New England Journal of Public Policy

Volume 8
Issue 1 *Special Issue on Homelessness: New England and Beyond*

Article 27

3-23-1992

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In 1987, in response to reports of large numbers of veterans among America's homeless, the Department of Veterans Affairs established two new national health care initiatives, which have seen over 40,000 homeless veterans since their inception. We present here evaluation and treatment data on a sample of 14,000 of them. Because of differences in their design, the two programs vary in the degree to which they emphasize community outreach, homelessness prevention, and the provision of aftercare services to patients discharged from other VA programs. In spite of these differences, veterans treated in the two programs have similar health care problems and show similar degrees of improvement at the conclusion of residential treatment. About one third of those admitted complete residential treatment successfully; one third are known to be in stable community housing at the time of discharge; and more than one third are employed. These modest success rates reflect both the severity of psychiatric disorder and social dysfunction in this population, and the limited ability of health care programs to address the full range of problems faced by the homeless mentally ill, even when services are specifically tailored to meet their needs. In designing programs for the homeless, it is particularly important to link health care efforts directly with sustained vocational rehabilitation services, housing subsidies, and income supports. New VA initiatives in all three of these areas have been undertaken and are described.

Among the most prominent and sorrowful developments of the past decade was the emergence of a growing and increasingly visible population of homeless persons in virtually every major city in America.[1] The first accounts of this "new mendicancy" came from New York City in 1981,[2] but within a few years studies from dozens of cities had brought the poor health, deep poverty, and social alienation of the homeless to public attention.[3]

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Accounts of high prevalences of psychiatric illnesses among the homeless, at first based on casual observation,[4] were subsequently confirmed by rigorously conducted surveys.[5] Between one third and one half of the homeless suffer from serious psychiatric illnesses and half from substance-abuse disorders. Initially it was suggested that psychiatric illness itself, or at least the lack of available hospital treatment for psychiatric illness, was a major cause of homelessness. Others pointed out that it was the lack of appropriate community-based psychiatric care that left the mentally ill at risk for homelessness.[6] By the end of the decade, however, most experts identified the declining availability of low-income housing and the increase in urban poverty as the prime *causes* of homelessness, and saw the mentally ill as among those most vulnerable to being caught in the squeeze between limited personal resources and high rents.[7]

Several early studies also made specific note of the substantial numbers of veterans of the U.S. armed forces among the homeless. By the end of 1989, sixteen studies had appeared, indicating that between 32 percent and 47 percent of homeless males were veterans,[8] as compared to 29 percent of males in the general U.S. population.[9] In view of the recent estimate by Wright[10] of 500,000 homeless persons in America on an average night (about 80 percent of whom are males), it is possible that there are as many as 100,000 to 200,000 literally homeless veterans in America each night. It has been suggested in the popular press that the unexpectedly high proportion of veterans among the homeless might be explained by the presence of large numbers of psychologically scarred Vietnam combat veterans. A recent study, based on data from the programs described in this chapter, however, found that the age-adjusted proportion of Vietnam era and Vietnam theater veterans among the homeless is no greater than the proportion in the general veteran population. A plausible explanation for the large proportion of veterans among the homeless has yet to be suggested.

In 1987, the Veterans Administration — since renamed the Department of Veterans Affairs (VA) — like many other public health care systems, responded to the reports of severe health problems among the homeless by initiating two national health care initiatives: the forty-three-site Homeless Chronically Mentally Ill Veterans Program and the twenty-site Domiciliary Care for Homeless Veterans Program.[11] Located in thirty states and the District of Columbia, these programs assisted over 40,000 homeless veterans during their first four years of operation. We begin by comparing the design and implementation of these two programs, then review evaluation data on several thousand veterans to see if differences in program design are associated with differences between the programs in (1) the sociodemographic and clinical characteristics of the veterans evaluated; (2) the selection of patients for admission to residential treatment; and (3) veteran housing and vocational outcomes at the time of discharge. We also examine the ways in which the programs are similar to one another and, more generally, the role of specialized health care programs in addressing the burgeoning national crisis of homelessness.

Specialized Health Care Services

Experienced clinicians and health care planners have generally agreed that assisting homeless mentally ill persons is an immense clinical challenge and that both specialized health care services and residential treatment are essential parts of any effort on their behalf.[12] In 1985, the Robert Wood Johnson Foundation and the Pew Memorial Trust funded the Health Care for the Homeless (HCH) project, an influential nineteen-city demonstration program of community-oriented outreach services which

showed that *some* of the homeless would make use of health care services if they were delivered to them in the community.[13] No residential component was included in the HCH program, and perhaps as a result, only half of all HCH patients were ever seen more than once. More recent studies that have examined the outcome of treatment programs for the homeless have suggested that clinical success requires a combination of clinical and residential services.[14] Although many health care initiatives for the homeless have included a residential treatment or housing placement component, only a few have placed a major emphasis on direct provision of long-term housing.

Six service elements have been emphasized in published descriptions of innovative health care programs for the homeless mentally ill: mobile community outreach;[15] provision of basic material resources;[16] accessible psychiatric and medical care;[17] assertive case management;[18] residential rehabilitative treatment;[19] and preventive efforts directed at keeping hospitalized mentally ill persons with inadequate housing resources from becoming homeless.[20] These elements have guided VA planners as they approached the challenge of developing new programs for homeless veterans.

The Two Initiatives

The Homeless Chronically Mentally Ill (HCMI) and Domiciliary Care for Homeless Veterans (DCHV) programs are based on five core clinical components: (1) community outreach; (2) clinical assessment; (3) psychiatric and medical treatment; (4) advocacy, case management, and linkage with VA and non-VA health care and social support services; and (5) provision of time-limited residential rehabilitation. While both programs offer each of these basic components to some degree, they have evolved somewhat different programmatic emphases. The HCMI program was designed to facilitate the entry of the often alienated homeless mentally ill veterans in the community into treatment. Its efforts center on community outreach by two-clinician teams who make contact with homeless veterans in shelters, soup kitchens, and on the streets; case management to link homeless veterans with health care and social services and to facilitate their continued access to those services; and residential treatment, provided through specially funded contracts with community providers.

The DCHV program, in contrast, places less emphasis on outreach and case management and provides its treatment and and more emphasis on residential rehabilitation services on the grounds of VA medical centers. The DCHV program, in addition to treating veterans contacted through outreach, frequently accepts homeless veterans who are referred from other VA programs, providing them with preventive aftercare services. While both these programs have been described in previous publications[21] a systematic comparison of their origins and operation, and a general consideration of the role of health care programs in the overall effort to assist the homeless mentally ill, has not yet appeared. The study of these programs is greatly facilitated by the fact that they were evaluated with a common set of instruments and procedures, by a single evaluation team at VA's Northeast Program Evaluation Center (NEPEC).

Program Design and Implementation

The HCMI and DCHV programs were designed and implemented under the leadership of VA Central Office (VACO) officials of the Veterans Health Administration of the Department of Veterans Affairs.[22] Each program was shaped by its legislative

background, historical traditions and recent trends within the specific VACO services responsible for their implementation, the expected duration of funding at the time of program implementation, and the nature of the designated residential treatment resources.

