

# HOMELESS VETERANS' ISSUES

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JOINT HEARING  
BEFORE THE  
SUBCOMMITTEE ON BENEFITS  
AND  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED SIXTH CONGRESS  
SECOND SESSION

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MARCH 9, 2000  
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## **HOMELESS VETERANS' ISSUES**

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**THURSDAY, MARCH 9, 2000**

**HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON BENEFITS,  
AND THE SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON VETERANS' AFFAIRS,  
*Washington, DC.***

The subcommittees met, pursuant to notice, at 10:03 a.m., in room 345, Cannon House Office Building, Hon. Jack Quinn (chairman of the Benefits Subcommittee) presiding.

Present: Representatives Quinn, Filner, Hayworth, Stearns, Peterson, Carson, Rodriguez, Shows, and Evans.

### **OPENING STATEMENT OF CHAIRMAN QUINN**

Mr. QUINN. Good morning everyone. We would like to begin somewhat on time in deference to schedules for many of our guests, of course, and witnesses this morning that we will hear from as we talk about the homeless situation as it relates particularly to our veterans in the United States.

I would like to begin by welcoming all of you here this morning on behalf of the two subcommittee, the Subcommittee on Benefits and the Subcommittee on Health, for a joint hearing on homeless veterans' issues. It is also an opportunity for me to extend a special thank you and welcome to Ms. Heather Renee French, Miss America 2000, for making herself available to us this morning to share her views on how we can best help homeless veterans to help themselves and their families. I know that Ms. French travels extensively, we are told only one day off a month, a tougher schedule than a member of Congress—actually, a much tougher schedule than a member of Congress. (Laughter.)

Some say we only work one day down here. Seriously, though, we know you travel extensively, Miss America. We also know that veterans are close to your heart. You are close to them, and your effort, your appearance here this morning certainly helps us do our job a little better, we hope.

I want to point out for the record in beginning this morning, we know that the Urban Institute in 1988 estimated that over 600,000 people were homeless in America. Ten years later, a study that was cosponsored by HUD and HHS reported that there were between 500,000 and 600,000 homeless men and women living in shelters and on our streets. This was 10 years later, ladies and gentlemen.

Chairman Stearns and I have called this hearing to examine Federal and private sector efforts to assist the homeless veterans populations. On any given night, it is estimated that more than

275,000 veterans will sleep in doorways, in boxes, and on grates throughout the country, including this Capitol city. That is the equivalent of 17 infantry divisions homeless tonight in our own country. Some estimates put the homeless veterans population even higher. I am not sure if anyone knows the true figure.

In a nation that is rich with resources, I am not sure how we can knowingly ignore a segment of society that has fought for the freedoms that all of us sometimes take for granted.

Today we will hear from the administration officials that represent the Department of Veterans Affairs, the Department of Housing and Urban Development, and the Department of Labor. In addition, we have witnesses from the frontlines to speak with us this morning. We look forward to hearing everybody's testimony.

I would like to recognize Congressman Clifford Stearns, chairman of the Health Subcommittee, for opening remarks at this point.

**OPENING STATEMENT OF HON. CLIFF STEARNS, CHAIRMAN,  
SUBCOMMITTEE ON HEALTH**

Mr. STEARNS. Good morning, everybody, and thank you, Mr. Chairman. Thank you for holding this joint hearing this morning between our two subcommittees, of course, yours focuses on the benefit aspect and mine on the health and health-related programs.

We are both underscoring the important point, that is, that the challenge of overcoming the problems of homelessness among veterans is a challenge that crosses jurisdictional lines. Just as our committee works together on this important problem, government agencies at all levels must work cooperatively to make a difference, and as we have learned, this is not a job that any one agency or even government generally can do alone. We have learned over the years that homelessness is a complex problem which often involves mental illnesses or substance abuse and which may require many kinds of assistance—health care, housing, employment assistance, and income support.

Our first witness, Heather French, Miss America, probably says it best when she says, "It takes a network of partnerships to be able to provide a full range of services to homeless veterans."

I think we have an excellent lineup of witnesses today. Their testimony certainly underscores Ms. French's point that no one entity can do the job alone. I note that Ms. French and other witnesses also make another important point that must be a concern to all of us this morning. Specifically, their testimony indicates that the greatest source of potential funding to combat homelessness, the Department of Housing and Urban Development, still provides only 2 percent of its \$1 billion appropriation to veteran-specific programs. This is a troubling issue we really need to explore.

Much of the testimony we will hear today illustrates that community organizations that are dedicated to serving homeless veterans are truly unique resources. These organizations, working with the VA, HUD, and other governmental agencies, can bring together all the resources needed to help veterans overcome the multiple problems that contribute to homelessness. There are success stories out there and the question is, how can we replicate those successes in other communities?

In her testimony, Ms. French makes an excellent recommendation which I think can produce real results. She proposes a modest allocation of HUD funds to the National Coalition for Homeless Veterans to provide needed technical assistance to homeless veterans' service providers. A lack of skills in grant writing should not be a barrier preventing capable, committed organizations from winning funds needed to help all of our veterans. So I hope we can all of us unite this morning behind Ms. America and all of us support her idea.

Mr. Chairman, we made important progress last year in the Veterans' Millennium Health Care and Benefits Act to improve and extend programs targeted at homeless veterans and I look forward to working to make further progress this year.

Mr. QUINN. Thank you, Clifford. Thank you very much.

My partner on our Benefits Subcommittee is Bob Filner from the great State of California and I yield to him at this point.

#### OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman, and thank you for providing this forum where we are focusing on the needs of veterans who now find themselves homeless. I think we all know that the image of those who have served our country sleeping in doorways and alleyways and cardboard boxes and on steam grates is a shameful one. Our country's economy is stronger now than at any time in our nation's history. If we cannot, if we do not address the needs that we are addressing today, when will we?

As you all know, veterans comprise anywhere between a third and a half of our homeless population, but only about 3 percent of funding for the homeless from the Department of Housing and Urban Development is directed to specific programs for homeless veterans. I urge HUD to assure that veteran-specific programs are receiving a fair share of the funding that we are providing today.

I am also disappointed that testimony today will indicate that the ability of homeless veterans to achieve and maintain sobriety and emotional stability needed to overcome the problems which cause homelessness is being impeded by reductions in VA's substance abuse and mental health treatment programs and staff. I hope that our Veterans Health Administration will discuss today what steps will be taken to assure that homeless veterans are provided the substance abuse and mental health care that they so desperately need.

Like everyone here, Ms. French, Miss America, we are grateful for your testimony and your appearance today. I think your efforts throughout our country during your year as Ms. America should be seen as a quest to reclaim America's own humanity. When we avert our eyes from the homeless, when we turn our back on our veterans, we are really reducing our own humanity and I hope that we can recover that through your efforts this year.

I also want to thank someone else, from San Diego. I call her Miss San Diego, Lynne Heidel, who is the chairperson of our San Diego Center City Development Corporation. That downtown quasi-government agency has recognized the need for appropriate treatment facilities for seriously mentally ill homeless veterans, and they know that the need is not being met in San Diego today. I

hope today's witnesses will address ways of meeting this dire need of the mentally ill veterans for additional and better coordinated facilities.

So thank you Miss San Diego, thank you Miss America, and we look forward to your testimony.

Mr. QUINN. Thank you, Bob.

You have heard from the subcommittee chairs and vice chairmen and I would like to turn now to the full committee ranking member, Mr. Lane Evans.

