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Substance Abuse Disorders and Veteran Homelessness

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Walden University
2021

Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

Veterans constitute a significant proportion of the homeless population in the United States. Studies indicate that substance abuse is a major issue these veterans face that can result in homelessness. Despite improvement since 2009, substance abuse among this population remains a significant problem. The objective of this study was to gain a better understanding of the experiences of homeless and substance-abusing veterans to provide information to government agencies that may help them develop a practical approach for addressing the issue. The social cognitive theory and Lowry's dimension on federalism provided the theoretical framework for this study. A general qualitative research approach was used, and semi-structured interviews were conducted with13 homeless veterans from several agencies located in Houston. Thematic analysis was used to analyze qualitative data acquired in the study using NVivo qualitative data analysis software to provide insight into veterans' experiences and to improve their treatment, social, and economic well-being. Results revealed a connection between substance abuse and veteran homelessness and presented suggestions for resolving the problem. Significant policy implications for veterans' treatment, social, and economic well-being could improve the success of veterans' affairs initiatives by involving other relevant institutions besides the U.S. Department of Veterans' Affairs in attaining this effort resulting in positive social change.

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Dedication

I dedicate this dissertation to my mother and grandparents. As a kid, they saw me as being gifted and talented. I was able to do things that teenagers and some adults struggled to do. They knew that I would grow up and do something special in their hearts. I ended up dropping out of high school, and I could see the disappointment on their faces. I always promised myself that I would make it up by doing something special for them. I graduated with a Master's degree, but I do not feel special enough. I believe all of them would be incredibly proud of me to know that I went from struggling to earn a GED to now earning a Ph.D. Therefore, I dedicate this dissertation and degree to them.

Acknowledgments

I thank my Lord and Savior, Jesus Christ, because, at times, it seemed as if He had to hold my hands and help pull me through. Working on this degree has been the hardest thing I have ever done in my life. At times I felt I was well over my head, but the Lord kept pulling me through, and if you are reading this statement, you are reading it from my dissertation that has been completed. God is good.

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I thank the lifeline of my dissertation, my editors, who helped me tremendously. I attempted to do my dissertation independently, but now realize that it would have been impossible without them.

I want to acknowledge one of my best friends, who has been on this educational journey with me from the beginning when I earned my GED. She was the only friend who came to Hawaii to see my ceremony when I received my GED, and she has been a consistent friend throughout my educational journey, which lasted for over three decades. Her name is Mrs. Tonja Johnson, who has been a wonderful friend since high school. I owe her a tremendous amount of thanks for the inspiration that I gained watching her work so hard and earn her degree so early in her life. In addition, I was inspired by her dedication to work and willingness to learn.

Finally, I give thanks to my best friends since childhood. Her friendship and her kinship have been unmatched. We have been friends since we were wearing diapers. Her name is Mrs. Patty Jones, and she has always encouraged me never to give up and realize that where we came from does not have to be where we end up. Thank you all so very much.

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Chapter 1: Introduction to the Study

Veterans in the United States experience exacerbated rates of homelessness compared to civilian populations (Tsai & Rosenheck, 2015). According to the United States Department of Housing and Urban Development (2020), approximately 568,000 homeless people in the United States, 63%, live in sheltered locations such as emergency shelters or transitional housing systems. Another 37% of the population lives in unsheltered areas, including the streets, abandoned buildings, and other places considered tolerable for habitation by the homeless (United States Department of Housing and Urban Development, 2020). According to the National Alliance to End Homelessness (2018), approximately 49,993 homeless veterans in the United States in 2014. Through various measures implemented by the United States Veteran Affairs Department (2020), homeless veterans have been reduced significantly over the years. According to the United States Department of Veteran Affairs, there were 37,085 homeless veterans in January 2019, which decreased 2.1% from the 37,878 January 2018 statistics. Statistically, the number of homeless veterans in the United States between 2014-2019 has reduced by approximately 25.18%. The Department of Housing and Urban Development confirmed that the homeless prevalence rate has declined among unsheltered and sheltered homeless veterans.

The most consistent risk factors for veteran homelessness are substance abuse issues and mental health problems (National Alliance to End Homelessness, 2018; Tsai & Rosenheck, 2015). The United States Conference of Mayors found that 68% of cities reported that substance abuse was the most significant cause of homelessness for single

adults (National Alliance to End Homelessness, 2018). Veterans have high rates of substance abuse disorders, and some substance abuse issues are inherently linked with veterans undergoing treatment for various problems. Those problems include posttraumatic stress disorder (PTSD), chronic pain, and migraines, which are treated with addictive drugs, such as opioids (Teeters et al., 2017). While PTSD has been examined concerning veteran homelessness, researchers have paid less attention to substance abuse concerning treatment for psychological disorders as they relate to homelessness (Tsai & Rosenheck, 2015). Therefore, addressing the lived experiences of veterans that have been affected by homelessness and substance abuse can have significant social change implications. Understanding these common issues may help guide informed decision-making regarding factors that may influence the healthcare, social, and economic wellbeing of the veterans in the United States.

Within Chapter 1, the background of the problem, the problem statement, and the purpose of the study are explored. This section will also include the research questions and the research's theoretical framework. Next, the chapter provides a list of definitions for the study and the study's assumptions, limitations, and delimitations. Finally, the section will conclude with a summary and a transition to Chapter 2, the literature review.

Background

Homelessness is a prevalent problem among veterans with multiple causes. Still, few policies exist that directly target the various causes of homelessness. For example, the National Alliance to End Homelessness (2018) stated that in January 2014, there were 49,933 homeless veterans identified by the communities across America, which

represents a 56% decrease from the veterans counted in 2010. Homelessness occurs because of several factors, such as economic instability, physical disability, mental health problems, or substance abuse (Dunne et al., 2015).

Many veterans may experience homelessness because of challenges relating to coping and adjusting to life after the service after their experiences overseas (Meshad, 2017). Amin (2017) explored the causes and risk factors of PSTD among veterans. The study reported that among the common reasons include the experience of killing another person and lack of training to deal with the same. It is as well as the presence of anger traits before PTSD. During their transition to civilian life, veterans experience sudden changes that may cause them to feel uncomfortable. Some veterans find it challenging to fit in; thus, they become withdrawn from the issues facing them (Meshad, 2017). Koven (2017) argued that most families of veterans returning home are often less experienced or not trained and prepared on what to expect and how to deal with them. As a result, many spouses of returning veterans find it difficult to cope, which further compounds the PSTD problems. Akoondzadeh et al. (2018) also reported several factors such as sensitivity to noise, feeling of insecurity, the unexpected reaction from spouses and sometimes children, and dependency on taking medicine are issues that further accelerate the veteran's behavior social isolation, which may consequently lead to homelessness. As a result, some veterans develop problems, leading to other issues such as substance abuse and homelessness (Meshad, 2017).

Some researchers have examined the connection between veteran homelessness and substance abuse (Tsai & Rosenheck, 2015; Dunne et al., 2015). For example,

Metraux et al. (2017) examined the correlation between veterans' homelessness and military and post-military experience. Metraux et al. (2017) interviewed 17 post-9/11 veterans in the United States. The results indicated that military service experiences that exacerbate mental health problems, including PTSD, are significantly associated with homelessness. The authors further reported that a significant number of the veterans associate their homelessness challenges to nonmilitary issues such as the inability to find proper employment and underlying poverty conditions. Prior research has demonstrated that substance abuse in homeless veterans "decreases opportunities for obtaining housing or employment. Increases levels of interpersonal conflict increase risks of HIV infection and other serious health problems and increases exposure to criminal behavior" (Dunne et al., 2015). They are making the ability to obtain housing more difficult to obtain.

Additional issues relating to veteran homelessness may arise because of the nature of current military service. Aronson et al. (2019) reported that the number of veterans facing numerous challenges in the United States had increased significantly since the September 11, 2001, terrorist attack in the United States. The veterans have had to contend with multiple deployments due to increased hostility towards the United States, both locally and abroad. The increased deployment has, in turn, resulted in an increased number of challenges, especially transitioning of the veterans into healthy societal life. Additionally, Aronson et al. found that many veterans face transitional challenges, including education, finance, health, employment, and social relationships. These findings indicate various experiences that may influence veterans' experiences and the

need for a widespread, in-depth understanding of veterans' experiences with substance abuse and homelessness.

Information about veterans' lived experiences with homelessness, and substance abuse is essential because there are resources available to help homeless veterans that require accurate, nuanced evidence to target services. According to the United States Interagency Council on Homelessness (2010), the proposed V.A. budget for F.Y. 2013 contained nearly $1.4 billion for programs that prevent and end homelessness among veterans. However, without reliable information about the experiences of homeless veterans, these programs cannot appropriately reach their goals of reducing homelessness in this vulnerable population. One issue that might influence the reliability and, therefore, the quality of services is that homeless veterans may underreport substance abuse when engaging with these services because they mistrust the agencies providing aid or potentially fear the effects of substance abuse disclosure (Padgett et al., 2006). An improved policy that accounts for the lived experiences of veterans who suffer from homelessness is required to alleviate this issue among veterans.

Despite the abundance of research regarding homelessness among veterans and the services extended to them, there is still a gap regarding the lived experiences of homeless veterans, particularly relating to substance abuse as a cause of homelessness, which can inform public policy. What problems the veterans had before having substance abuse issues is not known. Factors like preexisting health and mental conditions and previous substance abuse, as well as the stressors of their service, might exacerbate substance abuse problems. Moreover, substance abuse issues might stem from

medications prescribed to mitigate health issues arising from service, like PTSD, and not having any issues related before being treated with the medications prescribed (Tsai & Rosenheck, 2015). As such, building my study, I built upon previous research by concentrating on veterans' lived experiences with substance abuse as a potential factor causing recurring homelessness that has remained relatively unexamined in the literature and policymakers.

Problem Statement

Substance abuse is a significant problem in homeless veterans and indicates many underlying issues (Dunne et al., 2015; Norman, 2012; Tsai & Rosenheck, 2015). Researchers have sought to understand the best approaches toward addressing homelessness within veteran populations through housing plans or mental health treatment (Tsai et al., 2017). Although there have been significant improvements since 2009 with billions of dollars spent on supporting homeless veterans, substance abuse among this population remains a problem (National Alliance to End Homelessness, 2015; U.S. Interagency Council on Homelessness, 2010). Part of the issue is a lack of information veterans may underreport their substance abuse issues to avoid losing aid or mistrust the agencies providing that aid (Padgett et al., 2006). However, government agencies, administrations, researchers, and nonprofits cannot design effective interventions to address homelessness among veterans (Padgett et al., 2006). Previous studies indicate extensive research on healthcare issues affecting veterans, particularly mental and chronic diseases. Some studies have also examined homelessness among veterans, but not as much as mental health.

Furthermore, only a few studies I found have explored the link between substance and drug abuse and homelessness among veterans. Like the issue of healthcare among veterans, several studies have examined drug and substance abuse among veterans. I sought to fill the gap – the link between substance and drug abuse and homelessness among veterans.

Purpose of the Study

The purpose of the study was to explore the lived experiences of veterans that have been affected by homelessness and substance abuse that may influence the healthcare, social, and economic wellbeing of the veterans in the United States. I examined participants' perceptions regarding their experiences with substance abuse and homelessness. A qualitative research tradition was used to address the research question and contribute to research related to homelessness in veterans. As I wanted to understand the connection between homelessness and substance abuse embedded within a unique social context and cultural setting, a general qualitative research design was appropriate and apt to answer the research questions (Yin, 2014). A general qualitative research study is a research design that uses real or practical human experience to answer the research questions (Yin, 2014). I interviewed veterans who have experienced homelessness and substance abuse to obtain the data. The findings can contribute to social change by providing national policymakers with firsthand accounts of homeless veterans who struggle with substance abuse. These components are essential; they help inform the local, state, and federal government regarding the safeguards to put in place to assist the

veterans returning from combat to keep them from turning to substances to cope with readjustment.

The study has significant implications for public policy administration related to the healthcare, social and economic wellbeing of the veterans in the United States. The U.S. Department of Veteran Affairs takes care of the country's veterans. Currently, it is the only federal agency that directly takes care of the veterans. However, collaboration from other institutions, especially from healthcare and housing, could significantly enhance the effectiveness of the veteran affairs programs.

Research Question

RQ1: What are the lived experiences of veterans that have been affected by homelessness and substance abuse that might influence their healthcare, social, and economic wellbeing?

Theoretical Framework

The theoretical frameworks used for this study were the social cognitive theory (SCT) and Lowry's (1996) dimension on the federalism model. Together, these two frameworks allowed me to establish a deeper understanding of veterans' experiences and whether and how those experiences can be addressed through policy.

The SCT was developed by Bandura, who wished to establish "a unified theoretical framework for analyzing the psychological processes that govern human behavior" (Wulfert, 2014, p. 1). Bandura's SCT does so by attempting to identify "the determinants of human action and the mechanisms through which they operate" to

understand how those behaviors may change (Wulfert, 2014, p. 1). Add summary/synthesis to integrate the quote fully.

Bandura's SCT is an appropriate choice for the study because not only did it underpin the findings, but it supported the research question and the study approach. Because the study approach is qualitative, focusing on the lived experiences of a group of individuals, Bandura's SCT allowed me to glean valuable information regarding the determinants of these individuals' behavior, specifically as they pertain to substance abuse and homelessness. Furthermore, SCT allowed for recommendations towards various parties regarding how these individuals' actions can change. Additionally, SCT underpinned the research question in that the problems involve the factors that active military veterans experience that led to substance abuse and homelessness.

SCT will also help because it assumes personal control over circumstances (Wulfert, 2014). Homeless veterans have been involved in experiences that may have led them to believe that resorting to substance abuse would help them in some way (Ellison et al., 2016). My goal was to identify which external determinants have become internalized within the self-regulatory processes through which behavior is mediated and mitigated to lead to potential personal changes that improve homeless veterans' circumstances. Boston University School of Public Health (2013) explained that SCT considers the unique way individuals acquire and maintain behavior while also discussing the social environment in which individuals perform the act. Therefore, SCT provided an appropriate framework for the proposed study.

Lowry (1996) originally developed the dimension of the federalism model in environmental pollution control, but it has since been widely applied in the health policy arena. The model focuses on the state and the federal government's influence on implementing public policy. The fundamental components of the model include a focus on federalism, a focus on the potential impact of competition among the states, and other variables such as group interests, political culture, and federal support or aid (Lowry, 1996).

Lowry (1996) posited that the state's level of responsibility towards a problem depends on the level of severity of the problem. According to Lowry, the state and the federal relationship in policy implementation depends on federal aid and the extent to which other states compete for the same resources. In the United States, all the states have a department in charge of Veteran Affairs. However, different states have various levels of severity of the veterans' problem of homelessness and drug and substance abuse. Specifically, Lowry (1996) argued that state intervention mechanisms such as leadership, innovation, and development of policies should be more stringent and effective than similar efforts by the federal. The assumption herein is that the problem is tackled by both the state and the federal government. However, based on the state's knowledge and experience with the severity of the problem, it should have more intervention than the national state. Using the model, I assumed that Texas has more efforts or response towards the veteran's situation than the federal government.

Despite the variation in severity of the problem, the United States federal government uses a population-capitation system to determine the amount of aid

channeled to a specific state (Basu et al., 2017). As a result, states with larger populations always receive more assistance than those with a relatively more minor population. This method ignores the potential effect of internal factors that could be significant determinants of the severity of the veterans' problems, which could be a substantial source of the current issues faced by the veterans in the United States today. According to Lowry (1996), if the federal intervention or involvement is low, yet the interstate competition is high, there was little correlation between the state policy intervention and the severity of the problem.

The public-policy framework is relevant in this study because of its nature, which focuses on public policy intervention. VA provides an unparalleled range of homeless programs and mental health treatments delivered through a comprehensive, integrated continuum of care, unmatched in the private sector (Lowman & Sheetz, 2021). As a result, the corporation and interactions between the state and the federal government are critical. Lowry (1996) posited that interaction with the state through communication is crucial for successfully implementing a given public policy. A high level of both state and federal government interaction is therefore needed. The prevalence of homelessness among veterans in the United States and other related problems such as drug and substance abuse and suicide could result from the disjoint between the state and the federal government. Specifically, the federal government intervention could be below, yet the severity of the problem is high.