Legislative Bases

Both the HCMI program and the DCHV program were initiated in 1987 through legislation passed during the 100th Congress. The legislation that funded the HCMI program (Public Law 100-6) authorized a program that would provide time-limited residential treatment for homeless chronically mentally ill veterans through contracts with non-VA providers. Contract residential treatment was specifically identified in the legislation as an alternative to hospital care, reflecting a growing congressional interest in encouraging community-based approaches to VA mental health care. The DCHV program was established by Public Law 100-71, which called on the VA to identify "underutilized space located in VA facilities in urban areas in which there are significant numbers of homeless veterans" to be allocated for the care of the homeless.

The emphasis of both programs was thus on assisting the homeless through provision of time-limited residential rehabilitation and treatment. The principal difference in their legislative foundations was that in the HCMI program, residential treatment was to be provided through contracts with non-VA facilities, while in the DCHV program, residential treatment would be located in underutilized space on the grounds of existing VA medical centers. In their legislative origins, therefore, the HCMI program had a distinctive community orientation, while the DCHV program, as a result of its physical location, was associated with other programs operating within the same medical center.

Historical Traditions and Recent Trends in Implementing VA Services

Implementation of the HCMI program was the responsibility of VA's Mental Health and Behavioral Sciences Service (MH&BSS). Directed by a psychiatrist, the MH&BSS bears responsibility for oversight and planning of all VA mental health programs. Implementation of the DCHV program, in contrast, occurred under the leadership of the chief of Domiciliary Care Programs, an experienced health care administrator with mental health program management background, working in VA's Geriatric and Extended Care Service. Traditions and trends in these services are somewhat different and further shaped the emphases of the two programs.

The HCMI program and VA mental health care. The principal development in VA mental health care, during the past 30 years, as in other public mental health systems, has been the shift in the locus of care from hospitals to the community. Between 1956 and 1989, the number of VA psychiatric inpatients declined from 63,000 to 21,000, and there were major increases in the provision of psychiatric outpatient treatment, day treatment, and foster care. Concern about the quality of life of the "deinstitutionalized" mentally ill in MH&BSS, as elsewhere, has grown in recent years and led to renewed efforts to provide comprehensive community-based assistance through community support programs, intensive case management, structured rehabilitation programs, time-limited residential rehabilitation, and supported housing. The design of the HCMI program reflects these interests

in its emphasis on outreach, community-based case management, and community-based residential rehabilitation.

The DCHV program and VA Geriatric and Extended Care Service. The DCHV program builds on a century-old VA tradition of providing care to homeless, frequently elderly veterans with either psychiatric or medical disabilities. The first domiciliaries were established in the late nineteenth century[23] to provide long-term care to disabled veterans of the Civil War. Since that time, the VA Domiciliary Care program, which now includes over 8,000 beds, has provided often lifelong residential and health care service to thousands of veterans, many of whom have been homeless.

Since the mid-1980s, however, the Domiciliary Care program, consistent with the overall thrust of extended care services in VA, has been moving away from its "old soldier's home" traditions and toward a more active treatment model. In 1983, a formal Mission Clarification Statement urged a clinical focus on bio-psycho-social rehabilitation in VA domiciliaries and emphasized the objective of preparing veterans for community reentry. As pressure to reduce hospital lengths of stay mounted after implementation of the VA's Diagnosis Related Group–based Resource Allocation Model in 1984,[24] domiciliaries were increasingly used by medical center managers to facilitate discharge and community reentry from acute inpatient programs.

In keeping with this background, the DCHV program evolved as a medical center–based initiative, emphasizing aftercare and social and vocational rehabilitation. Outreach and sustained community-based care, while conducted at most sites, were secondary features, and the primary emphasis was placed on developing effective therapeutic milieus at each site.

Resources

In addition to differences in their legislative mandates and the traditions and trends of the services responsible for their implementation, the HCMI and DCHV programs also differed in their initial funding time frames and in the residential resources available to them.

Duration of funding. The HCMI program was initially funded on an emergency basis, with $5 million for only six months of operation. Although the program was eventually funded on a recurring basis at almost $13 million per year, at the time of its implementation the program faced the prospect of being a short-lived effort. Because of the need for rapid implementation, and possibly an equally rapid dismantling of the program, a large number of sites (43) were funded, each with a small staff and a modest budget for residential treatment. Since residential treatment in the HCMI program is paid on a per diem basis, the number of contract beds at each site would not influence the unit cost of service, and economies of scale were not considered in determining funding levels at each site. On average, each HCMI site supports sixteen veterans per day in residential treatment at three different residential treatment facilities per site.

Although the DCHV program was also initially funded on a nonrecurring basis, it, unlike the HCMI program, was implemented with the explicit expectation that it would eventually receive recurring operational funds at about the same level as the HCMI program, $10.4 million per year, with an additional one-time allocation of $4.5 million for building renovation. The DCHV program was to be entirely staffed and supported by VA, without contracts with non-VA providers. To maximize cost

efficiency, each domiciliary included at least forty operational beds. Ten DCHV sites were located at sites where no domiciliary program had previously existed ("new" sites), at which forty to seventy-five beds were planned. Ten additional DCHV programs were planned for medical centers that already supported domiciliaries ("established" sites). At these, only twenty-five DCHV program beds were projected, on the assumption that these sites would draw clinical and administrative support from the existing domiciliary, as well as from the parent VA medical center.

Table 1

Program Sites and Their Standardized Metropolitan Statistical Area (SMSA) Populations, HCMI Veterans Program and DCHV Program

HCMI Veterans Program		DCHV Program	
New York, NY	9,120,346	Brooklyn, NY	9,120,346
Long Beach, CA	7,477,503	West Los Angeles, CA	7,477,503
Los Angeles (OPC), CA	7,477,503	Cleveland OH	1,898,825
West Los Angeles, CA	7,477,503	Portland, OR	1,242,594
San Francisco, CA	3,250,630	Milwaukee, WI	1,389,000
Washington, DC	3,060,922	Dayton, OH	830,070
Houston, TX	2,905,353	Little Rock, AR	393,774
Boston, MA	2,763,357	Hampton, VA	364,449
St. Louis, MO	2,356,460	American Lake (Tacoma), WA	158,501
Pittsburgh, PA	2,263,894	Palo Alto, CA	< 100,000
Atlanta, GA	2,029,710	North Chicago, IL	< 100,000
San Diego, CA	1,861,846	Lyons, NJ	< 100,000
Denver, CO	1,620,902	Coatesville, PA	< 100,000
Tampa, FL	1,569,134	Montrose, NY	< 100,000
Phoenix, AZ	1,509,052	Bay Pines, FL	< 100,000
Cincinnati, OH	1,401,491	Hot Springs, SD	< 100,000
Kansas City, MO	1,327,106	Biloxi, MS	< 100,000
Buffalo, NY	1,242,826	Leavenworth, KS	< 100,000
Portland, OR	1,242,594	White City, OR	< 100,000
New Orleans, LA	1,187,073	Mountain Home, AR	< 100,000
Indianapolis, IN	1,166,575		
San Antonio, TX	1,071,954		
Salt Lake City, UT	936,255		
Louisville, KY	906,152		
Nashville, TN	850,505		
Dayton, OH	830,070		
Syracuse, NY	642,971		
Wilkes-Barre, PA	635,481		
East Orange, NJ	556,972		
Tucson, AZ	531,443		
Mountain Home, TN	433,638		
Charleston,SC	430,462		
Little Rock, AR	393,774		
Hampton, VA	364,449		
Augusta, GA	327,372		
Bath (Rochester), NY	< 100,000		
Walla Walla, WA	< 100,000		
Cheyenne, WY	< 100,000		
Roseburg, OR	< 100,000		
Tuskegee, AL	< 100,000		
Perry Point, MD	< 100,000		
Hines, IL	< 100,000		

