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National Comparison of Literally Homeless Male and Female VA Service Users: Entry Characteristics, Clinical Needs, and Service Patterns

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A B S T R A C T

Background: Although there are growing numbers of homeless female U.S. veterans, the U.S. Department of Veterans Affairs (VA) has traditionally served a predominantly male population; thus, it is important to examine differences between homeless female and male veterans in their service needs and the current provision of VA homeless services.
Methods: A national registry of 119,947 users of VA homeless services from 2011 to 2012 was used to 1) estimate the proportion of female veterans among VA homeless service users, 2) examine the proportion of VA homeless service users who are literally homeless by gender, and 3) report differences between female and male VA homeless service users who are literally homeless on sociodemographic and clinical characteristics, as well as on outreach, referral, and admission patterns for an array of specialized VA services.
Findings: Of VA homeless service users, 8% were female compared with 7% among all homeless veterans, 6% among all VA service users, and 7% among all veterans. Of female VA homeless service users, 54% were literally homeless, slightly fewer than the 59% of male VA homeless service users. Comparing literally homeless VA service users, females were younger, 21% more had dependent children, 8% more were diagnosed with non–military-related posttraumatic stress disorder, and 19% to 20% more were referred and admitted to VA's supported housing program than males.
Conclusions: Female veterans use VA homeless services at a rate similar to their use of general VA services and they have unique needs, especially for child care, which may require additional specialized resources.
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As women have become a rapidly growing segment of the U.S. veteran population (Blackstock, Haskell, Brandt, & Desai, 2012; Meehan, 2006), the proportion of homeless veterans who are female has also increased. This has led to national concern, not only because the numbers have increased, but because female veterans seemed to be at greater risk for homelessness than female non-veterans. Several previous studies and government reports have shown that female veterans are almost twice as likely to be homeless than female non-veterans in the general population; among those in poverty, female veterans are more than three times as likely to be homeless compared with their female non-veteran counterparts, whereas male veterans are at lower risk compared with their male non-veteran counterparts (Fargo et al., 2011; Gamache, Rosenheck, & Tessler, 2003; U.S. Department of Housing and Urban Development [HUD] & U.S. Department of Veterans Affairs [VA], 2011). In response, the VA has dramatically increased funding for a variety of homeless services (VA, 2009) and female veterans have become a growing priority for these specialized programs (Washington, Bean-Mayberry, Riopelle, & Yano, 2011; Yano et al., 2006), although it remains unclear how successful VA has been in engaging homeless female veterans.

Because the VA has traditionally served a predominantly male population, it is increasingly important to understand

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the distinctive characteristics and needs of homeless female veterans and how they differ from those of male veterans. For example, previous studies have found that homeless female veterans are more likely to have children with them, often have greater needs for privacy (in predominantly male environments like shelters and VA programs), face more problems finding family housing, are less likely to have well-paying jobs, and often need gender-related care more than men (Buckner, Bassuk, & Zima, 1993; Hamilton, Poza, & Washington, 2011; North & Smith, 1993; Rukmana, 2010). Greater rates of military sexual trauma have also been reported among homeless female veterans as compared with males (Hamilton et al., 2011; Pavao et al., 2013; Washington et al., 2010).

One recent study compared female and male veterans in VA-funded transitional housing programs and found that female veterans were younger, had shorter homeless histories, were less likely to be employed, and reported more psychiatric symptoms but less substance use (Tsai, Rosenheck, & McGuire, 2012). Two other recent studies of Iraq and Afghanistan veterans who used VA homeless services found that females were more likely to have a high school education and to have diagnoses of mood or anxiety disorders, but had lower rates of substance use disorders and posttraumatic stress disorder (PTSD), and were less likely to have a history of incarceration (Blackstock et al., 2012; Tsai, Pietrzak, & Rosenheck, 2012). These findings suggest that there are important differences between homeless female and male veterans that may need to be considered in the design and provision of services.

It is also important to recognize that veterans are at different states in the process of entering and exiting homelessness when they present for services. Some are marginally or unstably housed, whereas others are stably housed or residing in an institution but are at risk of becoming homeless. Individuals who are "literally homeless," those who are the focus of this study, reside in a public or private place not meant for human habitation (streets, vehicles, abandoned buildings) or stay in an emergency shelter (U.S. Interagency Council on Homelessness, 2012). Studies on homeless service delivery have not always made the distinction between these different states of homelessness and few have focused specifically on those who are literally homeless, even though they are arguably in greatest need for immediate services.

