

# Social Determinants of Mental Health Care Systems: Intensive Community Based Care in The Veterans Health Administration

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## Abstract

## Background

Since deinstitutionalization in the 1950s-1970s, public mental health care has changed its focus from asylums to general hospitals, outpatient clinics and specialized community-based programs addressing both clinical and social determinants of mental health. Analysis of the place of community-based programs within a comprehensive health system such as the Veterans Health Administration (VHA) may illuminate the role of social forces in shaping contemporary public mental health systems.

## Methods

National VHA administrative data were used to compare veterans who exclusively received outpatient clinic care to those receiving four types of specialized community-based services, addressing: 1) functional disabilities from severe mental illness (SMI), 2) justice system involvement, 3) homelessness, and 4) vocational rehabilitation. Bivariate comparisons and multinomial logistic regression analyses compared groups on demographics, diagnoses, service use, and psychiatric prescription fills.

## Results

An hierarchical classification of 1,386,487 Veterans who received specialty mental health services from VHA in Fiscal Year 2012, showed 1,134,977 (81.8%) were seen exclusively in outpatient clinics; 27,931 (2.0%) received intensive SMI-related services; 42,985 (3.1%) criminal justice services; 160,273 (11.6%) specialized homelessness services; and 20,921 (1.5%) vocational services. Compared to those seen only in clinics, veterans in the four community treatment groups were more likely to be black, diagnosed with HIV and hepatitis, had more numerous substance use diagnoses and made more extensive use of mental health outpatient and inpatient care.

## Conclusions

Almost one-fifth of VHA mental health patients receive specialized community-based services addressing, most prominently, major social determinants of health and multimorbid substance use disorders.

## Background

Care for people with psychiatric disorders has undergone extraordinary changes in the past 70 years from a focus on asylum care to a “de facto” system of diverse, largely non-institutional services [1–3]. A distinctive feature is the provision of intensive community-based services for the most vulnerable, those long thought to be the most inadequately served [4]. In 1950, care for people with SMI, provided in over 500,000 state mental hospital beds [5], and was a target of public scorn [6]. By 1970, the majority of these beds had been closed and acute care was provided primarily in general hospitals, with longer term institutional care in nursing and board and care homes [7], and outpatient care in public clinics bolstered by newly developed antipsychotic and other psychiatric medications. By 1980, a substantial academic literature had developed decrying the failures of de-institutionalization and the neglect of people with the greatest needs [8]. Researchers had shown that Assertive Community Treatment (ACT) [9] and other forms of intensive community-based care could provide humane services in non-institutional settings [10] at little or no additional cost [11]. Here too, critics claimed programs were woefully under-funded [12]. Specialized psychiatric rehabilitation services were also developed to restore community adaptation and productive functioning [13–15], but these services were also believed to be severely underfunded [16, 17].

In the 1980s an unanticipated crisis of homelessness emerged. Initially viewed as a failure of deinstitutionalization because many homeless adults had SMI [18], it was eventually recognized to be more a consequence of the loss of affordable housing and the decline in public income support [19, 20] - a one-two punch that fell hard on people with SMI and addictions [21]. This highly visible subgroup of homeless adults was recognized to need income, housing and specialized community outreach services as well as psychiatric care.

In an apparent rebound of institutionalism, the criminal justice system exploded, in large part due to harsh new drug laws, and became an unwanted new asylum for people with psychiatric disorders representing, to many, a de facto criminalization of mental illness [22–24]. In response, diversion programs were designed to create a channel from the criminal justice system to mental health services [25].

The current system of community-based care for people with SMI thus developed in response both biomedical innovations and what has increasingly been referred to as social determinants of mental health [26] (by which is meant, social determinants of mental illness) [27–29]. The result has been a non-institutional system composed of two broad components: a standard clinic-based component backed by a limited hospital capacity, that serves the majority of patients, providing medications and behavioral therapies and a second, outwardly facing, community focused component providing more resource intensive services to patients most impacted by “social determinants” in need of specialized intensive care. These community-based services were once conceptualized as replacing care previously provided by state hospitals, but, as suggested above, they emerged in response to a broad array of social and economic developments.

The Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) is a nationally integrated health system with a specific mission to provide comprehensive healthcare to veterans of military service [30]. In many ways VHA mental health care has followed the same evolution as outlined

above in other public mental health systems, adopting the same biomedical innovations and responding to the same social phenomena with specialized services. The VHA, however, is distinctive in that its electronic health records system comprehensively document sociodemographic characteristics and clinical diagnoses as well as service use and prescribed medications. VHA data thus offer a unique opportunity to examine place of intensive community-based mental health services in a 21st century system of care .

This study uses national VHA data on 1.3 million veterans who received specialized mental health services from VHA in FY 2012, 240,000 (18%) of whom received intensive community-based services that can be classified in four types: 1) ACT-like intensive case management and recovery-oriented day program services for veterans disabled by serious mental illness (SMI) [31, 32] [33]; 2) outreach service to veterans involved in the criminal justice system [34, 35]; 3) outreach and housing services for homeless veterans [36–39], and 4) rehabilitation and community-based employment services [40].

In this study veterans receiving these four specialized community-based services are compared to those who received only clinic-based services on socio-demographic and diagnostic characteristics and on patterns of mental health and medical service use.

There has been particular interest in recent years in multi-morbidity, the co-occurrence of mutually exacerbating psychiatric, substance use and medical disorders which are responsible for severe functional impairments and place extensive demands on health care systems [41, 42]. We sought to pay simultaneous attention to both social determinants of health and clinical multi-morbidity in an examination of factors that might illuminate the place of intensive community-based programs in contemporary mental health service delivery.

