



Department of Veterans Affairs Office of Inspector General

Homeless Incidence and Risk Factors for Becoming Homeless in Veterans

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Glossary

| | |
|-------------|--|
| DCHV | Domiciliary Care for Homeless Veterans |
| DD214 | <i>Certificate of Release or Discharge from Active Duty</i> |
| DoD | Department of Defense |
| DSS | Decision Support System |
| Form X | VA HCHV Intake Assessment |
| FY | fiscal year |
| HCHV | Health Care for Homeless Veterans |
| HCMI | Homeless Chronically Mentally Ill |
| HUD | Department of Housing and Urban Development |
| HUD-VASH | HUD-VA Supportive Housing |
| ICD-9-CM | <i>International Classification of Diseases, Ninth Revision, Clinical Modification</i> |
| LC Database | an OIG database with information on nearly 500,000 veterans |
| MST | military sexual trauma |
| OEF | Operation Enduring Freedom |
| OHI | Office of Healthcare Inspections |
| OIF | Operation Iraqi Freedom |
| OIG | Office of Inspector General |
| PTSD | post-traumatic stress disorder |
| RRTP | Residential Rehabilitation Treatment Program |
| TBI | traumatic brain injury |
| TRICARE | Military health plan |
| VBA | Veterans Benefits Administration |
| VHA | Veterans Health Administration |

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Executive Summary

Introduction

On November 3, 2009, Secretary Shinseki announced a five-year VA plan to end homelessness among veterans. Primary prevention of homelessness (preventing the newly homeless from occurring) is an integral strategy of eliminating homelessness in veterans. The most challenging aspect of primary prevention efforts is to identify high-risk populations to target for outreach. The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted this study to estimate incidences of becoming homeless (the newly homeless) after military separation, identify risk factors for veterans becoming homeless, and describe utilization of VA specific homeless services by homeless veterans.

To conduct this study, we analyzed the integrated data from VA and the Department of Defense (DoD) for the population of almost 500,000 male and female veterans who separated from the military from July 1, 2005 to September 30, 2006. Nearly half of this population served in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) before their separation. Of the veterans in the population, we followed the 310,685 DoD (including TRICARE) or VA (including VA purchased care through fee basis or contractual agreement) users who had not experienced any homeless episodes before separation from the military, for their experience encountering their first homeless episode (becoming homeless) from the time they left the military through September 30, 2010.

We also reviewed relevant laws, regulations, and program documentation. We conducted a review of relevant reports and studies on homelessness and researched VA homeless programs. We met with VA experts and academia who conduct research on homelessness.

Results

OEF/OIF and women veterans experienced higher homeless incidences after military separation. At 5 years after separation from the military, 3.7 percent of the veterans experienced an initial episode of homelessness (the newly homeless). OEF/OIF and women veterans experienced higher incidences of homelessness than their non-OEF/OIF and male counterparts. The 5-year homeless incidence rates ranged from 3.2 percent for non-OEF/OIF men to 4.0 percent for OEF/OIF women veterans. OEF/OIF veterans experienced higher homeless incidences than non-OEF/OIF veterans at each year of the first 5 years after discharge.

Among the veterans who became homeless, the median times to the first episode of homelessness were close to 3 years, indicating half of new homeless episodes occurred 3 years after discharge from active duty. The median times varied from 34 months after

leaving the military for OEF/OIF men to 38 months for non-OEF/OIF women. OEF/OIF homeless veterans encountered their first homeless episode slightly sooner than their non-OEF/OIF counterparts after discharge from active duty.

Veterans who experienced homelessness after military separation were younger, enlisted with lower pay grades, and were more likely to be diagnosed with mental disorders and /or traumatic brain injury (TBI) at the time of separation from active duty. At discharge from active duty, 79–84 percent of homeless veterans were under age 35, in contrast to 64–74 percent of domiciled veterans. Most (70–78 percent) of the homeless veterans were enlisted and in the lower pay grades of E1–E4, compared with 39–51 percent of the domiciled veterans.

Nearly half or more (from 48 percent for OEF/OIF men to 67 percent for non-OEF/OIF women) of homeless veterans were diagnosed with some mental disorders, about double their domiciled counterparts (from 21 percent for OEF/OIF men to 34 percent for non-OEF/OIF women). Mental disorders included substance-related disorders and all mental illness. We also included in the study the following six specific mental illness categories for separate examination: anxiety disorders (excluding post-traumatic stress disorder (PTSD)), PTSD, adjustment disorders, mood disorders, personality disorders, and psychotic disorders. The percent of homeless veterans diagnosed with TBI was nearly 2–3 times higher than their domiciled counterparts.

Presence of mental disorders (substance-related disorders and/or mental illness) is the strongest predictor of becoming homeless after discharge from active duty. Consistently, a much higher percent of the newly homeless veterans are diagnosed over time than their domiciled counterparts in each of the four subpopulations defined by OEF/OIF status and gender. Nearly half or more (ranging from 48 percent for OEF/OIF men to 67 percent for non-OEF/OIF women) of the newly homeless veterans were diagnosed with some mental disorders prior to discharge from active duty; the rate of diagnosed mental disorders among newly homeless veterans increased to 64–76 percent before becoming homeless and increased to 81–92 percent at the end of the study. In fact, the percent of newly homeless veterans diagnosed with mental disorders, each of the 6 specific mental illness categories and substance-related disorders, and TBI prior to their first homeless episode, exceeded their domiciled counterparts at the end of the study across each of the four subpopulations defined by OEF/OIF status and gender. We found that 78–83 percent of newly homeless veterans diagnosed with some mental disorders at the end of the study were in fact diagnosed before they became homeless.

Homeless veterans, especially women, had received disproportionately higher military sexual trauma (MST)-related treatment than domiciled veterans and the majority of the newly homeless women veterans who received MST-related treatment had received the treatment before they became homeless. At the end of the study, the percentages (29 for non-OEF/OIF and 34 for OEF/OIF women, 3 for non-OEF/OIF and 2 for OEF/OIF men) of homeless veterans who had received

MST-related treatment were over 3 times higher than those of their domiciled counterparts (5 for non-OEF/OIF and 9 for OEF/OIF women, 0.2 for non-OEF/OIF and 0.3 for OEF/OIF men). Even prior to their first homeless episode, a higher percent of the homeless veterans had received MST treatment than their domiciled counterparts at the end of the study. Among the homeless women veterans who received MST-related treatment, 60 percent of non-OEF/OIF and 72 percent of OEF/OIF homeless women had received MST treatment prior to their first homeless episode. Among the male homeless veterans who received MST-related treatment, 46 percent of non-OEF/OIF and 53 percent of OEF/OIF homeless men had received the treatment prior to their first homeless episode. This reveals that MST is a risk factor for becoming homeless in veterans, especially in women veterans.

Homeless veterans were more likely to receive compensation for service-connected disabilities and receive higher disability ratings. Over half (51–62 percent) of the homeless veterans were receiving VA compensation for their service-connected disabilities at the end of the study, higher than their domiciled counterparts (35–40 percent). Even prior to their first homeless episode, 46–59 percent of the homeless veterans were receiving VA compensation, which was over 10 percentage points more than their domiciled counterparts. We observed that 83–95 percent of the homeless veterans who were receiving VA compensation at the end of the study were in fact receiving the compensation prior to their first episode of homelessness. In comparison to their domiciled counterparts, the median (50 percent for OEF/OIF males and 40 percent for others) disability ratings for homeless veterans before they became homeless are equal to or 10 percentage points higher, and their median ratings (50 percent for non-OEF/OIF and 60 percent for OEF/OIF) at the end of the study are 10–20 percentage points higher than the 40 percent median ratings of their domiciled counterparts at the end of the study. Patterns are similar, albeit varying in degree, when we limit to those only receiving VA compensation for service-connected disabilities with a disability component for mental health.

Approximately 65 percent of homeless veterans utilized the VA’s Health Care for Homeless Veterans (HCHV)/Homeless Chronically Mentally Ill (HCMI) Program; OEF/OIF and women homeless veterans were more likely to utilize the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program. By the end of the study, approximately 65 percent of homeless veterans utilized HCHV/HCMI program where clinical staff of HCHV and Grant and Per Diem Programs provide services to HCMI veterans with mental illness and/or substance-related disorders. OEF/OIF and women homeless veterans were more likely to utilize HUD-VASH and telephone HUD-VASH homeless programs than their non-OEF/OIF and male homeless counterparts. Under the HUD-VASH program, VA is responsible for screening the veterans for eligibility, assisting in the housing search, and providing appropriate treatment and case-management to promote stability once housed.

Conclusions

In this first ever large-scale, population-based, longitudinal study, we determined the incidences of becoming homeless (the newly homeless) after leaving the military; we compared the demographic characteristics and the disease (TBI, mental illness, and substance-related disorders) diagnoses over time of homeless veterans with those of their domiciled counterparts, in the 4 separate subpopulations defined by OEF/OIF status and gender, to describe and identify risk factors for becoming homeless in this veteran population.

We found that 3.7 percent of these veterans experienced their first episode of homelessness (the newly homeless) at 5 years after separation from the military. Veterans who experienced homelessness after military separation were younger, enlisted with lower pay grades, and were more likely to be diagnosed with mental disorders and /or TBI at the time of separation from active duty than their domiciled counterparts. We observed that about half of the new episodes of homelessness occurred 3 years after discharge from active duty. This suggests a window of opportunity for preventing veterans from becoming homeless after discharge from active duty.

Presence of mental disorders (mental illness and or substance-related disorders) is the strongest predictor of becoming homeless after discharge from active duty. Consistently, a much higher percent of the newly homeless veterans are diagnosed over time than their domiciled counterparts in each of the four separate subpopulations defined by OEF/OIF status and gender. Thus, it may be beneficial for VA homelessness primary prevention efforts to focus on the treatment of veterans with mental disorders as well as on their housing risk.

Although the percent of OEF/OIF veterans diagnosed with mental disorders and specific categories (except for PTSD) of mental illness before discharge from active duty are generally lower than their non-OEF/OIF counterparts, the percentages of mental disorder diagnoses among newly homeless OEF/OIF veterans are higher than those of their non-OEF/OIF counterparts over time: prior to becoming homeless and at the end of the study. This signifies that the impact of serving in OEF/OIF on becoming homeless is partly manifested as the intermediate outcomes of mental disorders. Thus, our study implies that enhanced access to effective mental health services and substance use treatment may facilitate a reduction in occurrences of newly homeless veterans and should remain a focus of primary prevention efforts.

Homeless veterans, especially women, had received disproportionately higher MST-related treatment than domiciled veterans, even prior to their first homeless episode. Among the women homeless veterans who received MST-related treatment, 60 percent of non-OEF/OIF and 72 percent of OEF/OIF homeless women had received MST-related treatment prior to their first homeless episode. This reveals that MST is a risk factor in veterans for becoming homeless, especially in women veterans.

The findings are new, and they are surprising in that a higher (46–59) percent of the homeless veterans than their domiciled (35–40 percent) counterparts (at the end of the study) had access to some stable and seemingly moderate funds before their first homeless episode to prevent becoming homeless. More studies are called for to investigate the relationship between service-connected disability payments and their impact on homelessness.

We defined homeless veterans as veterans whose medical records included a V60.0 secondary diagnostic code for “lack of housing” from DoD (including TRICARE) or VA (including purchased care through fee basis or contractual agreement) or who have used VA homeless assistance services. Thus, our identification of homeless veterans relies on accurate coding of veterans housing situation by clinicians and the completeness and the accuracy of the administrative data from VA homeless assistance programs. In addition, we excluded veterans who did not use DoD/TRICARE and VA/VA purchased care after discharge from active duty as we have no data on them. These limitations are not just specific to our study. Studies, evaluations, and reports that use VA administrative data all encounter the same issues.

By incorporating DoD treatment data with VA data, for the first time, we are able to identify veterans who did not suffer any homeless episodes before discharge from active duty to study the occurrence rate of the newly homeless and investigate the effect of mental disorders and TBI diagnoses during military service on becoming homeless. We also innovatively looked at risk factors at the time of becoming homeless for the homeless veterans, in addition to the two points in time—at discharge from active duty (baseline) and at the end of the study. This provides us broader insights on the pathways of the risk factors and their effect on veteran homelessness.

The population-based nature of our study precludes the potential bias inherent in samples selection and permits the use of appropriate domiciled control groups. The inconsistent findings from many studies on homelessness are partly attributable to whether selecting participants from homeless individuals or from individuals diagnosed with mental disorders, in addition to the use of inappropriate control groups.

The longitudinal cohort nature of our study on risk factors associated with homelessness eliminates the limitations of most studies that employ a cross-sectional design. In these cross-sectional studies, participants were assessed for homelessness and risk factors simultaneously at a particular time period. Consequently, from these studies, we cannot distinguish the newly homeless from the chronically homeless and cannot determine causality or temporal sequence of risk factors and homelessness. Based on these studies, it thus remains unclear whether the newly homeless and chronically homeless share the same risk factors and whether, say, a diagnosis of a mental disorder (substance-related disorders and/or mental illness) preceded homelessness, or whether substance-related disorders and/or mental illness are the result of adaptations to the stresses and dangers associated with the homeless experience. Our longitudinal cohort study allows us to

clearly demonstrate that the presence of mental disorders is a predictor of becoming homeless in veterans. It also allows us to exclusively investigate risk factors over time to better understand their pathways and effects on veteran homelessness.

Recommendation

We recommended that the Under Secretary for Health, in ongoing efforts to end homelessness among veterans, consider the risk factors for becoming the newly homeless in veterans identified in this report and adjust, if necessary, the current strategies to prevent veterans from becoming homeless.

Comments

The Under Secretary for Health concurred with the findings and recommendation. The implementation plan is acceptable, and we will follow up until all actions are completed.



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Introduction

Purpose

On November 3, 2009, at the National Summit on Homeless Veterans, Secretary Shinseki announced a five-year VA plan to end homelessness among veterans. VA 2011 budget included \$4.2 billion to prevent and reduce homelessness with over \$3.4 billion for core medical services and \$799 million for specific homeless programs and expanded medical programs.¹

Primary prevention of homelessness (preventing the newly homeless from occurring) is an integral strategy of eliminating homelessness in veterans. The most challenging aspect of primary prevention efforts is to identify high-risk populations for outreach. The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted this study to

- Estimate incidences of becoming homeless (the newly homeless) after military separation,
- Identify risk factors associated with veterans becoming homeless after military separation, and
- Describe utilization of VA specific homeless services by homeless veterans.

Background

Homeless Veterans. Homeless veterans were first identified following the War of 1812, and were seen in increasing numbers following the Civil War. World War I veterans returned to face an economic depression; many believe that a surge in veterans' homelessness after World War II was avoided by the passage of the GI Bill.² During the 20th century, sociologists began to identify certain demographic factors associated with the phenomenon. The economics and politics of poverty gained attention during the 1960s. Thousands of Vietnam veterans were visibly homeless upon military separation. In subsequent decades, much attention was paid to the physical, emotional, and mental health issues of the homeless in the aftermath of deinstitutionalization of the seriously mentally ill. With the War on Drugs of the 1980s, the media shined a spotlight on the dangers of substance abuse, including loss of livelihood and housing. Recent developments include a shift towards Harm Reduction, Safe Havens, and the Housing First model, to move those with unresolved mental health or substance use issues into housing first, then work towards stabilization. Today's veterans are returning stateside to

¹ Statement of Pete Dougherty, Director, Homeless Programs, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States Senate, March 24, 2010.

² The Servicemen's Readjustment Act of 1944, also known as the GI Bill (Public Law 78-346) established funding for a college education for returning soldiers.

a climate of high unemployment and economic downturns. Trends, attitudes towards helping the homeless, and services available to them, have varied widely over time.

Homeless Definition. Throughout the twentieth century, fragmented efforts were made at local, regional, and national levels to assist the growing numbers of homeless individuals and families. One basic issue underlying the lack of coordination was the lack of a firm definition for who was homeless, thus who was eligible for services. Progress towards that objective came in July 1987 when Congress passed the McKinney-Vento Act (Public Law 100-77), establishing a definition of homelessness which would be utilized as the criteria for federal assistance to programs and agencies targeting the homeless population. In this legislation, a homeless person was defined by one or more of the following conditions without regards to length of time, with present circumstance as a defining feature.

- an individual who lacks a fixed, regular, and adequate nighttime residence; or
- an individual who has a primary nighttime residence that is
 - a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
 - an institution that provides a temporary residence for individuals intended to be institutionalized; or
 - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

In 2009, Congress broadened the definition of those who can receive homeless services using federal monies by incorporating imminent homelessness into the definition. Recognizing the distinction between those with an acute episode of homelessness and those with more chronic patterns, this served to enable prevention efforts to reduce homelessness by serving those at risk of losing their housing and create programs to rapidly re-house those who are in the acute phase of homelessness. The Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act) specifically included the following persons in the new definition:

- those living in transitional housing (not exclusively for the mentally ill),
- who are in imminent threat of losing their housing,
- fleeing a situation of domestic violence or other life-threatening condition, and
- unaccompanied youth and certain types of homeless families with children.

Five-Year Plan to End Veterans' Homelessness. In 2010, the Opening Doors report was published (the Federal Strategic Plan to Prevent and End Homelessness). This comprehensive and ambitious framework to address homelessness among all citizens, including veterans, places VA prominently within the strategy. When Secretary Shinseki announced a 5-year plan to end homelessness among veterans, he articulated six strategic pillars to combat homelessness:

1. Outreach/Education
2. Prevention
3. Treatment
4. Housing/Supportive Services
5. Income/Employment/Benefits
6. Community Partnerships

The VA intends to ameliorate homelessness by increasing collaboration with public entities, including Departments of Education, Labor, and HUD, and private entities including Veterans Service Organizations and community agencies. The overarching strategy includes targeting risk factors for homelessness, via expanding the Post 9/11 GI Bill, promoting employment of veterans including veteran-owned small businesses, improving access to preventive medical care (particularly mental health care), and by enlarging the supply of transitional and affordable permanent housing options for homeless veterans. At the time of the announcement in 2009, homelessness among veterans was estimated at 131,000. In December 2011, HUD and VA jointly announced that homelessness among veterans declined 12 percent in 2011.³

VA Homeless Programs.