Nature of the Study

I used a general qualitative approach for this study. According to Creswell and Creswell (2017), the primary strength of qualitative research is its ability to assist researchers' understanding of social or human problems from a more exploratory perspective. Qualitative research involves progressing from the facts presented to a general theme or conclusion (Tracy, 2013). Qualitative research is naturalistic in that it focuses on a social phenomenon in a natural setting and is made up of a variety of approaches (Denzin & Lincoln, 2011). I conducted X interviews with homeless veterans. I worked with several agencies in Houston that provide services to the target population to recruit participants. These agencies included the Michael E. DeBakey VA Medical Center, the Coalition for the Homeless, and the Star of Hope Houston. I developed the questionnaire. The instrument was reviewed by three independent experts in public policy administration.

I analyzed the data according to the thematic analysis approach developed by Braun et al. (2018). NVivo software was used to create the coding categories from which a thematic analysis was used to establish the main themes. The interviews were recorded and then transcribed by a neutral third party. Nvivo was used to help develop coding and categories in which the ideas will emerge. A general qualitative approach was used to access the lived experiences of veterans that have been affected by homelessness and substance abuse (Davis et al., 2018). My goal was to understand the experience of homelessness and substance abuse from the perspective of homeless veterans and these impacts on healthcare, social, and economic wellbeing.

Definitions

Homelessness: According to the Substance Abuse and Mental Health Services (SAMHSA, 2014), there are three main categories of homeless classification: unsheltered, sheltered, and doubled up. The meaning of unsheltered consists of homeless people, in a car, or in another form of shelter that is not considered a home (i.e., has no fixed address). The next group, sheltered, consists of individuals who live in temporary housing due to life circumstances; these temporary forms of a house can range from battered women's shelters to welfare hotels. The final group doubled up and constituted individuals who lived with friends or others for a short time (SAMHSA, 2014).

Substance abuse: Substance abuse is the willful continuance of a drug regardless of its effect on social life, occupation, personal psychology, and physical health (Ham & Hope, 2003).

Veteran: a person that has served in the armed forces who ended their terms in the military and were not dishonorably discharged (United States Department of Veteran Affairs, 2020).

Assumptions

I assumed that all the participants would recall their experiences that led them to become homeless. I also thought that all the participants were forthcoming in their interviews and appreciated the research to make life better.

Since the study is qualitative, the recommended generalization is often topic-specific or internal generalization (Thorne et al., 2016). However, this study assumes that homeless veterans experience similarities relating to substance abuse, homelessness, and

mental health. Furthermore, the veterans are entitled to similar support services from the V.A. office. Because of several similar experiences and entitlements of the veterans, the study assumes that the results extend to the broader veteran population.

Qualitative research is usually vulnerable to bias, especially from the researcher, due to an active role in collecting, analyzing, and interpreting the data (Aspers & Corte, 2019). I was aware of the potential vulnerabilities and controlled bias by using scientifically recommended procedures such as transcription and member checking.

Scope and Delimitations

This study explores veterans' lived experiences with substance abuse and homelessness. One factor not included in the scope is the potential mental health complications of drugs administered to the veterans who had injuries or illnesses. Opioids and related psychological problems, including opioid disorders, are widely documented, including their use in curing PTSD and severe depression among veterans (Bernardy & Montaño, 2019). Still, I did not explore the specific medications that may result in substance abuse. I also did not include homeless veterans yet not affected by the problem of drug and substance abuse.

The focus of the study was only on veterans who live in Houston, Texas. Texas is one of the most populated states by veterans in the United States Department of Veteran Affairs (2020). The area has a relatively high prevalence rate of homeless veterans and has substance abuse issues. Therefore, the study will not include a population outside of this area.

Limitations

The standard limitations of qualitative studies limit the present study. For example, I took an active role in data collection, analysis, and interpretation. Therefore, the method is often considered less valid and highly vulnerable to bias by the researcher (Drucker et al., 2016). Furthermore, there is no standardized logical way of analyzing the qualitative data for purposes of uniformity. However, standard procedures for thematizing data and reducing researcher bias will be employed to address these limitations to the best of the researcher's ability.

One potential limitation stems from the study's nature to explore the lived experiences of homeless veterans regarding substance abuse. While veterans are not necessarily considered a vulnerable population according to the institutional review board (IRB), some participants may meet specific criteria that would classify them as a vulnerable population. Being a possible vulnerable population is a limitation. I requested assistance from the organizations that provide services to homeless veterans. It was a limitation, but the researcher was able to gain their cooperation by explaining that the researcher is research that could potentially help reduce the number of homeless veterans.

Another standard limitation in qualitative studies is the low number of participants and the limited sample location. Qualitative studies often use a relatively small number of participants to avoid the high discrepancy or varied response from the participant (MacLure, 2017). Further, participants will only stem from Houston, TX. The results may not generalize to a broader audience.

Significance

This study is critical because of the need to understand the experiences that veterans have with homelessness and substance abuse. These nuanced experiences may help inform more effective financial decision-making and provide programs that target this population more effectively. Veterans' most common factor for returning to homelessness is substance abuse (Dunne et al., 2015; Tsai & Rosenheck, 2015). If the significant factor for homeless veterans is substance abuse, the government may have to focus on addressing substance abuse problems to reduce or eliminate homelessness. The study will add to the body of knowledge regarding substance abuse among homeless veterans. If substance abuse is an issue, the government should develop a treatment method for the veterans.

The social change implication of the study is to provide information about veteran homelessness and substance abuse. Resultantly, public programs may better provide policy and programmatic solutions that coincide with these experiences. The rising number of homeless veterans may cause potential recruits to reconsider joining the military. Security is a critical element in the United States and significantly depends on the voluntary decision of the citizens to enlist into the U.S. military and other defense forces (Spoehr & Handy, 2018). The post-service life of veterans is relatively different from other professions. Despite the government's deliberate efforts to improve the conditions of the veterans, it seems many veterans getting into the civilian population are declining to grow by the day (Bialik, 2017). As a result, the government may be inadequately prepared to take care of the challenge. Therefore, it is essential to establish

areas of vulnerability and develop public policies that can enhance the program's effectiveness. Public-private partnership policies, for example, can be used to improve funding and other related programs of the veterans. This policy is an area where private entities could play a key role, perhaps garnering more public support, donations, and funding partners with other private entities (Pedersen et al., 2015).

Summary

With many studies conducted on veterans' homelessness, most researchers suggest that veterans have mental disorders, criminal histories, and are affected by poverty, with some suggesting that many have substance abuse issues (Tsai & Rosenheck, 2015). I explored the relationship between veteran homelessness as it relates to substance abuse. These lived experiences provide firsthand accounts of why and how these individuals got to where they are, demonstrating a sequence of decisions that could improve in future instances of veteran homelessness. Chapter 2 reviews the literature related to the study to clarify the gap in knowledge and make a case for the research.

Chapter 2: Literature Review

The overrepresentation of homeless veterans on the streets of America is a timely and concerning problem. Multiple studies have been conducted to understand the best approach towards fixing the issues of homelessness within veteran populations (Padgett et al., 2006). Although there has been a marked improvement since the early 2000s, and billions of dollars were spent on supporting homeless veterans (United States Interagency Council on Homelessness, 2010), substance abuse remains rampant among this population (Dunne et al., 2015; Tsai & Rosenheck, 2015). Further, veterans may be unlikely to report substance abuse because of a fear of losing resources or mistrust of researchers and agencies (Padgett et al., 2006). As a result, there are barriers to addressing the growing issue of underreported substance abuse in the homeless veteran community.

The purpose of the study was to explore the lived experiences of veterans that have been affected by homelessness and substance abuse that may influence the healthcare, social, and economic wellbeing of the veterans in the United States. Within the following chapter, I present an exhaustive review of the literature about policies that support homeless veterans, defining veteran homelessness, substance abuse among veterans, perceptions regarding homeless veterans, and various support services that assist in ending veteran homelessness. In addition, the literature review will address the problems associated with the systems that are related to homelessness and substance abuse, along with mental illness.

Literature Search Strategy

This study includes information that supports public policy to educate the public on the problem of homeless veterans. The literature review is to gain an understanding of the behaviors that are associated with the causes and effects of veteran homelessness. The databases used in conducting the library searches were EBSCOhost, ProQuest, Google Scholar, and American Doctoral Dissertations. Other databases were used during the search process, as well. The searches included articles published within the last five years. A few of the sources are not within the previous five years, as these are primary sources.

The search included the following keywords*: veteran homelessness, military substance abuse, homeless aging veterans in transition, social cognitive theory, post-traumatic stress disorder, substance abuse, homelessness,* and *reducing veteran homelessness*. Before generating the returns, the selected peer-reviewed feature ensures that all the literature created would fit this designation. Additionally, once I identified principal authors, their work was reviewed for other relevant research, and other works cited by those authors were similarly considered. Equally, I reviewed recognized peer-reviewed journals, especially in specially themed issues, for other relevant work.

Theoretical Framework

A theoretical framework is crucial in research since it provides the underlying theory on which the studied variables perceive to be related. A theoretical framework comprises the theories expressed by experts in the field you plan to research. You draw upon to provide a theoretical coat hanger for your data analysis and interpretation of

results (Kivunja, 2018). In a literature review, the theoretical framework provides the basis for understanding the relationships between the variables under study. In this section, the social cognitive theory and Lowry's public policy model are used as the underlying theories to explain the existing relationships expressed in the current literature or the expected relationship of the variables studied herein.

Social Cognitive Theory

The theoretical framework that will underpin the proposed study is Bandura's (1986) social cognitive theory (SCT), which was developed to establish a unified conceptual framework for analyzing the psychological processes that govern human behavior. Bandura asserted that SCT was instrumental in explaining the processes that determine social action to understand how those behaviors may change. Furthermore, SCT explains how individuals acquire and maintain tone while also considering the social environment in which individuals act (Bandura, 1986).

Bandura (1986) used SCT to explain that behavior and the environment together can result in various positive and negative influences that have the potential for individuals to be the product and producer of their problems. Bandura asserted that three factors are vital in establishing SCT: behavior, environment, and person. First, action equals complexity, duration, and skill. The ecosystem constitutes a situation, role models, and relationship. Finally, the person is composed of cognition, self-efficacy, motives, and personality. Depending on the use, the influences can be either positive or negative. SCT stresses the importance of the interaction between behaviors, personal factors, and the environment through observation, imitation, and modeling; this process is referred to as

the reciprocal causation model (Bandura, 1986). A person teaching a lesson to a class is an example of an environmental influence on cognition and personal behavior. If one of the students seeks more information and sees them asking the question, this exemplifies individual factors influencing behavior. When the person teaching conducts a review, behavior affects the environment.

SCT is a unique system in which individuals acquire and maintain behaviors influenced by the social environment (Tougas et al., 2015). An essential aspect of SCT is that it takes care of the individual's experience, which is assumed to be a critical determinant of the current behaviors and expectations. It implies that someone has had a specific practice in the past, whether positive or negative. It determines whether the person is likely to engage in the same or related behavior in the present and future. Six fundamental elements explain SCT. The most important construct of SCT is reciprocal determinism, which posits that individuals' actions are shaped through learned experience, social and behavioral interactions. These factors respond to stimulate the achievement of a specific goal (Bandura, 1986). The veterans' lived experiences, including PSTD, and the social environment they mostly detached from are likely to influence the veteran's drug and substance abuse disorder development.

Another critical construct of SCT is behavioral capacity, which refers to the individual's ability to perform a specific behavior based on their set of skills and knowledge (Hall et al., 2015). This construct is applicable in the current study because veterans are often less prepared psychologically for the traumatizing experiences they face in the combat field unless they have been there often. Also, when they come back,

they are equally less prepared on how to fit in the community and live a healthy life. Since the social environment is a critical determinant of an individual's behavior, detachment from the same, which is common among veterans, is likely to stimulate the development of a substance abuse problem. Not knowing how to cope after returning from the battlefield, such as PTSD, may make a veteran dependent on drugs and substance abuse.

Another critical aspect of SCT that is crucial to the current paper is observational learning, which posits that individuals' behaviors are shaped by learned observation from others (Bandura, 1986). Unfortunately, most veterans have a poor experience with their colleagues and friends who probably could not cope in society after service. The suicide rate, for example, is high among veterans. Suppose such is the learned observations by veterans from their colleagues. In that case, it is only reasonable to expect obnoxious behaviors from most veterans, hence the high instances of drug and substance abuse among veterans across the United States. Lastly, reinforcement is a critical construct of the SCT, which asserts that external or internal reactions to a person's behavior are likely to reinforce or change their behavior (Bandura, 1986). As such, when the society, especially the immediate family such as wife and children, reacts negatively, such as rejection, destructive behaviors such as substance abuse are likely to be reinforced and accelerate their conditions.

Bandura's (1986) SCT is widely used in a variety of studies from different disciplines, with the intent of establishing a theoretical understanding of helping diverse populations. The theory is particularly prevalent within the field of healthcare, was used

to assist in creating self-management interventions for older adults with chronic diseases. (Seal et al., 2007) explain self-regulation regarding behavioral change among individuals with various health conditions. Due to its previous use among populations in need of self-management, self-regulation, and lack of behavioral change, SCT is appropriate for interpreting my study's topic.

SCT is closely aligned with the topic of study as it may explain the issues experienced by homeless veterans. Assuming the alignment between SCT and homeless veterans is justified, the problem is that homeless veterans cannot refrain from substance abuse due to negative behaviors, which may cause them to become homeless again. (Gutman & Greenfield, 2017) posited that unsupervised homeless adults who have chronic mental illness and substance abuse issues would fall into the problem of not sustaining healthy living conditions. These individuals are at significant risk of returning to unhealthy living standards if unsupervised, as they can get better through abstaining from substance abuse. Maintaining a strict regimen of medication is greatly diminished. In many cases, these are the conditions that led them to be homeless in the first place.

Lowry's Public Policy Model

Another framework that informed the study is Lowry's (1996) dimension on the public policy model. It focuses on the relationship between the state and the federal government regarding policy development and intervention. Lowry that different locations have various levels of problem severity. Texas, for example, may have more homeless veterans with problems of drug and substance abuse than other states. The intervention by the state towards a specific problem is, therefore, dependent on the

magnitude of the problem. As Lowry (1996) argued, if both the state and the federal government are involved in the implementation of a given public policy, the state should always have more effort or intervention towards the problem than the federal government because of the extent to which the state has direct knowledge and experience with the problem's magnitude. Texas considered having more understanding of veterans' veterans' issues than the federal government.

Lowry (1996) further posited that the relationship between the state and the federal government is dependent on interstate competition and the level of federal aid to a given state. In the case of Veterans Affairs, all the states in the United States compete for the resources provided by the federal government. Regarding the effectiveness of a given public policy, Lowry (1996) argued that a high level of state and federal government intervention towards a given problem is more effective in mitigating a public policy issue. In such states, communication, interaction, and cooperation between the two government levels are always high. The reverse is true in that low state and federal government intervention result in poor policy implementation. Other than the social cognitive theory, the literature review will also focus on how state and federal government intervention impacts policy implementation.

Literature Related to Key Concepts

The literature review topics include a definition of homelessness defined and the effects of homelessness. Subsequently, risk factors for veteran homelessness were addressed, particularly substance abuse. Finally, causes that influence substance abuse among veterans, perceptions of homeless veterans, services provided to homeless

veterans, and support systems and organizations that assist homeless veterans are addressed. The chapter will end with a summary.

Defining Homelessness

Homelessness has a different meaning depending on the country or geographical location. Regardless of the name and how it is defined, homelessness is still a problem that must be corrected, or the numbers will continue to climb, and it may attract other people to being homeless (Lee et al., 2021). Busch-Geertsema et al. (2016) asserted that global homelessness has three different categories. Those categories are:

- People without accommodation
    - People that are sleeping in the streets, on a park bench, or in a park behind a building
    - People sleeping in a place with a roof but not considered a home that a human can use for housing, such as an abandoned building.
- People living in temporary or crisis accommodation
    - People are staying in night shelters. The shelter may be an accommodation provided by the government or an organization helping to provide temporary housing for homeless people. It could be women and children that are moving away from domestic violence.
- People living in severely inadequate and insecure accommodation
    - People that are squatting homes that were left abandoned.
    - People are living in extended-stay hotels, and similar conditions

Homelessness can be defined in other ways as well. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), homelessness often exists in multiple forms, making the ability to craft a single definition difficult. While the traditional view of homelessness included only people living on the street, this is not always the case. As it stands, the reports surrounding homelessness have continuously been updated and refined as the body of knowledge developed. The descriptions do have similarities, but they do have specific differences.