## Methods

### Sample

Using national VHA data from FY 2012, a total of 1,386,487 veterans were identified who had used specialty mental health care. These veterans were classified into groups by the types of services they received. Community based services include those predominantly delivered outside the offices of the health care system to directly address social risks to health such as homelessness, incarceration, poor social functioning, poverty, and lack of employment skills. These services are not always provided outside of health system facilities, but they are all heavily focused on practical skills, supports for community living, and addressing individual social as well as medical circumstances. Since some veterans receive services from multiple programs, we classified them hierarchically, for analytic purposes, in mutually exclusive categories, including first, the most intensive long-term programs for SMI, followed by the two outreach programs addressing veterans involved in the criminal justice system or who were homeless, and then psychiatric rehabilitation programs, often provided as an ancillary to other clinical services. The remaining group was veterans seen only in office-based outpatient clinics. Thus while some veterans were treated in more than one community program (21.3% of those seen in any community program), they were only included in one group in our analytic classification and most veterans seen in intensive community based programs (62.2%) were also seen in clinic settings.

### Measures

Measures, obtained from a pre-constructed dataset from the Northeast Program Evaluation Center, documented sociodemographic variables including age, sex, race, geographic residence (urban or rural), national region, income, VA pension status, service-connection disability status (VA income support programs), and homelessness in the past year (identified through use of specialized homeless services and the V60 ICD9 code). Geographic measures were obtained through zip codes using the Rural-Urban Commuting Area classification [43].

Medical diagnoses were selected based on those included in the Charlson comorbidity index, an aggregate measure of comorbidity that predicts 1-year mortality using a weighted sum of medical comorbidities [44]. In addition to the Charlson index itself, medical diagnoses known to be associated with mental illness and substance use were included, such as hepatic disease, human immunodeficiency virus infection (HIV) and pain diagnoses, using an array of codes described elsewhere [45].

Psychiatric diagnoses included schizophrenia, bipolar disorder, major depressive (ICD-9

296.2-296.39) and other depressive disorders (ICD-9 300.4x, 296.9x, 301.10-301.19, 311.x), posttraumatic stress disorder (ICD-9 309.81), anxiety disorders (ICD-9 300.xx excluding 300.4), and personality disorders (ICD-9 301.9). In addition, 7 drug use disorders were included in the analysis: opiate (ICD-9 304.0x or 305.5), cannabis (ICD-9 304.3x or 305.2), cocaine (ICD-9 304.2x or 305.6), barbiturates (ICD-9 304.1x), amphetamines (ICD-9 304.4x or 305.7), and hallucinogens (ICD-9 304.5x or 305.3).

As a measure of multi-morbidity, summary variables were created as a count of the number of medical diagnoses, psychiatric diagnoses, and substance use diagnoses, and the total number of psychiatric and substance use diagnoses.

VHA outpatient health service utilization was derived from clinic stop codes representing general psychiatric care, substance use specialty care, primary care, emergency department visits, and each of the four types of community psychiatric care.

Psychotropic medication fills were classified as antipsychotics, antidepressants, anxiolytic/sedative/hypnotics, stimulants, anticonvulsants/mood stabilizers and lithium.

### Analysis

Bivariate analysis were used to compare veterans treated only in mental health clinics to those who received services from each of the four hierarchically classified types of intensive community based services.

Because the subgroups examined in involve many tens of thousands of Veterans, small group differences with little clinical importance would likely be statistically significant. We thus relied on effect sizes to identify substantial differences between groups. Cohen's *d* was calculated for continuous variables (the difference in means between groups divided by their pooled standard deviation) and risk ratios, for dichotomous variables representing proportions. A cutoff value of  $> 0.20$  or  $< -0.20$  was used as a threshold for at least a small difference in Cohen's *d* [46] and risk ratios of  $> 1.5$  or  $< 0.67$  for dichotomous variables.

Multinomial logistic regression analysis was then used to identify the set of measures that independently differentiated veterans who had been treated in each of the four sub-specialty community health programs from those treated in mental health clinics only. Variables included in the multivariable analyses were those we had previously identified as being substantially different between the groups based effect size differences in bivariate comparisons.

All analyses were conducted using SAS statistical software (version 9.2; SAS Institute Inc., Cary, NC).

## Results

Among the total of 1,386,487 veterans who had received specialty mental health services, 252,110 (18.2%) received specialized intensive community-based services: 27,931 (2.0%) SMI intensive case management or day programs; 44,345 (3.2%) criminal justice outreach; 180,033 (13.0%) specialized homelessness services; and 61,295 (4.4%) vocational rehabilitation services. In our unduplicated hierarchical classification 27,931 (2.0%) were classified in the intensive SMI services group; 42,985 (3.1%) in the criminal justice outreach group; 160,273 (11.6%) in homelessness services; and 20,921 (1.5%) in vocational services.

Bivariate analysis showed that veterans treated in criminal justice, homeless and vocational programs were substantially younger than those seen exclusively in outpatient mental health clinics. Veterans in the employment program group but not in the SMI program group had lower incomes (see comparisons using Cohen's *d* in the right hand columns of Table 1). Veterans seen in each of the four community-based programs were substantially more likely to be black, and less likely to be from isolated rural areas.

Table 1

Bivariate comparison of demographic characteristics of veterans in community care treatment and mental health clinics only.

