Mary J. Huber, Ph.D.
Director of Research, Substance Abuse Resources
& Disability Issues, Wright State University

June, 2010

Substance Abuse and Employment of Homeless Veterans

Introduction

There has been growing interest and need in helping unemployed homeless veterans with substance use disorders (SUD) (Rosenheck & Mares, 2007). Unfortunately, SUD is not the only mental illness veterans struggle with. Other mental health issues include post-traumatic stress disorder (PTSD) and/or traumatic brain injury (TBI) (Rosenheck & Fontana, 2007; Warden, 2006). Clinicians, physicians, and employment specialists need to be cognizant of the combination of the mental health needs of veterans, in particular those returning from Iraq and Afghanistan because of the association between mental illness, homelessness, and unemployment. (Hoge, Auchterlonie, & Miliken, 2006; Rosenheck & Mares, 2007; Warden, 2006). Seal, Bertenthal, Miner, Sen, & Marmar (2007) reported that 25% returning from combat received a mental health diagnosis; 56% had two or more distinct mental health illnesses. Mental health diagnoses were detected soon after the first VA clinic visit, and 60% initial mental health diagnoses were made in health clinics, mostly primary care settings. In summary, Hoge and colleagues (2006) reported that 35% of Iraq war veterans accessed mental health services in the year after returning after returning home. ■

Current Statistics on Homeless Veterans and the Unique Injuries from the Wars

A conservative estimate of the number of homeless veterans is 131,000; one in four of all homeless people are from the military (Dept. of Veterans Affairs, Bureau of Labor Statistics, 2009). Most of these homeless veterans served in the Vietnam war, with 10% being female. Recent statistics from the Iraq and Afghanistan wars estimate approximately 3,717 veterans are homeless; again 10% being female. The homeless rate of veterans since 9/11 is higher, estimated to be 7,400. Finally, the jobless rate for post-9/11 veterans is 11.3%, higher than the national average (Department of Veterans Affairs, Bureau of Labor Statistics, 2009).

There are unique and different injuries experienced by the troops fighting in Iraq and Afghanistan compared to past wars. As a result of the improvised explosive devices (IED), the most common physical injury is a traumatic brain injury (TBI) (Warden, 2006). These blasts result in three common types of brain injuries: the primary injury is the wave-induced injury resulting from the wind caused by the blast, the second is when a person's head is hit by a flying object; and the third is when the blast is so powerful the person is flown in the air and his/her head hits the ground or another object (Warden, 2006). It is estimated that 68% of 33,000 wounded soldiers have experienced blast related injuries (Warden, 2006). Compounding the symptoms of a TBI is the cumulative effect of multiple blasts or multiple injuries; many of which are not diagnosed (Martin, Lu, Helmick, French, & Warden, 2008). These symptoms include: vision, hearing, and speech problems, dizziness and sleep disorders; unrecognized substance abuse; and memory loss.

Another common mental health issue experienced by veteran is post traumatic stress disorder (PTSD). The Veterans Administration (VA) defines PTSD as a type of anxiety that affects people who've experienced a particular traumatic event that creates intense fear, helplessness or horror. Approximately, 20% (one in five) of Iraq veterans seeking help have PTSD with whomen suffering more pronounced and debilitating forms of PTSD (Hoge et al, 2006). This number is considered to be a low estimate of the actual incidence of PTSD because it only includes veterans who are seeking help. Many veterans report that they were unlikely to seek help out of fear that their commanders and fellow colleagues would treat them differently and it would affect their career. Thus, the actual incidence of PTSD is assumed to be higher than reported (Hoge et al., 2006). ■

Contents

Introduction 1
Current Statistics on Homeless Veterans and the Unique Injuries from the Wars 1
Employment Strategies for Working with Veterans: IPS and MI 2
Case Study: Frank 3
Supervising and Motivating Staff Working with Veterans who are Dually-Diagnosed 3
Resources and Suggestions for Serving Homless Veterans 3
References 4

National Technical Assistance Center

Mike West, Ph.D. -- mwest@vcu.edu
Valerie Brooke, M.Ed. -- vbrooke@vcu.edu
Jennifer McDonough, M.S. -- jltodd@vcu.edu

Virginia Commonwealth University, Rehabilitation Research and Training Center on Workplace Supports and Job Retention

Employment Strategies for Working with Veterans: IPS and MI

The Department of Veterans Affairs (VA) compensated work therapy (CWT) program has long provided veterans with an opportunity to work in sheltered workshops or in transitional employment programs either on VA grounds or with community employers (Kashner et al., 2002). More recently, a successful supported employment technique called the Individual Placement and Support (IPS) model which emphasizes rapid job placement, a focus on competitive jobs, ongoing support, client choice of jobs, integration of vocational support and clinical care is effective in employing veterans (Roseneck & Mares, 2007). Experimental studies have robustly demonstrated the effectiveness of IPS in employing persons with severe mental illness (Becker & Drake, 2003; Bond, 2004; Bond, Drake, & Becker, 2008; Cook et al., 2005; Mueser et al., 2004).

