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Alcohol and drug use disorders among homeless veterans: Prevalence and association with supported housing outcomes

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HIGHLIGHTS

- 60% of homeless veterans entering supported housing had a substance use disorder.
- 54% of those with a substance use disorder had both alcohol and drug use disorders.
- Veterans with alcohol and drug use disorders had more extensive homeless histories.
- Substance use disorder was not associated with worse supported housing outcomes.
- Supported housing can house veterans regardless of their substance abuse.

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ABSTRACT

This study examines the prevalence of alcohol and drug disorders among homeless veterans entering the Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) program and its association with both housing and clinical outcomes. A total of 29,143 homeless veterans were categorized as either having: no substance use disorder, only an alcohol use disorder, only a drug use disorder, or both alcohol and drug use disorders. Veterans were compared on housing and clinical status prior to admission to HUD-VASH and a smaller sample of 14,086 HUD-VASH clients were compared on their outcomes 6 months after program entry. Prior to HUD-VASH, 60% of program entrants had a substance use disorder and 54% of those with a substance use disorder had both alcohol and drug use disorders. Homeless veterans with both alcohol and drug use disorders had more extensive homeless histories than others, and those with any substance use disorder stayed more nights in transitional housing or residential treatment in the previous month. After six months in HUD-VASH, clients with substance use disorders continued to report more problems with substance use, even after adjusting for baseline differences, but there were no differences in housing outcomes. These findings suggest that despite strong associations between substance use disorders and homelessness, the HUD-VASH program is able to successfully house homeless veterans with substance use disorders although additional services may be needed to address their substance abuse after they become housed.

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1. Introduction

One of the major identified risk factors for homelessness is substance abuse (Caton et al., 2005; Greenberg & Rosenheck, 2009; Johnson, Freels, Parsons, & Vangeest, 1997). An estimated range of 41 to 84% of homeless adults have a substance use disorder (Bassuk, Buckner, Perloff, & Bassuk, 1998; Goldfinger et al., 1996; Gonzalez & Rosenheck, 2002; North, Eyrich, Pollio, & Spitznagel, 2004) and there is a large research literature documenting the negative effects of such disorders on psychosocial functioning in clinical and non-clinical populations (Boles & Miotto, 2003; Ron, 1986; Weinberg, Rahdert, Colliver, & Glantz, 1998). While substance abuse among homeless adults may be well-documented, less is known about the associations between the provision of supported housing and the experience of alcohol and drug use disorders.

Permanent supported housing, defined as services that offer subsidized rent with community-based case management, has become the favored service model for homeless adults (Hopper & Barrow, 2003; Leff et al., 2009). However, there has not been a clear role for substance abuse treatment in supported housing services. Moreover, there continue to be differing opinions about if, when, and how supported housing should be offered to homeless adults with substance use disorders. For example, some programs have no requirements for sobriety or treatment in order to receive housing (Tsemberis, 1999),

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while others have required abstinence for housing or made housing contingent on treatment (Lipton, Siegel, Hannigan, Samuels, & Baker, 2000; Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005; Milby et al., 1996).

These discussions are particularly pertinent for the U.S. Department of Veterans Affairs (VA) as the well-being of homeless veterans is of public concern and the VA has set a national goal of ending homelessness among veterans in the coming years (United States Department of Veterans Affairs, 2009). One of the main programs funded to help veterans exit homelessness is the Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) program. The HUD-VASH program provides subsidized housing with case management services, but formal substance abuse treatment is not provided as a core part of the program (Rosenheck, Kasprow, Frisman, & Liu-Mares, 2003), although some HUD-VASH teams have substance abuse specialists. The HUD-VASH program has served thousands of homeless veterans, yet there remains incomplete understanding of how substance use disorders impact veterans who are enrolled in supported housing. A better understanding of this issue can help services plan when and how substance abuse treatment should be offered to supported housing clients, if at all.

Moreover, an often overlooked issue is that substance use disorders include both alcohol and drug use disorders, which may represent different clinical problems. Alcohol and drug use can occur either concurrently or singly (Arias & Kranzler, 2008; Stinson et al., 2005; Zeiger et al., 2012). Greater specificity may be needed on differences between alcohol and drug abuse and the combination of the two disorders in relation to homelessness and other clinical outcomes. For example, how are homeless adults with only alcohol use disorders different from those with only drug use disorders or those with both alcohol and drug use disorders? Previous studies on polysubstance abuse and dependence have suggested negative and complex effects on clinical and neurocognitive outcomes among those who abuse multiple substances (Fernandez-Serrano, Perez-Garcia, & Verdejo-Garcia, 2011; Nixon, 1999; Rounsaville, Petry, & Carroll, 2003; Teesson, Farrugia, Mills, Hall, & Baillie, 2012), although the effect of comorbid alcohol and drug use on housing and clinical outcomes has not been studied.