For example, SAMHSA (2014) indicated three main categories of homeless classification. The first is unsheltered, which consists of homeless individuals in a car or another shelter not considered a home (i.e., no fixed address). The second, *sheltered*, consists of individuals who live in temporary housing due to life circumstances; these temporary forms of a house can range from battered women's shelters and welfare hotels. Finally, SAMSHA's third category *doubled up*, constitutes individuals who live with friends or others for a short amount of time.

While SAMHSA (2014) provides a working definition and classification system, the process of defining homelessness is further complicated by the variance in time in which a person remains homeless. According to SAMHSA, chronic homelessness is a state where a person has been homeless for more than a year or has been homeless at least four times within three years. Curtis et al. (2013) extended the definition of homelessness, asserting that there was the concept of *immensely homeless*, which includes the following parameters:

(a) families do not have fixed or adequate nighttime residences, (b) families that will be losing their homes within 14 days due to various factors, and (c) families that have small children who have moved twice within 60 days.

According to Salhi (2017), a homeless individual is a person who has no house, except for a situation where the person is a member of a family where they live. Based on this broad category, a homeless person can be under various types, including someone whose primary residence during the night is a private facility such as shelter. It can also be a home or shelter supervised by the public, and these residences or housing are provided for temporary accommodations. Another category of homelessness is a person who is living in a transitional home. Another definition of homelessness is when an individual cannot maintain the terms and conditions of modern living and is forced to live with friends or relatives temporarily. Also, before being admitted to a hospital, or sent to prison, or any facility in which they spent a relatively long time, homeless people are homeless if they do not have a stable home condition when they return from the various facilities.

Homelessness can be children put into situations that cause them to live in other than usual terms. For example, they may live in foster care or with friends that are not family members. Fry et al. (2017) asserted that over 100 million children live on the streets worldwide. However, the homeless people live on the streets and those living in unsuitable accommodations. These accommodations can be motels, youth hostels, or living with a friend (Curtis et al., 2013).

Causes and Effects of Homelessness

Major depressive disorder and alcohol use disorders are two disorders that cause the most significant problems for the homeless population. Major depressive disorder (MDD) and alcohol use disorder (AUD) are two of the top five sources of disease burden among all medical diseases in high-income countries as reported by the World Health Organization and are relatively common. According to the National Institute of Mental Health (2019), at least 7.1% of adults in the United States have experienced one episode of major depression. The study further shows that the primary symptoms were prevalent among women, 8.7%, than among men, 5.3%. Additionally, major depression episodes were high among 18-25 (13.1%). In yet another report, the National Institute of Mental Health (2019) found that at least 5.8 people in the United States have alcohol use disorder of 18 and over. The report further shows that men are diagnosed with AUD 9.2 million more than women 5.3 million.

Yoon et al. (2015) also asserted that both MDD and AUD were 26.2% of the problem that caused homelessness versus 6.7% of those diagnosed with only MDD.

People are experiencing homelessness face medical, social, and environmental challenges to their physical and mental health. O'Toole et al. (2013) indicated three different types of health problems for the homeless: those caused by homelessness, those that cause homeliness, and those that make treating the homeless difficult. Moreover, persons experiencing homelessness suffer from medical illness, problematic substance use, and psychiatric disorders (Kertesz, 2015). Homeless individuals often do not access care until their health is dire; O'Toole et al. (2013) asserted that more than 40% of

homeless people use the emergency department for their medical needs. This reliance on the emergency department is because homeless people have several different problems with transportation, availability, and the ability to keep primary care provider appointments (O'Toole et al., 2013).

The challenges are more significant when severe psychiatric disorders, substance use disorders, and other mental illnesses. For example, Kip et al. (2016) asserted that among veterans who lived in homeless shelters than those recruited from the community, those from the shelters experienced more psychopathology and had less combat experience. They also had more cases of sexual assault that may have been a contributing factor to their mental health diagnoses.

Homeless people with mental illness cause the system to be more complicated than those who do not have mental health issues (Chrystal et al., 2015). When people experience homelessness, they have many medical, social, environmental, physical, and mental health (Chrystal et al., 2015). For example, Chrystal et al. (2015) indicated that the homeless disproportionately suffer from medical illness, problematic substance use, and psychiatric disorders. Managing these disorders, along with the access and utilization, becomes more complicated. Patients with mental illness are seen for primary care less often than those without mental illness, which makes the management of chronic diseases worse and raises premature mortality rates (Chrystal et al., 2015).

Kertesz (2015) also asserted that mental health treatments compounded with other issues might be problematic because homeless individuals do not get treated for the other problems as often as those that do not have mental health issues. Veterans suffering from

mental health may not seek help from other chronic health issues (Kertesz, 2015). The other problems demonstrate similar behaviors that may make it difficult to determine the root of the problem. It causes problems in accessing primary care but increases hospital and emergency care use. The trial continues even into the next generation. Once their children grow up, some of them may experience the same issues, and this will cause a burden on the medical community addressed in subsequent generations.

Byrne et al. (2017) conducted a study examining the association of housing instability and the cost of health care and behavioral health care. The study compared the prices associated with inpatients and outpatient health care. The study also examined veterans experiencing brief periods of housing and ongoing periods of housing instabilities. There were 5794 veterans used in this study, and 4934 (85%) experienced short periods of housing instability, and 860 (15%) experienced ongoing housing instability. The average incremental cost between the veterans experiencing ongoing compared with those experiencing brief periods of volatility was $7573.

There was a significantly higher level of inpatient cost, and the value to outpatient services was less than the veterans who suffered brief episodes of housing instabilities. There is a 30% higher inpatient cost for veterans with ongoing housing instability than those with short chapters. Veterans who experienced current episodes had a higher chance of outpatient care such as emergency and urgent care, mental health, and substance abuse services than those who experienced brief housing instability.

Prevalence of Homelessness Among Veterans

While many veterans remain homeless, the numbers decrease, which shows some progress. National Alliance to End Homelessness (NAEH) (2015) asserted that in January 2016, there were 39,471 homeless veterans identified in America. The numbers are still high, but a substantial 56% decrease from similar statistics NAEH collected in 2010. Even though the number of veterans remained over-represented in the homeless population across America, the reduction in numbers is a sign of progress.

Although there have been some improvements in homelessness rates, disparities in homelessness remain. For example, Tsai and Rosenheck (2015) reported that homeless veterans comprise 12.3% of the homeless population in the United States, while all veterans represent only 9.7% of the total population of the United States. Of the homeless veterans in the United States, the NAEH (2015) reported that 91% are male, 98% are single, 76% live in a city, and 54% have a physical or mental disability.

In understanding the prevalence of homelessness, it is essential to understand the risk factors for homelessness. Some risk factors that predispose individuals to become homeless include mental illness, substance abuse disorders, and unemployment (Dunne et al., 2015). Woolsey and Naumann (2015) asserted that other risk factors are childhood instability, mental illness, substance abuse, inadequate social supports, and being from a low-income family. Woolsey and Naumann also acknowledged that veterans have more risk factors that further complicate the risk factors. For example, veterans may have PTSD, and female veterans may have experienced sexual assaults while serving in the

military (Woolsey & Naumann, 2015). Discussed in the following section are risk factors for veterans.

Risk Factors for Veteran Homelessness

Different causes result in veteran homelessness, each presenting a unique challenge. There have been multiple studies conducted describing the risk factors associated with homelessness. Tsai et al. (2015) asserted that there is an order for the risk factors that are the most consistent and reliable when it comes to homelessness. Among the most significant factors are substance use disorder and mental illness. Low income, social isolation, adverse childhood experiences are important risk factors. However, they do not have the same impact on the veterans being homeless. Veterans diagnosed with having dual disorders have a higher risk of being homeless (Bowe & Rosenheck, 2015). These causes must be addressed to create solutions to veterans' homelessness.

The primary homelessness objectives addressed in the literature are a combination of substance abuse and mental illness. Tsai et al. (2014) revealed that substance use disorders were the most significant risk of homeless veterans. The threat was six times greater for veterans than any other disease. "One challenge faced by many homeless veterans is substance abuse. About 70 percent of homeless veterans have a substance abuse problem (Dunne et al., 2015; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014)

In a study conducted to compare the self-reported purpose of homeless veterans with non-veterans and emergency room visits, Dunne et al. (2015) asserted that substance abuse and mental illness contributed to a high rate of the issues that caused veterans to be

homeless. These psychological conditions include malnutrition, violence, incarceration, diabetes, tuberculosis, exposure, and substance use. Dunne et al. (2015) further posited that over half of the participants suffer from mental illnesses, and over 70% suffer from substance abuse problems. When they have alcohol and substance abuse problems, there is an even higher risk of homelessness. Compared to participants with no substance abuse problems, the participants that had no substance abuse problems experienced less history of homelessness.

Dunne et al. (2015) also asserted that veterans who suffer from substance abuse have a more difficult time obtaining housing and employment and have a higher risk of incarceration associated with interpersonal conflicts and other issues caused by substance abuse. According to the self-reported evidence used by Dunne et al. (2015), the primary cause of homelessness among veterans and non-veterans was unemployment, and the second most common cause was an alcohol or drug problem.

Dunne et al. (2015) asserted that of the causes reported; unemployment is 45.8%, alcohol/drug problems were 17.8%, physical/medical problems were 10.2%, mental/emotional issues were 5.9%, divorce/breakup and foreclosures were at 2.5%. Salhi et al. (2018) studied the causes of different types of homeless veterans. The study participants were both the episodically homeless and the chronic homeless. Salhi et al. (2018) asserted that these groups of homeless veterans are linked to mental illness and substance abuse. A study conducted by Tsai et al. (2014) further demonstrated the prevalence of substance abuse among homeless veterans in a housing program. There is an association of drugs and alcohol among the homeless veterans in the plans. Of the

veterans sampled, 60% reported substance abuse issues. Of that number, 54% said they had drug and alcohol abuse issues.

A study conducted by Cusack and Montgomery (2017) set out to determine the bidirectional nature of homelessness and incarceration. The incarceration may not have been the problem. Still, because of the confinement, the status of the person changes, and finding employment is more complicated, which makes being able to pay for housing more difficult. Studies show that veterans incarcerated risk the possibility of being homeless. Cusack and Montgomery (2017) asserted that the care they seek decreases because of the increased risk among those who have a drug use disorder.

When inmates are released from correctional institutions, depending on how long they have been away and the crime they were sentenced for, they may find time to have families to accommodate them. Even if they get accommodation, it is always temporary. As per the definition by Salhi et al. (2018), such people who are living with friends or relatives because of a lack of stable house conditions are homeless. The problem is further compounded by the inability to secure employment because of the criminal record. Cusack and Montgomery (2017) also showed risk factors when exiting the HUD-VASH because of incarceration. It is two times more likely for veterans that had drug abuse disorders. The veterans who had access to compensation related to a service-connected disability were less likely to exit the programs.

Some characteristics may also become risk factors for homelessness. For example, Seal et al. (2007) asserted that the operations in Iraq and Afghanistan had produced the most ground combat since the Vietnam War. The effects of ground combat

cause many problems; they must address the issues once they have returned from battle. The veterans will more than likely have many mental health issues to deal with once they have separated from the military. Seal et al. (2007) also asserted that veterans from OEF/OIF would be eligible for up to 2 years of free mental health service from the V.A. The information is critical to address the mental health issues before they are separated and go out into the community without assistance from the V.A.

The living conditions of the veterans before and after serving in the military will determine how well they transition from the military. Most of the veterans were teenagers and lived with their parents when they went into the military (Shaheen, 2018). After a few years in the military, their parents may have adjusted to being adults and not retained their living arrangements. When the veterans leave the military, several do not have much to go back. Metraux et al. (2017) asserted that one-third of the veterans become homeless within two years from separating from the military. Those that become homeless may have been unprepared for the transition from military service and were more than likely had no stable housing arrangement when they left the military. The veterans had harsh living conditions from a life in the military where they had accommodations that took great care of them. Once they leave the military, they return to civilian life, where they must do most things independently. It becomes their pathway to homelessness.

Although the number of homeless veterans, including women, has been declining over the years, the vulnerability of women veterans in terms of homelessness and potential substance abuse is higher. According to Saunders et al. (2018), women's vulnerability is based on their difficulty integrating into civilian life and potential sexual

trauma during the service. The problems are further compounded for those who cannot integrate into civilian life and typically live with their children. However, childhood problems and trauma are not limited to female veterans. Benda (2002) suggested that treatment for this population should target residual feelings from childhood and attributions about the self in addition to substance abuse and psychiatric problems. Cognitive strategies aimed at bolstering self-efficacy and lessening depression used in conjunction with addressing substance abuse and mental treatment may help program participants secure and sustain employment (Benda, 2002).

Substance Abuse Among Veterans

As indicated above, substance abuse is a common cause of homelessness among veterans (Dunne et al., 2015; Salhi et al., 2017). Tsai et al. (2014) conducted a study on homeless veterans entering the Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) and compared two groups of veterans: those who had alcohol disorders and those who had both drug and alcohol disorders. Of the study participants, 60% had a substance abuse disorder; 54% experienced drug and alcohol use disorders (Tsai et al., 2014). Some studies show that veterans with post-traumatic stress disorder (PTSD) also suffer from substance use disorders (SUD). The National Center for PTSD (2018) asserted that 46.4% of the people with PTSD would also demonstrate symptoms of SUD. One study showed that 27.9% of women and 51.9% of men with PTSD also suffer from SUD. Women were 2.48 times more likely to meet the criteria of having both PTSD and SUD, and men were 4.46 times more likely to meet the criteria for alcohol abuse and dependence.

The high prevalence of substance abuse is problematic because of the adverse outcomes associated with SUD. The National Center for PTSD (2018) asserted that people who have both PTSD and SUD have poorer treatment outcomes and an increased risk of comorbidities because of their disorders. These comorbidities include additional psychiatric problems, functional problems, and medical, legal, financial, and social (National Center for PTSD, 2018). Bowe and Rosenheck (2015) asserted that veterans diagnosed with both PTSD and substance use disorders are likely to have been diagnosed with HIV, liver disease, psychiatric, schizophrenia, and other ailments and illnesses. They were also expected to have been homeless and received V.A. benefits that support their disabilities.

Moreover, Coker et al. (2016) asserted that prior studies of patients with PTSD and SUD show that there may be a significant risk of having a relapse for those with PTSD and SUD. Therefore, veterans who have substance abuse issues experience problems that significantly affect their ability to remain in a home. If a homeless veteran receives only housing and does not treat the substance use disorder, they more than likely will become homeless again because the root problem is not corrected.

Services Provided to Homeless Veterans

Having services that provide services to homeless veterans is helpful in many ways. The type of services provided will help reduce or eliminate the number of homeless veterans. However, those services must be tested and proven to impact the people for whom they provide services. Many have benefited the community and the

people they support, and others may need to adjust their methods to provide more effective services.

Veterans' Health Administration's "Homeless Patient Aligned Care Team" (H-PACT) conducted an observational study of 33 VHA facilities that support homeless veterans. O'Toole et al. (2013) asserted that the 33 different facilities observed served over 14,000 patients. They used the data from 3,543 homeless veterans enrolled in the programs from October 2013 through March 2014. Over 96% of the patients enrolled in the VHA programs receive homeless services. There are 33 sites studied and of those sites examined, 82% offer hygiene care (i.e., showers, hygiene kits, and laundry service), 76% offer transportation services, and 55% offer clothing, 42% had a food supply system and provided meals and other services about food. Veterans that served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) are eligible for medical assistance for a certain amount of time once they have separated from the military. The United States Department of Veteran Affairs (2019) indicated that veterans who served in combat operations after November 11, 1998, will be eligible to receive free health care for five years after their discharge.

This type of follow-up treatment is essential for addressing issues that may stem from service. Decker et al. (2017) assessed veterans that attended a residential substance use treatment program, and participants studied for five years after discharge. It was to determine if certain factors would cause them to relapse or if the treatment was effective. The medical, psychiatric, and emergency room visits were examined. They also used the details about the demographic, diagnostic, and prior treatment as independent variables.

The study concluded that participants who did not complete the procedures had a higher relapse rate than those who completed the treatments. Moreover, Decker et al. (2017) asserted that if a person with mental illness were to try living independently, they would struggle because they do not have the social skills required to obtain a house. Conversely, if a person were to develop excellent social skills, they would have a better chance of acquiring and retaining a home.

