DEPARTMENT OF VETERANS AFFAIRS

The Lodge Project: A Permanent Housing Model for Homeless Veterans

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Introduction

The 2011 Veterans Administration (VA) Point-In-Time count, taken on a single night in late January, identified more than 67,000 homeless Veterans in the US.[1] In November 2009, Secretary of Veterans Affairs Eric K. Shinseki announced that VA would end homelessness among Veterans in five years. Although the number of homeless Veterans has decreased by 7% in the past year, the VA has declared that it "will not be satisfied until no Veteran has to sleep on the street."[2]

In an effort to address the issue locally, the Iowa City VA Health Care System (ICVAHCS) has collaborated with the Iowa City homeless shelter (Shelter House) to identify local needs and potential solutions. Iowa City is an urban area (metro area population 152,586) surrounded by rural, mostly agricultural areas with small towns. The ICVAHCS includes the Iowa City Medical Center plus 9 community-based outpatient clinics (CBOCs) serving 45,000 Veterans, of which 64% are rural. The homeless Veteran population served by the ICVAHCS is estimated to be 985 (Figure 1).

Collaboration between Shelter House and the National Alliance of Mental Illness of Johnson County resulted in the formation of a Lodge model for permanent housing with priority for homeless rural Veterans in Eastern Iowa. Based on the concept developed by George Fairweather,[3] the Lodge is aimed at psychosocial rehabilitation by providing permanent, independent, self-managed cooperative housing for four to six financially employed occupants for as long as the client chooses. Outcome research for the nearly 50 active

Key Findings

- The Lodge program shows promise as a permanent housing model for homeless rural Veterans located in an *urban area* (Iowa City) having appropriate resources to support the program, and is probably less suited to more rural communities.
- Hindrances to program effectiveness among Lodge clients were identified, foremost among these being alcohol/substance abuse. A need for better communication among the agencies and providers involved was also identified.
- Primary facilitators for the program are one-on-one communication between Veterans and agency members, and communication between outreach social workers and VHA psychologists.

Lodges across the Midwest and Northeast US have shown good psychological outcomes and work performance, high medication compliance, and low recidivism.[4]

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funding was also provided by the VA Office of Rural Health for trainers and program evaluation. Nearly 50 Lodges are active across the Midwest and Northeast US. Outcome research on these facilities has shown good psychological outcomes and work performance, high medication compliance, and low recidivism.[3]

Most Veterans who are referred to the Lodge are residents of Shelter House and identified by staff as Veterans and potentially eligible. Others are referred to the program by ICVAHCS social workers and the Iowa Veterans Home. To be eligible for the Lodge, participants must have a serious and persistent dual-diagnosed mental illness (i.e., schizophrenia, schizoaffective disorder, bi-polar disorder, or major depressive disorder). Participants must be willing to take prescribed medications, not have been suicidal in the past three months, not currently abusing drugs or alcohol, and be willing to work 20 hours a week.

Graduate students from the University of Iowa College of Education work with Lodge participants improve their basic living skills. Graduate interns and volunteers also work closely with Shelter House staff to continue the training process for future participants.

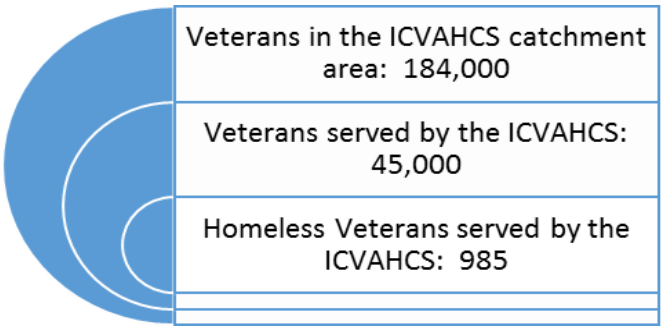
This report describes Phase 1 of an evaluation of the Iowa City Lodge (composed of two Lodge houses, each with six single bedrooms) initiated in May 2011, focusing on providers and clients. The evaluation identifies ways VA can better partner with the community to address homelessness in an urban community serving a rural population. ("Rural" conforms to the definition established by the VA Office of Rural Health.[4]) A follow-up Phase 2 will apply the findings of Phase 1, further enhancing the program's efficiency.

