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## Epidemiology of Homelessness Among Veterans

EMILY BRIGNONE, JAMISON FARGO, AND DENNIS CULHANE

Now is not the time to let up or get complacent. With our goals in sight in many communities across the country, we all need to work harder and smarter towards achieving them.

—Secretary Erik Shinseki, *May 30, 2014*

### Introduction

In this chapter, we address the epidemiology of homelessness among US Veterans, including a discussion of the methodological challenges relevant to the enumeration and description of homelessness as well as a presentation of current estimates and trends in homelessness among Veterans. The chapter begins with a brief overview of homelessness among Veterans historically, with the remainder of the chapter focusing on the prevalence and incidence of homelessness among Veterans over the past decade. The methodological considerations discussed in this chapter include issues surrounding conceptual definitions of homelessness, implications related to the time frame used for estimates, a comparison between point prevalence, period prevalence, and incidence, and a description of various approaches for using primary and administrative data to estimate the magnitude and composition of homelessness among Veterans. Finally, we present recent national estimates of the prevalence and incidence of homelessness among Veterans, along with a summary of trends over time, and segmentation of estimates by demographic, geographic, and housing status characteristics.

## Historical Overview

Homelessness among US Veterans has been documented as early as the post-Civil War period, when a considerable number of former soldiers became “vagrants.”<sup>1</sup> (p. 67) Later, many World War I Veterans were affected by the homelessness crisis of the Great Depression.<sup>1</sup> (p. 319) With the expansion of Veterans’ benefits through the G.I. Bill and the economic upswing of the 1940s, homelessness among Veterans declined substantially, and it remained relatively low throughout the 1950s and 1960s.<sup>2</sup> In the years following the Vietnam War, however, the presence of Vietnam Veterans among the homeless became more highly visible, and the link between military service and homelessness began to enter public awareness.<sup>1</sup> (p. 382)

Rates of homelessness continued to rise through the 1970s and 1980s due to economic recessions, decreases in affordable housing, the war on drugs, and the deinstitutionalization of patients with serious mental illness.<sup>3,4</sup> By this time, the modern concept of homelessness was established, and homelessness among Veterans became a major concern often regarded by the public and media as a national failure and source of shame. Community surveys conducted in the 1980s indicated that Veterans were overrepresented among the homeless population compared with the general population.<sup>5</sup> Subsequent national surveys following the Gulf War corroborated this finding.<sup>5,6</sup>

With the return of a new era of service members from post-9/11 conflicts in Iraq and Afghanistan (Operations Iraqi Freedom, Enduring Freedom, and New Dawn [OEF/OIF/OND]), patterns of homelessness among Veterans began to change. In contrast to Vietnam-era Veterans, who generally did not become homeless until 5 to 10 years after their discharge from service, significant numbers of OEF/OIF/OND Veterans are becoming homeless soon after discharge.<sup>7</sup> For example, results from one population-based study indicate that during the present era, half of new homelessness episodes occur within 3 years of discharge.<sup>8</sup> Many experts point to the hallmark injuries of these conflicts, post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI), as potential contributors to the shift toward more rapid development of homelessness.<sup>9,10</sup>

In late 2009, a five-year plan to end homelessness among Veterans was enacted by the US Department of Veterans Affairs (VA) under the direction of Secretary Eric Shinseki and President Barack Obama.<sup>11</sup> Billions of dollars have since been invested in the expansion of services for homeless Veterans.<sup>8,12</sup> The overall framework for ending Veteran homelessness was developed by the VA and National Center for Homelessness Among Veterans,<sup>13</sup> and adopted by the US Interagency Council on Homelessness in the Federal Strategic Plan to Prevent and End Homelessness, *Opening Doors*.<sup>14</sup> This plan, originally presented to Congress in 2010 and most recently updated in 2015, focuses on several

key areas, including providing affordable housing and permanent supportive housing, increasing meaningful and sustainable employment opportunities, reducing the financial vulnerability of Veterans, and transforming the homeless crisis response system with a focus on prevention and rapid rehousing.

## Why Study the Epidemiology of Homelessness Among Veterans?

Establishing reliable estimates of the incidence, prevalence, and composition of homelessness among Veterans is important for several reasons. First, these estimates are necessary for evaluating how the rates of homelessness among Veterans are changing in response to policies, programming, and other contextual factors. Such estimates are also important for service provision planning because the size and composition of the homeless Veteran population directly affects the budgetary and staffing needs of prevention and intervention programs. Relatedly, like the changing characteristics of the overall Veteran population, the characteristics of Veterans who experience homelessness are also in transition. There is considerable variability in the demographic and health characteristics of Veterans who experience homelessness, in the frequency and chronicity of their homelessness experiences, and in their relative state of deprivation. Understanding the composition of this population, including anticipated changes over time, can improve the tailoring of services to meet the needs of this diverse and evolving population.