Residential treatment resources and site location. The nature of residential resources available to each program also had a significant influence on program development, particularly in the location of program sites. HCMI sites were most often located in large cities where non-VA community residential treatment programs were well established, and many were located in or near neighborhoods where the homeless congregate. Over half (51%) of HCMI sites are in standard metropolitan statistical areas (SMSAs) of over one million population, and only 16 percent are in cities of fewer than 100,000 (Tables 1 and 2). In the late 1980s, a time of declining budgets for mental health services in many urban localities, residential treatment facilities were often eager to establish contracts with VA.

Table 2

Distribution of Program Sites by SMSA Size: HCMI and DCHV Programs

SMSA Size	HCMI		DCHV	
> 2,000,000	11	25.6%	2	10.0%
1,000,000 to 2,000,000	11	25.6%	3	15.0%
100,000 to < 1,000,000	14	32.6%	4	20.0%
< 100,000	7	16.3%	11	55.0%
Total	43	100.0%	20	100.0%

Since space at VA medical centers located in urban areas was usually fully committed, most of these hospitals lacked space in which to locate DCHV programs. As a result, the majority of DCHV programs were located in rural or suburban locations, at medical centers that, before deinstitutionalization, had housed large psychiatric populations and therefore had ample underutilized space. Only 25 percent of DCHV sites are located in SMSAs over one million, and 50 percent are in cities of fewer than 100,000 (Tables 1, 2). Differences in geographic locality may also have contributed to the different clinical emphases of the two programs. The fact that DCHV programs were often located at some distance from large concentrations of the homeless may also have led them to focus their attention on homeless veterans who had come to the medical center for acute medical or psychiatric treatment.

Similar as they are in many of their basic clinical components and objectives, the HCMI and DCHV programs differed in several important ways. While the HCMI program was oriented toward both identifying and treating alienated, underserved homeless veterans in urban community settings, the DCHV program was designed to be more medical center focused, providing rehabilitative care to veterans who had recently completed other VA programs; helping them sustain clinical gains; and preventing their return to homelessness. These differing emphases reflect a multiplicity of internal and external forces, including different legislative origins, contrasting traditions and agendas of their implementing services, and specific features of their financial and residential resource bases. It is particularly noteworthy that the differences between the programs did not arise out of any explicit plan to establish a diversity of programs for homeless veterans, nor out of any sense that the two programs might serve contrasting subgroups of homeless veterans with different needs.

Similarities between the two programs are as noteworthy as their differences. Both programs were essentially health care programs, whose main mission is the treatment of illness on an individual basis. They were only secondarily concerned with solving individual housing and income programs, and had virtually no responsibility for addressing the larger societal processes that many feel are the root cause of homelessness.[25]

Veteran Characteristics and Selection for Admission

In this section and the next our attention turns to evaluation data on the clinical operation of the HCMI and DCHV programs, specifically to a comparison of characteristics of veterans they assessed (including those not admitted to residential treatment); characteristics of those who were admitted to residential treatment; the influence of various veteran characteristics on the likelihood of admission to residential treatment; and the outcome of residential treatment at the time of discharge.

Methods

Data gathering procedures. During the first year of operation (May 1987–March 1988 for the HCMI program; November 1988–November 1989 for the DCHV program) patient-specific data reflecting the clinical operation of the two programs were collected in three phases. At the time of initial contact with each program, veterans were assessed with a standardized interview form. Those who were admitted to residential treatment were further assessed with a more detailed evaulation battery. Finally, at the end of each episode of residential treatment, a structured discharge summary was completed.

Training sessions in the proper use of the forms were held with representatives from each site. On completion, each form was individually reviewed for completeness and consistency by staff at NEPEC. Anomalous or inconsistent responses were checked, by phone, with staff members from the site.

Instruments. The Intake Form for Homeless Veterans (IFHV) documents basic sociodemographic data, past psychiatric and substance-abuse hospitalization, and current self-reported psychiatric, medical, alcohol, and drug problems. A ten-item Psychiatric Problem Index (PPI), based on three self-report items and seven clinician observations, is used to identify non-substance-abuse psychiatric problems. On a sample of 1,318 veterans from the HCMI program, a score of 2 or more on the PPI was associated with the presence of a major psychiatric disorder (schizophrenia, affective disorder, for example) as determined by a psychiatrist's clinical examination, with a sensitivity of 80 percent and a specificity of 58 percent.

The IFHV also documents receipt of disability payments, the duration of the current episode of homelessness, residence at the time of the IFHV assessment, the mode of first contact with the program, and the veteran's level of interest in services offered.

The evaluation battery completed at the time of admission to residential treatment provides more detailed information concerning past homelessness, educational background, marital status, current and past employment, current income, criminal history, length of residence in the current city (an indicator of residential transience), health service utilization during the previous six months, and several additional psychiatric symptoms.

The standardized discharge summaries document the length of stay in residential treatment, employment status, housing status at the time of discharge, and the primary reason for discharge, that is, successful completion of the program, dropped out, asked to leave for violating program rules, transferred to another institutional program, or other.

Analysis. The statistical significance of differences in the proportions of veterans with various characteristics in the two programs was evaluated using the 95 percent confidence interval of differences between proportions. To determine veteran characteristics independently associated with admission to residential treatment in each program, logistic regression analyses were conducted in which admission was the dependent variable and various veteran characteristics were independent variables.

Characteristics of Veterans Assessed

Number of veterans assessed. Altogether 10,524 veterans were assessed by the HCMI veterans program during the ten-month evaluation period (245 per site) as compared to 4,063 veterans in the first twelve months of the DCHV program (203 per site). This difference reflects the relative emphasis on outreach and case management services, in addition to residential treatment, in the HCMI program.