#### OPENING STATEMENT OF HON. LANE EVANS

Mr. EVANS. Thank you, Mr. Chairman. I want to note that this is the tenth anniversary of the National Coalition of Homeless Veterans and how fortunate we have been here in Congress to have your assistance in those 10 years. That is also why I am joining Miss America in calling for a line item in the HUD appropriation to provide \$750,000 to the National Coalition on Homeless Veterans. These funds are needed and will be used to establish a program of technical assistance for providers that want to develop proposals to treat homeless veterans. So I look forward to the hearing today, Mr. Chairman, and thank you for yielding.

Mr. QUINN. Thank you, Lane, and thank you for your ongoing support during the year on these and other issues.

[The prepared statement of Congressman Evans appears on p. 51.]

Mr. QUINN. I would like to yield for a brief moment to Ms. Carson, who was with us earlier this morning and who is a steadfast supporter of ours when it comes to this issue.

#### OPENING STATEMENT OF HON. JULIA CARSON

Ms. CARSON. Thank you very much, Mr. Chairman and the members of the committee for having this hearing. I want to especially thank Miss America for being here today to have this issue before the eyes and ears of America and that America will not miss an opportunity that it is required to undergird the people who fought laboriously in the wars that preceded us here today and who are now constituting a great percentage of homelessness around this country, Indianapolis, Indiana, in particular, and I want to thank those who are here from my district, Indianapolis, to support you. As I was coming over this morning, people confused me with Miss America and I was very happy about that. (Laughter.)

I did not deny it, so you may have a problem. (Laughter.)

But we have been in the forefront of fighting for veterans on this committee, many of whom know firsthand, very personally, the plight of veterans in this country, homelessness specifically. Julia Carson is my name by marriage to a veteran of the Korean Conflict who was 100 percent disabled. Subsequently, a very short-lived, unfortunate relationship, marriage, with a young man who was a Vietnam veteran who I had known for over 30 years, but the man that I married was not the man that I knew, given the situation in Vietnam and the kind of situation that he found himself in when he returned to the United States of America.

I could extol all the virtues of the work that I have done in Congress on behalf of the veterans, but that is not necessary. I did it

from my heart. We have an institution in Indianapolis for which the veterans are very happy that I was able to create. There is a long list of things. There is a van running around with my name on it for veterans.

But I just want to tell you, people do not listen to Congress. I did not, either, until I became one. But they are going to listen to Miss America, a beautiful individual whose heart is in the right place and who is going to inspire this country to ensure that we as a country do not miss America's responsibility for veterans in this country. Thank you so very much for being here.

Mr. QUINN. Thank you, Ms. Carson.

The committee is fortunate to have Mr. Ron Shows on our full committee, who is one who helps us in all of our efforts, and I would like to yield to Mr. Shows at this time.

#### **OPENING STATEMENT OF HON. RONNIE SHOWS**

Mr. SHOWS. Thank you, Mr. Chairman and members of the committee. Ms. French, I was lucky enough to be at the press conference you had in Washington right after you got elected—got elected, I guess it is something we think about here. (Laughter.)

But after you won Miss America, and I was really impressed with what you said. My father is also a World War II veteran, captured at the Battle of the Bulge in World War II. I have also seen him go through trials and tribulation, not because of the people at the VA did not have the dedication, but because the money is just not there for them to operate. There are a lot of problems out there that we need to help with the veterans, and not only is homelessness one of them, but health care and insurance for the retirees and the veterans out there. They really have problems with these, and I really appreciate you bringing this one point to the attention of the country, and you will get more attention than we will, I promise you. Thank you, and it is good to have you here this morning.

Mr. QUINN. Thank you, Mr. Shows.

Finally, we are going to hear from the vice chairman of the Benefits Subcommittee, Mr. J.D. Hayworth from Arizona.

#### **OPENING STATEMENT OF HON. J.D. HAYWORTH**

Mr. HAYWORTH. Mr. Chairman, thank you, and it is an honor to be here at this joint subcommittee hearing. It is an honor to have Ms. French here representing all America in this plight. Theodore Roosevelt called the Presidency the bully pulpit, a chance to highlight problems, concerns, and offer solutions. In a similar fashion, Miss America 2000 utilizes her title and her crown as a crucible for advocacy. We thank you not only for pointing out a problem, because there tends to be a feeling in our society that if we just identify problems, that alone is virtuous. Well, that is only part of the equation, as we know. It is not only identifying problems but finding a way in a tangible, rational fashion to offer solutions and alternatives and it is in that spirit that we welcome you today, Ms. French, and look forward to your testimony. Thank you.

Mr. QUINN. Thank you, Mr. Hayworth.

I told you if we gave them all a chance, they would say something, did I not?

Ms. FRENCH. Absolutely.

Mr. QUINN. We are done with the introductions. Miss America, your full and written testimony may be submitted for the record and you may summarize, if you wish, your comments here this morning. You may begin.

**STATEMENT OF HEATHER FRENCH, MISS AMERICA 2000**

Ms. FRENCH. Thank you. Chairman Quinn, Chairman Stearns, members of the committee, I do thank you so very much for allowing me to speak before you today, and not only as Miss America 2000 but first and foremost as Heather French, the daughter of a disabled Vietnam veteran, also a Marine.

I must say that my first experience with veterans happened at age four. My father began taking me to VA hospitals at a very early age when he would receive treatment, and at that time, the VA was an all-day event. They used to have the bingo board from one to 1,000 and my father would go in and receive number 999 and it seemed at that time that it was a 4-hour wait.

But what I did in that 4 hours changed my life. In fact, in that 4 hours, I got a chance to listen to the most amazing stories, some of terrific victory and some of tremendous tragedy, and it was at that point that my father taught me the best lesson I have ever learned in my life, and that was where veterans are concerned, it is better to listen not just with your ears, but with your heart.

And as I grew, I never forgot that lesson and I started volunteering at a homeless shelter in Cincinnati, Ohio, and I learned there about the 275,000 homeless veterans that sleep on the street every night and it broke my heart. I had no idea that with 27 million veterans in this country there were some that were falling through the cracks. And although there is not one point that I can hit that is for full blame, it is this nation's responsibility to take care of those men and women.

We have long prided ourselves on never leaving our wounded behind, but the reality is, we have, and as Miss America 2000, I have chosen to be a bold advocate for those forgotten heroes. I have had the chance to travel across the Nation, 20,000 miles a month, one day off, getting to see all types of homeless programs for veterans, whether they are VA programs or community-based organization programs or to stand-downs, which are events that are coordinated by government agencies or community-based organizations. But, you know, the most important part of my year, I have been able to reach out and actually physically hold hundreds and thousands of veterans, veterans who have given their unconditional service for this country.

One such veteran, who is a friend of mine now, Ron Silvey from Kentucky, so graciously gave me the most precious gift I will ever receive this year, and that was his Purple Heart. He handed this to me to keep with me every day while I am on the road as a symbol of what our freedom is and that freedom is not free and that the red stripes on that flag are for the blood that was shed for our country. This is a symbol of the men and women we fight for.

I have gotten the chance to see the success stories, the Don Walkers down in the South who were formerly homeless veterans, now homeowners, now full-time employees, reunited with their

families. That is success and it happens every single day across the country. I have been able to see those programs that work.

But in order for them to work even more so in the future, we need access, access to substance abuse recovery, mental health programs, affordable housing, and employment opportunities. These men and women deserve this, and it is not as if we are donating our time or donating our money. They were given a promise that they would be taken care of for serving our country, and the reality is, it is time to pay them back and it is time to bring them home.

And what a year to do that in this new millennium, going into a new century. What better way to go into a new century than remembering our past. I believe it is Abraham Lincoln that once said, "A country that does little to remember its past will do little to remember in the future," and I think that hits the hearts of every U.S. citizen in this country.