## Conceptual Definitions Relating to Homelessness Among Veterans

To begin to examine the epidemiology of homelessness among Veterans, definitional issues relating to the terms “homelessness” and “Veteran” must be addressed. For the purposes of eligibility for VA services, these terms are defined in Title 38 of US Code.<sup>15</sup> In Title 38, “Veteran” refers to “a person who served in the active military, naval, or air service, and who was discharged or released from service under conditions other than dishonorable.” This definition of Veteran status is often not completely aligned with definitions used in other studies that attempt to quantify and describe homelessness among Veterans. For example, studies that use data from outside the VA often consider the term “Veteran” to include anyone who self-reports as having served in the military, regardless of active-duty or discharge status. There are both practical and theoretical reasons for this. It may not be feasible for researchers

to validate the official Veteran status of each individual who self-reports having served in the military. Alternatively, researchers may be interested in the housing experiences of individuals who served in the military but are not eligible for VA services. Notably, even self-reported measures of Veteran status likely result in the underestimation of Veterans among the homeless population. Recent studies indicate that approximately one-third of Veterans experiencing homelessness did not identify as Veterans to community homeless service providers.<sup>16,17</sup>

One example of the difference between VA-defined Veteran status and Veteran status as operationalized in research literature is the Annual Homeless Assessment Report (AHAR),<sup>18</sup> which is the most complete source for the prevalence and incidence of homelessness among Veterans. For the purposes of this report, Veteran status is self-reported, and the population of Veterans includes Veterans with every active-duty or discharge status, regardless of VA eligibility. Given that several hundreds of thousands of Veterans are ineligible for VA benefits as a result of their discharge status, along with research suggesting that these Veterans may be overrepresented among the homeless,<sup>19,20</sup> this definitional difference could potentially result in nontrivial discrepancies in estimates across studies from these sources.

Veterans are considered by the VA to be homeless if they meet the definition of “homeless” that is codified in section 103(a) of the McKinney-Vento Act.<sup>21</sup> The different ways in which an individual or family may be defined as homeless under this section of McKinney-Vento are described here:

*Literal Homelessness:* Homelessness that occurs when an individual or family lacks a fixed, regular, and adequate nighttime residence. This can include:

- Having a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by charitable organizations or federal, state, or local government programs);
- Exiting an institution where one temporarily resided (such as a jail or hospital) and having resided in a shelter or place not meant for human habitation.

*Imminent Homelessness:* Homelessness that occurs when individuals will imminently lose their housing, including housing they own, rent, or live in without paying rent or housing they are sharing with others, and rooms in hotels or motels not paid for by charitable organizations or federal, state, or local government. This can include:

- Receiving a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;
- Having a primary nighttime residence that is a room in a hotel or motel and lacking the resources necessary to reside there for more than 14 days;
- Having credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days;
- Having no subsequent residence identified and lacking the resources or support networks needed to obtain other permanent housing.

Homelessness may also be defined among Veterans in families with children and youth under other federal statutes under the following circumstances:

- Having experienced a long-term period without living independently in permanent housing or having experienced persistent instability as measured by frequent moves over such a period, and expecting to continue as such for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

Definitions of homelessness may also vary slightly between studies and may also change over time. Notably, under Title 38, the conditions specified under section 103(b) of the McKinney-Vento statute do not constitute homelessness. This section, which was added to McKinney-Vento under the 2009 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act,<sup>21</sup> designates individuals fleeing domestic violence or other life-threatening conditions as homeless. Several bills containing provisions that would update the VA definition to include section 103(b) have been introduced, but none had passed at the time that this chapter was written.

## Challenges to Identifying and Enumerating Homelessness Among Veterans

In addition to variation in the conceptual definitions of homelessness across studies, other issues exist that can complicate the epidemiological examination of homelessness. These include methodological considerations relating to the time frame specified for estimates, data sources and the associated operationalization of conceptual definitions, and practical challenges inherent in finding an often hidden and transitory population.

## TIME FRAME FOR ESTIMATES

Depending on the time frame selected for the enumeration of homelessness, estimates can represent counts of individuals experiencing homelessness at a particular point in time (point prevalence), counts of individuals who experienced homelessness at any point during a certain time frame (period prevalence), or counts of individuals who became newly homeless during a certain time frame (incidence). Although each type of estimate provides unique and valuable information, the time frame selected has considerable implications for the overall magnitude of counts and the types of homelessness identified in counts.

Point prevalence counts generally take place on a single night and provide an unduplicated estimate of the magnitude of homelessness at a particular point in time. These counts help to inform short-term service provision planning, such as determining shelter capacity needs. However, because of the dynamic nature of homelessness, counting only those experiencing homelessness on a single night underestimates the true magnitude of homelessness. Homelessness is frequently characterized on the basis of frequency and chronicity of episodes. A single, brief episode of homelessness followed by a return to permanent housing is referred to as temporary or transitional. Homelessness characterized by multiple brief episodes of homelessness is referred to as episodic. Finally, as currently defined by the US Department of Housing and Urban Development (HUD), chronic homelessness refers to homelessness occurring among individuals with disabling conditions that lasts at least one year, or four or more separate episodes of homelessness occurring within three years with a combined time spent homeless of at least 12 months.<sup>22,23</sup> Point prevalence estimates tend to capture individuals experiencing chronic homelessness while underrepresenting those who are experiencing temporary or episodic homelessness.<sup>24,25</sup> Because different types of homelessness are associated with different individual characteristics and service needs, descriptions of the homeless population that are based on individuals identified in point prevalence counts are likely skewed toward the characteristics of the chronically homeless.