There has yet to be a comprehensive comparison of literally homeless female and male veterans in the initial mode of engagement with VA homeless services, in the programs to which they are referred, and to which programs they are admitted. A variety of specialized programs for homeless veterans have been developed by the VA in recent years, which provides the opportunity to examine the likelihood that various services are both offered and actually provided to homeless female and male veterans.

The current study used a recently implemented national registry of homeless veterans to achieve three aims: 1) Compare the proportion of female veterans among VA homeless service users and other population samples, 2) examine the proportion of female and male VA homeless service users who are literally homeless, and 3) report differences between literally homeless female and male veterans on individual entry characteristics as well as outreach, referral, and admission patterns for a variety of homeless-related services. The results may be of value in understanding current gender differences in service utilization and in guiding the development of gender-specific interventions to best assist homeless female veterans.

Methods

Main Data Source

The Homeless Operations Management and Evaluation System (HOMES) is an online VA data collection system. HOMES is one of several data streams to a comprehensive homeless registry that offers a near real-time resource for service providers, policymakers, administrators, and researchers on the population of VA homeless service users. HOMES reflects the primary data collection of specialized homeless programs and may provide numerous benefits, including the ability to track the care of homeless veterans, evaluate the effectiveness of interventions, target resources that can be used to prevent homelessness, and identify best practices toward VA's plan to end homelessness among veterans. The current study used client-level data from April 2011 to November 2012, which was approved by the appropriate institutional review boards. The original dataset included 148,465 records. Some veterans had more than one record; in those cases, a random record was sampled resulting in a total of 119,947 (7.99% women, 92.01% men) homeless veterans who reported their gender across 142 sites.

Other Data Sources

Three other data sources were used as a basis of comparison to the proportion of female VA homeless service users in HOMES. The 2013 Point-In-Time counts collected by HUD was used to describe the proportion of women among sheltered and unsheltered homeless veterans. VA administrative data from fiscal 2012 were accessed to identify the proportion of women among all VA health service users. The 2010 National Survey of Veterans (Westat & Department of Veterans Affairs, 2010) was examined to estimate the proportion of women among all U.S. veterans. Finally, the 2011 Annual Homelessness Assessment Report to Congress (U.S. HUD, 2012) was examined to obtain an estimate of the proportion of women among the sheltered homeless adult population.

Program Descriptions

Five main programs that fall under the umbrella of VA homeless services are briefly described. First, the HUD-VA Supportive Housing program offers homeless veterans HUD Housing Choice vouchers to subsidize their rent and supportive case management from VA staff to help them acquire and retain permanent housing. Second, the Grant and Per Diem program funds community agencies to provide structured transitional housing for homeless veterans where they can stay for up to 2 years with the goal of helping them to achieve residential stability, receive treatment for mental and addictive disorders, increase their skill levels and/or incomes, and obtain greater capacity for community reintegration. Third, the Healthcare for Re-entry Veterans program assists incarcerated veterans soon to be re-entering the community by connecting them to needed VA health services to prevent recidivism and homelessness through outreach, pre-release assessments, and post-release referrals and linkages to medical, psychiatric, and social services. Fourth, the Veterans Justice Outreach program, in contrast, serves veterans recently involved in the criminal justice system to avoid the unnecessary criminalization of mental illness and extended incarceration by providing direct outreach, assessment,

diversion, and case management services along with acting as a liaison with local courts, jails, and local justice system partners. Fifth, the Domiciliary Care for Homeless Veterans program provides time-limited residential rehabilitation and treatment services on VA grounds, including medical, psychiatric, substance abuse treatment, and vocational rehabilitation.

Measures

VA homeless staff conduct in-person assessment interviews with all homeless veterans who are prospective clients of VA homeless programs using a structured form that collects information on background characteristics, homeless history, and health status. Administrative data on the method of initial contact/outreach, and the programs veterans are referred and admitted to are documented by VA staff and collected by HOMES.

Background characteristics

Age, gender, race, marital status, year of education, and military service era are documented. Veterans are asked about how many children they have under the age of 18 who are in their legal custody (dependent children). Employment history and current income are assessed by asking veterans to describe their employment pattern in the last 3 years and what their total income was in the past month. Veterans are also asked whether they are VA service-connected for a psychiatric condition or a non-psychiatric condition. Incarceration history is assessed by asking veterans how much total time they have spent in jail or prison during their lifetime. For this study, their responses were then coded dichotomously as having an incarceration history or not.

