APPENDIX A. PEER REVIEW COMMENTS/AUTHOR RESPONSES

PEER REVIEW COMMENTS - Epidemiological evidence regarding homelessness among Veterans

Reviewer No.	Comment	Response
Question 1: Are the objectives, scope, and methods for this review clearly described?		
1	Yes.	
1	Comments: The numbers and letters used in the research objectives are distracting. I would use 1-4 and then use bullets for the sub questions.	We have revised the format of the document to comply with the standard VA Evidence-based Synthesis Program (ESP) style template. We think this should address the concerns of the reviewer.
1	In addition, the methods section should precede the discussion on the structural causes of homelessness.	This has been corrected in a way that follows the template of the ESP program.
1	The description of data sources could benefit from elaboration on limitations and that the limitations of the current research are a laundry list – are there key issues that you could group?	We have added a more detailed section describing the limitations of the datasets and hope that this addresses the concerns of the reviewer.
2	Yes.	
2	Very well-defined research questions.	
3	Yes.	
3	The key questions defined are very cogent and relevant to the current policy issues and priorities facing VA. The evidence synthesis reflects a tremendous amount of work and the authors should be commended.	
3	The conceptual model developed as part of this paper is nicely conceived and constructed and I feel it could be more prominently represented in the paper as (1) a means of organizing the data (2) a contextualizing in greater detail of the intermediate and mediating roles postulated in the paper. Toward both of these objectives, the schematic could be streamlined somewhat to more clearly define these relational dynamics.	We thank the reviewer for their comments on the Conceptual Model. We have modified the model and hope that the relationships are easier to follow. We've also relocated the Figure and discussion of the model and hope that it acts, as the reviewer suggests, as a frame for organizing the subsequent discussion of the topic.
4	It was very comprehensive.	
Question 2: Is there any indication of bias in our synthesis of the evidence?		
1	No.	
1	The paper is balanced and fair.	
2	No.	
2	For the most part no- see comment 4.4 below.	
3	Yes - limited	

RETURN TO CONTENTS

Reviewer No.	Comment	Response
3	The biggest problem and challenge with this synthesis is that for much of the research on homeless persons and homeless Veterans, there are inconsistent definitions, metrics for assessment, and methodologic rigor assigned to sampling, unmeasured population dynamics, geographic biases, etc. You do a very nice job of describing this at the beginning of the paper but it needs to be more prominently factored into some of the conclusions presented in the body of the paper. An example of this is in the discussion about social support and its role in homelessness, combat exposure, etc. There are objective measures of social and social support networks (we used the Rand Social Support Network Survey in our studies) that have been highly correlated with several features of homelessness. The surrogate measure of marital status is far weaker, nontemporal, and without any validation that I am aware of – I am concerned about any conclusions being drawn off that metric. Similarly, as you have noted, homeless research on substance use and abuse has historically been challenged by inconsistencies in how use is measured, whether it reflects current use while homeless or pre-homeless (and more likely contributant use). There are also definite distinctions between hazardous use, abuse, and dependence and its impact on functioning, risk, and capacity to engage in services. Knowing which studies employed any of the Addiction Severity index modules in making their determinations would be helpful in considering the rigor of the data being presented. Greater attention to this level of detail is needed in the synthesis. This is an area where you may find expanding the search beyond homeless veterans to homelessness in the general population will be of help. The only other concern that needs to be addressed is the age of some of the data – inferences drawn from data that are now 20-25 years old may not be relevant to the dynamics of homelessness today.	Corrected. We have included a more direct discussion describing the inconsistencies that we found among the various studies that examine the prevalence of substance abuse or mental illness among homeless Veterans. We have also identified additional measures that might provide better insights into issues of social support and social capital.
Question 3: Are there any studies on the epidemiology of homelessness among Veterans that we have overlooked?		
1	No.	
1	This review is one of the most comprehensive that I've read.	
2	No.	
2	Very thorough assessment of the literature and innovative use of emerging search programs	
3	Yes - limited	
3	The challenge for the team to consider is whether it is better to take well-constructed and methodologically rigorous studies about homelessness in the general population and apply them to homeless Veterans over what are sometimes less well constructed or significantly biased data (in terms of selection bias, validity/reliability of findings, etc.) that is specific to homeless Veterans. Many of papers specific to homeless veterans are drawn from samples of veterans enrolled in VA programs or services for homeless persons and reflect a level of engagement, support and capacity that may not be reflective of the overall population of homeless veterans – most of whom do not get there care in the VA. This is particularly relevant when causality or dimensional relationships are being inferred or considered.	Because of the exploratory nature of this review, and because the purpose of the report was to provide background on what's known about homelessness among Veterans, we felt it better addressed the goals of the report to identify and report on studies specifically about Veterans and to discuss the limitations of those studies. We supplemented this with a brief background discussion of the literature on homelessness more broadly and hope that this report will prove useful in identifying the need for more methodologically rigorous and broadly applicable studies about homelessness among Veterans.