Rosenheck & Mares (2007) reported on a study were veterans who returned from the Iraq or Afghanistan wars received the IPS intervention (i.e., an employment specialist). They concluded that those who received IPS maintained competitive employment longer than a comparison group that did not receive IPS. In addition, the veterans worked more days per month over the two-year follow-up period, and the mean number of days housed during follow-up when compared to a comparison group. Rosenheck & Mares (2007) concluded that a sustained training program can be used to implement IPS in systems that have had little past experience with this approach. All of the facets of the model do not need to be utilized for it to be effective in increasing employment.

IPS is predicated on the belief that work skills training prior to job placement is not efficient or effective for persons with more severe disabilities, but rather real work experience with domain- and job-specific support is the best method for connecting and maintaining these individuals with jobs. The basic principles of IPS include the following:

1. vocational rehabilitation is an integral part of mental health (including SUD) treatment,
2. the goal is competitive employment in work settings integrated into a community's economy, not segregated in sheltered work settings,
3. veterans are expected to obtain jobs directly, rather than first engaging in lengthy pre-employment training,
4. VR services are continuous and based on real work experience in the community,
5. follow-along services from mental health providers are time unlimited, based on veteran needs, and
6. the choice of work site and related services are based on veteran preference and choice (Becker & Drake, 2003; Bond, Drake, & Becker, 2008).

The relationships between the employment specialist (ES) who is implementing the IPS model, the veteran and employer are fundamental (Bond, 2004). Depending on how involved the veteran wants the ES to be in the employment process is up to them. Strategies the ES can utilize include such things as emphasizing to potential employers the positive characteristics inherent in many veterans such as integrity, teamwork, loyalty, leadership skills, and triumph over adversity (American's Heroes at Work, 2010). In addition, educating employers about what IPS can offer to the workplace with respect to supporting the veteran on the job, assisting the veteran with learning new skills, and maintaining contacts with employers is imperative (Becker & Drake, 2003; Bond, 2004).

Employment Specialists are faced with a wide variety of situations and contexts within which they are expected to function. They may not have the resources to implement the IPS model. Another option for Employment Specialists to consider when working with veterans is a technique called Motivational Interviewing (MI). MI is not a therapy (although it is sometimes used as such); rather, it is a way of being with people (Miller & Rollnick, 2002). Miller and Rollnick (2002) defined MI as a client-centered, directive method for enhancing intrinsic motivation for change by exploring and resolving ambivalence. MI is the strategic use of fundamental skills to reduce resistance and work with the underlying ambivalence that is common in making behavior changes. The spirit of MI is achieved by intentionally focusing on a collaborative partnership with the veteran, evoking the veteran's own ideas and solutions regarding his or her change, and openly supporting the veteran's autonomy and choice (Moyers, Martin, Manuel, Hendrickson, S. & Miller, 2005).

The fundamental principles of MI are as follows:

a. rolling with resistance rather than confronting it,
b. expressing empathy for veterans' experiences,
c. developing discrepancy between where veterans find themselves and where they would like to be, and
d. supporting a veteran's self-efficacy (Miller & Rollnick, 2002).

MI is consumer-centered, and the veteran is considered the expert on his or her life. MI focuses on the veteran's desires, abilities, reasons, or needs for positive behavior change. Employment Specialist use techniques to help develop and consolidate commitment to change. On the surface MI sometimes appears intuitive, nevertheless it takes a depth and breadth of understanding in order to apply it effectively (Miller & Rollnick, 2002). It is important to recognize that Employment Specialists are often successful because they already have some considerable natural ability and desire to help people. MI builds upon these skills.