Current housing status and homeless history

Veterans are asked how they would describe their current housing situation with various response options, including "literally homeless," "imminent risk of losing housing," "unstably housed/at risk of losing housing," and "stably housed." Literally homeless is understood to be in accordance with the HUD definition, that is, residing in a public or private place not meant for human habitation, including living on the streets, in vehicles, in abandoned buildings, or staying in an emergency shelter (U.S. Interagency Council on Homelessness, 2012).

For their homeless history, veterans are asked how long their most recent episode of homelessness was for and how many episodes of homelessness they have experienced in the past 3 years. Veterans were categorized as chronically homeless if they met the federal definition of being continuously homeless for 1 year or longer and/or having four or more episodes of homelessness in the past 3 years (HUD, 2007).

Health status

Medical history is assessed by asking clients whether a doctor or nurse has ever told them they had the following medical conditions: HIV/AIDS, hepatitis C, tuberculosis, chronic obstructive pulmonary disease, heart disease, stroke, diabetes, seizures, chronic pain, or other medical condition. Client are also asked to rate their physical health in the past month on a 5-point scale from 1 (poor) to 5 (excellent), which was categorized as excellent/very good, good/fair, and poor.

Psychiatric history is assessed by clinicians in their assessment interview and through review of any existing medical records. Psychiatric diagnoses are determined and categorized as affective disorders (including depression), military-related PTSD and non–military-related PTSD, other anxiety disorders, substance use disorders (alcohol use or drug use disorder), and psychotic disorders (schizophrenia, bipolar disorder, or other psychotic disorder). Clients are further asked whether they have ever been hospitalized for a psychiatric problem (not including residential treatment or hospitalization for a substance use problem).

Data Analysis

First, the proportion of females among VA homeless service users (from HOMES) was calculated and compared with the proportion of females among all U.S. veterans (from the National Survey of Veterans), all VA health service users (from VA administrative data), and among all sheltered homeless veterans (from the Annual Homelessness Assessment Report to Congress). Second, the proportion of female and male VA homeless service users who reported they were literally homeless was calculated. Third, comparisons were made between literally homeless female and male veterans on background characteristics, homeless history, health status, and service patterns. Bivariate comparisons were conducted using independent *t*-tests and χ^2 tests. A log transformation was conducted on total income because of a non-normal distribution. Multivariable analyses were conducted on homeless history, health status, and service patterns controlling for significant background differences (age, race, education, dependent children, employment history, total monthly income, and incarceration history) using logistic and multinomial regressions. Given that the sample included the population of VA homeless service users and the sample size rendered nearly all differences as significant even at the $p < .001$ level, Cohen's *d* was calculated for continuous variables and the difference in percentages between cells was calculated for dichotomous variables as useful measures of effect size. Differences of ± 0.5 on Cohen's d and $\pm 5\%$ were considered substantially meaningful magnitudes.

Results

Of all VA homeless service users in HOMES ($n = 119{,}947$), 7.99% were women. Of all homeless sheltered and unsheltered veterans in HUD's Point-In-Time data ($n = 56{,}436$), 7.78% were women (8.44% among sheltered and 6.76% among unsheltered). Of all VA service users in VA administrative data ($n = 5{,}452{,}308$), 6.41%, were women. Of all veterans in the National Survey of Veterans ($n = 22{,}172{,}806$), 7.15% were estimated to be women. Of all sheltered homeless adults in the Annual Homelessness Assessment Report to Congress ($n = 392{,}316$), 37.20% are estimated to be women. Thus, homeless women who used VA homeless services were similar in proportion to that of women among all homeless veterans, somewhat greater than the proportion among all VA service users, similar to the proportion among the general veteran population, and much less than the proportion of females among all sheltered homeless adults.

Of all VA homeless service users in HOMES ($n = 119{,}947$), 70,344 (58.65%) were literally homeless. Of all female VA homeless service users ($n = 9{,}583$), 53.90% were literally homeless; and of all male VA homeless service users ($n = 110{,}364$), 59.06% were literally homeless, a difference of about 5%. Thus, more than half of female and male VA homeless services users were literally homeless, and females were slightly less likely to be literally homeless than males.