Program Assessment Design

1) ***Participant assessment***. Increase in independent living skills and decrease in mental health problems are measured in training program participants. Assessments are made at 60-day increments following admission to the program and at the completion of training. Measures used are

- Independent Living Skills Survey (ILLS)[6] – covering 12 skills areas (e.g., hygiene, safety, money management, eating)
- Beck Depression Inventory (BDI-II)[7] – focused on intensity of depressive symptoms

Figure 1. ICVAHCS homeless Veteran population



Exterior of one of two Iowa City Lodge houses

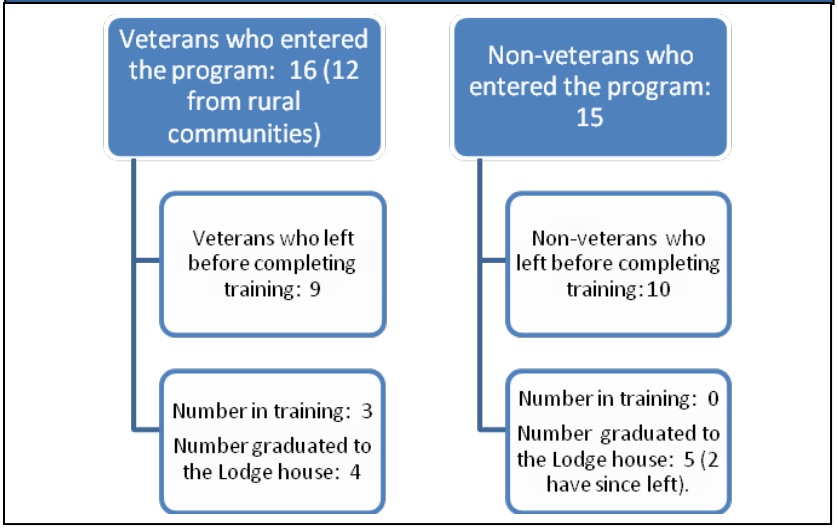
Interior view

- Problem Solving Inventory (PSI)[8] – focusing on problem solving confidence, personal control, and approach-avoidance styles
- Brief Symptom Inventory (BSI)[9] – focusing on psychological and somatic symptoms
- Semi-structured, qualitative interviews

Two Veterans have completed the assessment while 5 are currently in the process of completing it. (Results will be published in a later brief.) Veterans were also asked their impressions of the Lodge as a whole.

In the past 18 months, 16 Veterans entered the training program and 4 completed training and are living in the Lodge. Fifteen non-Veterans entered the program and 5 completed training, two of whom no longer live at the Lodge (Figure 2). Outcome data on those who have left the Lodge will be gathered in the next assessment.

Figure 2. Veterans and non-Veterans who entered the program



2) ***Provider assessment***. Program facilitators were interviewed to identify expediters and obstacles to program effectiveness. To date, 29 interviews of community and VA providers of services to homeless Veterans have been completed with plans for 15 more.

Assessment Findings

Veteran responses

All of the 16 Veterans who began training reflected positively on certain aspects of the program. The first of the graduates stated, "*This program gives people an opportunity to better their situation which may not otherwise be possible."* As well, the program gave him work experience that made him *"feel more productive; self-worth tends to increase with employment."*

Provider responses

Qualitative interviews with 15 VA and 14 community providers identified the following **expediters and obstacles to program effectiveness**.

Institution-centered Obstacles

- *Limited chronic substance abuse (SA) treatment options for Veterans*. Long-term SA care and wet shelters (i.e., a safe shelter for chronic active alcohol and drug users) are not available, and on-site assessment for SA needs is limited. Availability of drugs and alcohol to Lodge trainees while living at the Shelter House is also problematic.
- *Lack of coordination between community providers and VA.* Regulations can limit benefits and restrict inclusion in different programs (i.e., membership in one program may exclude membership in another). Data barriers exist. For example, VA is reluctant to release Veterans' hospital discharge information to Shelter House staff. Non-VA physicians sometime encounter difficulty in providing care for Veterans or collaborating in Veteran care.
- *Lack of coordination among VA providers as well as community providers.* VA's Outpatient Substance Abuse Treatment Program has sufficient funding, yet lacks post-recovery support. Other VA programs require rigid inclusion criteria, resulting in neglect of some Veterans. Individual community providers face funding issues that prevent participation in one program if he or she is employed in another.
- *Institutional authority and expertise concentrated too extensively in certain individual "champions."* This can impair day-to-day decision-making and limit procedural understanding.
- *Lack of referrals despite a pool of possible candidates, implying lack of provider awareness of criteria for suitable candidates*.