Health Care for Homeless Veterans (HCHV). Established under Public Law 100-6, the HCHV program allows the VA to offer “veterans suffering from serious mental illness, including veterans who are homeless, outreach and care, treatment, and rehabilitative services (directly or by contract in community based treatment facilities, including halfway houses).”⁴ In order to fulfill the objectives of the HCHV program, each VA medical center has a dedicated HCHV Coordinator who oversees the care for homeless veterans and maintains working relationships with community-based organizations serving veterans.⁵ The main focus of the HCHV program is outreach to those veterans in the community who are not utilizing VA services. In 2009, the National Coalition for Homeless Veterans (NCHV) estimated that VA served approximately 25 percent of veterans in need,⁶ indicating a continued need to pursue aggressive outreach to homeless veterans. The HCHV program educates veterans on applicable programs, encourages homeless veterans to utilize VA programs, and serves as a gateway for program entry. As a result of outreach efforts, HCHV has served over 383,000 individual veterans since its origination in 1987.⁷

Stand Downs. Stand Downs are one to three day events jointly coordinated by the VA and local community organizations serving the homeless to provide “one stop shopping” for many needed services (food, clothing, sleeping bags, counseling, referrals to

³ VA-HUD joint Press Release, December 13, 2011.

⁴ *United States Code, 2006 Edition, Supplement 4, Title 38 – Veterans’ Benefits*, 2010.

⁵ Each Veterans Integrated Service Network also has a Network Homeless Coordinator.

⁶ National Coalition for the Homeless, Homeless Veterans fact sheet, September 2009.

⁷ *The Fiscal Year 2012 Budget for Veterans’ Programs*, 2011.

housing/medical services, etc.). While tangible goods are provided (some goods are provided through the VA Excess Property for Homeless Veterans Initiative), the underlying aim is outreach. In 2011, there were nearly 190 planned Stand Downs throughout the country. In the past, Stand Downs were only for veterans but in recent years, non-veteran homeless individuals have also been able to benefit from some of the resources at Stand Downs.

Drop-in Centers. Drop-in Centers are federally funded facilities where homeless veterans can obtain hygienic and rehabilitative services during the day⁸. For street homeless, this is a venue to shower and do laundry, while staff hope to use the opportunity to form a relationship and encourage more formal engagement, follow-up, and treatment. Some Drop-In Centers receive VA funding through the Grant Per Diem (GPD) Program. Drop-in Centers are a prime location for HCHV staff to reach out to homeless veterans.

National Call Center for Homeless Veterans (NCCHV). Established in partnership with the National Suicide Prevention Hotline, the VA created the NCCHV. NCCHV was fully implemented on March 1, 2010, and provides free, 24/7 access to information about homeless resources for at-risk or homeless veterans, concerned friends or family members, and agencies serving the homeless. In the first year of operation, the call center received 20,831 calls from veterans. Among the veteran callers, 32 percent were homeless and 57 percent were at risk of becoming homeless.⁹ When an individual calls the NCCHV, they are given a brief screening by a trained counselor and then provided with information based on their particular need. If a veteran needs more assistance or follow-up, the counselor contacts the local VA medical center Homeless Point of Contact (POC) for direction, with the expectation that all calls are addressed by the POC by the next business day. While this is not true outreach, this creates another mechanism for homeless veterans to “reach in” and seek assistance.

Veterans Homelessness Prevention Demonstration Program (VHPD). This pilot program is a partnership among VA, HUD, Department of Labor (DOL), and local community agencies, to explore ways the Federal government can successfully intervene early to prevent homelessness. VHPD services were initiated during April 2011 and are projected to provide assistance to over 1,200 veteran families for the next 3 years. The primary foci of this program are veterans returning from wars in Iraq and Afghanistan, female veterans, veterans with families (especially those with a single parent as head of household), and National Guard Reservists being discharged from the military. VHPD offers the opportunity to understand the unique needs of this new cohort of veterans and intervene to help them regain and maintain housing stability. This pilot is limited to five cities, all of which are in close proximity to military bases. VHPD staff provide outreach, education, and case management, while partnering agencies provide tangible financial assistance to prevent homeless or promote rapid re-housing (funds for back due rent,

⁸ *Hearing on VA's Plan for Ending Homelessness Among Veterans*, 2010.

⁹ *The Fiscal Year 2012 Budget for Veterans' Programs*, 2011.

security deposits, and time limited rental and/or utilities assistance, and other supportive services).

Health Care for Re-Entry Veterans Program (HCRV) and the Veteran Justice Outreach Program (VJO). The HCRV and VJO are complementary programs intended to prevent homelessness among at-risk and homeless veterans who are incarcerated or facing possible incarceration. Both programs involve outreach and community partnerships with the judicial system. In HCRV, outreach to prisons and jails is conducted with veterans “pre-release” helping incarcerated veterans re-enter society by connecting them with treatment and rehabilitative services upon release. The VJO program aims “to avoid the unnecessary criminalization of mental illness and extended incarceration among veterans by ensuring that eligible justice-involved veterans have timely access to VHA mental health and substance abuse services when clinically indicated, and other VA services and benefits as appropriate.”¹⁰ Both of these programs provide similar services, but at different “intercept” points during a veteran’s involvement with the judicial system (prevention of homelessness upon discharge from the justice system versus prevention of criminalization and incarceration which increases risk of future homelessness).

Supportive Services for Veteran Families Program (SSVF). In 2008, the SSVF program was established under Public Law 110-387. VA makes grants available to community agencies to provide services to low-income (<50 percent area median income) veterans and their families meeting one of three criteria:

- a) in permanent housing but at risk of becoming homeless,
- b) homeless, but moving into permanent housing within 90 days, or
- c) have left permanent housing within the past 90 days and are seeking new permanent housing (“rapid re-housing”).¹¹

Veterans and their families can receive tangible assistance for security deposits, back due rent, time limited rental and/or utilities assistance, and other supportive services. This is aimed to help those with an episode of acute homelessness, as opposed to those with chronic, long-term homelessness. In FY 2012, VA will make \$100 million in grants available for the SSVF program.

Domiciliary Care for Homeless Veterans (DCHV). The DCHV is one of several programs available as part of the VA Mental Health RRTPs (MH RRTPs).¹² This program specifically targets homeless veterans with mental health issues and provides them with structured rehabilitative services in a time-limited residential treatment

¹⁰ Michael J. Kussman, MD, former VA Undersecretary for Health, *Information and Recommendations for Services Provided by VHA Facilities to Veterans in the Criminal Justice System, 2009.*

¹¹ *Supportive Services for Veteran Families (SSVF) Program Fact Sheet*, DVA, VHA, Office of Patient Care Services.

¹² Other veterans who may benefit from residential treatment but are not necessarily homeless may participate in other RRTP programs, such as PTSD-RRTP, Substance Abuse RRTP.

program with a goal of reducing homelessness and successful transition into the community. Veterans engaged in the DCHV program receive a range of health care services including assessment, mental health and medical treatment as needed, and medication management. Additionally, veterans receive rehabilitative psychosocial and vocational training. This multi-faceted inter-disciplinary approach addresses some of the common risk factors for homelessness in an attempt to ease the transition back to an independent lifestyle. Operating at 43 sites with over 2,000 beds, the DCHV program had nearly 8,000 episodes of care in FY 2010.¹³

Homeless Veteran Dental Program (HVDP). Authorized under 38 U.S.C. § 2062 and funded by VA's Office of Dentistry, HVDP offers homeless veterans not ordinarily entitled to VA Dental Care a "one-time course of dental care" if the care is deemed a medical necessity. In order to be eligible, veterans must have received care for 60 consecutive days at a domiciliary, therapeutic residence, or other VA funded community residential care program, or a setting receiving funding through the VA's Homeless GPD Program.¹⁴

Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH). In 1992, VA partnered with the United States Department of Housing and Urban Development (HUD) to establish a program to reduce homelessness among veterans. The HUD-VASH program expanded dramatically following the 2008 Consolidated Appropriations Act (PL 110-161), which gave the program an additional \$75 million in funding. HUD-VASH combines HUD's Section 8 Housing Choice Vouchers (HCV)¹⁵ with "case-management and clinical services provided by the Department of Veterans Affairs (VA) at its medical centers and in the community."¹⁶ Under this program, HUD releases funds to the public housing authority that directly pays the property owner who an eligible veteran has entered into an approved leasing agreement with. The VA is required to screen the veterans for eligibility, assist in the housing search, and provide appropriate treatment and case-management to promote stability once housed. Eligibility criteria follow the McKinney-Vento Act but also include those veterans who are at imminent risk of homelessness due to eviction or discharge from an institution.¹⁷ As of June 2010, 15,304 formerly homeless veterans have been placed in housing with supportive case management under this program.¹⁸

¹³ *The Twenty-Second Progress Report on the Department of Veterans Affairs Domiciliary Care for the Homeless Program: Fiscal Year 2010*, DVA, Northeast Program Evaluation Center (NEPEC), 2011.

¹⁴ *Dental Care*, in *38 USC 2062 and Eligibility Guidelines for a One-Time Course of Dental Care for Certain Homeless and Other Enrolled Veterans*, DVA, VHA, Editor 2007.

¹⁵ Section 8 vouchers are vouchers for those with low income to get subsidized rent, administrated through a local city or county Housing Authority. Typically, participants pay 30 percent of their income towards rent and HUD pays the difference to the landlord.

¹⁶ *Federal Register*, 2008, Office of the Federal Register, National Archives and Records Administration, p. 25026-25028.

¹⁷ HUD-VASH Frequently Asked Questions, accessed from www.va.gov/homeless, accessed January 2012.

¹⁸ John Kuhn, MSW, MPH, Presentation at the 2010 VHA National Mental Health Conference, July 2010.

Supportive Housing (SH). The SH program operates similarly to the HUD-VASH program in that it offers case management to veterans and works to place them in permanent housing. However, Section 8 housing vouchers are not provided to participants in this program. VA staff help homeless veterans find landlords, roommates, and furniture and access community resources, and they case manage these veterans to help promote housing stability.

Homeless Providers GPD Program. Under 38 CFR 61.0, VA's Homeless Providers GPD Program provides funding to public and non-profit organizations providing housing and supportive services to the homeless. In order to receive funding, no more than 25 percent of the homeless individuals utilizing the organization's services can be non-veterans. Grants received from the VA can be used to help construct, renovate, and/or procure facilities or purchase vehicles to transport the homeless to supportive services. Per Diem funds help eligible organizations pay for the operational costs of providing housing and services to homeless veterans.¹⁹ VA staff provide case management of GPD Program participants while enrolled. As this housing is intended to be transitional (providing an opportunity to fully stabilize and save funds for permanent housing), veterans may live in a GPD Program housing facility for up to 24 months.

Employment Initiatives. VA's Compensated Work Therapy (CWT) Program is a vocational rehabilitation program offered to veterans that aims to match a veteran's strengths with local job opportunities to promote integration back into civilian life. Homeless veterans can benefit by utilizing the CWT/transitional residence (TR) Program, which may be one of the tracks within medical center RRTPs. Participants accepted to the CWT/TR Program live in a supervised environment, apply some CWT earnings towards current living expenses, and save remaining earnings to, ideally, move into permanent housing. Currently, there are over 30 CWT/TR Programs.

The Veterans' Employment and Training Service branch of the DOL administers the Homeless Veterans' Reintegration Program (HVRP). This program provides grants to eligible organizations to implement homeless veteran employment assistance programs. These grants require that outcomes data are provided, with an emphasis on moving homeless veterans into the workforce. DOL also makes available similar grants through the Homeless Female Veterans and Veterans with Families Program (HFVWF) and the Incarcerated Veterans Transition Program (IVTP).

Benefits Counselors. Public Law 102-590 provides the funds for VBA to maintain veterans' service representatives (benefits counselors) dedicated to assisting homeless veterans who are applying for monetary or other benefits. Public Law 107-95 established minimum staffing levels for these staff at each VA Regional Office. These staff expedite the benefits application process for homeless veterans, thereby helping to establish what may be the only source of income for these veterans.

¹⁹ VA *Homeless Providers Grant and Per Diem Program*, in 38 CFR 61 p. 1049–1070.

VA Homeless Data Collection and Program Evaluation.

Project Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG). Project CHALENG administers an annual survey on the status of homeless veterans to VA and non-VA homeless providers. VA established Project CHALENG in 1994 to help coordinate efforts between VA and non-VA entities that work with homeless veterans. For example, these reports include an inventory of the local supply and demand for emergency shelter, transitional housing, permanent housing, and other supportive services. Each local community may prioritize unmet needs differently. Survey results are utilized by VA to prioritize needs at a local level and plan for needed services and staffing. According to the 2009 CHALENG Report, there are roughly 107,000 homeless veterans on a single night.

Homeless Management Information System (HMIS) and Homeless Operations Management and Evaluation System (HOMES). In 2011, HUD and VA made mandatory the recording of homeless veteran data into HUD's HMIS.²⁰ All community organizations receiving federal funding to serve homeless persons must enter data into this centralized system. Extracting from this system, VA should be able to obtain more accurate counts of homeless veterans and utilization patterns and measure progress towards the Five-Year Plan. Data from the HMIS is aggregated and provided to Congress in the Annual Homeless Assessment Report (AHAR). VA's counterpart to HMIS for data collection of veterans in VA programs is HOMES. During 2011, VA staff began to enter data into HOMES for veterans seen in VA homeless programs (HCHV, HUD-VASH, DCHV, HCRV, and VJO).

Northeast Program Evaluation Center (NEPEC). This VA Center conducts program evaluation of services available to homeless veterans including HUD-VASH, CWT, and DCHV. NEPEC's multiple doctoral level staff are highly utilized by VHA to identify system performance problems, evaluate program impact on both clinical outcomes and costs, and provide ongoing monitoring of system performance.²¹ NEPEC staff are involved in the aggregation and analysis of HOMES data.

National Center on Homelessness Among Veterans. This VA center works collaboratively with academic partners to translate research findings into policy and practice, aiming to educate VA and community partners about emerging and evolving best practices towards ending veteran homelessness.

MST. VA uses MST to refer to the experiences of "physical assault of a sexual nature, battery of a sexual nature or sexual harassment that occurred while a veteran was serving

²⁰ John Kuhn, DVA, presentation at the NCHV Annual Conference, June 2011 and Deputy Under Secretary for Health for Operations and Management memorandum December 21, 2010, *VA Participation in the Homeless Management Information System (HMIS)*.

²¹ <http://vaww.nepec.mentalhealth.va.gov/index.htm>, accessed January 2012.

on active duty or active duty for training.”²² Sexual harassment is further defined as “repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.” Both males and females can experience MST, and the perpetrator can be of the same or of the opposite gender. Like other types of trauma, MST can negatively affect a person’s mental and physical health, even many years later.

The Veterans Health Care Act of 1992 (Public Law 102-585) authorized VA to provide outreach and establish MST counseling and treatment programs for women veterans who experienced incidents of sexual trauma while on active duty. In 1994, VA’s authority was expanded to include counseling and treatment for men (Public Law 103-452). The Veterans Health Program Improvement Act of 2004 (Public Law 108-422) extended VA’s authority to provide MST treatment permanently and extended MST counseling and related treatment to veterans whose MST occurred while serving on active duty or active duty for training. Based on these statutes, VHA Directive 2005-015, *Military Sexual Trauma Counseling*, dated March 25, 2005, mandated universal screening of all enrolled veterans for a history of MST and mandated that each VA medical facility appoint an MST Coordinator to oversee the screening and treatment referral process.

Directive 2005-015 also recommended the use of clinic stop code 524 so that collection of MST treatment data is accessible and consistent across the VA system. Clinic stop codes are identifiers used in VHA’s managerial cost accounting system, the Decision Support System (DSS), to indicate the primary clinical group providing the services. DSS is a congressionally-mandated resource management tool. Implementation began throughout VHA in 1994.

In 2010, at the request of the Senate Veterans’ Affairs Committee Chairman Daniel K. Akaka, the OIG conducted the *Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma*,²³ which investigated allegations of charging veterans at the Austin Outpatient Clinic for treatment as a result of MST. The investigation found that the clinic stop code specifically designated for MST-related care was inconsistently implemented at VHA medical facilities. In response to the OIG report recommendation, VHA Directive 2010-033, *Military Sexual Trauma (MST) Programming*, dated July 14, 2010, replaced the 2005 Directive. The revised Directive requires checking an MST indicator box on the encounter form if the treatment or counseling is related to MST, instead of using clinic stop code 524.

Under VA’s universal screening program for MST, all veterans seen at VHA facilities are asked whether they experienced sexual trauma during their military service. The brief screening instrument contains the following two questions:

²² Title 38, USC, Section 1720D, *Counseling and treatment for sexual trauma*.

²³ VAOIG report number 09-01110-81, issued February 4, 2010, <http://www4.va.gov/oig/54/reports/VAOIG-09-01110-81.pdf>

- Did you receive uninvited and unwanted sexual attention, such as touching or cornering, pressure for sexual favors, or verbal remarks?
- Did someone ever use force or the threat of force to have sexual contact with you against your will?²⁴

Patients are considered positive for MST if they respond affirmatively to either screening item. It is important to note that only veterans who have chosen to seek VA health care are screened for MST. Therefore, MST positive screen rates cannot be used to make any estimate of the MST rate among all those serving in the U.S. military, nor does a positive response indicate that the perpetrator was a member of the military.

VA provides free, confidential counseling and treatment for veterans' mental and physical health conditions resulting from MST. Veterans do not need to have reported the incidents when they happened or have other documentation that they occurred. Appropriate services are provided for any injury, illness, or psychological condition resulting from MST. In addition, veterans do not need to be service-connected and may be able to receive this benefit even if they are not otherwise eligible for VA health care.

VA Disability Compensation. Service-connected disability compensation is part of the VBA Compensation and Pension (C&P) program. It provides a tax-free monetary benefit paid to veterans who are disabled by injuries or diseases that were incurred or worsened during their military service. This benefit compensates veterans for the average loss in earnings capacity in civilian occupations commensurate with the severity of the service-connected conditions. Generally, service-disabled veterans who were discharged from military service under other than dishonorable conditions are entitled to compensation benefits, regardless of their income or employment status.

Disability compensation varies with the degree of disability and the number of a veteran's dependents (spouse, children, and dependent parents) and is paid monthly. As of December 1, 2011, the basic monthly compensation payments ranged from \$127 for a 10 percent-disabled veteran, to \$2,769 for a 100 percent-disabled veteran. For disability ratings of 30 percent or higher, VA pays additional benefits for veterans' dependents. For example, if a 60 percent-disabled veteran has a spouse and one child, the monthly payment increases by \$160, from \$1,009 to \$1,169. For very serious disabilities, such as the loss of limb(s), VA pays additional special monthly compensation.