Table 1
Background Characteristics of Literally Homeless Male and Female Veterans

	Female (n = 5,165), n (%)	Male (n = 65,179), n (%)	Test of Difference, t or χ^2	Effect Size, d or Δ%
Mean age (SD)	43.97 (11.48)	51.25 (10.74)	44.08*	−0.65†
Race				
White	2,375 (47.60)	34,669 (54.64)	111.83*	−7.04%†
Black	2,347 (47.04)	26,507 (41.78)		5.56%†
Other	267 (5.35)	2,272 (3.58)		1.77%
Married	372 (7.30)	4,724 (7.35)	0.02	−0.05%
Years of education	13.71 (1.93)	12.87 (1.84)	30.12*	0.45
Theatre of operations				
WWII/Korean War	20 (1.10)	490 (2.03)	964.72*	0.93%
Vietnam War	175 (9.64)	9,740 (40.41)		−30.77%†
Persian Gulf War	573 (31.55)	4,793 (19.89)		11.66%†
Afghanistan/Iraq	872 (48.02)	5,659 (23.48)		24.54%†
Other	176 (9.69)	3,420 (14.19)		−4.50%
Has dependent children	1,528 (29.58)	5,667 (8.69)	2274.20*	20.89%†
Employment history, past 3 years				
Employed	2,284 (44.66)	25,886 (40.12)	98.86*	4.54%
Unemployed	1,713 (33.50)	20,416 (31.65)		1.85%
Disabled/retired	1,117 (21.84)	18,212 (28.23)		−6.39%†
VA service-connected for				
Psychiatric condition	419 (8.11)	2,996 (4.60)	128.07*	3.51%
Other condition	950 (18.39)	8,218 (12.61)	141.29*	5.78%†
Total monthly income‡	689.53 (1071.72)	578.60 (1097.56)	11.88*	0.10
Any incarceration history	1,876 (37.47)	44,947 (71.99)	2601.76*	−34.52%†

* $p < .001$.
† Medium effect size differences (d ≥ ±0.50 or Δ% ≥ ±5.00%).
‡ Test of difference was performed on total income after a log transformation.

Table 1 shows the comparison between female and male VA homeless service users who were literally homeless on background characteristics. Homeless female veterans were, on average, 7 years younger than homeless male veterans and were much more likely to have served in Iraq and/or Afghanistan. Noting medium and large effect size differences ($d \geq \pm 0.5$ or $\Delta\% \geq \pm 5\%$), 21% more homeless female veterans had dependent children with almost one third of homeless women having dependent children. Among literally homeless females with a substance use disorder (n = 1,634), 289 (16.79% had dependent children with them). Among literally homeless females, 35% fewer had a history of incarceration and they were less likely to be disabled/retired but more likely to be VA service-connected for a non-psychiatric condition than male veterans.

Bivariate comparisons show that homeless female veterans were less likely to be chronically homeless than male veterans (Table 2). There were few notable differences (>5% difference) between homeless female and male veterans on physical health, although 9% more homeless male veterans had hepatitis C. More substantial differences were observed in psychiatric diagnoses as homeless female veterans were more likely to be diagnosed with affective disorders, military-related and non–military-related PTSD, and other anxiety disorders than homeless male veterans; however, 25% more homeless male veterans were diagnosed with substance use disorders (22.48% for alcohol and 15.73% for drug use disorders).

Adjusting for sociodemographic differences, these differences remained significant and adjusted odds ratios showed that homeless female veterans had more than two times the odds of having non–military-related PTSD than male veterans and nearly half the odds of having a substance use disorder (odds ratio = 0.57 for alcohol and 0.61 for drug use disorders).

Table 3 shows the initial mode of contact with homeless female and male veterans (first section of the table), program referrals (second section), and program admission patterns (third section). The most common initial contact to VA homeless services was through self-referrals. There were no substantial gender differences in the initial mode of contact.

For program referrals, the HUD-VA Supportive Housing program was the most common program to which homeless male and female veterans were referred. The proportion of women among those referred to HUD-VA Supportive Housing program was 19% greater than the proportion of males, although 9% more homeless male veterans were referred to the Grant and Per Diem program, and only male veterans were referred to the Healthcare for Re-entry Veterans program.