Period prevalence counts, on the other hand, tend to provide more comprehensive estimates of the magnitude of homelessness than point prevalence estimates. They are also more likely to reflect the true diversity of homelessness experiences and of the individuals who experience homelessness. This is important for informing policy and programming that appropriately balances remedial services for the chronically homeless with preventive efforts that target the distinct needs of individuals who experience or are at-risk for temporary or episodic homelessness.<sup>26</sup>

## SELECTION OF DATA SOURCES

Both administrative and primary data sources can provide important insights regarding the epidemiology of homelessness among Veterans, with certain benefits and limitations inherent in each. Data from administrative sources are generally inexpensive and nonintrusive, can be collected relatively quickly, and can often provide individual-level data for samples covering vast geographic areas. They often include longitudinal data, which can provide insights into the dynamic patterns of homelessness, and their retrospective nature allows for flexibility in the selection of time frames for estimates.

Because of the integrated nature of the VA Health Care System and the broad range of homeless services it provides, researchers have the unique opportunity to estimate homelessness among Veterans through the use of VA administrative health care data. Diagnoses related to homelessness and use of homelessness-related services can be administratively monitored to identify Veterans experiencing homelessness. To this end, the VA maintains a centralized database of Veterans who receive services in VA-funded homeless programs called Homeless Operations Management and Evaluation System (HOMES). Records pertaining to homelessness may also be linked at the individual level to demographic and health care data within the VA system, allowing for high-level analysis of the relationships between homelessness and demographic and military service characteristics, health care utilization patterns, and medical and mental health status. When linked, such data can be used to evaluate conceptual and statistical models that advance our understanding of homelessness among Veterans. Outside of the VA, other administrative systems are used to track homelessness among Veterans. One example is the Homeless Management Information System (HMIS) that is employed by state and local governments to record information, including Veteran status, about individuals who receive homeless services in their communities.

Despite the many benefits of administrative data, there are certain limitations to their use in estimating the prevalence and composition of homelessness among Veterans. Most important, this approach operationally defines homelessness based on the presence of homelessness-related clinical care or social service use, thus excluding individuals who do not or cannot use these services. This issue is particularly relevant for VA-based services because VA eligibility depends on military service and character of discharge criteria.<sup>27</sup> Veterans who experience homelessness but are ineligible for VA services are not represented in these data, despite potentially being at higher risk for homelessness for reasons related to their eligibility. Unlike administrative data from VA, representation in HMIS is not dependent on VA eligibility factors. However, for Veterans experiencing homelessness to be entered into HMIS, they must initiate homelessness-related services, which may not occur for a variety of reasons.



Thus, dependence on service engagement for the identification of homelessness among Veterans may result in incomplete counts as well as samples containing bias because of systematic differences between those who do and those do not engage in homeless services. However, estimates based on HMIS data are highly useful for service provision planning because these data are likely to be largely representative of those who will seek similar services in the future.

Primary data collection can allow researchers to examine homelessness among Veterans independently of eligibility factors or use of homeless services. However, the collection of primary homelessness data presents several practical challenges. First, in addition to potentially substantial underreporting of Veteran status,<sup>16,17</sup> homelessness, particularly temporary and episodic homelessness, is often not easily identifiable. For example, individuals lacking permanent housing may sleep in motels, cars, or vacant buildings. Many stay with family members or friends on a short-term basis, often moving in and out of homelessness from one unstable housing situation to the next.<sup>28</sup> Thus, enumeration efforts that rely on the visibility of homelessness will inevitably miss a considerable portion of this population. This is especially true for in-person counts because these estimates usually represent point prevalence because of the labor-intensive nature of data collection. Another method for examining homelessness among Veterans is through primary data collection methods such as surveys that assess self-reported experiences of homelessness. Using this approach, researchers can specify one or more time frames of interest for homelessness, such as currently homeless, homeless at any point in the past year, or homeless at any point in the past. This allows for both point and period prevalence counts. However, representative sampling that allows for broader inference with respect to homelessness is particularly difficult. Given the relatively rare nature of homelessness, large samples are required. In addition, multiple sampling frames may be needed to ensure sufficient coverage of hard-to-reach populations that are more likely to experience homelessness.

## ESTIMATES OF VETERAN HOMELESSNESS

While determining the exact prevalence and incidence of homelessness among Veterans is not possible because of the practical and methodological issues discussed in the preceding sections, a careful comparison of estimates gathered using a variety of methods can provide insights that, in aggregate, provide a meaningful and holistic view of the epidemiology of homelessness among Veterans. This strategy is often referred to as the “family of studies” approach and is frequently discussed and endorsed in the general homelessness literature.<sup>28,29</sup> In the summaries that follow, we present several recent estimates of homelessness among Veterans, including point prevalence, annual prevalence, and incidence, as well as changes over time. These estimates are based on the



highest quality national data sources available, including AHAR,<sup>18</sup> HMIS,<sup>30</sup> American Community Survey,<sup>31</sup> administrative databases maintained by the VA and the VA Office of Inspector General (OIG),<sup>8</sup> and the National Health and Resilience in Veterans Study.<sup>32</sup> These studies are summarized and synthesized in the remaining sections of the chapter.

