adults were interviewed. Most the respondents were white males which is consistent with the first Ohio study and the Illinois study. The second Ohio study reported slightly more females than male respondents. Twenty-one percent of the Cecil study respondents were female and approximately 57% of the respondents had children. This finding suggests that some of the respondents probably fit into the young family category or the women with children category identified in the Ohio studies. The median age was 46 in this study which was considerably higher than the median age of 30 and 29 reported in the Ohio studies.

The Ohio studies reported a high percentage of their respondents were living doubled-up with friends and family. This was true for only 7% of the Cecil respondents. The literal or street homeless percentages were very different in rural Ohio than they

were in Cecil County, Maryland. Fifteen percent of the respondents in rural Ohio identified as living on the street, whereas 41% were literally homeless in Cecil County. Shelters users were also higher in Cecil County at 43% compared to 30% in the rural counties of Ohio. Cecil County respondents were similar to other rural homeless in that they were not transient individuals. Over half (65.3%) of the respondents reported always living in Cecil County. Veteran status was collected and approximately one-fourth (27.8%) of the respondents reported that they were veterans. These veterans were all male with 80% reporting that they were combat veterans. The question of what war era they fought in was not asked, however an assumption was made that many were of the Vietnam era because of the age of the respondents. This was a gap in this study and it would have been helpful to know if the veterans were mostly identified in the category of street homeless or sheltered homeless.

The cross-sectional studies described in the previous paragraphs are mostly outdated reporting homeless data from the 1980s, 1990s and early 2000. The National Survey of Homeless Assistance Providers and Clients (NSHAPC) reported similar demographic information of the rural homeless. The NSHAPC data is also outdated but is the most comprehensive national survey of homelessness prior to the implementation of HMIS by HUD (Perl, 2015). The NSHAPC found that the majority of homeless individuals in the rural sample were non-Hispanic white males (Burt et al., 1999). Similar findings were found in other rural homeless studies (Aron, 2004; Center for Family and Community Life, 2005, Roth & Bean, 1986). The NSHAPC national survey reported that homeless adults living in rural areas were older than adults living in urban communities; 78% were age 35 years or older. (Burt et al., 1999).

In reviewing the literature on rural homelessness, the major reasons cited for rural homelessness were economic reasons and family conflict and family separation (Cummins et al., 1998; First et al., 1994; Hoover & Carter, 1991; Roth et al., 1987). These two causes can be linked to existing homeless frameworks based on urban populations which discuss structural and personal problems as the main causes of homelessness. Structural issues encompass but are not limited to lack of employment and lack of affordable housing stock. Family conflict may be linked to economic reasons but may also include other reasons like domestic violence or mental illness or substance abuse which are considered personal problems. Family conflict has also been found to be a major stressor of psychiatric crisis in a study of psychiatric hospitalizations in a rural population (Camacho, Ng, Bejarano, Simmons, & Chavira, 2010).

Rural cross-sectional survey studies have found lower rates of mental illness, alcohol and drug problems in self-reports by rural homeless adults compared to urban homeless adults (Cummins et al., 1998; First et al., 1994; Roth et al., 1987). Using standardized instruments in these studies allowed for comparisons although reliability and validity was not always reported. Veterans were not the focus of these research studies and no generalizations on these causes of homelessness can be discussed regarding veteran status. We know that almost 14% of the respondents in the First et al. (1994) study and 28% of the participants in the Cecil County study were veterans and that most of these were thought to be Vietnam era veterans. Not much else is known about the veterans that participated in these studies. The causes of veteran homelessness is not specifically articulated in the rural homeless research literature.

Qualitative research studies. Qualitative research focusing on rural homelessness is even more scant than the quantitative studies mentioned previously. Qualitative researchers gathering data on the experiences of homelessness have generally focused on urban areas (Giamo, 1989; Liebow, 1993; Snow & Anderson, 1993). However, the work of Fitchen (1992) and Hilton and DeJong (2010) and Trella and Hilton (2014) focused on homelessness in rural areas.

Fitchen (1992) used unstructured interviews with 20 individuals and several focus groups to explore housing problems and homelessness in upstate New York. Using information from these sources she constructed a questionnaire on residential history to interview 40 low-income women living in precarious housing situations but not literally homeless. These women were at or below the poverty level and were receiving some type of social service support and lived in rural places. Additionally, she interviewed 20 individuals or couples applying for public assistance to reach those more likely to be homeless.

Fitchen (1992) made the point that people living in inadequate or unsafe housing, doubling up with relatives or moving frequently are only a day away or a relative away from becoming literally homeless and that the definition of homelessness in rural areas should be expanded to include people who find themselves in these situations. People living at or below poverty level many times have to choose inadequate or unsafe housing because this is what they can afford to put a roof over their head. Some may find cheap apartments to rent. Either choice puts them in a vulnerable position where they may have to move frequently prior to becoming homeless. Adding these indicators to the definition

of homeless would expand the definition to include these factors relevant to homelessness in rural areas

A more recent study focusing on rural homelessness was conducted by Hilton and DeJong (2010). Interviews were conducted with 55 homeless individuals living in the Upper Peninsula of Michigan using a grounded theory approach. Interviews began in shelters and continued until theoretical saturation was reached. Non-shelter users were then targeted until consistent patterns emerged, so saturation was presumed to be met.

Hilton and DeJong (2010) identified five categories of rural homeless coping patterns. They identified the doubled-up homeless and called them couch hoppers. This category has been used frequently in the other studies included in this literature review and this group was referred to as resource homeless people in Roth and Bean (1986) because they had friends or families that were helping them. A second category of homeless people described in Hilton and DeJong (2010) were people whom owned housing that was unfit to live in because there was no heat, electricity or running water and categorized them as circumstantial homeless. This group of homeless people owned substandard housing but did not have the resources to make the house inhabitable. A third related category was identified as mixed users, meaning that their coping method frequently changed, and they moved from place to place. The first three categories of homelessness that Hilton and DeJong (2010) identify are the same three categories that Fitchen (1991) suggested should be added to the definition of rural homelessness. The final two categories were individuals using shelters or motels and campers who lived outdoors or in automobiles. These two categories are comparable to the street people and shelter people described in the Ohio studies.

Over half of Hilton and DeJong's (2010) participants had strong ties to the Upper Peninsula of Michigan. This finding supports prior research that a majority of the rural homeless are not transient individuals. They questioned their participants as to why they stay in a cold, remote area of Michigan during the cold and snowy winters and found that participants had strong connections to the area. The relationships with friends and family may be strained and they may not be able to live with the relative; however, they may receive other types of assistance like transportation to an appointment or food and clothing. Help may be limited because the family member may be struggling financially too. Upon becoming homeless many people stay in the area where they have a history and know others. They may be able to draw on support from people they know and with limited resources would find it difficult to move any distance.

The couch hopper (couch surfing) literature was expanded by Hilton and DeJong (2010) as they found positive and negative experiences related to this category depending on the age of the homeless person. Young adults reported more positive experiences while older adults found the experience to be negative. Hilton and DeJong (2010) found that the couch hopping group displayed a heavy reliance on family and friends and used a mix of formal and informal assistance. One theme that emerged was feeling that they were a burden to those helping them. The host family may be struggling too and may only be able to offer a couple of days of shelter. If they are renting the landlord may not allow extra people living in the residence. Sometimes the homeless families split up to share the burden across two homes. Overcrowding becomes a problem and the homeless family may move to another temporary situation before becoming literally homeless. A

priority was managing the network of family and friends and trying to limit the burden by moving frequently among households willing to help.

Building on the work of Hilton and DeJong, (2010), Trella and Hilton (2014) conducted in-depth interviews with 114 homeless adults over a four-year period to study the relationship between homeless people and their non-homeless family members. This study took place in the Upper Peninsula of Michigan. Almost half (45%) of the participants were staying in shelters, 30% were staying with family and friends and 25% were literally homeless. Based on their help-seeking behavior, participants were identified as having characteristics of high or low thresholds for asking for help from their relatives.

One of the characteristics of having a high threshold for asking for help is not asking for help unless it was a last resort. Some homeless people have abused family relationships and will not ask for help unless there is no other option. These people have experienced some sort of personal failure in their family relationships that keeps them from frequently asking for help from their relatives. Respondents with a high threshold did not necessarily expect help from family members when they asked and were willing to take any help offered. Some realized that the family member may be struggling financially as well. Some respondents did not ask for help from family because they said they were responsible for their circumstances and understood the consequences of poor decisions. Others valued the concept of being self-sufficient. Taking responsibility and being self-sufficient are values found in rural culture (Smalley, 2012). Another attribute for having a high threshold for asking for help is having an extensive social network that

limits the need for asking for help from one person. Some respondents found it easier to ask for help from friends with no partners or children.

A characteristic of low threshold for asking for help from family members is viewing their episode of homelessness as a temporary situation and expecting their family should help them. Personal problems for causing homelessness were not a consideration for some of the respondents. On the other hand, some homeless people have no alternative but to turn to their relatives for help. Some mothers with children were in the low threshold for asking for help because of the risk of Child Protective Services (CPS) involvement. Respondents with a low threshold for asking for help perceived their situation as high need for help and had fewer social networks to rely on for help other than family members.

The work of Trella and Hilton (2014) begins to connect the concept of rural culture and asking for help when homeless. There is a sense of self-reliance and a strong work ethic that guides people to meet their own needs in rural communities, which may hinder asking for help (Daley, 2015). Using a grounded theory approach Trella and Hilton (2014) were able to identify relationship patterns between homeless people and their non-homeless family members and to learn about social networks that provide help in coping with homelessness. Identifying factors to explain if family relationships were helpful to the family member were included in their study. The norms, behaviors, expectations, and value systems of the family seemed to impact the decision of homeless people in asking for help in some of the examples provided by Trella and Hilton (2014). Specifically, the examples of taking responsibility for their homeless situation and being

self-sufficient in their circumstances are rural culture values. A further discussion of rural culture is provided next.

Rural Culture

According to the US Census Bureau (2010) one in five Americans resides in rural areas. Rural environments consist of economic, religious, historical and geographic factors that create a unique culture that influences the individuals and families living in that culture (Smalley et al., 2012). Industries traditionally linked to rural areas like farming, fishing, logging, ranching, and mining are associated with independence, strong work ethic, and personal responsibilities which are personality traits found in rural culture (Smalley et al., 2012). These jobs are physically demanding and there is a sense of self-reliance and a strong work ethic that guides people to meet their own needs (Daley, 2015). Many rural residents must travel considerable distances to receive healthcare or mental health care. People living in rural areas may believe that they need to be self-reliant for physical and mental health needs and may not want to burden friends and relatives with helping to get them to provider agencies that are not local to where they are living (Smalley et al., 2012). Geographic isolation is common in some rural environments and may impact the use of medical care providers and seeking mental health care services for rural residents (Health Resources and Service Administration [HRSA], 2014).

Other considerations associated with rural culture are the stigma connected to seeking help. Perceived stigma has been found to be prevalent in rural communities (Komiti, Judd, & Jackson, 2006). Self-reliance brings with it a sense of pride in being self-sufficient. Seeking outside help for problems may be viewed as failure and may

foster shame for the individual and their family members needing help (Daley, 2015). This is compounded by the generally negative perception toward someone receiving mental health services in rural areas (Smalley et al., 2012). Individuals may find it difficult to access help anonymously for fear of being recognized entering an agency serving clients with mental health issues (Parr & Philo, 2003). Individuals seeking help for or identified as having a mental illness may be viewed as unstable and may lose housing or employment opportunities or chances for social support; resulting in isolation, low self-esteem and diminished feelings of self-worth (Smalley et al., 2012). When focusing on the problem of rural homelessness considering the connection of rural culture to the problem of rural homelessness may add insight into the behaviors of people experiencing homelessness in rural areas. The concepts of being self-sufficient, having a strong work ethic, experiencing shame and stigma may be areas of connection between rural homelessness and rural culture to consider when studying this problem. These variables can guide the choices and decisions made by homeless individuals during their homeless experiences.

The quantitative and qualitative research literature on rural homelessness does not shed very much light on the pathways into homelessness for rural veterans. Veteran status was asked for in some studies, but the analyses did not include veteran specific findings. The qualitative research literature did not identify veteran status of participants and is very thin regarding rural homelessness. Findings from the three studies discussed show us that homelessness can be viewed on a continuum with the people at one end living on the cusp of becoming homeless and those at the other end being literally homeless. A definition of homelessness that includes all aspects of the continuum seems warranted in

rural homeless research and the counts of homeless people living in rural areas would increase substantially if people staying with friends and relatives were included in the count.

It is possible that many veterans fall into homelessness for the same reasons as the general population of homeless in rural areas. Economic reasons and family conflict may be leading causes of homelessness for this subpopulation. There is a large body of literature focused on veteran homelessness which will be reviewed next.

Veteran Homelessness

The VA's plan to end homelessness continues to bring an increase of funding and services for this population. To qualify for homeless veteran programs a person must meet two conditions. They must have served in the active military, naval, or air service without a dishonorable discharge and they must meet the McKinney-Vento federal definition of a homeless individual as someone lacking a fixed, regular, and adequate nighttime residence or one whom resides in a temporary shelter, an institution or a place not ordinarily used as a regular sleeping accommodation for a human being (Perl, 2015). Imminent loss of housing is also included if an individual or family will lose their housing within 14 days. Other federal definitions include unaccompanied youth and homeless families with children if they have experienced 60 days without living independently in permanent housing, have moved two or more times in a 60 day period or they are expected to continue in unstable housing due to chronic disabilities, chronic physical or mental health, substance addiction, the presence of a child or youth with a disability, history of childhood abuse or multiple barriers to employment (Perl, 2015).

Homeless veterans living doubled-up with friends or relatives would not be included under this definition.

Homeless veterans are often the subjects of research studies; however, research generally focuses on urban problems and does not usually differentiate between urban and rural homelessness. Veterans are overrepresented in the homeless population compared to nonveterans (HUD, 2017). When homeless veterans were compared to homeless nonveterans the veteran participants were found to be older, male, and more likely to have graduated from high school (Rosenheck & Koegel, 1993; Tessler, Rosenheck, & Gamache, 2002; Tsai, Mares, & Rosenheck, 2012).

Risk factors for veteran homelessness. Tsai and Rosenheck (2015) completed a systematic review evaluating 31 research studies to assess risk factors for homelessness in veterans. Across studies substance use disorders and mental illness were consistently found to be the greatest risk factors for veterans. Not surprisingly economic factors were found to be a factor in homelessness. Social isolation, adverse childhood experiences, and incarceration were relevant to homeless risk factors. A discussion of risk factors follows. Some studies have looked at veteran status as a risk factor. That discussion is next.

At least three studies have tried to determine if veteran status was linked to homelessness. To assess if veteran status increased the risk of homelessness, Mares and Rosenheck, (2004) recruited 631 homeless individuals receiving VA healthcare benefits and enrolled in the Therapeutic Employment Placement and Support Program in their study. The nine recruitment sites were in urban centers and the findings were not reported in a way to account for participants living in rural areas. Participants were asked if military service increased their risk of homelessness. Approximately a third (31%)

responded that it somewhat (18%) or very much (13%) increased their risk of homelessness. The average first episode of homelessness was 14 years after discharge suggesting that military service did not directly cause homelessness. Only 8% of the participants became homeless within a year of discharge from military service and 25% when discharged for five years.

Fargo et al. (2012) used HMIS data and the American Community Survey to determine if veteran status increased the risk of homelessness. Like the Mares and Rosenheck (2004) study, the dataset came from 11 urban CoCs so veterans living in rural geographic CoCs were not included. Compared to nonveterans, male veterans were almost 50% as likely and female veterans were almost twice as likely to be homeless as nonveterans suggesting that veteran status does increase the risk of homelessness. The time span from discharge to first episode of homelessness was not included so no comparisons to the Mares and Rosenheck, (2004) study can be made on this variable. The length of time separated from military service is an important variable to consider when determining if veteran status impacts homelessness and the next study included the variable.

During 2012, the Department of Veteran Affairs Inspector General's office released a report on the incidence and risk factors for becoming homeless in veterans. This was a large scale (n=310,685) longitudinal study that followed veterans discharged from active duty for five years. This was a retrospective study which used the LC population database to track the first incidence of homelessness after discharge for veterans. The LC population database is a unique database that consists of a combination of VA and Department of Defense (DOD) files (U.S. Department of Veterans Affairs

Office of Inspector General, 2012). Veterans using VA or DOD services after discharge are included in the database. To be included in the study the participants had no history of homelessness prior to enlisting in military service and they had to be using VA or DOD treatment options after discharge.

At five years post discharge 3.7% of the participants were homeless. Half of these had experienced homelessness during the third year after discharge. Results found that Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans and women veterans experienced slightly higher homeless incidents than non-OEF/OIF veterans and male veterans. Veterans experiencing homelessness tended to be younger (under age 35) and enlisted at lower pay grades and receiving compensation for a service related disability. Almost half were diagnosed with a substance or mental illness disorder and/or a Traumatic Brain Injury (TBI). Like the previous two studies, data for veterans living in rural areas was not separated for this study and the participant had to be using either VA or DOD services for inclusion.

Veteran status may be related to homelessness, however there is not a clear connection based on the literature presented. We do know that some veterans do become homeless after they are separated from service, however the length of time varies. Only a small percentage seem to experience homelessness within a year and the median length of time was three years which would allow for an intervention for this population to decrease the number of veterans experiencing homelessness. One of the studies found differences between males and females related to homelessness and that will be discussed next.

Gender differences. Differences have been found between homeless female veterans and male veterans. Homeless female veterans have been found to be younger than homeless male veterans (Fargo et al., 2012). The age groups at highest risk for homeless women are the 18-29 age group and for men the 45-54 age group (Fargo et al., 2012). Female veterans are more likely than male veterans to experience homelessness as part of a family with children (Byrne, Montgomery & Dichter, 2013). Approximately half (45%) of homeless female veterans have children (HUD, 2010). In a study of male and female veterans entering a transitional housing program, women were found to be less likely to have alcohol dependence, less likely to be working, more likely to have a mood disorder and more likely to have been hospitalized for a psychiatric problem at intake than their male counterparts (Tsai, Rosenheck, & McGuire, 2012).

Homeless female veterans are sometimes compared to housed female veterans in research studies. One study found that not having a job, having a disability or being in poor health, being diagnosed with Post-Traumatic Stress Disorder (PTSD) or an anxiety disorder and experiencing military sexual trauma (MST) increased the risk of becoming homeless (Washington, Yano, McGuire, Hines, Martin & Gelberg, 2010). Washington et al., (2010) found that most of homeless female veterans had received treatment for MST prior to becoming homeless which suggests that MST is a risk factor for homelessness for this population. Trauma, substance abuse, and mental illness were linked to homelessness for female veterans in other studies (Hamilton, Poza, Hines, & Washington, 2011). A discussion of PTSD and trauma is next.

Post-Traumatic Stress Disorder/Trauma. PTSD has not been shown to cause homelessness, but a significant relationship was found between PTSD and other risk

factors related to homelessness: other psychiatric disorders, substance abuse, unemployment and interpersonal relationship problems (Rosenheck & Fontana, 1994). In a study including OIF/OEF veterans 75% reported PTSD related to combat experience (Tsai et al., 2013). Stress related to deployment, combat, and serving in a war-zone were shown to have an indirect effect on becoming homeless for Vietnam veterans (Rosenheck & Fontana, 1994). Medical issues, mental health problems, presence of substance abuse and social factors are related to the risk of becoming homeless for veterans (Kline, et. al, 2009). Social isolation after discharge, having a psychiatric disorder and or substance abuse issues and being unmarried were found to be risk factors for homelessness for Vietnam veterans reintegrating into community living (Rosenheck & Fontana, 1994). Rosenheck and Fontana (1994) also identified homeless risk factors that were present prior to entering the military: conduct disorder, experiencing physical or sexual abuse or other traumatic events in childhood, and foster care placement in childhood.

History of abuse was included in the study of homeless youth by Thrane et al. (2006). The study found no statistically significant differences between rural and urban groups in age of running away, involvement in deviant subsistence strategies or rate of street victimization. One of the findings that were troubling for rural youth was that at higher levels of physical abuse, rural youth remained in their families longer. This finding suggests that rural youth may be exposed to higher levels of physical abuse than their urban counterparts before running away from home. Exploring past abuse and trauma should not be ignored for rural populations of homeless even though when studied individually, homeless factors for unaccompanied youth may look different than that of homeless adults. Research shows that adult homelessness is often related to structural or

economic factors, but youth homelessness may be due to conflict with parents or other household members, eviction, and other personal circumstances which is not different for homeless youth in urban areas (National Coalition for the Homeless, 2009). The information on youth was included in this section because childhood abuse emerged as a category in the current study.

Era of military service. Some researchers have looked at the era of military service to determine if individuals whom were drafted into service were at higher risk of homelessness than those whom willingly volunteered to serve (Tessler, et al., 2002). Research focusing on urban homeless veterans with serious mental illness found differences between the groups. Participants in the all-volunteer force were more likely to be homeless for less than a year, working for pay and to have problems with alcohol, drugs and psychiatric issues, but were less likely to be married than the drafted veterans. Similar differences were found in the same age group of non-veteran homeless, so the all-volunteer force was not at higher risk for homelessness than the post-Vietnam era participants (Tessler, et al., 2002). When OEF/OIF veterans were compared to other war eras low pay grade, psychotic disorders and substance use were risk factors for all veterans (Metraux, Clegg & Daigh et al, 2013). This study found that homelessness increased for non OEF/OIF veterans with a TBI and for OEF/OIF veterans with PTSD.

Rural Veterans

Over a fourth (27%) of the 6.1 million veterans in the US resides in rural areas (VA Office of Rural Health, 2011). Rural veterans earn less and are more likely to be unemployed than urban veterans (West & Weeks, 2006). Most (91%) rural veterans are white males (National Center for Veterans Analysis and Statistics [NCVAS], 2012).

Rural veterans tend to be older than veterans living in urban areas (Cully, Jameson, Phillips, Kunik, & Fortney, 2010). Sixty- eight percent of rural veterans are 55 and older (NCVAS, 2012). Rural veterans don't use the VA health care system as much as their urban counterparts. Approximately a third (30%) of the veterans enrolled in the VA health care system live in rural areas and 7.8% live in isolated rural areas (VA Office of Public and Intergovernmental Affairs, 2015). More physical health problems among veterans using VA services were found in rural veterans than urban veterans (Weeks, Wallace, Wang, Lee, & Kazis, 2006). Twenty-seven percent have at least one disability (NCVAS, 2012). Veterans using VA mental health services consisted of 26% in rural areas and 6.3% in isolated rural areas. When considering age groups of new military recruits, 12 % of the 18-24 year-old recruits come from rural areas as compared to 7.5% of individuals that age in the general population (Kane, 2006).

Almost 30% of all homeless veterans are living in nonurban areas. Few studies to date distinguish differences between veterans in urban areas and nonmetropolitan areas. The research literature on rural veterans is very limited and lacks consistency on what is rural, when comparing rural veterans to their urban counterparts (Smalley et al., 2012).

Most studies focus on veterans in urban areas where VA services are located. Many rural areas don't have a VA close by and the veterans have to travel to the urban VA medical centers to get care. Veterans utilizing VA services can be found in federal databases and some studies utilize this information to include homeless veterans in their research, but few have included geographic location as a variable when presenting findings.

Veterans represent 11% of homeless individuals in the US. Similar to other homeless populations, mental illness, substance abuse and physical disabilities are risk factors for becoming homeless for veterans (Smalley, et al., 2012). Less information is known about the homeless in rural settings that don't use VA services and are more difficult to access and locate. Living in a rural area can make it difficult for a homeless veteran to access services to address the issues of homelessness. In the effort to end homelessness for veterans, rural veterans are gaining access to HUD-VASH vouchers which are discussed next.

HUD-VASH/Housing First

In 1992 HUD and the VA partnered to form the HUD-VASH (HUD-VA Supported Housing) Program. This program combined HUD Section 8 rent subsidy vouchers with case management provided by the VA to house chronically homeless veterans. The public housing authority (PHA) determined the eligibility of HUD Section 8 housing based on income of the applicant. Anyone having Lifetime Sexual Offender Register Status is not eligible. This includes the veteran applying for the HUD-VASH voucher or anyone over 18 that would be living in the housing (U.S. Department of Veterans Affairs, 2011).