I think that as I have gone across and have seen the 10,000 homeless women veterans, as well, who are living on the streets that it is time to create programs that can facilitate all needs of those veterans. And yes, there are more internal disabilities today than there are external disabilities. But these men and women are not just walking amputees, they are not just walking drug and alcohol abusers. These are Medal of Honor winners, Purple Heart recipients, men and women like your father, your grandfather, my sister, my brother, who are veterans.

I have my whole entire life been enriched by the experience I have had through my father, through seeing his struggles firsthand, and that has brought me so much closer to these veterans. And I can tell you that in my experiences of meeting and greeting these homeless veterans, that they are not just statistics but they are names and they have lives and they have souls. It has been a privilege to be able to go across the country and to see and greet them and to bring their stories back to you, to tell you that veterans do want help.

It has long been the myth that homeless veterans do not want help, they do not trust anyone. But the reality is, they do, and I have never seen such an outcry as I have seen this year, as I have seen in holding their hands and looking at their faces. And I can tell you that the most beautiful faces in America that I have seen are not ones with crowns on their head but they are the eyes of our veterans. Those are the most beautiful people in this country.

I have taken this crown across America as a symbol not just as Heather French who won Miss America, but as a symbol that each stone represents every veteran in the United States.

A veteran in the spinal cord unit down in Dallas, TX, came up to me once and he said, you know, if this crown represents me, can I pick out my stone? And I said, I would be more than happy to let you pick out your stone. However, all the big stones are taken by the Marines. (Laughter.)

But it would be my pleasure to let you pick out one of the smaller stones. But he wheeled up to me in his wheelchair and he pointed to this stone, the smallest stone in my crown and said, if I can just be but that sparkle in your crown, I would be honored. And I said, well, you do not understand. It would be my honor to be able to represent you.

So this year, there is a young woman who stands for veterans, who loves veterans and believes in their service, and I am encouraging you today that not just as a committee member, but as an American citizen, do not just listen with your ears but listen with your hearts. Take that lesson that my father taught me and honor those who did not make it home by serving those who did. It is the most precious gift that you can give them, is to bring them home in this new millennium.

So thank you so much for hearing my testimony, and I hope that as you hear the others after me and you get to hear about the tremendous efforts that are being made throughout this country, that you will know that this means community involvement. It means joint ownership. And it means it is time that—all of us sent them over there to war. It is going to take all of us working together to bring them home. It is time to sever those burnt bridges and to reconnect and rebuild true relationships between community-based organizations and government agencies because that is when success will happen. That is when we will be able to truly live up to the promise of never leaving our wounded behind. Thank you. (Applause.)

[The prepared statement of Ms. French appears on p. 55.]

Mr. QUINN. Thank you very much, Ms. French. We would ask you to stay for a minute or two for some brief questions from the members of the panel and then you can be on your way. Like all witnesses, we keep you for a few minutes later.

Ms. FRENCH. That is all right.

Mr. QUINN. Thank you so much for that compelling testimony. We, of course, have your written statement with statistics, numbers, and some of the other things we will hear this morning, but to hear it from you and from your heart means as much to us as it does to all those veterans across the country.

I can tell you that yesterday, just yesterday here on the House floor, the full membership of the House voted on a resolution to remember Korean veterans in this Congress and in the country. With the help of you and other members, I intend to challenge members of the Veterans' Affairs Committee this year. Indeed, I think we need to challenge all the members of the House and the U.S. Senate to stand up for the things you talked about this morning, to make certain that 275,000 veterans are not asleep on the streets and in boxes and on grates.

You know, what is interesting is we will go to the floor, the floor of the House, and talk about things like our action yesterday and others, and those are the right things to do, of course, and we are here to do those things. But when we talk about homeless veterans, you are correct, it is a person and a face and a voice with feelings and sometimes pain, and it is not an activity that is happening in another country, away from our soil. We are going to deal with a trade issue in China. We have dealt with defense issues, where we send money elsewhere, foreign aid. Land mines are an issue for me, and that is in another country. That does not happen here.

But I challenge any member of this House and Senate to go home to their district on any weekend and come back and tell us there are not veterans sleeping on the streets. I challenge them to do that this year with your help and your reign. And I challenge

them to come back here on Monday and Tuesday, then, seeing and talking to those veterans in their own districts, on their streets, in their buildings where they attend meetings and the churches they go on Sunday, and then to come back here on Monday and Tuesday and Wednesday and Thursday when we vote and to not turn their back on those people.

Actions speak louder than words, and with your help and the rest of the subcommittee, we intend to challenge the people in this House to stand up for the money that is necessary to have it done.

Ms. FRENCH. Thank you.

Mr. QUINN. We thank you for your comments this morning.

Ms. FRENCH. Thank you. (Applause.)

Mr. QUINN. I yield for a question at this time from the chairman of the Health Subcommittee, Mr. Stearns.

Mr. STEARNS. Thank you, Jack.

Miss America, I think like most of us in this room, we were touched by your sincerity and your presentation. In your written testimony, you made reference to the fact that only 2 percent of HUD's funds go to veteran-specific projects, and so is it possible I could have you elaborate on that? It seems to me that HUD might adopt a veterans' preference or a veterans' set-aside to assure that perhaps considerably more than just the 2 percent of HUD funds go to veterans, because we can come this morning and talk, as I have—this is my 12th year in Congress, serving on the Veterans' Committee for 12 years, and we can come and talk about this, but the bottom line is going to be getting the funds, getting the resources, getting the partnerships across this country to eradicate the tragedy of homeless veterans living in the boxes and living on the streets. I think in Washington, DC, in the winter, as many of us have seen when we go back to our apartments, we will see the grates and we will see veterans actually living on the grates with all their belongings.

And so towards a solution, I might ask you just to elaborate a little bit on your idea of increasing the HUD funds above the 2-percent level, if you would be so kind.

Ms. FRENCH. Well, you know, I just think it is a shame that our veterans make up 23 percent of the homeless population and 33 percent make up the male homeless population and less than 2 percent goes towards veterans. I think that that is an issue. Of course, first and foremost, I believe that veterans should be taken care of first and foremost, because they, above all other citizens of the United States, were willing to pay that ultimate sacrifice, to go into battle and to die for our country.

So I have a real problem thinking that we have to fight for funding for homeless veterans. I think that they should have preferential treatment in the homeless population because it was not entirely their fault they wound up that way. These men and women did not come back home the same, and I can speak from experience of my mother talking about my father. She said, when he came home from the war, that is not the man that I married. Something happened to those men and women. They have seen worse things in their daytime than we have seen in our nightmares, and that is why I think HUD has to pay special treatment to those men and women because the government owes it to them.

And I think that a larger percent of that funding should find its way to homeless veteran-specific programs.

Mr. STEARNS. Thank you, Mr. Chairman. Thank you, Miss America.

Ms. FRENCH. Absolutely.

Mr. QUINN. Mr. Filner.

Mr. FILNER. Once again, I want to thank you for helping this Nation focus on an issue that it would prefer not to. Again, your travels and your passion for this is going to do a lot of good.

I know there are probably rules about Miss America's participation in politics, and I do not want you to get partisan or specific, but I hope as the year goes forward you will comment on the adequacy of legislation that is going to be produced, on how important votes are in certain regard. I hope you will not shy away from the process.