This study examined national data from the HUD-VASH program to describe the prevalence of several varieties of substance use disorders at the time of program entry and their association with diverse outcomes. It was hypothesized, first, that homeless veterans with any substance use disorder would have worse housing (i.e., fewer nights in own place and more nights homeless) and clinical status at program admission and over the first 6 months after program admission than those with no substance use disorder. It was further hypothesized that among homeless veterans with any substance use disorder, those with both alcohol and drug use disorders would have worse outcomes than those with only alcohol or only drug use disorders.

2. Methods

2.1. Program description and data source

The HUD-VASH program is the largest permanent supported housing program for homeless veterans and operates at over 130 VA facilities nationwide (Kasprow, Rosenheck, Dilella, Cavallaro, & Harelik, 2009). The HUD-VASH program represents collaboration between two U.S. Departments, HUD and VA, with HUD providing the Section 8 housing vouchers and the VA providing the case management services. At each site, veterans referred to HUD-VASH are reviewed by a multidisciplinary HUD-VASH admission committee who determine who is admitted to their program. Although HUD-VASH staff members in each program are trained on national guidelines, individual programs differ on their focus, structure, and operating procedures because of different leadership, site needs, and populations served.

National admission criteria for the HUD-VASH program during the period of this study include eligibility for VA services, income eligibility for a housing voucher, meeting HUD's definition of being homeless (residing in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily reside), and having a clinically assessed need for case management services. There are no national exclusion criteria, except for a criminal record involving a sexual offense; however, individual programs make their own determinations of which veterans to admit into their program.

Once accepted into the program, clinical assessments are conducted with veterans to identify specific problem areas and goals, and to develop a joint treatment plan. Then case managers assist veterans with obtaining their Section 8 voucher and locating an apartment, providing ongoing intensive case management support using a modified Assertive Community Treatment (ACT) model (Lipton et al., 2000). Case managers are encouraged to provide weekly face-to-face contact, deliver community-based care, and provide linkages to VA and non-VA services (Kasprow, Rosenheck, Frisman, & DiLella, 2000). Retaining the housing subsidy is not contingent upon involvement in VA services, although continued involvement is encouraged. HUD-VASH case managers complete a form documenting the clinical process of care every three months the veteran is in the program.

Administrative national data on the HUD-VASH program from January 2008 to April 2011 were obtained for analysis. Data on a total of 29,143 HUD-VASH clients were based on information collected by HUD-VASH clinicians as part of a national program evaluation effort during their regular clinical duties and through forms completed by referring clinicians. This study focused on data at program admission and the first 6 months in the program to allow adequate time for veterans to receive the housing intervention while maximizing the numbers available for follow-up. This study was approved by the institutional review boards of VA Connecticut Healthcare System and Yale University School of Medicine.

2.2. Measures

2.2.1. Background characteristics and psychiatric diagnoses

Information on age, gender, race, marital status, military history, and homeless history were based on veteran self-report and confirmed by their clinicians. Psychiatric diagnoses were provisional diagnoses made by referring VA clinicians who were either the veteran's primary mental health clinician or VA homeless staff during their outreach efforts. Diagnoses were based on the clinical judgment of referring clinicians, review of medical records, and consultation with other health providers.

2.2.2. Housing status

Veterans were asked where they spent the past 30 nights in each of seven living arrangements, which were collapsed into five categories: nights in their own place (in own apartment, room, or house), nights in someone else's place (in the apartment, room, or house of a family member or friend), nights in a transitional housing/residential treatment (transient hotels, boarding homes, VA and non-VA residential treatment programs), nights in an institution (in hospitals, nursing homes, prisons, and jails), and nights homeless (in shelters, outdoors, or in vehicles).

2.2.3. Clinical status

Mental health status was assessed with both self-report and clinician-rated measures. Self-report measures included a mental health symptom score, which was a summed score of 8 dichotomous items from the psychiatric subscale of the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980) and a social quality of life score, which was a mean score (7-point Likert scale) of 3 items from the Heinrich–Carpenter Quality of Life Scale (Heinrichs, Hanlon,