Malte et al. (2017) also asserted that the AHCM provides case management to the community to help homeless veterans. They suffer from SUD (substance use disorder) issues that cannot obtain housing because they have a problem controlling their SUD issues. The case management provides the support to help secure and maintain a house through resources and coordination with the community. In addition, the case managers can provide support through psychiatric, medical, vocational, and other services that address substance abuse issues. Malte et al. (2017) asserted that the Addiction Treatment Center provided substance use treatments. They received at least 90 days of treatment involvement. The procedure was both grouped and individual formats, as well as patients were in the inpatient and residential programs. All the patients received the same services regarding screening and treatment planning.

Malte et al. (2017) sought to determine if the Addiction/Housing Case Management (AHCM) program effectively improved the veteran's substance use, functional outcomes, and mental health and lowered the use of acute healthcare. A sample of 181 veterans was randomly assigned to two groups: the AHCM and the House Support Group (HSG), with the latter being the control group. The respondents received a

treatment program for 12 months. In addition, the AHCM provided individualized housing, mental health care, community outreach, and life skills training. On the contrary, the control group involved weekly drop-in support. The participants would come once a week to the house support and receive services meant for the homeless veterans and those with substance abuse disorder. The results indicated that the number of days housed by the homeless veterans in both cases increased significantly. In addition, Malte et al. found that participants in the HSG received a higher number of days in the housing units than the experimental group.

Furthermore, respondents in the HSG experienced a significant decline in the number of visits to the emergency department than the experiment group. Additionally, the ASI composite for alcohol scores increased for the HSG. In general, the study did not find a significant difference between the HSG and the AHCM.

Likelihood to Use Services

Several factors may influence homeless veterans' willingness to participate in their services. To reduce homelessness among Veterans, the Veterans Health Administration conducted a study to gather data on patients that received social assistance. Montgomery et al. (2016) asserted that screening predictors varied among gender. Among women, the predictors were drug abuse and psychosis diagnosis and being unmarried. Among men, being younger, not married, not service-connected/Medicaid-eligible increased the odds of using the facilities for homelessness.

Seal et al. (2007) aimed to (1) describe the proportion of OEF/OIF veterans seen in V.A. facilities who have received single or multiple mental health and psychosocial

diagnoses and the timing and clinical setting of first mental health diagnoses. (2) identify subgroups of OEF/OIF veterans at high risk for receiving mental health diagnoses after returning from military service in Iraq and Afghanistan (Seal et al., 2007). Seal et al. assessed data from 165,351 OEF/OIF (Operation Enduring Freedom/Operation Iraqi Freedom) veterans new to the V.A. health care system. The participants must have been recently enrolled, and they had to be on the U.S. Department of Defense, Defense Manpower Data Center database. Of the participants enrolled, 29% had accessed VA health care, and over half came from the Defense Manpower Data Center and VA Health Eligibility Center. The study found that more than half (53%) did not have the required OEF/OIF service separation dates of September 30, 2001, through December 31, 2005. More than half (53%) of the veterans included in the roster lacked OEF/OIF service separation dates. Seal et al.'s study is critical because it demonstrates that other factors contribute to the health of veterans being homeless and substance abuse. The problems need to be addressed. This study shows that different areas lead to gaps in the research as they are being studied.

Costs of Ineffective Services

The value of services used to help veterans are concerned about how much is spent on the benefits. Chinman et al. (2017) asserted that veterans who are experiencing homelessness face many health care challenges from mental and physical health issues. They are also faced with medical, social, and environmental challenges. Some veterans' health problems cause more complex situations concerning medical illnesses (Chinman et al., 2017). When the veterans must go to the medical facility, the cost is much higher.

After all, they end up having more illnesses because they may have other problems. They might have been preventable if the veteran had received medical treatments earlier (Chinman et al., 2017). Chinman et al. (2017) also asserted that the use of emergency services is more significant because this may be the only form of medical services they may receive.

Effectiveness of Services

The type of services and support that primary care providers give can influence the services' effectiveness. When patients can select a provider that better fits their needs, they will receive a more favorable outcome with the services offered. Chrystal et al. (2015) asserted that tailored services had the best results with primary care for homeless people diagnosed with psychiatric symptoms. The patient's ability to switch their primary care providers on demand had the best outcome. It helps the patient know if what they have is working for them.

Studies have shown that veterans had other risk factors that served as predictors that contributed to the number of homeless veterans. For example, Tsai et al. (2017) indicated drug use and single status as the highest predictors of homelessness. Other factors, such as low income, African American race, alcohol use, and age range 46-55, predicted homelessness to a lesser extent.

The veterans who offered mental health services had significantly higher success than those in accommodations that did not provide the same services. One stride forward in treating veterans is reducing sobriety requirements. Chinman et al. (2017) reported that HUD-VASH adopted the Housing First philosophy. This policy states that there is no

need for the individual to demonstrate complete sobriety before receiving housing and services provided by case management. Coker et al. (2016) also asserted a relationship between the trauma and medications used to treat the injury. The studies reveal the difference between the types of treatment used in addressing the problems. Long-term PTSD Residential Rehabilitation Programs (PRRPs) and Specialized Inpatient PTSD Units (SIPUs) had significant, although small, associations with substance use. When participants were in more extended care, received prescribed medication, and planned participation in program reunions, they had slightly improved alcohol outcomes (Coker et al., 2016). When it came to illicit drugs, the results were similar. Except for having a history of incarceration, the outcomes were poorer.

Chinman et al. (2017) and Byrne et al. (2017) explained a goal to reduce emergency department visits among homeless veterans. When veterans are homeless, the only medical support is the emergency department. Because they use it so often, it will cost a lot of money to sustain. O'Toole et al. (2013) asserted that 3,543 patients enrolled in VHA homelessness programs showed a 19% reduction in the use of emergency department services and a 34.7% reduction when it comes to hospitalizations. Three features significantly associated with the significant performance: 1) high staffing ratios than other sites, 2) integration of Social Supports and social services into the clinical scare, and 3) outreach to the integration with community agencies. O'Toole et al. (2013) compared homeless and non-homeless veterans recently enrolled in a medical home. This comparison was conducted among homeless veterans to see if there could be a reduction in emergency department visits. There were 127 homeless and 106 non-homeless

veterans followed during this study. Each of the groups had similar medical and mental health issues. The results from the survey will show the difference when comparing homeless and non-homeless veterans. O'Toole et al. (2013) asserted that 127 homeless and 106 non-homeless veterans with both groups having similar rates of medical and health diagnoses followed. Of the group studied, 25.4% of those homeless and 18.1% of non-homeless reported active substance abuse. It accessed that the results for the homeless veterans had higher use of primary, mental health, substance abuse, and ED care during the first six months of the study.

Further, Byrne et al. (2017) indicated a decrease in emergency department care when veterans enrolled in H-PACT. If the veterans reduce the re-offered services, they will have a better outcome for the system overall. If the veterans can find a solution for reducing the numbers, then the non-veteran will also find a solution. The military leads the way in finding a way to make things better. They should also have a part in this problem.

The role of females has expanded in the military and current deployments. As a result, women are exposed to the same things that male veterans have. Therefore, services must be evaluated concerning female veterans. According to Tsai et al. (2014), homeless female veterans were more likely to enter the HUD-VASH program than homeless male veterans and have several distinctive strengths, including their younger age, ability to work with their case managers, and connection to natural supports. However, many homeless female veterans have experienced various forms of trauma that can affect their psychosocial recovery. They may face more barriers in finding supported housing that

can adequately accommodate their dependent children as they must consider issues such as safety, schooling, and child-oriented services. However, like male veterans, female veterans were able to show dramatic improvements in housing outcomes once admitted to the HUD-VASH program (Yoon et al., 2015). These efforts should continue, and gender-specific interventions capitalizing on the strengths of female veterans should be encouraged (Tsai et al., 2014). Also, in most cases, female veterans will not have the same problem finding housing as their male counterparts. According to case managers, Tsai et al. (2014) asserted that female veterans are more likely to live with someone or find a home.

Malte et al. (2017) compared the differences between addiction/housing case management (AHCM) and a housing support group (HSG). The study was to determine if there was an improvement in housing, substance use, mental health, and functional outcomes. A total of 181 homeless veterans were used and picked at random. The homeless veterans received treatment for 12 months. The AHCM provided housing and substance use, and mental health management services. To ensure control of the measurements, the HSG conducted weekly drop-ins. Malte et al. (2017) asserted that the results revealed that in the study, of the 181 veterans that were studied, 74 (81.3%) AHCM and 64 (71.1%) HSG entered into the program. The research shows that the veterans from the HSG group had a better outcome for the emergency department visit than those from the AHCM group. In addition, the study shows that the veterans that were in the AHCM group remained in substance treatment longer. Both programs showed an improvement, but the HSG showed more significant gains. This study is

critical because it shows that applications studied for their effectiveness to find out what works to decrease the problems of homeless veterans.

Regarding VA Supported Housing, the supervision programs had the best outcome. If they did not have the proper support, the veterans unwilling to change would go back to doing what they did first. Gabrielian et al. asserted that several veterans who exited the program found it helpful if the case managers constantly watched them. If they did not have the oversight, the behaviors would come back again because of control. Gabrielian et al. also asserted that veterans in the program, those who remained, and those who exited the VASH program felt that SUD (substance use disorders) was under-addressed. In addition, the VASH was placed in drug-infested areas. Therefore, it would increase the veterans' risk of returning to doing drugs before.

The gap in the literature remains regarding the most significant thing causing the veterans to become addicted in the first place. Veterans may have already been using drugs and alcohol before service, might start during service, or only develop a substance abuse problem once treated for other medical or mental illnesses. If some type of treatment that the military uses to help the veterans is causing them to become addicted, it should be explored. For example, Rosenberg et al. (2018) insert that the nation quickly understands the harms of long-term opioid therapy (LOT). Even if the doses are low, they cause significant damage because of LOT, including overdose and opioid use disorder. However, LOT shows improvement in pain, function, and quality of life without having sufficient evidence. Moreover, additional information is required regarding the efficacy of existing services. A great deal of research explains that the veterans are experiencing

PTSD and substance abuse issues, but not so many explain whether and how the addiction developed.

Improving service access to the veterans at the community level has been of significant concern in the effective management of the Department of Veterans Affairs. As such, newer policies have been developed to mitigate these challenges. One policy is the Veteran Affairs Mission Act, signed by President Donald J. Trump in 2018. The administration created an independent commission whose mandate is to improve the current facilities that provide services to the veterans. The purpose of the policy is to develop community programs that care for veterans. Also, this policy allows the veterans to receive services from private healthcare providers and increase funding for hiring more healthcare workers and benefits to the caregiver.

Similarly, the Veterans Choice Program Extension and Improvement Act aims at improving services provided to the veterans under conditions. The bill allows the veterans to seek healthcare from doctors who are non-VA in cases where they must wait longer to receive service from the otherwise assigned VA doctors. Alternatively, the bill allows the veterans to seek healthcare from non-VA if they live 40 or more miles from the VA facility. Another essential policy recently enacted is the Veteran Affairs Accountability and Whistleblower Protection Act, established in 2017. Bill's purpose is to provide guidelines for judges to expedite disciplinary actions appeals against employees of the VA (Prasad, 2017). They considered having engaged in misconduct while dispensing their duties. The executives working in VA offices cannot appeal disciplinary actions against them in the policy. The system allows other employees to request

disciplinary decisions against them. However, among the existing policies, a fundamental gap exists regarding how private partners can be incorporated to improve service delivery to veterans. Most of the systems only have provisions for the involvement of the individual partners under conditions. There is no comprehensive policy that allows private parties to provide services to veterans.

Homeless Veterans

The veteran population in Texas as of 2017 was estimated at 1,538,195, which is the second-largest in the United States after California (Texas Workforce Investment Council, 2016). Generally, most of the veteran population is located in the Southern states. Of the veteran community in Texas, 89.2% are men compared to the non-veteran population, 46% men. The remaining 11% of the veterans in Texas are women. The report also indicates that most of the veteran population in Texas are non-Hispanic whites (60.1%). In the non-veteran community, non-Hispanic whites are 37.2%, implying a disproportion of veterans and non-veteran people. The second-largest population of veterans in Texas is Hispanic (18.8%), which is less than the non-veteran Hispanic population in Texas, 37.2%, similar to non-Hispanic whites. The African American veteran population in Texas is 14.3%, higher than the corresponding non-veteran population, 11.9%. Asians constitute the minor veteran population (1.6%).

Crain (2019) conducted a qualitative study on the factors that enhance or limit veterans' successful transition into civilian life after serving in the military in Texas. The study found that lack of adequate funding, veteran attitude towards the services, and veteran warrior ethos are limitations to veterans' successful transition.

Summary

Veterans' homelessness problems are not just mental health issues. Mental health issues are compounded with substance use disorders and alcohol use disorders, which further complicate the matters associated with veterans being homeless. Some veterans use medication prescribed to help with their illnesses and other related problems. Drugs used to treat mental illness can add to veterans experienced before. Instead of having just a mental illness, veterans end up with twin problems that cause more problems to fix than they had before receiving the assistance they were seeking. To treat either disorder may require multiple costly services and may not provide the results that will benefit the veteran or correct the problems they may have to prevent them from being homeless. If a veteran is dually diagnosed with PTSD and substance abuse disorders, it may cause even more significant challenges. The likelihood of returning to homelessness once they have received housing is higher. There is evidence that shows that this problem further complicates the situation.

Being homeless may be one problem, and if it were the only problem, providing housing to homeless veterans could solve that issue. The real question is what causes the veteran to become homeless even after receiving a place to stay, and they cannot maintain the house once they get one. Those causes are disorders that need addressing. These disorders range from mental health disorders, substance abuse disorders, unemployment, and other disorders associated with the behaviors that cause homeless veterans to lose the housing they receive as part of a VA-assisted program to help veterans have a house. In addition, some of the accommodation set up for the veterans is

in the wrong area. Some of them are in a drug-infested place, which will create an environment where the veteran has a substance abuse disorder. They can interact with the people who have the drugs and relapse and end up in the same situation before.

They address the risk factors of finding the solutions to end homelessness among veterans. The risk factors help push the veterans to the point where they become homeless. The risk factors start as early as childhood, and a particular situation will cause the problem. In this research, each risk factor needs the same attention to prevent making a mistake and doing something that will shape the veteran homeless. It is easy to say that veterans have a mental illness, but a lot harder to explain that before they join the military, they must go through many tests to deem them mentally fit to serve. There is something that caused them to have a mental illness. Some of it may be their military service, some of it may be their PTSD, and some may be the substance and medication they take to fix the problem they once had. Their new disorder becomes the addiction to the medicine they sought to cope with the first problem.

The results of studies related to substance abuse among veterans show that one of the main risk factors of veterans' homelessness is substance abuse. The second most significant risk factor is mental illness. These are similar issues for non-veterans, but they have other problems that can further complicate the system when a veteran is homeless. For example, a veteran may have been exposed to combat and have issues with PTSD and other items associated with the military. Moreover, some female veterans are homeless, and the numbers are increasing. Though they may have a better social network to provide them with a place to stay, having them on the streets is not something that we

need. The problem is not just because they are a female veteran, but because they are at risk of being assaulted. Chapter 3 indicates the methodology used to examine this problem.

Chapter 3: Research Method

The purpose of the study was to explore the lived experiences of veterans that have been affected by homelessness and substance abuse and how these impacts their healthcare, social, and economic wellbeing. It is an issue of concern considering the risks taken by veterans while protecting the country, yet when they are out of service, some of them live undesirable life.

This chapter presents the methodology for the research study. First, the research design and rationale include the research questions and an overview of the approach and research design. The second section highlights the role of the researcher. Finally, in the third section, I discuss the research methodology, including participant selection, data collection, and data analysis processes—a discussion of the methods of establishing trustworthiness in this research presented before the chapter summary.

Research Design and Rationale

This research study was designed to address one research question and associated supporting question:

RQ1: What are the lived experiences of veterans that have been affected by homelessness and substance abuse that might influence their healthcare, social, and economic wellbeing?