## ANNUAL HOMELESS ASSESSMENT REPORTS TO CONGRESS

The most comprehensive and current source of estimates of homelessness among Veterans is the AHAR,<sup>18</sup> a report that has been produced by HUD and submitted to the US Congress annually since 2007. The AHAR includes both point prevalence and period prevalence estimates of homelessness as well as estimates of the extent of sheltered homelessness (living in transitional housing, emergency shelters, or safe havens) and unsheltered homelessness (living in locations not suitable for human habitation) on a national level. The data provided in the AHAR are used to track progress of the goals set forth in the Federal Strategic Plan to Prevent and End Homelessness and to inform federal, state, and local strategies to prevent and intervene in homelessness.

The AHAR is presented as a two-part report. Part 1 of the AHAR includes point prevalence estimates based on a point-in-time count of homeless individuals. These counts are conducted by local jurisdictions called Continuums of Care (CoCs). CoCs are responsible for coordinating homeless services within a particular geographic area. In the AHAR, CoCs are classified into three categories according to the size and type of area they cover. “Major City CoCs” cover the 50 largest cities in the United States, and “Balance of State (BoS) or Statewide CoCs” are composed of multiple rural counties or an entire state. The remaining CoCs fall somewhere in between these categories and are classified as “Smaller city, county, and regional CoCs.” Point-in-time counts are conducted on a single night in January and provide unduplicated, one-night estimates of homelessness, including separate counts for individuals experiencing sheltered and unsheltered homelessness. Veteran status is recorded for all individuals counted, and since 2009, AHAR has included separate point-in-time counts of homeless Veterans.

Part 2 of each annual AHAR is released the following year and includes period prevalence estimates based on HMIS data. Each CoC maintains its own HMIS and records individual-level information on sheltered homelessness as evidenced by receipt of homeless services. These one-year estimates include individuals who experienced sheltered homelessness at any point during the given year. Certain client characteristics, including Veteran status, are also captured. Each HMIS may be tailored to meet local needs, but all must conform to federal standards to allow for aggregation and comparisons at the national level.

Each CoC submits point-in-time and one-year estimates to HUD. These reports may then be aggregated to form statewide and nationwide estimates. Since the origination of the AHAR nearly 10 years ago, estimates of homelessness among Veterans have improved considerably, and they continue to improve as a result of high CoC participation, refinement, and clarification of procedures, as well as the integration of VA-funded community-based Veterans housing services into HMIS. With more than 400 CoCs providing data, recent estimates effectively cover the entire United States. The most recent AHAR reports available at the time this chapter was written were Part 1 of the 2016 AHAR<sup>33</sup> and Part 2 of the 2015 AHAR.<sup>34</sup>

On the night of the 2016 point-in-time count, 39,471 Veterans were identified as homeless. These estimates indicate that the representation of Veterans among the homeless on a given night is roughly proportional to their representation in the overall adult population (9.2%). However, Veterans remain overrepresented among the sheltered homeless population on a given night, making up approximately 10% of that group.

Demographic characteristics for these Veterans are presented overall and separately by sheltered and unsheltered status in Table 2.1. Approximately 91% of Veterans experiencing homelessness on a given night are men, 8% are women, and less than 1% are transgender. Hispanic ethnicity is reported by 9%. Roughly 60% are White and 30% are Black or African American; the remaining 10% are Veterans who identify as multiracial, Native American, Pacific Islander, or Asian. The vast majority of Veterans (97%) experiencing homelessness on a given night are not part of households that include children. Approximately two-thirds are sheltered and one-third are unsheltered.

There is substantial variability between states and CoCs regarding the proportion of Veterans experiencing homelessness in that area who are unsheltered. In terms of states, on the high end, between 58% and 61% of Veterans experiencing homelessness on a given night in Hawaii, Mississippi, and California are unsheltered. On the low end, between 0% and 4% of Veterans experiencing homelessness on a given night in Rhode Island, New Hampshire, and Massachusetts are unsheltered.

Since the AHAR began tracking Veteran status since 2009, point-in-time counts of homelessness among Veterans have decreased by 46% (33,896 fewer Veterans in 2016 than in 2009). These declines have been steeper among unsheltered relative to sheltered homeless Veterans, reflecting a decrease of 56% versus 39%, respectively. Figure 2.1 illustrates the annual point-in-time counts overall as well as separately for sheltered and unsheltered homelessness among Veterans from 2009 through 2016.

Between 2009 and 2016, declines were seen across all categories of CoC (major city CoCs; smaller city, county, and regional CoCs; and balance of state or statewide CoCs), as well as in 43 states and the District of Columbia. California,