	Mental Health Clinic (1)		Vocational (2)		Homelessness (3)		Criminal Justice (4)		SMI Services (5)		21
N=	1,134,377		20,921		160,273		42,985		27,931		El
Demographics	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Cr
Age (years)	55.22	15.45	48.69	12.30	52.15	12.01	52.18	15.64	54.02	11.96	-0
Income (\$)	25,339.03	42,872.53	15,658.00	22,245.30	12,602.47	22,973.72	19,912.26	42,170.73	20,693.33	23,364.20	-0
	%	N	%	N	%	N	%	N	%	N	Ri
Male	90.3	1,024,217	89.7	18,766	90.5	145,034	94.5	40,611	88.5	24,714	0.
Race											
White	77.5	879,022	62.0	12,968	52.8	84,636	68.1	29,281	65.0	18,149	0.
Black	16.2	183,291	31.2	6,522	39.1	62,738	25.0	10,766	28.5	7,957	1.
Hispanic	17.0	192,678	14.7	3,079	12.6	20,138	11.8	5,059	10.0	2,789	0.
Mixed	2.1	23,692	2.5	516	2.7	4,356	2.1	910	3.2	898	1.
Other	1.6	18,251	1.2	247	1.1	1,716	1.4	606	1.7	473	0.
Residence type											
Urban area residence	68.8	780,219	78.9	16,499	85.0	136,183	76.5	32,877	81.4	22,737	1.
Large rural area residence	11.5	130,283	9.5%	1,979	6.7%	10,688	9.4%	4,057	8.3%	2,330	0.
Small rural area residence	8.9	100,520	5.1%	1,075	4.0%	6,372	6.7%	2,886	4.6%	1,297	0.
Isolated rural area residence	6.7	75,455	3.6%	756	2.6%	4,144	5.2%	2,233	2.7%	750	0.
OEF/OIF era	17.6	200,092	19.5	4,085	9.9	15,798	17.9	7,715	8.8	2,453	1.
Service connected 50% or more	39.1	444,072	20.2	4,227	15.0	24,062	20.5	8,830	43.2	12,074	0.
Service connected < 50%	18.9	214,572	19.7	4,117	17.0	27,195	16.1	6,907	11.7	3,264	1.
Homeless during the year	1.4	15,932	10.7	2,235	86.2	138,219	30.6	13,169	28.3	7,894	7.

(1) Non-substantial differences involving less than 5% of the sample are not shown. Data available on request.

Veterans in the criminal justice, homeless and vocational program groups were all less likely to have a service-connected disability rating of 50% or more than those seen in clinics. There were few differences on the Charlson index of medical co-morbidity although those in vocational program group had a lower index of medical problems than those seen in clinics, and veterans treated in each of the four community program groups had greater risks of HIV and hepatic diagnoses.

Most dramatic were the substantially 2–3 times greater numbers with any drug or alcohol abuse or dependence diagnoses in all four community-based program groups as compared to the clinic group, with Cohen's *d*s of greater than 0.5 for the total number of such diagnoses and risk ratios for each specific drug and alcohol use diagnosis greater than 2.0 (Table 2).

Table 2  
Bivariate comparison of diagnoses of veterans in community care treatment and mental health clinics only. (1)

	Mental Health Clinic (1)		Vocational (2)		Homelessness (3)		Criminal Justice (4)		SMI Services (5)		2 vs 1	3 vs 1	4 vs 1	5 vs 1
N=	1,134,377		20,921		160,273		42,985		27,931		Effect Size			
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Cohen d			
<b>Multimorbidity</b>														
Number of psychiatric diagnoses	1.79	1.11	1.87	1.42	1.60	1.49	1.43	1.53	2.62	1.483	0.067	-0.151	-0.294	0.000
Number of SUD diagnoses	0.27	0.62	0.70	1.04	0.87	1.16	0.75	1.13	0.80	1.130	0.571	0.797	0.643	0.000
Number of psychiatric and SUD diagnoses	2.05	1.33	2.56	1.91	2.47	2.18	2.18	2.27	3.42	2.068	0.332	0.272	0.084	0.000
Charlson medical severity diagnosis index	2.81	2.44	1.96	1.99	2.32	2.16	2.45	2.53	2.80	2.185	-0.347	-0.199	-0.144	-0.000
<b>Medical diagnosis</b>														
	%	N	%	N	%	N	%	N	%	N	Risk Ratio			
Insomnia	8.2	92,536	8.3	1,736	6.6	10,592	6.3	2,709	6.6	1,830	1.017	0.810	0.773	0.000
Congestive heart failure	48.7	552,483	47.4	9,911	48.6	77,896	46.0	19,793	61.5	17,184	0.973	0.998	0.945	0.000
Chronic obstructive pulmonary	14.8	167,951	12.5	2,623	14.7	23,540	14.3	6,165	19.4	5,412	0.847	0.992	0.969	0.000
Diabetes mellitus	23.3	264,173	16.7	3,487	17.0	27,240	16.9	7,283	27.0	7,535	0.716	0.730	0.728	0.000
Cancer	7.2	81,768	3.9	822	5.1	8,208	6.2	2,677	5.8	1,619	0.545	0.710	0.864	0.000
Human immunodeficiency virus	0.5	6,226	1.4	287	1.5	2,420	0.9	369	1.0	275	2.499	2.751	1.564	0.000
Headache	9.5	107,605	12.0	2,514	8.8	14,084	8.4	3,610	10.5	2,926	1.267	0.926	0.885	0.000
Any pain	56.2	637,256	63.0	13,186	58.4	93,525	52.7	22,673	61.1	17,054	1.122	1.039	0.939	0.000
<b>Psychiatric Diagnosis</b>														
Any psychiatric disorder	92.2	1,045,820	85.9	17,972	78.2	125,382	68.4	29,403	99.4	27,757	0.932	0.849	0.742	0.000
Schizophrenia	4.8	54,401	6.5	1,367	6.3	10,148	3.9	1,662	47.8	13,360	1.362	1.320	0.806	0.000
Other psychotic disorder	2.5	28,651	3.8	801	4.4	7,094	3.6	1,529	13.9	3,878	1.516	1.752	1.408	0.000
Bipolar disorder	6.9	78,011	11.2	2,333	9.0	14,406	7.5	3,236	22.9	6,395	1.622	1.307	1.095	0.000
Major depressive disorder	21.1	239,616	22.9	4,799	17.1	27,390	13.9	5,987	26.9	7,512	1.086	0.809	0.659	0.000
Other depressive disorders (eg, dysthymia)	43.7	495,951	44.9	9,399	39.5	63,253	33.2	14,263	41.5	11,589	1.028	0.903	0.759	0.000
PTSD	41.8	473,699	30.2	6,323	24.7	39,653	25.4	10,937	34.8	9,717	0.724	0.592	0.609	0.000
Anxiety disorder	26.1	296,466	26.0	5,447	19.8	31,672	18.8	8,070	25.9	7,238	0.996	0.756	0.718	0.000
Adjustment disorder	10.2	115,639	13.4	2,805	13.5	21,685	12.2	5,245	10.0	2,787	1.315	1.327	1.197	0.000
Personality disorder	2.7	30,676	6.1	1,283	5.9	9,442	5.5	2,375	11.5	3,226	2.268	2.179	2.043	0.000
Other psychiatric diagnosis	18.8	213,714	21.5	4,506	20.2	32,454	19.2	8,269	26.4	7,367	1.143	1.075	1.021	0.000
Dual diagnosis	19.0	215,937	39.2	8,191	44.8	71,813	38.4	16,527	43.9	12,251	2.057	2.354	2.020	0.000
<b>Substance Use Disorder</b>														