Program admissions mainly reflected program referral patterns. The HUD-VA Supportive Housing program was the most common program to which homeless veterans were admitted. The proportion of homeless female veterans was greater by 20% than males admitted to the HUD-VA Supportive Housing program, whereas 8% more homeless male veterans were admitted to the Grant and Per Diem program. To examine this further, analyses of gender differences on referral and admission to the HUD-VA Supportive Housing program were repeated controlling for sociodemographics and substance use disorders, which found that female veterans still had 1.76 times the odds of being referred and 1.81 times the odds of being admitted to the HUD-VA Supportive Housing program than male veterans.

Discussion

Using data on the population of homeless VA service users in 2011 and 2012, we found that female veterans constitute about 8% of all VA homeless service users, whereas they make up 7% of homeless veterans, 6% of all VA service users, and 7% of all veterans. This finding suggests many female veterans are using VA homeless services and at a rate similar to their use of general VA services. The results, at least partly, support the progress VA has made in making homeless services readily available for female veterans (Washington et al., 2011; Yano et al., 2006). The

Table 2
Homeless History and Health Status of Literally Homeless Female and Male Veterans

	Female (n = 5,165), n (%)	Male (n = 65,179), n (%)	Test of Difference, χ^2	Δ%	Adjusted Odds Ratio*	95% CI for Odds Ratio
No. of homeless episodes in past 3 years						
0	0 (0.00)	1 (0.00)	22.82†	0.00	–	–
1–2	3672 (72.33)	45,161 (70.73)		1.60	1.00	.90–1.12
3–4	950 (18.71)	11,579 (18.13)		0.58	1.15	1.01–1.30
≥5	455 (8.96)	7,108 (11.13)		−2.17	Ref	Ref
Duration of most recent episode of homelessness (mo)						
<1	1,029 (20.24)	12,482 (19.51)	246.56†	0.73	1.11	1.00–1.22
1–5	1,568 (30.85)	15,632 (24.43)		6.42‡	1.32	1.20–1.45
6–12	737 (14.50)	8,501 (13.29)		1.21	1.15	1.03–1.28
13–24	782 (15.38)	9,024 (14.10)		1.28	1.28	1.15–1.42
>24	967 (19.02)	18,346 (28.67)		−9.65‡	Ref	Ref
Chronically homeless	2,138 (41.75)	31,741 (49.25)	106.95†	−7.50‡	.97	.91–1.04
Rating of physical health						
Poor	804 (15.90)	10,990 (17.27)	18.43†	−1.37	1.51‡	1.35–1.69
Fair/good	3,493 (69.09)	42,079 (66.13)		2.96	1.39	1.27–1.52
Very good/excellent	759 (15.01)	10,561 (16.60)		−1.59	Ref	Ref
Chronic medical condition						
HIV/AIDS	50 (0.97)	1,129 (1.73)	16.92†	−0.76	0.65	0.48–0.89
Hepatitis C	292 (5.66)	9,854 (15.13)	346.73†	−9.47‡	0.69	0.60–0.79
Tuberculosis	139 (2.70)	3,200 (4.91)	51.99†	−2.21	0.78	0.65–0.93
COPD	303 (5.88)	5,528 (8.49)	42.86†	−4.45	1.24	1.09–1.41
Heart disease	326 (6.32)	7,011 (10.77)	100.85†	−4.45	0.83	0.74–0.95
Stroke	103 (2.92)	1,762 (3.84)	7.72	−0.92	1.23	0.99–1.53
Diabetes	446 (8.65)	8,132 (12.49)	65.76†	−3.84	0.85	0.76–0.94
Seizures	234 (4.54)	3,211 (4.93)	1.59	−0.39	1.06	.92–1.23
Chronic pain	1,938 (37.59)	24,293 (37.31)	.15	0.28	1.11	1.04–1.18
Psychiatric diagnoses						
Psychotic disorder	940 (18.20)	9,910 (15.20)	32.91†	3.00	1.39	1.28–1.52
Affective disorder	2,336 (45.23)	24,041 (36.88)	142.13†	8.35‡	1.43	1.35–1.53
Military-related PTSD	1,239 (23.99)	9,030 (13.85)	394.24†	10.14‡	1.24	1.14–1.34
Non–military-related PTSD	743 (14.39)	4,233 (6.49)	453.32†	7.90‡	2.61‡	2.38–2.87
Other anxiety disorder	1,375 (26.62)	10,761 (16.51)	342.76†	10.11‡	1.62‡	1.51–1.75
Substance use disorder	1634 (31.64)	37,102 (56.92)	1236.79†	−25.28‡	0.55	0.51–0.59
Any psychiatric hospitalizations	2,070 (41.06)	23,779 (37.35)	27.30†	3.71	1.34	1.25–1.43

Abbreviations: CI, confidence interval; COPD, chronic obstructive pulmonary disease; PTSD, posttraumatic stress disorder; Ref, Reference group.

