

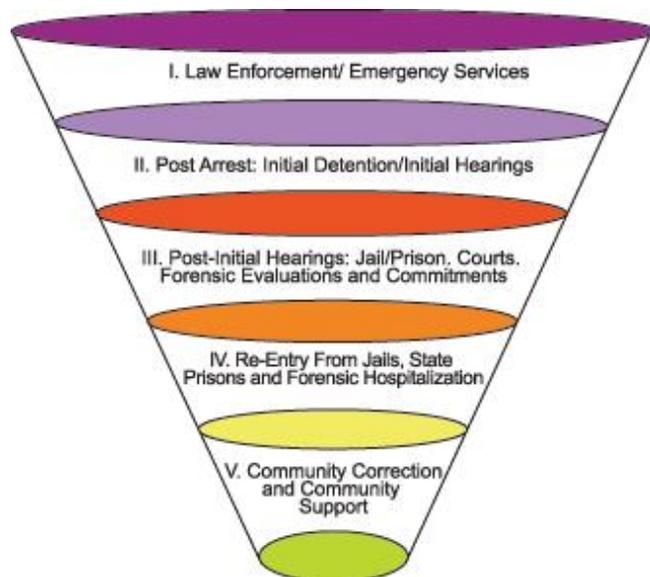


Breaking the Cycle of Veteran Incarceration and Homelessness: Emerging Community Practices

Like other single individuals experiencing homelessness, there is a high prevalence of criminal justice system-involvement among Veterans experiencing homelessness. About one-half of all Veterans experiencing homelessness who have participated in VA homeless assistance programs are involved in the justice system.¹

For Veterans and other people experiencing homelessness, homelessness and criminal justice system-involvement are a double jeopardy—where the experience of one contributes to and exacerbates the risk of the other. The experience of homelessness can increase one’s risk of justice system involvement, especially given community policies that criminalize behaviors associated with homelessness (so-called “quality of life” offenses). Incarceration in prison or jail increases the risk of homelessness and often leads to increased barriers to obtaining housing. Many Veterans may be caught on a repeated cycle of homelessness and incarceration. The [strategies to end Veteran homelessness](#) must therefore also encompass efforts to address and reduce justice system involvement. This means including criminal justice settings in the set of locations where Veterans experiencing and at-risk of homelessness are identified and engaged, spanning every step in the criminal justice process, from arrest to reintegration back to society. It means partnering with corrections departments to prevent the homelessness of Veterans who are re-entering the community from prison or jail. It also means partnering with law enforcement and courts to divert Veterans from jail or advance alternatives to incarceration.

The [Substance Abuse and Mental Health Administration \(SAMHSA\) GAINS Center’s](#) Sequential Intercept Model provides a useful framework for comprehensively addressing and reducing criminal justice involvement as part of efforts to end Veteran homelessness. This model maps all of potential points at which a Veteran (or any individual) can be assisted as they move through the criminal justice process.



As seen in the image to the right, the Sequential Intercept Model can be viewed as a series of filters, where communities should aim to intercept individuals at early points to prevent individuals experiencing or at-risk of homelessness from penetrating deeper into the criminal justice system.²

To help communities implement effective strategies to prevent and end homelessness among justice-involved Veterans, the following pages offer some strategies and emerging community examples at each of the intercept points within the criminal justice system.

¹ U. S. Department of Veterans Affairs. VA’s Veterans Justice Outreach Program: Services for Veterans Involved in the Justice System, 2014.

² Munetz, M.R. & Griffin, P.A. Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services* 57(4): 544-549, 2006.

Intercept Point 1: Law Enforcement/Emergency Services

The best way to break the cycle of homelessness and criminal justice system-involvement among Veterans is to prevent it in the first place. Communities should adopt policies and implement practices that avoid criminalizing behaviors associated with homelessness. In addition, communities can partner and work with law enforcement officials and emergency services to ensure that Veterans experiencing homelessness are assisted through housing and supportive services, rather than arrested.