Demographic characteristics. Veterans assessed by the two programs were similar in gender but slightly different in age and race. Those assessed in the HCMI program were somewhat younger than those assessed by the DCHV program (Table 3) and more likely to be black or Hispanic, most likely because HCMI program sites were more often located in densely populated urban areas with larger minority populations. Both programs, however, contacted large percentages of minorities, a well-documented characteristic of homeless populations across the country.[26]

Table 3

Characteristics of All Homeless Veterans Assessed by the HCMI Veterans Program and the DCHV Program, Including Those Not Admitted to Residential Treatment

	HCMI Veterans Program N = 10,524	DCHV Program N = 4,063	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
Age				
< 35	26.5%	22.1%	4.4%	2.9% - 5.9%
35-44	37.0%	40.5%	-3.5%	-5.2% - -1.7%
> 44	36.5%	37.4%	-0.9%	-2.7% - 0.8%
Total	100.0%	100.0%		
Gender				
Male	98.6%	98.0%	0.7%	0.2% - 1.2%
Female	1.4%	2.0%	-0.7%	-1.2% - -0.2%
Total	100.0%	100.0%		0.0% - 0.0%
Ethnicity				
White	58.2%	65.6%	-7.4%	-9.1% - -5.6%
Black	33.6%	29.1%	4.5%	2.8% - 6.1%
Hispanic/other	8.2%	5.3%	2.9%	2.0% - 3.8%
Total	100.0%	100.0%		

Table 3, continued

	HCMI Veterans Program N = 10,524	DCHV Program N = 4,063	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
Mode of First Contact				
Outreach	56.8%	18.1%	38.8%	37.2% - 40.3%
Came to VA (any)	24.5%	74.2%	-49.7%	-51.2% - -48.1%
Other	18.6%	7.7%	10.9%	9.8% - 12.0%
Total	100.0%	100.0%		
Current Residence				
Apartment, room, house	15.4%	20.6%	-5.2%	-6.6% - -3.8%
Shelter or no residence	75.9%	41.6%	34.3%	32.6% - 36.0%
Institution	8.7%	37.8%	-29.1%	-30.6% - -27.5%
Total	100.0%	100.0%		
Duration of Homelessness				
Not homeless–1 month	24.8%	43.3%	-18.4%	-20.1% - -16.7%
1 month–1 year	43.3%	37.9%	5.3%	3.6% - 7.1%
> 1 year	31.9%	18.8%	13.1%	11.6% - 14.6%
Total	100.0%	100.0%		
Past Hospitalization (Any)				
Past psychiatric hospitalization	33.1%	36.2%	-3.1%	-4.8% - -1.4%
Past alcohol hospitalization	44.2%	59.1%	-14.9%	-16.7% - -13.2%
Past drug hospitalization	15.5%	25.7%	-10.2%	-11.7% - -8.6%
VA Hospital, Past 12 Months	38.4%	68.7%	-30.3%	-32.0% - -28.6%
Psychiatry	19.4%	29.5%	-10.1%	-11.7% - -8.5%
Substance abuse	16.3%	29.5%	-13.1%	-14.7% - -11.6%
Medical	13.2%	21.0%	-7.7%	-9.1% - -6.3%
Surgical	5.3%	7.2%	-2.0%	-2.8% - -1.1%
Intermediate medical	1.8%	4.0%	-2.2%	-2.8% - -1.6%
Financial Support				
Service connected (medical or psychiatric)	12.7%	16.5%	-3.8%	-5.1% - -2.5%
Any public support	51.6%	34.3%	17.3%	15.6% - 19.0%
Current Health Problems				
Psychiatric problems	43.0%	38.1%	4.9%	3.1% - 6.6%
Alcohol problems	49.4%	55.0%	-5.6%	-7.4% - -3.8%
Drug problems	16.8%	17.7%	-0.8%	-2.2% - 0.6%
Dual diagnosis (psychiatric/ substance abuse)	23.6%	17.6%	6.0%	4.5% - 7.4%
Chronic medical problems	53.3%	53.9%	-0.6%	-2.4% - 1.2%
Serious medical problems	46.2%	42.8%	3.4%	1.6% - 5.1%
Treatment Needs				
Mental health Rx	33.0%	36.1%	-3.1%	-4.8% - -1.4%
Detoxification	19.1%	5.4%	13.7%	12.7% - 14.7%
Substance-abuse Rx	47.4%	40.4%	7.0%	5.2% - 8.8%
Interest in Services				
Doesn't want services	21.6%	2.2%	19.4%	18.4% - 20.3%
Wants all services	70.6%	91.5%	-20.9%	-22.1% - -19.6%
Other	7.8%	6.3%	1.5%	0.6% - 2.4%

Mode of first contact. Consistent with the different clinical emphases of the two programs, the greatest difference between the HCMI and DCHV programs was in the mode of first contact with veterans (Table 3). Over half (57%) of veterans assessed by the HCMI program were contacted through outreach, only 25 percent came to VA programs on their own (either self-referral or referred from another VA program), and 19 percent came through other routes. In contrast, in the DCHV program, 74 percent came to VA on their own, 18 percent were contacted through outreach, and 8 percent through other routes.

It is notable, however, that, in spite of the HCMI program's specific emphasis on outreach, 43 percent of those assessed in it were contacted through routes other than outreach. Both programs became well known among the homeless in their areas, and eventually veterans began to seek assistance from them on their own, independently of any outreach efforts. The HCMI program, like the DCHV program, was also rapidly identified by other VA medical center programs as a potential aftercare resource for homeless veterans completing acute care programs. Some HCMI sites made special efforts to preserve the community outreach orientation of the program, which might otherwise been used almost exclusively to facilitate the transition of homeless inpatients to the community.

Residential status and duration of homelessness. Substantial differences were also apparent between the two programs in the veterans' current residences and the duration of their current episodes of homelessness. Compared to those assessed by the DCHV program, a greater percentage of veterans assessed by the HCMI program were living in a shelter or were without any residence at the time of assessment (76% versus 42%) and a smaller percentage were residing in an institution (9% versus 38%). In addition, HCMI veterans were more likely to have been homeless for over one year (32% versus 19%), while a smaller percentage of veterans had been homeless for less than one month or were at risk for homelessness but not homeless at present (25% versus 43%). These differences are probably related to the differences in the mode of first contact.

Past hospitalization and financial support. Veterans assessed in the HCMI program were somewhat *less* likely than veterans assessed in the DCHV program to ever have been hospitalized in the past, at either a VA or non-VA hospital, for psychiatric, alcohol, or drug problems (Table 3). Furthermore, 30 percent fewer veterans assessed in the HCMI program had been hospitalized at a VA facility during the twelve months prior to assessment (Table 3). When recent hospitalization is examined by type of problem, veterans in the HCMI program are observed to be especially less likely than those in the DCHV program to have been hospitalized in VA psychiatric (10 percent fewer than in the DCHV program) or substance-abuse programs (13 percent fewer than in the DCHV program). In contrast to the substantial differences in both past and recent hospitalization, much smaller differences are apparent in the percentages of veterans receiving either VA service-connected or non-VA public support payments like Social Security and welfare.

Current health problems. Only modest differences were noted between veterans assessed in the two programs in the frequency of current mental and physical health problems. Altogether, 5 percent more veterans assessed in the HCMI program had psychiatric problems (43% versus 38%), 6 percent fewer had alcohol problems (49% versus 55%) and 6 percent more had both psychiatric and substance-abuse problems (24% versus 18%). While these differences are statistically significant, they are not

of major clinical or programmatic importance. It is also striking that the prevalence of medical problems was similar in the two programs (Table 3).

