Factors Associated with Homelessness Among US Veterans

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Author roles, affiliations, and contributions to the present report (using the CRediT taxonomy) are summarized in the table below.

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PREFACE

The VA Evidence Synthesis Program (ESP) was established in 2007 to provide timely and accurate syntheses of targeted health care topics of importance to clinicians, managers, and policymakers as they work to improve the health and health care of Veterans. These reports help:

- Develop clinical policies informed by evidence;
- Implement effective services to improve patient outcomes and to support VA clinical practice guidelines and performance measures; and
- Set the direction for future research to address gaps in clinical knowledge.

The program comprises 4 ESP Centers across the US and a Coordinating Center located in Portland, Oregon. Center Directors are VA clinicians and recognized leaders in the field of evidence synthesis with close ties to the AHRQ Evidence-based Practice Center Program. The Coordinating Center was created to manage program operations, ensure methodological consistency and quality of products, interface with stakeholders, and address urgent evidence needs. To ensure responsiveness to the needs of decision-makers, the program is governed by a Steering Committee composed of health system leadership and researchers. The program solicits nominations for review topics several times a year via the program website.

The present report was developed in response to a request from the VA Offices of Enterprise Integration (OEI) and Planning and Performance Management (OPPM), which has established an Integrated Project Team (IPT) on Homelessness. The scope was further developed with input from Operational Partners (below) and the ESP Coordinating Center review team.

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Operational Partners

Operational partners are system-level stakeholders who help ensure relevance of the review topic to the VA, contribute to the development of and approve final project scope and timeframe for completion, provide feedback on the draft report, and provide consultation on strategies for dissemination of the report to the field and relevant groups.

Dave Zlowe
VA Evidence Lead
Office of Enterprise Integration

Peer Reviewers

The Coordinating Center sought input from external peer reviewers to review the draft report and provide feedback on the objectives, scope, methods used, perception of bias, and omitted evidence (see Appendix D in Supplemental Materials for disposition of comments). Peer reviewers must disclose any relevant financial or non-financial conflicts of interest. Because of

their unique clinical or content expertise, individuals with potential conflicts may be retained. The Coordinating Center works to balance, manage, or mitigate any potential nonfinancial conflicts of interest identified.

EXECUTIVE SUMMARY

Key Findings

- Studies conducted among Veteran populations evaluated individual-level risk and protective factors for homelessness. We did not identify any studies of structural factors examined at the community level, such as housing access and affordability.
- Adverse childhood experiences (ACEs), discharge status aside from honorable, lower service-connected disability rating or no service-connected disability rating, history of military sexual trauma, and presence of a mental health condition and/or substance use disorder were consistently associated with an increased risk of experiencing homelessness in studies providing longitudinal evidence. Additionally, enlisted status (vs drafted or commissioned status) and lifetime trauma history were associated with homelessness in cross-sectional studies.
- Honorable discharge, higher military pay grade, and higher service-connected disability rating were consistently associated with a lower risk of experiencing homelessness in longitudinal studies. Completing more years of service was associated with lower risk in cross-sectional data.
- Veterans who were male, Black, and/or unmarried were more likely to experience homelessness, while those living in rural areas appeared to have lower risk. Additionally, having a lower education level or identifying as transgender were associated with greater risk of experiencing homelessness.
- Individual-level risk factors for homelessness may be best understood as factors that increase a Veteran's vulnerability to structural drivers of homelessness. To date, little research has been conducted on the effects of structural factors, such as those that reduce housing security or make stable housing difficult to obtain, on Veteran homelessness risk. Consequently, our understanding of the mechanisms the lead to homelessness among Veterans is incomplete. Future research should aim to integrate community and individual factors to provide a more comprehensive understanding of the pathways to Veteran homelessness, which if incorporated into a predictive model of homelessness, would likely result in a more accurate assessment of a Veteran's vulnerability to homelessness.

Although estimates of homelessness among Veterans have been declining since 2009 (the first year these data were reported), homelessness remains more common among Veterans compared to non-Veterans. Circumstances leading to homelessness are often complex because they can involve both community-level factors, such as local housing policies and market conditions, and factors at the individual level, such as having a mental health or substance use disorder. A social-ecological framework for understanding homelessness underscores that individual-level factors alone do not predict homelessness; rather, these factors characterize individuals who may be more vulnerable to broader societal and economic forces that create conditions of homelessness.

Veterans may have unique individual-level vulnerabilities to homelessness, including those stemming from a history of combat exposure or experiences of military sexual trauma. They may also have unique protective factors, such as access to health care (including mental health care) and case management supports. The aim of this systematic review was to synthesize available

evidence on factors associated with homelessness among Veterans to inform cross-VA efforts to reduce and prevent Veteran homelessness and identify research gaps. Ending Veteran homelessness is a VHA priority.

From 103 potentially relevant studies, we included 2 systematic reviews, 15 longitudinal studies, and 43 cross-sectional studies. Studies evaluated individual-level risk factors for homelessness. We did not identify any studies of factors examined at the community level. Using a best-evidence approach with a focus on studies employing longitudinal data to establish cause and effect, we categorized risk and protective factors as occurring before, after, or during military service or spanning these timeframes (ES Table). Cross-sectional data, which by design cannot usually establish that a given factor preceded homelessness, were included to highlight factors not addressed in longitudinal studies.