The HUD-VASH program targets chronically homeless veterans experiencing frequent episodes of homelessness. The chronic homeless often struggle with physical or mental health issues and possibly substance abuse issues. In 2008 veterans no longer had to have a diagnosis of chronic mental illness or substance abuse to obtain a HUD-VASH voucher. As of October 2012, the VA made the Housing First Model the official policy of the HUD-VASH program (National Center on Homelessness Among Veterans (2014).

The Housing First Model was created through the Pathways to Housing program in 1992 under the premise that housing is a basic right for humans and that people can make their own choices in regard to treatment (Tsembris, 2004). The idea was to get a homeless person into housing as quickly as possible to provide the basic need of shelter and then wrap around them with support services to address treatment needs. Homeless people with substance abuse and mental illness were the first to be offered the Housing First approaches to ending homelessness (Tsembris, 2004).

Participants in the program were put into apartments and were offered support services by the Assertive Community Treatment (ACT). Participants did not have to complete treatment to receive housing. Services available through the ACT team were mental and physical health, substance abuse treatment, education, and employment (Tsembris, 2004). Consumers could choose the services they wanted to engage in. The Housing First Model has proven to be an evidence based and cost-effective program (Padgett, Gulcur & Tsemberis, 2006; Siegel et al., 2006; Tsemberis & Eisenberg, 2000). Retention rates have remained at 85-90% (Pathways to Housing, 2015).

The VA adopted the Housing First Model as an effective way to help veterans gain housing. To receive an available HUD-VASH voucher a veteran would have to meet the definition of homelessness set forth in the McKinney-Vento Homeless Assistance Act as amended by the HEARTH Act of 2009. Eligibility for HUD-VASH is determined at the local level by the PHA and VA. The veteran also has to be willing to participate in case management services and must meet the eligibility criterion for VA health care (U.S. Department of Veterans Affairs, 2017). The program has administered over 85,000 HUD-VASH vouchers since it began in 2008 (HUD, 2017).

Summary

This review of the research literature has included a discussion of homelessness in the United States including risk factors associated with homelessness. We know that health problems or disabilities can cause medical bankruptcy and eventual homelessness (National Health Care for the Homeless Council, 2014) and that chronic diseases are found at higher rates in homeless populations (Schiff, 2015). Alcohol and or drug dependence have been shown to be as high as 50-70% in homeless populations and some homeless individuals have both a major mental disorder and a substance abuse disorder (Schiff, 2015). Trauma, including PTSD and TBI are associated with homelessness (Briere & Scott, 2006; Topolovec-Vranic et al., 2012; Tsai, Pietrzak, & Rosenheck, 2013) and mortality rates are higher when compared to the general population (Baggett et al., 2013). Most of the homeless literature is focused on urban homeless populations, however, a review of the rural homeless literature was included in this literature review.

The research literature regarding rural homelessness is clearly outdated and reveals very little about veteran homelessness in rural areas. We do know that there are both similarities and differences when comparing homelessness in rural areas to urban areas. Both structural problems like affordable housing, unemployment, and poverty can be found in both rural and urban areas and personal problems like substance abuse and mental illness exist in both settings. Economic reasons were often cited as causes of homelessness and family conflict or disruption was also mentioned often (Cummins et al., 1998; First et al., 1994; Hoover & Carter, 1991; Roth et al., 1987). We know from the literature that rural homeless individuals are not as visible as they are in urban areas which can make them more difficult to identify for research purposes. They are more

likely to live in an automobile, in substandard housing or doubled-up with friends or relatives. We learned that the rural homeless are not a very transient group, many live in the same areas that they were born and raised in. Having ties in the area appears to help some people from becoming literally homeless and makes for a less transient group of homeless people.

Homeless subtypes emerged as to where people choose to live when homeless in a rural area. Roth & Bean (1986) identified street people who do not use shelters, shelter people, and resource people whom do not use shelter but have enough personal resources to stay in cheap hotels or with family and friends for short periods. To further identify the type of groups we can find within the three subtypes of street homeless, shelter people, and resource people, the findings in First et al. (1994) provided further descriptions of homeless people and identified five major groups of rural homelessness. The identified groups were: young families, working individuals unable to afford housing, women in need of child care or with limited job skills, older men whom have been homeless longer and likely disabled with few social supports, and disabled people without social networks to live independently.

Rural cross-sectional survey studies have found lower rates of mental illness, alcohol and drug problems in self-reports by rural homeless adults compared to urban homeless adults (Cummins et al., 1998; First et al., 1994; Roth et al., 1987). The ages of rural homeless participants varied within the homeless studies presented. The median ages in the Ohio studies were similar at 29 and 30 whereas the Cecil County study had a median age of 46 which was much higher than the Ohio studies. The Ohio studies, the

Illinois study and the Cecil County study all reported that the homeless population was mostly white males in the rural areas represented in each study.

The Ohio studies reported a high percentage of their respondents were living doubled-up with friends and family. This was true for only 7% of the Cecil County respondents. The literal or street homeless percentages were very different in rural Ohio than they were in Cecil County, Maryland. Fifteen percent of the respondents in rural Ohio identified as living on the street whereas 41% were literally homeless in Cecil County. Shelters users were also higher in Cecil County at 43% compared to 30% in the rural counties of Ohio. Cecil County respondents were similar to other rural homeless in that they were not transient individuals. Over half (65.3%) of the respondents reported always living in Cecil County. The Cecil County results are of interest because of the close proximity to the current geographic study area of the Lower Eastern Shore of Maryland.

Missing from the rural homeless research is information regarding homeless veterans. Over a fourth (27%) of all veterans live in rural areas (VA Office of Rural Health, 2011) so this is a sizeable group to focus on.

We know that almost 14% of the respondents in the First et al. (1994) study and 28% of the participants in the Cecil County study were veterans and that most of these were thought to be Vietnam era veterans. Not much else is known about the veterans that participated in these studies.

We know veterans are overrepresented in the homeless population compared to nonveterans (HUD, 2017) but there is no apparent reason why that is based on the current literature. When homeless veterans were compared to homeless nonveterans the veteran

participants were found to be older, male, and more likely to have graduated from high school (Rosenheck & Koegel, 1993; Tessler, Rosenheck, & Gamache, 2002; Tsai, Mares, & Rosenheck, 2012). The age groups at highest risk for homeless women are the 18-29 age group and for men the 45-54 age group (Fargo et al., 2012). Female veterans are more likely than male veterans to experience homelessness as part of a family with children (Byrne, Montgomery & Dichter, 2013) and Washington et al., (2010) found that MST is a risk factor for homelessness for this population.

The research literature shows us there is a relationship between PTSD and other risk factors related to homelessness such as other psychiatric disorders, substance abuse, unemployment and interpersonal relationship problems (Rosenheck & Fontana, 1994). Reintegrating into civilian life can be a difficult transition for veterans with a psychiatric disorder and or substance abuse issues. Social isolation after discharge and being unmarried were found to be risk factors for homelessness after discharge and experiencing physical or sexual abuse or other traumatic events in childhood, or foster care placement in childhood were risk factors present prior to military service (Rosenheck & Fontana, 1994).

Few studies to date distinguish differences between veterans in urban areas and nonmetropolitan areas. The research literature on rural veterans is very limited and lacks consistency on what is rural, when comparing rural veterans to their urban counterparts (Smalley et al., 2012). Most studies focus on veterans in urban areas where VA services are located. Many rural areas don't have a VA facility close by and the veterans must travel to the urban VA medical centers to get care. Veterans utilizing VA services can be found in federal databases and some studies utilize this information to include homeless

veterans in their research, but few have included geographic location as a variable when presenting findings.

The lack of recent literature on rural homeless veterans many be due to the limited number of researchers gathering information on rural populations of the homeless. Another factor is the limited number of service sites that are available to help homeless people living in rural areas. A third consideration is that many homeless people in rural areas do not utilize the services available to them because of mistrust of formal helping agencies.

Although the body of research literature is very limited and dated regarding the subject of rural homelessness, the research thus far does provide a foundation to explore the implications for social work practice and policy regarding the rural poor and homeless. The rural homeless are not as visible as those living in urban areas and different approaches to helping may be warranted. Implementing a standard definition of homelessness to include the doubled-up population would be a good start. Finding people that are doubled up is often difficult, since they may not be identified as easily because they don't use shelters and may not use other homeless services. Living in unfit housing and moving frequently among cheap housing appears to be an indicator of someone becoming homeless. Support to keep these residents with a roof over their heads would be a worthwhile investment of resources.

Locating the homeless may be challenging in rural areas and finding adequate resources may be even more challenging to a community. Communities may need to implement greater outreach services to reach the rural homeless and rural continuums of care for this population may need to take on a regional approach to supply adequate

services and to make the best use of limited resources. Social networks are strategic supports to many homeless people and assistance to people helping the homeless needs to be supported. Rural areas will have to design homeless services in their communities to meet the needs and coping behaviors of the homeless living in their areas.

My research study begins to address the gap in research literature pertaining to homeless veterans living in rural areas. I interviewed 17 homeless veterans to explore the pathways into homelessness for this group. More information was needed to identify the lived experience of homelessness for these individuals and the ways they cope with the homeless lifestyle. Giving a voice to the experience of homelessness for this population was lacking in the research literature. To end veteran homelessness these individuals must be included in the plan and interventions and services must be grounded in approaches to meet the needs of this vulnerable group of individuals. The methods of used are presented in the next chapter.

Chapter 3: Methods

The review of literature in the previous chapter described both quantitative and qualitative research methods used in research studies with rural homeless people. Surveys utilizing quantitative methods are helpful in providing descriptive characteristics and can measure severity of symptoms on variables of interest for this population. Quantitative methods would be less helpful when describing the complex interactions of the human experience which can lead an individual or family into homelessness. For that reason qualitative research is more appropriate to use in this research study. Qualitative research methods were more suited to answer the research questions, "What are the pathways to homelessness for rural veterans?" and "What are the self-identified contributing factors to homelessness for a sample of rural veterans?" The purpose of the service provider interviews was to supplement and triangulate the information of the veterans. The service provider participants are referred to as staff/administrators in this study.

These questions can best be answered in a natural setting using qualitative research methods. In person interviews yielded deeper understanding to the lived experienced of the individual giving them an opportunity to share their thoughts, feelings, values and beliefs about their circumstances. A deeper understanding of their descent into homelessness was the goal of this study. Systematic analysis of the data provided valuable input into answering these research questions through the words of the veterans experiencing homelessness.

The study focused on adding to the research literature on the three constructs of being a veteran, residing in a rural area, and experiencing homelessness. The method of inquiry for this research study was a limited grounded theory approach. Grounded theory

is based on symbolic interactionism concepts and is recommended when researchers are examining situations or problems to which individuals must adapt (Corbin & Strauss, 2008). Homelessness is a situation that individuals must adjust and adapt to daily. Grounded theory techniques, allows the researcher to move beyond a description of what is happening towards understanding the process by which it is happening (Corbin & Strauss, 2008; Strauss & Corbin, 1998). The grounded theory process involves the key components of theoretical sensitivity, constant comparison, theoretical sampling, and theoretical saturation (Oktay, 2012). Based on these components and the analytic skill of the researcher, themes emerged from the data to explain the pathways into homelessness of veterans living in rural areas. Systematic procedures were used to gather and analyze data.

Geographic Area

The study area encompassed the three lower counties, Wicomico, Worcester, and Somerset on Maryland's Eastern Shore. These three counties make up the region of MD 513 CoC. Wicomico County is the largest of Maryland's nine Eastern Shore counties, encompassing 374 square miles (US Census, 2010). Wicomico County has one urban area as classified by the 2010 Census (Appendix A). The remainder of the county is agricultural, forest, wetlands, or waterways. According to the 2010 Census, Wicomico County has a population of 98,733. The county's population at the last Census was 66.6% White, 23.8% African-American, 4.5% Hispanic, 2.5% Asian, 0.2% Native American and 2.3% other races. The rate of persons living below the poverty level in Wicomico County is 17% compared to the Maryland State rate of 9.8%.

Worcester County is located in the southeastern corner of Maryland's Eastern Shore, forming the state's easternmost boundary. It is bordered by the Maryland counties of Wicomico and Somerset to the west, the Atlantic Ocean to the east, and Sussex County, Delaware, and Accomack County, Virginia respectively to the north and south. Worcester County has no identified urban areas but has two urban clusters areas of Ocean Pines and Pocomoke City (Appendix B). An urban cluster is defined as a population center of between 2,500 and 50,000 that is not near an urbanized area (US Census, 2010). Worcester County has an estimated total population of 51,620 (US Census, 2010). Worcester County encompasses 468 square miles of land and stretching 32 miles from north to south and 33 miles from east to west. The county's population at the last Census was 80.0% White, 13.9% African-American, 3.3% Hispanic, 1.3% Asian, 0.4% Native American and 1.1% other races. The rate of persons living below the poverty level in Worcester County is 10.9% compared to the Maryland State rate of 9.8%.

Somerset County, on Maryland's Eastern Shore, is the state's southernmost county, bordered by the Maryland counties of Worcester to its east and Wicomico to its north. The Chesapeake Bay forms its western boundary and Virginia lies to its south. Essentially a rural jurisdiction, Somerset County encompasses 320 square miles of land. The county stretches approximately 27 miles from north to south and 28.5 miles from east to west. Somerset County has no identified urban areas but has two urban clusters identified as Princess Anne and Crisfield (Appendix C). Somerset County has an estimated total population of 26,470 (US Census, 2010). The county's population at the last Census was 51.0% White, 42.8% African-American, 3.8% Hispanic, 0.9% Asian,

0.4% Native American and 1.1% other races. The rate of persons living below the poverty level in Somerset County is 23.4% compared to the Maryland State rate of 9.8%.

These rural areas have high rates of poverty and unemployment. The annual unemployment rate during 2016 for Wicomico County was 6.0%, Worcester County was 9.0%, and Somerset County was 7.0% (Maryland Department of Labor, Licensing and Regulation, 2014). All three counties unemployment rates were higher than the State rate of 4.3% during the same time period. Using five year population estimates (2012-2016) the Census Bureau estimates the number of veterans in the civilian population 18 and over to be 8.6% in Wicomico County, 10.9% in Worcester County, and 8.4% in Somerset County compared to 8.6% for the State average (US Census, 2010).

Sample and Data Collection

The Internal Review Board (IRB) at the University of Maryland Baltimore approved this study. Originally the focus of this study was on veterans who have experienced homelessness for the first time between 2008 and 2017 for the following reasons. The HUD-VASH program expanded during 2008 resulting in awards of 79,000 HUD-VASH vouchers to homeless veterans between 2008 and 2015 (HUD, 2015). The homeless definition was changed to include people at risk of becoming homeless in 14 days through the HEARTH Act in 2009. The U.S. Interagency Council on Homelessness introduced the Opening Doors, Federal Strategic Plan to Prevent and End Homelessness during 2010. Ending and preventing veteran homelessness became a priority through implementation of the Opening Doors 10 year plan. Anchoring the study to include individuals experiencing homelessness for the first time between 2008 and 2017 would have focused data collection to include only individuals whom have experienced

homelessness during a time when an extensive system of benefits were available to veterans including healthcare, disability, pension assistance and homeless services.

Recruitment of homeless veterans was a difficult task to begin with and I expected to be recruiting veterans who served in the OEF/OIF war eras prior to becoming homeless. After interviews began with the sixteen staff/administrators working at agencies providing services to homeless veterans, it became obvious that limiting the sample to veterans who became homeless after 2008 was not feasible for the proposed study area because the agencies were seeing mostly older veterans who did not serve in the OEF/OIF conflicts. After this information was revealed I completed a protocol modification to change the eligibility criterion to include veterans who had experienced homelessness at some point in their adult life (18 or older). The modification was approved and this allowed for the recruitment of seventeen veterans whom had experienced homelessness in their adult life. Only fifteen of the interviews were used in this study. One of the participant interviews was brief and his responses had no depth, so there was no data that could be coded for this study. The second veteran revealed during his interview that his episode of homelessness occurred while living in an urban area, so his responses were not included in the themes for rural homeless pathways in this study.

Two samples were used in this study: veterans whom have experienced homelessness as an adult and agency staff or administrators providing services to homeless veterans living in the MD 513 CoC. Padgett (2008) says that researchers using grounded theory techniques should use a moderately sized sample of 20 to 30 carefully selected persons, but the sample size can be smaller or larger. A total of 33 participants were recruited for this study: sixteen staff/administrators and 17 veterans. The table

below displays the number of interviews each month for staff/administrators and veterans.

Table 1

Number of Participant Interviews Completed by Month

Participant Type	February 2017	March 2017	April 2017	May 2017	June 2017	July 2017	Total
Staff/administrators	3	8	3	0	0	2	16
Veterans	0	5	3	3	2	2	15

Sample making decisions in qualitative research studies generally requires purposeful selection (Maxwell, 2005). I began the study with staff/administrator interviews, and approximately 45 days later began to interview homeless veterans concurrently with agency staff/administrator interviews. The staff/administrator participants represented agencies providing services to homeless veterans to get their perspective on veteran homelessness and existing homeless services. Staff/administrators were also asked to help recruit homeless veterans for this study.

Purposeful sampling was used for the staff/administrators participants. Silverman (2014) tells us to choose the sample with care and to use critical thinking in selecting cases. Recruiting staff/administrators at a variety of agencies that provide services to homeless veterans was the focus for this sample. The staff/administrator participant was someone at the agency having knowledge about homeless veterans such as the Executive Director of the agency, the person responsible for administering veteran services at the agency, or case managers. I asked each of the identified interviewees if further

permission from the agency was required prior to proceeding with the interview. Additional permissions were not necessary for any of the sixteen participants. In-person interviews were completed and audio recorded. The interviews varied in length from 19 minutes to 99 minutes.

Initially I let the CoC members know during a monthly CoC meeting that I was conducting a research study to gather information about veteran homelessness in the MD 513 CoC region. I informed them of the study purpose and the data collection plan and allowed an opportunity for them to ask questions about the study. I requested and received a letter of support from the CoC for this study. After obtaining IRB approval for the study I announced at a CoC monthly meeting that I was ready to begin data collection and I would be contacting individuals providing services to homeless veterans to request an interview. I let them know that participation was voluntary.

Inclusion criteria for a staff/administrator participant included, (a) individual is employed by an agency that provides services to homeless veterans, and (b) individual has a working knowledge of the homeless veteran population. Exclusion criteria was, (a) individual is not employed by an agency that provides services to homeless veterans, and (b) individual has no working knowledge of the homeless veteran population. The criteria for staff/administrator interviews excluded agencies serving the homeless population, but not necessarily veterans that are homeless. I passed out a recruitment flyer (Appendix D) approved by the IRB to each member present at the meeting describing the research study purpose and my contact information. I asked agencies to inform their veteran clients about the study and to distribute the flyer to potential participants. Some agencies also posted the flyer in a place where their clients might see it. Using shelters and service

agencies to recruit participants has been done in other studies (Trella & Hilton, 2014). This may have created a bias of just homeless veterans that are known to the staff/administrators or who use services.

Approximately a week after the meeting I began contacting the staff/administrator participants at each agency serving homeless veterans in the MD 513 CoC region to set up interview times. Most interviews occurred in the agency where the staff/administrator was employed. There were four exceptions to this. One meeting took place in my private office on a day when the interviewee was on campus for another reason. The other three took place in a coffee house away from other patrons and service counters. Privacy was maintained for all interviews. Interviews took place between February 3, 2017 and July 17, 2017.

Prior to beginning the semi-structured interviews, I asked the staff/administrator participant if I could audio record the interview for transcription and data analysis purposes. All participants agreed to be audio recorded. Audio recordings and transcribed interview data are maintained on a password protected computer. The interview guide used is in Appendix E. Printed transcripts and interview notes are stored in a locked file cabinet. At the end of the interview I asked for referrals for other staff/administrators that provide services to homeless veterans at their agency or in the community. Using this method I had access to people in the MD 513 CoC whom are knowledgeable about veteran homelessness.

The staff/administrators interviews began in February and the first veteran participant interviews began in March. Interviews for both the staff/administrators and veterans continued through July of 2017. No staff/administrator interviews occurred in

May or June, however I decided to interview two more staff/administrators in July. One of the staff/administrators had started a new homeless housing program and the other was located in a county where only one other staff/administrator interview had been completed. Both staff/administrators were providing services to homeless veterans and met inclusion criteria. Eight veteran participants received the recruiting flyer from a service provider participant and either initiated the phone call to participate in the study or had the staff/administrator make the call for them. The other veteran participants were recruited using snowball sampling.

Purposeful sampling and snowball sampling, a form of purposeful sampling were used to recruit veteran participants. Snowball sampling is when your participants help identify other potential participants that meet the eligibility criterion and are known to the participant (Lyons & Doueck, 2010). Several veterans shared the flyer with other veterans they knew who then called to set up an interview. Purposeful sampling methods included both male and female veterans who served during OEF/OIF, Vietnam, or during peacetime. The inclusion criteria for veteran participants was, (a) self-reports veteran status, (b) has met the homeless definition of McKinney-Vento-lacks a fixed regular and adequate nighttime residence or resides in a shelter, institution or place not ordinarily inhabited or is living doubled up with friends or family at least once since the age of 18, and (c) is 18 or older. Exclusion criteria included, (a) not a veteran, (b) not homeless at least once since the age of 18, and (c) under 18.

In-depth interviews were held with veterans whom are currently experiencing or who have experienced homelessness as an adult. I explored pathways into homelessness for veterans experiencing homelessness in rural areas using a semi-structured interview

guide utilizing open-ended questions to facilitate the in-depth interviews (Appendix F). Interviews took place between March 16, 2017 and July 18, 2017.

Fifteen interviews were conducted and ranged in time from 24 to 62 minutes. Locations for interviews varied. Four took place at agencies where a staff/administrator person had been interviewed as a participant for this study. In these cases the staff/administrator member had helped to set up the interview and it was convenient for the participant to meet at the agency. In all four cases a private room or office was used for the interview. Five participants were using emergency shelters and requested the interviews be held at the location where they were currently staying. In three cases I was able to use a private room at the site for the interview and two interviews occurred on a bench outside the shelter with no one close enough to hear the conversation. Five participants called me directly to participate in the study and I met these individuals at the local library where a private meeting room was used for each of the interviews. One participant was outside in a public place and I stopped to have a conversation to tell them about my study. They met the inclusion criteria and agreed to be a participant. The interview took place where we were standing in a public space. No one else was close enough to hear our conversation.

The definition for rural used in this study is based on the US Census Bureau list of Census Places. The Census Bureau can track population statistics based on incorporated towns and cities which have legally defined boundaries and census designated places (CDPs) which are unincorporated places determined by local boundaries to have large concentrations of people. To meet the inclusion criterion of living in a rural area the participants must live in an area outside of CDPs with 50,000 or more people. To

determine rurality it is appropriate to use population-based statistics when trying to make decisions between what is rural and what is not rural (Daley, 2015).

Incentives encourage participation and compensate the respondent for their time (Padgett, 2008). Participants received compensation for their time in the amount of $20 paid in cash. Trella and Hilton (2014) and Metraux, Cusack, Byrne, Hunt-Johnson, and True, (2017) found that $20 was valuable enough for participants but not overly valuable to persuade reluctant veterans to participate. When meeting with the participant for the first time I reviewed the informed consent information sheets approved by the IRB with them. The purpose of the study was explained to the participant and they were informed that participation was voluntary and if at any time they wanted to end the interview that they could. I asked permission to use an audio recording device to record the interview. All participants gave permission. Participants were assured confidentiality to the best of the researcher's ability. To ensure confidentiality a fictitious name was assigned to each participant when transcribing the interview data. Contact information, audio recordings and transcribed interview data are maintained on a password-protected computer. Printed transcripts and field notes are stored in a locked file cabinet. After reviewing the informed consent information documents with the participants they received a copy. Demographic information on age, gender, and race, was collected during the interview.

The participants were homeless individuals with limited resources. Many problems are associated with the homeless population including physical and mental health concerns and substance abuse. None of the participants seemed to be in crisis or distressed at the time of the interview. I gave each participant a copy of the Wicomico,

Worcester and Somerset Counties Resource Guide for the Homeless which contains a comprehensive list of helping agencies in the MD 513 CoC region.