**Table 2.1 Demographic Characteristics of Veterans Included in the 2016 Point-In-Time Count of Homelessness**

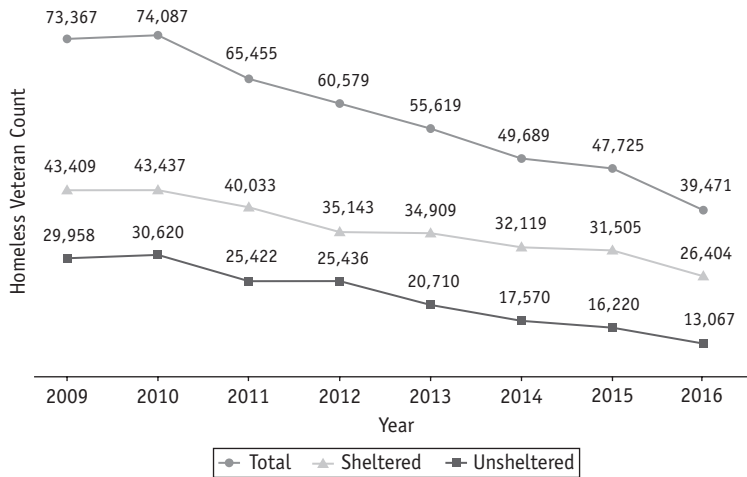
| <i>Characteristic</i>     | <i>Overall<br/>39,471 (100%)<br/>N (%)</i> | <i>Sheltered<br/>26,404 (%)</i> | <i>Unsheltered<br/>13,037 (%)</i> |
|---------------------------|--|---------------------------------|-----------------------------------|
| <i>Gender</i>             |  |                                 |                                   |
| Female                    | 3,328 (8.4%)                               | 2,208 (8.4%)                    | 1,120 (8.6%)                      |
| Male                      | 35,955 (91.1%)                             | 24,104 (91.3%)                  | 11,851 (90.7%)                    |
| Transgender               | 188 (0.5%)                                 | 92 (0.4%)                       | 96 (0.7%)                         |
| <i>Ethnicity</i>          |  |                                 |                                   |
| Non-Hispanic              | 35,913 (91%)                               | 24,513 (92.8%)                  | 11,400 (87.2%)                    |
| Hispanic                  | 3,558 (9%)                                 | 1,891 (7.2%)                    | 1,667 (12.8%)                     |
| <i>Race</i>               |  |                                 |                                   |
| White                     | 22,965 (58.2%)                             | 14,974 (56.7%)                  | 7,991 (61.2%)                     |
| Black or African American | 12,987 (32.9%)                             | 9,869 (37.4%)                   | 3,118 (23.9%)                     |
| Asian                     | 253 (0.6%)                                 | 153 (0.6%)                      | 100 (0.8%)                        |
| Native American           | 1,087 (2.8%)                               | 501 (1.9%)                      | 586 (4.5%)                        |
| Pacific Islander          | 331 (0.8%)                                 | 125 (0.5%)                      | 206 (1.6%)                        |
| Multiple races            | 1,848 (4.7%)                               | 782 (3%)                        | 1,066 (8.2%)                      |

Adapted from Part 1 of the 2016 AHAR Report

New York, and Florida saw the largest absolute decreases in terms of numbers of homeless Veterans (4,233–8,361 fewer Veterans); Louisiana, New York, and Kansas saw the largest percentage decreases (74%–80% lower). Hawaii, Utah, and South Carolina saw the largest increases in terms of absolute numbers (109–171 more Veterans), while Utah, Vermont, and Hawaii saw the largest percentage increases (34%–102% higher).

One-year estimates of Veteran homelessness as reported in the AHAR are still considerably higher than point-in-time estimates, despite only reflecting sheltered homelessness. By expanding the time frame of the measurement from one night to one year, many more experiences of temporary and episodic homelessness are captured. In 2015, sheltered homelessness was recorded for 132,847 Veterans. This equates to approximately one in 170 Veterans. Veterans are overrepresented among the one-year estimates, making up 11.5% of adults who experience sheltered homelessness during the year but only 9.2% of the

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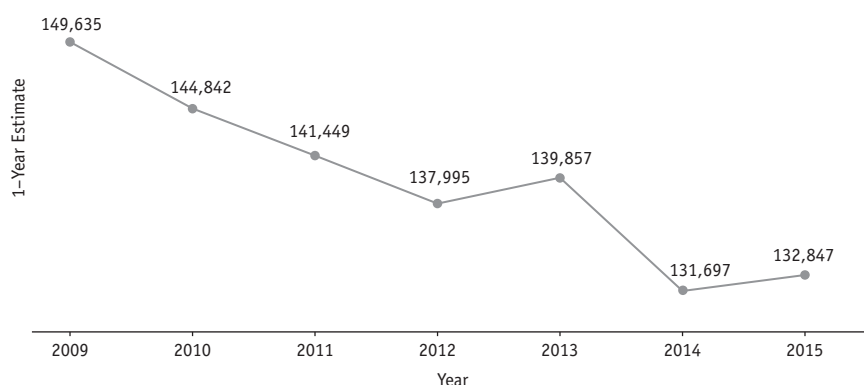


*Figure 2.1* Point-in-time estimates of Veterans experiencing sheltered and unsheltered homelessness, 2009–2016. Data sources: US Department of Housing and Urban Development. (2016). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress: Part 1 Point-in-Time Estimates of Homelessness*. Retrieved from Washington, DC: <https://www.hudexchange.info/resource/5178/2016-ahar-part-1-pit-estimates-of-homelessness/>

general adult population. This contrasts with the point prevalence estimates in the point-in-time portion of the AHAR, in which Veterans' share of homeless and general populations are similar. This is likely a reflection of their higher propensity for sheltered relative to unsheltered homelessness, as is reflected in the point-in-time count.