(1) Non-substantial differences involving less than 5% of the sample are not shown. Data available on request.

	Mental Health Clinic (1)		Vocational (2)		Homelessness (3)		Criminal Justice (4)		SMI Services (5)		2 vs 1	3 vs 1	4 vs 1	5 vs 1
Any substance use disorder	9.9	112,789	28.3	5,917	35.5	56,838	29.5	12,662	33.5	9,347	2.845	3.567	2.963	3.567
Alcohol	13.8	156,291	29.5	6,173	33.9	54,290	30.1	12,938	31.3	8,732	2.142	2.459	2.185	2.459
Cannabis	3.8	42,884	9.8	2,057	11.9	19,030	10.1	4,348	12.1	3,378	2.601	3.141	2.676	3.141
Cocaine	2.5	28,593	12.3	2,565	17.7	28,334	13.1	5,610	15.0	4,201	4.864	7.014	5.178	7.014
Opioid	3.9	44,190	13.0	2,716	17.2	27,577	15.8	6,797	15.9	4,436	3.333	4.417	4.059	4.417
Sedative/hypnotic	0.5	5,127	1.2	241	1.4	2,278	1.5	625	1.5	431	2.549	3.145	3.217	3.145
Amphetamine	0.5	5,969	1.7	352	2.6	4,246	2.9	1,244	2.2	627	3.198	5.035	5.500	5.035

(1) Non-substantial differences involving less than 5% of the sample are not shown. Data available on request.

Numbers of non-substance use psychiatric diagnoses were substantially greater in the SMI program group with Cohen's *d* of .69 and fewer in the criminal justice programs with Cohen's *d* of -.29. Individual diagnoses most strongly associated with the SMI programs included schizophrenia, and bipolar disorder. While proportions of veterans diagnosed with personality disorder were greater in all four community program groups than in outpatient clinics, they were 4 times more common in the SMI programs even though personality disorder is not considered a serious mental illness (Table 2).

Veterans in each of the four community program groups had far more psychiatric and substance use outpatient visits than those seen in outpatient mental health clinics (Table 3), and participants in the SMI and vocational programs had more general psychiatry visits over and above the visits to specialized community service programs themselves and three times as many total mental health outpatient contacts (totaling 51.63/year) overall. Veterans in all community program groups were more likely to have been hospitalized for psychiatric treatment compared to those seen in mental health clinics alone. There were no substantial differences in primary care or medical specialty visits although veterans seen in the criminal justice and SMI programs were more likely to have had medical hospitalizations (Table 3).

Table 3

Bivariate comparison of service utilization and psychotropic prescription fills among veterans in community care treatment and mental health clinics or

	Mental Health Clinic (1)		Vocational (2)		Homelessness (3)		Criminal Justice (4)		SMI Services (5)		2 vs 1	3 vs 1	4 vs 1
N=	1,134,377		20,921		160,273		42,985		27,931		Effect Size		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Cohen d		
General psychiatry visits	5.81	9.27	15.96	22.89	16.51	24.43	11.83	22.54	67.37	74.42	0.602	0.634	0.357
General psychiatry visits excluding community-based programs	5.81	9.27	10.60	20.01	8.04	19.65	6.00	16.69	15.98	28.61	0.389	0.181	0.016
Substance abuse clinic visits	0.90	7.91	7.76	25.47	8.08	26.01	8.31	24.94	7.17	25.34	0.515	0.539	0.556
Medical surgical visits	9.60	11.12	10.66	11.40	10.07	11.76	9.54	12.27	13.45	14.53	0.092	0.040	-0.006
Primary care visits	3.43	3.50	4.02	3.86	3.93	4.24	3.27	3.96	4.71	5.08	0.156	0.134	-0.044
Speciality medical clinic visits	6.17	9.35	6.64	9.40	6.14	9.52	6.26	10.16	8.74	12.12	0.049	-0.003	0.010
Emergency room visits	0.60	1.58	1.06	2.32	1.37	2.97	1.22	2.67	1.87	4.13	0.232	0.388	0.313
	%	N	%	N	%	N	%	N	%	N	Risk Ratio		
Any mental health inpatient treatment	2.8	32,134	8.0	1,674	10.3	16,581	9.4	4,029	25.2	7,037	2.825	3.652	3.309
Any medical surgical inpatient treatment	7.9	90,143	8.7	1,814	11.6	18,563	12.0	5,154	14.3	4,007	1.091	1.458	1.509
Psychotropic medication prescriptions	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Cohen d		
Antidepressant prescriptions	5.67	9.79	6.45	16.22	5.84	13.63	5.26	13.52	12.37	25.31	0.069	0.015	-0.037
Antipsychotic prescriptions	1.76	8.09	2.65	11.73	2.53	10.53	2.06	9.29	16.41	35.24	0.089	0.077	0.030
Anxiolytic/sedative/hypnotic prescriptions	2.90	5.64	2.29	6.57	1.92	5.71	1.78	5.33	4.77	9.73	-0.104	-0.167	-0.192
Stimulant prescriptions	0.16	1.28	0.20	3.52	0.10	1.74	0.10	1.38	0.13	1.32	0.024	-0.042	-0.042
Anticonvulsant/Mood Stabilizer Prescriptions	1.55	6.09	2.08	8.64	2.19	9.04	2.04	9.04	7.12	21.19	0.072	0.087	0.067
Lithium prescriptions	0.13	1.65	0.25	2.51	0.21	2.51	0.18	2.18	1.47	9.95	0.052	0.033	0.022
All Psychotropics	13.03	21.03	14.74	33.21	14.40	30.33	13.85	30.64	43.05	70.05	0.068	0.054	0.033
Opiate Prescriptions	7.51	7.50	6.72	7.70	7.20	8.32	6.81	8.61	7.49	9.38	-0.101	-0.040	-0.090
Intensive community treatment programs	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Cohen d		
SMI Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.58	67.38	n/a	n/a	n/a
Criminal justice outreach, jail diversion visits	0.00	0.00	0.00	0.00	0.00	0.00	2.45	4.27	0.19	1.64	n/a	n/a	n/a
Homelessness visits	0.00	0.00	0.00	0.00	7.49	10.95	2.70	8.45	3.30	10.08	n/a	n/a	n/a
Vocational rehabilitation visits	0.00	0.00	5.36	9.63	1.54	5.93	1.03	5.05	1.56	6.08	n/a	n/a	n/a
Total intensive community treatment visits	0.00	0.00	5.36	9.63	9.04	13.41	6.18	12.46	51.63	68.38	n/a	n/a	n/a