I do not know what the rules are for being Miss America, and I do not expect you to comment in a partisan nature, but if legislation is not adequate, I hope you will say that. I hope you will get people to understand that they participate in this process, too. That is, when we in partnership with you put in the legislation, it goes to a subcommittee in the House. I hope you will educate people out there about their ability to affect that process and get involved in it, because you have that ability more than most people in this country and you can show them how their efforts can have political consequences and results. So I hope you will, as the process proceeds, not shy away from commenting on that process.

Ms. FRENCH. Thank you, and I will not shy away. In fact, I have encouraged all the veterans I have come across to be very proactive in their political stance, to write letters to their Congressmen and women, their Senators, because even if ten letters fall on their desk, that makes such a big difference. And even encourage them to vote. With 27 million veterans in this country, that is a large voting population and they can make a difference. I think that with their distrust in the system, that traveling as much as I can, I try to impart in them to once again gain trust by taking hold of their responsibility for that. So thank you. I will continue to do that.

Mr. FILNER. And I would urge you to advise the folks you come into contact with, these letters to us are very important. But I would also say, I have a little law that I give to my own constituents: "However you communicate with a public official in private, find a way to do it in public." That is, whatever letter you write, write a letter to the editor. If you make a phone call, get on the talk shows. Go to the PTAs, the churches, the service clubs. Get them involved because we respond to that public opinion, believe me. It is a lot easier to lobby us, but the real hard job is to lobby the American people, and when they change, we will change.

So I hope you will get them into that public process to let us know that this is something that right now we can do. We have the resources to do this. This is difficult, but this is not rocket science in the sense that we do not have the resources, we do not have the knowledge. We have all that. It is the question of commitment and will, and I thank you again for strengthening the American will to deal with this.

Mr. QUINN. Thank you, Mr. Filner. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

In all your travels, and I assume you are going to get to more homeless clinics than any member of this committee probably will have time to get out to, and I appreciate that, but what have you seen as a successful program in terms of features that you look towards to establish a good program?

Ms. FRENCH. What have I seen so far?

Mr. EVANS. Yes.

Ms. FRENCH. Oh, there are a number, and I have to apologize for those listening if I forget to mention your particular program. But the ones I have seen that have made a tremendous effort in putting nonprofit and for-profit together to combat this disease would be, of course, L.A. Vets, U.S. Vets. The National Coalition for Homeless Veterans has done a tremendous job in working with them.

I was in Hawaii where they are opening up a new veterans center down there called Barbers' Point, which will be sort of the one-stop shop. We will be able to take care of veterans' needs in a comprehensive facility. The New England Shelter for Homeless Veterans has done a tremendous job in putting training in the hands of these homeless veterans, so that you are not just taking care of temporary fixes but more permanent solutions, where education and training are, I think, are in the most dire need.

I think that MCVETS, which is sort of in your right back door, the Maryland Center for Veterans Education Training, Colonel Williams has done a tremendous job with that facility. I mean, as young as it is, about 6 years old, I believe, I visited that facility as Miss Kentucky. That was my first facility I got to see on a national scale, and I must say that it had been to me at that time the national role model for how centers should be established because he has gone after that with such fervor and with such belief that the men and women in that facility have been tremendous success stories.

So I think those are just a handful, but you are talking about programs all across the country. In most every State, there is a program that is working. And again, I apologize for those of you in the audience if I have forgotten to mention. I have done so many, and every day I am in a different city and get to see specific programs that are working and I would be more than happy to give you a list of those.

Mr. EVANS. I hate to get partisan by any means, but I think the Marines in this audience today have been uncharacteristically silent when we mentioned your father, so could all of them join me in saying *semper fi*.

Ms. FRENCH. Thank you.

Mr. EVANS. Please stand up and be heard. There are no Marines in this audience?

Ms. FRENCH. They stay very quiet sometimes. (Applause.)

Mr. EVANS. Thank you, Mr. Chairman.

Mr. QUINN. Ms. Carson, a question at this point?

Ms. CARSON. We really can deal with it. Yesterday was Domestic Violence Day. In Indianapolis, we have an inordinate number of homeless veterans who are violent through no fault of their own, and I was just going to ask if you had seen any specific program that dealt with that, because I know we had to go out on the street

and literally drag in people for medical attention. Do you know of a program that deals with the violence of the homeless veterans?

Ms. FRENCH. I have not come across a program where that is a specific need, but I do know programs that do an extraordinary service by reaching out to veterans to bring them in, veterans who do not want to come in and are in constant contact. I have been to several VA hospitals that have outreach programs that are very successful, as well, and I think that they need more hands.

That is why I say funding is the biggest issue, because with 275,000 homeless veterans, there is going to be a percentage that do not trust the facilities and do not want to come in, but it is going to take more hands to get out in the streets to bring them in. I think there are several programs that do a successful job at doing that, going out and hunting for those men and women.

Mr. QUINN. Thank you.

Mr. SHOWS, a question?

Mr. SHOWS. Not really a question, but just something I would like to request you to do for me. Watch what we do with the budget surplus. I am telling you, we have been telling people all these years we have not had the money to help.

Ms. FRENCH. And now we do.

Mr. SHOWS. We have got military retirees and health care benefits taken away from them when they are 65. We have got our veterans' hospitals that need help. We have got outpatient centers that need help. And for one time, we do have additional money. So help us and encourage us sometimes. We may not be putting this money where we need to be putting it. But I appreciate you being here today.

Ms. FRENCH. Thank you. It is a concern that I have heard across the country, that success for us and those are our veterans. So I can tell you now that people say we live in peacetime and we live in good days. I am not so sure that that is exactly true.

Mr. QUINN. And if I may, Ms. French, on top of that, for the programs that are operating, and Linda knows this and can prove it everywhere across the country for what works, if we had the money to spend for it, we could prove it was working. We already know that it works. Bob Filner is right. We have the wherewithal to do it. We just need to have the intestinal fortitude to spend it the right way.

We thank you again and I thank the members here. We have been called to a vote, and just so that the other panels are aware of it, the timing was perfect for you. Heather, this works out just great. We are going to recess here. We have two votes on the House floor, a 15-minute vote which is about halfway over now and a 5-minute vote. We are going to recess and come back in about 20 minutes.

Ms. FRENCH. Excellent. Tell them all I said hello.

[Recess.]

Mr. QUINN. Good morning, and please accept our apologies for the interruption. We have been told that we are good for about an hour or so before we are interrupted again for more votes on the House floor, and that will be one vote when it happens. My recommendation is that we get to it with our second panel this morning.

I would like to welcome Dr. Fran Murphy, Mr. Peter Dougherty, Ms. Estella Morris, Ms. Henrietta Fishman, and Mr. Angel Caban. I mention to our witnesses this morning that we are operating under the 5-minute rule, as you are aware. Your full written testimony has been accepted and will become part of the record and we would ask you to summarize this morning in 5 minutes or less.

If it is okay, Mr. Dougherty, I am going to start from that side of the table and work my way this way.

Mr. DOUGHERTY. Thank you, Mr. Chairman. I thought I was going to be here to help answer questions.

Mr. QUINN. You have answered the first one. Next?

(Laughter.)

Mr. QUINN. Dr. Murphy.