Data Analysis

Data analysis techniques were used with both samples of participants. The limited grounded theory techniques used included the key components of theoretical sensitivity, constant comparison, theoretical sampling, and theoretical saturation (Oktay, 2012). Theoretical sensitivity allows the researcher to analyze the data collected and give meaning to it. Sensitivity may come from reading the research literature on the topic or process being studied. Being familiar with prior research allows the researcher to be sensitive to the issue being studied. Researchers also bring professional and personal experience to the research topic. Charmaz, (2006) says that theoretical sensitivity can be developed through theorizing; looking at the issue from several perspectives to make comparisons and to build on ideas. The use of gerunds is encouraged when writing memos and during coding to put emphasis on actions and processes to develop theoretical sensitivity (Charmaz, 2006).

The constant comparison method is used as a systematic procedure in the analysis of qualitative data. Constant comparative analysis describes a systematic search for similarities, and differences across interviews, incidents, and contexts (Strauss & Corbin, 1994). Interviews were transcribed into the latest edition of qualitative data analysis software NVivo 11 (QSR International, 2015). I began with open coding when reviewing the interview transcripts. The coding tips by Oktay, (2012) were followed: code phrases that evoke strong emotions; that describe action; symbolic interaction concepts such as sense of self, roles, or justifying actions and look for phrases that reflect assumptions like

always or never. From the data key points were marked with a series of codes, as each line of the interview was read. Examples of open codes in this study were childhood upbringing, military culture, adjusting to civilian life, burning bridges, coping strategies, and becoming homeless. Ideas and possible themes or codes were grouped into similar concepts. Categories were formed that were relevant to answering the research question pertaining to homeless pathways for veterans living in rural areas and to determine the contributing factors identified by the participants.

Participants were compared and contrasted across, situations and settings as suggested by Padgett (2008). Inductive coding was performed on the data and memo's written to record my ideas and decisions made during analysis. Coding decisions should be documented using memoing (Padget, 1998). As themes were identified, I reviewed the transcripts again to make certain the data was coded reflecting the identified themes. After open coding of an interview was completed then axial coding began. According to Oktay (2012) axial coding is the bridge between open coding and selective coding. Axial coding allows for concepts and themes to be explored further and properties, where dimensions of a category are specified (Creswell, 1998). An example of axial coding was exploring the code of social support in the context of the interviews. Social support had three dimensions: high social support; low social support; and no social support. The category of support was operationally defined by the level of support received by friends, family, or others. Axial coding relates categories to subcategories and through this process conceptual frameworks are formed (Strauss & Corbin, 1990). Large amounts of data can be sorted, synthesized, organized and put together in different ways through axial coding (Creswell, 1998). Axial coding answers questions about the context and

conditions under which something occurs and the consequences attached to the occurrence (Oktay, 2012).

Upon identifying relevant concepts during this study through initial interviews, I was able to use theoretical sampling to guide subsequent sample selection. Theoretical sampling is, "a process in which continued sampling occurs concurrently with data analysis that has commenced immediately upon receipt of the data; the introduction of new data is directed by the gaps, unanswered questions, and underdeveloped ideas in the emerging theory" (Fassinger, 2005, p. 162). This process allows for confirmation of categories and theoretical concepts to occur and continues until categorical and theoretical saturation of core concepts occurs (Glaser & Strauss, 1967).

Theoretical sampling is data driven and is used to answer questions that come up during the analysis. During theoretical sampling I focused on recruiting younger veterans to the study because I had reached data saturation with older veterans. I also recruited a female participant to the study to compare and contrast similarities and differences to the male participants. Fifteen interviews were completed to ensure a range of experiences and perspectives. Oktay (2012) describes this process as an opportunity to test out ideas about possible relationships, conditions and consequences and sets the stage for identifying important themes in developing theory using selective coding.

Selective coding helps identify the main category or themes that have been developed and relates other important concepts to the main category (Oktay, 2012). The main theme will be a category coded often in the data; it is abstract and is related to the other categories (Glaser & Strauss, 1967). This is followed by analysis of prior data categories and how they relate to the main theme. More data gathering can occur to

address gaps and proposed theoretical relationships (Oktay, 2012). The main category in this study were the experiences of veteran participants becoming homeless. Many subthemes related to this category emerged through analysis. Data was collected until no new information on the concept was available. This is called data saturation. When the main category or theme has been explored to a depth of identifying various properties and dimensions under different conditions, the research has reached the level of data saturation necessary when using grounded theory techniques (Corbin & Strauss, 2008).

Researcher's Positionality

My area of interest and expertise is with the homeless population. I have served as the Program Director for the Community Emergency Shelter Project, a cold weather shelter for homeless men, for the past fifteen years. I have participated as a research assistant in several community needs assessments and substandard housing studies. I was the research assistant for the Cecil County Homeless Study. I have conducted many key informant interviews and facilitated both youth and adult focus groups. I have presented at several community homeless awareness workshops and also maintain active memberships on several community Boards supporting services for the homeless population.

I was born and raised in a rural community, and as an adult, I have made the decision to live on the Eastern Shore of Maryland which is a rural area. I have provided Social Work services in a non-urban setting since my first field placement in 2001, and have worked in the Social Work Field Education office at Salisbury University since 2007. I possess a working knowledge of the homeless population, resources available, service barriers, and have working relationships with local homeless resources and

advocacy groups. This knowledge helped me to better understand the plight of the homeless veteran.

My interest in rural veteran homeless issues emerged when Dr. Gioia, a UMB professor, invited me to a meeting on the Eastern Shore of Maryland regarding her research with rural veterans returning from the wars in Afghanistan and Iraq. The discussion around rural veteran issues sparked my curiosity and I began searching the research literature surrounding rural homeless veterans. When I discovered that there was very little research completed with this population I decided to focus on rural veteran homelessness for this research study.

My father was a veteran of the Coast Guard but no one else in my family was a veteran. I do not have a strong link in my personal life to military service but I do understand the cost of freedom. Growing up as a child during the Vietnam War I knew several families that lost a son in the war. This opened my eyes to the sacrifice that military personnel and their families make when they enlist in military service. I have a deep respect for the US and for the men and women who volunteer to protect the freedoms available in our country through military service. I am among those who believe that more should be done to address the healthcare and housing needs of US veterans. The deep seated patriotism that is part of who I am could be a potential for bias when performing research with rural homeless veterans. Individuals who serve in the armed forces should have access to healthcare and housing upon their return to civilian life. In my opinion, when a veteran is living homeless it is unjust and as a country we are failing to meet the needs of that individual. However, I also understand that homelessness is a complex issue and that depending on the circumstances, some veterans may prefer to

live outdoors in isolation or with other homeless individuals. To minimize bias I focused on extending unconditional positive regard to all interview recipients so that the respondents were not influenced by my values and beliefs. I tried to stay neutral regardless of the responses to the questions I was asking. I was mindful of my role as a researcher when performing the in-depth interviews.

My work with the rural homeless community could be a potential source of bias. Knowing some of the staff/administrators prior to the interview could have allowed for assumptions from me and the potential for skipped questions because I thought I may have already known the answer. In an effort to stall any preexisting ideas from guiding this study, I was consistent in my use of the interview guide during interviews to limit the potential for this type of bias.

Trustworthiness and Ethical Considerations

Creswell (2009) recommends strategies for reliability and validity during a qualitative research study. Qualitative reliability involves checking the accuracy of the data (Gibbs, 2007). This can be accomplished by checking transcripts to make sure they are accurate after they are transcribed. I reviewed transcripts multiple times for consistency of coding used in the data analysis.

Qualitative validity is a necessary component of a research study to check the accuracy of the research findings and Creswell, (2009) recommends using one or more strategies to accomplish this goal. I used information from two sources in an effort to triangulate data for this study. I interviewed staff/administrators and homeless individuals which provided two perspectives on the pathways to homelessness for this population. The researcher brought the personal bias of not being a veteran and never experiencing

homelessness or extreme poverty. To ensure rigor I recorded documentation of my decisions made during data collection, coding, and analysis. This allowed for my findings to be verified. Striving for transparency as I conducted this qualitative research study adds credibility to the research (Bryman, 2006).

Chapter 4: Results

Two samples of participants provided data for this study: veterans and staff/administrators. The significant theme that emerged in this study from both samples was the chronic alcohol abuse of homeless veterans. Homeless veterans living in rural areas have been found to have more current or past alcohol dependence when compared to homeless veterans living in urban areas (Gordon et al., 2015). The themes that emerged are presented chronologically beginning with risk factors in childhood and then moving on to the transition from military to civilian life. Other themes presented are mental health issues, making choices, and financial strain. All of the themes presented have the theme of alcohol abuse and or substance use weaving through them. Substance use and abuse is discussed as a stand-alone theme even though it is discussed in the other theme areas.

This section begins with a description of study participants including gender differences within the veteran sample. Reasons for joining the military are presented in this section to reflect individual motivations for enlisting in military service. A brief discussion including the return of the participants to their geographic home area is presented and followed by the major themes that emerged from participant interviews regarding their circumstances as it relates to veteran homelessness.

Study Participants

Thirty-one semi-structured interviews were included in this study. All 31 interviews took place in the three lower counties, Wicomico, Worcester, and Somerset on Maryland's Eastern Shore. Data was collected between February and July 2017. Sixteen participants were employees of agencies that provided services to homeless veterans.

Demographic information was not collected on theses sixteen participants, since these characteristics could be used to identify them.

Fifteen participants were veterans whom were currently experiencing homelessness or had experienced homelessness in their adult lifetime. Eleven (73%) were currently experiencing homelessness and four (27%) were currently housed but had been homeless at least once as an adult. Fourteen males and one female participated. Nine (60%) of the veteran participants were white, five (33%) were African American, and one was American Indian. The mean age of the veteran participants was 52 with ages ranging from 34 to 78 with 76% spanning the age range of 40-59.

The gender, race, and age range of the veteran participants aligned with reported information from the staff/administrators in regard to gender and ages of the homeless veterans they encounter in their agencies. All agencies represented reported seeing more males than females and eleven of the agencies reported seeing older veterans seeking services through their agencies. Two agency representatives said they saw more White homeless veterans than African American veterans whereas everyone else reported the races being mostly even between White and African American veterans using homeless services.

All of the veterans enlisted voluntarily into military service. Most of the veteran participants served during peacetime. The oldest veteran enlisted after the Korean conflict and before the Vietnam War Era. One served during the Vietnam War but stayed stateside. Ten enlisted after Vietnam and before the Persian Gulf War and the wars in Afghanistan (OEF) and Iraq (OIF). One veteran's unit received orders in 1983 to go to

the conflict in Grenada, however he was within 60 days of discharge and stayed behind. Three veterans served during the more recent war eras: OEF and OIF.

Veteran participants had been separated from military service anywhere from 10 to 56 years with a median of 33 years at the time of the interviews. Nine of the participants reported obtaining honorable discharges, while two received a general discharge for medical reasons and one received an other than honorable (OTH) discharge. Four of the participants did not report discharge status. Gender differences in this sample are discussed next.

Gender Differences in Veteran Sample

Differences have been found between homeless female veterans and male veterans. Homeless female veterans have been found to be younger than homeless male veterans (Fargo et al., 2012). This held true with the participants in this study. The female participant was younger than all the male participants. A prior study of homeless women found the age groups at highest risk for homelessness were women in the 18-29 age group and for men the 45-54 age group (Fargo et al., 2012). The female participant was 34; ten of the sixteen male participants fell into the 45-54 age group and the mean age of the male veterans was 53.

Female veterans are more likely than male veterans to experience homelessness as part of a family with children (Byrne, Montgomery & Dichter, 2013). The female participant had no family or children of her own. In a study comparing homeless female veterans to housed female veterans not having a job, having a disability or being in poor health, being diagnosed with Post-Traumatic Stress Disorder (PTSD) or an anxiety disorder and experiencing military sexual trauma (MST) increased the risk of becoming

homeless (Washington et al., 2010). The female veteran participant has Asperger's Syndrome, a TBI, and developed epilepsy because of the TBI. As soon as her income from the government stopped she quickly lost her housing and became homeless.

Veteran status is an integral part of this study so the reasons why the participants joined the military are included in this section. All of the veterans enlisted voluntarily, and they were asked their reasons for joining the military; the themes are presented next. All names have been changed to pseudonyms to maintain confidentiality. Table 2 in Appendix G contains the demographics and selective characteristics for the fifteen veteran participants.

Reasons for Joining the Military

There are many reasons someone might enlist in military service: family tradition, desire to serve your country, learning new skills, employment, and personal improvement to name a few. The participants in this study gave the following reasons for enlisting in the service.

Current circumstances. Five participants joined because their current circumstances did not seem to be leading them to a successful job or career path. Daniel described it like this, "Everybody else around me was going to jail or… dropping out of school and getting dead end jobs. I was looking around me and like, oh man, I don't want this to be my life." Daniel joined for a better life and to leave his current circumstances.

Cecil received urging from his Air Force veteran father whom told him, "You ain't gonna lay around here man. Go do something. Why don't you join the Army?" Cecil didn't have any other plans and decided to enlist in the Army at his father's insistence.

Emmett received urging from his mother to find a job. Emmett said his mother was hounding him to get a job and he was actively trying but the economy was struggling on the Eastern Shore in 1981. He describes the job situation when he joined the service, “All of the big businesses were gearing up to leave, and there was limited jobs. If you didn't know anybody back then at a job, you didn't get a job.” He was contemplating the service as a viable option because he had uncles that had served. After a conversation with a friend whom had come home from basic training he made the decision to go in.

At 26, Alan had completed college and was bored with his life. He said the recession had hit and he wasn’t working so he decided to enlist. Jason flunked out of college and was influenced by the commercials on television, "Be all you can be, in the Army." He went into the Army, “Just to get away from here.” Further analysis revealed that Jason may have been feeling that he was letting his parents down by flunking out of college because he got there on a scholarship and when he failed he had to figure out what to do next. The commercials influenced his decision to join the army but also provided an honorable alternative to college. He did not tell his parents that he had quit college and showed up at Christmas time in his uniform. He said his mother was disappointed that he had quit college to join the military but supported his decision.

Avoid the draft. Henry and Neal, the oldest two participants at 78 and 66 years respectively, joined to avoid the draft. Between 1940 and 1973 the draft was used to fill vacancies not covered by volunteers in the military. When Henry turned 18 he enlisted to, “Get it over with,” to avoid taking the chance of being drafted. He entered the Army in 1958 which was after the Korean conflict and before Vietnam, so he was in during peacetime. Neal joined the Air Force at 19, “I did it so I wouldn’t die in Vietnam, my

lottery number was 127 which meant I'd be in the Army infantry and I was a dead duck." Neal thought his chances of survival would be greater by joining the Air Force.

Career. Two participants intended to make a career out of military service. Damon joined for a career and as a means to provide income to take care of his elderly parents, "I felt that if I went to the military, did a career there, I'd be able to take care of them better." Ellie's involvement with ROTC and ultimately her decision to join was influenced by her stepmom's family members that she interacted with for several years during her childhood. The father of her stepmom had served in Vietnam as a chopper pilot and influenced Ellie's decision to enlist. "I wanted to be a lifer. I wanted it so bad… I wanted the education; I wanted the college." Another motivating factor for Ellie that was mentioned earlier was that she did well when participating in military structure learned in ROTC and wanted to make a career out of military service.

Family tradition. Cliff followed his brother's example, "He was like my hometown recruiter." Adam describes joining the service as family business, "My dad was in the Marine Corp, my grandfather in the Navy, the other grandfather was in the Army. I mean, we can trace back, at least on one side of my family, all the way back to the Revolutionary War. God and country's been bred into me since birth."

Veteran participants enlisted in military service for a variety of reasons. A common reason was the limited local employment opportunities. Making a career out of it and family tradition was motivation for some and two decided to join rather than be drafted. Some of the veteran participants spoke about where they lived when they discharged from the service. That discussion is next.

Returning Home

Seven of the participants were raised on the Eastern Shore of Maryland and all seven returned to the area within a year of discharge. Two participants grew up in Baltimore and returned to this area after discharge. These two experienced homelessness while living on the Eastern Shore. Six participants spent their childhoods in other states in the Northeast of the United States: Maine (1), Vermont (1), Pennsylvania (2), and New Jersey (2). They returned to their home states upon discharge. Five of the six experienced homelessness in their home state prior to moving to the Eastern Shore of Maryland. All six had experienced homelessness on the Eastern Shore

Slightly less than half of the participants were originally from the Eastern Shore. Those living in other areas moved to the Eastern Shore for various reasons. One became familiar with the area through hunting, two came to be near the beach, and the remainder came because of friendships or family relationships with people living on the Eastern Shore. All experienced homelessness while living on the Eastern Shore.

The veteran participant data related to homeless pathways is presented next. The staff/administrator's data follows the veteran data.

Veteran Participant Data: Pathways to Homelessness for Rural Veterans

The purpose of this study was to explore pathways to homelessness for rural veterans and to find out from veterans what the contributing factors to homelessness were for them. Fifteen veterans shared varying amounts of information providing a context to their homelessness.

Each interview was coded in its entirety and then grouped into themes as a means of synthesizing and making meaning of the data. Similarities and differences were found

on several themes for this group of veterans. The most significant finding was the pervasiveness of substance abuse in the lives of homeless veterans. This finding is confirmed in other homeless veteran studies (Adler et al., 2015; Gordon et al., 2010) and a connection to substance abuse can be found in each of the other categories presented. The first theme presented pertains to risk factors in childhood that may lead to adult homelessness. The veterans were asked about their family growing up. The risk factors are discussed in the next section.

Theme 1: Risk Factors in Childhood

Housing stability, childhood abuse, and out of home placements have been identified as risks to homelessness in other studies (Rosenheck & Fontana, 1994; Tsai, 2013). Three of the participants discussed these issues as part of their childhood. Daniel discussed childhood dysfunction as early as three years old and losing housing stability when he was 16 years old:

> My real father was an alcoholic and left when I was three. My mother married another man who ended up being a very violent person…we grew up in a very violent, atmosphere. And then when I got to be a teenager…course I started rebelling and getting into trouble, like most teenagers tend to do…and started experimenting with alcohol and drugs and ended up getting kicked out of the house at 16.

Daniel experienced a tumultuous childhood that resulted in getting ejected from his home. He temporarily lived in a trailer with no heat on a friend's property. He continued to attend high school and eventually moved in with an aunt and uncle until he graduated and entered the military. He experienced housing instability and childhood abuse which

are two of the three risks factors experienced in childhood that are linked to adult homelessness.

Henry was raised in an orphanage along with his brother and sister until they were separated and placed in different homes. He left the orphanage at 16, got his license and searched for family members. He spoke fondly of his mother and said he was 17 when he met his father, but they never had a relationship. He found his brother and sister but by that time his sister had become pregnant and was living with an abusive partner. At 18 he joined the military. Henry did not disclose any childhood abuse and it was difficult to ascertain the relationship level he had with his mother and siblings.

Ellie described her mother as having medical and mental health problems. The man she calls her father came into her life at six months and stayed until she was seven. Ellie said her childhood was abusive. When Ellie was twelve she was taken to San Diego (she doesn't identify by whom) where she left her living situation and became literally homeless. She ended up in Arizona living in a community of people surviving in underground cement tunnels. She went into foster care at 13 and returned to Maine, her home state, at some point. Ellie was emancipated at 16. She participated in ROTC in high school and entered the military as soon as she could. Ellie experienced all three of the risk factors in childhood that have been linked to adult homelessness: housing instability, childhood abuse, and out of home placements.

Further analysis of these three cases reveals similarities and differences between the three. It is obvious that these three participants experienced adverse childhood events and all three mention a significant event occurring at the age of 16. Daniel identified himself as a rebellious teen which came into being as a reaction to and result of the

violent atmosphere of his childhood home, but he also normalizes his rebellion and getting into trouble as something "that most teenagers tend to do." He may have been comparing himself to the other teens that he was hanging out with and doing similar things, yet his behavior resulted in being ejected from his house at 16. At 16 he became responsible for making his own decisions.

The other two participants ended their relationship as a, "state child" at 16. Henry left the orphanage where he was living at 16 to search for his siblings and Ellie was emancipated at 16. Less is known about Henry's exit from the orphanage, but it seems like he takes on the role of champion as he tries to reconnect with his brother and sister. He finds his brother and then his sister. He said he threw his sister's boyfriend through a window because, "He beat the hell out of her." Henry said he threatened to kill him if he ever hit her again. Henry was describing himself as a protector of his siblings. At 16, Henry became responsible for making his own decisions.

Ellie viewed herself as being different from others her age. Some of the ways she described herself were: "I came from an abusive background, no home, no parents, no nothing; I have Asperger's, and dyslexia; I was one of those neurotic kids and I had neon blue hair and piercings." When she got involved with ROTC, she was really good at it and found a place to shine, receiving six varsity letters. She describes herself as being what the recruiters wanted, "They didn't care about my background, I took orders well, was competent, and could do what they wanted." Ellie found a place to belong in the Army. Ellie began taking full responsibility for her decisions at the age of 16 when she completed the emancipation process.

Housing stability, childhood abuse, and out of home placements are risk factors for homelessness (Rosenheck & Fontana, 1994; Tsai, 2013). These three cases are examples of people experiencing one or more of these risk factors in childhood and eventually experiencing homelessness as an adult. The cases provided some additional insight into a major change or decision that occurred while the individuals were 16 which resulted in empowering them to make decisions for themselves. All three voluntarily joined the military. The remaining participants did not reveal any of the three risk factors that may occur in childhood, however several did mention adverse life events such as parents becoming divorced or separated.

Eight of the remaining twelve participants described growing up in two-parent middle class families. One participant said that both parents were alcoholic, while another said his father was an alcoholic. The remaining four participants said their parents had separated or divorced but did not mention any additional negative childhood experiences other than the separations. The most negative comment came from Emmett whose parents separated leaving Emmett to spend most of his time with his grandmother. He described the man his mother remarried as a "bit of a jerk." Emmett used the example that after he enlisted in the Army, this man asked him about going to college but had not offered any guidance previously so that Emmett could have taken the SAT exams and applied to colleges while still in high school. With the exception of his stepfather, Emmett considered his family as close knit.

The childhood experiences of the veteran participants varied: three experienced childhood abuse, abandonment, or out of home placements; four others experienced the separation or divorce of their parents; two had at least one parent that was an alcoholic;

and six reported being raised in two parent households. Twelve of the veterans had enlisted by the time they were 19, one at 21 and another after college at 26. Three veterans did not disclose the age they enlisted. The next theme discussed is the transition from military to civilian life.

Theme 2: Transition from Military to Civilian Life

The second major theme is the transition from military life to civilian life. Military life meets basic needs and provides structure for individuals enlisting in the service. Meals and housing are provided. Participants learn customs and traditions of military culture. Duty and loyalty are a part of the culture. There are chains of command and codes of conduct that are followed, and obedience is expected. Discipline, selfless service and teamwork combine to get assigned tasks done. Comradery with individuals serving together is the norm. Emmett described how soldiers are militarized:

> You got your meals, your housing, clothes. Everything you need is paid for, because when you go into the military, a lot of people don't realize that you're not a person anymore. You're assigned, like if you were a job and you're assigned with this clipboard. That's what you are when you're in the military. And a lot of people don't get that point as far as, why do soldiers do what they do? Because you're government property.

Military life is very rigid, whereas civilian life is very flexible and some veterans struggle to find their way in the world of civilians. When veterans are discharged the civilians in their life and in the community to which they return may not understand military culture and what the veteran may have experienced while enlisted. One study describes this disconnection from people back home and losing the structure and purpose that the

military provided as the concept of normal is alien (Ahern, Worthen, Masters, Lippman, Oza, & Moos, 2015). The veteran may expect the civilians to mirror the traits of military culture. This is unrealistic and can lead to disillusionment with civilian life. Ellie described struggling with disillusionment in civilians upon her return to civilian life:

> You're gonna get let down. When you live in an environment where you have to depend on the person next to you to watch your six, you depend on them, you know they will come through. You cannot do that out here. It doesn't exist in our society, in our world today. People aren't raised with these values and tenets anymore, and if you expect that from them, you're going to get hurt, bad. And you're going to be severely disillusioned and you're going to hate the world. And it took me a long time to come to terms with that, a very long time, because I expected people to adhere to this code of conduct that just didn't exist.