Veterans served by the SMI program group also had three times as many psychotropic prescription fills as those only seen in outpatient clinics, but substantial differences in psychotropic prescription fills were not seen in association with other community-based programs. Veterans who received SMI services filled far more antipsychotic prescriptions.. There were no substantial differences in numbers of prescriptions for opiates (Table 3).

Multinomial logistic regression showed that, independent of other factors, veterans in the homeless and vocational program groups had lower incomes and were less likely to have a service-connected disability status of greater than 50% than those in the mental health clinic group. Veterans serviced by criminal justice programs had a lower total number of non-substance use psychiatric diagnoses (psychiatric multi-morbidity) whereas those in SMI programs had a substantially higher number of such diagnoses. Perhaps the most dramatic independent association was that Veterans in each of the four community program groups were diagnosed with more numerous substance use disorders than those in the clinic group (Table 4).

Table 4

Multinomial logistic regression with multimorbidity characteristics, comparing veterans treated in community psychiatry care with those in mental health.

	Vocational		Homeless		Criminal Justice		SMI Services	
	OR	Standardized Regression coefficient	OR	Standardized Regression coefficient	OR	Standardized Regression coefficient	OR	Standardized Regression coefficient
Demographics								
Age	0.977	-0.191**	0.993	-0.0574**	0.991	-0.075**	1.002	0.015**
Income	1.000	-0.200**	1.000	-0.413**	1.000	-0.040**	1.000	-0.062**
Black race	2.040	0.156**	2.570	0.206**	1.422	0.077**	1.799	0.128**
Small rural area residence	0.638	-0.068**	0.509	-0.102**	0.836	-0.027**	0.513	-0.100**
Isolated rural area residence	0.635	-0.059**	0.478	-0.097**	0.896	-0.015**	0.406	-0.118**
Pension	1.142	0.014*	1.614	0.050**	1.018	0.002**	2.480	0.095**
Service connected 50% or more	0.466	-0.202**	0.394	-0.246**	0.493	-0.187**	1.279	0.065**
Diagnoses								
Connective tissue disease	0.822	-0.011	0.772	-0.014**	1.018	0.001**	0.643	-0.024**
Hepatic disease	1.207	0.021**	1.255	0.025**	1.014	0.002**	1.070	0.0070
Human immunodeficiency virus	1.480	0.018**	1.268	0.011**	1.011	0.001**	1.075	0.0030
Dementia	0.233	-0.094**	0.304	-0.077**	0.868	-0.009**	0.709	-0.022**
Multi-morbidity								
Number of psychiatric diagnoses	1.004	0.003	0.840	-0.115**	0.714	-0.222**	1.482	0.260**
Number of substance use disorder diagnoses	1.666	0.217**	1.953	0.285**	2.025	0.300**	1.663	0.217**
Service Use								
General psychiatry visits excluding community-based programs	1.019	0.130**	1.015	0.106**	1.009	0.062**	1.018	0.126**
Substance abuse clinic visits	1.018	0.132**	1.016	0.118**	1.019	0.141**	1.013	0.097**
Medical surgical clinic visits	1.012	0.076**	1.006	0.036**	1.008	0.048**	1.007	0.047**
Emergency room visits	1.065	0.070**	1.105	0.111**	1.107	0.113**	1.073	0.078**
Any mental health inpatient treatment	1.446	0.043**	2.138	0.089**	2.516	0.108**	3.267	0.139**
Any medical surgical inpatient treatment	0.850	-0.026**	1.081	0.013**	1.270	0.038**	0.899	-0.017**
All psychotropic medications	1.001	0.017*	1.000	-0.004	0.998	-0.033**	1.007	0.100**
*p < .01, **p < .0001								

## Discussion

This study used national VHA data to compare the proportions and characteristics of the 82% of veterans treated exclusively in mental health outpatient clinics to the 18% of veterans treated in four different types of specialized intensive community-based programs. Veterans treated in all four types of community programs were distinguished most strikingly, by being diagnosed with 2–3 times more numerous substance use disorders, were more likely to have HIV and hepatic disease, to be from urban areas, of black race and also had 3–13 times more mental health outpatient visits, most of which were in community-based programs themselves. Veterans served in the specialized programs for SMI veterans (only 2% of the total) were much more likely than clinic patients to be diagnosed with psychotic disorders, to manifest psychiatric multimorbidity and personality disorders and had 13 times more total visits, receiving over three times as many prescriptions for psychotropic medications.