* Controlling for significant background differences (i.e., age, race, education, dependent children, employment history, total monthly income, and incarceration history). Males are the reference group for all odds ratios.

† $p < .001$.

‡ Notable differences (Δ% ≥ ±5.00% and .50 ≥ odds ratios or odds ratio ≥ 1.50).

VA has had to make adaptations in serving homeless female veterans, such as finding accommodations suitable for dependent children. One of the striking findings was that 30% of literally homeless female veterans had dependent children at the time of engagement with VA homeless services. If the VA is to provide comprehensive services for homeless female veterans, lack of child care services remains an unaddressed issue (Mattocks et al., 2011; Street, Vogt, & Dutra, 2009). Also, there continue to be homeless female veterans who do not engage with VA homeless services, which has been a problem among female veterans in general in using VA services (Goldzweig, Balekian, Rolon, Yano, & Shekelle, 2006; Washington et al., 2011), suggesting outreach and providing more appropriate services for females remains important.

Over half of VA homeless service users were literally homeless at the time of initial engagement, which reflects the fact that VA homeless services are directed toward prevention for veterans at risk of becoming literally homeless as well as to serve veterans who are currently homeless. Female veterans were slightly less likely to be literally homeless than male veterans, which is consistent with previous studies that have found homeless female individuals are often able to establish social resources and rely on the goodwill of others to keep them from being literally homeless (Bassuk et al., 1997; Milburn & D'Ercole, 1991; Rowe & Wolch, 1990).

Literally homeless female veterans often had different psychosocial profiles than literally homeless male veterans. For example, female veterans were more likely to be dealing with affective, anxiety, and non–military-trauma-related psychiatric problems than substance use problems, which was more prevalent among male veterans. Although we could not determine what types of non-military trauma were experienced, sensitivity to these issues may help with building rapport and engaging homeless female veterans. Homeless female veterans also seemed to be somewhat physically healthier than homeless male veterans, because they were less likely to have HIV/AIDS and hepatitis C. These findings may be important in contributing to our understanding of the different service needs of homeless female veterans.

Given the different psychosocial profiles of literally homeless female and male veterans, we explored whether there were gender differences in their referral and admission patterns to various VA services. Although there were no substantial differences in their initial point of contact, there were some major differences in program referral and admission patterns. Altogether, the proportion of literally homeless female veterans referred and admitted to the HUD-VA Supportive Housing program was 19% to 20% greater than among males, and they were less likely to be referred and admitted to VA's Grant and Per Diem transitional housing program. This finding suggests

Table 3
Initial Contact, Program Referral, and Program Admission Patterns by Gender

	Female, *n* (%)	Male, *n* (%)	Test of Difference, χ^2	Δ%
Initial point of contact				
n	5,125	64,665	—	—
Street/community outreach	1,041 (20.31)	14,423 (22.30)	10.92	−1.99
Justice system outreach	40 (0.78)	1,182 (1.83)	30.28*	−1.05
Referral from residential/transitional program	647 (12.62)	10,427 (16.12)	43.58*	−3.50
Referral from mental health services	400 (7.80)	4,442 (6.87)	6.44	0.93
Referral from medical services	436 (8.51)	5,540 (8.57)	0.02	−0.06
Referral from emergency department	34 (0.66)	506 (0.78)	0.88	−0.12
Referral from VA homeless hotline	253 (4.94)	1,182 (1.83)	227.87*	3.11
Referral from criminal justice system	26 (0.51)	943 (1.46)	31.37*	−0.95
Referral from others	850 (16.59)	9,271 (14.34)	19.36*	2.25
Self-referred	1,398 (27.28)	16,749 (25.90)	4.68	1.38
Program referrals				
n	4,147	51,549	—	—
HUD-VA Supportive Housing	2,372 (57.20)	20,008 (38.59)	554.21*	18.61†
Grant and per diem	1,364 (32.89)	21,500 (41.47)	116.88*	−8.58†
VA medical service	1,095 (26.40)	13,440 (25.92)	0.47	0.48
VA mental health service	1,078 (25.99)	13,225 (25.51)	0.48	0.48
Healthcare for Re-entry Veterans	0 (0.00)	330 (0.64)	26.55*	−0.64
Veterans Justice Outreach	83 (2.00)	2,162 (4.17)	46.91*	−2.17
Domiciliary Care for Homeless Veterans	327 (7.89)	5,298 (10.22)	23.13*	−2.33
VA vocational rehabilitation service	308 (7.43)	3,890 (7.50)	0.03	−0.07
VA disability compensation	342 (8.25)	2,851 (5.50)	53.94*	2.75
VA emergency department	62 (1.50)	698 (1.35)	.64	0.15
Program admissions				
n	3,932	48.923	—	—
HUD-VA supportive housing	2,244 (57.07)	18,309 (37.42)	591.10*	19.65†
Grant and per diem	1,318 (33.52)	20,528 (41.96)	106.91*	−8.44†
Healthcare for Re-entry Veterans	0 (0.0)	269 (0.55)	21.73*	−0.55
VA vocational rehabilitation service	34 (0.86)	647 (1.32)	6.00	−0.46
Veterans Justice Outreach	59 (1.50)	1,175 (3.63)	49.19*	−2.13
Domiciliary Care for Homeless Veterans	332 (8.44)	5,313 (10.86)	22.28*	−2.42