Service needs. Differences between the two programs in the clinicians' assessments of the need for mental health or substance-abuse treatment were also modest (Table 3). It is notable, however, that 14 percent more veterans assessed in the HCMI program were felt to need detoxification, presumably because those contacted in the community were more likely to be acutely chemical dependent, and because DCHV veterans were more likely to have received detox services.

Veterans' interest in services. A final, and quite striking, contrast is that a substantially greater percentage of veterans assessed in the HCMI program were reported by the evaluating clinician to be uninterested in services (22% versus 2%), either because they did not want any assistance (8.3%) or because they wanted only basic material services and not the treatment provided by the program (13.2%). This finding is particularly salient in view of the apparent similarity in clinical problems and clinically assessed need for services among veterans evaluated by the two programs. Veterans contacted through outreach appear less likely than others to feel a need for the services they are offered.

Characteristics of Veterans Admitted to Residential Treatment

Altogether, 20 percent (2,115) of veterans assessed by the HCMI veterans program were admitted to residential treatment, as compared to 55 percent (2,237) of those assessed by the DCHV program. The lower admission rate in the HCMI program reflects, once again, its dual focus both on providing contract residential treatment and on community outreach and case management services.

When the characteristics of veterans admitted to contract residential treatment in the HCMI program are compared with the characteristics of those admitted to the DCHV program, the contrasts noted in the previous section are still apparent, but their magnitude is substantially reduced (Table 4). Veterans admitted to residential treatment in the HCMI program were still considerably more likely to have been contacted through outreach (49% versus 11%) and less likely to be living in an institution (15% versus 44%) than those admitted to the DCHV program.

Table 4

Characteristics of Veterans Admitted to Residential Treatment in the HCMI Veterans Program and in the DCHV Program

	Admitted to HCMI Residential Treatment N = 2,115	Admitted to DCHV Residential Treatment N = 2,237	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
Age				
< 35	24.7%	22.1%	2.6%	0.1% - 5.2%
35-44	40.0%	42.7%	-2.6%	-5.6% - 0.3%
> 44	35.3%	35.3%	0.0%	-2.9% - 2.9%
Total	100.0%	100.0%		
Gender				
Male	98.6%	97.9%	0.7%	-0.1% - 1.5%
Female	1.4%	2.1%	-0.7%	-1.5% - 0.1%
Total	100.0%	100.0%		

Table 4, continued

	Admitted to HCMI Residential Treatment N = 2,115	Admitted to DCHV Residential Treatment N = 2,237	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
Ethnicity				
White	59.9%	66.6%	-6.7%	-9.6% - -3.8%
Black	33.2%	28.1%	5.1%	2.3% - 7.9%
Hispanic/other	6.8%	5.3%	1.6%	0.1% - 3.0%
Total	100.0%	100.0%		
Mode of First Contact				
Outreach	48.7%	11.4%	37.2%	34.7% - 39.8%
Came to VA (any)	26.7%	80.0%	-53.3%	-55.8% - -50.7%
Other	24.6%	8.6%	16.1%	13.8% - 18.3%
Total	100.0%	100.0%		
Current Residence				
Apartment, room, house	10.4%	16.8%	-6.4%	-8.5% - -4.4%
Shelter or no residence	74.5%	39.4%	35.1%	32.4% - 37.9%
Institution	15.1%	43.8%	-28.7%	-31.3% - -26.2%
Total	100.0%	100.0%		
Duration of Homelessness				
Not homeless–1 month	20.8%	39.7%	-18.9%	-21.6% - -16.2%
1 month–1 year	48.5%	40.5%	8.0%	5.0% - 11.0%
> 1 year	30.7%	19.8%	10.9%	10.9% - 10.9%
Total	100.0%	100.0%		
Past Hospitalization (Any)				
Past psychiatric hospitalization	42.0%	35.2%	6.7%	3.8% - 9.7%
Past alcohol hospitalization	55.0%	60.1%	-5.1%	-8.1% - -2.1%
Past drug hospitalization	19.6%	28.1%	-8.5%	-11.0% - -6.0%
VA Hospital, Past 12 Months	57.7%	71.2%	-13.4%	-16.3% - -10.6%
Psychiatry	29.8%	30.0%	-0.2%	-2.9% - 2.6%
Substance abuse	28.2%	43.6%	-15.4%	-18.2% - -12.6%
Medical	17.0%	20.5%	-3.6%	-5.9% - -1.2%
Surgical	7.5%	6.8%	0.7%	-0.9% - 2.2%
Intermediate medical	2.2%	3.4%	-1.2%	-2.2% - -0.2%
Financial Support				
Service connected (medical or psychiatric)	12.5%	15.3%	-2.8%	-4.9% - -0.8%
Any public support	36.2%	34.3%	1.9%	-1.0% - 4.8%
Current Health Problems				
Psychiatric problems (2)	50.2%	37.5%	12.8%	9.8% - 15.7%
Alcohol problems	51.9%	55.0%	-3.1%	-6.1% - -0.1%
Drug problems	18.0%	18.0%	-0.0%	-2.3% - 2.3%
Dual diagnosis (psychiatric/ substance abuse)	27.1%	16.4%	10.6%	8.2% - 13.1%
Chronic medical problems	52.6%	52.1%	0.5%	-2.5% - 3.5%
Serious medical problems	45.2%	41.9%	3.2%	0.3% - 6.2%
Treatment Needs				
Mental health Rx	76.4%	49.8%	26.6%	23.9% - 29.4%
Detoxification	14.7%	3.1%	11.6%	9.9% - 13.4%
Substance-abuse Rx	52.1%	42.0%	10.2%	7.2% - 13.2%
Interest in Services				
Doesn't want services	5.9%	0.9%	5.0%	3.9% - 6.1%
Wants all services	90.8%	94.7%	-3.9%	-5.5% - -2.4%
Other	3.3%	4.4%	-1.1%	-2.2% - 0.1%

More extensive data were gathered on veterans admitted to residential treatment in the two programs, permitting further examination of their similarities (Table 5). Remarkably, for the majority of variables on which data are available, differences between veterans admitted to residential treatment in the two programs are not statistically significant.