Compensation payment rates are not proportional to the corresponding degrees of disability; higher disability ratings have disproportionately larger monetary benefits than lower ratings. For example, the basic monthly 100 percent disability compensation payment rate of \$2,769 is 21.8 times the 10 percent disability payment rate of \$127 and 3.5 times the 50 percent disability payment rate of \$797.

²⁴ Department of Veterans Affairs, *Military Sexual Trauma Independent Study Course*. Released January 2004. http://www.publichealth.va.gov/docs/vhi/military_sexual_trauma.pdf. (p. 14). Accessed 03/13/2012.

Scope and Methodology

The study population included all veterans aged 17–64 who were discharged from active military duty between July 1, 2005, and September 30, 2006, did not experience any episodes of homelessness before separation from active duty, and used DoD (including TRICARE) or VA (including VA purchased care through fee basis or contractual agreement) care after separation. We followed this cohort through September 30, 2010.

To address the study objectives, we reviewed relevant laws, regulations, and program documentation. We conducted a review of relevant reports and studies on homelessness and researched VA homeless programs. We met with VA subject matter experts and academia who conduct research on homelessness.

VA special assistance programs targeting homeless veterans consider veterans to be homeless if they meet the McKinney-Vento definition for “homeless individual.” We operationally defined *homeless veterans* as veterans who

- Used VA specialized homeless veterans programs,
- Had a completed VA health care for homeless veterans intake assessment (VA Form X), and/or
- Received an ICD-9-CM diagnostic code of V60.0 (indicating lack of housing) from VA or DoD.

Study Population and the LC Database.

We included all veterans aged 17–64 in the LC Database who did not experience an episode of homelessness before separation from active duty and used DoD or VA care after separation. The population-based LC Database identifies and captures information on all veterans who separated from active military duty during July 1, 2005–September 30, 2006, whether or not they enrolled in VA health care or applied for VA benefits after separation (VA users or non-VA users).

The LC Database was created and is maintained by the OIG. It is derived from more than 100 files acquired from VA and DoD and integrates details from both VA and DoD data on nearly 500,000 discharged service members. The LC Database is the first and, to date, the only available population-based, comprehensive analytic database that integrates both VA and DoD data on these recently discharged veterans. This population-based approach eliminates potential bias in the selection of veterans. For example, veterans who are VA users may differ from non-VA users in fundamental ways that affect veterans’ decisions to transition to VA care and impact policy, planning, and resource decisions.

Updates to the LC Database. The OIG report *Quantitative Assessment of Care Transition: The Population-Based LC Database*²⁵ describes the LC Database in detail, including an overview of its structure, the methodology used to create it, data confidentiality issues, and the opportunity it provides for VA to make decisions using an evidence-based approach. We used the LC Database as part of our work to respond to some congressionally requested evaluations and reported our results in the following VA OIG reports:

- *Access to VA Mental Health Care for Montana Veterans*,²⁶
- *Review of Combat Stress in Women Veterans: Receiving VA Health Care and Disability Benefits*,²⁷ and
- *Prosthetic Limb Care in VA Facilities*.²⁸

We updated the database to include information through September 30, 2010. DoD medical treatment data was available only through March 31, 2009. Updates to the LC Database are summarized below.

VA Disability Compensation. Because of compensation payment variations for given disability ratings and dual eligibility for both compensation and pension, we chose to work with disability ratings directly. We added to the LC Database up to nine impairment-specific disability ratings and the combined total disability rating as of the end of September 2010. Note that the combined disability rating is not a simple sum of each specific disability rating. For example, multiple zero ratings of specific disabilities could result in a 10 percent combined disability rating. These disability ratings were taken from both the extract of the Benefits Delivery Network (BDN) database (referred to as the C&P file) and from the extract of Corporate Data Warehouse's VetsNet database (referred to as the Corporate file), as VBA is transitioning from the BDN database to the Corporate file.

VA and DoD Treatment Information and Vital Status. Veterans' vital status information and all VA (including fee-basis care) medical treatment information were updated through the end of September 2010. Limited by the data availability, DoD treatment information was updated to March 31, 2009. For this report, the LC Database covers DoD treatment information from FY 2004 through March 2009 and VA treatment information from FY 2004 through September 2010.

²⁵ VA OIG Report No. 07-00380-202, September 13, 2007, <http://www.va.gov/oig/54/reports/VAOIG-07-00380-202.pdf>.

²⁶ VA OIG Report No. 08-00069-102, March 31, 2009, <http://www.va.gov/oig/54/reports/VAOIG-08-00069-102.pdf>.

²⁷ VA OIG Report No. 10-01640-45, December 16, 2010, <http://www.va.gov/oig/52/reports/2011/VAOIG-10-01640-45.pdf>.

²⁸ VA OIG Report No. 11-02138-116, March 8, 2012, <http://www.va.gov/oig/pubs/VAOIG-11-02138-116.pdf>.

In addition to updating the original 11 diagnostic-specific indicators in the LC Database, we added new diagnostic-specific indicators. These indicators were created based on patients' specific ICD-9-CM diagnostic codes, using the same business rules detailed in the 2007 OIG report, *Quantitative Assessment of Care Transition: The Population-Based LC Database*.²⁹ ICD-9-CM groups these disease diagnostic codes into 17 broad categories. We created an indicator for each of the 17 broad ICD-9-CM categories, except for Neoplasms (140–239) that used two indicators, one for Malignant Neoplasms (140–208) and another for Benign Neoplasms (210–239).

Mental Disorders were defined as any ICD-9-CM diagnosis from 290.0 to 319.0, which corresponds to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised* (DSM-IV-R).

Additionally, we added the following specific categories of mental disorders using Hoge's definitions:³⁰

- Adjustment disorders. ICD-9-CM: 309.0, 309.24, 309.28, 309.3, 309.4, 309.9.
- Anxiety disorders. ICD-9-CM: 300.00, 300.01, 300.02, 300.21, 300.22, 300.23, 300.29, 300.3, 308.3, 309.81.
- Anxiety disorders excluding PTSD. ICD-9-CM: 300.00, 300.01, 300.02, 300.21, 300.22, 300.23, 300.29, 300.3, 308.3.
- PTSD. ICD-9-CM: 309.81.
- Major depression. ICD-9-CM: 296.2, 296.3.
- Mood disorders. ICD-9-CM: 296.0, 296.2–296.7, 296.80, 296.89, 296.90, 300.4, 301.13, 311.
- Personality disorders. ICD-9-CM: 301.0, 301.2, 301.4, 301.50, 301.6, 301.7, 301.81–301.84, 301.89, 301.9.
- Psychotic disorders. ICD-9-CM: 295.1–295.4, 295.6, 295.7, 295.9, 297.1, 297.3, 298.8, 298.9.
- Substance-related disorders. ICD-9-CM: 291, 292 (except 292.2), 303–305 (except 305.1 and 305.8).
- Alcohol-related disorders. ICD-9-CM: 291, 303, 305.0.
- Drug-related disorders. ICD-9-CM: 292 (except 292.2), 304, 305.2–305.7, 305.9.

²⁹ VA OIG Report No. 07-00380-202, September 13, 2007, <http://www.va.gov/oig/54/reports/VAOIG-07-00380-202.pdf>.

³⁰ Hoge CW, Lesikar SE, Guevara R, Lange J, Brundage JF, Engel CC, Messer SC, Orman DT: *Mental Disorders Among US Military Personnel in the 1990s: Association with High Levels of Health Care Utilization and Early Military Attrition*. *American Journal of Psychiatry* 2002; 159:1576–1583.

MST. MST indicators were created from two types of VHA Medical SAS data files—the MST Registry files and the Outpatient files. The MST Registry files were discontinued after FY 2005. The outpatient files (from FY 2005 forward) contained an MST indicator for each encounter that was checked by health care providers if the treatment or counseling was related to MST. We defined a patient as having MST if the patient was included in any MST registry files or had an MST indicator in any of the outpatient files. We used the FYs 2001–2005 MST registry files and the FYs 2005–2010 outpatient files to generate the MST indicators.

VA Homeless Intake Assessment. We acquired and added the files that garner the information from VA Form X to the LC Database. The HCHV intake assessment is completed by HCHV clinicians when they encounter a homeless veteran. The intake assessment files contain assessments performed from FY 2000 through December 2010.

The updated LC Database currently incorporates details about all 491,800 service members discharged or released alive from active military duty during the period July 1, 2005–September 30, 2006. Because of delays in reporting deaths, the total number discharged alive (491,800) in the current database differs from that (494,147) in the 2007 report, *Quantitative Assessment of Care Transition: The Population-Based LC Database*.³¹

Statistical Analyses

Our analyses included veterans in the LC Database who did not suffer any homeless episodes before discharge from active duty. We excluded veterans whose age at separation was under 17 or over 64 or date of birth was unknown. Age at separation was calculated using the date at separation and the date of birth. When date of birth was in conflict among the files, we used the date of birth from two or more sources that agreed; otherwise, we reset the birth date to the first one of the three files with a valid date in the order of the military discharge, VA treatment, and DoD treatment files.

We considered a service member as having served in a Reserve/National Guard unit if Reserve/National Guard status was indicated in any of the DoD’s Reserve Affairs roster, the OEF/OIF file provided to VA by DoD, or VA/DoD Identity Repository (VADIR) reserve files before their separation date from active duty. Similarly, we defined a service member as having served in OEF/OIF, if OEF/OIF status was indicated in the OEF/OIF file before their separation date.

For service branch, the “Other” category of service combined all branches other than Army, Navy, Air Force, and Marine Corps, including missing branch information.

We re-categorized service character as follows:

³¹ VA OIG Report No. 07-00380-202, September 13, 2007, <http://www.va.gov/oig/54/reports/VAOIG-07-00380-202.pdf>.

- **Honorable/General** incorporates “Honorable” and “General, Under Honorable Conditions.” This category also includes those judged “Honorable for VA Purposes” by VBA.
- **Other Than Honorable.**
- **Bad Conduct/Dishonorable** includes “Bad Conduct” and “Dishonorable” discharges. It also includes those judged “Dishonorable for VA Purposes” by VBA.
- **Uncharacterized** consists of those without character of service listed.

“Bad Conduct/Dishonorable” discharges issued by general courts-martial may bar veterans from receiving VA benefits. Therefore, veterans who separated administratively under “Other Than Honorable” conditions may request that their discharge be reviewed for possible re-characterization, for the purpose of obtaining VA benefits.

We grouped pay grade into five categories: E1–E4, E5–E9, O1–O3, O4–O10, and “Other.” The “Other” group included W1–W5, codes other than specified above, and missing pay grade information.

Awards for mental disability conditions contained all awards with VBA disability condition codes 9100–9599, including PTSD disability condition code 9411, as a specific mental disability.

The DCHV program is under the VA MH RRTPs. DCHV outpatient encounters were identified by clinic stop codes 725–727³² prior to the switch to 593–595³³ in FY 2009 at the request of the Office of Mental Health services. We employed the clinic stop codes 725–727 and 593–595 (for outpatient encounters) as well as specialty code 37 (inpatient) to capture the utilization of DCHV.

We identified all homeless episodes for each veteran in the study population from FY 2004 through FY 2010. An episode of homelessness is defined as the presence of one of the following:

1. Had a completed VA health care for homeless veterans intake assessment (VA Form X);
2. One of the following clinic stop codes in VA medical treatment records:
 - HUD-VASH (522),³⁴

³² NEPEC, *Health Care for Homeless Veterans Programs: The Twenty-Third Annual Report*, p. 276. March 25, 2010.

³³ VHA - Decision Support Office, *Reference D: Decision Support System (DSS) Identifiers FY09 Highlights and FY08 Overview*. <http://vaww.dss.med.va.gov/DSS%20Documents/DSS%20Identifiers-Stopcodes/D%20-%20Highlights%20of%20DSS%20ID%20changes%2008-19-08.doc>. October 1, 2008. Accessed 01/18/2012.

³⁴ Records patient visit by staff of the HUD-VASH program for homeless veterans and families of these veterans. Workload needs to reflect activity related to permanent housing as well as caring for formerly homeless veterans in

- Telephone/HUD-VASH (530),³⁵
 - HCHV/HCMI (529),³⁶
 - Telephone/HCMI (528),³⁷ and
 - Community Outreach to Homeless Veterans by Staff Other than HCHV and RRTPs (590);³⁸
3. ICD-9-CM V-code V60.0 (indicating lack of housing) in VA or DoD medical treatment records; or
 4. Homeless indicator on the veteran's VA Social Work Case (650) file/encounter form.³⁹

We excluded veterans who experienced any homeless episodes before military separation from the study. Veterans were counted as homeless veterans if they experienced at least one episode of homelessness after discharge from active duty.

For the veterans who had episodes of homelessness, we define the date of becoming homeless as the date of his/her earliest homeless episode.

Homeless incidence rates were calculated using the Kaplan–Meier method.⁴⁰ The separation (DD214) date from active duty was considered day zero (0) for calculation of follow-up duration. The follow-up cutoff date for the study was September 30, 2010. Veterans who did not experience any episodes of homelessness by the cutoff date and used VA health care in FY 2011 were censored as of September 30, 2010, or censored as of their last day of clinical encounter date at DoD or VA, whichever occurred last. The potential follow-up times ranged from 4 years to 5 years and 3 months. The Kaplan-Meier estimator takes into account censoring and different lengths of follow-up

permanent housing. Includes provider and other services including psychology, social work, nursing, rehabilitation, and support services.

³⁵ Records patient consultation or medical care management, advice, and/or referral provided by telephone staff of the HUD-VASH program to homeless veterans who are being case-managed in the HUD-VASH program, or who are being screened for placement, and to family members of these veterans.

³⁶ Records patient visit provided by clinical staff of HCHV and GPD Programs (except for programs with specific stop codes, such as the HUD-VASH program) to HCMI veterans with mental and/or substance abuse disorders or family members of such veterans. Includes provider and support services. This stop code is restricted to HCHV and GPD Programs approved by NEPEC. Programs not meeting this requirement should use DSS Identifier 590.

³⁷ Records patient consultation or medical care management, advice, and/or referral provided by staff funded through the HCHV programs (except for those programs assigned to other specific stop codes, such as the HUD-VASH program) to homeless veterans with mental and or substance abuse disorders, or to family members of these veterans.

³⁸ Records outreach services to veterans carried out by VA staff other than designated staff of the HCHV or RRTP programs. This identifier is used when the facility has no NEPEC approved HCHV program. Programs with NEPEC approved HCHV programs should use DSS Identifier 529.

³⁹ *VIReC Research User Guide: FY2006 VHA Medical SAS Outpatient Datasets*, p. 48

⁴⁰ Kaplan E.L., Meier P. Nonparametric estimation from incomplete observations. *J Cancer Res Clin Oncol*. 1958; 53: 457–9.

times. Log rank tests were used to test differences in four incidence curves defined by OEF/OIF status and gender.

We performed data analyses using SAS statistical software (SAS Institute, Inc., Cary, NC), version 9.3 (TS1M0).

The study was performed by OHI in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of Inspectors General on Integrity and Efficiency.

Results and Conclusions

The study population comprised all 310,685 veterans aged 17–64 in the LC Database who did not experience an episode of homelessness before separation from active duty and used DoD or VA care after separation (Exhibit 1). Of the 491,800 veterans in the LC Database, we excluded 180,748 veterans who did not use DoD or VA health care after separation and 320 who experienced a homeless episode prior to military separation. In addition, we excluded 47 veterans who were either younger than 17 (1) or older than 64 (44) at time of separation from active military duty, or whose dates of birth were unknown (2).

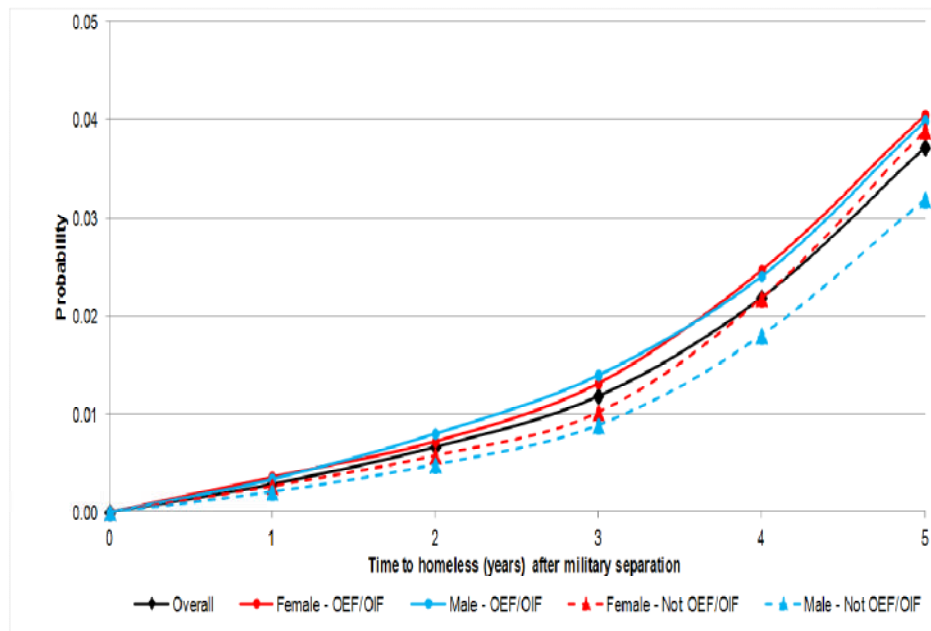
Exhibit 1. Study Population, Inclusions, and Exclusions

| | Number |
|---|----------------|
| LC Database population | 491,800 |
| Exclusions (Total) | 181,115 |
| Veterans who did not use VA or DoD care after military separation | 180,748 |
| Homeless episode prior to military separation | 320 |
| Age is missing | 2 |
| Age is less than 17 | 1 |
| Age is greater than 64 | 44 |
| Study population | 310,685 |

OEF/OIF and Women Veterans Experienced Higher Homeless Incidences after Military Separation than Their Non-OEF/OIF and Male Counterparts

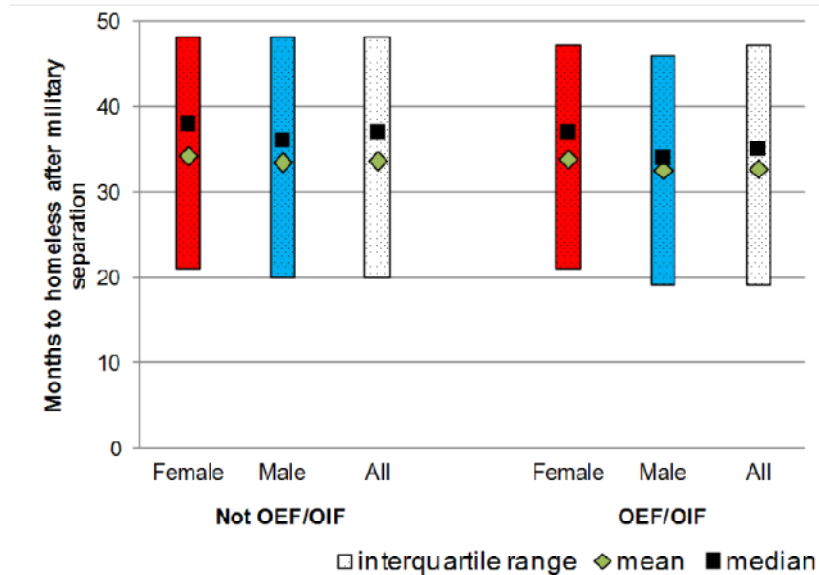
The veteran homeless incidence (the newly homeless) rate at 5 years after discharge from active duty is 3.71 percent with the 95 percent confidence interval of 3.71–3.72 percent (Exhibit 2). The four gender and OEF/OIF status specific incidence curves are statistically significantly different from each other ($p < 0.0001$). The 5-year homeless incidence rates by OEF/OIF status and gender vary from 3.2 percent for non-OEF/OIF men to 4.0 percent for OEF/OIF women veterans. OEF/OIF veterans experienced higher homeless incidences than non-OEF/OIF veterans at each year of the first 5 years after discharge. For the given OEF/OIF status, women veterans generally experienced higher homeless incidences than men, except for OEF/OIF veterans at the second and third year after separation from the military.