Ellie's disillusionment with civilians is clear from her comment. Ellie found readjusting to civilian life very difficult and describes how it led to homelessness:

> I lived isolated as a teenager and when I got out [of military service], I didn't know how to function in the normal adult social world. I didn't understand what was going on. I couldn't hold a job. I couldn't do any of those things. I expected everything to be like it was there [in military service] and it wasn't. I couldn't make sense of it, and I couldn't adapt quick enough, which leads to things like depression, stress, anxiety, which led immediately into drug use. I started using heroin. I was living on the streets and nobody is there to help.

Ellie describes being totally unprepared for life outside of military service. Immediately upon discharge she began the journey into homelessness. Adam struggled with the transition to civilian life. Adam stated that he was not prepared for life after the service:

> I went in straight out of high-school, so for the first seven years of my adult life I didn't have any responsibilities except for a cellphone bill and vehicle insurance. So getting out was a big shock as far as the cost of living, and how much rent was, and having to go grocery shopping… Getting vocational rehab skills can be especially difficult, even though we have our GI Bill … that pays for our tuition and our books, but I've still got to have a full-time job …to put a roof over my head and to put food in my mouth… that's one of the difficult parts, and for me it just took too long to figure out which way I wanted to go, and now I have no educational benefits left.

Adam describes the difficulty of finding his way after he was discharged. He stayed with family and friends, but his legal trouble and partying lifestyle caught up to him and he became homeless within five years of discharge.

This study had participants that transitioned successfully to civilian life and others that did not. To put this discussion in context I framed it around the length of time to the first episode of homelessness for the veteran participants.

Length of time to first episode of homelessness. There were vast differences in this group of participants as to when they became homeless after military service. Seven veteran participants experienced the first episode of homelessness within five years of discharge. The remaining participants reporting this information experienced homelessness much later in their life: four veterans between 21 and 27 years and three

veterans between 36 and 47 years after discharge. This finding was supported by another study where veterans reported homelessness did not occur until at least 10 years after they were discharged from military service (Perl, 2015). Further analysis was necessary to explore what was different between the group of participants that descended into homelessness within five years and those that didn't become homeless for 20, 30, or 40 years. I made the decision to look at war era and discharge type as starting points for further evaluation.

Fifteen participants reported the war era they served in and ten reported the type of discharge they received. When war era was compared to length of time post discharge for first episode of homelessness the three OEF/OIF veterans all became homeless within five years of discharge. This finding was supported by a longitudinal study that found OEF/OIF veterans were 3.7% more likely to be homeless within five years of discharge compared to non OEF/OIF veterans (US Department of Veterans Affairs Office of Inspector General, 2012). Two of the three participants in this study became homeless within the first year of their discharge and both had received a general medical discharge due to mental health issues: one because of a TBI and the other with a diagnosis of PTSD and Bipolar Disorder. Mental illness as a contributor to homelessness will be discussed as a topic later in this study report. The third OEF/OIF veteran received an honorable discharge and was not discharged for a medical reason, however he said he currently sees a mental health specialist every week. This veteran said he was drinking heavily when he became a civilian and he made a bad decision and got in trouble with the law and was incarcerated which led to his homelessness.

Two veterans whom served during peacetime and received honorable discharges had also experienced homelessness soon after discharge: one at one year and the other at four years. Further analysis revealed that both veterans were abusing substances, and both worked full time. The veteran whom became homeless less than a year after discharge was "couch surfing" and when he ran out of couches to sleep on he became homeless. The other veteran was married and did not become homeless until he separated from his wife and eventually divorced. In his case he was able to stay in housing until the relationship with his wife became severed. This finding led me to look more closely at the dimensions of social support that each veteran received.

Social support. The first year after discharge is considered the readjustment period for veterans reentering civilian life. Two key factors are identified: access to someone to discuss personal matters and material and social support (Rosenheck & Fontana, 1994). Recent studies have shown rural homeless adults rely on social support for resources (Jackson & Shannon, 2014; Trella & Hilton, 2014). The literature citing the benefits of social support is large. Social support has been shown to reduce alcohol intake (Groh, Jason, Davis, Olson & Ferrari, 2007), decrease mental health symptoms (Calsyn & Winter, 2002), and improve physical health in some individuals (Uchino, 2006). Low levels of social support have been linked to stress and depression (Dobkin, DeCivita, Paraherakis & Gill, 2001).

The dimensions of social support that were coded for this study were high level of social support, low level of social support, and no social support. High level of social support was coded when the veteran had a partner or spouse, friends, or relatives that helped them emotionally or financially. Low level of social support was coded when the

veteran received occasional help from friends or relatives and no social support was coded when the veteran had no friends or family that were helping them emotionally or financially. The level of social support appeared to play a major role as to when the veteran descended into homelessness.

When analyzing the role of social support and the first episode of homelessness for the five veterans whom became homeless in less than five years it was clear that Ellie did not have the key factors identified above: someone to talk to about person matters and material and social support. Ellie was coded as having no social support based on the following words:

> If I had had some sort of network of support that would have helped immensely. I had nothing. I had no family, no nothing. And the only things that I was running into was kids on the street that are like, 'Hey, I've got drugs.' And the drugs made it so I didn't think or feel anything, and as a result, there was peace in that. There was peace in not having to feel anything.

Ellie did not have a social support network to help her readjust and she had the added difficulty of trying to adjust with Asperger's Syndrome, a TBI and Epilepsy. Unfortunately, the social support she found were the people on the street selling drugs. Ellie's mental and physical illnesses and drug addiction quickly led her to homelessness after leaving the military.

Emmett was receiving some social support when he was couch surfing with people he knew prior to entering military service. Emmett moved out of his mother and step-father's house when he completed his military service:

> When I got back home, I moved out. And I was staying with some friends and that wasn't working, because at that time, it was drug use. I was using drugs then and I wasn't participating [paying bills] because they wanted me to do things as far as my money and everything and I didn't. So, that's when basically it all started about homelessness, because I wasn't the kind of person to stay with anybody a lot. I always worked. I always tried to do the best I could do so I had people that I'd met…people that you don't even think notice you step in and say, 'Look, you know, you can stay with me.' So I had a lot of people that I knew, older people, and they invited me in, so I stayed with them for a while. And then I went to some friends, and they had what you call a smokehouse. And that was where people go to smoke crack and… he [the owner] looked to me to be the person to go get him his drugs. So I told him…I'm not doing that no more. So then I was asked to leave about a week after that. It was November. So I had a friend that I was working for and he had a house… a shell… no walls 'cause I was working there, I was working with him. We were renovating the store and the house, so he said, 'You know, you can stay here if you want.' So that's where I stayed at for like two years.

Emmett's level of social support was coded as low because of the temporary nature of the support he received from people. When he was living with friends and in the smokehouse, the social support he received was negative as drug use was prevalent in these settings. Emmett described himself as always working and trying to do his best. These qualities may have been the reason that people would invite him into their homes to stay for a while. He had some financial resources and would not have been totally

dependent on them for support. Because of the instability of the housing situation; he could be on the streets at any time.

The other three veterans experiencing homelessness within five years of discharge had high social support initially. One was living with his sick parent and when the parent died, a sibling sold the house and the veteran became homeless. Another had family and friends offering him support until he was incarcerated and the final veteran, Jason, had a wife and family until his substance abusing behaviors severed the relationship and he became homeless. Jason married and was divorced after five years, "I loved my wife, I really did, but it just wasn't going to work. Alcohol abuse, drug abuse, and being in love was a terrible combination, and is what's led me here [homelessness]." Jason found resources to stay in a motel for two weeks before becoming literally homeless. Jason said that he always worked and took care of his family, "I'd go over there every Friday, see what the kids needed and pay for it. Then I'd leave and I'd go find me somewhere to lay down, and get drunk, and smoke weed, and that was it." Jason mentioned having family that would help too, even though he did not utilize the help very often.

Coding social support helped to put into context the point at which someone became homeless. Many other contributing factors were involved such as substance use and mental illness which impacted the level of social support that someone was experiencing, however when support was withdrawn or did not exist homelessness was imminent for these five veterans.

I coded social support for the veterans whom maintained housing for over 20 years to analyze their situations for the impact of social support. High social support seemed to be a protective factor for these veterans in maintaining housing stability.

Daniel received an honorable discharge and served during peacetime. He was coded as having high social support when he was discharged. Daniel had a plan when he left military service. He tried to work and go to college:

> I got some grants, but um, they didn't pay for everything obviously. And I couldn't juggle that and a full-time job, you know. I was trying to go for my bachelors of art. I wanted to go into commercial art… but it wasn't working out that way. My first job was doing hardwood floors, which I really like to do and I pretty much stayed in the construction trade from that point on.

He met his second wife when he got out of the military. They were married for about ten years when his wife divorced him for his partying lifestyle. He described himself as having a strong work ethic and he was able to maintain housing and employment after the divorce. His third relationship produced a son and this partner was addicted to crack cocaine and he was drinking heavily, so the relationship did not last very long. When they parted ways Daniel said, "It was like the beginning of the end." After they split up he had support from his family until they got tired of dealing with him. His drinking led to several hospitalizations which led to lost employment and eventually led to homelessness. Even though his relationships were dysfunctional, Daniel was able to manage housing stability through these relationships and through maintaining a job. When he reached the point when he had no income and social supports were no longer available, he descended into literal homelessness.

Cliff and Barry both received honorable discharges and served during peacetime. They were coded as having high social support. Cliff had a network of support in his family, he said he is the youngest in a family of eight and there is always somebody that

would help by letting him stay with them. He had additional supports in his community of friends that would help him. He was self-employed and maintained housing until he couldn't work anymore because of a knee injury. He was struggling with addiction and homelessness.

Barry has been married for 31 years. He had an alcohol problem in his twenties but has been sober since then. He was able to work and maintain housing until he was disabled. When Barry and his wife lost their home, they entered homelessness together and are still together today. During the time that Barry and his wife were losing their home, Barry's relationship with his siblings deteriorated as first his father got sick and died and then his mother died. Events that occurred during that time resulted in severed relationships as Barry said, "I don't have a family now."

Both veterans had high levels of social support and did not become literally homeless until a disability left them without a means to make a living. Both veterans experienced homelessness for about two years. Their homeless experience led them to VA services which helped end the cycle of homelessness for them. Cliff went into inpatient addiction treatment and from there he went into transitional housing available on the Eastern Shore for veterans. In the meantime, he had applied for and began to receive disability benefits from the VA. Cliff described the disability process as long and arduous. He said when he first applied he received a 10% disability rating and then asked for reevaluation and his rating was increased to 20%. He applied for reevaluation several times and got up to 70% disability after five or six years. This gave him enough income to live on and to achieve housing stability. Eventually he received a 90% disability rating. Because of this income, he was not eligible for HUD-VASH housing. Barry on the other

hand was eligible and received a HUD-VASH voucher which ended homelessness for him and his wife. Both of these individuals are examples of how social support helped to delay the onset of homelessness and how VA services helped to end the cycle of homelessness in their situations.

Neal and Henry both received honorable discharges. Neal served stateside during Vietnam and Henry served during peacetime. Both were coded as having high social support for many years through long marriages. Neal was 25 when he was discharged and moved back to the Baltimore area. He went to college and earned a Master's degree with a concentration in tax law. Neal worked for a while for a CPA firm before going out on his own. He ran his own CPA firm for 30 years. Neal said he got married at 20 and was married for 34 years until it ended in divorce. He has a son and daughter whom he does not stay in contact with. Neal said after his divorce, he started drinking heavily, but now has 12 years of sobriety. At the time of his interview, he was maintaining hope that he would receive an inheritance from his father who was very ill.

Neal retired to the Eastern Shore and had been renting an apartment in a senior community for around a year when he realized he could not afford housing, a vehicle and food. He let his car go back to the bank and eventually had to give up his apartment. Neal said he is not eligible for VA benefits but did not elaborate as to why he is not eligible. Neal has no friends or relatives to stay with and is currently using emergency shelters for temporary housing. He had not experienced living outdoors when I had met him. Neal said this is the first time he has experienced homelessness and describes the experience as uncomfortable, "I don't mean physically, it's just an uncomfortable place to be, emotionally." Neal successfully adjusted to civilian life, completed college and

had a career as a CPA. When he lost his marriage he also lost the relationship with his children and substance use became a factor in his life that may have played into poor planning for retirement. During retirement, he ran out of money and was no longer able to sustain his housing. With no social supports remaining in his life he became homeless.

Henry on the other hand was living in his automobile. He had substance abuse issues but has been sober for many years. Henry had been married three times. He was married to his third wife for 47 years. When his wife died, he lost his anchor in this life and his cycle of homelessness slowly began. Henry put it like this, "After she died, I got down in a ditch." Henry was around 70 when he became homeless. When she passed away, his social support was gone, and he became homeless.

Cecil was unlike the other veterans who maintained housing for 20 or more years before experiencing homelessness for the first time in that he did not receive an honorable discharge. His discharge type was other than honorable or OTH. He did not provide specifics but said he got into trouble in the service and received an OTH discharge. When he was discharged his parents were having problems and his mom was sick and living alone, so he went home to live with her and to help her. She died around nine years ago, and Cecil said, "It's been a battle for at least the last 10 years with homelessness, off and on. I been under the bridge and in the woods with a tent." He said he also had some legal trouble as a civilian. He was incarcerated but did not reveal when or for what. He did admit to a 30-year drug addiction which played a part in his life experiences. It seems like when his mother died Cecil, he lost his support network. He was coded as having low social support because he said, "I've been struggling with

homelessness for quite a many years, but just recently I couldn't stay no longer where I was at, and I had a family issue and I'm homeless."

The level of social support appeared to play a role in when the participants became literally homeless. High levels of support including family, friends, marriages and partners helped the participants with over 20 years of housing stability to stay housed until the relationship was disrupted for personal reasons or through death. Low levels of support resulted in a quicker decent into homelessness for the other five veterans.

Relationships with family members and significant others may provide social support to veterans exiting military service. In the absence of close social relationships, the transition to civilian life may be difficult. Divorce, separation, or losing a spouse to death supports the finding that unmarried status is a risk factor for becoming homeless (Rosenheck & Fontana, 1994). Mental health problems can be another factor that wears down family support. The theme of mental health as a contributor to homelessness is discussed in the next section.

Theme 3: Mental Health

Mental health issues are often linked to veteran homelessness. Some recruits have mental health problems before entering the military. The Department of Defense has mental health standards that recruits must meet and they do screen for significant mental issues. For example, a recruit with a history of suicide attempts or history of psychoses would not meet the standard. Emmett and Ellie mentioned the role of the recruiter regarding mental health issues and recruits entering military service. Emmett had the following to say:

> A lot of veterans have mental disorders that weren't diagnosed in the military because in the military, one of the biggest assets to the military is the recruiter. But he's also one of the biggest problems, because if you meet a minimum threshold, he's gonna put you in. So recruits with mental issues get in and they're not diagnosed. They go in the military and you either dig in or you rebel. And if you rebel and you don't do what you have to do or you have some mental issues and it's not diagnosed, you know you get written off as a medical or whatever kind of discharge you get and you're discharged.

Emmett made the point that individuals may be enlisting in the military with undiagnosed mental health issues. If the mental health issues get in the way of following orders and assigned tasks, then some recruits receive a medical discharge or depending on their behavior they could end up with a dishonorable discharge.

Ellie had the diagnosis of Asperger's Syndrome when she joined. She had this to say about her recruiter:

> My recruiter understood that I came from an abusive background and had no home, no parents, no nothing. They understood that I was a child of the system. They knew I had Asperger's. They knew I had dyslexia. They didn't care. I took orders well. I respond well to that and I do well in structure, and I listen, and that's what they wanted. Someone that was competent that could do what they wanted. So at 16, I took the ASVAB [Armed Services Vocational Aptitude Battery] and… because I was emancipated, they signed me in at 16 years old.

From Ellie's perspective, her Asperger's Syndrome was a positive characteristic to have as a military recruit.

Mental health and stability was brought up by several veteran participants as it relates to homelessness. Mental stability and homelessness was discussed by Daniel in some detail:

> It depends on somebody's mental stability, you know, your mental state. How much can you handle… what's your threshold… what makes you feel you have the need to escape? Because a lot of it is escaping from society. A lot of it is just getting away, not wanting to be that norm…Mental instability**,** you know, not being able to handle stress in one form or another. Wanting to run away from it. You try to drink it away or drug it away, not wanting to face it. You know, it's a form of denial.

Daniel's description brings awareness to the idea that each person has a threshold for handling stress in their life and how mental health plays a large part in the ability to manage stress. Mental instability lowers the individual's ability to manage the stress and negative behaviors like substance use.

Homelessness can help a person escape the behaviors that society expects from responsible adults. Cecil described the inability to handle responsibility in the following way:

> Unmanageability… unable to do the things necessary to keep a family home … or keep a job. Getting up, going to work, paying bills… maintaining a house. Responsibilities of a family… a lot of their motivating factor of them being on the streets is they are not willing, for one reason or another, to accept those responsibilities. You know, um, they feel if it's them on the streets, then it's them all they have to worry about, you know, they find where they can get a meal …

> have a little drink or some drugs to numb the pain of being on the streets, you know, warm up the body a little bit. And they have no worries. Some of them really feel that way. They have no worries. You know… they're not part of society. They don't feel like they want to be part of society.

Withdrawing from society as described by Cecil may be a rational choice for some individuals or it may reflect the lack of awareness and insight into mental health issues that may impact daily functioning.

Barry is an example of a veteran with limited insight into his mental health. He said his time in the service "messed me up." He said he would experience episodes of not wanting to leave his house and having "anxiety and panic attacks." When he got out of the service he tried to stay busy, "I needed to consume my mind into something, or else my mind it overtook me. So I submerged myself into that [playing the trombone], so I didn't break down, and stuff like that, but I did drink heavily. I mean, I was drunk sometimes, three times a day." Barry was able to work part-time doing maintenance work out of an office run by his mother. When his symptoms would prevent him from going to work, his mother would cover for him. This went on for three years until ownership changed and Barry lost this job. He then became self-employed doing home repairs. This allowed him time off when he was overwhelmed with anxiety. This worked for a while until he eventually lost his home to foreclosure. Over the next three years he had 23 jobs. Barry never mentioned seeking mental health treatment during this time.

Alan demonstrated insight into his mental illness. He left the service with a medical discharge due to PTSD and Bipolar Disorder. "The PTSD destroyed me. I started drinking heavily. Managed to get myself into trouble too." Alan is compliant with mental

health treatment and medication, “I'm taking five different meds every day, twice a day, to even me out, and I hate to take em. I really do, but I have to or I'd be drinking to self-medicate if I didn't have the proper meds for my depression, for my anxiety.” Alan took advantage of inpatient treatment for alcoholism and PTSD. These services helped stabilize him and he continues to use outpatient services. Substance use by participants is discussed next.

Theme 4: Substance Use and Abuse

All the veterans I spoke to reported alcohol abuse and in some cases drug use as primary or secondary contributors to their homelessness. Adam stated that, “Alcohol is a very prominent thing in the military, so we just keep drinking when we get out. Some of us turn to drugs, cause it's, you know, easier.” Similarly, Cecil talked about stress and alcohol addiction as it relates to military service:

> I don't think people realized the stress of being in the army, and I'm not a combat vet, so I can just only imagine being in a combat zone and having to deal with what you have to deal with. Then you come out here and a lot of guys, I've seen a lot of officers and sergeants in the military and get out and they got alcohol problems, and that's how they cope with what they've seen and what they did.

Daniel described experimenting with drugs and alcohol as a teen. Drugs and alcohol remained a part of his teenage years and then when he was in the military, it was common to “party half the night” as soon as he got off duty. “It was just part of military life.” Daniel’s story demonstrates the destructiveness of alcohol in his life. After discharge from the military, he continued going to bars after work while maintaining a job, a household, and family. “I was doing my duty as a citizen.” He said this went on for years,

“It [alcohol] starts to manifest itself and takes over your life, to where it’s all you think about and then you can’t function unless you’re drinking.” I had to have a drink just to move and act normal.” He said his wife divorced him because of his partying lifestyle. He reported contracting pancreatitis resulting in five hospitalizations within a one-year span. “I went to five ICUs in one year and continued to drink. That’s the insanity of it.” He said he went to rehab a couple of times but was not committed to staying clean. He lost jobs, didn’t have a place to stay and was staying with family until they got tired of him and ended up with nowhere to go.” This is how alcohol became his eventual path to homelessness.

Alcohol and drugs were a common coping mechanism among this group of participants. Cliff said, “You kind of get down on your luck…your self-esteem leaves you and your integrity starts disappearing and you don't have no hope and if your hopeless the first thing you do, you turn to the drugs and alcohol, … it becomes a problem because you're never going to do what's right … because that's your first priority, is the drugs and alcohol, not housing.”

Ernie described how losing a loved one to death can begin the spiral into homelessness, “They lose a loved one and they can't quite grasp life anymore. And they end up out here [streets] and they end up on the bottles [alcohol], you know, or the drugs because they can't handle losing that loved one, you know, in their life.”

Alcohol can be a part of the path to homelessness or it can be a symptom of the situation. Daniel spoke about individuals prioritizing the use of alcohol and being homeless:

> You know, it could [alcohol use] be as a result of being homeless, or it could be what got them homeless, you know, but it plays a major role and it's a lot of what keeps them down. What keeps them there, you know. It's a lot of the reason why they don't want to go to any places for help, because they know they gotta give that up. It's comfort to them. You know, they'd rather sleep in the woods and drink a beer than sleep in a warm bed and have to give it up. And that's sad, but like I said, that's the insanity, you know, the disease aspect of it, as far as that goes, you know, it's gotta be something. You know, and that's a sad fact.

Steven shared his opinion on the use of alcohol by street homeless:

> I've been homeless going on three years, so let's try to put this in perspective. The grand majority of 'em ... I can't say they're alcoholics by choice, because if you've ever been out there in the streets, you know that everybody who drinks out there has got a reason behind it, and if they weren't in the position that they are, they probably wouldn't drink. Shoot, I drink. You almost got to out there, 'cause it drives you crazy, and you're sitting there, and it's like, you don't have any work one day, there's nothing to do except go to the library, you get bored with that, or sit outside in the cold, and then you've gotta always put up with people looking down on you. The lack of compassion in this world, the heartlessness in this world, which I don't understand how it got that way.

Ernie spoke about the internal struggle he had in his relationship with alcohol:

> You're doing these things and…you're telling yourself the whole time in your mind… you gotta quit. You want to quit. You're crying out inside your head to

quit. But then you pick up another one. You can't… it seems like it's impossible… and a lot of people get so discouraged. They don't even resist it anymore.

Substance use impacts a person's decision-making process and every participant had a relationship with alcohol or drugs at some point in their adult life. Making poor choice was a theme that developed during the analysis and is discussed in the next section.

Theme 5: Making Choices

Making decisions with negative consequences was a common theme when participants were asked why they were homeless. Adam said, "Bad choices is really all it boils down to, one way or another. In my situation, I got in trouble with the law, you know, because of a bad decision that I made. It didn't help that there was alcohol involved. But ultimately it comes down to making a bad decision somewhere along the line."

Jason has maintained steady work as a mason since his discharge from the military and he credits his poor decision-making processes and homelessness with his limited success in life, "It's broad in scope but it would be the decisions that you make… it's not any direct cause, but all the decisions that you've made have led you here. Not doing what you need to do to take care of your business. Decisions come with rewards and consequences." As mentioned earlier alcohol and drugs were a part of Jason's story and played a part in the decisions he made.

Cecil shared how decisions led to legal trouble and impacted his release from service. He received an OTH discharge when he left military service:

For me as a veteran, I got in trouble. I'm not proud of it, and I've been in trouble in civilian life too…something happens and the bottom falls out of something,

> some situation in life, and you end up homeless, and then you're looking for your country to come to your aid. Hurry up and wait. Hurry up and wait. Hurry up and wait.

Cecil expressed the opinion that he expected more help from the government for his military service. The type of discharge he received limited the help that he was eligible for. Poor choices and financial strain had commonalities such as incarceration. Themes related to financial strain are discussed next.

Theme 6: Financial Strain

Incarceration history was not specifically asked about in the veteran interviews, however, three veterans brought it up on their own as a hindrance to finding viable employment and housing. Stephen, one of the three, used incarceration time to increase his education in business management, graphic arts, and Microsoft Office certification, however the only work he can find is through day labor programs. He is able to work construction type jobs but said he is feeling his age and the physical labor is getting more difficult to complete. He also has to maintain regular contact with his parole officer, which can impact his available work time. He attributes lack of work to his homeless situation, "Well, in my own case, lack of work ... and the fact that it's hard when you've got a jailhouse record to rent a place, or to even find other jobs." Criminal background adds another layer of difficulty to finding employment.