Table 5

Supplementary Admission Data on Veterans Admitted to Residential Treatment in HCMI and DCHV Programs

	Admitted to HCMI Residential Treatment N = 1,468 (69.4%)	Admitted to DCHV Residential Treatment N = 2,009 (89.8%)	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
Marital Status				
Married/widowed	6.6%	7.5%	-0.9%	-2.6% — 0.8%
Separated	15.7%	16.5%	-0.8%	-3.3% — 1.6%
Divorced	46.1%	47.3%	-1.2%	-4.5% — 2.2%
Never married	31.6%	28.6%	2.9%	-0.2% — 6.0%
Total	100.0%	100.0%		
Education (years)				
0–8	5.7%	4.0%	1.7%	0.2% — 3.1%
9–11	11.8%	12.1%	-0.2%	-2.4% — 1.9%
12	49.4%	46.6%	2.7%	-0.6% — 6.1%
13–16	31.3%	34.3%	-3.1%	-6.2% — 0.1%
>16	1.8%	2.9%	-1.1%	-2.1% — -0.1%
Total	100.0%	100.0%		
Usual Employment (Past 3 Years)				
Full time	32.6%	34.0%	-1.4%	-4.6% — 1.7%
Part time	34.5%	31.8%	2.8%	-0.4% — 5.9%
Retired/disabled	5.9%	5.8%	0.1%	-1.4% — 1.7%
Unemployed	24.4%	24.9%	-0.5%	-3.4% — 2.4%
Other	2.5%	3.5%	-1.0%	-2.1% — 0.2%
Total	100.0%	100.0%		
Total Income (Past 30 Days)				
None	34.4%	36.3%	-1.9%	-5.1% — 1.3%
$1–99	19.8%	20.6%	-0.8%	-3.5% — 1.9%
$100–499	37.2%	33.8%	3.5%	0.2% — 6.7%
>$499	8.5%	9.4%	-0.8%	-2.7% — 1.1%
Total	100.0%	100.0%		
Earned Income (Past 30 Days)				
None	71.6%	76.9%	-5.4%	-8.3% — -2.4%
$1–99	11.3%	9.1%	2.2%	0.1% — 4.2%
$100–499	14.1%	11.7%	2.4%	0.2% — 4.7%
>$499	3.0%	2.3%	0.7%	-0.3% — 1.8%
Total	100.0%	100.0%		
Now on Probation or Parole	10.5%	9.8%	0.7%	-1.4% — 2.7%
Number of Crimes Arrested For				
None	48.9%	49.2%	-0.3%	-3.7% — 3.0%
1–3 crimes	44.4%	42.5%	1.9%	-1.5% — 5.2%
>3 crimes	6.7%	8.2%	-1.5%	-3.3% — 0.2%
Total	100.0%	100.0%		

Table 5, continued

	Admitted to HCMI Residential Treatment N = 1,468 (69.4%)	Admitted to DCHV Residential Treatment N = 2,009 (89.8%)	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
Years Lived in This City				
6 months or less	25.3%	28.8%	-3.5%	-6.4% — -0.5%
1–2 years	8.4%	7.3%	1.1%	-0.7% — 2.9%
> 2–5 years	14.3%	12.0%	2.3%	-0.0% — 4.6%
> 5–10 years	9.3%	8.7%	0.5%	-1.4% — 2.5%
> 10 years	42.7%	43.2%	-0.5%	-3.8% — 2.9%
Total	100.0%	100.0%		
First Time Homeless?	51.2%	54.3%	-3.2%	-6.5% — 0.2%
Episodes of Homelessness (Life)				
None	10.6%	13.6%	-2.9%	-5.1% — -0.8%
1–2 episodes	54.1%	60.9%	-6.8%	-10.1% — -3.5%
3–5 episodes	19.0%	14.2%	4.8%	2.2% — 7.3%
6–10 episodes	9.2%	6.0%	3.2%	1.4% — 5.0%
> 10 episodes	7.1%	5.3%	1.8%	0.1% — 3.4%
Total	100.0%	100.0%		
Violence Is Current Problem	13.7%	7.9%	5.8%	3.6% — 7.9%
Suicide Attempt (Past 30 Days)	4.1%	1.4%	2.7%	1.5% — 3.8%
VA Outpatient Visits, Past 6 Months				
None	51.4%	44.8%	6.6%	3.3% — 10.0%
1–3 visits	25.1%	27.2%	-2.2%	-5.1% — 0.8%
>3 visits	23.5%	28.0%	-4.4%	-7.4% — -1.5%
Total	100.0%	100.0%		
VA Mental Health or Substance-Abuse Outpatient Visits (6 Months)				
None	79.4%	40.0%	39.4%	36.5% — 42.4%
1–3 visits	11.0%	16.1%	-5.1%	-7.4% — -2.8%
>3 visits	9.6%	43.9%	-34.3%	-37.0% —-31.7%
Total	100.0%	100.0%		
Lifetime Psychiatric Hospitalizations				
None	56.6%	62.7%	-6.1%	-9.4% — -2.8%
1–2	19.8%	21.2%	-1.4%	-4.1% — 1.3%
3–5	12.1%	8.8%	3.4%	1.3% — 5.4%
6–10	6.3%	4.6%	1.6%	0.1% — 3.2%
> 10	5.1%	2.6%	2.5%	1.2% — 3.8%
Total	100.0%	100.0%		

Veterans were similar on measures of marital status, educational background, employment history, current income, criminal history, residential history, number of times homeless, tendency to violence, recent suicide attempts, VA outpatient visits during the past six months, and lifetime psychiatric hospitalizations. The one area in which veterans admitted to residential treatment in the two programs do differ is in their use of outpatient VA psychiatric or substance-abuse services during the six months prior to admission. In the HCMI veterans program, only 10 percent had three or more such visits, as compared to 44 percent in the DCHV program.

In addition to the many notable similarities between veterans admitted to residential treatment in the two programs, Table 5 also reveals much about the harshness of

their circumstances: 46 to 47 percent are divorced; 24 percent have been unemployed for most of the past three years; 54 to 56 percent had a total income of less than $100 during the past month, and 1 to 4 percent had attempted suicide during the previous thirty days. In these characteristics, homeless veterans are seen to be quite similar to homeless persons described in other studies and surveys.[27]

Thus, while veterans assessed overall in the two programs were quite different in their mode of first contact with the program, in their residential status, and in their hospitalization history, those who were admitted to residential treatment were far more similar. It appears that while the programs initially make contact with quite different segments of the homeless veteran population, a similar selection process occurs with respect to admission to residential treatment.

Relationship Between Veteran Characteristics and Admission to Residential Treatment

To obtain a clearer understanding of the admission process in the two programs, logistic regression analyses of the relationship of various veteran characteristics to admission to residential treatment in each program were performed. In this analysis, an adjusted odds ratios of the likelihood of admission is computed for veterans with specific characteristics as compared to veterans without those characteristics, with the influence of all other characteristics included in the analysis statistically controlled.[28] When the adjusted odds ratio for a particular characteristic is greater than 1.0, the likelihood of admission is increased for veterans with that characteristic. When the adjusted odds ratio for a particular characteristic is less than 1.0, the likelihood of admission is decreased for veterans with that characteristic.

The results of these logistic regression analyses for both the HCMI and DCHV programs are presented in Table 6. The strongest predictor of admission to residential treatment in both programs was current admission to a VA medical center or other institution, which increased the likelihood of admission to residential treatment in the HCMI program by 3.9 times and to the DCHV program by 1.4 times. In the HCMI program a history of past hospitalization (excluding those currently hospitalized) and the presence of psychiatric symptoms also increased the likelihood of admission. It thus appears that in both programs, currently institutionalized veterans and those with past experience of institutional treatment were most likely to be admitted, probably reflecting both their greater need for treatment and their greater tolerance of the constraints imposed by institutional care.