Exhibit 2. Incidence of Homelessness After Military Separation by OEF/OIF Status and Gender



Among the veterans who became homeless, the median times to the first episode of homelessness were close to 3 years, indicating half of the new episodes of homelessness occurred 3 years after discharge from active duty. The median times varied from 34 months after leaving the military for OEF/OIF men to 38 months for non-OEF/OIF women. The median times of both men and women OEF/OIF homeless veterans were less than those of non-OEF/OIF homeless veterans (Exhibit 3), indicating OEF/OIF homeless veterans encountered their first homeless episode sooner than their non-OEF/OIF counterparts after discharge from active duty. The first homeless episode of newly homeless male OEF/OIF veterans occurred sooner than their women counterparts as revealed by the men's shorter median times than women's.

Exhibit 3. Time to First Homeless Episode After Military Separation by OEF/OIF Status and Gender



Veterans Who Became Homeless after Military Separation Were Younger, Enlisted with Lower Pay Grades, and Were More Likely To Be Diagnosed With Mental Disorders and/or TBI at the Time of Separation from Active Duty than Their Domiciled Counterparts

Exhibit 4 shows the baseline (at separation from active duty) characteristics of the study population by homeless status, OEF/OIF status, and gender. By the end of September 2010, 5,574 veterans in the study population had experienced their first (incidence) homeless episode after discharge from active duty. Women make up approximately the same percentage of the homeless cohorts as they do in the domiciled cohorts with 15.4 percent (861/5,574) and 15.2 percent (46,258/305,111), respectively.

**Exhibit 4. Baseline (at Military Separation) Characteristics of Study Population
by Homeless Status, OEF/OIF Status, and Gender**

| | Homeless Veterans (5,574) | | | | | | Domiciled Veterans (305,111) | | | | | |
|---------------------------|---------------------------|-------|-------|---------|-------|-------|------------------------------|---------|---------|---------|---------|---------|
| | Not OEF/OIF | | | OEF/OIF | | | Not OEF/OIF | | | OEF/OIF | | |
| | Female | Male | All | Female | Male | All | Female | Male | All | Female | Male | All |
| Age at separation (years) | 456 | 1,493 | 1,949 | 405 | 3,220 | 3,625 | 28,025 | 109,481 | 137,506 | 18,233 | 149,372 | 167,605 |
| mean | 27.1 | 27.7 | 27.5 | 28.2 | 28.5 | 28.4 | 29.4 | 30.7 | 30.4 | 29.6 | 31.4 | 31.2 |
| median | 25 | 25 | 25 | 26 | 25 | 25 | 26 | 27 | 27 | 26 | 28 | 28 |
| Age categories | | | | | | | | | | | | |
| 17–24 | 48.5 | 49.1 | 49.0 | 41.2 | 43.5 | 43.3 | 43.5 | 40.2 | 40.9 | 37.1 | 32.8 | 33.2 |
| 25–34 | 35.5 | 30.3 | 31.6 | 40.7 | 35.5 | 36.1 | 27.8 | 24.0 | 24.7 | 37.0 | 32.5 | 33.0 |
| 35–44 | 11.2 | 15.3 | 14.4 | 13.6 | 15.3 | 15.1 | 19.0 | 23.4 | 22.5 | 18.0 | 24.1 | 23.5 |
| 45–54 | 4.6 | 4.7 | 4.7 | 3.7 | 5.3 | 5.1 | 8.5 | 10.5 | 10.1 | 7.2 | 9.1 | 8.9 |
| 55–64 | 0.2 | 0.5 | 0.5 | 0.7 | 0.4 | 0.4 | 1.3 | 2.0 | 1.8 | 0.7 | 1.5 | 1.4 |
| Branch (%) | | | | | | | | | | | | |
| Army | 49.8 | 58.7 | 56.6 | 68.6 | 68.5 | 68.5 | 53.3 | 54.5 | 54.3 | 63.8 | 65.0 | 64.9 |
| Navy | 27.4 | 19.0 | 21.0 | 17.3 | 13.1 | 13.5 | 18.6 | 16.2 | 16.7 | 15.0 | 10.7 | 11.1 |
| Air Force | 17.3 | 9.5 | 11.3 | 10.1 | 4.0 | 4.7 | 21.3 | 16.0 | 17.1 | 16.7 | 10.6 | 11.3 |
| Marines | 4.0 | 10.3 | 8.8 | 4.0 | 14.4 | 13.2 | 5.0 | 11.0 | 9.8 | 4.4 | 13.7 | 12.7 |
| other | 1.5 | 2.6 | 2.3 | 0.0 | 0.1 | 0.1 | 1.9 | 2.3 | 2.2 | 0.1 | 0.1 | 0.1 |
| Character of service (%) | | | | | | | | | | | | |
| Honorable/General | 90.1 | 86.6 | 87.4 | 93.6 | 91.3 | 91.5 | 87.1 | 89.4 | 88.9 | 93.1 | 91.8 | 91.9 |
| Other than Honorable | 1.8 | 5.1 | 4.3 | 0.3 | 3.0 | 2.7 | 0.4 | 0.6 | 0.5 | 0.3 | 0.5 | 0.4 |
| BC/Dishonorable | 0.2 | 0.5 | 0.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 |
| Uncharacterized/missing | 7.9 | 7.8 | 7.8 | 6.2 | 5.7 | 5.7 | 12.5 | 10.0 | 10.5 | 6.6 | 7.8 | 7.6 |
| Military pay grade (%) | | | | | | | | | | | | |
| E1–E4 | 73.7 | 77.7 | 76.8 | 70.9 | 69.9 | 70.0 | 51.2 | 47.6 | 48.3 | 41.1 | 39.4 | 39.6 |
| E5–E9 | 22.4 | 19.0 | 19.8 | 26.4 | 28.8 | 28.5 | 33.9 | 38.3 | 37.4 | 47.3 | 49.2 | 49.0 |
| O1–O3 | 2.2 | 1.7 | 1.9 | 1.2 | 0.7 | 0.7 | 7.4 | 5.3 | 5.7 | 6.8 | 4.7 | 4.9 |
| O4–O10 | 1.3 | 0.9 | 1.0 | 1.5 | 0.4 | 0.5 | 6.8 | 7.5 | 7.3 | 4.1 | 5.3 | 5.1 |
| other | 0.4 | 0.6 | 0.6 | 0.0 | 0.3 | 0.3 | 0.8 | 1.4 | 1.3 | 0.7 | 1.5 | 1.4 |
| Military component (%) | | | | | | | | | | | | |
| Active | 90.8 | 87.9 | 88.6 | 65.4 | 62.5 | 62.8 | 87.7 | 85.5 | 86.0 | 53.7 | 47.3 | 48.0 |
| Reserve/Guard | 9.2 | 12.1 | 11.4 | 34.6 | 37.5 | 37.2 | 12.3 | 14.5 | 14.0 | 46.3 | 52.7 | 52.0 |

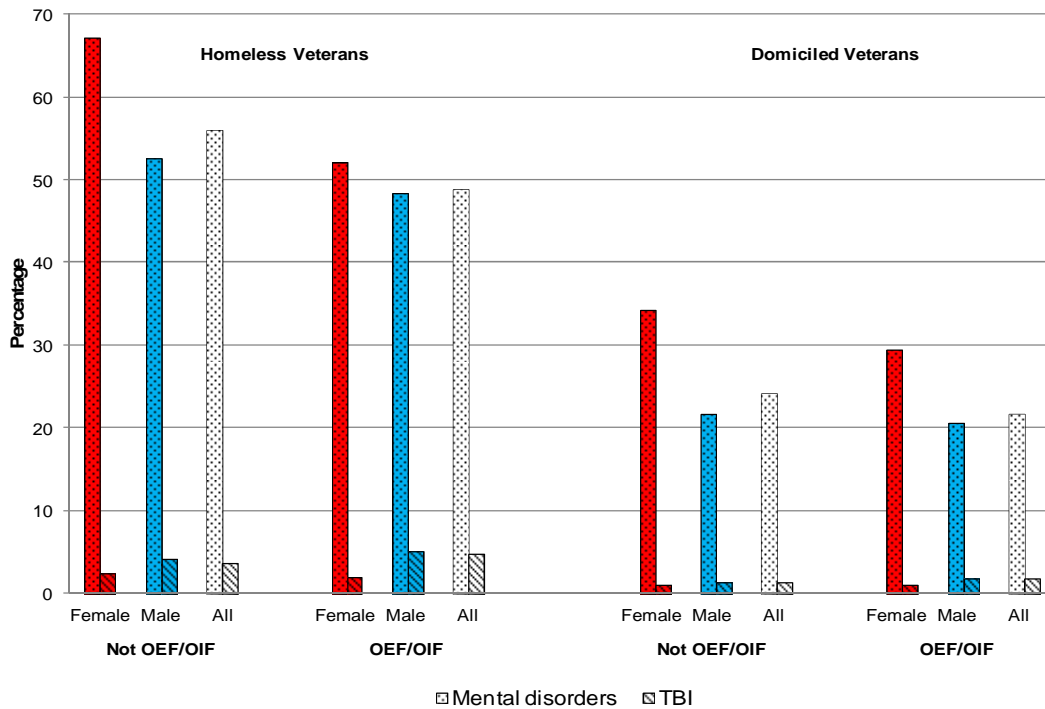
Regardless of OEF/OIF status and gender, veterans who experienced homelessness after military separation were younger and enlisted with lower pay grades at the time of separation from active duty than their domiciled counterparts (Exhibit 4). At discharge from active duty, 79–84 percent of homeless veterans were under age 35, with a median age of 25 regardless of their OEF/OIF status and gender, except for OEF/OIF females with a median age of 26. In contrast, 64–74 percent of domiciled veterans were under 35, with median age of 26 for females regardless of OEF/OIF status, and 27 and 28 for non-OEF/OIF and OEF/OIF males respectively. Most (70–78 percent) of the homeless veterans were enlisted and in the pay grades of E1–E4, compared with 39–51 percent of the domiciled veterans.

Exhibits 5–8 depict the percentages of veterans who were diagnosed with TBI or mental disorders prior to discharge from active duty (from FY 2004 to discharge) by homeless status, OEF/OIF status, and gender. Mental disorders comprise mental illness and substance-related disorders. The six specific mental illness categories we included in the study are anxiety disorders (excluding PTSD), PTSD, adjustment disorders, mood disorders, personality disorders, and psychotic disorders. PTSD is a specific type of

anxiety disorder in Hoge’s definitions;⁴¹ we used anxiety disorders to indicate “anxiety disorders excluding PTSD” in this report to separately report burdens of PTSD and anxiety disorders excluding PTSD. The category of mood disorders includes major depression (ICD-9-CM: 296.2, 296.3). For substance-related disorders, we also reported the results separately for its two subcategories: alcohol-related and drug-related disorders.

Across OEF/OIF status and gender, higher percent of homeless veterans were diagnosed with TBI and mental disorders than their domiciled counterparts before separation from the military. Nearly half or more of homeless veterans were diagnosed with some mental disorders (Exhibit 5): 52 percent and 48 percent for OEF/OIF female and male homeless veterans, respectively; and 67 and 53 percent for non-OEF/OIF females and males, respectively. These percentages were about double those of their domiciled counterparts: 30 percent and 21 percent for OEF/OIF female and male domiciled veterans, respectively; and 34 and 22 percent for non-OEF/OIF females and males, respectively. The percents of homeless veterans diagnosed with TBI were nearly 2 times higher than their domiciled women counterparts and about 3 times higher than their male counterparts, regardless of OEF/OIF status.

Exhibit 5. Veterans Diagnosed With Mental Disorders and TBI Prior to Military Separation, by Homeless Status, OEF/OIF Status, and Gender



⁴¹ Hoge CW, Lesikar SE, Guevara R, Lange J, Brundage JF, Engel CC, Messer SC, Orman DT: *Mental Disorders Among US Military Personnel in the 1990s: Association with High Levels of Health Care Utilization and Early Military Attrition*. American Journal of Psychiatry 2002; 159:1576–1583.

For each specific category of mental disorders diagnoses prior to military separation (Exhibits 6–8), the percentages of homeless veterans diagnosed were at least 2 times higher than those of their domiciled counterparts, regardless of OEF/OIF status and gender, except for the category of anxiety disorder (excluding PTSD) for OEF/OIF females (7.4 percent for domiciled and 13.8 percent for homeless). In particular, PTSD diagnoses in homeless veterans were about 3 times higher than those in their domiciled counterparts. The percentages of psychotic disorders for homeless veterans were over 7 times higher than those of their domiciled counterparts although all these percentages were under 5.

Mood disorders (including major depression) and adjustment disorders were the top two most diagnosed categories for women, and the percentages of homeless women diagnosed were more than double their domiciled counterparts. The percentages of homeless women diagnosed with mood disorders were 40.8 for non-OEF/OIF veterans and 31.1 for OEF/OIF. About 20 percent of homeless men were diagnosed with adjustment disorder and mood disorders regardless of OEF/OIF status. The percentages of homeless men diagnosed with substance-related disorders were similar: 22.2 for non-OEF/OIF veterans and 23.1 for OEF/OIF veterans.

Exhibit 6. Veterans Diagnosed With Anxiety, PTSD, and Adjustment Disorders Prior to Military Separation, by Homeless Status, OEF/OIF Status, and Gender

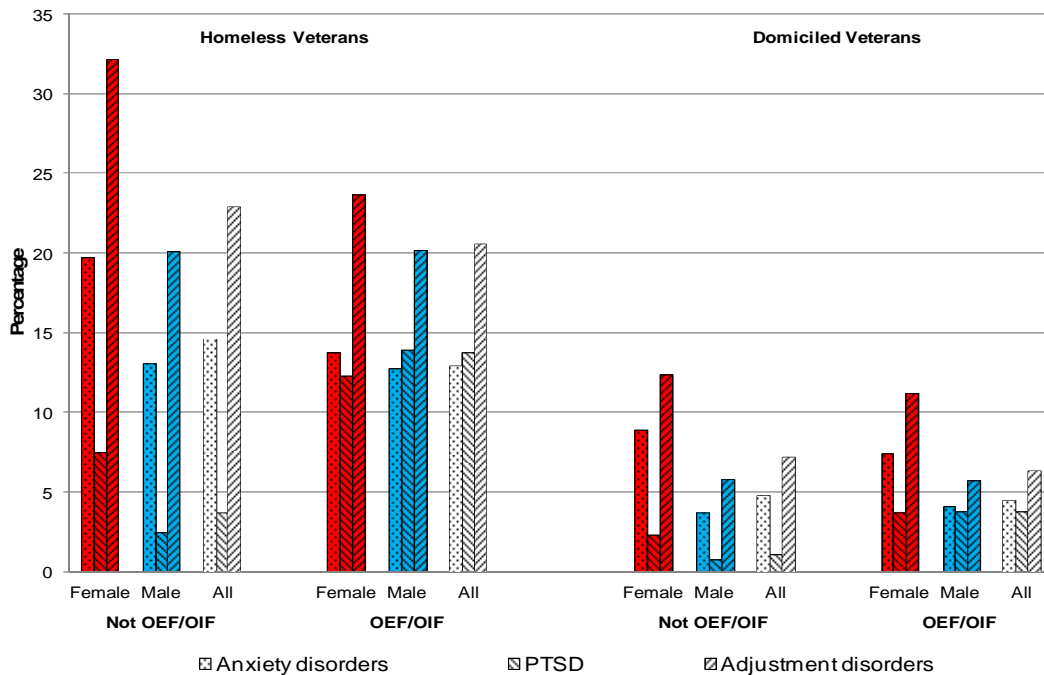


Exhibit 7. Veterans Diagnosed With Mood, Personality, and Psychotic Disorders Prior to Military Separation, by Homeless Status, OEF/OIF Status, and Gender