Changing behavior is not a linear process, and readiness to change is a fluctuating result that is tied to the interpersonal communication between the veteran and the Employment Specialist especially with respect to changes in using substances (Miller & Rollnick, 2002). Employment Specialists, therefore, strategically need to maintain a nonjudgmental stance in order to reduce defensiveness and facilitate a comfortable environment for the veteran. Employment Specialists need to be careful about what they say because resistance is viewed as not being something inherent in the veteran, but as something that can be evoked from the veteran through external influences. Whenever resistance is present, a Employment Specialist should drop back into an empathetic stance. When resistance is not present, the Employment Specialist attempts to develop discrepancy between the veteran's current behavior and his or her long term goals. ■

Case Study: FRANK

Frank was a 45 year-old, never married male who had sustained a number of traumatic brain injuries starting in childhood at the age of nine when he was hit in the head with a paint can while playing with friends. At that time, he experienced loss of consciousness for ten minutes. His next injury occurred as an adult when he was assaulted at the age of 44 and was unconscious for 30 minutes. His third TBI was sustained during a motor vehicle accident at the age of 45. He was unconscious for 45 minutes. He struggled with short-term memory problems, focus/paying attention, increased anxiety, and difficulty dealing with stress and managing his anger as a result of these injuries. Frank began drinking alcohol at the age of ten with a pattern of drinking 12 to 14 beers per day on a daily basis by the age of 17. He began smoking cannabis by the age of 15 with regular use by age 20. He started using crack cocaine at the age of 30 and developed a regular pattern by age 35. He was using up to $200.00 worth on a daily basis at the time of his most recent TBI. He stated that crack cocaine is his drug of choice. He has completed two inpatient drug and alcohol programs.

In addition to his motor vehicle accident and subsequent arrest, Frank has two drug possession charges, and three felony theft charges. He has been incarcerated for a total of seven years during his lifetime. He complained of experiencing depression and anxiety in the past, but did not feel like that was an issue at the time of his admission. He did exhibit a number of anti-social tendencies that either he experienced before his injuries or as a result of his injuries (i.e. impulsiveness, lying, irritability, aggressiveness, lack of respect for authority figures, and a lack of remorse).

Frank wanted to return to work. He had previously worked in heating and cooling, production, and installing ceiling fans for an insulation company. His longest job lasted approximately 30 months. Frank could be very charming and was able to do a nice interview. He had had a great deal of difficulty finding employment due to his legal problems. This continued inability to find employment caused his depression and anxiety to intensify and his ability to control his anger to decrease. It was helpful to use the job development techniques that are offered in the IPS model, however in this case Frank did not make the initial employer contact to eliminate his becoming frustrated at being turned down. The Employment Specialist was able to meet with potential employers ahead of time, determine if it was a good match for Frank taking into consideration some of his issues related to his TBI and mental health, find out their policies on past legal histories and advocate for him. All of these approaches are offered in the IPS model.

It is important to note that Frank has a number of strong points. He rarely ever missed work, was punctual and worked hard, however when he began to use drugs and alcohol, he was late or missed work completely. His anti-social tendencies caused him trouble with co-workers and supervisors. His inability to manage his emotions meant that it was not unusual for him to lose his temper at work and speak or act inappropriately. Frank lost several jobs as a result of the drug and alcohol relapses, mental health issues and the consequences of his behaviors which related to his numerous TBI's. Frank was taught to view these job loses not as failures, but as learning experiences. He began to attend AA and NA meetings and stayed clean and sober for a substantial amount of time. Frank's case illustrates that barriers can be overcome with the help of supported employment and treatment teams. Frank is currently working as a janitor. He requires minimal job coaching and he also participates in counseling sessions that employ MI techniques. ■

Supervising and Motivating Staff Working with Veterans Who are Dually-Diagnosed

It is pertinent for clinical directors and supervisors to provide guidance, support and motivation to their staff for employment services to be effective. For example, supervisors need to address the bias and stigma that may exist within their own staff (Becker & Drake, 2003; Hoge et al., 2006). Research has shown that many mental health professionals believe that persons with PTSD, TBI, or SUD cannot work (Bond, 2004). Supervisors can do many things to motivate their staff and address these issues. An effective strategy is to have staff reflect on the role work plays in their lives and discuss how work is part of getting on with life despite having a mental illness or physical injury. In addition, have staff role play what it might be like to be a veteran returning from Iraq or Afghanistan after being deployed for a year. The veteran may have issues such as PTSD or SUD and they are reuniting with family members who they have not seen in over a year. Finally, challenge staff's arguments of why work may not be useful to this population (Bond, 2004). ■