Individual Veteran-centered Obstacles

- Substance abuse. This problem was cited most frequently by provider interviewees (nationally, approximately 80% of homeless Veterans have

a substance/alcohol abuse problem[10]). Residence at Shelter House prohibits the use of alcohol or illegal substances, thus limiting Veterans' engagement with the Lodge program. Long-term prescription pain medication complicates SA issues.

- *Resistance to living at Shelter House*. Living at Shelter House is required while in training for Lodge living; many homeless Veterans are resistant due to sharing living space, close supervision and other restrictions.
- *Severity of mental health problems.* Many homeless Veterans have serious mental illness leading to poor skills necessary for social integration (e.g., interpersonal skills, money management, food preparation, personal hygiene, etc.).
- *Resistance to commitment.* Training for the Lodge is an open-ended, sometimes lengthy process, thus creating the impression of curtailed personal freedom.
- *Resistance to structured living.* Many homeless Veterans have become accustomed to living without coherent routine or framework and find change difficult. This includes resistance to financial employment.
- *Sex offender status*
- *Lack of trust in VA*
- *Lack of knowledge or misinformation about Lodge program*

Expediters of Program Effectiveness

- *Communication between VA homeless outreach social workers and VA psychologists*
- *Veterans' connection to VA homeless outreach social workers*
- *Positive relationships between VA homeless outreach social workers and Shelter House* staff
- *Veteran-to-Veteran communication*

The Implementation Process So Far

Preliminary Stage

(a) Variables that slowed the implementation process included:

- Redefinition of goals and expected behavior of program trainees
- Change in staff compilation (i.e., as the program's requirements were clarified, misinformation regarding the program resulted in staff turnover as well as changes in the program participant pool)
- Process for identification and referral of appropriate Veteran candidates
- After accepting the first trainees in May 2011, these early variables began to stabilize. Simultaneously, the program began to receive more referrals, showing increasing awareness of the program and potential for growth.

(b) Logistical issues related to Lodge locations affected the daily routine of members and staff. An example was the remodeling of one location while training out of another which was also in need of renovation. Transition to the alternate house and back to the remodeled house proved to be exceptionally difficult for all trainees and thus delayed progress. The setting for training has stabilized and is no longer a source of concern or delays.

Middle Development

- The referral process continued to develop slowly. The Lodge was in operation for nearly a year-and-a-half before Veteran referrals came at more than one per month. This was partially related to lack of information regarding or misunderstanding of admission criteria and lack of awareness of the program itself.
- Substance abuse created delays in many trainees' progress. Implementation of new screening procedures and drug testing throughout the course of training and after graduation has resulted in significantly reduced drug use.

Present Stage

- Once the Lodge staff was able to disseminate information more widely to the referral feeders the number of Veteran referrals increased significantly from one referral per month in the first year of operation to up to five per month in the second year. We are now confident that an effective referral process is in place. Shelter House is currently seeking funding to establish a third Lodge house in Iowa City.
- An in-residence training facility (as in other Lodge programs) is currently being

sought, avoiding the need for shuttling trainees between Shelter House and the Lodge house. A solution being considered is to recruit a program graduate to act as a residence coordinator for a live-in training Lodge (thus conforming to local zoning laws).

- Veteran and other participants who leave the program prior to graduation often return and reapply for admission. One Veteran has been admitted to and left the program twice and previous trainees have made enquiries regarding re-entering the program.
- In October 2012, nine candidates were on a waiting list to be screened for the program. Since that time the number waiting for entry into the program has varied from 4 to 9, indicating consistent interest in the program. Currently five potential applicants are awaiting interviews.
- The Lodge continues to draw abundant interest in volunteer and intern opportunities, indicating the program's growing recognition.

As part of the evaluation process, VA and community providers were queried about requirements for implementing a Lodge in a more rural location than that presently in Iowa City. The following factors were cited:

- Sufficient population of homeless Veterans in need of services to support the training and Lodge programs.
- Suitable local job opportunities for Lodge participants
- Transportation to VA health care centers from rural locations
- Importation of need staff from more urban locations if local staff is unavailable
- Community attitude accepting of Lodge program

The general consensus among both VA and community providers is that a Lodge like that in Iowa City may not be an option in a more rural community, primarily due to difficulty in accessing health care services, transportation, and need for suitable employment for participants.

Impact

The variables involved with implementing the Lodge program in Iowa City have begun to stabilize as recognition of the program and the number of referrals grows. However, based on experience thus far, consensus among both VA and community providers is that this model may not be suitable in a community more rural than Iowa City due to

- Lack of health care services
- Transportation of staff and clients
- Availability of employment for clients

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