**STATEMENTS OF FRANCES M. MURPHY, M.D., M.P.H., VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY PETER H. DOUGHERTY, DIRECTOR, VA HOMELESS PROGRAMS OFFICE, DEPARTMENT OF VETERANS AFFAIRS; ESTELLA MORRIS, LCSW, PROGRAM MANAGER, VA COMPREHENSIVE HOMELESS CENTER, CENTRAL ARKANSAS VETERANS' HEALTHCARE SYSTEM, LITTLE ROCK, AR; AND HENRIETTA FISHMAN, DCSW, CASAC, VISN 3, HOMELESS VETERANS TREATMENT PROGRAM, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ANGEL CABAN, MSW, SOCIAL WORKER, VISN 3, HOMELESS VETERANS TREATMENT PROGRAM, DEPARTMENT OF VETERANS AFFAIRS**

#### **STATEMENT OF FRANCES M. MURPHY**

Dr. MURPHY. Mr. Chairman and members of the committee, thank you very much for giving us the opportunity to discuss homelessness among veterans and VA's efforts to address homeless veterans' needs. Accompanying me this morning are Ms. Estella Morris, Program Manager of the Comprehensive Homeless Center of Central Arkansas Veterans' Healthcare System, Ms. Henrietta Fishman, Manager of the Network 3 Homeless Veterans Treatment Program service line, and you have met Pete Dougherty, who is the Director of Homeless Veterans' Programs. Mr. Angel Caban, formerly a homeless veteran who now serves as a supervisory social worker for Network 3 Mental Illness Research and Education Clinical Center, is also here with us today.

I will keep my comments short. I know that our time is precious this morning, and so I would ask that my entire testimony be entered into the record.

Mr. QUINN. Without objection, so ordered.

Dr. MURPHY. My testimony is pretty dense with statistics, which I think are important for an understanding of the magnitude of the problem that veterans have with homelessness. Because of that, VA has developed a wide range of programs and services to address homeless veterans' needs. These programs operate in partnership with community-based organizations and service providers and other federally-funded programs.

With the additional funding made available during this budget year, we will be able to significantly expand our homeless programs

and we plan to initiate new program evaluation efforts as required in the Millennium Act. While many special programs have been designed to address the special needs of homeless veterans, they do not function in isolation. It is important that they be incorporated into the comprehensive health care that we provide for veterans and also to be coordinated with the benefit services that the Veterans' Benefits Administration administers. In addition, VA relies heavily on its Federal, State, and community-based partners to assure that a full range of services are available for homeless veterans.

A number of speakers this morning have mentioned the magnitude of the problem among veterans. The Urban Institute's most recent report from February has estimated that between 300,000 and almost 500,000 veterans have experienced homelessness during the year of 1996.

The Veterans Health Administration is the largest integrated health care system in the country and has a primary mission to provide health care services to these veterans. For that reason, it is appropriate for VHA to take a lead role in homeless veterans' programs. As many of you recognize, in the majority of veterans, health problems are one of the underlying causes of homelessness. Eighty-one percent of homeless veterans were determined by our clinicians to have serious psychiatric and substance abuse problems. Up to 43 percent had serious mental health problems, 69 percent had alcohol and drug abuse problems, and 31 percent were dually diagnosed with those problems. So it is important for us, in order to be able to provide adequate health care services to those veterans, to be able to address the full range of the needs of homeless veterans.

I would like to take just a moment of your time to tell you about some of the ways that VA will significantly expand its program during the next year. VA is the only Federal agency that is currently providing substantial hands-on assistance directly to homeless persons. VA, using its resources or in partnership with others, has secured more than 8,000 transitional or permanent beds for homeless veterans throughout the Nation.

During this year, VA has increased funding for specialized services to homeless veterans by \$50 million. About \$40 million of that will go directly into the medical care appropriation, and the remainder will be available for the guaranteed loan programs under the multi-family transitional housing for homeless veterans programs.

In addition, VA will expand its homeless veterans programs in the year 2000 and under these programs, new staff and new programs that become fully operational are expected to treat 12,000 additional homeless veterans. Approximately one-third of these veterans will be provided care under contract residential treatment.

This year, VA will establish ten new programs dedicated to homeless women veterans. These programs are expected to serve 1,500 homeless women veterans per year.

In addition, VA expects to participate in 200 or more stand-downs, and through these stand-downs to provide homeless veterans, about 100,000 homeless veterans, services at these events.

In addition, VA is committing \$11 million to additional funding to the grants and per diem program and we estimate that 20,000 homeless veterans will receive services funded through the grants and per diem programs in the year 2000.

In conclusion, I would like to say that there was no glamour in these programs before Miss America took on this issue and shined a very bright light on these important programs and the needs of our veterans. But despite that, Mr. Clinton and the current administration have strongly supported the expansion of programs within the Department of Veterans Affairs, and I also want to recognize the efforts of this committee and the bipartisan support that these issues have received in Congress. With your help, we have been able to get the authority and the resources to provide these needed services to veterans, and I think that they are truly doing what you intended them to do.

VA Healthcare Services and other benefits programs form the core elements of a wide range of medical, work therapy, rehabilitation, transitional housing, and benefits programs. This is a large problem that VA recognizes it cannot solve alone. With the assistance of our community-based partners, veterans' service organizations, and others who are bringing thousands of veterans off the streets and into a continuum of care that offers them the health care and support services that they so desperately need.

The Department of Veterans Affairs is proud of its past contributions to homeless veterans' programs and we are also extremely proud of the talented, dedicated staff who work on these issues daily. Some of them are here today to tell you about their programs.

With that, I would like to conclude my testimony this morning and would be pleased to answer any questions that the committee may have.

Mr. QUINN. Thank you, Dr. Murphy, and I know I do and others have some questions for you. We appreciate you making it under the red light button there on your desk. Thank you.

[The prepared statement of Dr. Murphy appears on p. 60.]

Mr. QUINN. Ms. Morris, will you be next?

#### STATEMENT OF ESTELLA MORRIS

Ms. MORRIS. Yes. Chairman Quinn, Chairman Stearns, committee members, it is my pleasure to be here today to speak with you about the success of the homeless programs in Little Rock. The homeless program in Little Rock was one of 43 original programs that were implemented by the VA in 1987. Since then, we have been identified as one of the comprehensive homeless centers, providing a wide array of services to homeless veterans. In 1996, we moved to a community location where we could better provide services to homeless veterans and be more accessible to them and offer services outside of the medical realm, offer psycho-social type assessments, health care assessments, the ability to come in and use shower and laundry facilities and other services that homeless veterans need.

The primary goal of our comprehensive homeless center is to expedite the movement of veterans from the streets to permanent housing. In 1987, our innovative approaches to meeting these goals

resulted in our being named one of six clinical programs of excellence. In 1999, we again received this 2-year designation. We use a social treatment model that focuses on the strength of our veterans, and after 12 years, we take pride in knowing that we have consistently provided services of exceptional quality that adhere to the highest standards of health care, patient satisfaction, resource utilization, teaching, and program evaluation.

Our focus is on meeting homeless veterans where they are and helping them to address their needs in an environment that is conducive to their lifestyle. Without being enabling, we strive to be nonjudgmental in our manner and supportive in our services. This is especially important for veterans in housing, as we believe that those veterans who have been homeless in the past are at greatest risk of being homeless again in the future. Their satisfaction and continued success means that we have achieved some level of success in understanding what we need to do to move veterans from the streets to permanent housing.

I could cite years of documented evidence of the quality and quantity of services provided to homeless veterans in Little Rock. However, you should understand that my appreciation of the value of VA homeless programs moves beyond what I as a clinician at the VA homeless program in Little Rock have experienced over the past 13 years. I am the second oldest of 14 children, seven boys, seven girls. My youngest sister became homeless in Atlanta about 4 years ago, and as a result of that, she had to receive services from the VA homeless program in that area. She has since that time been stable and in permanent housing now for about 4 years.