Cecil was adamant that his biggest hurdle to employment was transportation, "I want the transportation before the house, because I can go get a job with the transportation and keep it… put me in a house, and I ain't got no car or no job, and see how long I got the house."

Barry said the same thing, “And then you have no car. I couldn't even get a carpenter job, when I was trying, cause I had…no transportation to jobs, everybody wants you to have transportation. You know, and the busing system is terrible down here (Eastern Shore).”

Emmett’s said having a job would reduce homelessness, “With a veteran working… you're working for a team, you're not an individual player…if a lot of veterans had a job, it would be, I think there would be less homelessness among veterans because you got that sense of duty to your job and you would be able to be around people, socialize. And you have a job and get a roof over your head.” Cecil said his sense of worth improves when he has a job, “I always do better when I'm employed and I work. It's not so much the material things you can get while you're employed, but you being employed it tends to pick your integrity up… self-sufficient ... I look at myself different when I look at myself in the mirror, 'cause I'm out doing this to get what I need to get.”

Ray cited unemployment as a factor in homelessness. Ray remembers the seventies and eighties when it was a lot easier to get employment. Emmett remembers that time as well, “I could get fired from a job today and get a job tomorrow.” Over the years major employers of non-skilled laborers have left the Eastern Shore and the current homeless veterans don’t necessarily have job skills that transfer to today’s workforce needs. Emmett compared his experience to other veterans:

> I worked before I went in the military. I had an understanding of work, getting a paycheck, budgeting your money, managing your money. A lot of these guys went in the military from high school. They went from Momma doing everything for them, your father helping you out when you needed it, to the military, getting everything you needed and then you get out. What life skills do you have? Most

people wouldn't be homeless if they had a job, because they had a work ethic. I think a lot of people are remembering the past and seeing how hard it is now to get a job. So I think a lot of them just give up.

Mental health issues and substance abuse make it difficult for many of the participants to work. In Alan's case it is PTSD. He is currently compliant with medication, attending counseling, and working toward recovery from alcoholism; he has been sober for several months. Adam is managing his PTSD enough to hold down a job. He schedules his weekly therapy for the same day each week, so his employer knows when he needs to be off work.

Henry and Neal collect social security, however, at the time of the interview it was not enough to secure housing. An additional barrier for Henry are his two canine companions. Henry will not secure housing without the dogs going with him. Neal said his homelessness was because, "I simply ran out of money." After Neal retired, his monthly income was not enough to sustain housing in his situation.

Lack of income and homelessness are linked. Several of the veteran participants worked or had an income to sustain housing. Emmett, Cliff, and Barry were examples of veterans whom were currently housed. Others described multiple issues around obtaining and keeping employment. It was generally agreed that there are few jobs that provide a living wage to support housing on the Lower Shore of Maryland. Transportation was another barrier to securing employment. Other common barriers were having an incarceration history or having unmanaged mental illness or substance use issues.

Six major themes emerged from veteran participant interviews around the topic of pathways to homelessness for veterans living in rural areas: risk factors in childhood,

transition from military to civilian life, mental health, substance use and abuse, making choices, and financial strain. Substance use and abuse permeated all of the other themes and was a part in the story of each veteran participant. The following section includes information provided by staff/administrators as they relate to these six themes.

Staff/administrators Data: Pathways to Homelessness for Rural Veterans

Sixteen staff/administrators of veteran services participated in this study to provide an alternate perspective for the topic of this study. Staff/administrators reported substance abuse and mental illness as two of the most prevalent causes of homelessness for rural veterans which coincides with the information provided by the veteran participants. Staff/administrators also recognized that some of the veterans they come into contact with had problems originating in childhood that were unresolved upon entering military service which supports risk factors in childhood mentioned by veterans. Comments by staff/administrators reinforced that the transition to civilian life is difficult for many veterans and more support for veterans is needed to address the problem. Staff/administrator's data confirmed that there is a lack of affordable housing and jobs to sustain housing are unavailable and contribute to financial strain for veterans seeking to maintain housing. Detailed comments around the themes that emerged from the staff/administrators interview data related to pathways to veteran homelessness are provided next.

Theme 1: Risk Factors in Childhood

Staff/administrators agreed that some of the individuals enlisting were not doing well prior to going in to the service. They mentioned that in some cases these are individuals that struggled in school or may be unaccompanied youth. The McKinney-

Vento Act defines unaccompanied youth as “a homeless child or youth not in the physical custody of a parent or guardian” (National Center for Homeless Education [NCHE], 2017). Family conflict may lead to a youth deciding to leave their parent or guardian. Research has shown that issues such as sexual orientation, substance abuse, incarceration, foster care, or neglect and abuse can lead a youth to leave their home (NCHE, 2017). Three of the veterans in this study mentioned having problems in their childhood that led to leaving their living situations at age 16. Daniel was kicked out of his house and lived in a camper, Henry left the orphanage where he was living, and Ellie became emancipated and left the foster care system. The staff/administrator’s data supports the veteran data suggesting that childhood risk factors may lead to adult homelessness. One participant put it this way:

> Sometimes the people who are recommended for service (military) are folks who had trouble. You know, they're not going to go to college, 'cause they don't have the grades. They're not going to do this, 'cause they don't have whatever. And they're unaccompanied youth, they're kids who have been on the fringe, they're parents have really struggled, they've struggled with their parents with school. And those are some of the folks who are going into the general recruitment.

Another staff/administrator used the following words:

> The homeless veterans we see did not go to the Naval Academy, do not seem to be highly prepared, and highly educated with the goal of being an officer. The army will take people who are disenfranchised. You know their families tell them to go get some discipline and go in the army! But they really had unresolved issues when they were teenagers. They never assimilated well. They weren’t great

> in school, they were okay. They always had aggressive tendencies. They still have those issues that aren't resolved so when they come back and there's no structure anymore…they're kind of lost souls.

The other reason people go in the army is because they may not have choices. You know maybe they were floundering. Childhood experiences and struggles were mentioned by staff/administrators as reasons that some people enter the military. They made the point that some individuals are struggling prior to entering military service and may use enlistment as means to get away from their current circumstances. The military may temporarily provide a structured environment where they become part of a unit and their struggles may subside while they are in that environment. When veterans are discharged they must make the transition to civilian life and some individuals struggle with the transition. Staff/administrators comments on this topic are included in the next section.

Theme 2: Transition from Military to Civilian Life

Staff/administrators identified the following issues related to veterans transitioning back to civilian life and becoming homeless: lack of reintegration services, lack of jobs, mental health issues, including trauma and substance use issues. One participant provided insight into what it is like for some veterans reentering civilian life:

> I think it's harder for them than it is for other homeless people, because of … their core values…When you are in the service, when you leave home, especially-particularly the ones that leave home and they go right into the service, everything's taken care of for them. Everything. They don't have to do anything. They come out, they're not used to going to the grocery store. They're not used to

> paying their own bills…it's like you're in a whole new world. So I think sometimes it just gets overwhelming. And it's easier sometimes just to live in the woods.

Multiple providers mentioned the structure provided while in the service and the lack of structure upon discharge. One provider said, "You give them structure, and then you put them out. And you know, it's kind of short sighted in terms of what do we expect? To expect that somebody who is marginalized is going to return and blossom, is not a realistic expectation." Another staff/administrator described reentry into civilian life in the following way, "They get out and flounder for a while. They are used to structure and things being set up for them." Another individual said, "Everything is regimented and planned out--then put back into society and left to manage their life on their own. You've not trained me or debriefed me. This is hard." Another staff/administrator who was a veteran, made the following statement about his own experience of exiting military service:

> The debriefing is really not there…I mean you go through, a lot of things, everything is regimented. You know for us, you know, it's more or less you know what you're gonna be doing at five AM in the morning, you're basically gonna know what you're gonna be doing all day long. So, now you're taking someone who's been in the field in the jungle with an M-16 all day long and you're putting them back in society. And you're saying now, you manage your life. Well, what? How am I to do this? You've not trained me. I've not been debriefed, I've not been anything. And a lot of times, that's, that's hard. That's very hard to do.

Staff/administrators said that there are not very many integration services available, so veterans don't seem to plan for returning to civilian life. Because of the lack of planning one participant said, "That some (veterans) end up homeless in a month. That's a real hardship for them that within a month they're homeless, they just don't know what to do." Several mentioned the lack of affordable housing options and that some of the housing that is available is in neighborhoods with high rates of crime and drug activity. One description was:

> The resources that are available to these people …are in a lousy neighborhood. Always with drugs, alcohol, crime all around them. Nothing that would contribute to their sense of stability. Because that's all they're going to be able to afford. So, you know, putting them out and you're almost guaranteeing that they are going to end up homeless again and be back out there again... That's a sad situation.

Another participant described the lack of housing as, "There are very minimal options. I mean, we have very little housing. The housing a lot of it is horrible and it cost a lot. I mean a lot of the landlords now are requesting first months ... last month's rent and the security deposit, so you have to come up with three months' worth of rent." Finding affordable housing is difficult.

A participant described their experience with homeless veterans and the supports lacking for this population:

> The lack of that planning, lack of support as they're leaving causes real hardship for folks. You know and I think if there is just a little bit of planning prior (leaving military service) you wouldn't get these people coming out and then they have nothing setup, then they are desperate then they turn to the drugs, the

> alcohol… mental illness (may be a factor). I think a lot of them, they've just kind of like lost their way, and they couldn't sustain a job and then once they got in that rut, then they couldn't get a job, then they couldn't do the job, then they got homeless, and then it just spiraled from there. A lot of them don't have the relationship of their families. And if they don't have that, you need that. I think that's with any homeless individual, though. If you don't have that relationship with family, someone who can help you, then a lot of times they come back ... and I can think of my own circumstances, with my own family member ... He came out of the service, and he has worn out everybody. He got into substance abuse; a lot of them get into substance abuse. And I don't think that that's something odd. I think that probably happens more often than you think. I think a lot of it is that the Shore's [Eastern Shore of Maryland] a tough place to make enough money to be able to afford to live on your own. And I think once they get down one time, it's really hard to get back up. So I would say, mental illness, substance abuse, and lack of support too. And jobs. I mean if you ask a lot of people they'll say it's the jobs. They can't get jobs. But I think that they have trouble maintaining a job because of the other problems.

The prior comments describe the interconnectedness of problems related to veteran homelessness. Substance abuse and mental illness make it difficult to find and maintain employment and can lead to homelessness especially if there is limited or no social support from family members.

One provider described the attitude of veterans that she has worked with as they reenter civilian life:

> When they're fresh out of the service, most of them are ready to get into the workforce. Most of them are ready to continue their lives, and then for various reasons, things fall apart. We don't have many jobs in the area anymore, Anybody that would come back home to be with family and there's no work, it's slowly going to eat away their self-worth, combine that with their mental health issues, if they have them and most…anybody that's prone for homelessness has the mental health issues. In this rural area, there is not enough work for the population, especially as far as unskilled labor, and I think that contributes heavily to the decline of the mental attitude of the veteran.

Another participant spoke to how the skills that a person learns in the military don't seem to translate to employment in the Lower Shore of Maryland:

> And you have some very bright individuals, I mean you're looking at sonar techs, and stuff that's coming out of the military, they're responsible for millions and million dollar equipment. To be able to understand it and operate it. And you're telling me they come home and there's nothing? They may not be able to work 40 hours a week, they may only be able to work, you know, a few hours and build up to that. Because that's not what they've been used to if they're just coming back. And, I mean, they (employers) have to understand that little things that wouldn't bother us can trigger and bother them, you know, like loud noises, crowds of people. Like all that affects them with their anxiety if they've been over, you know, deployed.

This participant went on to suggest that reintegration services could be used to:

> Turn out somebody that can do plumbing, do electrical, do those kinds of things where you can make a wage and everybody needs a plumber. Everybody needs an electrician. You need a masonry person ... So if they don't have that skill, you know the academic skillset, maybe they have the tradesmen ...work stuff.

Three participants related the person coming out of the military as having similar issues as someone exiting incarceration, "You know it's a terrible slippery slope and it's terrible to relate veterans with the prison population but I mean it's kind of the same. You're going from that institutional structured behavior to a world that you are not really prepared for." Another participant had the following to say:

> But for many of them, if the issues are severe enough, it's not unlike any other person coming out of prison. Especially if they've been deployed and things coming back into the workforce. They've changed. The environment and the family they left from hasn't. For them to go back to that [environment] would make them go back into the lifestyle that they were in. So, a lot of times, they become homeless because they move in with a friend, or a friend of a friend, or something like that. And that's considered homeless when you don't have a stable environment. Something happened in the environment in which they were living. Uh, sometimes it could be fire. It could be death. It could be that they have addiction problems which then their family alienates them. And then they become, despondent and things happen. So then there's that environmental situation that, really lends to them being homeless. I don't think anyone wakes up in the morning and says, I'm gonna be homeless today, or I wanna be homeless, but circumstances put them in that situation.

One provider made the observation that when some veterans are discharged they may not want treatment services or a job:

> We can only encourage them to seek, mental health treatment, substance abuse treatment, and encourage them to, if they can, get a job. A lot of them don't want to work. They went in the military, which is a very structured, strict environment and you come out and you got these other issues but then you also don't have a purpose…some of them probably can't work so they need to be assisted with disability, but some of them can. Which is a problem too. Employment has always been an issue on the Lower Shore…I don't really think anyone would actually deny services. It's just many of them [veterans] may have been burned a few too many times. And that could be keeping them from accepting the assistance and trusting somebody.

Another participant brought up the issue of trust and how it impacts providing services:

> They really only want to interact if need be, because I think it's because of how the population and society views them, and they have their encampments, it's where they're at. So even to get out there to link them to the services that could be available for them is extremely challenging because they don't trust the general population because if law enforcement finds out where the encampments are they go and uproot them. And I think with the veterans, you have to meet them at their level. Just because they tell you today they don't want mental health treatment or they don't want a ride to go look at these services that could be available for them, I think the world is so busy and people are busy with their jobs that they're like, they don't want services…okay, close that case. We're done. And I think that's a

> disservice, because it can't be that way. This is a population that they're not trusting people, they're homeless. I would assume they assume that everybody has an underlining agenda to try to, you know, get them out of homelessness and put them where we feel is fit for them. And I think that you really have to work extra hard to build that rapport with them so you can then link them to what they are appropriate for.

This participant gives insight into the attitude and mindset of some helping professionals. A helper may get frustrated with trying to help someone who says that they don't want help and they may quit helping. Secondly, a helping professional needs to listen closely to the needs of the homeless veteran and help them achieve their goals and not the goals that a staff/administrator thinks that they need. These could be two very different things. Another provider spoke about veterans who may not want help initially but then something may happen that makes them more open to make a change:

> They gotta want the help, that's the first step, but when they want the help the services gotta be there, and with the lack of services in certain areas, or the overuse of them, you don't get it in a timely fashion. So there might be a window where they're motivated for change.

This participant went on to say that he was in the military and he can generally make a connection because he is able "to speak the language." His point was that staff/administrators who are veterans may be able to make a connection when a non-veteran may not be able to.

One of the staff/administrators said that through their program they can help with housing, but a barrier for many veterans is maintaining the housing:

> We may put them in housing but can they maintain that housing, do they know how to cook, do they know how to clean, do they know how to pay their bills. You know, we would just assume yes but that's not the answer, it's not a yes. A lot of them need life skills training, especially if they've been in the military for a long period of time and went in young, you know military they tell you when to get up, they tell you when to go to bed, they tell you what to do. You know you get your pay and usually goes to a spouse or a family member and you don't really have to deal with that day to day life skills of paying your bills, getting up going to a job on time. These are things that need to be taught. So we're looking at veterans that need to be retrained and who need life skills training, they don't understand that they need that.

Staff/administrators working with homeless veterans discussed a multitude of issues that may arise during the transition from military life to civilian life. Upon return the veteran may be different due to the military experiences they have endured. For family members life may have moved on while the veteran was enlisted so the return may result in awkward relationships. Substance use and mental illness may be involved and may impact the family relationships. The loss of a structured environment can be another aspect of the veteran that causes them to flounder. Employment may be difficult to find, and things may quickly fall apart. Job training may be necessary to find viable employment that can maintain housing. Social support can be a protective factor, but other behaviors may compromise the amount of social support a veteran may receive. Trusting relationship are important and veterans seem to trust helping professionals that are veterans more so than non-veterans.

Theme 3: Mental Illness and Substance Abuse and Use

Staff/administrators reported mental illness and substance abuse as two of the most prevalent causes of homelessness for rural veterans. The two issues were commonly referred to as a single theme and are not separated for that reason. This information was no surprise as it has long been documented that substance abuse and mental health problems are primary risk factors for homelessness (Tsai & Rosenheck, 2015). One staff member estimated that 80% of the homeless veterans they come in to contact with have a mental illness or substance abuse problem that keeps them homeless. This finding supports the veteran data in which all participants reported substance use issues at some point in their lives.

Many homeless veterans have problems with both issues of addiction and mental illness and are dually diagnosed. One staff/administrator said that, "Substance use helps mask the mental health issues and feelings, and things." Another participant recounted a conversation he had with a homeless vet living in an empty building during a point in time count:

> It was the saddest thing to hear a veteran say that he consumes alcohol all day long, just to cope. This is how he deals with life, because facing life on life terms is just too much. That's sad. And we're talking about a person that, whether he has OTH, or honorable discharge, fought for his country, fought for the lives of others. And, there's no support, no one, just leaves him out there. How do we turn our back to that?

As discussed in the previous section several of the staff/administrators related the difficulty of maintaining employment while using substances or dealing with a mental

illness. One participant stated that, “Mental illness symptoms and substance abuse behaviors makes it hard to comply with treatment and to find and sustain employment that will allow them to live independently. One person suggested that all returning veterans may benefit from mental health services:

> I think for all veterans, when they're returning and so maybe not for Vietnam veterans at this point, but for other veterans, when they're coming back into society, I don't want to say mandatory, but almost mandatory mental health services, you know, once they come back to head off all this other stuff. People look down on homeless people, and I don't understand why. They're more inclined to help an animal shelter then they are a homeless shelter…Maybe they were in a car accident. Maybe they had a head injury. And they're just not the same person anymore, and they become estranged to their family... Some of these things I can think of, I know the people I'm thinking of because I'm talking about them. People that had good lives, good jobs. Something happened. Something catastrophic in their life, something traumatic.

One provider spoke specifically about untreated mental health:

> Mental health is not something that's really treated while you are in the military, they wait until you come out and then you have that PTSD, but they don't, they don't seek the services they need for that treatment because it's shaming. And then, they try to deal with it on their own, which causes problem within their family, so then there's separation, you know, divorces and things, and then they're kind of left on their own.

The following discussion is specific to PTSD. Post-traumatic stress disorder is prevalent with this population and self-medication of alcohol and other substances to calm anxiety and other PTSD symptoms is not unusual according to staff/administrators. One said, "They're coming in with PTSD, so they're not as trusting, building trust is difficult, it's good that we have a veteran on our staff that does outreach who talks the language." Staff/administrators agreed that trust can be built quicker when a worker who is a veteran works with a veteran client. This was also mentioned as an advantage in the discussion on transitioning to civilian life.

A staff/administrator gave a specific example of working with a veteran struggling with PTSD and the loss of his house and family. This particular veteran had done two tours of duty in Iraq and one in Afghanistan and when he returned his wife had connected with another guy and she had moved away with his two daughters. His house and family were gone filling him with anger and resentment. He had been kicked out of two or three veteran programs for assaulting other participants and had violated probation. In addition, his benefits were cut off and he didn't get any explanation as to why. He had a DD214, he was discharged honorably, but he didn't know why he suddenly didn't have his benefits. The worker eventually was able to get this individual into Perry Point for treatment, but this is a clear example of what some veterans return to after military service.

Staff/administrators said mental health issues play a big part in homelessness in veteran populations. Many returning veterans have experienced trauma and may be dealing with PTSD. A staff/administrator said that you have to consider the trauma that they have experienced and the betrayal:

> We have dealt with folks who were snipers and mercenaries, and some of the things that they were asked to do, as part of their service and their honor and their courage and all those kinds of things, triggered some feelings and emotions that may have altered their conduct, when they weren't on sniper duty. Or drinking or drugging, you know, they're commanded to work outside of the norms. And they step into another situation and they have difficulty discerning, where am I what am I in? And there's all that stuff going on… and remember a lot of the people when they were serving were young men and women. So developmentally (they were young), then they have a difficult time trusting… In addition to the trauma of what they've experienced what they've seen, what they've done. How they manage that. Um, you know, we've had folks employed who were veterans and had two or three tours in different places, and they struggled every day with the physical results, the emotional results of that trauma, but it was a struggle and a victory every day, but they struggled with that. You know when you patrol a three mile strip of road for twelve hours a day looking for IED's ... It does something to you... And without factoring that in, you may or may not get the outcome that you're looking for. You know, whatever that looks like. And I know that's the buzz word. I know trauma's the buzz word but it's you know, we look at it when we have children who were sexually abused as children, and how that plays out when they're adults. You know, or physically abused, how that can play out, it doesn't always but, so and these people, nine times out of ten were young people.

This staff/administrator went on to say that we really have to consider the impact of trauma on these veterans who were developmentally at a young age in their adult life

when the trauma occurred. Another participant said that over the last ten to fifteen years that staff/administrators are more aware of trauma and the need for PTSD treatment:

> If someone goes through trauma and there's no aftercare, then it's gonna seem like, well, there's just trauma and there's no help, so I would say, what we've done with veterans over the past ten to fifteen years where, yes, there is this traumatic experience, but we are going to screen you for PTSD, and we're going to give you these services, and we're going to acknowledge that PTSD is a real thing, we're going to acknowledge you've been through a traumatic experience and then provide you those services, there's going to be a different outcome. But if you have someone that is not being provided those services, and regardless of veteran status, then it's gonna seem like, well, all there is, is trauma and coping mechanisms.

Another major mental health theme discussed by the staff/administrators were Aging issues related to dementia. One related the problem to older veterans:

> Our Vietnam and Korean War veterans who have spent all these years stuffing all that down or have used alcohol or drugs to not deal with it, and now the amygdala has started to deteriorate, and they can't repress that stuff, and now it's mixed in with some dementia, then you really have problems.

Another spoke about the difficulty of housing for veterans with dementia or Alzheimer's:

> There's nowhere to put them, and they can't really live on their own. I'm seeing more older men, that either their mind is not still the same, whether they've had post-traumatic stress disorder or some type of brain injury, it's catching up to them right now. So we're seeing older men, not the younger generation quite

> yet… you know, there's really nowhere to put 'em because they might be getting dementia or Alzheimer's from the traumatic brain injury or something. But there's nowhere to put them. And they can't really live on their own. But there's nowhere to put them.

Another provider said, "We are noticing we are getting a much more aged population. So, we're very concerned with the need for assisted living and intensive case management because we are serving an older population. Aging did not come up in the veteran interviews as a problem.

Chapter 5: Discussion and Conclusion

The purpose of this qualitative study was to explore the pathways into homelessness for rural veterans and to identify the self-reported contributing factors to homelessness for a sample of rural homeless veterans. Staff/administrators working with homeless veterans provided information about the causes of homelessness for this population to provide another vantage point on the problem of veteran homelessness.

The homeless veteran participants did not match the rural veteran general population for race, in that most (91%) rural veterans are white males (NCVAS, 2012). However, the veteran participants were similar when comparing race demographics of the homeless veteran population. Study participants were 60% white and 33% African American compared to 50.2% white and 38.8% African American found in the total homeless veteran population (Perl, 2015). When comparing age, 68% of rural veterans are 55 and older (NCVAS, 2012) which is comparable to the mean age of 52 found in veteran participants in this study.

Rural Communities

The veteran participants lived in rural communities in three counties located on Maryland's Eastern Shore. The rural homeless are more hidden than their urban homeless counterparts. We tend to think of homelessness as an urban problem and homelessness is often portrayed as occurring in large cities in media coverage. We know statistically that most homelessness does occur in urban centers however it is also an issue in rural areas of the US. The causes of homelessness in rural areas are similar to the issues that lead to homelessness urban areas. Structural problems exist in rural areas, such as lack of affordable housing and poor housing quality. Some homeless people live in abandoned or

substandard structures to find shelter. One individual in this study lived in an uninhabitable structure undergoing repairs for two years. He strategically waited until after dark to arrive for the night so that neighbors would not know that he was living there. This homeless veteran is an example of how homeless individuals remain hidden in rural areas.