In the decades after the closure of public psychiatric hospitals in the 1950s-70 s, public mental health systems faced the question of how to address the broad needs of: 1) SMI patients who formerly would have been institutionalized, as well as the needs of emerging populations of 2) homeless and 3) criminal justice involved adults with mental health disorders and 4) those seeking rehabilitation/employment along with 5) the growing numbers of people newly seeking effective care for less severe problems. While there has been extensive documentation of the reduction in long term State and VHA psychiatric hospital beds [47, 48, 5], and many studies of the growth of outpatient mental health treatment generally [49–51]; we know of no system-wide studies of the place of intensive community-based services in any public mental health system nor of characteristics of people who use these services. The main reason for this lack

of studies is that, with the VHA as an exception, there are few integrated public mental health systems responsible for entire populations that have comprehensive electronic health records to support such an analysis.

On the one hand, available studies have shown that “the system” still faces challenges with respect to the treatment engagement of people with mentally ill illness [52]. On the other, the National Comorbidity Survey (NCS) and NCS Replication show that between 1990 and 2003, while the overall rates of mental illness did not significantly change, basic treatment rates for people with mental illness increased significantly [49] although many still did not receive adequate treatment [53]. Additionally, among people with SMI, rates of any mental health treatment increased from 24.3–40.5% [49]. Further data from the Healthcare for Communities Survey showed an increase in mental health specialty treatment for people with SMI from 39% in 1997 to 51% in 2001 with an even larger increase (from 47–76%) for the subgroup who perceived a need for treatment [51]. Most research on utilization of mental health services, however, has focused on people with mild to moderate mental illness. For example, studies based on the National Ambulatory Medical Care Survey that found that treatment for depression tripled between 1987 and 1997 [50], and that most antidepressants are prescribed by primary care providers [54, 55].

Local studies based on Medicaid data show that community programs continued to provide ACT and ACT-like services to the most seriously mentally ill and functionally impaired adults [56], though a recent survey suggested that less than 20% of non-VA community mental health facilities offer ACT [57] and even fewer offer other community services such as peer support, employment, and housing services [58]. While most research has focused on *either* people who use less intensive services (i.e. from standard mental health outpatient clinics) or specific community-based treatments like ACT or supported housing, no study to our knowledge has addressed the broad array of clinic *and* intensive community-based services offered in a national system or even in one community. The present study, based on VHA data showed intensive community-based service are provided to 18% of those receiving any specialty mental health services especially to those with multiple substance use disorders, severe mental illness, criminal justice involvement, and/or homelessness. A previous study of VHA care suggested that considering all patients with psychiatric diagnoses, one-third receive no specialty mental health treatment at all and receive care for mental disorders exclusively in primary or specialty care clinic settings [59]. These VHA studies, taken together, thus appear to be unique in mapping the major components of a complete contemporary mental health system in which most patients receive care in standard outpatient clinics but significant subgroups receive intensive community-focused care largely shaped by social determinants and SUD-related multimorbidity.

In view of this mapping, it is notable that several recent reviews have emphasized the unique role of mental health services in addressing social determinants of health as well as individual biomedical conditions [60, 26, 27]. The portrait of community-based care in VHA presented here illustrates the way mental health systems have been shaped by such social determinants. Shields-Zeeman described two types of intervention which she referred to as “social risk–informed” care and “social risk-targeted care.” Social risk–*informed* care tailors clinical plans to reduce the effect of social or economic adversity, most often in a conventional clinic setting, without necessarily targeting the social condition itself. Social risk–*targeted* care, in contrast, more directly helps patients to reduce social or economic adversity, and is more focused on community intervention. The community-based programs described here fall into both categories in that they seek to provide in vivo services at the individual level focusing on real world adaptation to challenging circumstances and directly addressing patient-level problems such as housing, criminal justice involvement, impaired activities of daily living, limited employment opportunities, social isolation and a stigmatizing environment. The developing conceptualization of mental health care within a social determinants of health framework, thus provides an overarching context for understanding the unique role of community-focused programs.

Several methodological limitations of this study require comment. First, our ability to identify services delivered through community-based programs is limited to those identified by specific clinic codes in VHA administrative records. There are, no doubt other programs in VHA that would conform to our concept of community-based care that were implemented through local initiatives, which we could not identify. However, those examined here were developed through national initiatives, often supported by special funding and are probably the largest and best defined. Perhaps the issue most neglected by this study is poverty, addressed by VA disability compensation and pension programs for many veterans. These programs were less commonly used by veterans served by outreach programs to criminal justice involved and homeless veterans although their access to these benefits likely increases after a period of program participation [61]. Crucial data are also not available on social security and local welfare programs.

Second, the definition of intensive community-based programs is not precise and while most programs addressed here involve frequent contact with veterans outside of health care facilities there is variability from program to program and facility to facility in the extent of in vivo as contrasted with office-based service delivery in these programs. Nevertheless, all of the programs are intended to address exceptionally serious clinical conditions and specific socially determined challenges to community adaptation.

Third, administrative diagnoses are not based on formal diagnostic instruments or criteria, but have the advantage of representing real-world clinical judgements.

Fourth, this study focuses on data from the VHA which offers the advantage of providing comprehensive national data from electronic health records. However VHA is federally funded and operated and serves only veterans, who are overwhelmingly male, and thus its generalizability to other populations and health systems is unknown. This study offers a sketch of one system which, it is hoped, will stimulate similar studies of others.