A younger brother who experienced a traumatic head injury while completing a tour of duty in Germany during the period of the Vietnam War also became a homeless veteran. As a result, he suffered migraine headaches and a severe sleep disorder marked by aggressive nightmares and pronounced insomnia. With no solution to his problem in sight, he turned to alcohol as a means of self-medication while living with me in Little Rock. The final straw came one night in 1985 when in the middle of the night I had to wrestle a hunting rifle from him when, in a fit of anger, he was about to go next door as a result of an argument with a neighbor and enter into an act that would undoubtedly have landed him in jail, or even worse, dead. That was a point when I as a family member had to say to him, you have to go and get help.

As a result, he relocated to San Diego with other family members, and while there, he learned about a brand new VA program that had started in the area from other homeless veterans who were living on the street where he ended up living for about a period of 8 months. He entered the program in San Diego and became one of the first graduates of that program and subsequently went on to work in the first stand-down that was held in this country. He credits that program for saving his life, and I do, too.

Mr. QUINN. I am sorry to interrupt you, but one of the organizers of that program from San Diego is right here, and we want to thank them for all the work that they have done. Al, would you stand up?

Ms. MORRIS. Yes, and I did speak to him this morning. (Applause.)

I have thanked him this morning. I really appreciate what they did. As I said, there is a lot that I can say as a VA employee, but what I experienced personally means so much more to me.

The success of the homeless program in Little Rock is highly dependent on the quality and dedication of the staff we employ and the genuine caring that we have for homeless veterans. However, much of what I do personally I give to homeless veterans in Little Rock as my way of saying thank you, thank you to the homeless veterans but also thank you to those clinicians from homeless programs stretching from the East Coast to the West Coast who extended a hand out and helped my brother and my sister to survive, to stand up, and to move forward in their time of need.

Again, I thank you for having me here. This concludes my statement. I would be pleased to entertain questions from the committee.

Mr. QUINN. Thank you, Ms. Morris, for both your perspective as an employee and also your personal story today.

[The prepared statement of Ms. Morris appears on p. 71.]

Mr. QUINN. Ms. Fishman.

#### STATEMENT OF HENRIETTA FISHMAN

Ms. FISHMAN. Mr. Chairman and members of the committee, it is indeed an honor to be here with you today representing the Network 3 Homeless Veterans Treatment Program Service Line. Within Network 3, which includes all of Southern New York and New Jersey, we have all of the specialized homeless treatment programs, ranging from outreach to treatment to rehabilitation, vocational rehabilitation, case management, transitional housing, and HUD-VASH permanent housing with long-term case management. In addition, we have a range of innovative partnerships and programs that have won national awards. Within our network, the very first VA drop-in treatment center project, TORCH, was originated, as well as Project Pride, which is a multi-agency program to provide vocational rehabilitation and job training in lieu of workfare so that veterans can return to productive lives in the community.

It is a joy to be here to be able to thank you for your support of these programs and to tell you a little bit about what is going on, what we are concerned about, and what we are proud of. Clearly, in the move from our facility-based programs to a network approach, what we have done in Network 3 is integrate our homeless programs into a network so that we really do have a seamless continuum. We look at our programs as one VA network of programs, so that if a homeless veteran has the bad luck of being homeless in an area where there are no specially funded programs, they are brought right into the mainstream to all of these programs, the goal being to really improve access to quality care.

Our network director, who has been beleaguered with our very obvious financial problems, Jim Farsetta, has made taking care of homeless veterans a priority in our network, to assure that homeless veterans receive one standard of care, that they receive the same quality treatment that any other veteran coming into the system receives. This is at some cost in that the recurring money for our homeless veterans' programs is part of the VERA allocation,

and it comes at a time of shrinking resources when we do have some concerns about where these programs will be in the future because of the competition for resources and the demand for the programs within our own infrastructure. We are very, very delighted that Mr. Evans has made mention of this in his testimony because it is something that is of concern, I think, not only within our network but across the country.

We face many challenges with the move to providing outpatient services. Those challenges are particularly noticeable when we look at homeless veterans who are homeless, and it is extremely difficult for them to come in for the excellent outpatient treatment services that we provide without safe, adequate housing to really take care of them while they are receiving services and give them the support that we needed.

There are many, many strengths certainly in our network, but in many others. We have an unusually caring and talented staff who push the envelope, and we like that. We like them not to work in the box. The only thing that really annoys us is that people do not really go out there and try something new. The worst that could happen is we fail. But at least out of that has come some really exciting programs and ideas, because we do not have the answers to curing homelessness and we have to keep trying.

We are proud of our programs and proud of the awards because the programs are really veteran-focused. They are not staff-focused. The focus is on what our veterans need to get their lives together. We are also proud of our partnerships with the community and the role that we are able to play in providing what we believe to be totally top-line services of excellence with all of the VA help that is provided.

But I want to make a point that so far has not been made, and I think it has to be stressed. We are particularly proud of the homeless and formerly homeless veterans who work side by side with us as a team. We have a network-wide Veterans' Advisory Council. They keep us honest. They tell it like it is, and they have been a driving force in really helping us look at what are the needs and what are the issues, and they work with us as volunteers. They work in our programs. They work with us to do peer-assisted case management.

Briefly, we are finding veterans are sicker. They are on the streets longer. They need longer runways for services. We need more help with HUD services. This has been talked about. We need more access to foreclosed property. We really do need to look at some of the issues with our middle-aged veterans from Vietnam and the barriers to employment, because our veterans very often are getting older.

But you know, the main thing I want to say in closing, with the challenges and the help we need, the excitement is that we take veterans who have lost hope, who do not know what hope is anymore, and we help them begin to dream, and we help them as a team to achieve dreams beyond their wildest hope, and one of those veterans is here with us today, Mr. Angel Caban.

[The prepared statement of Ms. Fishman appears on p. 77.]

Mr. CABAN. Thank you. My name is Angel Caban and I work alongside Henrietta, a formerly homeless veteran. It was not a long

trip for me from my place of residence, which was the A train, to the VA. I was hopelessly addicted to alcohol and drugs, sick and dying when I went into the VA. I met some wonderful professionals who extended a hand, a hand up, not a hand down.

I started my rebirth, if you will, 11 years ago. I had a GED. I completed work at Long Island University for credentialing in alcohol and substance abuse counseling. I received my undergraduate degree from Queens College. I received a master's in social work just last December. I have been working for the VA for the past 8 years. I have been paying taxes. I paid my own way through school. The VA did not pay my way through school, I did.

I would like, and I hope to speak for all veterans. I am from a family of 13—seven brothers. Four served in the military. Three became homeless, myself, my brother Danny, a Vietnam veteran, 25 years suffering PTSD, would not visit the VA. It took me to come around to get him to come around 3 years ago. He is now in his second year of college, and I am prouder of him than I am of myself, so I wanted to mention that. Another brother died in the street. He did not make it.

I am honored and proud to work with the veterans. I just had a meeting with them and told them I would be here. I was telling them that there is a circle and we tend to stay outside that circle and point our fingers and say, it is their fault. We like to externalize. It is their fault. They did not give me this. They did not give me that. I urge them, and I say, do as I did. Come in the circle and work from the inside, and that is what I hope I am doing at this time. Thank you.

Mr. QUINN. Thank you, Mr. Caban. We all appreciate very much your—

(Applause.)

Mr. QUINN. Thank you, and congratulations, as well. I think that, more than anything, we understand now, as we mentioned in our first panel this morning, that this is not just a problem of homelessness, that most often we know we are talking about medical problems, we are talking about alcohol problems, drug problems, marital problems, family problems, and it cannot be approached as a single solution of just a house with doors and windows and so on. It is a multi-faceted problem and needs to have a multi-faceted solution and that has come home loud and clear.