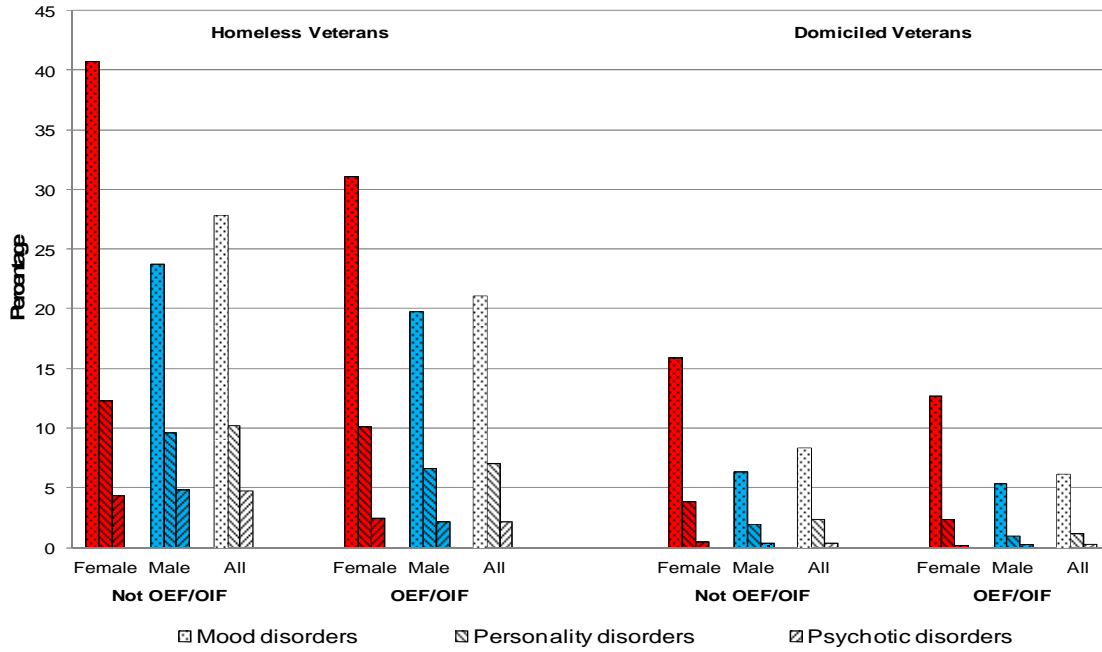
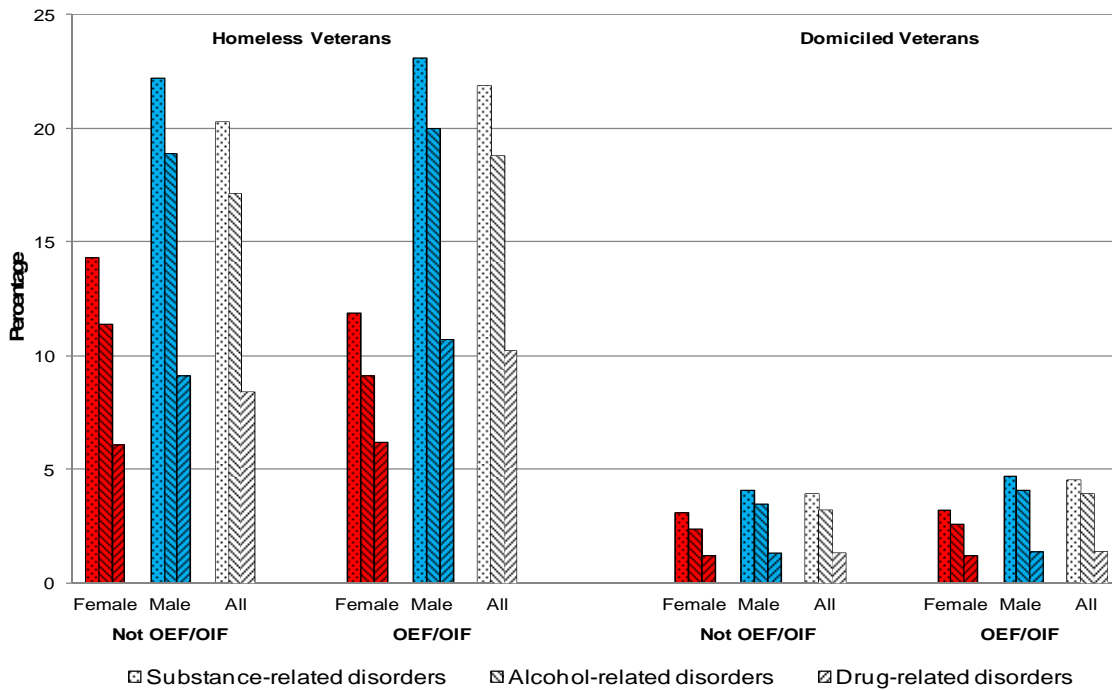


Exhibit 8. Veterans Diagnosed With Substance-Related Disorders Prior to Military Separation, by Homeless Status, OEF/OIF Status, and Gender



Within the homeless and domiciled veteran sub-populations, higher percentages of OEF/OIF veterans were diagnosed with PTSD than their non-OEF/OIF counterparts across gender. In contrast, non-OEF/OIF men and women experienced higher percentages of mental disorders and its specific categories of mood disorders, personality disorders, and psychotic disorders. We observed the following similar percentages for OEF/OIF and non-OEF/OIF:

- Anxiety disorder (excluding PTSD) for domiciled male veterans – 3.7 percent for non-OEF/OIF and 4.1 percent for OEF/OIF
- Adjustment disorder for homeless male veterans – 20.1 percent for non-OEF/OIF and 20.2 percent for OEF/OIF
- Substance-related disorders for
 - homeless male veterans – 22.2 percent for non-OEF/OIF and 23.1 percent for OEF/OIF
 - domiciled female veterans – 3.1 percent for non-OEF/OIF and 3.2 percent for OEF/OIF
 - domiciled male veterans – 4.1 percent for non-OEF/OIF and 4.7 percent for OEF/OIF

Women veterans were more likely to be diagnosed with mental disorders and with the specific mental illness categories of anxiety disorders (excluding PTSD), adjustment disorders, mood disorders, and personality disorders before separation from the military. Across homeless and OEF/OIF status, higher percentages of women veterans were diagnosed with mental disorders and with each of its specific categories of mental illness than their men counterparts, except for similar percentages of PTSD diagnoses for OEF/OIF veterans (regardless of homeless status) and psychotic disorders diagnoses for non-OEF/OIF homeless veterans and for OEF/OIF domiciled veterans. Fewer women veterans were diagnosed with substance-related disorders and its subcategories of alcohol and drug-related disorders (regardless of homeless and OEF/OIF status).

Homeless Veterans Were More Likely To Be Diagnosed With Mental Disorders, TBI, and/or Receive MST-Related Treatment after Discharge from Active Duty

Exhibits 9–12 chart the percentages of veterans who were diagnosed with TBI, mental disorders and its six specific categories of mental illness and substance-related disorders at VA (including VA purchased care through fee basis or contractual agreement) or DoD/TRICARE after discharge from active duty to September 30, 2010—the cutoff date of our study for the report—by homeless status, OEF/OIF status, and gender. The six specific mental illness categories of mental disorders we examined separately are anxiety

disorders (excluding PTSD), PTSD, adjustment disorders, mood disorders, personality disorders, and psychotic disorders. For substance-related disorders, we also included the results separately for its two subcategories: alcohol-related and drug-related disorders.

Exhibit 9. Veterans Diagnosed With Mental Disorders and TBI as of September 30, 2010, by Homeless Status, OEF/OIF Status, and Gender

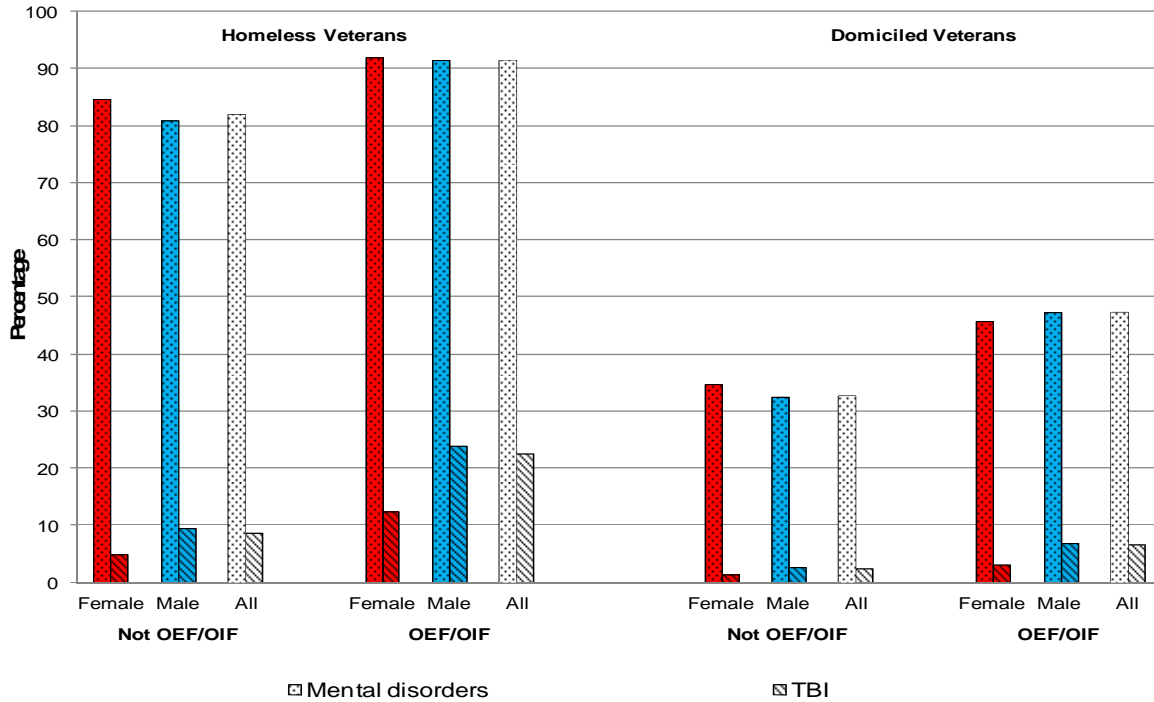


Exhibit 10. Veterans Diagnosed With Anxiety, PTSD, and Adjustment Disorders as of September 30, 2010, by Homeless Status, OEF/OIF Status, and Gender

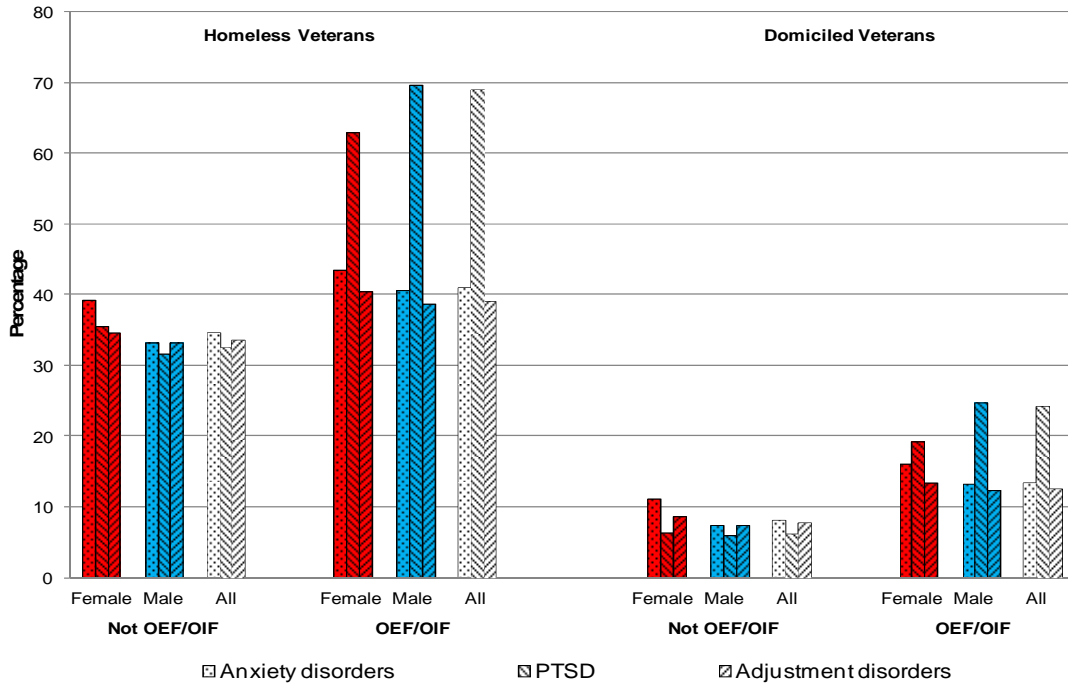


Exhibit 11. Veterans Diagnosed With Mood, Personality, and Psychotic Disorders as of September 30, 2010, by Homeless Status, OEF/OIF Status, and Gender

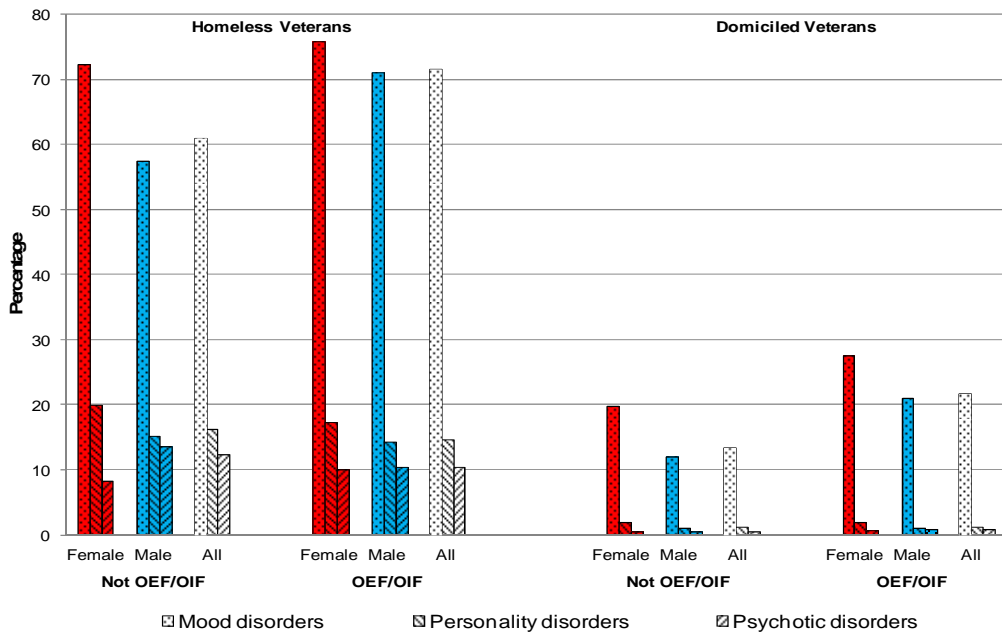
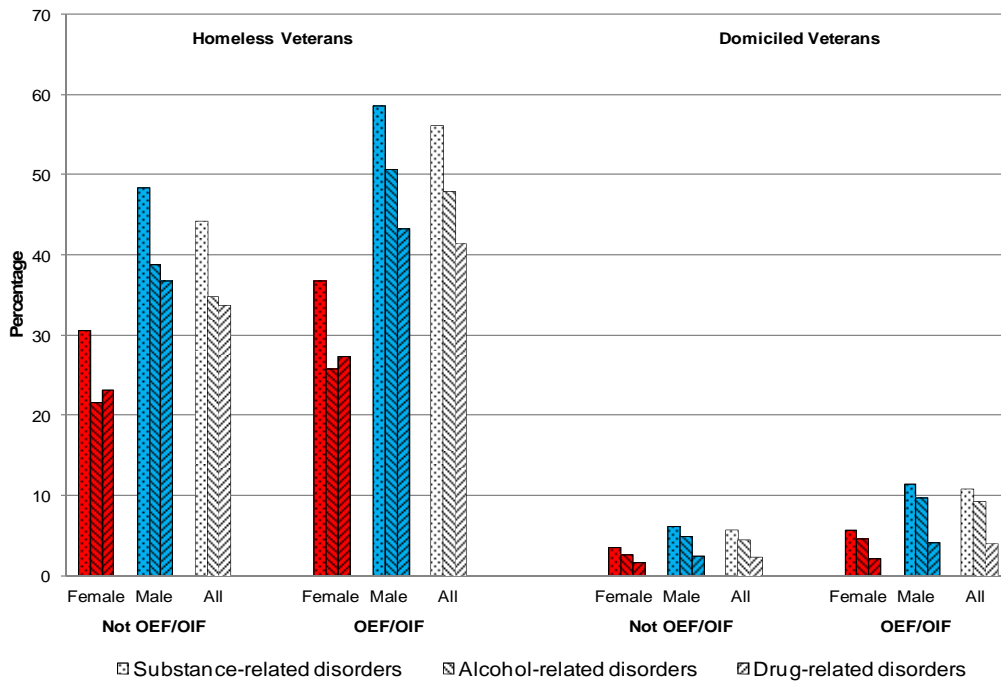


Exhibit 12. Veterans Diagnosed With Substance-Related Disorders as of September 30, 2010, by Homeless Status, OEF/OIF Status, and Gender



As of the end of September 2010, much higher percents of homeless veterans were diagnosed with mental disorders and TBI than their domiciled counterparts after military separation, regardless of OEF/OIF status and gender. Over 80 percent of homeless veterans in the study population were diagnosed with some mental disorders after separation from the military (Exhibit 9) across OEF/OIF status and gender, about double the percent of their corresponding domiciled counterparts. TBI diagnosis percentages for homeless veterans were over 3 times higher than those of their domiciled counterparts, regardless of OEF/OIF status and gender.

As of the end of September 2010, (Exhibits 10–12), the percentages of homeless veterans diagnosed with anxiety disorders (excluding PTSD), PTSD, adjustment disorders, or mood disorders were 2–5 times higher than those of their domiciled counterparts, regardless of OEF/OIF status and gender. The percentages of personality disorders for homeless veterans ranged from 14.3 to 20.0, compared with 1.0 to 2.0 percent of their domiciled counterparts, across OEF/OIF status and gender. The percentages of homeless veterans diagnosed with psychotic disorders varied from 8.3 to 13.6, in contrast to 0.5 to 0.8 of their domiciled counterparts across OEF/OIF status and gender. The percentages of homeless veterans diagnosed with substance-related disorders ranged from 30.7 percent for non-OEF/OIF females to 58.6 percent for OEF/OIF males, which were 5–8 times higher than their domiciled counterparts whose percentages varied from 3.6 percent for non-OEF/OIF females to 11.4 percent for OEF/OIF males.

Within the homeless and domiciled veteran sub-populations and across gender, a higher percent of OEF/OIF veterans was diagnosed with mental disorders and some of its specific disorder categories than their non-OEF/OIF counterparts at the end of the study. The exceptions were for the categories of personality disorders and psychotic disorders (Exhibits 9–12). These patterns differ from those at separation from active duty, which reveal non-OEF/OIF veterans generally had higher diagnosis percentages of mental disorders and the specific mental disorder categories other than PTSD.

To investigate further, we looked at the patterns of mental disorders diagnoses over time: at military separation (baseline), after military separation up to the date of first episode of homelessness (homeless veterans only), and as of September 30, 2010, (end of the study). These results are given in Exhibits 13–16.