## Conclusion

In 2012, almost one-fifth of VHA mental health patients received specialized community-based services addressing, most distinctively, major social determinants of health and multimorbid substance use disorders. Deinstitutionalization of the 1950s-1970 s was followed by several other major social changes that stimulated the development of novel community-based public mental health services. While the effectiveness, and cost-effectiveness of these specialized services has been demonstrated in randomized trials [62, 36, 63, 25], evaluation of the accessibility and effectiveness of such programs in the context of large regional and national service systems is a far more challenging task, and remains to be undertaken.

## Abbreviations

ACT - assertive community treatment

FY - fiscal year

HIV - human immunodeficiency virus

ICD - International Classification of Diseases

NCS - National Comorbidity Survey

SMI - severe mental illness

VA - Veterans Affairs

VHA - Veterans Health Administration

## Declarations

## Ethics approval and consent to participate

The study was approved by the Institutional Review Board committee of the VA Connecticut Healthcare System. A waiver of informed consent was obtained as the study used administrative data and there were no patient identifiers included

## Consent to publish

Not applicable

## Availability of data and materials

The data that support the findings of this study are available from the Veterans Health Administration but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of the Veterans Health Administration.

## Competing interests

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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## Authors' Contributions

RR and IB designed the study, and wrote and edited the manuscript. ES completed the data analysis. All authors contributed to and have approved the final manuscript

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## References

1. Talbott JA. (1983) Unified mental health systems: Utopia unrealized. vol 18. Jossey-Bass Inc Pub.
2. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry*. 1993;50(2):85–94.
3. Brown P. (1985) The transfer of care: Psychiatric deinstitutionalization and its aftermath.
4. Torrey EF. (1988) Nowhere to go: The tragic odyssey of the homeless mentally ill.
5. Directors NAO SMHP. Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014. VA: Alexandria; 2017.

6. Deutsch A. *The shame of the States*. 1st ed. New York: Harcourt; 1948.
7. Lamb HR. Deinstitutionalization and the homeless mentally ill. *Psychiatric Services*. 1984;35(9):899–907.
8. Zusman J, Lamb HR. In defense of community mental health. *Am J Psychiatry*. 1977;134(8):887–90. doi:.
9. Stein LI, Test MA. Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. *Arch Gen Psychiatry*. 1980;37(4):392–7.
10. Braun P, Kochansky G, Shapiro R, Greenberg S, Gudeman JE, Johnson S, Shore MF. (1981) Overview: deinstitutionalization of psychiatric patients, a critical review of outcome studies. *The American Journal of Psychiatry*.
11. Weisbrod BA, Test MA, Stein LI. Alternative to mental hospital treatment: II. Economic benefit-cost analysis. *Arch Gen Psychiatry*. 1980;37(4):400–5.
12. 10.1056/NEJM198312223092512  
Mosher LR. (1983) Alternatives to psychiatric hospitalization. Why has research failed to be translated into practice? *N Engl J Med* 309 (25):1579–1580. doi:.
13. Turner JC, TenHoor WJ. The NIMH Community Support Program: Pilot approach to a needed social reform. *Schizophr Bull*. 1978;4(3):319.
14. Becker DR, Drake RE. Individual placement and support: A community mental health center approach to vocational rehabilitation. *Commun Ment Health J*. 1994;30(2):193–206.
15. Anthony WA, Cohen MR, Farkas MD. *Psychiatric rehabilitation*. Center for Psychiatric Rehabilitation. Boston: Boston University, Sargent College of Allied Health Professions; 1990.
16. Bond GR, Becker DR, Drake RE, Rapp CA, Meisler N, Lehman AF, Bell MD, Blyler CR. Implementing supported employment as an evidence-based practice. *Psychiatric services*. 2001;52(3):313–22.
17. Bond GR, Drake RE. Making the case for IPS supported employment. *Administration policy in mental health mental health services research*. 2014;41(1):69–73.
18. Bassuk EL, Lamb HR. (1986) Homelessness and the implementation of deinstitutionalization. *New Directions for Mental Health Services* 1986 (30):7–14.
19. Scallet LJ. (1989) *Mental Health And Homelessness: Evidence Of Failed Policy? Project HOPE-The People-to-People Health Foundation, Inc.*
20. Burt MM. (1992) *Over the edge: The growth of homelessness in the 1980s*. Russell Sage Foundation.
21. Pepper B, Kirshner MC, Ryglewicz H. The young adult chronic patient: Overview of a population. *Psychiatric Services*. 1981;32(7):463–9.
22. Teplin LA. The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiologic Catchment Area Program. *Am J Public Health*. 1990;80(6):663–9.
23. Junginger J, Claypoole K, Laygo R, Crisanti A. Effects of serious mental illness and substance abuse on criminal offenses. *Psychiatric Services*. 2006;57(6):879–82.
24. Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. *Lancet*. 2002;359(9306):545–50. doi:.
25. Sirotych F. The criminal justice outcomes of jail diversion programs for persons with mental illness: a review of the evidence. *Journal of the American Academy of Psychiatry the Law Online*. 2009;37(4):461–72.
26. Hansen H, Braslow J, Rohrbaugh RM. From cultural to structural competency—training psychiatry residents to act on social determinants of health and institutional racism. *JAMA psychiatry*. 2018;75(2):117–8.
27. Shields-Zeeman L, Lewis C, Gottlieb L. (2019) *Social and Mental Health Care Integration: The Leading Edge*. JAMA psychiatry.
28. Compton MT, Shim RS. The social determinants of mental health. *Focus*. 2015;13(4):419–25.
29. Braslow JT, Messac L. Medicalization and Demedicalization—A Gravely Disabled Homeless Man with Psychiatric Illness. *N Engl J Med*. 2018;379(20):1885–8.
30. Roberts LW, Warner CH. (2018) *Military and Veteran Mental Health: A Comprehensive Guide*. Springer.
31. Rosenheck RA, Neale MS. Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Arch Gen Psychiatry*. 1998;55(5):459–66.
32. VA Illiana Health Care System D, Illinois Mental Health Intensive Case. Management Program (MHICM). . Accessed April 7, 2019.
33. Affairs USDoV. (2009) *Psychosocial Rehabilitation and Recovery Center (PRRC)*. . Accessed April 7, 2019.
34. Tsai J, Rosenheck RA, Kaspro W, McGuire W JF. Risk of incarceration and other characteristics of Iraq and Afghanistan era veterans in state and federal prisons. *Psychiatric Services*. 2013;64(1):36–43.
35. Affairs USDoV. (2019) *Veterans Justice Outreach Program*. . Accessed April 11, 2019.
36. Rosenheck R, Kaspro W, Frisman L, Liu-Mares W. Cost-effectiveness of supported housing for homeless persons with mental illness. *Arch Gen Psychiatry*. 2003;60(9):940–51.
37. Tsai J. *Homelessness Among US Veterans: A Critical Approach*. USA: Oxford University Press; 2018.
38. Tsai J, Kaspro WJ, Rosenheck RA. Latent homeless risk profiles of a national sample of homeless veterans and their relation to program referral and admission patterns. *Am J Public Health*. 2013;103(S2):239–47.
39. Affairs USDoV. (2019) *Homeless Veterans*. . Accessed April 11, 2019.
40. Affairs USDoV. (2019) *Compensated Work Therapy*. . Accessed April 11, 2019.
41. North CS, Brown ES, Pollio DE. Expanded conceptualization of multimorbidity to encompass substance use disorders and other psychiatric illness. *Ann Clin Psychiatry*. 2016;28(3):182–8.