We are going to hear later in one of our panels from a good friend of mine, Doug Haywood from Buffalo, NY, the Western New York Housing Coalition, who talks there—we have talked about transitional housing as well as permanent housing, as Ms. Morris pointed out here this morning. So we need to take that approach and you are a stunning example of how it can work, so thanks for doing that.

Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. Thank you all. Many of you who may hear other panels during the year have heard me say to certain VA officials, let us have some passion here. Let us have some real enthusiasm for the programs because it is real people we are serving. We get a lot of real bureaucratic, do I want to say mumbo jumbo? No, I will not say that. But I thank you all for giving us some passion, for giving us some stories. I hope, Ms. French,

that you are having this influence on everybody around the country, that we are talking about issues that are real, about real people, and we have to get that emotion and passion in it.

I certainly do not question any of your commitment or the success stories that we have had. If you stay for the later panels, you will hear some testimony about some of the, I guess, not so successful approaches or results. It seems, and Dr. Murphy, maybe you want to comment on that, that there are, in various locations, cutbacks in substance abuse and mental health personnel.

I can tell you, in San Diego, which we will have testimony on from Ms. Heidel and we also have our council member from San Diego here, Valerie Stallings, thank you, Ms. Stallings, that we have 1,900 severely mentally ill homeless persons and only 63 beds available to deal with them. That is not a VA situation but those are the statistics in San Diego.

In Massachusetts, the central part, there are no VA substance abuse or mental health counselors for veterans in the homeless shelters. Floridians say that some of their programs do not seem to be able to work with the VA. The VA is not being cooperative there. There will be testimony on various places at various times, so there seems to be an unevenness. There does not seem to be a national priority on this issue. Various places are doing things differently, so we need to hear from the top down that this is a priority.

But is what I am saying a fact and what are you doing about it? Do you need more resources to cover this? Do you need more internal management directives to make sure the regions are doing the thing with the highest priority, or a high priority?

Dr. MURPHY. The current situation with substance abuse programs, to my knowledge, in general terms is that we are seeing more than 10 percent greater numbers of veterans in those programs. There has been some consolidation. We are moving away from inpatient substance abuse programs to outpatient substance abuse programs, and with that, the resources have changed and potentially there have been some changes in the number of FTE in various program areas. We have focused on the quality outcomes for those programs and we are trying to assure that veterans who need access to those programs get substance abuse treatment and get mental health services.

Clearly, there have been some problems in some areas of the country. I cannot speak to the specific situations that you have mentioned, but I can look into them for you.

(Subsequently, the Department of Veterans Affairs provided the following information:)

VA has identified services to homeless veterans as a high priority.

With respect to the specific situations that Mr. Filner mentioned in San Diego, central Massachusetts and Florida, The following information is provided:

- Over the last 6 years VA has committed \$41 million to assist State and local governments and nonprofit organizations develop supported housing programs and supportive service centers across the country through VA's Homeless Providers Grant and Per Diem Program. When these projects are complete, more than 4,000 new community-based beds will be available for homeless veterans. Nearly 25 percent of these new beds are being developed in VISN 22, which covers southern California and parts of Nevada. In the San Diego area, VA has provided \$1,968,759 to support the development of 6 projects. When these projects are fully operational 154 new beds and a supportive service center will be available for homeless veterans.

- VA's Outpatient Clinic in Worcester, MA provides clinical care for veterans in the central part of Massachusetts, including homeless veterans who are in shelters. Currently, there are two mental health staff available at the clinic to meet the mental health treatment needs of veterans in the area. The Director of the VA Boston Health Care System has indicated that two additional mental health staff will be assigned to the Worcester clinic in the near future.

- During the past 6 years, VA has awarded 9 grants totaling more than \$3.0 million to community organizations in Florida. These awards are expected to create over 200 transitional housing beds for homeless veterans. Grant programs require VA collaborations and partnerships with community organizations from the development to the implementation of the projects. Staff of VISN 8 homeless programs have been active in helping community agencies secure grants by identifying existing gaps in service provision for homeless veterans and working with local providers to address those identified community needs.

Mr. FILNER. But has there been a cutback in personnel either because of budget situations at the top or because of the way the regions are prioritizing their needs? The anecdotes, by the way, should not be dismissed just as somebody's story. They are the front-line information from people who are dealing with the issue every day, and I take them very seriously as closer to the truth than something I may read in a report. I have learned in 20 years in politics to trust what people tell me in terms of their actual experience as opposed to generalized statements from Washington.

Dr. MURPHY. I believe that I did not dismiss them. I said that they were important and we would look into the specific instances that you mentioned. There is a commitment to maintaining quality mental health care and quality substance abuse care. We also have an initiative underway to improve access to care. This initiative will ensure that any veteran who needs specialized services can get an appointment within 30 days, including substance abuse treatment.

There may have been some problems with the flatline budget in the past. However, VA's budget is good this year and we are encouraging our network directors and our facility directors to hire frontline health care workers where there may have been cutbacks in the past, and that would include in the specific program areas that you are mentioning.

Mr. FILNER. I want you to stay for the panels that are coming. I have read their testimony. I get a different picture from reading and listening to folks from my own district and organizations and our city council and our downtown redevelopment areas trying to deal with the issue, and they do not get the same sense.

That is, if somebody walks into a VA facility and they are told that unless you are sober for 6 months, we are not going to treat you, that does not sound to me a very reasonable approach to this issue. And yet, does that come from policy? Does that come from a shortage of resources? I cannot tell from what you are saying.

But I want you to listen to this. I think it rings true to me, and if it is more resources, then we should be asked to try to provide that. If it is a management situation where people are not getting the same directives or they are acting differently in different places, then you have to make decisions on a management level. But I would like you to take these very seriously as the day goes on. Thank you.

Mr. QUINN. Thank you, Mr. Filner. (Applause.)

Mr. Rodriguez.

## OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Let me first start off by apologizing because I have another meeting that started about an hour ago and I need to go to it. I want to thank you for the type of work that you are doing, but I also just want to quickly cut to the chase. Apparently, we are not doing enough, and it might be in some communities, but it is not across the entire system.

What I am asking from the VA, and I know, Mr. Caban, you mentioned that we have a tendency of displacing blame, and as politicians, we do that a lot, but I am telling you that I feel a responsibility that we are not doing enough, either, and there is a need for us and there is a need for the VA to let us know what needs to occur to make sure we fill those gaps. Yes, we have some beautiful programs. I was glad to hear about Little Rock and some of those programs. But apparently we do not have those throughout the country and there is a need to. If we have that many homeless, then we are not doing our job yet.

In the area of mental health services, there is no doubt that when we established the community mental health centers that we would no longer have those situations throughout this country. We have too many people falling through the cracks.

I guess I am appealing to you to please let us know what you need. I know we kicked in \$1.7 billion last year. We are kicking in \$1.5 billion this year. If that is not enough, please let us know.

Let me also just share with you, I have a real problem with when you come up with a situation with the homeless and you have a medical model and you try to reach out. We need a community model. The same people that work in those settings are not the same people—

(Applause.)

Mr. RODRIGUEZ. The same mentality that exists in the hospital situation and that mentality are not the same kind of people that you need to utilize to go out and do the outreach and get below those bridges where those individuals are at to reach out.

So please, I appeal to you, let us know if you need more caseworkers to go out there to reach out, if you need different types of mechanisms. Apparently, we do have some beautiful programs out there. Let us see how we can duplicate those programs. It is embarrassing for us to have our veterans out there homeless and we need to do everything we can to reach out to them.