Exhibit 13. Veterans Diagnosed With Mental Disorders and TBI Over Time (Prior to Military Separation, Before Becoming Homeless, as of September 30, 2010) by Homeless Status, OEF/OIF Status, and Gender

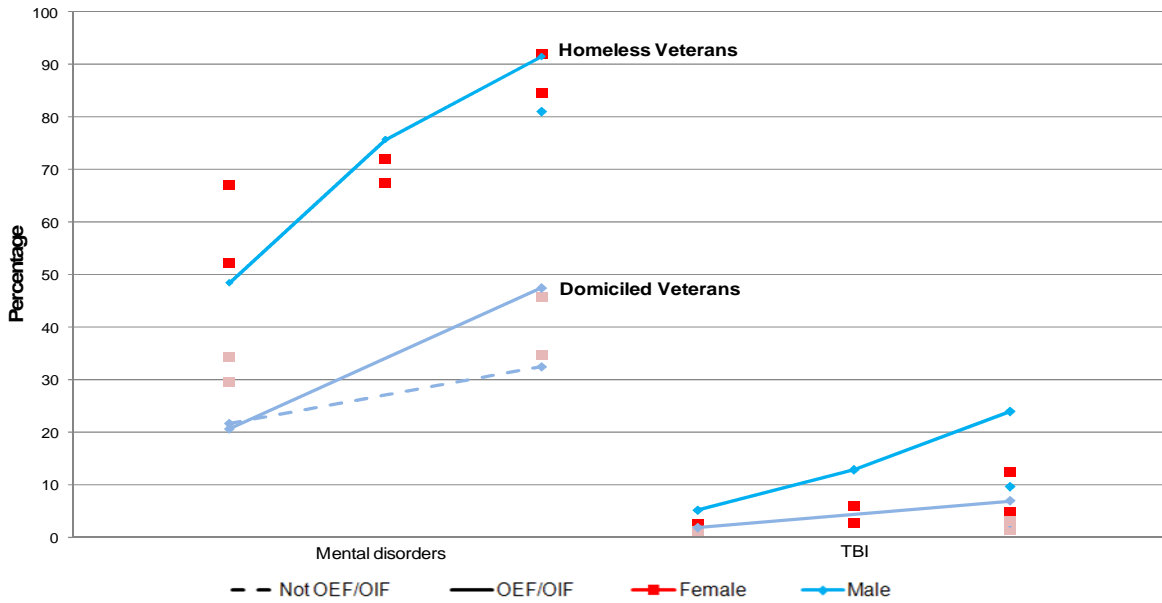


Exhibit 14. Veterans Diagnosed With Anxiety, PTSD, and Adjustment Disorders Over Time (Prior to Military Separation, Before Becoming Homeless, as of September 30, 2010), by Homeless Status, OEF/OIF Status, and Gender

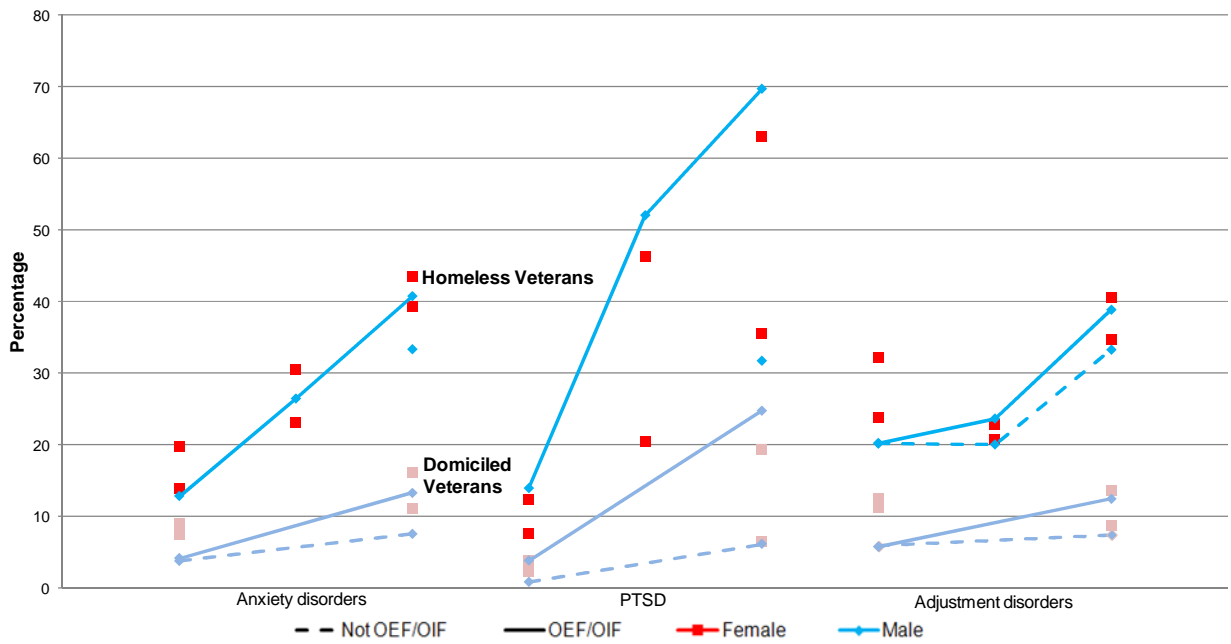


Exhibit 15. Veterans Diagnosed With Mood, Personality, and Psychotic Disorders Over Time (Prior to Military Separation, Before Becoming Homeless, as of September 30, 2010), by Homeless Status, OEF/OIF Status, and Gender

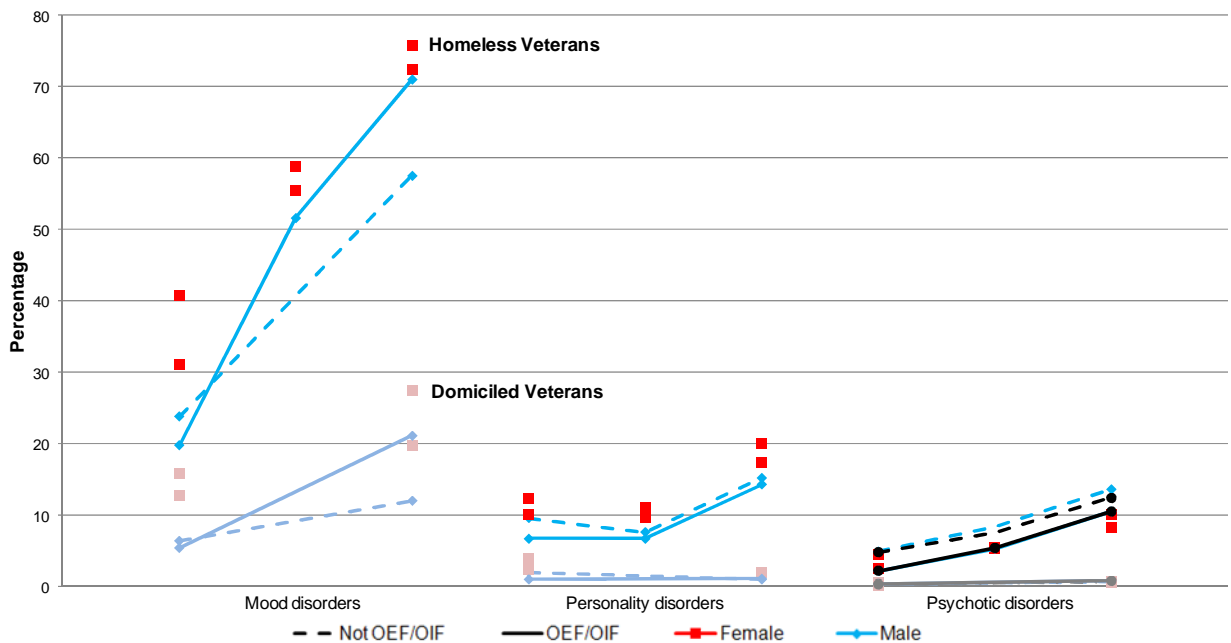
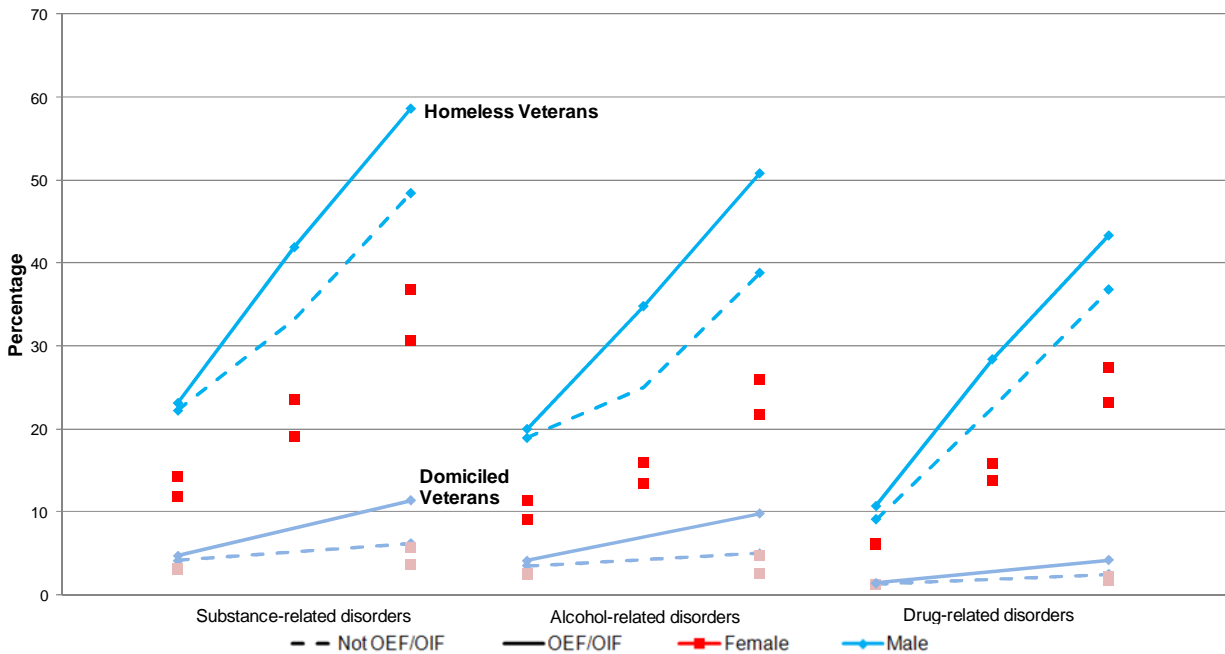


Exhibit 16. Veterans Diagnosed With Substance-Related Disorders Over Time (Prior to Military Separation, Before Becoming Homeless, as of September 30, 2010) by Homeless Status, OEF/OIF Status, and Gender



Homeless veterans who had served in OEF/OIF were more likely to be diagnosed with mental disorders prior to their first homeless episode than non-OEF/OIF homeless veterans. Exhibits 13–16 reveal that although the percentages of OEF/OIF homeless veterans diagnosed with mental disorders and some of the specific disorder categories prior to military separation are lower than those of non-OEF/OIF homeless veterans, these percentages for OEF/OIF homeless veterans exceed those of non-OEF/OIF homeless veterans for both males and females prior to their first homeless episode, except for the categories of personality disorders and psychotic disorders.

Majorities of the newly homeless diagnosed with mental disorders, each of its six specific categories and substance-related disorders at the end of the study were diagnosed before they became homeless, indicating mental disorders usually occurred before homelessness. Nearly 80 percent of homeless veterans diagnosed with mental disorders at the end of the study had been diagnosed before their first homeless episode, with the minimum of 78 percent for OEF/OIF women veterans and the maximum of 83 percent for OEF/OIF male veterans. For the specific mental illness categories, 47–78 percent of homeless veterans who were diagnosed at the end of the study had been diagnosed before they became homeless. For the mood disorders category (including major depressions) of mental illness, 71–78 percent of homeless veterans diagnosed at the end of the study had been diagnosed before they became homeless. For PTSD, 73 percent of homeless OEF/OIF women and 75 percent of homeless OEF/OIF men with PTSD diagnoses had been diagnosed before the occurrence

of their homelessness; for non-OEF/OIF homeless veterans, this percentage is 57 for women and 61 for men. We observed that 48–60 percent of homeless veterans diagnosed with TBI at the end of the study had been diagnosed before their first homeless episode. The percentages of newly homeless veterans diagnosed with mental disorders, each of the six specific mental illness categories and substance-related disorders, and TBI prior to their first homeless episode, exceed their domiciled counterparts at the end of the study after accounting for OEF/OIF status and gender.

Because clinicians may give a diagnosis to patients for the purpose of “ruling out” that disease, we further studied the patterns of veterans who were diagnosed with mental disorders or TBI for inpatient treatment only over time. Exhibits 17–20 show that although varying in degrees, the patterns are similar for inpatient only: despite the generally lower inpatient diagnoses prior to military separation, the percentages of OEF/OIF homeless veterans diagnosed for inpatient treatment prior to their first homeless episode generally top those of non-OEF/OIF homeless veterans for both males and females, except for the categories of personality disorders and psychotic disorders. Majorities of the newly homeless diagnosed with mental disorders, each of the six specific categories and substance-related disorders, and TBI for inpatient treatment at the end of the study were diagnosed before they became homeless, indicating mental disorders occurred before homelessness. The percentages of newly homeless veterans diagnosed with mental disorders, each of the six specific mental illness categories and substance-related disorders, and TBI prior to their first homeless episode, exceed their domiciled counterparts at the end of the study after accounting for OEF/OIF status and gender.

Exhibit 17. Veterans Diagnosed With Mental Disorders and TBI Over Time (Inpatient Only), by Homeless Status, OEF/OIF Status, and Gender

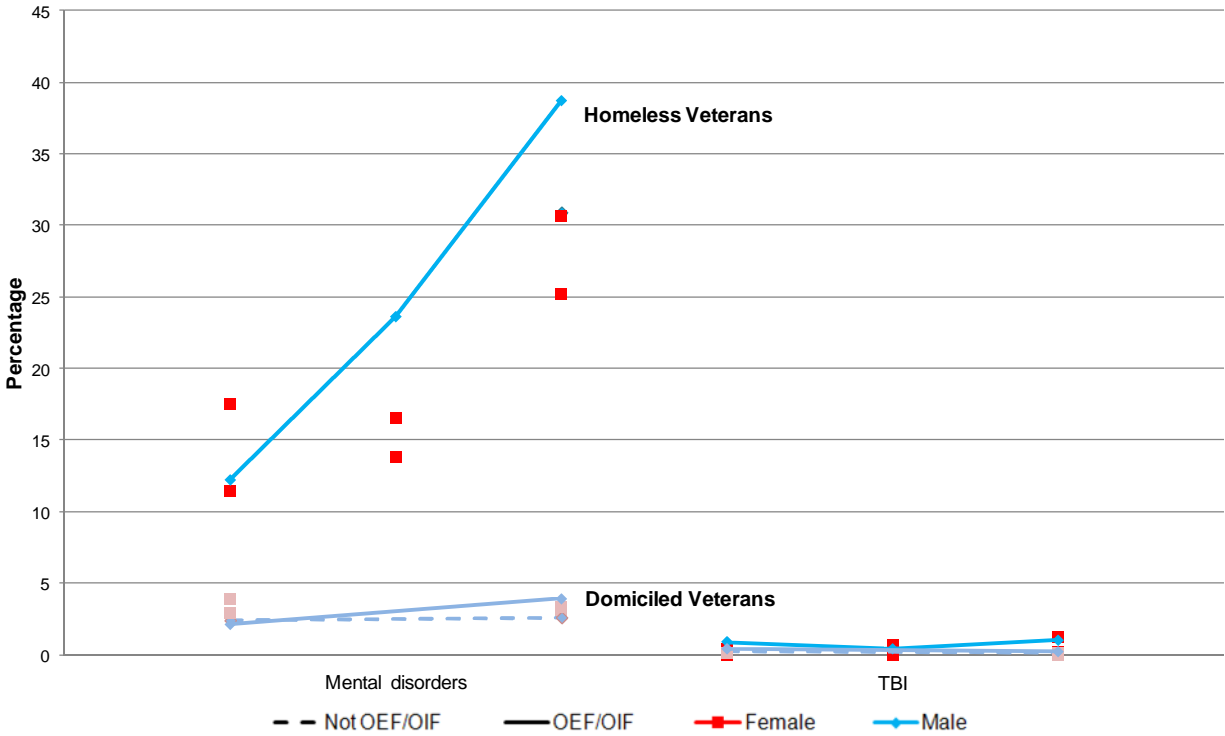


Exhibit 18. Veterans Diagnosed With Anxiety, PTSD, and Adjustment Disorders Over Time (Inpatient Only), by Homeless Status, OEF/OIF Status, and Gender

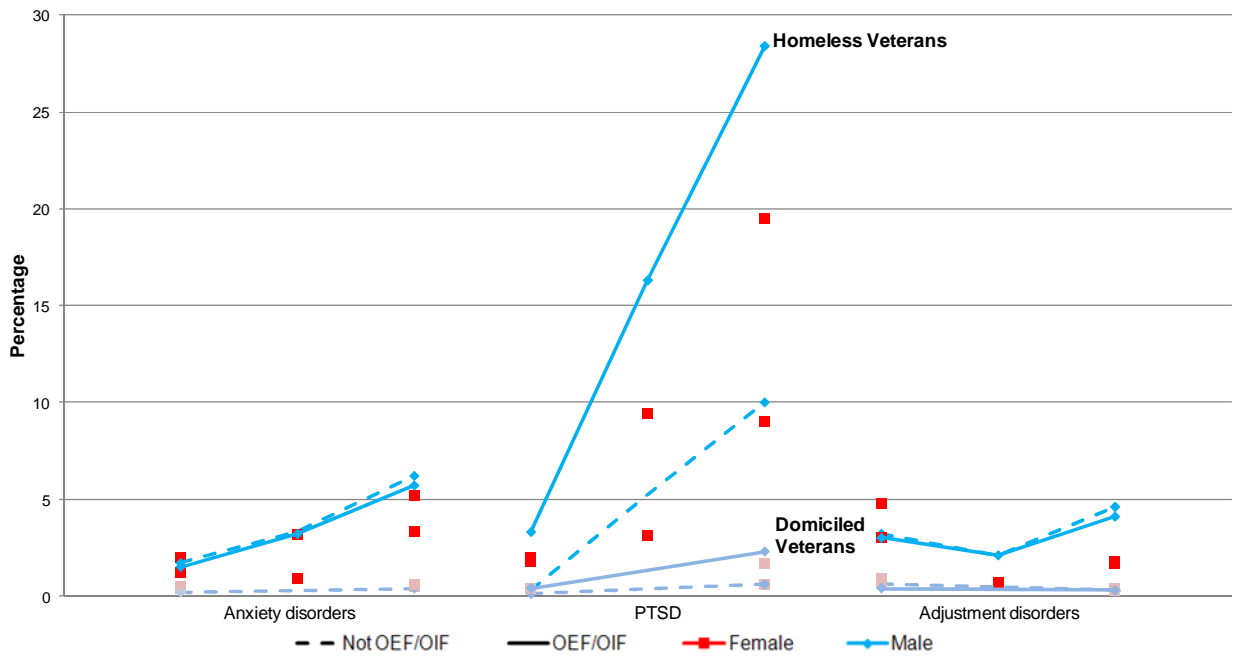


Exhibit 19. Veterans Diagnosed With Mood, Personality, and Psychotic Disorders Over Time (Inpatient Only), by Homeless Status, OEF/OIF Status, and Gender