One example of a successful early intervention model has been **Crisis Intervention Team (CIT)** programs, which are local initiatives designed to improve police officers' and the community's response to people experiencing mental health crises. While the CIT model has been widely used in communities for decades, more recently some communities have partnered with local VA medical centers and the Veterans Justice Outreach program to incorporate a streamlined process to identify individuals experiencing or at-risk of homelessness, including Veterans, and refer them to the homelessness assistance programs or VA Medical Centers. In Memphis, for example, to establish coordinated outreach and match best-fit interventions to individual needs, community partners have established a formal linkage between the Memphis Police Department's Crisis Intervention Team (CIT) and street outreach and service providers. In addition, VA staff trains law enforcement officers to recognize the signs of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and suicidal behavior in Veterans in crisis. A VA Medical Center and the Continuum of Care should establish a streamlined approach with Crisis Intervention Teams to identify individuals experiencing or at-risk of homelessness, including Veterans, and referring them to the appropriate interventions.

Resources:

- [Crisis Intervention Teams \(CIT\) Center](#) (NAMI)
- [A Resources for CIT Programs Across the Nation](#) (University of Memphis)

Intercept Point 2: Initial Detention/Initial Hearings

If a Veteran is arrested, he or she needs to be properly identified as a Veteran by the justice agency to access available interventions. Some states and counties have systematic procedures to identify Veterans. County jails in Los Angeles, San Diego, and San Francisco, for example, have instituted a process at intake and classification where corrections staff ask incoming inmates if they have ever served in the military.

States and communities whose justice agencies identify Veterans are able to refer them to VA specialists and caseworkers quickly to **screen for housing status or homelessness** and assess the needs of the Veterans, including housing and supportive services, and possibly divert them from traditional courts or prisons. In communities that do not have formal processes to identify Veterans, Veterans Justice Outreach specialists usually work closely with criminal justice agencies to identify and classify Veterans and formulate a **service plan** which addresses the individual's housing and service delivery needs.

Resources:

- [VA's Veterans Justice Outreach \(VJO\)](#)
- [Jail Diversion](#) (SAMHSA's GAINS Center for Behavioral Health and Justice Transformation)

Intercept Point 3: Jails/Prisons, Courts, Forensic Evaluations and Commitments

In some communities, Veterans identified early can access specialty courts or dockets that are better able to assess their needs and provide interventions to prevent recidivism and homelessness. These include mental health courts, community courts, and Veteran Treatment Courts.

Veterans Treatment Courts contain Veterans-only dockets. The premise of Veterans Treatment Courts is that the court will be able to assist Veterans and to ensure that Veterans are connected to benefits and treatment to which they are entitled because of their military service or other eligibility (such as disability or falling below a certain income threshold, or being at risk of homelessness). Since 2008, the Palo Alto VA Health Care System has been partnering

with the Santa Clara County court system to create a Veterans Treatment Court, presided over by Superior Court Judge Stephen Manley. In many instances, Judge Manley offers Veterans facing jail time a choice between receiving supervised treatment and jail. Even if a Veteran chooses jail time over receiving treatment, Judge Manley frequently reaches out to the Veteran and encourages him or her to access treatment. Additionally, some Veterans Treatment Courts have established real-time data sharing protocols between the court and VA, where, with the Veteran's consent, a VA clinician is able to provide the court with information about the Veteran's treatment and even schedule additional appointments.³

Veterans Treatment Courts have been demonstrated to be an important diversion from the cycle of incarceration and homelessness. Veterans who participate in VA services have experienced a 30 percent increase in stable housing in the year after court admission and an 88 percent reduction in arrests.⁴ By implementing Veterans Treatment Courts, justice system officials, VA, and community organizations are able to attack the cycle between homelessness and incarceration, giving these Veterans a much better chance for success.

Resources:

- [Justice for Vets](#)
- [Veterans Treatment Court](#) (National Institute of Corrections)

Intercept Point 4: Re-entry from Jails, State Prisons, and Forensic Hospitalization

When Veterans cannot be diverted from jail or incarceration, they should be provided with reentry services that help them before, during, and after the process of reentry to the community.

Many communities have built strong and collaborative **reentry support systems** to assist Veterans to leave prison or jail, reenter society, and follow their reentry plan to become independent and functioning members of the community. The **Health Care for Re-entry Veterans Program (HCRV)** includes a range of services intended to assist Veterans at a critical time during their reentry process and to offer a time-limited (usually six months prior to release to four months after release) continuum of reentry services. It is a multi-stage program focused on establishing contact with reentering Veterans, many with mental illness, and facilitating their access to a wide range of medical, psychiatric, vocational, and social services. The central goal of the HCRV Program is to promote successful community integration of reentry Veterans by conducting outreach to vulnerable Veterans, while they are incarcerated, to engage them in treatment and rehabilitation programs after release that will assist in preventing homelessness, re-adjusting to community life, and desisting from commission of new crimes or parole or probation violations.