The phenomenon central to this research study was the lived experiences of veterans who have been affected by homelessness and substance abuse that might influence their healthcare, social, and economic wellbeing. To address these research questions and the phenomenon, a general qualitative research approach was used in this

study. A qualitative process involves using nonnumerical data to express the findings of a research study (Aspers & Corte, 2019). Another characteristic of qualitative research is that it is highly subjective since the researcher plays an active role (Glesne, 2016). Qualitative research is a broad range of specific research designs applied in a study situation. The conventional methods include phenomenological, case study, content analysis, exploratory, and one-on-one interviews (MacLure, 2017). I used a personalized interview research design. The appropriateness of this technique depends on the purpose of the current research, which for my study was to explore the lived experiences of veterans who are homeless and with substance abuse disorder. The most significant results could best be obtained by directly having an in-depth interview with the veterans. A fundamental advantage of a one-on-one meeting is that it gives the researcher liberty to gather as much information through probing the respondent, which would not be possible using a quantitative approach.

Role of the Researcher

Since the study is qualitative, I took an active role in the entire research process. Most importantly, I collected, analyzed, and interpreted the data. I also was responsible for ensuring that the respondents' information was safely stored and not used for malicious purposes. Lastly, I had the ethical responsibility of reporting valid and factual results based on the outcome provided by the respondents.

I took special consideration to ensure that I had no professional or personal relationships with any participants. I did my best to conduct the interviews face to face to observe body language and facial expressions. It helped with an accurate assessment of

the information gathered from the participants. There were follow-up questions to ensure that the issues were clearly understood. Still, I did not attempt to lead or coheres the participants into answering the questions in any manner other than what was genuinely their experience. It helped to prevent any bias that may have been perceived.

I obtained permission from the IRB before approaching participants. After receiving IRB approval (approval number 03-09-21-0304382), I was respectful of any of the participant's beliefs and had an understanding that they may become sentimental during the interview. Therefore, the questions were self-reflecting to gain their personal experiences rather than seeking any preconceived answers. It also helped to ensure to ask the relevant issues.

Methodology

Participant Selection Logic

Texas has the second-largest veteran population after California (Texas Workforce Investment Council, 2016). As of 2014, the number of veterans living in the state was approximately 1.4 million. The large size of the target population makes Texas the right site from where rich information about the veteran's experience can be developed. The demographics of the veteran population in the United States differ significantly from that of the nonveterans. According to the Texas Workforce Investment Council (2016), most veterans in the United States, including Texas, are non-Hispanic whites (78%), while the non-White minority comprises approximately 68%. Also, about 91% of the veterans in the United States are male.

Most of the veterans of the age of 25 years and older have more post-high school qualifications; that is, some college or associate degree, and bachelor's degree than the nonveterans (64.9%) and (53.3%); Texas Workforce Investment Council, (2016).

I focused my study on homeless and drug-abusing veterans; therefore, purposive sampling was used. A purposive sampling design targets respondents whose characteristics are predetermined based on the study's objectives (Etikan et al., 2016). Sampling in research is the process of selecting a subgroup of participants from a more substantial target population so that the sample chosen represents the target population (Etikan et al., 2016). The relationship between the model and the target population is based on the purpose of the study. Therefore, it is imperative that the sample selected for the examination yield as accurate and representative information as it applies to the general population. For the present study, the inclusion criteria were as follows: (a) classified as homeless for at least one year; currently, (b) be enrolled in a temporary housing program, and (c) have been diagnosed with a substance abuse disorder or are administered treatment from substance abuse disorder. As such, the sample included veterans who are no longer homeless or actively abusing substances due to recovery efforts. In addition, the participants had to be psychologically fit to give accurate information for the study to ensure data quality.

Furthermore, participants may have included those currently in drug and substance-abuse management programs, including counseling. The researcher was able to recruit participants that met the requirements provided.

The study was proposed to include a minimum of 10 and a maximum of 25 participants. Boddy (2016) explored the issue of sample size in qualitative studies. The critique informed Boddy's research that qualitative research lacks proper sample size justification. Therefore, I sought to determine the appropriate sample size for a survey. The results indicated that the sample size of qualitative research is dependent on several factors, including the homogeneity of the sample population, the specific type of qualitative research, and the underlying paradigm. According to Boddy, if the sample size is uniform, the average sample size should be approximately 12 participants in most studies. Include information about how many participants you did have in this paragraph.

Metraux et al. (2017) suggested that saturation is a significant determinant of sample size in a research study. Data saturation in qualitative research is the point at which collection or analysis of more data is considered unnecessary (Saunders et al., 2018). For example, suppose a similar response is obtained from more than five respondents. In that case, it becomes logical to conclude that more answers to the same question are likely to elicit the same results. As such, it is reasonable to stop the interviews at that point. It is, however, crucial to be careful while determining the position of saturation. When the researcher perceives this point is reached, collecting more data becomes unnecessary. As a result, the specification of the preferred sample size in qualitative research design may be avoided because of the uncertainties of the saturation point (Saunders et al., 2018). In some cases, the saturation point may reach the objective before reaching the target sample size, while in other instances, saturation may

not occur until there are more respondents. Therefore, include whether saturation was met and after how many participants.

Instrumentation

A data collection instrument is a material or technique used to collect the respondents' research data (Drake et al., 2017). The choice of an appropriate device is dependent on the study objective or the general nature of the research. There are several instruments for collecting data. However, the data collection method also determines the selection of the appropriate tool for obtaining the same. The interview is a data collection technique that involves a conversation between the respondent and the researcher either directly or indirectly (Alshenqeeti, 2014). Direct interviews are the most dominant types and involve the researcher asking questions from a given research instrument while the respondent answers appropriately. My interview guide appears in Appendix A.

I collected data through interviews. Interviews were selected because of the general qualitative research design. It enables participants to provide as much information as they can. In addition, interviews allow a researcher to probe in cases where clarification is necessary, for example, if the researcher believes that the participant may not have understood a given question (Bryman, 2016). To effectively obtain the information from the respondents, I used an interview protocol to guide the interviews. An interview protocol is a set of open-ended questions used to elicit a response from the study participants (Coolican, 2017). The open-ended interview protocol is vital since it enables participants to provide adequate information from which themes can be derived (Coolican, 2017).

An interview protocol can be designed specifically for the present study or already developed, used several times, and validated to collect data (Neumann & Neumann, 2018). Since there was no preexisting and validated instrument for capturing relevant information for the present study, I developed a semi-structured interview protocol with guiding questions based on the research problem, purpose, issues, and background literature. The interview protocol was designed to capture the participants' relevant information, including demographic information. All questions were asked of all participants to explore participants' responses further.

Procedures for Recruitment, Participation, and Data Collection

The study was conducted in Houston, Texas. Texas has the second-largest veteran population after California (Texas Workforce Investment Council, 2016). As of 2014, veterans living in the state numbered approximately 1.4 million. The large size of the targeted population made Texas the right site from where rich information about the veteran's experience can be developed. The demographics of the veteran population in the US differ significantly from that of the nonveterans. According to Texas Workforce Investment Council (2016), many of the veterans in the United States, and hence Texas, are non-Hispanic whites (78%), while the non-white minority comprises approximately 68%. Also, about 91% of the veterans in the US are male, and the remaining 9% are females. Many veterans aged 25 years and over have more education qualifications (37%) than 28% of the nonveteran population. Texas State, where many veterans 66% are non-Hispanic whites, the remaining percentage is distributed among the ethnic minority groups. Also, 90% of veterans in Texas are male; the remaining proportion is

females. Also, veterans of the age 25 years and older have more post-high school qualifications; that is, some college or associate degree, and bachelor's degree than the nonveterans (64.9%) and (53.3%).

The researcher used qualitative data to address the research questions in this study. Primary qualitative data were used in the study. The data were collected through interviews. Data is critical in a research process since it provides the foundation on which reliability and validity of the survey are built hence, the rigorous nature of ensuring that data in any given study is obtained as accurately as possible. A problem regarding the research data can subsequently affect the entire outcome of a research. Therefore, this section must have careful development to ensure that the result of this study is valid and reliable.

The researcher recruited participants through two institutions in Houston, Texas: Star of Hope and the Michael E. DeBakey VA Medical Center. These institutions help veterans with issues of homelessness and substance abuse. As such, they likely have adequate data on veterans, both of whom are currently affected and those who have recovered from drug abuse and are no longer homeless. Considering the possible relation and attachment of the institutions and the rehabilitated veterans, the researcher will ask the institution to identify veterans who could be critical informants to the study. The assumption was that these institutions better understand the veterans' personalities, characteristics, background, mental and physical health conditions. Additionally, the workers from the two institutions are better placed to identify the veterans who are likely

to cooperate. Based on the recommendation and collaboration with the institutions, the veterans were requested to participate in the study.

With participants' permission, video or voice-recording techniques were used to ensure that the information was accurate when analyzed. Each meeting lasted less than approximately 50 minutes. There was a request through Walden University's IRB to have an alternate method for conducting interviews if the face-to-face sessions were unavailable. The application would have allowed the researcher to perform the interviews using the Zoom or Microsoft team's conferencing system if needed. In addition, it would have mitigated any social distance problems, but it was not required.

Data Analysis Plan

The researcher used thematic analysis to analyze qualitative data collected in this study, in conjunction with NVivo qualitative data analysis software. Thematic analysis is the development of trends and themes from a given data set (Braun et al., 2018). These themes make sense of qualitative data. Researchers often summarize the data provided by the respondent and assume that the analysis is adequate (Gregory et al., 2015). However, thematic data analysis is not only about analyzing the content of qualitative data; instead, it involves examining the deeper meaning of a set of data. As Braun et al. (2018) argued, thematic analysis has semantic and latent meanings, representing the former. The former represents the surface meaning derived from the given data set, while the possible purpose is more in-depth or insightful.

A thematic analysis follows six steps or stages, which are observed iteratively. The first step involved familiarization with the data. All interview transcripts were

uploaded to NVivo and read and re-read to become acquainted with the kinds of responses in the various transcripts. The second step involved the generation of the codes from the data transcripts provided. For every transcript using NVivo, researchers can code meaningful passages and segments of text to nodes or storage points in the program and generate titles for the codes. Making more codes provided the researcher with a wide range of data from themes developed. The third stage was the development of ideas. It involved formulating plans based on the codes that seem to occur frequently in the dataset. The benefit of NVivo was that it allows for storage and organization, and therefore easy retrieval, of the hierarchy of codes, subthemes when appropriate, and themes. Both major and minor issues were generated herein. The fourth stage was a review of the ideas. If two or more independent researchers are analyzed at this stage, the analysis reveals a concurrence of the related themes. The fifth stage involved refining the ideas to select primary and minor subjects. The last step was the write-up of the study findings.

Trust Concerns

The issue of trustworthiness arises because of the active role of the researcher. A concern in qualitative research is the vulnerability of the data to manipulation by the researcher. For example, the researcher may manipulate the outcomes to fit their expected results, impacting the validity and reliability of the study. Another issue related to trustworthiness is how the researcher can keep confidential information generated from the interview, hence the need for ethical considerations.

Peer review is yet another way to examine the credibility of research work, leading to trustworthiness. Fellow academicians, peers, and colleagues should be allowed to offer their feedback regarding a project like the one carried in this work. Fresh input from other scholars may challenge certain assumptions that have been carried out by a researcher and new perspectives given that would detach the project from a researcher. In addition, observations by a peer may help a researcher refine their methods and develop more credible ways of looking at their task.

On the other hand, Reflexibility would help a researcher review their project from time to time. Reflective commentary is applied in this case to assist in making all the methods within a research work appear valid (Connelly, 2016). Moreover, reflexibility would help a researcher, in this case, look at emerging patterns that may need to be applied within their research, making it more trustworthy.

Saturation is the other method for bringing credibility to research to trustworthiness to be attained. Saturation takes place in the data category so that there is quality in qualitative research. Therefore, researchers should ensure they have achieved data saturation in their work as they arrive at their conclusion. This way, it becomes easy to bring credibility and transparency to research.

On the other hand, prolonged contact allows a researcher to be at the site of data collection for a long time to have trust with participants, get rid of distortions, and have a broad aspect of variation. The period may be up to a year to ensure research that is carried outcomes in a transparent manner that can be trusted.

Transferability is an essential part of research as readers use it in using research work that has been concluded. Transferability is the same as external validity. This method, when applied generously, would make a reader use the implications of a researcher and utilize them for their work. Under this method, researchers should ensure they offer their readers thick descriptions, use a variation method that is full thick descriptions, use a maximum variation method, and work rich in content (Connelly, 2016). In short, a researcher's work should be credible enough to be used in a more significant population.

Dependability in research work means that in looking at the issue being examined, even if the study were carried from one time to the other, through the use of similar methods, similar participants, and within the same context, the same findings would crop out. Therefore, dependability, the process in research work, should be looked at from time to time in a detailed manner. A researcher in near times looks at the action once again and gets similar results.

Conformability ensures that research work has been carried out scientifically, and it is not dependent on the skills of humans or perception. There should be objectivity that is accurate within research without bias from the investigator in any way. A researcher should not have intrusions within a research work to ensure credibility is up to the task and well addressed (Connelly, 2016). Conformability, the results, and findings should be due to informants' thoughts and experiences and not the researcher's preferences in doing this research on homeliness and drug abuse in veterans in Houston, Texas.

Reflexivity is applied in ensuring there is conformability within a given research work. Researcher should examine their selves and the relationship they got with research work. A researcher should know the kinds of words they are using and how they can affect their research, and such situations should not be brought close to research work for credibility to be there.

Intra- and intercoder reliability should also be used in research work to ensure reliability and for it to be acceptable by other scholars. The terms mean that there should be a detailed analysis of the materials that have been written. Intercoder reliability ensures two investigators are used in the coding of articles; on the other hand, in tricorder reliability, in the manner consistent in the way the researcher does their coding.

Ethical Procedures

The nature of the present study involves sensitive information such as drug and substance abuse and homelessness, which participants may not wish to be disclosed. As such, the security of the information provided areas of concern. The participants were assured of the protection of the data. (see Appendix B) The voice recordings were stored digitally in files protected with password security and saved in secured servers where only the researcher can access them. The physical tapes will be destroyed after their contents are stored digitally and used to complete data analysis. Since the study involves human subjects, permission was obtained from the Walden University Institutional Review Board. Approval through tape-recorded consent was also collected from participants before data collection commences.

Noting that the information contained in this research work is susceptible, there was a need to ensure that there are agreements between participants and their researchers when it comes to data. For example, when going for documents from the IRB application, only the authorized personnel should access the given information (Pietilä et al., 2020). In other terms, the records should be kept in safeguarded premises to ensure no person gets them. In addition, computers used to store the papers should be well backed up and protected by the use of passwords to ensure no single person gets to access the files (Pietilä et al., 2020).

Regarding the ethical concerns in the recruitment of materials and the ways to address them, it should be noted that participants who take part in research work should not be related. In such a way, it would be easy to minimize the conflict of interest that may come up. Moreover, it would help ensure that a research work through data collection is precise and not biased. Participants should be allowed to read the terms and conditions of the research work. Withdrawing should happen before data collection begins unless there is an unavoidable situation.

Summary

This chapter provided the research methodology and design to address the proposed study's research problem, purpose, and question. In this study, the researcher used a qualitative research design. Phenomenological research is used since the study is concerned with the lived experience of the veterans. Correctly, the study used the focus of private interviews to collect data for the analysis. A minimum of 10 and a maximum of 20 respondents will be used in the study. The inclusion criteria in the study are that

participants are at least in their stable state of mind. Further, the study ensured that only participants recovering from substance abuse disorder; or under a treatment program were included. The collected data were analyzed using thematic analysis.

Chapter 4: Results

The purpose of this study was to explore the lived experiences of veterans that have been affected by homelessness and substance abuse and how these experiences impact their health care, social, and economic wellbeing. To address this purpose, I developed one research question: What are the lived experiences of veterans that have been affected by homelessness and substance abuse that might influence their health care, social, and economic wellbeing?

I present the results of this study in this chapter. First, I describe the research setting, participant demographics, and the data collection process. Then, I explain the process I used to analyze data, including discussing the evidence of the trustworthiness of data, before presenting the results. A summary paragraph highlighting the main findings concludes this chapter and transitions to Chapter 5.

Setting

The conditions of the research setting were affected by the COVID-19 restrictions. In this context, the organization I originally planned to work with and other shelters were restricted, so I could not include the participants from those organizations. Thus, I was forced to recruit participants differently for this study. In addition, since I had planned to use the primary organization's facilities for conducting interviews and could not due to COVID-19 restrictions, I interviewed some participants via the telephone. As a result, a few participants met me near the facilities.