Poverty rates are higher in rural areas. The poverty rate is 15.3% for rural Americans which is higher than the national average, which stands at 13.2% (US Census Bureau, 2010). Homeless individuals are generally poverty stricken individuals without the means to maintain housing. Poverty contributes to poor health circumstances and limited employment opportunities. Several of the homeless veterans in this study were employed, however, at least one reported being underemployed. He considered his skill set to be higher than the jobs he was getting through a temporary labor company. Another barrier to employment addressed by several veteran participants in this study was the lack of public transportation.

Poverty is related to stigma when seeking services at formal helping agencies (Smalley, Warren, & Rainer, 2012). The media often portrays the people living in rural communities as being backwards, uneducated, and lacking worldly experience and common sense. The positive traits of being independent and self-sufficient are part of rural culture. Pride is often related to the characteristic of self- sufficiency. Pride was a factor for veterans in this study. Several mentioned that pride kept them from seeking services and asking for help. Other obstacles to veterans receiving health care in rural areas may include less hospitals and doctors to meet the need, greater distance to VA healthcare services and limited transportation options (Office of Rural Health, 2015).

Homeless veterans living in rural areas may have limited access to services because VA health care centers are generally located in urban areas (Gordon, Haas, Luther, Hilton, & Goldstein, 2010). Health status of homeless veterans living in rural areas has been found to be poorer than the health status of homeless veterans living in urban areas (Gordon, Haas, Luther, Hilton, & Goldstein, 2010; Tsai, Ramaswamy, Bhatia, & Rosenheck, 2015).

Symbolic Interactionism: Homeless Pathways, Roles and Identities

This research study used the lens of Symbolic Interactionism to identify pathways into homelessness for a sample of homeless veterans living in a rural area. Veteran participants described their descent into homelessness in their own words providing a context into which this phenomenon occurred for each of them. The staff/administrator's perspective confirmed the pathways to homelessness identified by the veterans by providing a context for the interactions they have with the homeless veterans they come into contact with. The major pathways to homelessness identified by both samples were substance abuse, mental illness, economic factors, and adverse childhood events while, social support was a major protective factor in preventing housing instability for veteran participants in the sample.

Veteran identity. Using the lens of Symbolic Interaction to attach meaning to the lived experiences of the homeless veteran participants allowed this researcher to understand how the homeless pathways influenced the lives and became part of the identity that veterans constructed related to their homeless experiences. When using the lens of symbolic interactionism to study veteran homelessness it is necessary to consider the identities and roles that a homeless veteran may have. Individuals who have served in

the military have achieved the status of veteran and thus have a veteran identity that formed as a result of the time they spent in the role of soldier. Veteran identity is described as the "veterans' self-concept that derives from his/her military experience within a socio-historical context" and can be influenced by war era, location and length of service, combat exposure, service-connected disability, and rank (Harada, Villa, & Anderson, 2002). Most, but not all of the veteran participants in this study expressed pride in their military service and identified as a veteran which indicated that this was part of their identity.

One of the veteran participants expressed pride in the following words when I asked about military core values, "I will protect the United States of America from all enemies, both foreign and domestic." The veteran said that they took that oath at enlistment and still honor it today. Another veteran gave the following example of the military mindset, "Soldiers are militarized, and your whole mindset is different. We're supposed to be self-sufficient and people to our left and people to our right are supposed to be able to rely on us, as we rely on them." Another participant said that he identifies as a soldier, and is very patriotic. He likened military service to a family business because both grandfathers and his father all enlisted in various branches of military service. He said, "God and country's been bred into me since birth." Veterans spoke about the self-esteem they once had when they were a soldier. One remembered returning home on leave, wearing his Class A uniform and people were shaking his hand and asking questions about his uniform. This pride of service and commitment to the ideals of military service demonstrates how military culture can be ingrained in the person whom has served their country in the capacity of soldier.

Several veterans spoke about having values instilled in them as a child from their parents. They said the military values supported and shadowed the values they were brought up with and that these values are still important to them today. One participant said that the values he learned in childhood and in the military "keep me true to myself." The context for his comment was around his employment and doing the right thing in regards to customer service.

Some veterans said that it was not that hard to adjust to military expectations because they had many of the values already. Most of the veterans in this study talked about having values or a code of conduct. Several of the participants said that they don't panhandle. One said, "I've never done it. I can't bring myself to do that, I'll die first. I can't beg. That's the way I was raised." Another participant talked about taking care of his family even after getting divorced. "I still took care of my family. I'd go over there every Friday, see what the kids needed. If they needed shoes, take them shopping for shoes. If they needed groceries I'd put groceries in the house. If electric bill needed to be paid, if the rent needed to be paid I'd pay it." These examples show a sense of pride in doing the right thing and having standards for behavior even when homeless.

Rural identity. Military values such as honor, loyalty, integrity, and being self-sufficient align with the values and work ethic found in rural communities. Industries traditionally linked to rural areas like farming, fishing, logging, ranching, and mining are associated with independence, strong work ethic, and personal responsibilities which are personality traits found in rural culture (Smalley et al., 2012). These jobs are physically demanding and there is a sense of self-reliance and a strong work ethic that guides people to meet their own needs (Daley, 2015).

The traits of self-reliance and independence were observed in the sample of rural homeless veteran's interviewed for this study. One veteran described himself as "self-made" and not wanting help for anything. Another talked about having a false sense of pride and not wanting to admit they needed help or not willing to get that help. Several veterans talked about the training that a veteran receives when serving in the military. Soldiers are trained to perform duties and taught responsibility and to be self-sufficient. One said, "You are taught to evaluate the situation you are in." Being self-sufficient carried through as veterans described their path to becoming homeless. One participant put it this way, "Once I was homeless, I still remembered what I was and how it used to be. So rather than going to people and asking for help, you survive."

Most of the veteran participants identified as a survivor. Several had lived outside, even in the winter. One veteran said, "I can survive some pretty extreme conditions." Another said, "You survive out here, either by your wits or by the kindness of strangers and some of us are lucky enough to have the support of family." A participant shared that he never worried about living homeless because he knew how to survive. He said, "Once you've been out there for a while, it's like riding a bike, you never forget."

Survival includes learning where to go to get showers, where to find food and clothing, how to stay warm and learning where you can go in the daytime." One individual described situations in which he was living with someone and when the relationship would turn sour he would say, "I ain't gotta put up with that, I'm gone." He described this happening more than once in his life. He chose homelessness over asking his family for help, "I didn't want to put anybody in my family out, it's not their problem, it's my problem, so I try to handle my own problems. I don't even want then to see me

like that [living homeless]." Self-reliance and accepting responsibility can be observed in this example.

Another veteran shared that he did not want his adult children to know the situation he was in. The role of survivor and being self-reliant for these two veterans was still accompanied by shame in their homeless circumstances because they didn't want their families to know about their situation. These examples demonstrate the role of survivor that many of the veteran participants identified with. Being independent and self-sufficient were important qualities that most of these veterans possessed and aligned with what we know about rural identity.

Advocate. Some of the veterans in this study were knowledgeable about resources and others were not. Several veterans had successfully navigated services and had achieved housing. Others had no clue where to begin to ask for help. A participant told me, "I need a bed to sleep in and food to eat and I don't have knowledge of available services for people in my situation." One of the veteran participants demonstrating advocacy said, "These people need resources. They need people to sit down and tell them where to go, what to do, and give them information. If you don't have the information you are lost." He said, "I'm going to ask questions and I want answers, and if I don't hear from this person, I'm going to go somewhere else till I get the answers that I need." This veteran was adamant that other veterans needed to be told about the resources that they may be entitled to and he performed well in his role of advocate.

Peer support. Veterans appeared to value relationships with other veterans. One belonged to an online network of veterans for the past five years and feels supported by this group. Another said, "We're there for one another, whatever it is that we're going

through. Some of my best friends are veterans. We hang out and keep in touch." Veterans supporting veterans relates to the idea presented earlier that soldiers learn to depend on each other to do their jobs when performing military service. One participant said, "Veterans around veterans are okay, once you get veterans around civilians, it tends to throw if off a little bit." One of the veterans distinguished themselves apart from civilians by saying, "They're not like you, you're not like them, and you can't hold them to your standard." The veteran talked about being let down by civilians and not being able to depend on them, "to watch your six." They said that civilians do not adhere to the same code of conduct as a veteran does. This veteran was still using military language, such as, "watch your six" which reinforces the veteran identity. These examples demonstrate the military mindset of this veteran after being discharged for 12 years. I would like to mention in this section that none of the veterans interviewed mentioned being connected to veteran organizations which could be places that homeless veterans could seek support.

Disillusioned veteran. The disillusioned veteran was another identity that emerged in this study. One veteran spoke about the sacrifice that veterans make for this country and then it appears to be meaningless. This veteran linked veteran suicide to disillusionment, the civilian life, and the inability to adapt, "They can't readjust after it. They don't know how and nobody's there to help. A support network of other veterans would help immensely." Reintegration services to address the transition to civilian life are needed to help disillusioned veterans.

Another area of disillusionment for some veterans was getting let down by the VA. One veteran said, "It's harder to be a part of that system than it is to not be in that

system." Another participant used the following words to describe the VA, "A lot of us don't deal with them [VA], because we know it is mile upon miles of red tape that you have to cut through and the bureaucracy you have to deal with. You ask the VA about stuff, and they want to give the circle jerk on who you need to ask and how to get in touch with them, and other times they don't even want to answer the question."

Some veterans thought the system was not user-friendly on purpose so that it was difficult to access benefits. They spoke about the distance that a veteran has to travel to the VA from the Eastern Shore and the bureaucracy involved when trying to be approved for a medical treatment or procedure. Transportation takes three hours each way, plus the time you spend at the VA.

A veteran said with the general medical discharge that they have, it doesn't entitle you to benefits. The veteran had signed a six year contract and was discharged before completing the six years so they reported not being eligible for anything. They said, "It's a horrible set up and situation, and information and resources are needed." The veterans interviewed in this study seemed to think that many veterans are in this situation and it is not fair because they served their country and they are not getting anything in return. One veteran said, "They have nothing; they are just existing and it's really sad." I prefer my country, but how they treat you after, you're just rubbish." There was some discontent with VA services.

Another perspective presented around seeking services was that veterans don't want to be treated like someone special. One said, "I'm here for services. That's it." They made the point that some service providers try to attach to them but that is not what a veteran wants. "Just show me what I need to do and I'm good from there." Veterans are

not looking for friendship. A veteran participant put it in the following words, "I don't want to know your grandkids. Don't ask about mine. Help me with what I need." This veteran specified that some female workers take on a motherly role and that was not why he was at the agency seeking help.

Homeless identity. Homeless individuals have identities related to their homelessness (Parsell, 2011). This held true for the sample of rural homeless veterans in this study. One participant said, "People recognize your characteristic of being homeless not just by your looks but by your mannerisms. Things start to change manner-wise, compared to normal people. Your demeanor is different and you have to learn to be around people because you don't have your own space." Another veteran described his homeless identity in this way, "Being homeless is an image, I'm walking down the street and I got a big backpack and a bag and looking down at the ground while I'm walking." He said he is easily identified as a homeless person. This individual went on to say, "Your self-esteem leaves you and your integrity starts disappearing and you don't have no hope and you acquire a drinking problem or a drug addiction." Another veteran said that they never owned more than could fit into a backpack, "I have two pairs of jeans, six shirts, two pairs of shorts, and a towel. That's what I own. I've got prescription medication, sunglasses, electronics, chargers, ibuprofen, food, water, drink mix. Anything that you would need to live out of that bag."

Another part of the homeless identity described by some veterans was feeling invisible. One veteran was talking about the difficulty of living without a Social Security card, "I have nothing, I've been off the grid for so long that I don't exist." This veteran was able to work with a local agency to get their Social Security card and was

empowered by the process. This agency helped link the veteran to medical insurance which allowed access to a doctor and to medications for other health related issues. Having their social security card in their possession validated for this veteran that they do exist and they have an identity.

One veteran said, “People look at you weird, you’re either invisible or they just don’t want to acknowledge you.” He went on to say, “People look at the homeless as a bunch of drunks, we drink, admittedly, but stop and think about the reasons we got for drinking. We’re out in the cold, nobody seems to care, we’re isolated out there and there’s nobody there for us except each other. Living homeless can be an isolating experience for veterans and drinking and drugs help numb the pain for veterans in this situation.

Another participant said that the homeless are not represented in the decisions made in the community that will impact them. His words were, “Homeless don’t get no representation, it’s like the city decides what they’re gonna do to us, but we have no say in the matter. They don’t understand what it’s like to be homeless. We’re human beings, we’re not animals. I’m a nobody in the eyes of society.” One mentioned the loss of self-esteem, integrity, and hope that he felt when he was homeless and without a job. Another veteran remarked that he felt inhuman because he was left to live outside like an animal. ”One of the veterans felt that they did not fit well into society because they are socially awkward. These examples of the homeless identity reveal personal inadequacies faced by this population.

A participant talked about expected behavior among the homeless community, “Homeless people live by a code of conduct. If you live in a tent community, if you live

in the woods anywhere where there's more than one tent, it is base treachery that you get stabbed, if you go in amongst someone else's belongings and take their stuff or mess with their stuff. That will get you killed." The homeless community appears to have their own communication network. One veteran said if you want to know where to get help, then you talk to other homeless people to find out where to go. They said it is unsafe to ask other people because they won't take the time to help or they will call the police. A staff/administrator reinforced that news travels through the homeless community very quickly. They used the example of serving food at their agency. If the food being served is deemed good by those present, more individuals will show up than normal to take advantage of the meal.

Some veteran participants expressed hope in their circumstances and described themselves as a gentleman. One said:

> I realize I'm homeless, but I have hope and a positive attitude. It's my secret weapon. I always believe that things will get better. Maybe not this hour, maybe not today, maybe not tomorrow, but they will. I'm in this situation now, but it's not gonna last forever. I have manners, and I'm a gentleman, I'm courteous, kind and honest, and I say please and thank you which makes other homeless people think I'm a wimp. People in general think of homeless people as bums, as drug addicts, alcoholics and lazy. I am none of those things. It's frustrating, because I speak well and I have manners, if you met me on the street, you would have no idea I was homeless. I feel good helping others. It makes me happy. Homelessness is an uncomfortable place to be emotionally. I don't like to ask for

help but I've learned that if you don't tell people you have a problem, it's not gonna get fixed. So sometimes you have to swallow your pride and I have.

This individual provided a perspective on homelessness that does not fit the typical homeless stereotypes.

Homeless Pathways and Identities

ACEs. ACEs as a theme, came up in both interview samples. ACEs may begin a trajectory toward poverty and homelessness. Some veterans in this study experienced housing instability, child abuse, and/or out of home placement during childhood, which are risk factors for adult homelessness (Rosenheck & Fontana, 1994; Tsai & Rosenheck, 2015). One study found that individuals with higher levels of negative childhood events were more likely to experience homelessness, mental health problems and physical health issues (Montgomery, Cutuli, Evans-Chase, Treglia, & Culhane, 2013). The study included veterans as part of the sample. When comparing veterans to the nonveterans in the study, veterans had higher rates of homelessness, mental health problems and physical health problems (Montgomery et al., 2013). The diagram in Figure 1 conceptualizes the information shared by the veteran participants in this study who mentioned ACEs in their interviews, entered military service and eventually became homeless.

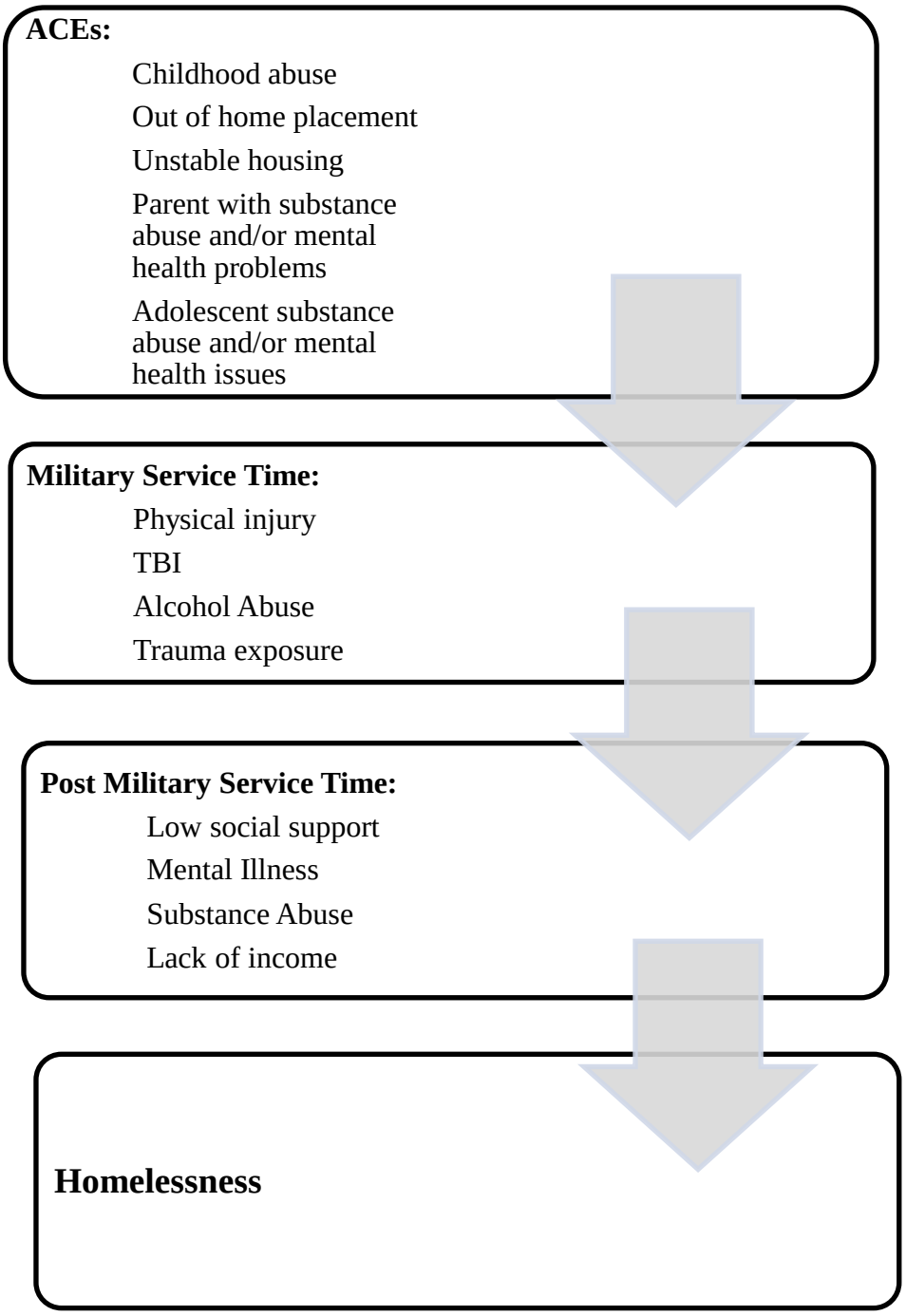


Figure 1. Pathway to Homelessness when ACEs are Present in Veteran Participants.

The events listed in the ACEs were reported as childhood experiences by three veteran participants who went on to enlist in military service. The ACEs may have been a factor in these individual's enlistment in the service. In this study approximately two-thirds of the veteran participants enlisted because of their current circumstances and lack of other options, leaving less than a third enlisting because of a career goal or because of family tradition.

Prior to enlistment, military recruits are screened to detect problems with prior drug or alcohol use, mental health or behavioral problems, and criminal justice involvement, however, waivers have been used for some individuals with these issues to reach recruiting goals (Gallaway et al., 2013). Soldiers receiving waivers have been shown to be more likely to test positive for illegal substances or to be screened for the Army Substance Abuse Program (ASAP), which screens for alcohol and drug use for enlisted individuals (Gallaway et al., 2013). This is evidence that the military does allow recruits to join military service who may not meet minimum standards using waivers. Participants in this study did not mention waivers as part of their enlistment, however it is possible that individuals enlisting because of their circumstances may fall into this theme and be more vulnerable to substance use in the AVF.

The items listed in the Military Service Time section of the diagram occurred while performing duties as an enlisted soldier. One individual received a TBI which caused some physical problems and eventually led to a general medical discharge. Heavy alcohol use was also occurring during service time for some veterans. The next section, Post Military Service Time displays characteristics that were present at some point after discharge and led to eventual homelessness. For example, two of the participants

reporting ACEs found employment and had social support when they were first discharged so their homeless episode occurred much later than the participant with no social support. Mental health was a factor for at least one of the individuals and all three were abusing substances.

The veteran participants connected adverse childhood experiences (ACEs) to their substance use. Adverse childhood experiences have been linked to alcohol and drug abuse as coping mechanisms to counter the stress caused by abuse and other dysfunction experienced in childhood (Felitti et al., 1998). One of the veterans whom was clean and sober at the time of the interview, realized that when he quit drinking he had to deal with the underlying issues of his abusive childhood. The recovery program he was in helped him become aware of the underlying issues which in his opinion was the first step in working on his problems. He recognized that he had resentment and anger toward his stepfather, possessed a fear of failure, and felt the need to be controlling. He had gained insight into these issues through treatment and realized they were connected to his drinking and drug use. He spoke about learning to suppress his emotions as a child when experiencing physical abuse. He went on to say that his time in the military further suppressed his emotions until he didn't feel emotion at all. He described himself as a "shell." Another veteran experiencing ACEs described his life as, "I got down in a ditch." Another said, "I had nothing, no family, no nothing." The pathway of substance abuse for all participants will be discussed next.

Substance abuse. Substance abuse was a theme in the narrative of each veteran's story and was part of their identity. Veterans and staff/administrators both reported that chronic alcoholism and/or drug use is a major cause of homelessness. Every veteran in

this study reported using alcohol, some from an early age. Veterans said that alcohol use was part of their military identity. Research has shown that alcohol consumption in military service members exceeds those of civilian populations across all age groups (Conradi, 2005). Drinking is a tradition in military service and is part of the military identity.

Drinking alcohol was confirmed as part of military culture in the study participants. They spoke of the stress of participating in military service and the prominence of alcohol. One veteran said, "90% of the people there drank, so it wasn't nothing to get off duty and party half the night and then get back up and do it all over again." Another veteran said, "I didn't notice it was a problem because everybody was doing it and it was just part of military life. Alcohol is a very prominent thing in the military so we just keep drinking when we get out. We come back from overseas and this is how we cope."

Substance abuse was used as a coping mechanism for each of the veteran participants. In some cases, drinking habits were formed while enlisted and continued when discharged. At least one veteran admitted to drinking and using drugs prior to entering military service. For some of the veterans the alcohol took over their life making it difficult to function as a civilian. Many were divorced because of their substance use and behaviors attached to it. Some said they turned to drugs because it was easier, "The drugs provided the peace in not having to feel anything."

For many of the veterans the drinking behavior continued as a civilian. A veteran described himself as, "Doing my duty as a citizen." Because he was working full time, paying bills, and taking care of his family and drinking heavily, he did not see drinking as

problematic because he was responsible in other ways. These examples reveal the role that alcohol can play in a veteran's identity within military service and post military service.

Without the structure provided in the military, some veterans descended into homelessness very quickly. The theme of substance abuse as a major pathway to homelessness is supported in other veteran studies (Tsai & Rosenheck, 2015). The rural homeless study in Cecil County found alcohol and drug abuse to be a primary cause of homelessness (Center for Family and Community Life, 2005). Even going back to the Ohio studies which were the first studies on homelessness in rural areas; alcohol and drug use was identified as a cause of homelessness in 7.3% of the participants (Roth & Bean, 1986).

A few of the veterans had people in their lives that encouraged them to seek treatment when they were finally ready to make a change to quit drinking or using drugs. Some veterans relapsed several times until they were motivated to finally achieve sobriety. Social support from family, friends, or individuals providing services, seemed to influence a few of the veterans to get sober. A couple of the veterans achieved sobriety due to health reasons like Parkinson's disease or having a heart attack. The impact of a major health event and the medication to address the disease acted as a deterrent to continued alcohol and drug use.

