



RESEARCH BRIEF

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Improving Recovery and Community Re-Engagement in the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program

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What do we know?

Veterans with a history of homelessness who participate in the U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program receive subsidized permanent housing and community-based supportive services. HUD-VASH is often credited for the 48% decrease¹ in Veteran homelessness from 2009-2018. Yet, permanent housing is only the first step towards recovery from homelessness. Extrapolated from the mental health literature, recovery from homelessness encompasses a deeper process of building a fulfilling life with autonomy and social relationships.^{2,3}

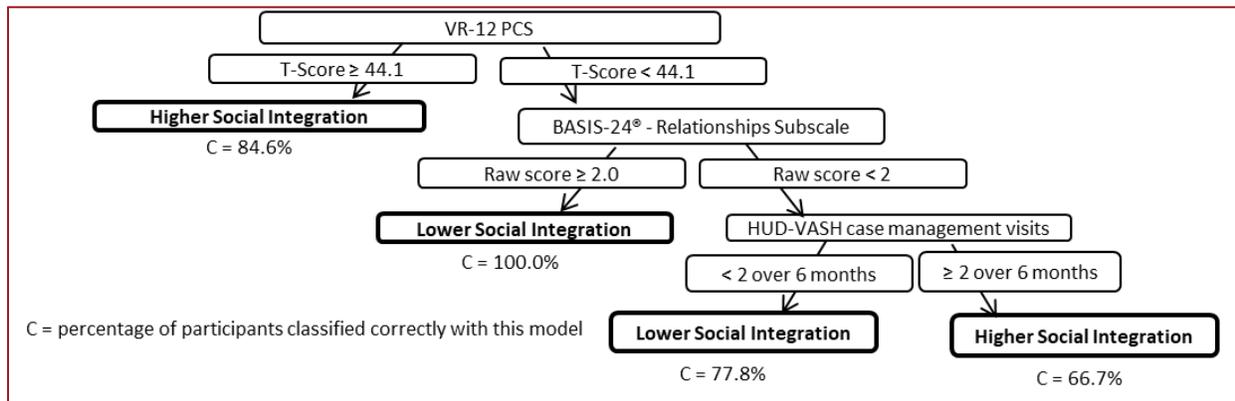
There is a dearth of knowledge about the HUD-VASH program's value and sustained impact on Veterans' social integration, encompassing social supports (from family and friends) and community involvement.⁴⁻⁶ Similarly, little is known about the HUD-VASH program's impact on Veterans' self-sufficiency, which we define as instrumental functioning,⁷ or an individual's ability to negotiate instrumental activities of daily living (IADLs), e.g., money management. Though clinical services are prioritized in HUD-VASH—with clear parameters to facilitate the acquisition and maintenance of rental units—there are few service guidelines to promote recovery among participants who successfully achieve housing.

New information provided by the study

Among Veterans housed through HUD-VASH at VA Greater Los Angeles (n=60), we used surveys and medical record review to characterize social integration and self-sufficiency, along with potential predictors of these constructs (demographics, health status, diagnoses, symptoms, neurocognition, and service use frequency). These data were complemented with semi-structured interviews on a subset of participants (n=26). We used a median split to dichotomize the sample into subgroups with higher vs. lower social integration, and higher vs. lower self-sufficiency. Classification and regression trees (CART)⁸ were used to identify the combination of potential predictors and their cut-off points that best-differentiated participants with higher vs. lower social integration, and higher vs. lower self-sufficiency. Quantitative and qualitative data were triangulated to characterize factors that affect these outcomes.

In CART analyses comparing participants with higher vs. lower social integration (Figure 1), those with better physical health status (Veterans RAND 12-item Health Survey's physical component score (VR-12 PCS)⁹ T-score ≥ 44.1) were predicted to have higher social integration. Among participants with worse physical health status, worse socially-relevant mental health symptoms (Behavior and Symptom Identification Scale (BASIS)-24 relationships raw score >2.0)¹⁰ predicted lower social integration. For participants with fewer socially-relevant mental health symptoms, fewer HUD-VASH case management visits (<2 over 6 months) predicted lower social integration. Of note, in normative outpatient mental health samples, the BASIS-24 relationships mean/standard deviation are 1.2/0.9;¹⁰ this model's BASIS-24 relationships cutoff score was about one standard deviation worse. This model correctly classified 80% of participants.

Figure 1. CART analyses for classifying Veterans with higher vs. lower levels of social integration



In qualitative analyses, participants primarily described social support from other Veterans in their neighborhoods. When asked about family connections, permanent housing improved some Veterans' relationships, often because they had a place for family to visit. For others, housing negatively affected relationships with family, largely due to geographic distance. Few described HUD-VASH supportive services as relevant to social support. Some participants felt engaged in their communities, e.g., at local senior centers; however, many cited neighborhood crime as a key obstacle to community involvement.

To capture self-sufficiency, we administered the Brief Instrumental Functioning Scale⁷, which assesses needs for assistance for any of six IADLs. Most participants (60.0%) did not need assistance for any measured IADLs. CART analyses did not yield a stable model to predict if participants had higher vs. lower self-sufficiency. Qualitatively, Veterans with lower self-sufficiency described strong reliance on HUD-VASH case management staff for IADL support, particularly assistance with medical appointments and money management. Often, this group described needing more frequent case management than what they received. Veterans with higher self-sufficiency were aware of available HUD-VASH support for IADLs, generally describing that supports were offered but that they declined them.

Particularly for Veterans with poor physical health or socially-relevant mental health symptoms, more intensive HUD-VASH case management and housing placement in neighborhoods that are geographically close to existing supports may improve social integration. Though many Veterans describe strong self-sufficiency, those that struggle with IADLs may need more intensive support. Careful triaging of HUD-VASH participants into discrete levels of case management intensity, including Assertive Community Treatment-level services, may improve recovery outcomes for program participants.

Opinions expressed in this brief represent only the position of the National Center on Homelessness among Veterans and do not necessarily reflect the official policy of the U.S. Department of Veterans Affairs

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