Men make up approximately 91% of Veterans who experience homelessness during the year, which is similar to their representation among the general Veteran population. For several other demographic characteristics, however, there are major differences between the general Veteran population and the sheltered homeless Veteran population. More than 50% of Veterans who experience sheltered homelessness during the year identify as a race other than White, whereas only 21% of the general Veteran population identifies as such. Veterans aged 62 years and older are vastly underrepresented among Veterans who experience sheltered homelessness. While Veterans in this age group make up more than half of the general Veteran population, they make up less than 15% of the sheltered homeless Veteran population. Conversely, Veterans between the ages of 41 and 51 years are overrepresented, making up less than 20% of the general Veteran population but 40% of the population of sheltered homeless Veterans. Finally, 53% of Veterans who experience sheltered homelessness have a disability compared with 28% among the general Veteran population.

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*Figure 2.2* One-year estimates of Veterans experiencing sheltered homelessness, 2009–2015. Data sources: US Department of Housing and Urban Development. (2016). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress: Part 2 Point-in-Time Estimates of Homelessness*. Retrieved from Washington, DC: <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf>

Between 2009 and 2015, one-year estimates of sheltered homelessness declined by 11.2% (16,788 fewer Veterans), despite slight increases recorded in 2013 and 2015. Annual one-year estimates for this period are illustrated in Figure 2.2.

There have been several shifts in the demographic composition of Veterans who experience sheltered homelessness since these data were first collected in 2009. First, while the number of Veterans experiencing sheltered homelessness is decreasing among men, it is increasing among women. The proportion of Veterans experiencing sheltered homelessness during the year who are Black or African American is also increasing, as is the proportion of those who are aged 51 years older. Table 2.2 includes a comparison of the demographic characteristics of Veterans experiencing sheltered homelessness in 2009 and 2015.

The AHAR is a valuable resource for understanding current and historical trends in the epidemiology of homelessness because it constitutes a nearly nationwide effort that uses complex methodologies to describe both sheltered and unsheltered homelessness over the long term. However, the AHAR is subject to certain limitations. First, the AHAR gives little information regarding the incidence of homelessness. Reports do not distinguish between individuals who are homeless for the first time and those who have episodic or chronic patterns of homelessness. This makes it more difficult to use these findings to develop strategies specifically geared toward primary prevention. There is also considerable variability between CoCs in terms of geography, population density, and the balance of unsheltered versus sheltered homelessness, which may lead to some degree of nonuniformity in the practical implications of the results.

**Table 2.2 Characteristics of Veterans Experiencing Sheltered Homelessness, 2009 and 2015**

|                           | 2009<br><i>N</i> = 149,633 | 2015<br><i>N</i> = 132,847 |
|---------------------------|----------------------------|----------------------------|
|                           | %                          |                            |
| Gender                    |                            |                            |
| Male                      | 92.6%                      | 91.1%                      |
| Female                    | 7.4%                       | 8.9%                       |
| Ethnicity                 |                            |                            |
| Hispanic                  | 10.9%                      | 7.6%                       |
| Non-Hispanic              | 89.1%                      | 92.4%                      |
| Race                      |                            |                            |
| White, Non-Hispanic       | 49.3%                      | 49.8%                      |
| White, Hispanic           | 8%                         | 5.1%                       |
| Black or African American | 34.2%                      | 38.6%                      |
| Other One Race            | 4.1%                       | 3.5%                       |
| Multiple Races            | 4.4%                       | 3.2%                       |
| Age (years)               |                            |                            |
| 18–30                     | 8.2%                       | 9.1%                       |
| 31–50                     | 44.7%                      | 33.2%                      |
| 51–61                     | 38.5%                      | 43.3%                      |
| 62 and older              | 8.8%                       | 14.5%                      |
| Household size            |                            |                            |
| One person                | 99.7%                      | 99.9%                      |
| Two or more people        | 0.3%                       | 0.1%                       |
| Disability status         |                            |                            |
| Disabled                  | 52.7%                      | 53.1%                      |
| Not disabled              | 47.3%                      | 46.9%                      |

Data are drawn from Exhibit 5.16 in the 2015 Annual Homeless Assessment Report (AHAR) to Congress, Part 2: Estimates of Homelessness in the United States.<sup>34</sup>

## VA OFFICE OF INSPECTOR GENERAL STUDY

In 2012, the VA OIG released *Homeless Incidence and Risk Factors for Becoming Homeless in Veterans*,<sup>8</sup> a study that estimated the rate of homelessness in the five years following discharge from active-duty military service. This study offers the unique benefit of establishing the incidence of homelessness in sample of Veterans with no history of homelessness. This allows for a specific focus on the epidemiology of first-time homelessness during the potentially vulnerable re-integration period, which may be considerably different than the epidemiology of repeat episodes of homelessness, or homelessness occurring as part of a protracted episode. These insights may help to inform the development of primary prevention strategies.

The population for this study included Veterans who were discharged from active-duty service between July 2005 and September 2006. The final cohort included 310,685 Veterans who were aged 17 to 64 years, used US Department of Defense (DoD) or VA care following discharge, and had not experienced homelessness before their service discharge.

This cohort was administratively followed for evidence of homelessness from the time of their discharge from service through September 2010. As discussed earlier in the chapter, because of the broad range of homelessness-related services provided by the VA, homelessness may be ascertained based on the presence of homelessness-related services and diagnoses recorded in the VA electronic medical records of Veterans. For the purposes of this study, Veterans were considered homeless if their electronic medical records reflected use of VA specialized homeless programs, completion of a VA health care for homeless Veterans intake assessment, or receipt of a diagnostic code indicating lack of housing.