Additionally, I visited some of them at their homes and interviewed them one-on-one. Besides, face masks had to be worn and adhere to social distancing protocols for

conducting the interviews due to the pandemic situation. Finally, I faced significant issues due to the ongoing COVID-19 restrictions. It created substantial challenges because it was difficult to record audio at times. The modification was because I had maintained distance while conducting interviews. However, I was able to play it repeatedly to understand the participants' responses.

Since the ongoing pandemic has affected many people, the participants were often conscientious about their interview approach. Hence, this situation had a significant impact on the overall recruitment process. The participants who allowed me to interview them were protected by wearing a mask, and I checked my temperature in their presence.

Demographics

Participants were men and women of all ages, ethnic backgrounds, and experiences. Seven participants were over 55 years old, and the other six participants were between 21–35 years old. There were nine men and four women. Only 12 participants answered the question about combat status; seven participants experienced combat during their military service, and five did not. Participants served in different military branches and worked in positions like health care specialist, cook, generator mechanic, and truck driver. Of the 12 participants who responded to military injuries or illnesses, ten reported receiving some injury or illness while in the military.

Table 1 presents the participant demographics of the different participants that were interviewed.

Table 1

Participant Demographics

Participant	Age	Gender	Ethnicity	Combat Status	Current Homeless Status
Al	55+	M	Hispanic	Y – Gulf War	No
Big Tex	21-35	M	African American	Y – Iraq and Afghanistan	No
Crow	21-35	M	African American	N	No
JF	55+	M	White	N	No
Lady CW	55+	F	African American	Y – Iraq	No
Lady RT	21-35	F	African American	Y – Iraq	No
Lady T	55+	F	Hispanic	Y – Iraq	No
LJ	55+	M	African American	Y – Gulf War	Unclear
Madam	21-35	F	White	N	No
OD	55+	M	White	N	No
Squid	55+	M	White	N	No
WS	21-35	M	African American	N	No
YS	21-35	M	African American	Y - Afghanistan	No

Data Collection

The data collected for this study was mainly primary, as face-to-face interviews were conducted with the participants. Additionally, some of the participants were interviewed over the telephone. In this context, the primary data collection method was the interview. The reason for using interviews in this research was that it allowed obtaining information on the lived experiences from the participants. The information collected through interviews was expected to be highly accurate compared to other data collection approaches (Denzin & Lincoln, 2011). Thus, I was also able to clear up irrelevant or inaccurate responses given by the participants. I did this by explaining the questions correctly to the participants. A total of 13 participants were selected to obtain relevant data and information. They were all from Houston, Texas. Out of the total 13 participants, two were found in local homeless shelters, and four participants were residing in their respective homes. Each of the participants was interviewed once. The duration for a single interview lasted 50 minutes.

Furthermore, I used an audio recorder to record the participants' responses. I gave two questionnaires to the participants, as most of the participants did not want me to record their responses. Nevertheless, I obtained adequate information to understand the relationship between alcohol abuse and homelessness.

The interviews were conducted in various locations in Houston, Texas. I had planned to recruit participants through a critical organization, a homeless shelter. However, one key variation was initially reported in the methodology. The variation was that I focused on handing out a business card with the same information rather than

posting the flyers at the homeless shelters. However, the shelters were concerned that any potential participants would not see it. Therefore, I recruited 13 participants with whom I conducted the interviews by handing out information on business cards. At the time of recruiting participants, I faced extreme difficulty. It was because of the ongoing restrictions implemented by the homeless shelters, including the organization I had planned to recruit participants. Thus, I applied a snowball method for recruiting the participants. Snowball sampling can be defined as a recruitment process wherein the research participants are requested to help researchers identify potential subjects.

Additionally, the currently registered research participants are used for recruiting additional participants for the research (Ghaljaie et al., 2017). Thus, the shelter organization recommended some former homeless veterans with whom I could conduct interviews.

Additionally, the people who took the business card also called me to interview them. The recordings of the interviews have been kept securely in a password-protected file. I will further ensure maintaining the individual files for the time required by Walden University.

Data Analysis

- Data for this study came from veterans who had experienced drug and alcohol abuse and homelessness. After I interviewed participants using audio recording, I transcribed all interviews, allowing me to listen, read, and review what participants discussed in their interviews. First, I transcribed interviews in MS Word. Then, I uploaded each transcript into

NVivo qualitative data analysis software, which is a tool that helps qualitative researchers organize and explore data. Finally, I used thematic analysis to analyze data in NVivo. Thematic analysis is a qualitative data analysis method that Braun et al. (2018) developed to explore patterns or themes in textual data. There are six steps to this process, which I employed to analyze interviews.

The first step of thematic analysis is to become fully immersed in the research data (Kothari, 2004), which I accomplished first as I transcribed the interviews and then during subsequent readings of the transcripts. It gave me a greater sense of the whole before analyzing data in greater detail. In the second step, I coded each interview transcript. I accomplished this by reading each transcript line-by-line and highlighting essential segments of text that related to the research questions and participants' experiences of alcohol and substance abuse and homelessness. An example of coded passages is shown in Table 2.

Table 2

Samples of Codes and Participant Statements

Code	Passage of Text
No substance abuse before military	"I wouldn't say that I did, but I experimented like any teenager would. Nothing too out of control." (Crow)
No substance abuse before military	No, I didn't. I did drink, but very little." (Lady RT)
Drinking embedded in military culture	"It's continual like it's every time we have downtime, we party." (Lady T)
Tried on own	"I tried a lot of different things, but I started going to church." (YS)

Once I completed the second step, I had a list of codes from all interviews. Table 3 presents this list of codes. Then, I moved to Step 3 of thematic analysis.

Table 3

List of Codes

Codes	
No substance abuse before military	Self-medicating with substance and alcohol.
Drinking as a problem before military	AA or similar
Pre-military alcohol consumption level	In-patient treatment
Consumption increased while in military	Tried on own
Drinking embedded in military culture	Substance abuse did not lead to homelessness
Military injury and abuse	Alternatives to medication as treatment
Preparation for transition	Length of time in treatment
Transition experience	Stop caring about responsibilities
Shock to move from structure to freedom	

In Step 3 of thematic analysis, I reviewed the codes from Step 2. Next, I began to combine codes that were similar into more significant categories. I did this by reading each code title, reviewing the code's contents, and then dragging and dropping codes together in NVivo. Next, I repeated all codes that could be placed into more significant categories or possible themes. In generating these themes, I gave them each an initial descriptive title that described the category's contents. Then, in Step 4, I reviewed in greater detail the themes I generated in Step 3. I again reviewed the code placement and text segments in each code, ensuring proper and proper placement. The excerpts of participants' interviews told a complete story about the experience. In some cases, I adjusted the categories and codes. I generated the subthemes that supported themes three and four in this step.

In Step 5, I named the themes and subthemes I generated in Step 4. Table 4 presents the alignment between the themes, subthemes, and codes. Then, in Step 6, I brought each of these steps together and drafted the results, which I present in this chapter.

Table 4

Alignment of Themes, Subthemes, and Codes

Theme	Subtheme	Code
1. Substance or Alcohol Use Was Not a Problem Before Military Service	No discernible subthemes	no substance abuse before the military, drinking was a problem before the army, pre-military alcohol consumption level
2. Relationship Between Substance or Alcohol Use and Military Service	No discernible subthemes	consumption increased while in the military, drinking embedded in military culture, military injury, and abuse
3. Transitioning from Military to Civilian Life	Preparation for Transition	preparation for the transition, self-medicating with substance and alcohol
	Transition Experience	transition experience, the shock to move from structure to freedom
4. Substance and Alcohol Abuse and Homelessness	Approaches to Treatment	AA or similar, in-patient treatment, tried on own
	Substance Abuse Contributed to Homelessness	substance abuse did not lead to homelessness, alternatives to medication as treatment, length of time in treatment, stop caring about responsibilities

Evidence of Trustworthiness

Credibility

I ensured that the conducted study was credible enough to derive satisfactory conclusions. Herein, I focused on making sure that all the participants were veterans. After interacting with the participants for some time, I realized that their experiences were genuine in the true sense. Additionally, the collected data were analyzed using NVivo for comparing the responses, while coding was done based on the obtained findings. In this way, the credibility of the data is maintained.

Transferability

The reason is that the respondents were from diverse backgrounds, thereby making it possible to generalize the results to the rest of the population. Also, the interview process allowed the interviewer to ask probing questions to gain a deeper insight on critical issues for veterans from areas of Houston, Texas. The information is found to help gain adequate details for understanding the reasons for the growing homelessness of the veterans in their respective units. Thus, the data focused on contributing factors for veterans to be homeless.

Dependability

The findings obtained from this study are dependable. The secondary sources were up to date. Also, the respondents were conversant with the topic under study. As a result, the results obtained were credible and reliable for use in policymaking or to conduct further research. I was further able to maintain dependability by ensuring that all

the participants were asked the same questions. However, there was an instance wherein I made changes considering that the participants did not understand specific questions.

Conformability

After completing the interviews, I listened to the recorded information. It was to ensure that the responses of the participants were presented. I further confirmed that the information could be transcribed while coding the collected data considering the participants. Before conducting the interviews, I read the consent letter to all 13 participants, to which they all agreed. Only then did I complete the interview process. I also provided them with my number and information to contact me whenever required. I could not reach all the participants by showing them the transcripts. The people I was able to reach agreed to the facts that were on the transcript and were accurate in the true sense.

Results

Theme 1. Substance or Alcohol Use was Not a Problem Prior to Military Service

Most participants reported no problems with alcohol or other substances prior to their military service. Only two participants acknowledged a drinking problem before they joined the military, but the problem was with alcohol only, not other substances. Al referred to himself as “a drinker,” but stated, “I won’t say that it was a problem.” LJ also drank prior to joining the military. LJ said he drank “like normal people would drink,” which was when he was off work for the day. LJ reported drinking “maybe a six-pack a night,” which he suggested was what a “normal person” might drink in an evening.

Madam was the only participant who acknowledged her alcohol use prior to the military was a problem, and she represented a discrepant case here. “Yes, I was drinking before I went into the military…the second I got alcohol in my hands, that was it for me,” Madam said, meaning that alcohol was her substance of choice. Madam started drinking at the age of 14, and at 18 lived with her father in Germany, where drinking was normalized and part of everyday culture. This normalization of drinking, coupled with public transportation to protect people from drinking and drinking made Madam feel “it was safe, in a sense, to drink, so that definitely kick-started [my drinking] a little bit.” Other than Al, LJ, and Madam, participants described not only not having a substance or alcohol use problem before the military, but that they had never really used alcohol or other substances at all. Squid referred to himself as a “spring chicken” when he joined the military and said that he did not even take pain medications before entering the military. Big Tex was also young when he entered the military, so had no real opportunity to spend his leisure time drinking or taking drugs. “I was too young to drink, and my mother didn’t play,” said Big Tex, “I never use any pills or even Aspirin; all of that stuff made me sick.”

JF also described the impact of a strict parent on his drug and alcohol use. “My dad was really strict, so no, didn’t do no drugs back then,” said JF. He described his surprise upon joining the military and seeing “all my new buddies, there it is, there it is.”

Others talked about casually experimenting with drugs and alcohol before entering the military but did not view themselves as having a problem with either. Crow said, “I wouldn’t say that I did [have a problem], but I experimented like any teenager

would. Nothing too out of control." YS experimented in a similar way. "I may have smoked some weed once and I used to drink with my uncles, but I won't say it was an abuse problem," said YS. WS, who also drank casually before entering the military, said,

> I did drink a little bit, but I thought that I was going to put that aside when I went into the military. Instead, my drinking habit got worse. The work that we had to do was very hard, so we had a lot of parties when we got off from work.

WS's experience appeared typical of the experience of many participants who did not drink or abuse other substances prior to joining the military. Upon entering the military, participants discovered their substance and alcohol consumption and use changed and identified a direct relationship between the military and an increase in drinking. This relationship is the subject of the next theme.

Theme 2. Relationship Between Substance or Alcohol Use and Military Service

Despite participants' lack of use of alcohol and other substances prior to entering the military, once participants were in the military, they noted an increase in their alcohol consumption and attributed this to being in the military. The relationship between the military and substance and alcohol consumption is the topic of this second theme.

Not all participants began abusing drugs and alcohol during their military service, but many described an increase in consumption. Al, who was in his mid-20s when he joined the military, was the only soldier old enough to buy beer, and quickly became a favorite friend of the younger soldiers. Al explained how this contributed to his drinking problem:

> I was the only one who was over 21 and I could go in and buy the alcohol for the youngsters. You know that I'm not going to buy without getting my fair share, either. So, they made sure they hooked me up with a little something extra at times. I didn't have a lot of rank, but they looked up to me and I ended up being the life of the party most of the time. The only problem is, I ended up being the drunk of the party most of the time. And man, did we ever have a party. When it was payday, we would party until we pretty much got broke. But I will say that if anything, it would be the parties and the young soldiers wanting to drink because they are not being looked at by their parents.

Big Tex also described the partying that occurred when he joined the Army. He said that he did not drink much before joining the military, but after joining, "all we did was have parties. We even partied before and after the parties sometimes." Like Al, Big Tex attributed the partying and alcohol consumption to the young age of adults who join the military and are on their own for perhaps the first time in their lives. "It is not good for kids that just got out of high school and now they have money to buy whatever they want, and most of it is alcohol," Big Tex explained.

Big Tex and Al described the crux of the issue, which was that drinking and, to a lesser extent other substance use, was embedded in military culture. Lady T described this in greater detail:

> You are away from your family in a foreign country, and you have to make the most of your environment. So, there will be downtime and we would have, you know, somebody might be coming in with some alcohol…And when you're in a

> party, you know, you guys are partying together, hanging out. This is your group, So, it's deemed okay…But it's continual, like, it's every time we have downtime, we party…Whatever the reason is, we find ourselves on the base in our rooms partying, drinking, or whatever anybody pops up to do, we were opened to doing it.

The situation that Lady T described in this excerpt further underscores how partying and drinking were embedded in military culture. The amount of partying that occurred in the military was precisely how Lady RT became caught up in this lifestyle of abusing alcohol. "The young soldiers drink all the time," Lady RT explained. She continued, "The soldiers that are too young can just get the older one to get it for them. That's how I got my alcohol when I was underage."

YS also described the culture of partying in the military. "I think that the environment in the military is there, because we have people from all over these different states," said YS. YS believed that, because of the range of backgrounds, "It kind of feel like we are competing with each other to see who have the best parties where we are from. That's the environment that do make us drink so much."

Participants described how their time in the military increased their drinking, drawing a direct link between joining the military prior to the legal drinking limit and being away from home for the first time to partying and drinking too much. For most participants, this is when their problems with drinking began. However, most of these participants only had problems with alcohol abuse and not substance abuse, and there was a clear reason for this. Drug testing in the military was a common occurrence and so the

workaround was to consume alcohol instead of other illicit substances. Squid explained that “the military was big on urinalysis and stuff like that, so you just didn’t want to get caught up with that. YS also noted this when describing why soldiers prefer drinking to other substances:

> When it comes to substance abuse, I don’t think there is a lot of that in the military because they piss us too much. If you have a problem in the military, you will get caught after a while. With the drinking, you can wear that off before the formation the next day.

Participants articulated a relationship between the military and increased consumption of alcohol, but not other substances. Indeed, for most participants, their time spent in the military was when their problem with alcohol began. Participants attributed this to the frequent partying that occurred, and that the military’s use of drug testing kept other substance use at bay, but still allowed for excessive drinking. Once participants were out of the military, their excessive drinking continued through their transition and into civilian life.

Theme 3. Transitioning from Military to Civilian Life

The subject of this theme is the experiences participants had when transitioning from the rigorous structure of the military to the freedom of civilian life, and how this impacted the alcohol and substance abuse problems they developed during military service. Two subthemes supported the creation of this theme: preparation for transition, and transition experiences with substance and alcohol abuse. Both subthemes highlight different facets of the transition experience.

Subtheme 3A. Preparation for Transition

Most participants described a relatively positive transition from military service to civilian life. These participants believed that, for the most part, the military had done a good job of preparing them for the transition out of the military. When they did not feel prepared, they blamed this on themselves. Al said that he still worked around the base as a civilian so "I didn't take the training serious at all…I guess after being a civilian working around the base, you don't get a transition." Al said that, had he known that he was going into civilian life, he would have done more to prepare. JF said he was ready to leave the military and become a civilian at the time, and that he had adequate preparation. However, looking back, JF said, "I wished I had stayed in. I would have been retired and done something else."