Individuals with histories of repeated involvement in jails and instances of homelessness may need long-term housing solutions with supportive services, namely, **permanent supportive housing**. Many communities are implementing the **Frequent Users Systems Engagement (FUSE) model**. FUSE attempts to connect incarcerated individuals with histories of frequent use of jails and emergency shelter services to permanent supportive housing in order to promote housing stability and reduce the involvement of participants in the criminal justice and emergency service systems. While communities have adapted the FUSE model to suit their unique local needs, there are three core pillars to the implementation of the model: 1) using data to identify a specific target population of high-cost, high-need individuals who are shared clients of multiple systems, such as jails, homeless shelters, and crisis health services; 2) a collaborative effort between public systems and policymakers to address the needs of shared clients and to shift resources from costly crisis services and toward permanent supportive housing; and 3) enhancing supportive housing with targeted and assertive recruitment through in-reach into jails, shelters, hospitals, and other settings. The FUSE

³ Blue-Howells, J.H., Clark, S.C., van den Berk-Clark, C. & McGuire, J. The U.S. Department of Veterans Affairs Veterans Justice Programs and the Sequential Intercept Model: Case Examples in National Dissemination of Intervention for Justice-Involved Veterans. *Psychological Services*. 2013, 10(1), 48–53.

⁴ U.S. Department of Veterans Affairs. Veterans Health Administration Homeless Operations and Management and Evaluation System. April 2011 through 2013.

model has been implemented and tested in many communities, including New York City, Los Angeles, Chicago, and at least 10 states.

Resources:

- [The Health Care for Re-entry Veterans \(HCRV\) Program](#) (VA)
- [Frequent Users Systems Engagement \(FUSE\) Model](#)
- [Re-Entry Resources \(SAMHSA's GAINS Center for Behavioral Health and Justice Transformation\)](#)

Intercept Point 5: Community Corrections and Community Support

Once a Veteran is released into the community, the goal is to empower the Veteran to become independent, build life and work training skills, and participate in the services identified in his or her reentry plan. A Health Care for Re-entry Veterans Specialist may continue to provide **post-release case management services** for a brief time. A Veteran should also be connected to **permanent housing and ongoing supportive services**, through VA's homeless assistance programs, the Department of Housing and Urban Development's homeless assistance programs, other federal, state, community, or private programs. USICH has developed the [Quick Guide on Assisting Veterans through VA or Non-VA Programs](#) to help communities help guide decisions regarding which set of programs may be the best fit for Veterans.

A community should also partner with a local Homeless Veterans Reintegration Program (HVRP), Reentry Employment Opportunities (REO) program, and public workforce systems to engage the individual in **employment and training**. If the Veteran's reentry plan is not progressing smoothly, a HCRV specialist may provide crisis intervention.

A promising approach to ensure a Veteran will follow the reentry plan and remain in the community has been the use of **peer-to-peer mentors**. For example, Maryland initiated the Re-Entry Associate Program in 2013. To promote effective mentorships, the program recruits volunteer associates that serve as mentors to incarcerated Veterans and continue to serve as a support system for a year after the Veteran is released.

Resources:

- [The Reentry Employment Opportunities \(REO\) program](#) (DOL)
- [Best Practices Identified for Peer Support Programs](#) (Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury)

Additional Resources

To help you incorporate a focus on addressing and preventing justice system involvement as part of your efforts to end Veteran homelessness, here are some resources that your community might find useful:

- [10 Strategies to End Veteran Homelessness](#)
- [Quick Guide on Assisting Veterans through VA or Non-VA Programs](#)
- [Video on VA's Justice-Involved Programs](#) (508-compliant [version](#))
- [VA's Veterans Justice Outreach \(VJO\)](#) program page (with regional specialist contacts)
- [VA's Health Care for Re-Entry Veterans \(HCRV\)](#) program page (with regional specialist contacts)