Several characteristics were associated with a *decreased* likelihood of admission in both programs: homelessness of less than one month's duration; current receipt of public support payments (from either VA or non-VA sources); current residence in an apartment, room, or house, and having been initially contacted through outreach. In the HCMI program, veterans who had been homeless for over one year were somewhat less likely to be admitted. These results suggest that both programs gave lower priority for admission to veterans who had some access to basic resources, namely, those who had been homeless briefly or had public financial support or housing. It is especially notable that those contacted through outreach were considerably less likely to be admitted than other veterans, most probably because they felt less need or were less tolerant of the constraints imposed by residential treatment.

While veterans assessed for these two programs differed substantially in their mode of first contact with the programs, in their current residential status, and in their past

and recent history of institutional care, they were generally similar in their current clinical, sociodemographic, and social adjustment characteristics. The admission selection process appears to have worked in similar ways in the two programs, with more institutionally oriented veterans, veterans who have been homeless for over a month, and veterans who lacked public financial support having a greater chance of admission than others. The special emphasis on outreach in the HCMI program clearly *did* allow the program to contact a segment of the homeless mentally ill veteran population that would not have been reached otherwise. However, those admitted to residential treatment in the two programs were similar to one another. It thus appears that while outreach programs may, in fact, reach underserved segments of the homeless population, segments not served by more conventional programs, those who are most readily engaged in treatment are quite similar to those who seek treatment on their own.

Table 6

Logistic Regression Analysis of Veteran Characteristics Associated with Admission to Residential Treatment (HCMI) or Domiciliary Care (DCHV)

I. Admission to Residential Treatment (HCMI)

	Odds Ratio	95% Confidence Interval
Currently Hospitalized in VA Medical Center	3.9	4.7–3.3
Past Hospitalization (Psychiatric, Alcohol, or Drug)	2.1	2.4–1.9
Psychiatric Symptoms	1.2	2.3–1.0
Homeless > 1 Year	0.9	1.0–0.8
Homeless < 1 Month	0.8	0.9–0.7
Contacted Through Outreach	0.7	0.8–0.6
Receives Any Public Support	0.7	0.7–0.6
Living in an Apartment, Room, or House	0.5	0.6–0.4

II. Admission to Domiciliary Care (DCHV)

	Odds Ratio	95% Confidence Interval
Currently Hospitalized in VA or Other Institution	1.4	1.6–1.2
Dual Diagnosis (Psychiatric and Substance Abuse)	0.8	0.9–0.7
Living in an Apartment, Room, or House	0.7	0.8–0.6
Homeless < 1 Month	0.7	0.8–0.6
Receives Any Public Support	0.7	0.8–0.6
Contacted Through Outreach	0.4	0.4–0.3

The Process and Outcome of Treatment

Although data on the important linkage, advocacy, and case management activities of the two programs will not be presented here, some preliminary information on the process and outcome of residential treatment can be reported.

Length of Stay

The principal measure of treatment process available for comparison in the programs is length of stay. Although substantial differences exist between the programs in average length of stay (75 days in HCMI versus 109 in DCHV), the two programs experi-

ence roughly similar termination rates during the first week of treatment (10% in HCMI versus 5% in DCHV) (Table 7). A somewhat greater rate of early dropouts is apparent during the first month of treatment in the HCMI program, perhaps because veterans are more often admitted directly from the community and are, therefore, less well prepared for the structured demands of residential treatment.

Differences between the programs are somewhat greater at the other end of the length of stay continuum, with 10 percent fewer veterans in the HCMI program staying for over 180 days (9% in HCMI versus 20% in DCHV). Both programs tend to have lengths of stay of about six months, but in the HCMI program a formal extension of the residential treatment contract is required after the first six months of treatment. Differences in length of stay between the two programs may also reflect the historical tradition of long lengths of stay in VA domiciliaries.

Table 7

Length of Stay in Residential Treatment: HCMI Veterans Program and DCHV Program[a]

	HCMI Veterans Program	DCHV Program	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV
0–7 Days	9.93%	4.54%	5.39%	-0.30% — 11.08%
8–30 Days	23.63%	16.80%	6.82%	1.55% — 12.10%
31–90 Days	33.51%	30.84%	2.67%	-2.20% — 7.53%
91–180 Days	23.77%	28.29%	-4.52%	-9.61% — 0.56%
> 180 Days	9.16%	19.52%	-10.36%	-15.84% — -4.88%
Total	100.00%	100.00%		

[a]Data in this table are based on all discharges (N = 2,091 [HCMI] and 2,307 [DCHV]), not just those for which an HVEB was completed at the time of admission.

Clinical Status at Discharge

Data on posttreatment outcome in these two programs are being gathered at a limited number of sites but have not yet been fully analyzed. However, preliminary information on the outcome of residential treatment is available, from the discharge summaries, in three outcome domains: program status at the time of discharge, residential status, and employment status.

Program status at discharge. There was no significant difference in the percentage of veterans in each program who successfully completed residential treatment (34.4% in HCMI versus 35.2% in DCHV), although there were some differences in the rates of specific types of unfavorable discharges. A significantly greater percentage of veterans admitted in the DCHV program dropped out or were discharged for a rule infraction, while slightly more veterans in the HCMI program were too ill to continue in residential treatment and were transferred to another program for further institutional care (Table 8). The modest proportion of those admitted who successfully completed residential treatment in these programs reflects the significant difficulties encountered in engaging the homeless mentally ill in treatment. Other programs that treat impoverished substance-abusing patients have reported similarly low rates of program completion.[29]

Residential status. About one third of those discharged from residential treatment in each program were known to be moving to an apartment, room, or house at the time of discharge. Veterans discharged from residential treatment in the HCMI pro-

gram were significantly living in such settings less often than those discharged from the DCHV program, and they were more apt to be living in another institutional setting (Table 8). These differences, however, most likely reflect the greater duration of homelessness among HCMI veterans and their lower prior use of institutional treatment. DCHV veterans were more likely to have completed an episode of hospital treatment prior to admission to the DCHV program, and as a result, they may have been more ready for community reentry than veterans in the HCMI program.

Table 8

Clinical Status at Discharge from Residential Treatment from the HCMI Veterans Program and the DCHV Program

	HCMI Veterans Program N = 1,453	DCHV Program N = 1,870	HCMI-DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
A. Discharge Status				
Successful completion	34.4%	35.2%	-0.8%	-4.0% — 2.5%
"Kicked out"	19.8%	25.1%	-5.3%	-8.2% — -2.5%
Dropped out	27.2%	30.7%	-3.5%	-6.6% — -0.4%
Transferred	8.5%	4.8%	3.8%	2.0% — 5.5%
Other	10.1%	4.3%	5.8%	4.0% — 7.6%
Total	100.0%	100.0%		
B. Residential Status				
Apartment, room, house	32.5%	45.1%	-12.5%	-15.8% — -9.2%
Institution	26.9%	19.0%	7.8%	4.9% — 10.7%
None/unknown	34.0%	33.5%	0.5%	-2.7% — 3.7%
Other	6.6%	2.4%	4.2%	2.7% — 5.7%
Total	100.0%	100.0%		
C. Employment Status				
Full time	24.2%	28.3%	-4.1%	-7.1% — -1.1%
Part time	13.4%	8.7%	4.7%	2.5% — 6.9%
Vocational training	4.9%	7.4%	-2.5%	-4.1% — -0.9%
Unemployed	35.9%	39.2%	-3.3%	-6.7% — 0.0%
Retired/disabled	16.7%	14.1%	2.5%	0.1% — 5.0%
Other	5.0%	2.2%	2.7%	1.4% — 4.0%
Total	100.0%	100.0%		

Employment status. Differences in overall employment status at discharge were also minimal, with almost 40 percent employed in both programs. The proportion of veterans in the HCMI program who were working in full-time jobs at the time of discharge was less than in the DCHV program (24% versus 28%), but the proportion who were working at part-time jobs was greater (13% versus 9%).