Reviewer No.	Comment	Response
4	My only concern is that the substance abuse prevalence section is a little light, I believe more literature exists. Also, the reference was from an older study. For example O'Connell, Kasprow, Rosenheck, 2010 report on HUD VASH client demographics and include data on substance abuse. Also, Rosenheck fairly frequently reports this data as well in his studies.	We have revised our discussion of the substance abuse issues and hope that it addresses the concerns of the reviewer.
Question 4: Please write additional suggestions or comments below. If applicable, please indicate the page and line numbers from the draft report.		
5	Page 3, Question 1a: Report states Veterans are 2x the risk of homelessness compared to the general population. Need to clarify comparison as children should not be included in denominator. Also, since men are more likely to be homeless (not just Veterans), comprising almost two-thirds of all homeless adults, it is important to factor this into comparisons. Without these adjustments it appears veteran status alone places individuals as far greater risk.	We have added language to address the reviewers comment.
5	Page 4, Question 2b: Homeless Veterans are more likely to be African-American. This is not addressed.	We have included additional language addressing the over-representation of Blacks among the homeless and of the over-representation of Veterans, both Black and White among the homeless.
5	Page 7: When discussing the minimum wage the paper uses 2004 as a reference point to describe the impact of its declining value; however, the minimum wage was increased after that date. This makes the selection of 2004 appear to be used to bias the conclusion. Also, 14 states have minimum wages higher than the federal minimum wage. It may be more effective to describe the declining value of the minimum wage in relation to the increasing FMR of apartments.	We have edited the text to provide a more general description of the declining value of the minimum wage in relation to the cost of housing.
5	Page 12 (bottom), Question 1b: Paper states Veterans are more likely to be unsheltered than other groups. AHAR does not state this as factual, only speculates that this is a possibility.	We have revised the language to indicate the speculative nature of this perspective.
5	Page 13, Question 1b: "Kuhn reports 24% increase in homeless families". Need to clarify statement as it leads the reader to incorrectly conclude that this is the increase in overall family homelessness. This increase only reflects what VA staff report they have seen *at their facilities.*	We have revised the language here to be clearer that we are reporting on an increase in staff reports of increases in people seeking services.
5	Page 24, Incarceration: No mention is made on the impact of child support. Legal assistance for child support is ranked as the second highest unmet need in the CHALENG report. Unpaid and unaffordable child support obligations often act as a significant barrier to a Veteran's ability to resume independent community living. This burden is particularly acute among ex-offenders. The typical incarcerated parent owes $20,000 in child support when released from prison, with payment schedules averaging $225 to $300 per month (Center for Law and Social Policy, 2008). Minimum wage workers have little hope of making these payments while supporting themselves. Unresolved child support debts can result in liens against bank accounts, denial of credit, inability to secure a lease, failure in background checks commonly a part of job applications, forfeiture of driver's licenses, and ultimately re-arrest.	We have expanded this section to address the issue of child support and thank the reviewer for their very helpful comment.

Reviewer No.	Comment	Response
5 (cont.)	As child support payments are deducted automatically from paychecks, workers often quit once their pay is garnished, returning to the underground economy to avoid child support. For ex-offenders, participation in the underground economy often means a return to illegal activity (Center for Law and Social Policy, 2007). Hence, legal assistance around the issue of child support is one key to helping Veterans meet their obligations to society, while still having the means to avoid relapsing to homelessness.	
1	The manuscript needs a thorough copy edit.	We agree and have done so.
1	On page 9, please expand on the limitations of each data source.	We have added a more detailed section describing the limitations of the datasets and hope that this addresses the concerns of the reviewer.
1	Page 10: this is a laundry list and the narrative doesn't flow. Is there a better structure? Perhaps grouping?	We agree that this section needed better organization. We have reorganized so that similar topics are addressed together, and, as suggested by the reviewer have added subheads to make clear how the topics are grouped together.
1	Page 11. Second paragraph: double check the definition. I think the first line is inaccurate. McKinney-Vento does include those living in transitional housing as homeless.	We checked Perl (2009) and the McKinney-Vento Act. No change to our statement is needed. Currently, only those living in transitional housing for the mentally ill are included. The Hearth Act will add others living in transitional housing to the definition of homelessness.