Lady CW desired better preparation for the transition and said she felt a little stuck after she left the military. This contributed to her substance abuse. Lady CW said,

> There should be some trial period, like basic training, to get us adjusted to civilian life. I was not prepared. And once I started taking the medicine they gave me, I became dependent on them…I was getting out of the military with a problem I didn't have before I went in…I should have known this would not be good for me and stayed in the [military] until I was better…I was just stuck out there. Felt like I was set up for failure. I didn't have a clue how civilian life was supposed to work for me.

WS said, "The military made a real good attempt to give us a good transition," and YS said, "they tried to do a good job." OD, however, felt differently, and represented

a discrepant case. OD joined the military and went to boot camp, where he suffered a back injury that led to a discharge only two months into boot camp. OD said that, due to his discharge from boot camp, there was no preparation for the transition. “They didn’t, just let me go back home,” said OD. OD recalled feeling as prepared as possible at the time to move into civilian life but said he did not like that “I joined the military to do something with my life and now, I was not going to be able to complete what I started.”

Participants overall had positive transitions to civilian life but described the shock that came with moving from a structured environment to one with more freedom. Participants like Lady CW said they felt like they were ready for the transition but quickly found they were not. “My very disciplined lifestyle was all out of order. It was hard to cope with being an everyday person,” Lady CW explained. Lady T described the challenge similarly: “You’re excited about the new step in your life, but when you actually get out, the transition is challenging…you’re used to a regimented routine.” Lady T said she felt “discombobulated” and “out of sorts.” Madam found the transition “very much a shock” and likened the experience to moving from a structured household with a parental figure to suddenly having freedom.

Subtheme 3B. Transition Experiences with Substance and Alcohol Abuse

The drinking problems that participants developed while in the military continued as they transitioned out of the military, and those who developed further substance abuse issues did so during this transitional period. When participants transitioned out of the military, they began to self-medicate both their physical and emotional injuries. After Al was back in civilian life, his leg injury started to bother him again, but the drugs the VA

gave him for the pain did not help. “I do know that they made me feel bad and I stopped taking them,” Al explained, “They didn’t help the pain, so I went to the real doctor, and that doctor was drinking. It didn’t make the pain go away, but I didn’t really care once I got drunk.”

Big Tex also described self-medicating, an issued a warning:

> I would give you my advice, that if you are injured, don’t do any drinking to help you heal. If you do, just like it was for me, even when you heal, you will have a drinking problem, because it will take a lot of drinking to help you.

Like Al and Big Tex, Crow turned to alcohol to self-medicate. During his transition, Crow said, “the drinking did make the day-to-day malarkey easier.” Squid did, too, saying he used “more alcohol than anything for killing my pain.”

Several female participants also turned to alcohol to self-medicate during and after their transition from the military, often after medication for injuries failed to work. Lady CW recalled leaving the military and moving in with her mom after “doing so well on my own” during her military service. “I started taking medicine for pain, and I wanted the drugs more than anything. It became hard to get the prescriptions, and eventually, I started drinking alcohol because it was cheaper and easier to get,” explained Lady CW. After a while, the alcohol numbed the pain and Lady CW said she drank “to make me feel a little better.”

For Lady T, the pain was more psychological, and she began drinking to cope. Lady T elaborated:

> Well, the antidepressants really, they kind of play on your mental psyche. So, I had to, I stopped taking them on my own accord. Then, I started drinking to help me cope…I had a lot of thoughts of suicide and harming others while on the antidepressants. I didn't like that feeling, so I started drinking, I guess to curtail my hurt…then that became my crutch…There was something about alcohol that took the edge off the pain, the feelings I was having. And so, you know…one drink led to two and then before you know it, it became a comfort thing, where I felt like if I didn't have it, I really couldn't function.

After participants left the military, even when they described their transition experiences as relatively positive, the drinking habits they developed in the military seemed to worsen. This was because participants had a difficult time adjusting to the freedom of a lifestyle without the structure of the military. Participants also used alcohol as a coping mechanism or pain reliever once they were civilians again. From there, participants became increasingly dependent on alcohol and other substances, to which they attributed their homelessness. This is the topic of Theme 4.

Theme 4. Substance and Alcohol Abuse and Homelessness

Participants recognized a link, even if indirect, between their substance and alcohol abuse and homelessness. Only two participants explained that their alcohol and substance abuse problems did not contribute to their being homeless. One aspect of participants' experience with substance and alcohol abuse and homeless was the approaches they had taken to treating their substance and alcohol abuse. This is the topic of the first subtheme of Theme 4. The second subtheme includes a discussion of the ways

in which participants linked their homelessness to their alcohol and substance abuse. In the se

Subtheme 4A. Approaches to Treatment

Participants sought treatment for their alcohol and substance abuse in many places. Three participants joined Alcoholics Anonymous (AA) or similar step programs. Crow had a good experience seeking help through AA, because "I learned that I was not the only one, and my story was quite similar to a lot of others." Lady CW also took advantage of step programs, and this has helped her remain sober. "So far, so good, for many y ears now," said Lady CW. Lady RT described how seeing others at AA that she never expected to see "made me sober just seeing them." Al also went to AA meetings, but unlike other participants who appeared to have made the decision to attend meetings on their own, he was sent to meetings as part of his stay at the Salvation Army. He attended for about six months and said, "that pretty much helped me out a lot by itself."

Three other participants found help through in-patient treatment facilities. LJ's stay was 90 days, and he said that "I felt good about myself and everything." Squid credited a 30-day program for help getting his substance abuse "under control." One aspect of in-patient treatment that may have been helpful was getting away from friends and family who were enabling, and even participants who did not attend in-patient treatment recognized this benefit. Big Tex tried to quit drinking, but said he had "too many family members that was drinking too, so that didn't work." Big Tex said that even the people who were in 12-step meetings with him were "still drinking after the classes," so he had to cut these people out of his life to help himself.

The programs participants attended lasted anywhere from one month to ongoing treatment and recovery. Al went to classes for six months, and Big Tex was in and out of treatment for about a year, during which he relapsed a few times. Big Tex said that now he ushers at his church and "that keeps me good." Crow has attended AA meetings for over a year and said he is "still in recovery." Lady CW has also been in programs consistently for about a year, as has YS, who reported still going to AA meetings because, as he said, "I do not want to fall back."

Participants' problems with alcohol and substance abuse developed while in the military and continued after leaving the military, as participants self-medicated their injuries and illnesses. However, participants had tried myriad approaches to treatment, including 12-step programs and in-patient treatment facilities. As many participants had been homeless or were facing homelessness, this might have been a motivation to work on their alcohol and substance abuse. In the next subtheme, I explore how participants believed their substance abuse problems contributed to their experiences of being homeless.

Subtheme 4B. Alcohol and Substance Abuse Contributed to Homelessness

All participants but one described the problems they had with alcohol and substance abuse before becoming homeless, so there was a clear link between military service, transitioning from military to civilian life, continuing challenges with alcohol and substances, and becoming homeless. JF described using drugs prior to becoming homeless to "feel something different," because he "had so many near-death experiences, I seen a lot of people die."

The connection between substance and alcohol abuse and homeless was very clear to participants. Lady T articulated this connection:

> There was something about alcohol that took the edge off the pain, the feelings I was having. And so, you know, it started off as oh, maybe I'll just have a drink to calm my nerves…It provided a refuge, so to speak, to where I didn't have to feel or have to deal with the things that were going on inside my head mentally. And, over time, once you just continue in a pattern, you know, you lose sight of things, you lose sight of being responsible, of showing up for work, or realizing that you need work to provide your livelihood…So, you're feeling within your own brain, and you're not really concerned as to whether the bills get paid…Before you know it, you have an eviction notice, before you know it, they're repossessing your vehicle.

This spiraling pattern is what led Lady T to become homeless and was also the way that other participants became homeless, too. Crow explained that he was drinking too much, saying, "You kind of get a feeling [your friends] don't want you around no more. When you have no ride home, or not really a home to go to, that is when you know you are really homeless." This path to homelessness was also similar to what Lady RT experienced. She said her drinking was "what broke up my marriage" and that when she and her husband were having problems with drinking, "it led me to just saying the heck with it, I may as well go and live on the streets." Lady RT lived on the streets until the flood, when she began treatment.

OD explained the connection between his alcohol abuse and homelessness:

> I have seen a friend that went downhill and eventually he got to the point that it was so hard to keep him around. It was hard to see him homeless; at the same time, it was hard to having them in your house and so they go from living in a house to the yard and a lot of them end up homeless because the family just can't deal with them anymore. It got that way for me, and that is why I ended up in the position that I was in. I went from the house that I was able to rent in to not being able to pay the rent, because I would use the money to buy beer and other things that I wanted.

Participants were able to clearly articulate the path from substance and alcohol abuse to homeless, and this path was similar across participants. The drugs and alcohol participants used to numb themselves and self-medicate after they left the military became a problem. Instead of only numbing their thoughts and their pain, drugs and alcohol also numbed participants' ability to care about taking care of everyday tasks, like paying their bills, which would keep them homed, either in rentals or in friends' houses. As a result, veterans with substance and alcohol abuse problems.

Summary

I presented the results of this study in Chapter 4. Due to the ongoing COVID-19 pandemic, I relied mainly on phone interviews to collect the data. Of the nine men and four women the researcher interviewed, 12 reported experiencing combat during their military service, while ten reported suffering some type of injury or illness in the military. This study's research question asked, what are the lived experiences of veterans that have been affected by homelessness and substance abuse that might influence their health care,

social, and economic wellbeing? Participants reported that alcohol and/or substance abuse were not problems prior to joining the military, but their experiences in the military led them to alcohol/substance use. After leaving the military, participants' experiences were characterized by self-medicating for the negative health impacts, including psychological, the military had on them. This self-medicating led them to spiral and end up homeless, which participants attributed to their addiction. Participants sought help from many resources to get sober, and all participants reported no longer being homeless at the time of interviews. In the next chapter, I will discuss the four themes from data analysis in greater depth and in relation to the extant literature on the topic. Additionally, I will describe the limitations of this study and present recommendations based on these findings.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to determine the relationship between substance and drug abuse and homelessness among veterans. I explored the lived experiences of veterans that have been affected by homelessness and substance abuse. I also examined how the plight has adversely affected the healthcare, social, and economic well-being of the veterans in the United States. The findings can contribute to social change by providing national policymakers with firsthand accounts of homeless veterans who struggle with substance abuse. Therefore, the study answers the question, "What are the lived experiences of veterans that have been affected by homelessness and substance abuse that might influence their healthcare, social, and economic wellbeing?"

Interpretation of Findings

The responses apply to a greater population than the study sample. Therefore, the findings and results herein can be used to make inferences and generalizations about the larger population (wellbeing of the veterans in the United States). When asked if substance abuse was an issue before joining military service, only one respondent (out of the 13) reported having a substance abuse problem before joining the military. This response conforms to the military enlistment standards of drugs and substance abuse in the United States. Typically, the standards state that any alcohol or drug-related conviction before joining the military will be disqualifying and require a moral waiver to proceed with the recruitment process (Department of the Navy, 2005). Furthermore, most military institutions in the United States have zero tolerance for drugs and substance abuse; a drug test is required before entry (Pinckney, 2019).

Ten respondents reported that they had not used any substances or alcohol before the army. However, these respondents also confirmed that several situations pushed them to drug and substance abuse after joining the military. One such circumstance was peer pressure, and this agrees with Padhy et al. (2014), who outlined that one of the prevalent causes of substance abuse among youth is peer pressure. Two participants attributed peer pressure to uncontrollable partying and alcohol consumption among the young adults who join the military and are on their own for perhaps the first time in their lives. According to Brian and Carey (2006), peer pressure works the same way with drugs as with alcohol. Alcohol consumption is more accepted and popular among minors than illicit drug consumption (Dhull & Beniwal, 2017). Illicit drugs have a stronger link to criminal activity and effects outside of the social group. Peer pressure can push someone into uncontrollable behavior. It could also lead to dangerous short-term behavior and plant seeds for long-term, harmful habits (Brian & Carey, 2006).

Besides peer pressure, a significant number of respondents reported that alcoholism, drug addiction, and substance abuse were embedded in the military culture. It gives a clear explanation of how the environment can influence people's behavior and motivate them to act. Studies have found that one of the most significant influences on an individual's addiction is the environment. The environment includes an individual's work, home, and school atmosphere. It also comprises of whether the atmosphere accepts and avails alcohol and drugs. Working or living in an environment where drugs are accessible and available increases an individual's vulnerability to addiction (Solinas et al., 2010). Regular or semiregular exposure to substances normalizes drug usage and

makes people more vulnerable to drug-seeking behavior and, as a result, addiction. The U.S. military does not formally condone the illegal or improper use of drugs or alcohol (Golash-Boza, 2014). The Department of Defense's stated contention that illegal drug use and abuse of alcohol, among other things, is against the law (Miller et al., 2013). However, participant responses from my study indicated a connection between alcohol use and military service.

Some participants described their transition from the military to civilian life as positive, while others reported its contribution to their substance abuse. However, for most, the drinking problems they developed while in the military continued as they transitioned out of the military. Those who developed further substance abuse issues did so during this transitional period. Many veterans who have served in the military may have co-occurring disorders such as depression or PTSD (NIDA, 2019), contributing to substance abuse. Most participants in this study used other substances upon leaving the military, especially those who had suffered injuries during their time continued to self-medicate. A 2017 study examining National Survey on Drug Use and Health data found that, compared to their nonveteran counterparts, veterans were more likely to use alcohol (56.6% vs. 50.8% in 1 month) and to report heavy use of alcohol (7.5% vs. 6.5% in 1 month) (National Institute of Alcohol Abuse and Alcoholism, 2019). This health data gives a candid view that most veterans are likely to experience to become more addicted during their transition to civilian lives.

Most participants attributed substance abuse to homelessness. This statement reflects the report published by the National Institute of Alcohol Abuse and Alcoholism

2019), which stated that substance abuse is both a cause and a consequence of homelessness. It frequently occurs after people have lost their homes. From the research, those who struggled with substance abuse sought treatment and worked programs to help them overcome their addiction. That means, although a significant number of homeless persons indeed battle with substance abuse, addictions should be treated as illnesses that require treatment, counseling, and support to overcome. Other challenges participants reported experiencing in their civilian lives included the shift, substance misuse, and homelessness. The same 2017 study examining National Survey on Drug Use and Health data found that 65% of veterans who enter a treatment program report alcohol as the substance they most frequently misuse, almost double that of the general population (National Institute on Drug Abuse, 2019).

Eleven (75%) of the participants in this study recognized a significant link between their substance and alcohol abuse and homelessness. Substance abuse is frequently the result of homelessness, and substance abuse is also the cause of homelessness (National Institute on Drug Abuse, 2019). According to Briggs and Reneson (2017), 38% of homeless persons struggle with alcohol addiction, whereas 26% battle addiction to other drugs. These persons also use substances to find relief from their troubles. Unfortunately, alcohol and drugs exacerbate their difficulties and limit their capacity to live a good life.

Participants had tried diverse approaches to treatment, including 12-step programs such as AA, in-patient treatment facilities, and the 30-day Squid credited program. The programs lasted from 1 month to ongoing treatment and recovery and showed

participants' willingness to seek treatment for their alcohol and substance abuse. Unfortunately, many veterans may not receive the assistance they require because they are hesitant or unable to seek assistance (Ferguson et al., 2021). As a result, they may be at a higher risk of suicide if they do not receive the assistance they require. According to the National Institute on Drug Abuse (NIDA, 2019), suicide rates among veterans are higher than the general population. For example, every day in 2014, about 20 veterans committed suicide.

Limitations of the Study

Since the ongoing pandemic has affected many people, the participants were often conscientious about their interview approach. Hence, this situation had a significant impact on the overall recruitment process. Below are the limitations of the study.

- Restricted access due to the Covid-19 pandemic: My access to the organization and shelters I originally planned to work with was restricted. Therefore, I could not include as many participants in the study as I initially intended. As a result, I was forced to recruit participants in other ways for this study.
- Interferences in the data collection process: Since I had planned to use the organization's primary facilities to conduct interviews and could not due to COVID-19 restrictions, I had to interview some participants via the telephone. Other interviews were conducted in participants' homes which required additional COVID-19 restrictions.

- Poor recordings: It was not easy to record audio mainly because of the required social distancing requirements. Because of this, the audio quality was not very clear, and during transcription, I had to play the audios repeatedly to understand the participants' responses.
- Self-independent data: My data was limited based on participants' interpretations of their experiences. It contains several potential sources of bias like (a) selective memory, (b) telescoping, (c) attribution, and (d) exaggeration.