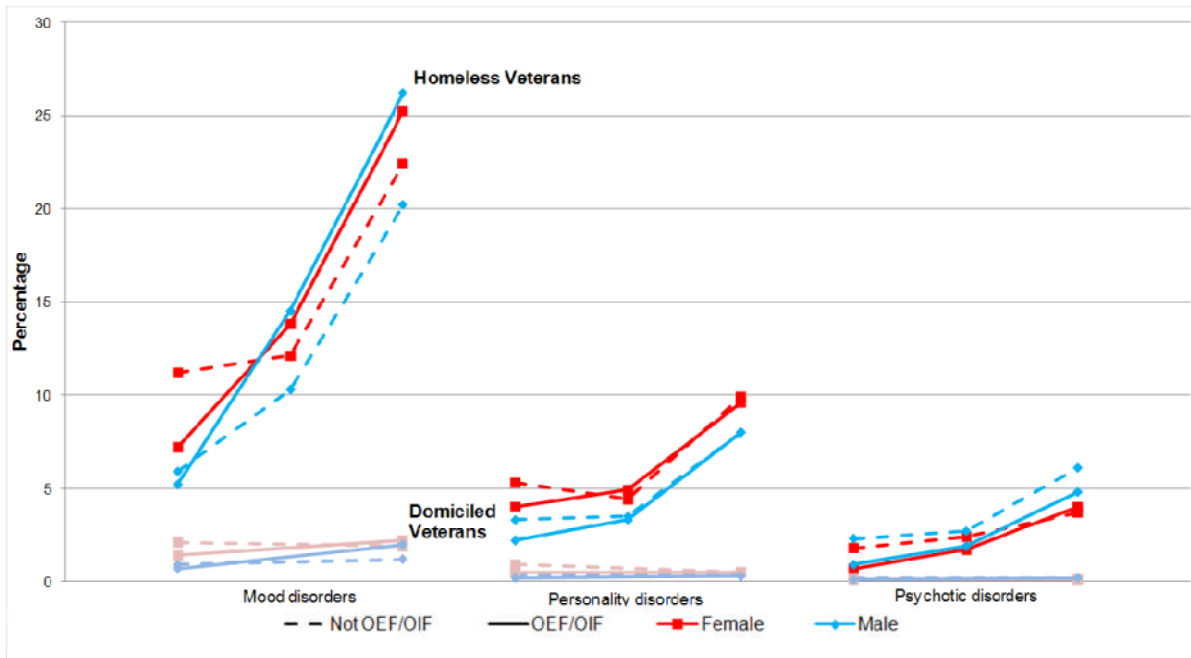
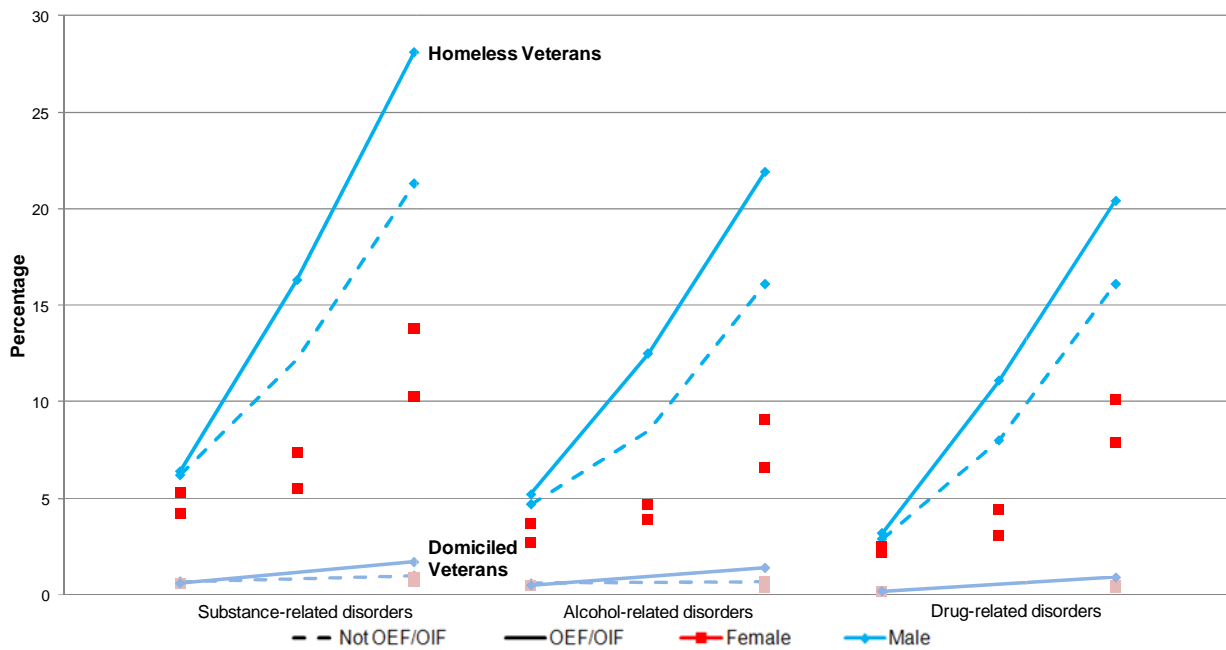
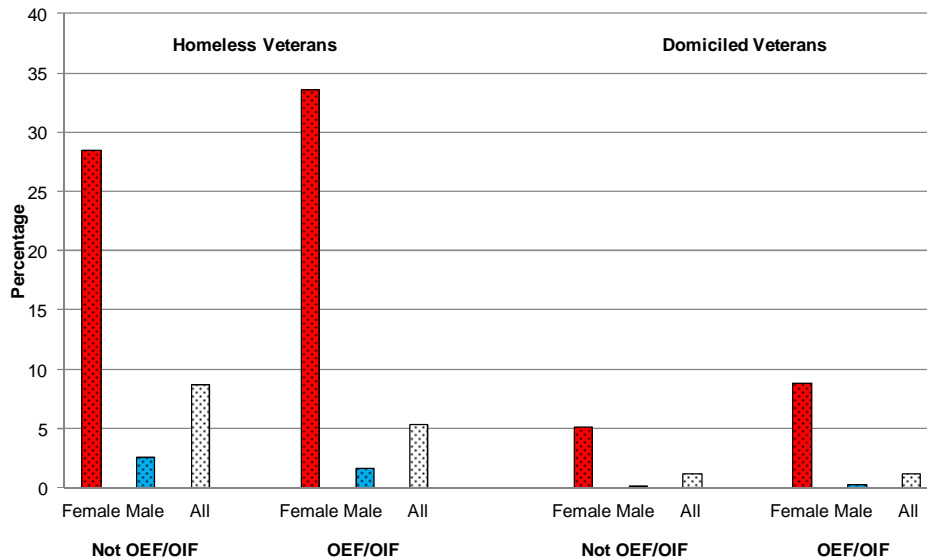


Exhibit 20. Veterans Diagnosed With Substance-Related Disorders Over Time (Inpatient Only), by Homeless Status, OEF/OIF Status, and Gender



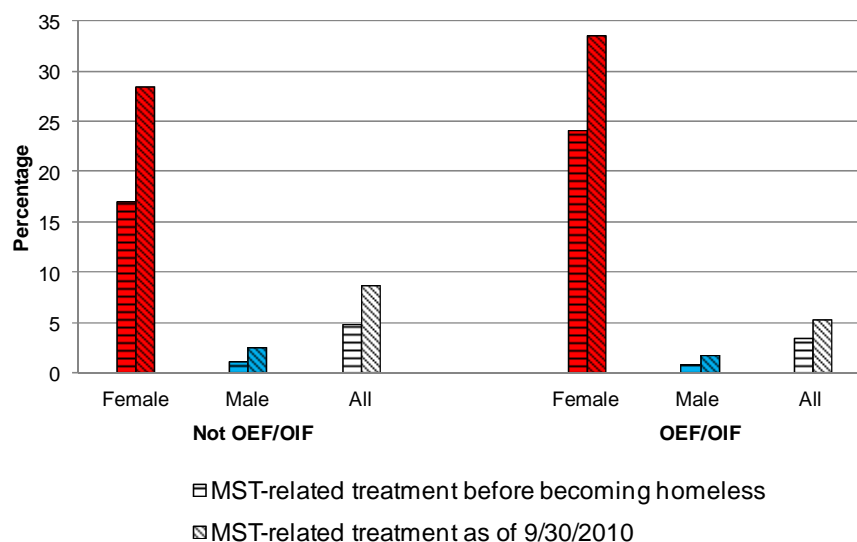
Homeless veterans, especially women, had received disproportionately higher MST-related treatment than domiciled veterans. At the end of the study, the percentages of homeless veterans who had received MST-related treatment were over 3 times higher than those of their domiciled counterparts (Exhibit 21). Among females, 28.5 percent of non-OEF/OIF and 33.6 percent of OEF/OIF homeless veterans received MST-related treatment at VA, compared with 5.1 percent of non-OEF/OIF and 8.9 percent of OEF/OIF domiciled females who received MST-related treatment. The percentages of women OEF/OIF veterans who received MST-related treatment exceed those of non-OEF/OIF veterans whether they experienced episodes of homelessness or not. Among males, 2.6 percent of non-OEF/OIF and 1.7 percent of OEF/OIF homeless veterans received MST-related treatment at VA, while 0.2 percent of non-OEF/OIF and 0.3 percent of OEF/OIF domiciled veterans did.

Exhibit 21. Veterans Who Received MST-Related Treatment as of September 30, 2010, by Homeless Status, OEF/OIF Status, and Gender



A majority of the newly homeless who received MST-related treatment by the end of the study had received the treatment before they became homeless. Nearly 50 percent of male homeless veterans who received MST-related treatment had received the treatment prior to their first episode of homelessness, whether or not they served in OEF/OIF (Exhibit 22). Among female homeless veterans who received MST-related treatment, 60 percent of non-OEF/OIF and 72 percent of OEF/OIF service members had received the treatment prior to their first homeless episode. Higher percents of homeless veterans had received MST-related treatment than domiciled veterans, even prior to their first homeless episode.

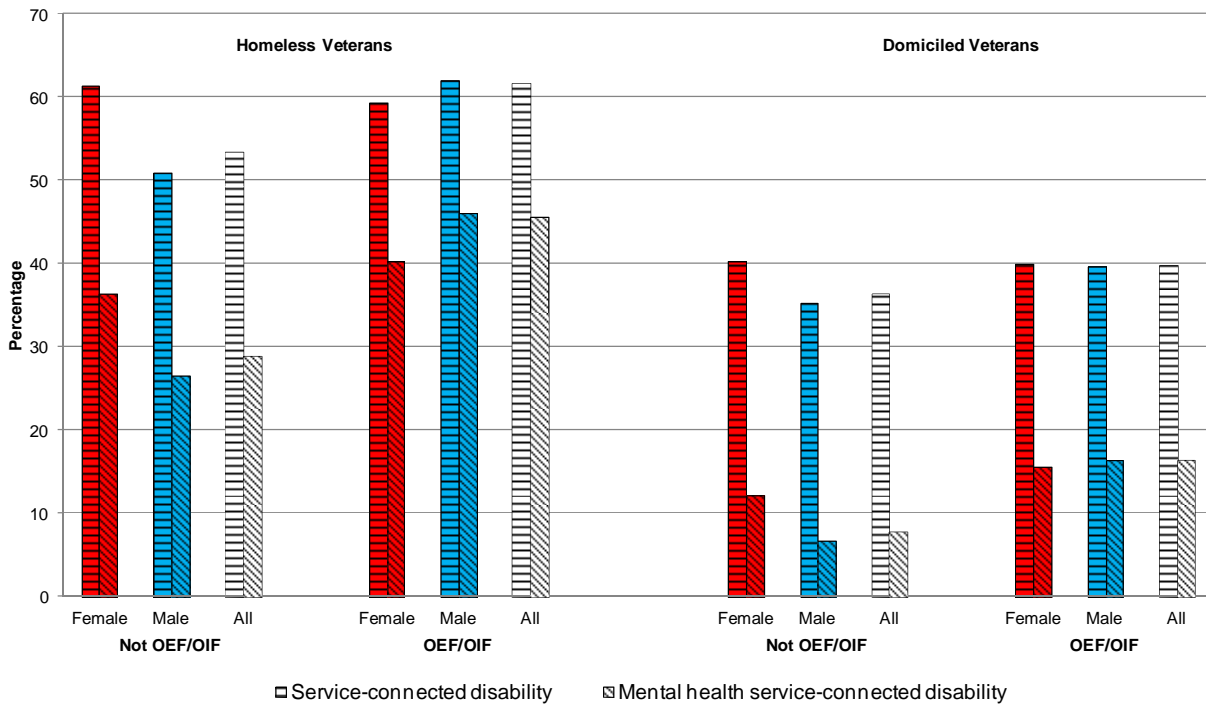
Exhibit 22. MST-Related Treatment Received by Homeless Veterans Prior to Becoming Homeless and as of September 30, 2010, by OEF/OIF Status and Gender



Homeless Veterans Were More Likely to Receive Compensation for Service-Connected Disabilities and Have Higher Disability Ratings

Homeless veterans were more likely to receive compensation for their service-connected disabilities and have higher disability ratings than their domiciled counterparts as of September 30, 2010. Exhibit 23 gives the percents of veterans receiving compensation for their service-connected disabilities and for service-connected disabilities with some components for mental health at the end of the study, by homeless status, OEF/OIF status, and gender. As of September 30, 2010, 51–62 percent of homeless veterans were receiving service-connected disability compensation, compared with 35–40 percent of their domiciled counterparts. Particularly, 27–46 percent of homeless veterans were receiving compensation for their service-connected disabilities with some components for mental health, more than double their domiciled counterparts (7–16 percent).

Exhibit 23. Veterans Receiving VA Compensation for Their Service-Connected Disabilities (as of September 30, 2010) by Homeless Status, OEF/OIF Status, and Gender



Among those veterans who were receiving compensation for their service-connected disabilities, homeless veterans were receiving higher disability ratings than their domiciled counterparts (Exhibit 24). As of the end of September 2010, the median service-connected disability ratings were 50 percent for non-OEF/OIF and 60 percent for OEF/OIF homeless veterans, compared with 40 percent for their domiciled counterparts. Among the homeless veterans who were receiving compensation for their service-connected disabilities with some components for mental health, the median disability ratings were 70 percent, 10 percentage points higher than their domiciled counterparts.

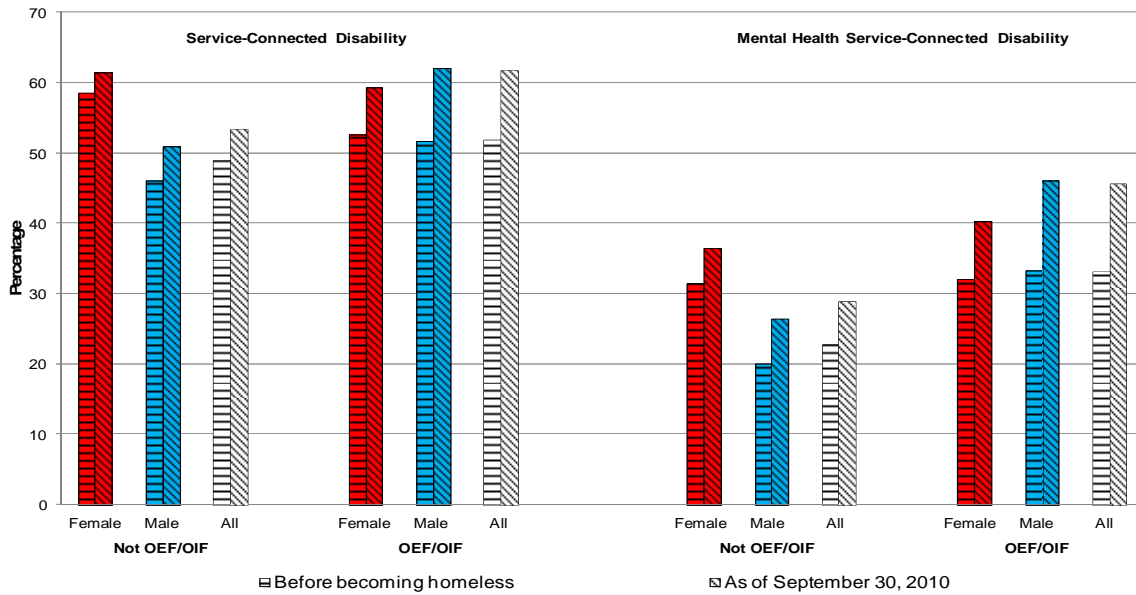
Exhibit 24. Disability Ratings Among Veterans Receiving VA Compensation for Their Service-Connected Disabilities by Homeless Status, OEF/OIF Status, and Gender

| | Homeless Veterans (5,574) | | | | | | Domiciled Veterans (305,111) | | | | | |
|---|---------------------------|-------|-------|---------|-------|-------|------------------------------|---------|---------|----------------|---------|---------|
| | Not OEF/OIF | | | OEF/OIF | | | Not OEF/OIF | | | OEF/OIF | | |
| | Female | Male | All | Female | Male | All | Female | Male | All | Female | Male | All |
| | 456 | 1,493 | 1,949 | 405 | 3,220 | 3,625 | 28,025 | 109,481 | 137,506 | 18,233 | 149,372 | 167,605 |
| As of September 30, 2010 | | | | | | | | | | | | |
| Service-connected disability | | | | | | | | | | | | |
| Overall percentage rating, mean | 52.2 | 50.9 | 51.3 | 54.3 | 58.1 | 57.7 | 43.8 | 42.6 | 42.9 | 41.5 | 42.6 | 42.5 |
| Overall percentage rating, median | 50 | 50 | 50 | 60 | 60 | 60 | 40 | 40 | 40 | 40 | 40 | 40 |
| Mental health service-connected disability ¹ | | | | | | | | | | | | |
| Overall percentage rating, mean | 64.5 | 67.5 | 66.6 | 65.9 | 68.1 | 67.9 | 57.9 | 61.2 | 60.2 | 56.7 | 58.7 | 58.5 |
| Overall percentage rating, median | 70 | 70 | 70 | 70 | 70 | 70 | 60 | 60 | 60 | 60 | 60 | 60 |
| Before becoming homeless | | | | | | | | | | | | |
| Service-connected disability | | | | | | | | | | | | |
| Overall percentage rating, mean | 46.7 | 44.4 | 45.1 | 47.0 | 50.7 | 50.3 | Not applicable | | | Not applicable | | |
| Overall percentage rating, median | 40 | 40 | 40 | 40 | 50 | 50 | Not applicable | | | Not applicable | | |
| Mental health service-connected disability ¹ | | | | | | | | | | | | |
| Overall percentage rating, mean | 59.6 | 61.2 | 60.7 | 58.8 | 62.8 | 62.3 | Not applicable | | | Not applicable | | |
| Overall percentage rating, median | 60 | 60 | 60 | 60 | 60 | 60 | Not applicable | | | Not applicable | | |

¹ Disability conditions codes: 91xx–95xx

Even prior to their first homeless episode, higher percent of homeless veterans had received VA compensation for their service-connected disabilities and for their service-connected disabilities with some components for mental health than domiciled veterans did. We found that 46–59 percent of homeless veterans were receiving disability payments prior to their first homeless episode, which were at least 10 percentage points more than their domiciled counterparts. In fact, for non-OEF/OIF homeless veterans, 95 percent of women and 90 percent of men who were receiving compensation for their service-connected disabilities at the end of the study were receiving the compensation prior to their first episode of homelessness (Exhibit 25); for OEF/OIF homeless veterans, the percentage was 89 percent for women and 83 percent for men. In terms of receiving compensation for their service-connected disabilities with some components for mental health, 72–86 percent of homeless veterans who were receiving the compensation at the end of the study were receiving it before their first episode of homelessness. The median disability ratings for the homeless veterans before they became homeless are the same as those of domiciled veterans at the end of the study, except for the OEF/OIF homeless men whose median rating prior to their first homeless episode is 10 percentage points higher than their domiciled counterparts at the end of the study (Exhibit 24).