Resources and Suggestions for Serving Homeless Veterans

Partnership among various groups is essential in assisting veterans return to work. The collaboration between the VA, National Institute of Drug Abuse, and the Department of Defense (DoD) resulted in programs and employment policies that serve veterans with disabilities. Central to this initiative was the belief that employment is fundamental to adulthood, the quality of life, and economic freedom. In addition, advocacy groups, counties, state disability councils, human resource organizations, employment service providers, Centers for Independent Living, and state agencies can all be part of the process in assisting these veterans. Below is an outline of recommendations (Department of Veterans Affairs, 2009) towards new policy and practice implementation:

- Maintain and update a website of collaborators
- Develop a policy component for an annual employment conference with the stakeholders
- Develop policy briefs and issue papers to gather input and build consensus from stakeholder groups on policy changes needed to shape improved employment outcomes for veterans with disabilities
- Develop and update measured outcomes highlighting progress in advancing employment policies and practices
- Collaborate with the VA, PVA, DoD to Integrate systems change policy initiatives across federal, state and local agencies
- Strengthen and build new alliances to enlarge the circle of employment champions

References

- America's Heroes at Work (Spring, 2010) Newsletter http://www.americasheroesatwork.gov/newsroom/Newsletters/
- Becker, D. R. & Drake, R.E. (2003). A working life for people with severe mental illness. New York, Oxford University Press.
- Bjork, J. M. & Grant, S. J. (2008). Does traumatic brain injury increase risk for substance abuse? Journal of Trauma Nursing; 15(3):94-99.
- Bond, G. R. (2004). Supported employment: evidence for an evidence-based practice. Psychiatric Rehabilitation Journal, 27:345–359.
- Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. Psychiatric Rehabilitation Journal, 31(4): 280-290.
- Cook, J. A., Leff, H. S., Blyler, C. R., et al (2005). Results of a multisite randomized trial of supported employment interventions for individuals with severe mental illness. Archives of General Psychiatry, 62:505–512.
- Department of Veterans Affairs, Bureau of Labor Statistics, (2009).
- Hoge, C. W., Auchterlonie, J. L. & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. Journal of Medical Association; 295:1023-1032.
- Kashner, T. M., Rosenheck, R. A., Campinell, A. B., et al: (2002). Impact of work therapy on health status among homeless substance dependent veterans. Archives of General Psychiatry, 59:938–945.
- Mares, A. S. & Rosenheck, R. A. (2006). Attitudes towards employment and employment outcomes among homeless veterans with psychiatric and substance abuse problems. American Journal of Psychiatric Rehabilitation; 9; 145–166.
- Martin, E. M., Lu, W. C., Helmick, K., French L. & Warden DL. (2008). Traumatic brain injuries sustained in the Afghanistan and Iraq wars. American Journal of Nursing; 108(4):40-47.
- Miller, W.R. & Rollnick, S. (2002). Motivational interviewing: Preparing people to change. Second Edition, New York: Guilford Press.
- Moyers, T. B., Martin, T., Manuel, J. K., Hendrickson, S. M. & Miller, W. R. (2005). Assessing competence in the use of motivational interviewing. Journal of Substance Abuse and Treatment, 28(1);19-26.
- Mueser, K. T., Clark, R. E., Haines, M., et al: (2004). The Hartford study of supported employment for persons with severe mental illness. Journal of Consulting and Clinical Psychology, 72:479–490.
- Rosenheck, R. A. & Fontana, A. (2007). A model of homelessness among male veterans of the Vietnam War generation. Northeast Program Evaluation Center, VA Medical Center, West Haven, CT 06516.
- Rosenheck, R. A. & Mares, A. S. (2007). Implementation of Supported Employment for Homeless Veterans with Psychiatric or Addiction Disorders: Two-Year Outcomes. Psychiatry Services, 58; 325-333.
- Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning From Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities. Archives of Internal Medicine, 167(5):476-482.
- Veterans Adminstration.GOV/Homeless, (2009).
- Warden D. (2006). Military TBI during the Iraq and Afghanistan wars. Journal of Head Trauma Rehabilitation; 21(5):398-402.

Virginia Commonwealth University, School of Education and Department of Physical Medicine and Rehabilitation is an equal opportunity/affirmative action institution providing access to education and employment without regard to age, race, color, national origin, gender, religion, sexual orientation, veteran's status, political affiliation, or disability. If special accommodations are needed, please contact Vicki Brooke at (804) 828-1851 VOICE or (804) 828-2494 TTY. This activity is funded through a grant (#HV-16488-07-75-5-51) with the U.S. Department of Labor, Veterans Employment and Training Services.