42. Bhalla IP, Rosenheck RA. A Change in Perspective: From Dual Diagnosis to Multimorbidity. *Psychiatr Serv.* 2018;69(1):112–6. doi:.
43. Morrill R, Cromartie J, Hart G. Metropolitan, urban, and rural commuting areas: toward a better depiction of the United States settlement system. *Urban geography.* 1999;20(8):727–48.
44. Charlson ME, Pompei P, Ales KL, MacKenzie CR. A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. *Journal of chronic diseases.* 1987;40(5):373–83.
45. Barry DT, Sofuoglu M, Kerns RD, Wiechers IR, Rosenheck RA. Prevalence and correlates of co-prescribing psychotropic medications with long-term opioid use nationally in the Veterans Health Administration. *Psychiatry research.* 2015;227(2–3):324–32.
46. Cohen J. (1988) *Statistical power analysis for the behavioral sciences* 2nd edn. Erlbaum Associates, Hillsdale.
47. Sharfstein SS, Dickerson FB. Hospital psychiatry for the twenty-first century. *Health Aff.* 2009;28(3):685–8.
48. National Mental Health Services Survey (N-MHSS) Administration SAaMHS. (2016) *Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS): 2014. Data on Mental Health Treatment Facilities.* BHSIS Series S-87. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville, MD.
49. Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, Wang P, Wells KB, Zaslavsky AM. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med.* 2005;352(24):2515–23.
50. Olfson M, Marcus SC, Druss B, Elinson L, Tanielian T, Pincus HA. National trends in the outpatient treatment of depression. *Jama.* 2002;287(2):203–9.
51. Mechanic D, Bilder S. Treatment of people with mental illness: a decade-long perspective. *Health Aff.* 2004;23(4):84–95.
52. Appelbaum PS. The ‘quiet’ crisis in mental health services. *Health Aff.* 2003;22(5):110–6.
53. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2005;62(6):629–40.
54. Mojtabai R, Olfson M. (2008) National patterns in antidepressant treatment by psychiatrists and general medical providers: results from the national comorbidity survey replication. *The Journal of clinical psychiatry.*
55. Rhee TG, Rosenheck RA. Initiation of new psychotropic prescriptions without a psychiatric diagnosis among US adults: Rates, correlates, and national trends from 2006 to 2015. *Health services research.* 2019;54(1):139–48.
56. Gilmer TP, Stefancic A, Ettner SL, Manning WG, Tsemberis S. Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. *Arch Gen Psychiatry.* 2010;67(6):645–52.
57. Spivak S, Cullen BA, Green C, Firth T, Sater H, Mojtabai R. (2019) Availability of Assertive Community Treatment in the United States: 2010 to 2016. *Psychiatr Serv:appips201900032.* doi:.
58. Spivak S, Mojtabai R, Green C, Firth T, Sater H, Cullen BA. (2019) Distribution and correlates of Assertive Community Treatment (ACT) and ACT-like programs: results from the 2015 N-MHSS. *Psychiatric services:appi.* ps. 201700561.
59. Gupta N, Bhalla IP, Rosenheck RA. Treatment of Veterans with Psychiatric Diagnoses Nationally in the Veterans Health Administration: A Comparison of Service Delivery by Mental Health Specialists and Other Providers. *Administration Policy in Mental Health Mental Health Services Research.* 2019;46(3):380–90.
60. Shim RS, Compton MT. Addressing the social determinants of mental health: if not now, when? if not us. who? *Psychiatric services.* 2018;69(8):844–6.
61. Chen JH, Rosenheck RA, KasproW WJ, Greenberg G. Receipt of disability through an outreach program for homeless veterans. *Military medicine.* 2007;172(5):461–5.
62. Phillips SD, Burns BJ, Edgar ER, Mueser KT, Linkins KW, Rosenheck RA, Drake RE, McDonel Herr EC. Moving assertive community treatment into standard practice. *Psychiatric services.* 2001;52(6):771–9.
63. Frederick DE, VanderWeele TJ. Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support. *PLoS one.* 2019;14(2):e0212208.