RETURN TO CONTENTS

Reviewer No.	Comment	Response
General Comments		
6	I have two serious problems with your conceptual model: First, you group PTSD and Mental Illness together, in the center of the model, and directly associate them with homelessness (giving the association a strong arrow and two asterisks, which are the strongest form of association you have in the model). This contradicts what you state in several places in your report, where you say there is a lack of evidence directly relating PTSD and homelessness (e.g., pps 29 and 33). The problem here, obviously, is that MI and PTSD should not be coupled like this. MI is of course a catchall term and PTSD is a specific diagnosis. Associations with MI in general should best be broken down into more specific components. Even severe mental illness (which typically includes only schizophrenia and major affective disorders) is a better designation than just MI. And PTSD should have its own box, which, according to the evidence you review, should NOT have a direct association with homelessness. Including the model as it is would be seriously problematic, as it would in effect create a PTSD-Homelessness link that future research could use cite from this review. Second, alcohol and substance abuse have only weak, indirect associations with homelessness in the model. This would contradict your text, where on p 28 you cite, among others, a Wenzel study and a Winkleby et al. study as finding such associations. It also runs counter to a broad range of research among non-Veterans who make this SA-homelessness association. If you mean to disassociate homelessness and SA, as you effectively do in the model (and invite others to cite you), then you need to insert specific text in the report that explicitly explains your decision to do this.	1) We thank the reviewer for sharing these concerns. Further discussion led to a substantial revision of the model for overall clarity. We dropped the use of the more general term "mental illness." "Underlying psychiatric illness" was added to a box labeled "shared early life exposures," since the strongest evidence on this issue for a homeless veteran population comes from Rosenheck and Fontana 1994, which used psychiatric treatment before age 18 as a variable. As our reports notes, it is unfortunate that few studies involving homeless veterans actually assess for schizophrenia, unless they are among individuals seeking treatment for mental illness, in which case the sampling frame raises serious issues for the generalizability of any associations found. There is now a box labeled "PTSD/Depression/Anxiety." While frequent comorbidity might provide justification for this cluster, our model groups these conditions together because a) the veteran-specific evidence cited (Washington and Yano 2010) also groups PTSD and anxiety disorders together, and b) because the general homelessness literature cited finds associations between depression and homelessness (as well as psychiatric disorders). Our report states that "the evidence linking PTSD to homelessness remains limited by the small number, small size and/or non-generalizable sampling methods of existing studies." This is not the same thing as stating that there is no evidence, and we stand by the model's representation of an association between PTSD/Depression/Anxiety and homelessness. Here as elsewhere in the revised model, we have added a black box along the association pathway to indicate that the mechanism for the association is poorly understood. We hope this will encourage users of our model to direct future efforts towards understanding mediating factors. 2) We thank the reviewer for pointing out the discrepancy between the research that we site describing the association between substance abuse and homelessness and the weak link presented in the conceptual model. We have revised the model to indicate that substance abuse has a strong association with homelessness, but that the path through which substance abuse effects the risk of homelessness remains unknown. We also note in the text that evidence for substance abuse as a causal factor for homelessness has been inconsistent. Much of the research on substance abuse and homelessness employs a cross-sectional sampling frame, and thus, cannot demonstrate cause and effect. We discuss the limitations of studies examining substance abuse and homelessness in detail in our "Assessing the Limitations of the Current Research" section.