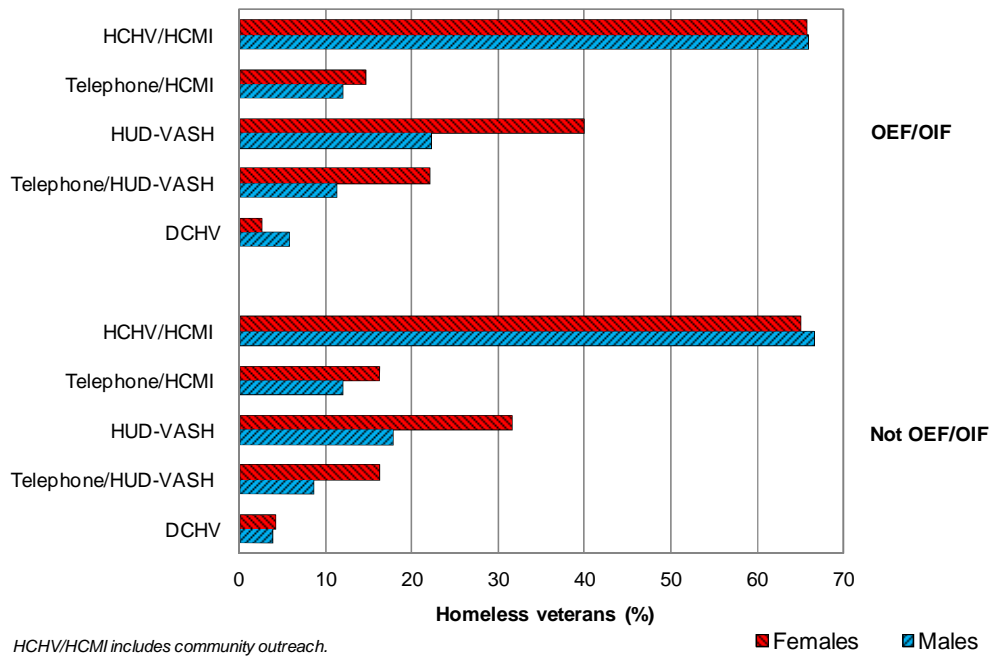
Exhibit 25. Homeless Veterans Receiving VA Compensation for Their Service-Connected Disabilities, Prior to Becoming Homeless and as of September 30, 2010 by OEF/OIF Status and Gender



Approximately 65 Percent of Homeless Veterans Utilized VA’s HCHV/HCMI Program; OEF/OIF and Women Homeless Veterans Were More Likely To Utilize the HUD-VASH Program than Their Non-OEF/OIF and Male Homeless Counterparts

Exhibit 26 shows the utilization pattern of VA homeless assistance programs by homeless veterans after discharge. Across OEF/OIF status and gender, approximately 65 percent of homeless veterans utilized HCHV/HCMI program by the end of the study. Under the HCHV/HCMI program, clinical staff of HCHV and GPD Programs provide services to HCMI veterans with mental illness and/or substance-related disorders or to family members of such veterans.

Exhibit 26. Utilization of VA Homeless Programs by Homeless Veterans by OEF/OIF Status and Gender



OEF/OIF and women homeless veterans were more likely to utilize HUD-VASH and telephone HUD-VASH homeless programs than their non-OEF/OIF and male homeless counterparts. Under the HUD-VASH program, VA is responsible for screening the veterans for eligibility, assisting in the housing search, and providing appropriate treatment and case-management to promote stability once housed.

The DCHV program is under the umbrella of the VA MH RRTPs. More male OEF/OIF homeless veterans utilized the DCHV program than their women counterparts.

Conclusions

Using the integrated data from both DoD and VA for the population of nearly half a million veterans discharged from active duty from July 1, 2005 to September 30, 2006, we followed the 310,685 veterans—who did not suffer any homeless episodes before separation from the military—in this population for their experience encountering their first homeless episode (becoming homeless) after leaving the military through September 30, 2010. In this first ever large, population-based, longitudinal study, we determined the incidences of becoming homeless (the newly homeless) after leaving the military; we compared the demographic characteristics and the disease (TBI, mental illness, and substance-related disorders) diagnoses over time of homeless veterans with those of their domiciled counterparts in the four separate subpopulations defined by OEF/OIF status and gender, to describe and identify risk factors for becoming homeless in this veteran population.

In this large-scale, population-based, longitudinal study of veterans who were recently discharged from active duty, did not experience any homeless episodes prior to the discharge, and used DoD (including TRICARE) or VA (including purchased care through fee basis or contractual agreement) care after discharge from active duty, we found that 3.7 percent of these veterans experienced their first episode of homelessness (the newly homeless) at 5 years after separation from the military. OEF/OIF and women veterans experienced higher incidences of homelessness than their non-OEF/OIF and male counterparts. The 5-year homeless incidence rates vary from 3.2 percent for non-OEF/OIF men to 4.0 percent for OEF/OIF women veterans. OEF/OIF veterans experienced higher homeless incidences than non-OEF/OIF veterans at each year of the first 5 years after discharge. We observed that about half of the newly homeless occurred after 3 years discharged from active duty. This suggests a window of opportunity for preventing veterans from becoming homeless after discharge from active duty.

Veterans who experienced homelessness after military separation were younger, enlisted with lower pay grades, and were more likely to be diagnosed with mental disorders and/or TBI at the time of separation from active duty than their domiciled counterparts. Mental disorders comprise substance-related disorders and all mental illness. We included in the study the following six specific mental illness categories for separate examination: anxiety disorders (excluding PTSD), PTSD, adjustment disorders, mood disorders, personality disorders, and psychotic disorders. At discharge from active duty, 79–84 percent of homeless veterans were under age 35, in contrast to 64–74 percent of domiciled veterans. Most (70–78 percent) of the homeless veterans were enlisted and in the lower pay grades of E1–E4, compared with 39–51 percent of the domiciled veterans.

The presence of mental disorders (mental illness and or substance-related disorders) is the strongest predictor of becoming homeless after discharge from active duty. Consistently, much higher percent of the newly homeless veterans are diagnosed over time than their

domiciled counterparts after accounting for OEF/OIF status and gender. Nearly half or more (ranging from 48 percent for OEF/OIF men to 67 percent for non-OEF/OIF women) of the homeless veterans were diagnosed with mental disorders prior to discharge from active duty; the diagnosed homeless veterans increased to 64–76 percent before becoming homeless and increased to 81–92 percent at the end of the study. In fact, the percentages of newly homeless veterans diagnosed with mental disorders, each of the six specific mental illness categories and substance-related disorders, and TBI prior to their first homeless episode, exceed their domiciled counterparts at the end of the study within each of the four subpopulations defined by OEF/OIF status and gender. We found that 78–83 percent of the newly homeless diagnosed with mental disorders at the end of the study were diagnosed before they became homeless. Thus, it may be beneficial for VA homelessness primary prevention efforts to focus on the treatment of veterans with mental disorders as well as on their housing risk.

The percentages of OEF/OIF veterans diagnosed with mental disorders and specific categories (except for PTSD) of mental illness before discharge from active duty are generally lower than those of their non-OEF/OIF counterparts. However, the percentages of the newly homeless OEF/OIF veterans who were diagnosed with mental disorders are higher than those of their non-OEF/OIF counterparts over time: prior to becoming homeless and at the end of the study. This signifies that the impact of serving in OEF/OIF on becoming homeless is partly manifested as the intermediate outcomes of mental disorders. Thus, our study implies that enhanced access to effective mental health services and substance use treatment may facilitate a reduction in occurrences of newly homeless veterans and should remain a focus of primary prevention efforts.

Homeless veterans, especially women, had received disproportionately higher MST-related treatment than domiciled veterans, even prior to their first homeless episode. At the end of the study, the percentages of homeless veterans who had received MST-related treatment were over 3 times higher than those of their domiciled counterparts. Among the women homeless veterans who received MST-related treatment, 60 percent of non-OEF/OIF and 72 percent of OEF/OIF homeless women had received the treatment prior to their first homeless episode. This reveals that MST is a risk factor in veterans for becoming homeless, especially in women veterans.

Over half (51–62 percent) of the homeless veterans were receiving VA compensation for their service-connected disabilities at the end of the study, higher than their domiciled counterparts (35–40 percent). Even prior to their first homeless episode, 46–59 percent of the homeless veterans were receiving disability payments, which were at least 10 percentage points more than their domiciled counterparts. We observed that 83–95 percent of the homeless veterans who were receiving compensation for their service-connected disabilities at the end of the study were in fact receiving the compensation prior to their first episode of homelessness. The median (50 percent for OEF/OIF males and 40 percent for others) disability ratings for the homeless veterans

before they became homeless are the same as or 10 percentage points higher, and their median ratings (50 percent for non-OEF/OIF and 60 percent for OEF/OIF) at the end of the study are 10–20 percentage points higher than the 40 percent median ratings of their domiciled counterparts at the end of the study. Patterns are similar, albeit varying in degrees, when we limit to only those receiving VA compensation for service-connected disabilities with some components for mental health. These findings are new, and they are surprising in that higher (46–59) percent of the homeless veterans than their domiciled (35–40 percent) counterparts (at the end of the study) had access to some stable and seemingly moderate funds before their first homeless episode to prevent becoming homeless. More studies are called for to investigate the relationship between service-connected disability payments and their impact on homelessness.

We defined homeless veterans as veterans who have received a V60.0 secondary diagnostic code for “lack of housing” from DoD (including TRICARE) or VA (including purchased care through fee basis or contractual agreement) or have used VA homeless assistance services. Thus, our identification of homeless veterans relies on accurate coding of veterans housing situation by clinicians and the completeness and the accuracy of the administrative data from VA homeless assistance programs. In addition, we excluded veterans who did not use DoD/TRICARE and VA/VA purchased care after discharge from active duty as we have no data on them. These limitations are not just specific to our study. Studies, evaluations, and reports that use VA administrative data all encounter the same issues.

By incorporating DoD treatment data with VA data, for the first time, we are able to identify veterans who did not suffer any homeless episodes before discharge from active duty to study the occurrence rate of the newly homeless and investigate the effect of mental disorders and TBI diagnoses during military service on becoming homeless. We also innovatively looked at risk factors at the time of becoming homeless for the homeless veterans, in addition to the two points in time—at discharge from active duty (baseline) and at the end of the study. This provides us broader insights on the pathways of the risk factors and their effect on veteran homelessness.

The population-based nature of our study precludes the potential bias inherent in samples selection and permits the use of appropriate domiciled control groups. The inconsistent findings from many studies on homelessness are partly attributable to whether participants were selected from homeless individuals or from individuals diagnosed with mental disorders, in addition to the use of inappropriate control groups.

The longitudinal cohort nature of our study on risk factors associated with homelessness eliminates the limitations of most studies that employed a cross-sectional design. In these cross-sectional studies, participants were assessed for homelessness and risk factors simultaneously at a particular time (period). Consequently, from these studies, we cannot distinguish the newly homeless from the chronically homeless and cannot determine causality or temporal sequence of risk factors and homelessness. Based on these studies,

it thus remains arguable as to whether the newly homeless and chronically homeless share the same risk factors and whether, say, a diagnosis of mental disorders (substance-related disorders and/or mental illness) preceded homelessness, or whether substance-related disorders and/or mental illness are the result of adaptations to the stresses and dangers associated with the homeless experience. Our longitudinal cohort study allows us to clearly demonstrate that the presence of mental disorders is a predictor of becoming homeless in veterans. It also allows us to exclusively investigate risk factors over time to better understand their pathways and effects on veteran homelessness.

Recommendation

We recommended that the Under Secretary for Health, in ongoing efforts to end homelessness among veterans, consider the risk factors for becoming the newly homeless in veterans identified in this report and adjust, if necessary, the current strategies to prevent veterans from becoming homeless.

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 09, 2012

From: Under Secretary for Health (10)

Subj: **OIG Draft Report, Homeless Incidence and Risk Factors for Becoming Homeless in Veterans**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations. The Veterans Health Administration (VHA) is committed to the Department's efforts to end homelessness among Veterans, and recognizes the value and critical role prevention plays in achieving this goal. Your report helps in this effort by outlining the risk factors associated with Veterans becoming homeless.

2. VHA will continue to support the need to consider and address risk factors for becoming homeless through several programs and services outlined in the attached action plan. As a component of universal prevention, VHA will also continue to promote and coordinate access to needed specialized mental health and substance use treatment services, especially those services that promote a trauma informed-trauma responsive model for Veterans who have experienced either combat and or sexual trauma.

3. Thank you for the opportunity to review the draft report. A complete action plan and a technical comment that clarifies information reported for the Domiciliary Care for Homeless Veterans (DCHV) program are attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

(original signed by:)

Robert A. Petzel, M.D.

Attachments

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

OIG Draft Report, Homeless Incidence and Risk Factors for Becoming Homeless in Veterans

Date of Draft Report: January 27, 2012

| <u>Recommendations/ Actions</u> | <u>Status</u> | <u>Completion Date</u> |
|-------------------------------------|---------------|----------------------------|
|-------------------------------------|---------------|----------------------------|

OIG Recommendation

We recommended that the Under Secretary for Health, in ongoing efforts to end homelessness among veterans, consider the risk factors for becoming the newly homeless in veterans identified in this report and adjust, if necessary, the current strategies to prevent veterans from becoming homeless.

VHA Comment

Concur

VHA recognizes the value and critical piece that prevention plays in achieving the overall goal of ending Veteran homelessness and will consider and address risk factors for becoming homeless through a number of programs including:

- VHA's National Center on Homelessness Among Veterans is developing a universal at-risk screening instrument that can be utilized to identify at immediate risk for homeless Veterans, and get them connected to both Department of Veterans Affairs (VA) and community resources that promote housing stabilization and treatment engagement. VHA's National Center on Homelessness Among Veterans is also engaged in collaborative research initiatives that will inform VA policy and practice to ensure that VA program resources are tailored to models that most effectively prevent Veterans from becoming homeless and rapidly reconnect Veterans to housing and treatment resources if they should become homeless.

- The Supportive Services for Veteran Families Program is expanding funding to private non-profit organizations and consumer cooperatives that assist very low-income Veterans and their families whom are at eminent risk for homelessness by providing a range of supportive services designed to promote housing stability and to reduce the risk of falling into homelessness.
- VHA is providing access to treatment services for Veterans who have substance abuse and mental health issues. A total of 148 substance use disorder (SUD) clinical positions have been funded in VHA homeless programs since 2010. These clinical staff positions are located in either the Health Care for Homeless Veterans Program or the Department of Housing and Urban Development–VA Supportive Housing Program to ensure Veterans have access to ongoing SUD treatment services.

As a component of universal prevention, VHA homeless programs will also continue to promote and coordinate access to needed specialized mental health and substance use treatment services, especially those services that promote a trauma informed-trauma responsive model for Veterans who have experienced either combat and/or sexual trauma.

In process

Ongoing

Technical Comment

Page 15, last paragraph, and page 16, first paragraph, as well as page 40, Exhibit 26: The Office of Inspector General (OIG) report indicates that because Domiciliary Care for Homeless Veterans (DCHV) encounters were identified by clinic stop codes 725–727 prior to the switch to 593–595 in Fiscal Year 2009 at the request of the Office of Mental Health Services, OIG used the stop codes 725–727 and 593–595 to capture the utilization of DCHV in this report. VHA’s Office of Mental Health Services notes that treating specialty (TS) code 37 should be the only variable used to capture the utilization of DCHV. The DCHV program is an inpatient bed program, and utilization is reflected by admission and subsequent discharge from the DCHV bed section in TS code 37.

OIG Response

We employed both outpatient (clinic stop) codes and inpatient (treating specialty 37) code in order to capture all uses of DCHV by homeless veterans, not just inpatient stays alone. As noted in Footnote 32 of the report (page 15), we used the same clinic stop codes as those used by the

VA Northeast Program Evaluation Center (NEPEC) for capturing DCHV outpatient encounters. NEPEC conducts program evaluation of services available to homeless veterans including HUD-VASH and DCHV.

OIG Contact and Staff Acknowledgments

| | |
|-------------------------|---|
| OIG Contact | For more information about this report, please contact the OIG at (202) 461-4720. |
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