Over the course of study follow-up, 5,574 Veterans became homeless (1.8%), with an overall median time of approximately 3 years to the first evidence of homelessness. Using the Kaplan-Meier method to account for variability in the length of administrative follow-up, the estimated homeless incidence (newly homeless) rate for the 5-year period immediately following discharge from active-duty service was 3.7%.

Service in OEF/OIF conflicts was associated with a shorter median time to first homelessness and a higher homeless incidence rate. There were also demographic differences between those who became homeless during study follow-up (homeless cohort) and those who did not (domiciled cohort). While the median time to first homelessness was shorter among men, homeless incidence rates were higher among women. On average, those in the homeless cohort were younger at their time of separation from service than those in the domiciled (never homeless) cohort and were more likely than those in the domiciled cohort to have a pay grade in the lower enlisted range of E1 through E4.



Although this study offers several useful insights regarding the incidence of homelessness among newly returning Veterans, it is also subject to certain limitations. The population of Veterans who separated from the military during the specified period was 491,800, yet the analytic sample only included 310,685 Veterans (63%). The reason for nearly all of these exclusions was lack of VA or DoD care following separation from military service. Some portion of the sample excluded may not have met the official VA definition for “Veteran.” Others were likely eligible for VA or DoD care but chose not to use it. It is unknown how results from the analytic sample might generalize to Veterans who choose non-VA services or no services at all. Further, as discussed earlier in this chapter, factors related to eligibility may relate to risk for homelessness. Thus, results from this study may underestimate the incidence of homelessness among a more broadly defined Veteran population.

## ONE-YEAR INCIDENCE AND PREDICTORS OF HOMELESSNESS STUDY

More recently, Tsai and colleagues used administrative data from the VA to estimate the incidence of homelessness among a particular population: Veterans who were referred to VA specialty mental health clinics.<sup>35</sup> In this 2017 study, a retrospective cohort design was used to estimate the one-year incidence of homeless among 306,351 Veterans who were referred to anxiety and PTSD clinics over a four-year period. Similarly to the previously described study, homeless incidence was defined as use of VA homeless services or a diagnostic code indicating lack of housing.

Of the total sample, 5.6% experienced homelessness within 1 year after referral to VA specialty mental health care. Risk for homelessness varied along sociodemographic and diagnostic lines. Women had higher risk for homelessness than men (7.6% vs. 5.4%). Veterans aged 55 years and younger were at highest risk by age, with particularly high risk among those aged 46 to 55 years (9.3%). Risk was also higher among Veterans who were Black relative to White (9.5% vs. 4.9%) and divorced or never married relative to married (8.2% vs. 3%). Veterans who were diagnosed with alcohol use disorders (12.1% vs. 4.6%) or drug use disorders (17.2% vs. 4.5%) had higher risk than those without these diagnoses. Finally, those who did not have a VA service-connected disability rating had higher risk than those who did (7.2% vs. 3.6%). Additional sociodemographic and clinical correlates of homelessness among Veterans are discussed in detail in subsequent chapters.

While this study is subject to similar limitations as the previously described study, these estimates are particularly useful in that they represent a population of Veterans that is both high risk and accessible to VA providers. Thus, they

may help to inform efforts to prevent homelessness through early monitoring of known vulnerable populations.

## PREVALENCE AND RISK OF HOMELESSNESS AMONG US VETERANS STUDY

In a 2012 study by Fargo and colleagues,<sup>36</sup> the prevalence of Veterans among the homeless population, poverty population, and general populations was estimated. HMIS data were obtained for 130,554 individuals experiencing homelessness across seven CoCs in 2008. The American Community Survey (ACS), a survey administered by the US Census Bureau annually that collects demographic, social, and economic characteristics from a sample of households in all US counties,<sup>31</sup> was used to estimate the total Veteran and non-Veteran populations for each of the seven CoCs.

Of the 130,554 adults who received homeless services in the seven selected CoCs, 8.2% were Veterans. In comparison, Veterans made up a smaller portion of both the ACS poverty and the ACS general population (3.3% and 7%, respectively). Results of this study indicated that both male and female Veterans were overrepresented in the population experiencing homelessness compared with Veterans living in the general population (1.3 and 2.1 times higher for males and females, respectively) or the population living in poverty (2.1 and 3 times higher for males and females, respectively). Homelessness was also experienced to a greater degree among both male and female Veterans compared with non-Veterans for both the general population (1.4 and 2.3 times higher for males and females, respectively) and the population living in poverty (2.2 and 3 times higher for males and females, respectively).

This study offered unique insights into the prevalence of Veterans experiencing homelessness, the overrepresentation of homelessness among Veterans relative to both the general and the poverty populations, and homeless non-Veterans. Limitations of this study include self-reported Veteran status as available in HMIS and use of a convenience sample of seven CoCs, which although representing 10% of the US homeless population in terms of absolute numbers, may not have been representative of the entire US homeless Veteran population.