* $p < .001$.
† Notable differences (Δ% ≥ ±5%).

permanent supported housing is VA's primary tool in ending homelessness among female veterans. We considered the possibility that this may be because homeless female veterans were more likely to have dependent children or because they were more likely to be sober, a requirement for entry into many VA transitional housing programs (Tsai, Rosenheck, Kasprow, & McGuire, 2012). However, these differences remained even after controlling for these factors. More likely, these differences reflect the lack of appropriate transitional-type housing for females offered by VA, because they are often male-dominated environments (Tsai, Rosenheck, & McGuire, 2012). This may be important; it can take several months after admission to the HUD-VA Supportive Housing program before being able to move into an apartment (Tsai, O'Connell, Kasprow, & Rosenheck, 2011) and female veterans may need temporary housing in the meantime. Data in this study did not provide information on where female veterans stayed while waiting for HUD-VA housing, and should certainly be an area for future data collection efforts.

Literally homeless female veterans were about equally likely as male veterans to be referred to other VA services, including medical, mental health, vocational rehabilitation, and disability compensation. No homeless female veterans were referred or admitted to VA's prisoner re-entry program, because they were dramatically less likely to have a history of incarceration and also because they were less likely to have problems with substance abuse. However, this study relied on administrative data and was not able to capture detailed, in-depth information about specific referral and admission decisions as they related to the different psychosocial profiles of homeless female veterans. This may be an area useful to examine in future research. A promising new VA program, which was not examined in this study, is the Supportive Services for Veteran Families program. The Supportive Services for Veteran Families program focuses on rapid rehousing and provides outreach, case management, and temporary rental and other financial assistance to veteran families to help them stay in or acquire permanent housing. Future studies should examine the effectiveness of this program in providing for homeless and at-risk female veterans.

Some of the potential limitations of the study have been mentioned, but others include the use of cross-sectional data, reliance on broad measures of health, and diagnostic information provided in clinical documentation rather than through standardized assessment methods. However, these weaknesses are counterbalanced by the strengths of the study, which include use of inclusive data on the population of VA homeless services users, a focus on meaningful effect sizes rather than *p* values, examination of a variety of VA services, and findings that may be relevant to future program planning and development.

Implications for Practice and Policy

Outreach for homeless female veterans continues to be important, especially because the VA is often a male-dominated environment that may not always be an appealing place for females to seek services. Given the needs of homeless female veterans, trauma-informed care and services that offer child care

and parenting support should be encouraged and promoted, particularly in VA's supported housing program where the majority of literally homeless female veterans are referred and admitted to. The VA needs to continue to adapt its homeless services to the increasing number of female veterans it will be serving.

Conclusions

A sizable proportion of veterans who use VA homeless services are women and many present with different problems than male veterans. Although the VA has expanded the types of different homeless services they offer in recent years, permanent supported housing seems to be the primary method to help female veterans exit homelessness and additional resources may be needed to help them with their unique needs, including help with parenting and child care, trauma-informed care, and mental health treatment focused on affective regulation rather than substance abuse relapse prevention. Finally, this study suggests the use of HOMES and other VA administrative data can be used as a method of quality monitoring and evaluation to ensure the types of services are provided to those who need it.

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