In responding to the crisis of homelessness as it has emerged during the past decade, the Department of Veterans Affairs developed two national health care programs with somewhat different clinical emphases to help homeless veterans suffering from medical, psychiatric, and substance-abuse problems. Data available from the evaluation of these two programs are among the most extensive available from any health care program for the homeless mentally ill, and thus provide a unique opportunity to consider the place of specialized health care programs in the national response to the crisis of homelessness.

Veterans Evaluated

Veterans evaluated by the two programs, as well as those who were admitted to residential treatment, were quite similar in their sociodemographic characteristics and in the prevalence of current clinical and social adjustment problems. Homeless veterans are not markedly different from other homeless males in the severity of their health care problems and in their abysmal social circumstances. One way in which they do differ, of course, is in their military and, more specifically, combat experience.

In several previous studies, we have examined the combat experience and combat-related psychological problems of homeless veterans.[30] While combat veterans do tend to have somewhat more severe psychological problems than other homeless veterans, it is the nightmare of their homelessness, rather than their war-related symptomatology that appears to be most in need of immediate clinical attention,

New Initiatives

As a result of the evaluation results reported here, a number of new initiatives have been launched by VA, each of which seeks to link innovative mental health services with additional types of assistance. These initiatives have been inspired by a desire to expand the range of help provided, and by the wish to link VA health care services more directly with other types of largely non-health-related assistance.

The first effort is an internal VA program, the Compensated Work Therapy/ Therapeutic Residences Program, a long-term effort to provide vocational rehabilitation and transitional housing to homeless substance abusers. In this initiative, VA purchased community residences in which homeless veterans who have completed a substance-abuse treatment program can live and work in a "dry" supportive community for up to eighteen months. Particular emphasis is placed on the interrelationship of sobriety maintenance and work. Patients are required to participate in a supported community employment program, VA's well-established Compensated Work Therapy Program, and to contribute, out of their earnings, to the upkeep and maintenance of the residence.

The second effort involves a collaborative outreach effort undertaken in conjunction with the Social Security Administration (SSA) for those homeless veterans who are medically or psychiatrically disabled and cannot return to work, at least in the short run. Through this collaboration, claims representatives and disability determination specialists funded by SSA have begun to work, on site, with VA clinicians to provide stronger links between VA clinical services and the financial assistance available through the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs. In this initiative, therefore, VA clinicians team up with SSA personnel to broaden the range and responsiveness of services they can provide and to improve ease of access to financial support for those who cannot work.

A third initiative, a collaboration between VA and the Department of Housing and Urban Development (HUD), was slated to begin at nineteen HCMI and DCHV sites in the spring of 1992. For this program, the HUD-VA Supported Housing program (HUD-VASH), HUD has agreed to set aside 750 Section 8 housing vouchers for use by veterans. VA case managers have been deployed to work intensively, over many years, with the homeless mentally ill veterans admitted to this program. It is

believed that the availability of Section 8 vouchers will greatly facilitate the housing procurement process for these veterans, and that the combination of accessible and flexible housing subsidies and sustained case management will result in greatly improved clinical outcomes.

In each of these efforts, and in others that cannot be fully described here, VA has sought to link its clinical initiatives with other types of service, often nonmedical in nature, to offer a comprehensive range of integrated assistance. The data presented here suggest that the homeless mentally ill require far more than health care services and that health care programs seeking to assist them must vigorously link their efforts with those of other agencies and resource pools.

On any given night, there may be as many as 200,000 homeless veterans in America. If every one of the 70,000 beds in the entire VA health care system was used to provide shelter and care for these veterans, just over one third of those needing assistance could be helped. Although these statistics are rough estimates, they clearly demonstrate the immensity of the homeless problem in America.

The homeless are, perhaps, as diverse as any other group of Americans. They come from small towns and big cities, from all racial and ethnic groups, and they face a variety of social adjustment and health care problems. No single program could meet the various needs of this entire population, nor could any single program meet the needs of even one small subgroup. Multiple and diverse approaches are needed and, as we have shown, large agencies like VA are developing a broad spectrum of humane, caring programs that successfully make contact with a variety of segments of the homeless population. It must be acknowledged, however, that the results of even innovative health care programs like those reported here are modest at best, and woefully inadequate to address the full measure of the tragedy of homelessness in America. Nevertheless, these programs must not be abandoned or devalued because they cannot address all the needs of all the homeless mentally ill or because their clinical success is partial. Rather, they must be regarded as crucial pilot efforts through which the health care community is gaining experience in providing assistance to the homeless and through which we are learning new ways that health care programs can be broadened and expanded to better meet the needs of the homeless mentally ill.

Neither health care programs nor any other single type of service program can end the tragedy of homelessness in America. Homelessness is only the tip of a much larger constellation of interrelated social problems that include the deterioration of American cities, the shift away from an industrial economy, the regressive redistribution of wealth,[31] and massive minority unemployment.[32] A major reorientation of national priorities will be needed before these profound social problems, including homelessness, can be addressed on the scale required. In the overall scheme of things, current health care efforts on behalf of the homeless must be regarded as partial, exploratory, and even experimental. They will not in themselves put an end to homelessness among the mentally ill. But the clinical successes of these programs, as well as the professional experience and expertise gained through them, must not be dismissed because they do not represent a full solution to an imposing problem. Current gains in knowledge and experience will be of vital importance if and when the nation commits itself, on the massive scale required, to addressing the problems of the homeless mentally ill and the larger problems of what we must, once again, regard as the "other America." ❧

After four years of operation, the HCMI and DCHV programs have become well-established entities within VA's overall health care effort. Paul Errera, M.D., and Richard Olson, M.H.A., deserve primary credit for the progress of their programs, and we want to thank them for their support of our evaluation efforts. Gay Koerber, M.A., of the Mental Health and Behavioral Sciences Service has been a beacon of orientation for VA's homeless programs nationally. At NEPEC, Sharon Medak, Dennis Thompson, Alex Ackles, Bernice Zigler, Linda Corwel, and Pamela Gott have contributed to the success of our evaluations through their meticulous attention to detail. Virginia Emond, Karen Arena, and Vera Ratliff, who form NEPEC's nerve center, have played a vital role in integrating the national information network that makes program evaluation possible. Above all, we want to thank the program directors, staff clinicians, and evaluation assistants at the seventy-one HCMI and DCHV sites, whose courage and caring have made these programs happen. To all, we extend our thanks.

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