## NATIONAL HEALTH AND RESILIENCE IN VETERANS STUDY

In a 2016 study, Tsai and colleagues estimated the lifetime prevalence of homelessness among Veterans using data from the National Health and Resilience in Veterans Survey.<sup>32</sup> The National Health and Resilience in Veterans Survey is nationally representative survey of Veterans that is ascertained from a larger, probability-based, nonvolunteer sample of US households. The study sample

included 1,533 Veterans with a broad range of sociodemographic and military service characteristics.

Overall, 8.5% of surveyed Veterans reported experiencing homelessness during their adult life. Among these, the average cumulative duration of homelessness was nearly two years, and only 17.2% reported using VA homeless or social services during the time that they were homeless. Those who were White or lived in rural areas were less likely to have used VA homeless services. As noted by the study authors, it was unclear how ineligibility for VA services may have contributed to nonuse. In any case, this study provides additional evidence that VA-based homelessness estimates likely miss a significant portion of Veterans who experience homelessness.

The study also identified several correlates of lifetime homelessness. Veterans with a history of homelessness had lower incomes and reported more physical and mental health symptoms. Interestingly, although older respondents were expected to be at greater risk for lifetime homelessness due to more years at risk, the likelihood of lifetime homelessness was greatest among Veterans aged 35 to 44 years. As suggested by the authors, higher rates of premature mortality among older Veterans who experienced homelessness may have contributed to this effect.

Because this survey assessed history of homelessness over the long term, responses may have been subject to some recall bias. The survey also did distinguish between different types of homelessness (e.g., episodic vs. chronic) and did not ascertain how long ago homelessness occurred. For this reason, changes to homelessness over time are difficult to infer. Regardless of these limitations, this study provides novel insights into the lifetime prevalence of homelessness among Veterans and provides important context for other estimates, including sociodemographic, clinical, and service use characteristics of Veterans who experience homelessness.

## Summary and Conclusions

Reliable estimates of the size and composition of the population of Veterans that experience homelessness are needed to inform appropriate prevention and intervention efforts. Because of the practical and methodological complexities involved in understanding the epidemiology of homelessness, no single study provides complete details. However, the collective evaluation of estimates yielded by diverse methodologies provides a nuanced view of these epidemiological issues, including point prevalence, period prevalence, and incidence rates; sheltered and unsheltered status; and the demographic, military service, and geographic characteristics of the Veterans who experience homelessness.

In the past decade, homelessness among Veterans has declined substantially. When Veteran status was first recorded in the HUD point-in-time count in 2009, 73,367 Veterans experiencing homelessness were identified. In the 2016 point-in-time count, 39,471 were identified—a decline of nearly 50%. There have also been significant declines in one-year estimates of sheltered homelessness among Veterans over this period. Between 2009 and 2015, the number of Veterans experiencing sheltered homelessness declined 11%, from 149,635 to 132,847 individuals.

The differentially larger decline in point-in-time estimates relative to one-year estimates suggest that the average length of time spent homeless by Veterans who do experience homelessness has decreased. This is reflective of progress toward achieving what is referred to as “functional zero” in homelessness among Veterans. Functional zero refers to a system in which episodes of homelessness are rare, brief, and nonrecurring; in which shelter is provided in the event of homelessness; and in which individuals who experience homelessness are moved quickly to permanent housing.<sup>37</sup> While these recent declines are encouraging, Veterans continue to be overrepresented among the homeless, particularly among those who experience sheltered homelessness over the course of a year. Despite making up approximately 9.2% of the overall adult population, Veterans made up 11.5% of adults who experienced sheltered homelessness in 2015.

The epidemiology of homelessness among Veterans will continue to evolve in response to a variety of factors. Broader economic conditions, including employment opportunities, availability of affordable housing, and access to health care, may also contribute to the growth or mitigation of homelessness among Veterans. Continued funding and availability of homeless and related supportive services that are responsive to these conditions is needed to sustain the declines that have occurred in recent years.

The future of homelessness among Veterans also relates closely to the changing composition of the Veteran population. As the proportion of women Veterans increases, the proportion of women among the population of homeless Veterans can also be expected to increase. In addition, the housing-related needs of Veterans will change as the Veteran population ages. Finally, changes to the military workforce, including the overall size of the force, the background and characteristics of service members and new recruits, and the members’ service-related experiences and exposures, may also eventually manifest in changes to the prevalence or incidence of homelessness. Several of these issues are discussed in detail in the later chapters of this book.

While recent years have brought significant improvements in the estimation of homelessness among Veterans, future research may provide more refined and actionable estimates through the integration of higher quality data and analytic techniques. This may include technological advancements

in data collection efforts. For example, in 2015, a mobile app was made available to assist communities with point-in-time counts.<sup>38</sup> The app captures GPS location coordinates for each survey. This detailed information can improve service deployment by helping CoCs to understand the specific locations where outreach and services are needed. This and other similar tools have the potential to improve quality, consistency, and precision of large-scale data collection efforts. Longitudinal data may also become more highly integrated into research, including details related to the initial entry into homelessness, the length of homelessness episodes, and returns to homelessness following rehousing. These high-level epidemiological details can be used to develop sophisticated profiles of homelessness that facilitate more precise targeting and tailoring of strategies to prevent homelessness, reduce the length of homelessness episodes, and prevent the reoccurrence of homelessness following rehousing.

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