Reviewer No.	Comment	Response
6	Your review of the CHALENGE and AHAR counts should do more to look at the methodological problems involved in the estimates. CHALENGE, as you say, has traditionally relied at least partly on expert assessments, which (as you never point out) is a notoriously inaccurate means to assess homeless population size (plenty of cites available on this) and biases towards overcount. This is not a slam on CHALENGE but a recognition that they were doing their best with the limited data that was available and that the report primarily seeks to examine needs and needs fulfillment among the homeless Vet population. AHAR on the other hand, due to their reliance on mainstream homeless services data, is biased towards undercount. This leaves, as you point out on 22, a substantial gap (52,000 to 107,000) in the Vet estimates which, instead of examining further, you sidestep by only saying both numbers address the "seriousness of the problem." As I said earlier, the Vet-AHAR bridges these two methodologies, both in its estimate and in its methodology, and needs to be included here. One other note here, in your stating the overrepresentation of risk for homelessness among Veterans, you need to distinguish between studies such as were done by Rosenheck and his colleagues that sex and age adjust the populations to get a more accurate representation of risk, and other studies that don't.	We have expanded on the discussion in this section and have included a discussion of the recently released Veteran AHAR along with data from that report. However, we feel that we adequately discussed the methodological problems of the CHALENG and AHAR counts along with the strengths and weaknesses of the epidemiology of the homeless more generally. We understand the reviewer to be referring to the study by Rosenheck and Frishman (1994) of Vietnam-era Veterans that suggested that over-representation was attributable to disproportionate numbers of Veterans in the youngest cohorts (age 20-34) of homeless White males, and the follow-up study by Gamache and colleagues (2001). We do not disagree with the reviewer about this. However, we are suggesting that, for the reasons discussed in the section on Assessing the Limitations of the Current Research, more work needs to be done to understand why Veterans are over-represented.
6	On 28-29, you state question #2a but don't put any text to answer it. This is confusing, and the reader might assume, but cannot be sure, that this question is answered in the text to 2b. Why not combine these questions, then, or at least signal somewhere that 2a is answered in 2b	We agree, this was confusing and have combined the questions as suggested by the reviewer.
6	On page 29, you mention that there appear to be "unique, military related pathways by which Veterans acquire these risks [for homelessness]" yet there are NO specifics, and NO citations, to specific pathways either in the response to Question #2b or in the response to Question #3, the section in which the author states these pathways will be taken up in more detail, beyond a weak finding by Rosenheck and colleagues between heavy combat and homelessness. The omission in offering up specific evidence to back up this assertion, considering this is a "Best Evidence Synthesis" is very surprising.	The concept of a pathway, as used in our report, is crucially different from a direct association. Given that the existing evidence does not find that Veterans differ substantially from non-Veterans in terms of the risk factors most strongly associated with homelessness in general, it is important to try to understand what, if anything, is qualitatively different about Veterans' experiences that might increase their risk of these shared or common exposures. The conceptual model was revised to clarify how military specific exposures are associated with a number of other exposures that are in turn shared with the general population; these shared exposures are more often directly associated with homelessness, but the influence of military-specific exposures on the prevalence or severity of shared exposures may be significant. These chains of exposures are the pathways referenced. The discussion of these issues has been expanded under the section describing the evolution of the conceptual model on pages 13-14. More generally the section devoted to answering Key Question 3 is structured to explore the evidence for these pathways, which, as the report suggests, might include the specific salience, in a Veteran population, for examining military sexual trauma and/or combat exposure as precursors to PTSD/Anxiety/Depression, or post-deployment readjustment difficulties leading to low income.

APPENDIX B. TECHNICAL EXPERTS CONSULTED AND REVIEWERS

TECHNICAL EXPERTS CONSULTED

Ted Amann
Director of Homeless Programs
Central City Concern
Portland, Oregon

Monica Beemer
Executive Director
Sisters of the Road
Portland, Oregon

Lillian Gelberg, M.D., MSPH
Professor of Family Medicine
UCLA Geffen School of Medicine
Los Angeles, California

Don Miller
Chief Counsel
Housing and Urban Development
Portland, Oregon

Fran Randolph
Director of the Division of Services and Systems Improvement
SAMHSA, Center for Mental Health Services

Jim Reuler, M.D.
Professor, Department of Medicine
Oregon Health and Science University
Portland, Oregon

Robert Rosenheck, M.D.
Director, Northeast Program Evaluation Center and
Professor of Psychiatry and Public Health
Yale University School of Medicine
New Haven, Connecticut

Annetta C. Smith
Population Division
U.S. Census Bureau

REVIEWERS

Mary K. Cunningham
Senior Research Associate
Urban Institute

Amy Kilbourne, Ph.D., MPH
VA Serious Mental Illness Treatment Resource and Evaluation Center

John Kuhn
National CHALENG Coordinator

Stephen Metraux, Ph.D.
National Center for Homelessness Among Veterans

Thomas O'Toole, M.D.
Providence VA Medical Center

David Smelson, Psy.D.
Bedford VA Medical Center

RETURN TO CONTENTS