A common thread in seeking help for veterans was "hitting rock bottom." Veterans achieving sobriety said that individuals have to be motivated to make the changes in their life necessary to live substance free, gain employment and achieve housing stability. In essence they have to change that part of their identity. It was difficult

for some to ask for help because they had to swallow their pride and learn some humility when seeking help. Several of the veterans who were no longer homeless had the opinion that if you were homeless and wanted help then you just have to work with the VA outreach workers to get the help you need. Three or four veterans had taken advantage of the inpatient substance abuse programs offered by the VA and were sober at the time of their interviews. These individuals viewed homelessness as a temporary situation that occurred when drugs and alcohol were their priority instead of maintaining housing. The main barrier for them was the distance to the treatment facility when you lived on the Eastern Shore of Maryland.

One veteran whom had been through the VA inpatient program was participating in follow-up services that were offered about 40 minutes from the shelter he was staying in. He also mentioned traveling once a week to a VA hospital that was over two hours a way to receive dental care. Transportation is provided if you are willing to put in the time it takes for appointments and travel to the facility. It takes the better part of a day for a one-hour appointment with the dentist. This individual was focused on maintaining his sobriety and healthcare needs even though the time and travel he invested in his recovery were quite extensive. He was an example of an individual wanting to change his substance abusing identity.

Mental health. Mental health problems were a cause of homelessness identified by veterans and staff/administrators. Mental illness as a main cause of homelessness is reinforced in other veteran studies (Tsai & Rosenheck, 2015). PTSD was self-reported in some of the veterans and staff/administrators said they were seeing homeless veterans with PTSD. Post-Traumatic Stress Disorder has not been shown to cause homelessness,

but a significant relationship was found between PTSD and other risk factors related to homelessness: other psychiatric disorders, substance abuse, unemployment and interpersonal relationship problems (Rosenheck & Fontana, 1994).

Mental illness and substance abuse were interconnected for some of the veterans interviewed. They spoke about countering the symptoms of PTSD, depression, and anxiety with drinking heavily and the trouble that this brought on. Relationships were easily severed under these circumstances and working was next to impossible under these conditions. Homelessness followed quickly for the veterans in this situation and incarceration occurred for one veteran experiencing PTSD and substance abuse.

Even in the absence of mental illness, veterans spoke about the influence of drugs and alcohol on their decision making and how making poor choices got them into trouble. A couple of veterans were incarcerated due to poor decisions they made. Some veterans had a social support system that helped them to maintain housing while using substances until the relationship ended through divorce or death. Substance abuse with or without mental illness guided the trajectory to homelessness for many of the veterans interviewed.

Several veterans were able to maintain employment for many years until the unreliable behavior resulting from alcohol or drug use made it difficult to work which eventually led to economic problems and eventual homelessness. Child abuse is another factor and has been shown to have a negative impact on employment in adulthood (Sansone, Leung, & Wiederman, 2012) and has been linked to substance abuse which could impact a person's ability to be employed. The connection of substance abuse with

mental illness, employability, experiencing ACEs, or a lack of social support has led to homelessness for the veterans participating in this study.

Mental health was a component of identity for several veteran participants. One example was a participant who was planning his life with his fiancé. This individual was committed to maintaining his mental health in the process of moving in with his fiancé. His exact words were, "I have a future planned for myself. Whatever it entails for me to do, I got to do it. I'm still going to have to go to counseling every week, regardless if I don't want to. My mental health comes before anything in the world."

This veteran was very insightful about his mental illness and was committed to taking his medication every day. He said without it he would be "wandering the streets" or drinking to self-medicate. He said he hates to take them but knows he has to. He is also working towards getting a Maryland ID card so that he can be put on a rental lease with his fiancé. He said, "It's hard to go through all these hoops and red tape, just to stay with her, but I have to do it." He said he has been on a "long road" but he is finally getting there. He has priorities and has made the choice to use counseling instead of alcohol. This veteran has educated himself on existing services and is taking advantage of them. He has the social support of his fiancé and is coping with the stress of having a mental illness. He is in recovery and attends weekly sessions with a counselor to maintain his sobriety. He is a good example of someone overcoming the barriers related to homelessness.

Overcoming homelessness. Transitioning out of homelessness can be a daunting task for someone with substance abuse issues or mental illness. Fitzpatrick (2005) described combining economic, material, interpersonal, and individual resources to overcome homelessness. He said the four categories are necessary for leading a balanced

life and transitioning out of homelessness. Employment or education, accessing services, having social support and having the ability to cope with the stresses that cause homelessness such as mental illness or substance abuse are the components of the four categories (Fitzpatrick, 2005). The previous example support the categories suggested by Fitzpatrick for ending homelessness. The individual was educated on services and was accessing them which led to his ability to cope with the stresses in his life such as PTSD and Bipolar disorder. He also had social support in his fiancé with plans to move in with her.

A second example of an individual possessing resources in the four categories was a veteran who identified as a Christian, and traced the turning point for him back to an encounter with God, in which he asked for help and promised God he would obey Him. This veteran talked about having false pride that was hindering asking for help, but because of the promise he had made he followed through and has been clean and sober for 18 months. He said, "I had to swallow my pride and learn some humility and get the help that I needed."

This veteran has demonstrated substantial improvement in overcoming homelessness. He has a good job, a car was given to him and he did what was necessary with the Motor Vehicle Administration to regain his driver's license. He said he hadn't had a license for 13 years and he had to take drug and alcohol classes as part of the process. Completing these tasks demonstrate the level of commitment to making positive change that was part of this individual's identity.

This individual volunteers in the community in which he is living and leads a celebrate recovery ministry as part of rebuilding his new identity as a good citizen. He

said it took a year of working on himself and a solid foundation of recovery to start reaching out and helping other people. He said the key was addressing the underlying issues of child abuse that played a part in the substance abuse he was participating in. This veteran viewed himself as "nobody special" and said that the opportunity provided by this faith based program was available to anyone who really wants to change. He said that making that change and doing the right thing is very difficult. This veteran had resources in the four categories of economic, material, interpersonal, and individual resources and was achieving a positive life balance. He had good insight into his problems and was on his way to breaking the cycle of homelessness in his life.

Both of these veterans had their priorities in line for a successful exit out of homelessness. They were in the process of changing their identities from homeless veteran to housed veteran by combining economic, material, interpersonal, and individual resources to overcome homelessness.

Economic issues. Economic problems were another common theme to emerge in this study. Veterans and staff/administrators agreed that there were few job opportunities that provide a living wage for homeless veterans in rural areas. Barriers to employment identified by both groups were transportation, housing instability, incarceration history, physical disability, substance use and mental health issues. The theme of economic factors such as low income, poverty, and unemployment have been shown to be risk factors for homelessness in other veteran studies (Tsai & Rosenheck, 2015). Unemployment was the number one reason cited for homelessness in the Cecil County study (Center for Family and Community Life, 2005) and half of all the participants in

the 1980's Ohio studies cited economic reasons as the cause for homelessness (Roth & Bean, 1986).

Employment and identity. Some of the veterans were employed and this was a part of their identity. One veteran works for a temporary employment agency but only gets one or two days of work a week. He said that his computer skills are never considered when receiving job assignments. He described the work as, "Only lasting a few hours long, or I'm picking up after contractors who are too lazy to pick up after themselves." He appeared to feel undervalued in the work he was able to obtain. Some veterans related working as a way to cope with homelessness. "If you don't have a job, something happens to you. When you have a job you got that sense of duty to your job. You would be around people to socialize and if you have a job, you can get a roof over your head. When I don't work, then I've got too much time to do other stuff."

Several veterans said that they have always worked. Some of them related employment to being self-sufficient and it allowed them to get what they needed to survive. Employment was a source of pride for some of the participants. One participant saw himself as being one of the best in his profession. He said, "I'm the show runner of masonry and I know a lot about it that a lot of people don't. If not for my homelessness and poor decision making process, I'd probably been a lot further in life than I am." This individual had pride in his skill and saw himself as being self-sufficient. He said, "I don't use food stamps, I save that for somebody that really needs them cause I work. But medical, I need that." Working tended to provide some self-esteem and integrity to those who had jobs.

Another veteran talked about how he was Military Police (MP) in the service but this skill was seen as a barrier when he applied to local law enforcement jobs. He reported being told that because of his MP training that local law enforcement were not interested in trying to retrain him to meet their needs. This individual was in the process of trying to manage his life and make better decisions. He said, "Employment is important because you have to make money to pay your bills, It's my own stuff that has gotten in way. I'm pretty much my own worst enemy." He is showing some insight into his problems and is committed to traveling over an hour to get to the VA for mental health treatment. He schedules his appointment the same day each week and lets his employer know. This individual is another example of a homeless veteran making necessary changes and transitioning their identity to that of a housed veteran.

The homeless pathways found in this study were consistent with other studies on veteran homelessness and the primary finding of chronic alcohol and drug use supports the veteran homeless literature Substance use disorders and mental illness were consistently found to be the greatest risk factors for veterans in a systematic review of 31 research studies (Tsai & Rosenheck, 2015).

Intersectionality. Intersectionality is important to discuss when considering the marginalized population of homeless veterans. A veteran's gender, race, age, mental illness, and/or incarceration history may be interconnected and result in social injustice, disadvantage, and/or discrimination. Research has shown veterans are disproportionately represented in homeless populations. Male veterans were 1.4 times more likely than nonveterans to be homeless (Gamache, Rosenheck, & Tessler, 2001) and female veterans were three to four times more likely to experience homelessness than non-veteran women

(Gamache, Rosenheck, & Tessler, 2003; Hamilton, Poza, & Washington, 2011). Several studies have shown the male veterans most at risk of homelessness were the veterans enlisting after the Vietnam War when the AVF was implemented; African American veterans were 1.4 times and non-Black veterans 2.0 times as likely to be homeless as nonveteran homeless individuals in this age group. (Fargo et al., 2012; Gamache, Rosenheck, & Tessler, 2001; Rosenheck, Frisman, & Chung, 1994). This trend also emerged in the current study when seven participants reported serving in the military during the first ten year period after the AVF began. The AVF was implemented on July 1, 1973.

Six of the participants serving in the first ten years after the AVF began were in their 50's and one was in his 60's at the time of their interviews. Several were experiencing medical conditions that were difficult to manage while living homeless, such as Parkinson's disease, heart disease, seizures, and physical disabilities and mental health issues. Proper nutrition and preventive healthcare were not options for most of this sample of veterans and it is difficult to find employment when experiencing these types of health issues.

The veteran participants that were working or receiving VA disability benefits seemed to be faring better than those whom did not have a steady income. One of these veterans was receiving social security benefits but not VA benefits. However, the social security benefit was not enough for him to maintain housing and food, and he was not eligible for VA benefits. This veteran was very concerned about the occasional seizures he experiences and feared falling and hitting his head. He said the last time he had a seizure, he woke up in a nursing home and didn't know how he got there. He was

released after a couple of days and was currently staying in an emergency shelter which allows a 30 day stay, which is hardly enough to rectify his housing situation. Emergency shelters in a rural area like the Eastern Shore of Maryland are generally are not set up to address health issues in general, which makes it hard to manage symptoms that require care and constant monitoring while living homeless. Thus, older homeless persons are especially vulnerable because of their likelihood of having chronic health conditions that impact their daily lives.

The VA does offer some options for veterans experiencing dementia related issues. , However, the staff/administrator participants said that there are limited resources on Maryland's Eastern Shore for aging veterans without benefits, which makes finding support services next to impossible for this population. Without benefits and the paucity of dementia related services, homeless veterans are left on their own to manage these challenging conditions without assistance and often find themselves in extremely vulnerable situations. Most people with dementia have a caregiver to assist them with their daily living needs. This is generally not the case for a homeless person. The homeless person with dementia related issues would be hard to reach in a rural area and would not necessarily be seeking services. Aging related issues for the rural homeless is an important area that social work practitioners and researchers must focus on to develop evidence-based interventions and services.

Two participants were employed and were not using VA healthcare benefits. One of these veterans said that there were a lot of veterans in worse shape than he is and that he would rather leave benefits for someone who really needed it. The two individuals that were working had plans to obtain their own housing over the next six months. Their plans

were concrete, realistic, and achievable. One was in a faith based transitional housing program where he had achieved several months of sobriety. The program involved educational components, along with community service and continued participation in recovery classes. This veteran had also developed a support system which included mentors and other participants who were motivated to make a change in their life to interrupt the cycle of homelessness. He was even rebuilding a relationship with his 16 year old son. This veteran was overcoming the obstacles that were contributing to his homelessness and he had a plan to maintain sobriety and eventually maintain housing.

One of the veteran participants was not eligible for VA healthcare benefits because of his OTH discharge status. He felt that this was unfair because he had served his country but was denied benefits. He did not have immediate healthcare needs but said he could use a job. Transportation was a barrier for him finding viable employment. Additional barriers to employment and housing were his history of drug and alcohol abuse, depression, and history of incarceration. This veteran was African American, and African American homeless veterans make up 38.8% of homeless populations and only 11.3% of all veterans (HUD, 2013) which means they are disproportionately represented in homeless populations.

This veterans circumstances demonstrates how age, race, gender, unemployment, incarceration, depression, and history of substance abuse intersect in his life and contribute to homelessness. He is a 57 year old African American male veteran with depression, substance abuse issues and has a history of incarceration. He is homeless with no job and has no social support in his life. This individual was staying at an emergency shelter with no plan to secure employment or housing. He said that his self-

esteem is higher when he works, but without transportation his opportunities are limited. This veteran's situation is an example of how different components of his life are interconnected and strongly impact the opportunities he has to end the cycle of homelessness. This veteran was in a precarious situation without a plan for change.

These examples provide a context for viewing the impact of intersectionality on homeless individuals and how some individuals are able to overcome the risk factors that are negatively influencing their ability to work and maintain housing. When working with the marginalized population of homeless veterans the practitioner has to consider the interconnected factors around age, gender, race, employment status, incarceration history, substance abuse history, and mental health issues.

Strengths and Limitations

The strength of this study is the additional information added to the rural veteran homeless research literature. Veteran homelessness in rural areas is understudied and much of the available data comes from veterans enrolled in VA programs. This study succeeded in providing the viewpoint of the veteran using VA services, but also included participants who do not use VA services. Providing the staff/administrator's perspective was another strength of this study and supported the findings of the veteran participants.

A limitation of this study is that participants volunteered for this study and may differ from those who did not participate. Homeless veterans were difficult to find in the rural area of this study and staff/administrators helped to recruit participants by sharing recruiting flyers with potential participants. This technique allowed for some bias in that only veterans connected to staff/administrators had the opportunity to participate in the study. This may have resulted in an underrepresentation of homeless veterans. The

perspective of non-participants could be important and could have added additional insight into the problem of veteran homelessness. Their lived experiences and pathways into homelessness may have been different from the participants included in this study. Another limitation was not having additional co-researchers to conduct concurrent analyses which would have provided opportunities to improve the reliability and accuracy of the findings. Even with these limitations the study added to the rural homeless veteran literature.

Conclusion

Implications for Social Work

Practice. The military experience has not been shown to lead to homelessness (Mares & Rosenheck, 2004), however veterans are overrepresented in homeless populations. We do know that some veterans do become homeless after they are separated from service, however the length of time varies. Only a small percentage seem to experience homelessness within a year and the median length of time was three years, (U.S. Department of Veterans Affairs Office of Inspector General, 2012) which would allow for an intervention for this population to decrease the number of veterans experiencing homelessness. Military service provides a structured environment where basic needs are accounted for which allows for homelessness to be delayed for some individuals. Some individuals experience ACEs prior to entering military service which has been linked to adult homelessness.

Recognizing that housing instability, abuse and neglect and out of home placements in children and adolescents is a risk factor for adult homelessness in veterans, as well as the general homeless population is an area for continued focus in social work

practice. Bronfenbrenner's ecology of human development theory stresses the importance of the microsystem in human development. Microsystems are the interactions that a person has with their family, friends, neighbors, and schools in their environment.

This study has shown that adverse environmental impacts in childhood may be a risk factor for homelessness in adulthood. Social work practitioners working with children and youth generally attempt to identify negative childhood experiences to begin to address the impact of these experiences on the individual they are working with (Shonkoff & Garner, 2012). Social workers should recognize that adverse childhood experiences and functioning in adulthood are linked. Mental health symptoms, substance use behavior, and ACEs screening for adolescents experiencing housing instability, abuse and neglect and out of home placements may lead to earlier treatment, especially for individuals entering military service. Homeless risk should be assessed when working with adults who have revealed experiencing ACEs. Identifying areas of poor functioning could provide the necessary supports to prevent homelessness in veteran populations.

Trauma-informed care is important for working with homeless veterans and practitioners should seek to identify the different types of trauma experienced throughout the lifespan. Screening for ACEs in adults can help to identify the types of trauma the individual experienced in childhood. Military personnel are commonly exposed to combat trauma and MST is common for female veterans but can be found in male veterans as well. Trauma experienced during enlistment should be identified and treated to help prevent homelessness. Experiencing homelessness is dangerous and trauma can easily be experienced when living homeless so accessing trauma related to homeless experiences is necessary with this population.

Individuals who have experienced trauma may be experiencing shock, anger, self-blame, hopelessness, or anxiety and they may isolate themselves from others. Using substances to numb the feelings and emotions that are within them is common. Employment may be very difficult under these circumstances. Practitioners may need to educate veterans about the effect trauma is having on their functioning so referrals to appropriate services can be made.

Another consideration is the distrust that some veterans have of the VA. This can be difficult to overcome for veterans seeking help. Being genuine, validating the traumatic experience and having a non-judgmental attitude are important components for practitioners to incorporate into their work with veterans. Establishing social ties that are supportive may lead to improved health and functioning in adulthood (Dube, Felitti, & Rishi, 2013) and may benefit the homeless veteran population. Supportive relationships with other veterans is helpful and may guide a veteran to available services

Substance abuse and mental illness are deterrents for a successful transition for veterans entering civilian life and may lead to eventual homelessness. Screening for problem areas and providing treatment as part of reintegration services would be helpful in avoiding homelessness for veterans, however due to the acceptance of alcohol use in the military it is possible that few veterans would acknowledge they have a problem at discharge. Soldiers are able to maintain heavy drinking while in the structured military system where everything is provided for them. It is when they are discharged and left to manage on their own that problems may arise.

Heavy drinking is part of military culture and is ingrained in the behavior of many veterans exiting military service. A military culture change is needed around accepted

excessive drinking. Active military and military institutions need to be more accepting of services for mental health and substance abuse. The stigma around help seeking in the military is high. Soldiers may be seen as being weak or unfit for duty if they ask for help. Soldiers may worry what their peers will think of them if they seek mental health or substance abuse services. Peer support around these issues would be helpful in normalizing help seeking behaviors around mental health and substance abuse issues.

Serious mental health issues sometimes lead to discharge out of the military and loss of benefits. Treatment of mental health within the military and prior to discharge would help soldiers to adjust and adapt to civilian life before they are discharged. The stigma and perception that mental illness is a sign of weakness may change due to the DOD recognizing the importance of training social workers. This demonstrates the DODs commitment to invest in social work education. Actively identifying and treating the problems associated with addiction and mental health problems while individuals are still enlisted would help prevent homelessness in veterans when they area discharged to civilian life. Linking them to services in the geographic area they will be living in would help smooth the transition.

Providing mental health treatment at discharge poses challenges as well. The stigma associated with mental illness while in military service is well documented (Britt et al., 2008; Gibbs, Rae Olmsted, Brown, & Clinton-Sherrod, 2011; Gould et al., 2010; Rosen, et al., 2011). A systematic review of the literature revealed stigma as the greatest barrier to seeking mental health services during military service (Sharp et al., 2015). Unfortunately, the stigma associated with mental illness does not disappear upon discharge from service and is a documented problem for people living in rural areas.

Perceived stigma has been found to be prevalent in rural communities (Komiti, Judd, & Jackson, 2006). Seeking outside help for problems may be viewed as failure and may foster shame for the individual and their family members needing help (Daley, 2015). This is compounded by the generally negative perception toward someone receiving mental health services in rural areas (Smalley et al., 2012). Individuals may find it difficult to access help anonymously for fear of being recognized entering an agency serving clients with mental health issues (Parr & Philo, 2003).

Individuals seeking help for or identified as having a mental illness may be viewed as unstable and may lose housing or employment opportunities or chances for social support; resulting in isolation, low self-esteem and diminished feelings of self-worth (Smalley et al., 2012). Overcoming these barriers for homeless veterans is possible. Veterans seem to naturally trust their peers, so utilizing peer support for this population would help to counter some of the stigma attached to mental illness. Peer support could encourage earlier treatment before an individual becomes homeless or is in a mental health crisis.

An intervention to be considered with the homeless veteran population is the use of technology to connect them to services. Many homeless individuals go to libraries in their communities where they can access computers and the internet. Some libraries have begun to have social workers on staff to help the homeless clients that utilize the library. This type of intervention helps link homeless individuals with housing and other services. Information on local resources is available through local libraries.

Cell phones and internet access has been used with homeless populations to make contact with service agencies and with others in their social networks (Eyrich-Garg,

2010). There are some existing free cell phone programs available to individuals on Medicaid. Providing cell phones as an intervention could help homeless individuals maintain contact with case workers without physically meeting with them. Cell phones could be used to remind homeless individuals of appointments or other tasks they are trying to complete. Cell phones could be used to connect to assistance, engage in treatment and share information across a social networks. Interventions similar to telemedicine programs could be implemented and homeless individuals with smart phones could access services using this interface.

A final area for concern in social work practice are the aging homeless veterans. Several staff/administrators mentioned they are noticing a much more aged population. They were concerned for the need for assisted living and intensive case management for this age group. The consensus was that services are limited and lacking for this age group. Interventions to assist this population prevent homelessness are needed.

Policy. Transitioning from the military to civilian life is difficult and the military needs to do a better job of providing a transition phase for veterans. Meeting with the Transitional Assistance Program (TAP) does not seem to be enough to ensure a smooth transition to civilian life. Rural areas typically have less supportive services available and finding homeless veterans can be difficult. Skills learned in the military do not always transition to jobs in the civilian workforce. Homeless Veterans Reintegration Programs (HVRP) may not be easily assessable for veterans living in rural areas. Assessing work preferences and experiences and linking discharged veterans to employers open to training veterans for employment in the area in which they live may be a better option for veterans residing in rural areas. Integrating mental health services

and case management supports to follow the individual may strengthen this type of approach and would support job retention.

Veterans whom are working or receiving disability benefits have a better chance of maintaining housing. Receiving a regular income helps sustain a homeless veteran in the community. Filing for disability benefits can be difficult due to the bureaucracy of the VA. For homeless veterans, the added barriers of not having a permanent address, limited transportation options, and the lack of computer access can make it challenging. For veterans whom successfully complete an application, the wait for a response from the VA may take months. Streamlining the process and making it more user friendly would be helpful to veterans living homeless in rural areas.

In some cases, veterans may not be eligible or qualify for VA disability benefits and may find it necessary to rely on Social Security Disability Insurance (SSDI). **S**ubstance abuse has been identified as a major issue for the homeless veteran population and may prevent someone with a disability from being approved for SSDI. The individual's addiction must be considered as immaterial to the decision of whether the person is eligible for disability assistance from SSDI. We have seen in this study the effects of substance abuse on functioning and maintaining housing for veterans. Substance abuse is a disabling condition that requires ongoing support for someone struggling with addiction and homeless veterans should be eligible for SSDI and VA disability benefits to help them end the cycle of homelessness.

The key issues for the veteran homeless population are healthcare access, housing and jobs. Veterans living in rural areas have to travel great distances to access healthcare at VA hospitals. This is a barrier for some veterans whom do not want to take an entire

day for a medical appointment. There has been some debate in recent years as to whether to privatize the VA. In theory, privatization would allow veterans to have more choices in healthcare providers and to access benefits in their own areas. This option could improve needed services in rural areas that have limited resources. It is not yet clear what privatization would look like and efforts to dismantle the current VA healthcare system would certainly be met with resistance. The bottom line for US veterans is that they deserve a system of care that is easy to navigate and has excellent customer service.

Programs providing housing to veterans such as HUD-VASH are reducing veteran homelessness, however some veterans that work do not make a living wage and do not qualify for HUD-VASH. Expansion of the eligibility levels for veterans in this situation would be helpful to prevent homelessness for these working veterans.