Recommendations

The study's findings suggest many recommendations for providers, treatment institutions, and governments, as well as directions for future research. Homelessness can be a barrier to treatment for substance-abusing veterans. Targeting homeless veterans in need of treatment and providing support through outreach programs, case management, and housing assistance can help them enroll in treatment facilities and have excellent treatment results. Notably, traditional homeless Veteran housing options frequently demand participants to be sober or participate in treatment programs (Austin et al., 2014). As a result, many homeless veterans cannot access homes that might otherwise be available. Therefore, veterans who are yet to attain sobriety or are still exhibiting symptoms of relapse should consider VA-supported housing. The supported accommodation for homeless Veterans is a VA initiative that provides more than simply a roof over their heads.

The immediate solution to homelessness is housing. These accommodation options offer the houses without preconditions like income, employment, criminal records, and sobriety. The provided services and resources are typically tailored to the veteran's needs. While doing so, the government and affiliate providers should consider establishing rules for using the houses (Spring, 2016). The solutions should also provide short-term rental services to homeless veterans. The goal will help homeless veterans obtain housing quickly, increase self-sufficiency, and stay housed.

Community leaders can consider taking a coordinated approach to address homelessness among veterans. Since individual programs in the past have not been very productive, the stakeholders could consider a community-wide response that is data-driven and strategic. One such strategic solution would be coordinated entry. This strategy identifies, assesses, refers, and connects homeless veterans in crisis to housing and assistance to accommodation help. It paves the way for more efficient homeless assistance systems in three ways; (1) Helping the homeless veterans move through the system faster and obtain temporary houses within the shortest time possible. (2) Reduces new entries into homelessness by consistently offering prevention and diversion resources to homeless veterans up front (3) Improves data collection and provides accurate information on the kind of assistance researchers need to solve this issue.

Furthermore, establishing a plan could help stakeholders set goals and conceptualize what they should prioritize. The procedure can include objectives, processes, goals, and a timeline for evaluating the most vulnerable homeless veterans. It should also have strategic techniques to help measure the progress. Generally, planning brings together

providers, government officials, Continuum of Care leads, and funders to discuss the subject matter of veteran homelessness. Such a gathering will consider how to identify needs, structure assessments, integrate shelter diversion resources, map out existing intake processes, and sketch out a preliminary screening tool.

The stakeholders should also consider having a shared data system to collect program and system-level data on housing homeless veterans (Solari et al., 2020). A common and shared data system has numerous advantages. It adds to a smoother process of pairing individuals, kids, and families with the appropriate resources from the client's perspective. It can also enable a thorough examination of a community's homeless system, which is necessary to analyze incomes and, eventually, improve practice and performance. This strategy necessitates using local data to guide decisions about how to allocate resources, services, and programs to meet homeless needs in the community. Lastly, communities can use performance measures to examine progress and assess what steps they should take to reduce homelessness further.

While more than 7/10 (72%) veterans say transitioning from military to civilian is easy, 27% confirmed that it was tough for them - a figure that rises to 44% among veterans. As of June 2021, the veteran unemployment rate was 4.8%, up from 4.4% in May. The comparable non-veteran unemployment rate was 5.9% in June. Most confirm that what makes the transition daunting is the issue of moving from employment to unemployment. Millions of veterans in the US are financially exposed to homelessness and housing instability because they are unemployed and unable to pay the average rental expenses. Unemployment can lead to inability to pay rent, eviction, dependency on

extended family for shelter, and, in extreme cases, admission to a homeless shelter. That means the solution to these veterans is providing income support programs or unemployment compensation to help them withstand economic crises. Unfortunately, veterans experiencing homelessness frequently find these programs inaccessible, and the benefits provided may be insufficient to assist them in achieving stability. The primary purpose of homeless assistance programs is to help people increase and stabilize their incomes. While some veterans may be able to exit homelessness with a permanent rent subsidy that would protect them from the effects of income fluctuations, the majority will have to rely on income from work or benefits to pay their rent.

Stakeholders can invest in improving pathways to employment for homeless veterans. The availability of work supports for low-income households, such as childcare and transportation assistance, can also significantly impact whether or not a veteran can sustain employment. The stakeholders could also improve income supports programs for the homeless veterans. Despite efforts by the federal government and the community to improve the quality and accessibility of care for veterans, veterans continue to be at high risk of acquiring substance use and mental health disorders. More research into the quality of care provided to veterans and their short- and long-term treatment outcomes would help address the complex problems of treating post-veterans. The recommendations are divided into increasing patient-centered treatment for veteran addicts and expanding treatment accessibility and availability.

a) Increase the use of patient-centered treatment for veteran addicts

Most treatment facilities and providers specialize in either substance abuse or mental health treatment. However, there is an urgent need for these centers and persons to make the following modifications.

- Regularly assess both substance use and mental health outcomes during treatment to address both effectively.
- Include and accommodate veterans' treatment preferences in treatment decisions and offer care in military and veteran-friendly manner.
- Provide patients with a detailed post-treatment plan that focuses on preventing relapse.

b) Expanding Treatment Accessibility and Availability

Improving treatment availability and access for veterans with co-occurring drug use and mental health issues will necessitate a concerted effort by the treatment community. Treatment facilities and providers also.

- Consider measures to increase the capacity of VA medical centers and VA-affiliated hospitals and improve access to services for veterans with co-occurring disorders.
- Reduce barriers to care and encourage treatment facilities to use evidence-based treatments.

From the limitations of this study, I would recommend stakeholders, concerned institutions, and the federal government of the USA to continue establishing comprehensive research strategies for managing substance use disorders among veterans. The study questions might be complicated and vary depending on the demographic

subtype, indicating the need for more research. A 2019 study, for example, looked at the effectiveness of combining therapy for SUDs and PTSD and found that veterans with PTSD and co-occurring polysubstance use disorders may see better improvement in substance use but only minor improvement in PTSD symptoms. On the other hand, chronic pain is a common ailment among polysubstance users in a 2019 study. It demonstrated the need to add interdisciplinary pain management approaches into treatment to prevent long-term opioid medication dependency and promote recovery.

The research shows that parents play a significant role in preventing substance abuse among youth as they join new institutions like the military. For instance, talking with the child about the dangers of substance use and showing disapproval of such behavior are vital to shaping the individual's attitudes and behaviors. This study recommends the need for parents to stay involved in their child's activities even after the youth has joined the military. Capacity building for the newbies in military institutions is also vital in addressing alcohol and drug abuse. Such institutions should also consider creating forums to share experiences and equip the newbies with guidance and counseling skills.

Implications

Homeless veterans with a history of addictions have intimate perspectives on substance use. Their views offer meaningful insights to improve patient-centered care in primary care environments. The general finding that participants spoke openly about addiction is particularly important to service providers in clinical practice. Our findings may be helpful to such clinicians attempting to elicit addiction-related clinical history to facilitate treatment and recovery.

This research study shows a significant relationship between alcoholism and substance abuse and homelessness among veterans. This observation calls for creating awareness against drug and substance abuse among veterans as they join or continue training under a military institution. Individuals should be taught to effectively deal with peer and life pressure, seek help for mental illness, examine every risk factor, and live a well-balanced life. Creating awareness will bring veterans together to prevent non-medical use of drugs. It will also encourage open dialogues between friends and family members about alcoholism and substance abuse (Tsai & Rosenheck, 2015). Awareness sessions should also train individuals on the importance of discussing before taking new prescriptions with their doctor. The result is a well-balanced life characterized by healthy relationships. The individual will also enjoy stability in their individual, family, organizational, and societal life.

For instance, the individual could save and invest the money spent on substance abuse, leading to a healthy economic life. The individual will pay for the average house rent and provide for their basic needs. A well-balanced life also means an admirable social status. It refers to the relative rank of an individual along one or more social dimensions within a given social hierarchy. It includes prestige that is freely conferred deference afforded to individuals based on their virtues. Ultimately, the goal of eradicating alcoholism and substance abuse is to ensure that individuals can accomplish strategic, operational, and tactical objectives in their places of work.

In terms of personalized medicine, more study is needed on how to provide multidisciplinary, collaborative, and patient-centered care for veterans battling addiction

or similar conditions that may jeopardize recovery. Precision medicine research is also necessary to individually customize such interventions to improve care management for patient groups where distress and stress-related usage overlap. However, more research is needed to identify strategies to encourage the subsequent engagement of those who have recovered from addiction into appropriate treatment methods. Contextual factors like age, gender, ethnicity, race, sexual orientation, community resources, economic status, faith beliefs, physical illness, co-occurring mental, and other personal issues will significantly determine the appropriateness and utility of a treatment strategy.

It is also evident from many research studies that detoxification following an arbitrary maintenance period without continuing support is rarely effective in disengaging veterans from addiction and may lead to overdose or relapses over the decades. Therefore, researchers need to conduct more studies to determine if and how patients can transition from (Medication-assisted treatments to non-medication status within "personalized medicine" to provide veterans and clinical staff appropriate therapeutic guidance. For instance, therapies could be effective strategies in stabilizing the lives of veterans struggling with addiction. However, many critical clinical questions remain about whether, when, and how to discontinue the individuals from these medications. It is a vital concern in many other fields of medicine, as maintenance drugs are given without considerable change and sometimes without regard for other clinical developments.

The current failure to acknowledge and address substance use addictions among homeless veterans has reduced the quality and increased the costs of health care. Better integration between primary care and specialty care and additional treatment options

within primary care is needed. Primary care physicians need to be better prepared to identify, assist, and refer homeless veterans when appropriate. If treatment or training against addiction is delivered in primary care, it should be practical for delivery within these settings and engaging homeless veterans (Wells et al., 2013). That means rigorously controlled trials will be necessary for establishing efficacy.

Despite this, interventions that appear to be helpful in these studies are frequently unable to be implemented in real-world settings due to a lack of workforce training to involve the target population fully. Organizations like military institutions should develop a drug-free workplace program by educating and training staff about the effects of alcoholism and substance abuse on their health, society, work safety, and job performance (Khan, 2010). These institutions should also communicate to the military personnel the organization's value on the health of employees, families, and communities. At a minimum, the organization should educate the benefits of avoiding substance use. It should also provide materials on the risks of misusing alcohol, prescription drugs, and other drugs and inform individuals on preventing substance use problems (Stockings et al., 2016). Nonetheless, it should strive to provide general health promotion information on fitness and stress management topics.

Buying *a home* typically requires a healthy amount of *savings* for a down payment. Therefore, organizations should also train military personnel on the importance of investing and saving their income. Savings allow individuals to enjoy greater security in their life and during the transition to civilian life, they will not struggle to settle and establish a home (Atkinson et al., 2015). With sufficient amounts, individuals will

consider undertaking entrepreneurship training, providing them the aptitude to identify business opportunities and the required skills to act on them. It includes instruction in chance identification, commercializing a concept, managing resources, and initiating opportunities. This way, homelessness among veterans will be history. Such ideas could eliminate vices from peer pressure and idleness, separating individuals from alcoholism and substance abuse.

Military organizations should have drug abstinence programs that require monitoring measures like random drug tests (Sharbafchi & Heydari, 2017). Mandatory abstinence necessitates the imposition of specific and urgent consequences. Military institutions should also adopt programs that compel all military personnel to abstain from alcohol and other drugs. The interventions do not always include substance abuse treatment, reflecting that most drug-addicted military personnel do not meet the screening criteria. For many individuals, regular monitoring, alongside the adverse consequences of a failed urine test, provides powerful motivation to abstain.

A good example is South Dakota's 24/7 Sobriety Project - an innovative program to supervise individuals arrested because of their involvement in alcohol-related offenses. When there is evidence of renewed alcohol consumption, this program treats problem drinking by applying intensive monitoring, followed by rapid but small consequences (Long et al., 2010). Addicts were re-arrested for Drinking Under Influence (DUI) and other drug-related offenses. The individuals were also subjected to intensive surveillance and punishments under this program. Further, participants were obliged to take morning and evening breathalyzer tests or wear continuous alcohol-monitoring bracelets as part of

their bail conditions. The intervention was linked to a significant reduction in recurrent DUI and intimate relationship violence arrests in counties where 24/7 participants reached one-quarter of DUI arrests.

Addressing the lived experiences of veterans that have been affected by homelessness and substance abuse can have significant social change implications. These findings will provide details and recommendations to national policymakers with firsthand accounts of homeless veterans who struggle with substance abuse. By understanding what may be causing the substance abuse, they can make policies that will affect the use of alcohol and medications that contribute to the substance abuse of the US veterans that are contributing to them becoming homeless. These policies will have an impact that will reduce the number of veterans with substance abuse issues, and it will reduce the number of veterans who are homeless. Furthermore, reducing the number of homeless veterans can improve not having veterans living on the street. Finally, it will help prevent the stigma of veterans who have served their country and are left homeless once they separate from the military.

Conclusions

A significant relationship exists between substance abuse and homelessness among veterans. This kind of plight is usually characterized by despair and desperation among the homeless veterans, leaving most of them unsure about a brighter future. While solving homelessness seems to be a viable solution, solving the root cause (alcoholism and substance abuse) is paramount in combating the issue. Notably, veterans are similar

to civilians when it comes to homelessness. In addition to the hurdles posed by deployments, they must overcome the economic hardship that everyone endures.

Fortunately, increased investment and enhanced teamwork at the federal and municipal levels have dramatically reduced veteran homelessness over the last three years. However, there is still a call for evidence-based programs and outcome-driven initiatives to manage homeless veterans battling alcoholism or substance abuse proactively. Therefore, stakeholders should work on the findings and recommendations outlined in this research paper. That way, it will be easy for researchers and interested parties to identify early and develop preventive programs to eradicate alcoholism and substance abuse among homeless veterans.

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Appendix A: Interview Questions

Demographic Information

A. What is your gender?

a. True b. False

B. How old are you?

a. 18—20 b. 21-35 c. 36-54 d. 55 and above

C. Are you currently homeless, or have you been homeless in the past two months?

If yes, how long?

Days ____ Months ____ Years ____

D. What is your race/ethnicity?

Asian or Pacific Islander ____

Hispanic ____

White/ Caucasian ____

Black/ African American ____

Mexican ____

Indian ____

Native American ____

Latino ____

Other ____

If others, please, specify here _____

E. What is the name of the sheltered home(s) that provided services to you?

_____

Interview Questions

1. Can you briefly tell me about your military duty?
    a. What was your MOS_____
    b. Did you serve in Combat? Yes or No_____
    c. Did you receive any injuries or illnesses? Yes or No _____
    d. If so, were you prescribed medication to help cure or cope with the injury or illness? Yes or No _____
2. Before joining the military, did you have a substance abuse problem? Yes or No _ _____
    a. If yes, were things that you did while in the military that caused you to have a substance abuse problem. Yes or No _____

    _____

    _____

    _____
3. Can you briefly tell me about your transition from the military?
    a. Did you have a good transition? Yes or No _____
    b. Did you feel that you were well prepared? Yes or No _____
    c. Do you feel that you needed better preparation before the transition? Yes or No _____
4. Before becoming homeless, did you have a substance abuse problem? Yes or No _ _____

5. Since becoming homeless, do you feel as if the substance abuse issues contribute to you being homeless? Yes or No _____
    a. Yes, but I had the problem before the military
    b. Yes, but because of the injuries/illnesses that I had while in the military caused me to have the substance abuse problem.
    c. No, I just had hard times because of other reasons.
6. In your opinion, do you feel that the treatments from the military are causing veterans to have substance abuse issues? Yes or No _____
    a. Are you willing to elaborate? Yes or No _____
    b. _____

       _____
7. In your opinion, do you feel there are environmental factors in the military that contributes to service members having substance abuse problems? Yes or No ____ _____
    a. Are you willing to elaborate? Yes or No _____
    b. _____

       _____
8. In your opinion, do you feel that there are better treatments to handle injuries or illnesses better than just medicating them? Yes or No _____
    a. Are you willing to elaborate? Yes or No _____
    b. _____

       _____

9. In your opinion, do you feel that your substance abuse issues are the main reason that contributed to your homelessness? Yes or No _____
    a. Are you willing to elaborate? Yes or No _____
    b. _____

       _____
10. Is there anything else that you would like to add to the interview? Yes or No _____

    _____
    a. Are you willing to elaborate? Yes or No _____
    b. _____

       _____