Overall, the following individual-level factors were consistently associated with an increased risk of experiencing homelessness in studies providing longitudinal evidence: adverse childhood experiences (ACEs), discharge status aside from honorable, lower service-connected disability rating or no service-connected disability rating, history of military sexual trauma, and presence of a mental health and/or substance use disorder. Having a history of incarceration and non-military-related trauma in adulthood were also factors associated with an increased risk of experiencing homelessness, although these factors were only evaluated in a single study. Additionally, enlisted status (compared to drafted or commissioned status) and lifetime trauma history were associated with homelessness in cross-sectional studies. In contrast, honorable discharge status, having a higher military pay grade, and having a higher service-connected disability rating were consistently associated with a lower risk of experiencing homelessness in studies providing longitudinal evidence. Completing more years of service was also identified as a potential protective factor in cross-sectional studies. In terms of demographics, Veterans who were male, Black, and/or unmarried were more likely to experience homelessness, while those living in a rural area appeared to have a lower risk of homelessness. Additionally, having a lower education level or identifying as transgender were factors associated with a greater risk of experiencing homelessness in cross-sectional studies.

Among individual-level factors with longitudinal evidence (best evidence), the strongest associations (based on the magnitude of the reported effect size) were observed for higher military pay grade (lower homelessness risk), not being married (greater risk), discharge status aside from honorable (greater risk), any mental health diagnosis (greater risk), and ACEs (greater risk).

ES Table. Factors Associated with Homelessness Among Veterans

Longitudinal Evidence (Best Evidence)	Available Studies
Factors Associated with Lower Homelessness Risk	
Military Service Related	
Military pay grade (higher pay grade)✸✸	3 RC[1-3]
VA disability rating (SC)✸	7 RC[3-9]
Sociodemographic	
Rural geographic area✸	2 RC[7,8]
Factors Associated with Greater Homelessness Risk	
Sociodemographic	

Longitudinal Evidence (Best Evidence)	Available Studies
Marital status (not married)✸✸	7 RC[1,3,7-11]
Race (Black race)✸	8 RC[1,3-5,7,8,10-12]
Income (Lower income/financial status)✸	3 RC[11-13]
Military Service Related	
Discharge status (misconduct, dishonorable, other than honorable) ✸✸	4 RC[2,6,9,14]; 1 PC[15]
Military sexual trauma✸	4 RC[1,3,8,9]
Mental Health[a]	
Any mental health diagnoses✸✸	3 RC[3,6,13]
PTSD✸	6 RC[1,2,5,7-10]; 1 PC[12]
Depression✸	4 RC[5,7-9,11]; 1 PC[12]
Schizophrenia or other psychoses✸	4 RC[2,5,7-9]; 1 PC[12]
Mental health clinic usage (higher usage) ✸	1 RC[1]
Mood disorders✸	1 RC[2]
Adjustment disorders✸	1 RC[2]
Substance Use[a]	
Substance use clinic usage (higher usage)✸	2 RC[1,16]
Alcohol use disorder✸	4 RC[5,7-9,11]; 1 PC[12]
Drug use disorder✸	3 RC[5,8,9,11]; 1 PC[12]
Opioid use disorder✸	1 RC[8]
Any substance use or abuse✸	3 RC[2,7,10,17]
Other	
ACEs✸✸	1 RC[10]; 3 CS[18-20]
Adult non-military trauma✸	1 RC[10]
History of incarceration✸	1 RC[5,13]
Cross-sectional Evidence[b]	
Negative Correlation (Decreased Homelessness)	
Sociodemographic	
Education (higher level of education)✸	7 CS[18-24]
Military Service Related	
Years of service (more years of service)✸✸	3 CS[18,19,22]
Positive Correlation (Increased Homelessness)	
Sociodemographic	
Unemployment✸✸	3 CS[23-25]
Transgender Identity✸✸	3 CS[26-28]
Military Service Related	
Enlisted (not commissioned or drafted) ✸	2 CS[19,22]
Substance Use	
Inpatient substance abuse treatment✸✸	2 CS[29,30]
Tobacco use✸	4 CS[19,24,31,32]
Other	
Lifetime trauma history✸✸	2 CS[19,33]

Notes. ✸✸ Strong factor: risk ratios, odds ratios, and/or hazard ratios that were generally above 2.5 for increased (risk factor) or decreased (protective factor) risk. ✸ Moderate factor: had risk ratios, odds ratios, and/or hazard ratios that were generally from 1.5-2.5 for increased (risk factor) or decreased (protective factor) risk. [a] Measures likely overlap but were defined differently in each study. [b] Cross-sectional studies were only examined when no longitudinal evidence was available and more than 1 cross-sectional study examined the same factor. Some cross-sectional studies reported correlations or tested differences in continuous outcomes, and we prioritized studies reporting ratios to determine moderate or strong associations if available.

Abbreviations. ACE=adverse childhood event; CS=cross-sectional; PTSD=posttraumatic stress disorder; RC=retrospective cohort; SC=service connected.

Findings on combat exposure were mixed and the overall association between combat exposure and homelessness is unclear. Likewise, findings were inconsistent for other factors related to miliary service including service era and branch of service. Available evidence is mixed on the impact of chronic medical conditions and/or medical comorbidities on homelessness risk and does not suggest a general pattern of increased or decreased homelessness risk according to the presence of medical conditions, which were overall less frequently studied than mental health and substance-related disorders.

The evidence base has important gaps and limitations. Community factors, such as access to affordable housing, safety net spending, labor market conditions, and eviction policies and practices, may account for why some Veterans experience homelessness while others with similar individual-level vulnerabilities remain stably housed. To date, little research has been conducted on the effects of structural factors, such as those that reduce housing security or make stable housing difficult to obtain, on Veteran homelessness risk. Consequently, our understanding of the mechanisms the lead to homelessness among Veterans is incomplete. Future research should aim to integrate community and individual factors to provide a more comprehensive understanding of the pathways to Veteran homelessness, which if incorporated into a predictive model of homelessness, would likely result in a more accurate assessment of a Veteran's vulnerability to homelessness.