Rural pride can be a barrier to accepting help. Some veterans do not want to accept a housing voucher even if it means they would no longer be homeless. Veterans with combat trauma may not be ready to live around other people so providing housing voucher options in more isolated areas may be beneficial for some veterans. Other options may include building housing for a veteran community of residents. Veterans seem to trust other veterans more than civilians so housing veterans in the same community may overcome the issue of trust and feeling safe and would provide social support too.

The City of Salisbury has initiated a housing first model for chronically homeless individuals living in Salisbury, Maryland. The program successfully housed 10 adults in its first year. Homeless veterans may apply for this program. Efforts in Worcester County, Maryland are moving forward to build longer-term affordable housing for those

transitioning out of homelessness in the Ocean City, Maryland area. A local facility that was a pre-release center for incarcerated individuals is being considered as a possible housing location for homeless individuals in Wicomico County, Maryland. Policies to incorporate these types of programs in other areas of the Eastern Shore would help prevent homelessness.

The Supportive Services for Veteran Families (SSVF) programs are allowed to help veterans at risk for literal homelessness. Specific SSVF eligibility requirements include: applicant must be a veteran or in a family in which the head of household or spouse of the head of household is a veteran and who was discharged under conditions other than dishonorable; household gross annual income does not exceed 50% of area median income determined by HUD; at imminent risk of losing current housing, or have no housing, or support systems to prevent homelessness (U.S. Department of Veterans Affairs, 2017). The discharge status requirement allows veterans seeking services from SSVF programs who received a medical discharge or OTH to receive help if they otherwise qualify for SSVF services.

SSVF service provider agencies are constrained by the requirement that 60% of the funds are required to go toward rapid rehousing and 40% toward homeless prevention. More flexibility in using the funds where they are most needed for the veterans seeking help would allow agencies administering this program to better serve their clients. Life skills training are necessary to help veterans maintain housing once they receive it. Distances to available services is another barrier that needs to be addressed in rural areas. Transportation is available but there is not enough of it.

Sometimes service delivery in rural areas is fragmented which makes receiving services difficult for individuals seeking help.

Addiction services are under resourced in rural areas and have difficulty meeting the need in those areas. These services need to be expanded in rural areas. Addictions services that can meet the housing needs of the homeless veteran would be beneficial to this population. Transitional housing options are limited in rural areas. Long term faith-based residential programs have provided a successful option for some homeless veterans that are motivated to change their lifestyle.

More long term residential treatment programs with extended housing options including transitional housing are needed in rural areas to meet the needs of homeless veterans. Veterans identified with chronic substance use would benefit from residential shelters and transitional housing programs which allow for extended stays and provide opportunities for social support and a sense of community and belonging. Shelters with a 90 day stay or less may not provide enough time for someone with long term addiction issues to make the changes necessary in their behavior.

Jobs can be hard to come by for homeless veterans and their military skills rarely translate to civilian jobs. Rural areas like the Eastern Shore of Maryland have lost unskilled manufacturing jobs over the years and jobs that provide a living wage are not in abundance. Seasonal job opportunities may be available for a few months but disappear when winter arrives. Job training programs are available but don't have options for high skilled jobs that would provide a living wage. Programming to address this gap would allow for homeless veterans who are able to be trained to have the option to be trained for jobs that require a higher level of skill which would yield a higher income. Building

relationships with employers who are willing to hire and work around the needs of homeless veterans would allow for employment of this population. An employer may need to allow for flexibility for a veteran whom is maintaining mental health or addictions treatment. A useful transfer of skills learned in military to civilian occupations would improve employment stability, which would lead to better housing stability.

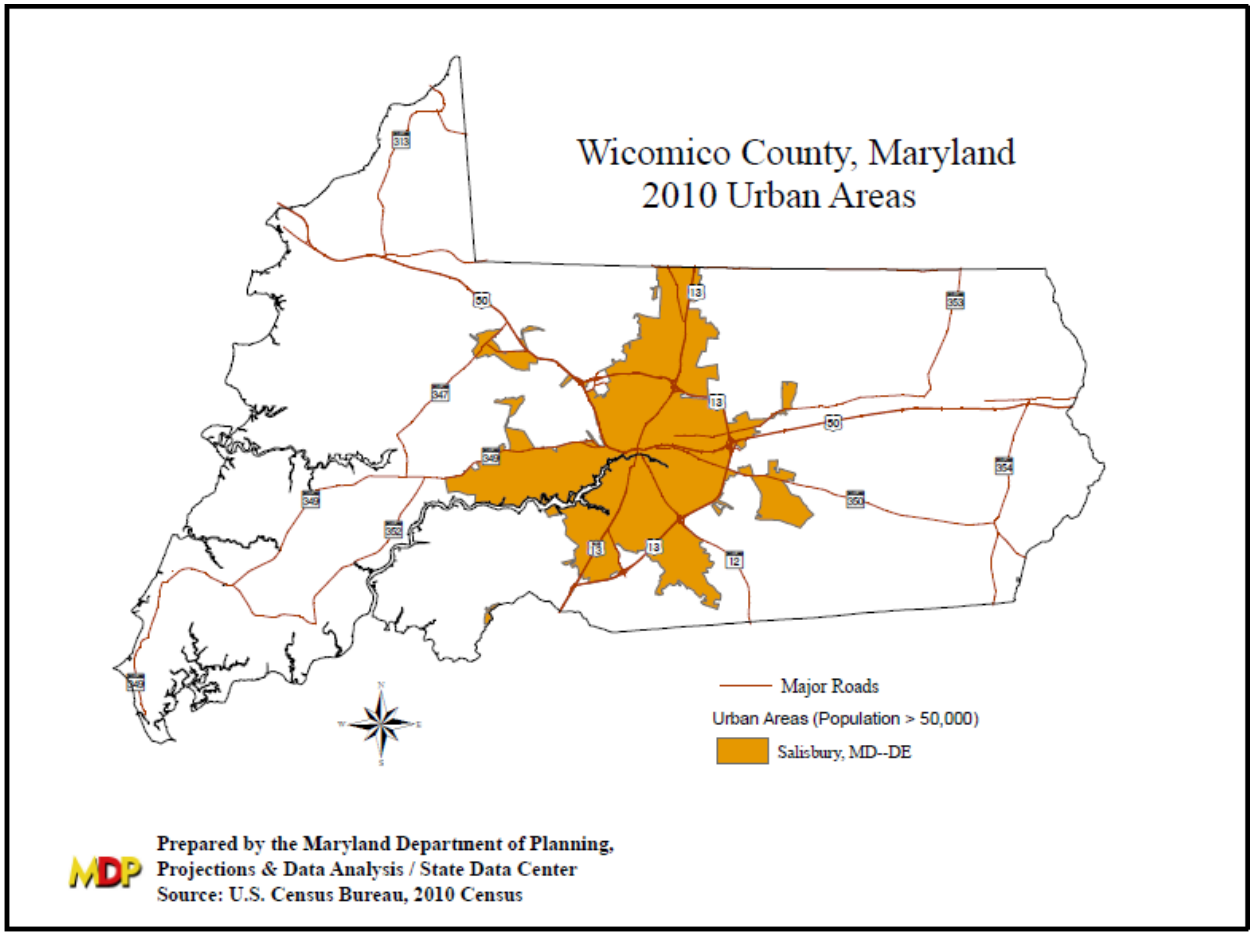
Research. Reaching homeless veterans who do not use VA healthcare and disability benefits is an area for further research. VA services are dependent on the type of discharge a soldier receives and minimum duty requirements. To be considered for VA disability benefits the veteran has to prove the injury occurred while serving in the military or a prior injury was made worse by serving in the military. With the VA resources available many veterans receive the help they need. More data is needed to understand why some veterans do not utilize VA services.

Social support may help motivate veterans to maintain housing. Transitional residential programs have shown evidence that peer support increases in these settings (Tsai et al., 2010). Research is needed to provide other interventions that may increase social support in veteran homeless populations.

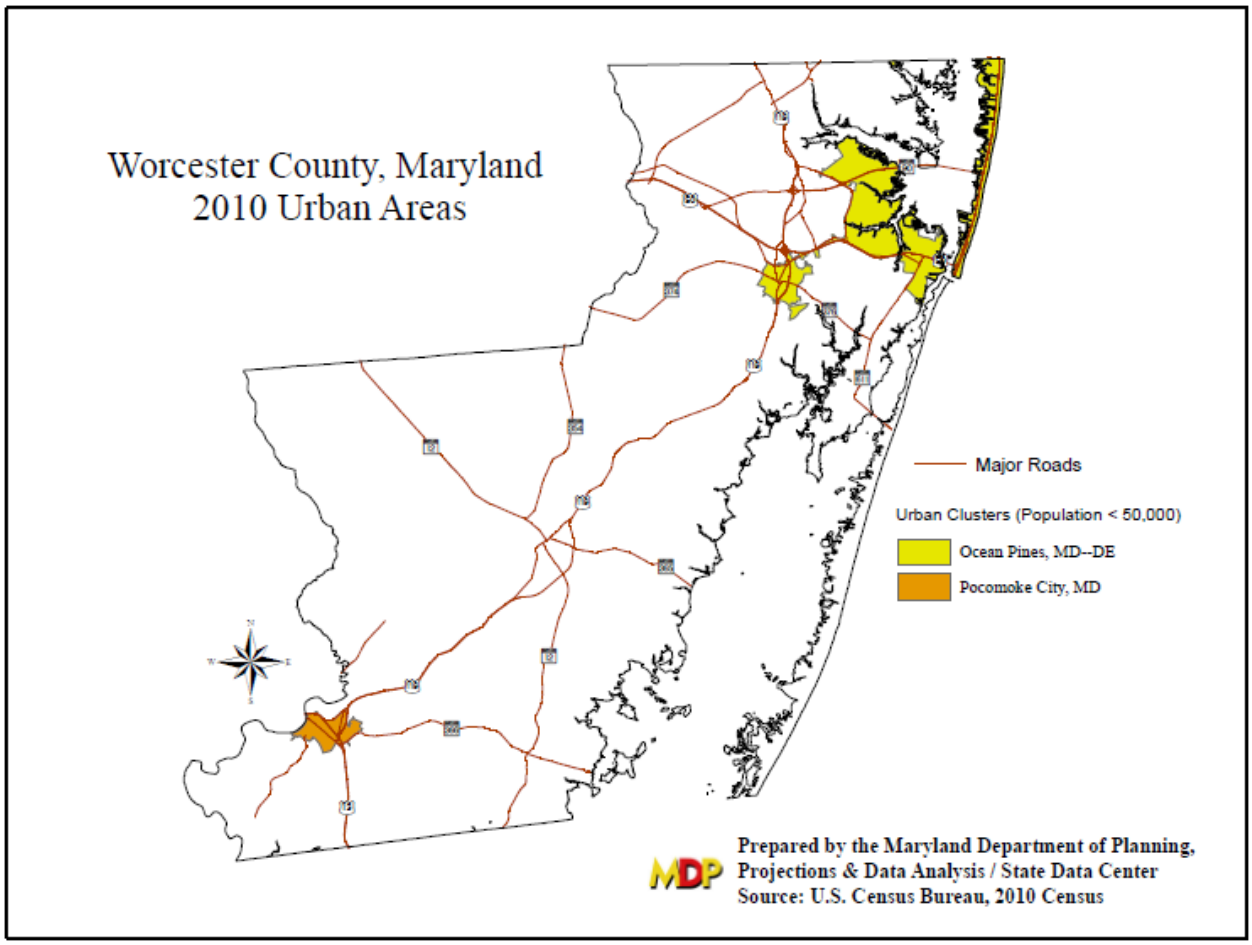
As a vulnerable population in American society, homeless veterans continue to be the focus of research to prevent and end homelessness. Most of the homeless research literature has focused on veterans living in urban areas. The purpose of this study was to add to the rural homeless veteran research literature by exploring the pathways to homelessness for a sample of rural veterans. This study identified substance abuse, mental health problems, economic problems, and ACEs as primary pathways into homelessness for this rural sample of veterans. Substance abuse and use were found to be

the most prevalent factors in becoming homeless for the veterans participating in this study. Addictions treatment options are limited in rural areas and VA treatment options are generally located in urban centers so rural veterans travel considerable distances for VA inpatient treatment options. Substance abuse treatment opportunities should continue to be a focus for this population and resources should be expanded in rural communities to better meet the needs of homeless veterans

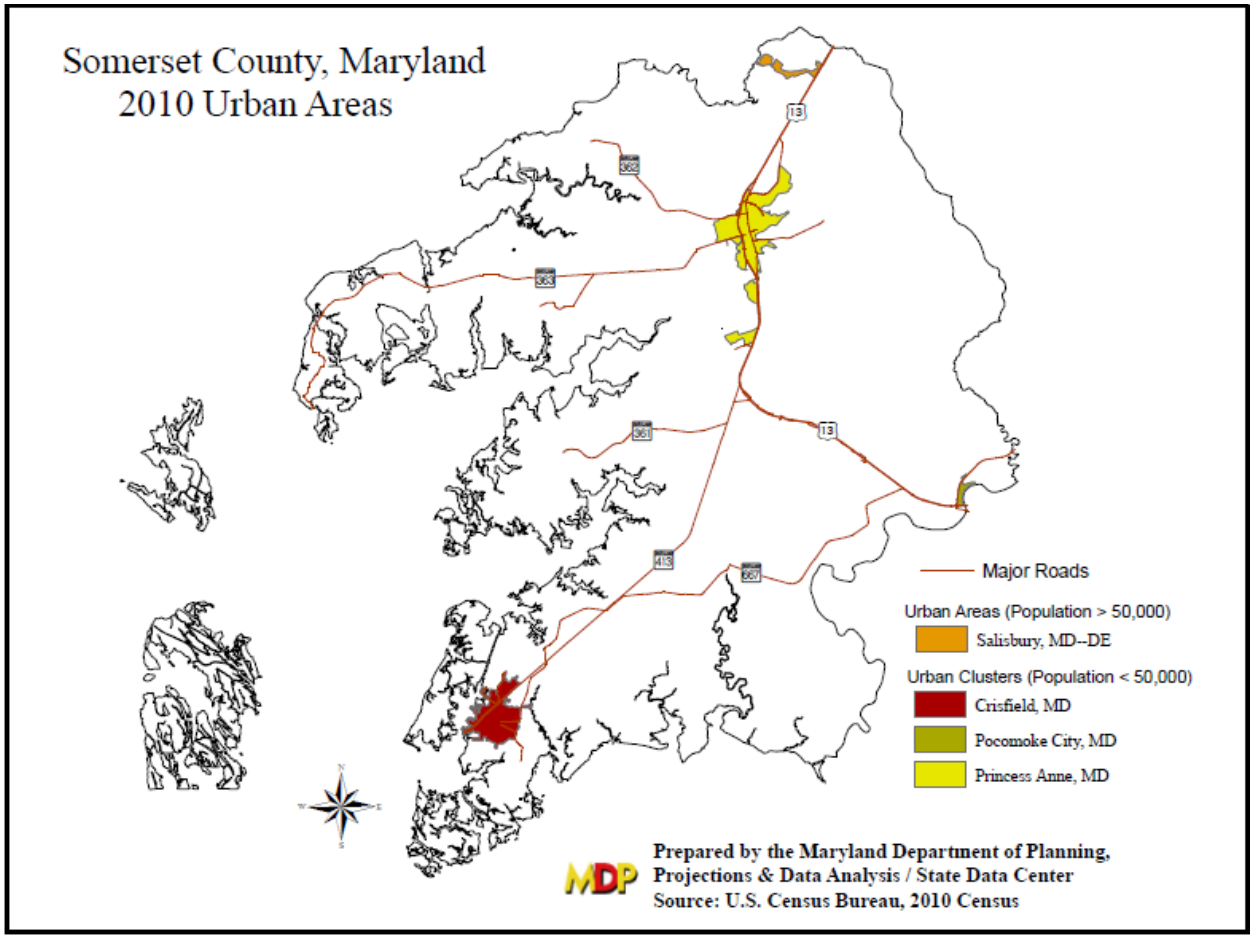
Appendix A


Wicomico County, Maryland
2010 Urban Areas
Major Roads
Urban Areas (Population > 50,000)
Salisbury, MD--DE
Prepared by the Maryland Department of Planning,
Projections & Data Analysis / State Data Center
Source: U.S. Census Bureau, 2010 Census

Appendix B


Worcester County, Maryland
2010 Urban Areas
Major Roads
Urban Clusters (Population < 50,000)
Ocean Pines, MD--DE
Pocomoke City, MD
Prepared by the Maryland Department of Planning,
Projections & Data Analysis / State Data Center
Source: U.S. Census Bureau, 2010 Census

Appendix C


Somerset County, Maryland
2010 Urban Areas
13
362
363
361
413
667
Major Roads
Urban Areas (Population > 50,000)
Salisbury, MD--DE
Urban Clusters (Population < 50,000)
Crisfield, MD
Pocomoke City, MD
Princess Anne, MD
MDP
Prepared by the Maryland Department of Planning,
Projections & Data Analysis / State Data Center
Source: U.S. Census Bureau, 2010 Census

Appendix D

HOMELESS VETERAN RESEARCH PARTICIPANTS NEEDED

PURPOSE: To better understand the problem of veteran homelessness from the perspective of a veteran.

ELIGIBILITY: Veterans experiencing homelessness or living doubled up with friends or family and living in Wicomico, Worcester or Somerset Counties in Maryland.

BENEFITS: Participation is voluntary and each participant will receive a resource guide listing all homeless resources in Wicomico, Worcester or Somerset Counties in Maryland.

COMPENSATION: Each participant will receive $20 cash for their time and effort in participating in a 60-90 minute interview with the researcher pending the completion of the interview. Compensation will be paid when the interview is completed.

CONTACT: For additional information contact Brenda Jorden,
Phone Number: 410-677-6559
Location: Salisbury University
1101 Camden Ave
Salisbury, MD 21801

Principal investigator: Dr. John Belcher
University of Maryland
525 W. Redwood Street
Baltimore, MD 21201
IRB Protocol: HP-00066545

Appendix E

Homeless Veteran Staff/administrators Interview Guide

1. Does your agency provide services to homeless veterans? These would be individuals whom lack a fixed, adequate, and regular night time residence.
2. On average how many homeless veterans do you come in to contact with each month? Has the number been increasing or decreasing over the past year?
3. Please describe the demographics of the homeless veterans that seek services with your agency (Families or single, male or female, younger or older, racial categories)
4. To the best of your knowledge how many of these veterans are chronically homeless? Chronic homelessness is defined as being homeless for more than a year or being homeless four or more times over the last three years.
5. How many of these veterans would you estimate that you see at your agency are at risk of becoming homeless but are not currently homeless? At risk of homelessness includes individuals whom have insufficient funds for continued housing, live with others due to economic hardship, live in unsafe or condemned housing, or are leaving an institution or system of care.
6. Please describe the eligibility criterion used by your agency to provide homeless services to veterans. What are the main reasons someone would not be eligible for services?
7. Honor, courage, loyalty, duty, respect, integrity, and selfless service are core values associated with military service. Do you see these values demonstrated in the veterans you work with? Can you think of examples in which these values hindered or helped the veteran you were working with?
8. In your opinion, what are the three main causes of homelessness among the veterans you come into contact with? Are there other causes you would like to mention?
9. In your opinion, what are the greatest needs facing homeless veterans?
10. Are there agencies providing services to meet the needs you identified?
11. Can you identify any gaps in services or unmet needs that are not available locally for homeless veterans?
12. What are three things that would help to end veteran homelessness?
13. What are the greatest barriers faced by homeless veterans in your opinion?
14. Are there stereotypes associated with being homeless? Or a homeless veteran?
15. From your point of view, what is the perception of how society views homeless veterans?
16. Do homeless veterans experience stigma related to homelessness?
17. People living in rural areas tend to be self-reliant, self-sufficient and have a strong work ethic. What are your thoughts about these values and how they relate to homeless veterans?
18. In your opinion do you think that homeless veterans from rural areas differ from those in urban areas? (services needed, how they describe themselves, demographic characteristics) Please describe how they differ.
19. Do you see any connections between rural culture, veteran status and homelessness?
20. Is there anything else you would like to share?

Appendix F

Veteran Participant Interview Guide

1. Please tell me about your current service history.
2. What was your experience as an active service person like?
3. Can you tell me why you joined the military? How old were you?
4. What did you expect to receive as a result of your military service?
5. What did your family think about your decision to join the military? Did your friends join? How old were you when you were discharged from the service?
6. Honor, courage, loyalty, duty, respect, integrity, and selfless service are core values associated with military service. Could you tell me the meaning these values have for you? Do these values impact the way you live your life?
7. Currently you are residing in a rural area of Maryland. Were you born and raised in a rural area? Could you tell me about your family growing up?
8. Why did you decide to return to this area to live?
9. How did you get to this point (of being homeless)?
10. Have you experienced other episodes of homelessness or near homelessness in your life?
11. In your opinion what are the main causes of veteran homelessness?
12. How do you cope with being homeless?
13. What are the most challenging barriers to overcome?
14. What has been most helpful to you?
15. Do you think there are stereotypes associated with being homeless? Or a homeless veteran?
16. From your point of view, what is the perception of how society views homeless veterans?
17. Have you experienced stigma related to your situation (homelessness)?
18. People living in rural areas tend to be self-reliant, self-sufficient and have a strong work ethic. What are your thoughts about these values and how they relate to you?
19. Some individuals don't like to burden others by asking for help. How do you feel about asking for help? Can you give me some examples of situations in which you have asked for help? Probe for housing or health care help?
20. What services are you using? Probe to see if they receive any VA services?
21. What services do you find to be the most helpful?
22. Please tell me what you could use that you are not receiving?
23. In your opinion, what are the greatest needs facing homeless veterans?
24. In your opinion what are three things that would help to end veteran homelessness?
25. In your opinion do you think that homeless veterans from rural areas differ from those in urban areas? (services needed, how they describe themselves, demographic characteristics) Please describe how they differ.
26. Do you see any connections between rural culture, veteran status and homelessness?
27. What year were you born?
28. What race do you identify with?
29. Is there anything else you would like to share?

Appendix G

Table 2
Characteristics for Veteran Participants

Pseud	M/F	Race	Age	Marital Status	Years in Military	War Era	Number of Years Homeless	Self-reported Physical/Mental Health Issues
Henry	M	W	78	W	4	PT	*9	Irregular heartbeat, open heart surgery, history of alcohol abuse
Neal	M	W	66	D	6	Viet	*1	Parkinson's, history of seizures, history of alcohol abuse
Cecil	M	AA	57	S	4	PT	*10	Depression, history of drug and alcohol abuse
Barry	M	W	57	M	3	PT	2	Anxiety, bad back and knees, DVT
Jason	M	AA	55	D	3	PT	*20	History of drug and alcohol abuse
Cliff	M	AA	55	S	3	PT	2	Depression, serious knee injury, history of drug abuse
Ray	M	W	54	D	3	UK	*8	History of drug and alcohol abuse

Emmet	M	AA	54	S	3	PT	6	History of drug and alcohol abuse
Steven	M	AI	53	S	UK	PT	*3	Alcohol abuse
Daniel	M	W	52	D	3	PT	*10	History of drug and alcohol abuse
Alan	M	W	51	S	14	PG, OEF OIF	*10	PTSD, Bipolar history of drug and alcohol abuse
Ernie	M	W	44	D	UK	UK	* 3	History of drug and alcohol abuse, heart attack
Myles	M	AA	40	S	UK	UK	4	History of drug and alcohol abuse
Adam	M	W	35	S	7	OEF OIF	*5	PTSD, history of drug and alcohol abuse
Ellie	F	W	34	S	6	OEF OIF	*11	Asperger's, TBI, history of drug and alcohol abuse, Epilepsy, Asthma, Dyslexia, ADHD, legally blind

Note. Pseud = Pseudonym; M = male; F = female; AA = African American; W = white; AI = American Indian; H = Hispanic; UK= unknown; W = widowed; D = divorced; M = married; S = single; PT = Peacetime; Viet = Vietnam; PG = Persian Gulf; OEF = Operation Enduring Freedom; OIF = Operation Iraqi Freedom; DVT = deep vein thrombosis; PTSD = post traumatic stress disorder; TBI = traumatic brain injury; ADHD = attention deficit hyperactivity disorder; * = currently homeless.

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