I know that I am talking to the choir, but please. I have been here 3½ years. I want to be able to say that we can start pushing forward on some of these things and some of these programs for these individuals and at least provide those opportunities. It is up to them to take advantage of them, but in some communities, we do not even have those opportunities.

I know that you have heard me say this, but I think we need to do a lot more than what we are doing now and we need to feel frustrated and angry, just like some of them do. When I first started, I can just give you one analogy. I remember my VA telling me, oh, Mr. Rodriguez, we did away with caseworker positions because now we have got a new system that is more responsive. We have got a 1-800 number. Well, I tell you, I tried calling that and that did not work. And if you have people that are mentally ill, they are not

going to call. You need to outreach. They are not going to come for an appointment. You need to outreach. So please keep on that. (Applause.)

Mr. QUINN. Now there is a man that is serious about outreach. He makes a statement and then goes and does it. I am with him. (Laughter.)

We appreciate the work, even in his absence. He did not give me a chance to talk about it, but Mr. Rodriguez is a great member on the full committee and a great help to us, and we appreciate all of his input.

I am going to take the liberty and exercise the prerogative of the chair and change our schedule here for just a bit as we release the second panel and before we get to the third panel. We are really lucky today to have one of our leaders in State government here across the country, the Governor of Wisconsin, Governor Tommy Thompson. Governor, I would like to ask you to come to the front and be introduced and say a few words. (Applause.)

Governor THOMPSON. Thank you so very much, Chairman Quinn. Mr. Filner, thank you very much for giving me this opportunity.

Mr. QUINN. Well, Governor, I have to tell you, you know that Mr. Boland will be testifying later, and he has been up on the Hill to testify for us before, and he's one of your shining stars there in the State of Wisconsin. I know you know that. And I also know that we talk here—and Miss America, who, if you have not met her, will say hello to you on your way out.

Governor THOMPSON. She was in Milwaukee to see our program.

Mr. QUINN. I tell you, we are lucky to put the right people together, and we are happy we could take the time to hear the great successes in Wisconsin. Please proceed.

#### **STATEMENT OF HON. TOMMY THOMPSON, GOVERNOR FROM THE STATE OF WISCONSIN**

Governor THOMPSON. Well, thank you so very much, Mr. Chairman. Let me just start out by thanking you for holding this hearing. It is a wonderful thing, and I appreciate this very much.

I am here, ladies and gentlemen, to lend my support to the National Coalition for Homeless Veterans. I also appreciate the support this Committee has already done, and continues to do the heard work that you are doing.

Several years ago—as you have already introduced my very good friend and my Secretary of Veterans Affairs, Ray Boland—he approached me with this idea of creating a veterans' assistance program for homeless veterans, the first state, I believe, in the country to do so. There were nay sayers who said, "Oh, we don't need another homeless shelter program", but I looked at the proposal and realized it was much more than another shelter. It was in fact a program that included a continuum of care and support services that would enable homeless veterans to change their lives. I liked the idea. I was willing to give it a try and included it in my biennial budget. The rest of the story, as they say, is history. This was 6 years ago.

Since we implemented the program in Wisconsin some 5 years ago, more than 3,000 veterans have resided at the transition centers that we have established all over the State. Many others have

been helped as non-residents. We have provided the services needed to receive health care, gain employment and affordable housing and build manageable budgets. Through collaboration with local units of government, non-profit organizations and the private sector, we have forged a continuum of care model that addresses the plight of homeless veterans on a statewide basis.

I am absolutely sold on this concept. Our role in government should be to provide the resources needed for community programs such as this to succeed. It is working in Wisconsin and in other states and communities across America. With your continued support, particularly of this coalition, I believe we have a good change to reach the coalition's objection to end veterans homelessness.

One of the problems communities provide is the phrase, "Is the financing necessary? How do we get the finances necessary to create the facilities needed for veterans' transitional housing?"

I am absolutely delighted, Chairman Quinn, that your Committee, and that Congress last year enacted H.R. 3039, which is the Veterans' Transitional Housing Opportunities Act of 1995, that gave the Veterans Department the opportunity to loan money, that authorizes the federal VA to provide loan guarantees to community providers.

We proved in Wisconsin that this is a viable concept.

Five years ago, before you passed the bill, one of our community providers, Tom Wynn, this wonderful gentleman here, who is here today, needed help to get a loan to purchase the facility to establish the program. The bank says, "We like the idea, but if you get the Veterans Department at the State to put in some money, we will provide the rest of the money." We did that under the leadership of Ray Boland. We were able to use our state funding to provide the security that was needed for him, Tom, to make the deal. As a result, he not only got the loan, he purchased the facility, but since then has housed more than 1,700 veterans in the Milwaukee program.

These are the kinds of things we need to do more of, and I know that the National Coalition of Homeless Veterans is ready to assist in making this happen. I applaud your efforts, the efforts of this coalition, to bring together the good ideas and the suggestions from around the Nation into one cohesive plan and public policy agenda.

Again, I appreciate this opportunity to tell you, now only about our success in Wisconsin, but how passionate and strongly I feel that this model can be replicated for veterans throughout the land. And if we can help the homeless veterans, we can allow our veterans to have the security, the kind of quality of life that they deserve. I applaud you for your leadership. I thank you for giving me this opportunity to come here and say that this program is working in Wisconsin. Give us some more help, and we will even expand it further. Thank you very, very much. (Applause.)

Mr. QUINN. Well, Governor, thank you very, very much for your show of support here today. We talked earlier this morning about funding and about how we need to cooperate and collaborate, whether it is local, State and Federal, the same way that the individual programs have to cooperate with each other, whether it is an alcohol problem or a marital problem, employment problem,

housing problem, the same thing is absolutely true. Wisconsin has proven it will work.

While you are here and we have the benefit of your experience, let me ask a quick question.

Governor THOMPSON. Sure.

Mr. QUINN. As we put our budgets together here—and I hope you also recognize that Bob Filner and I are partners in this, Democrats and Republicans; it is not a political issue for us here on the Hill, and we know it is not anywhere else. A question, I guess more general than anything else, as we put our budgets together—you mentioned the loan program as one example—the Housing Coalition and others help us direct that. Anything else in the form of the budget from us, from the federal level, that we could do to—we did H.R. 3039 together, with a lot of other people—besides that kind of a loan program that allows this gentleman to do that, anything else off the top of your head that we can be doing up here to help you out, whether flexibility or money-wise?

Governor THOMPSON. Well, first let me thank you for being such a bipartisan spirit. I think it is the kind of thing that the veterans need, and I applaud both of you.

I think you need to ask those questions of Ray Boland and Tom Quinn when they come up here, but I can assure you that what we need is we need the Veterans Department help. When we get the homeless shelters built—we can do that—what we need is we need to get the psychiatrists and the psychologists, the mental counseling, in there from the Veterans Department to assist. There is not a veteran right now that is a homeless veteran in Wisconsin that wants to help himself. We will be able to help them, but it would be nice to have a little bit more cooperative spirit. And I am not in any way criticizing what the Veterans Department is doing. All I am saying is it would be helpful if we could have more mental counseling by the Veterans Department to come in and help our homeless shelters.

Mr. QUINN. Excellent point. Thank you. Mr. Filner.

Mr. FILNER. Well, I am sorry you are here, Governor, because now I have to say something nice about a Republican. (Laughter.)

I mean, I am really—

Governor THOMPSON. I just got done saying something nice about this being bipartisan.

Mr. FILNER. I know. I am really appreciative of the leadership you are taking here. The political wisdom is that it is not politic to talk about helping others. We have gotten into this somehow across America, that it is just “me” and not all of us. We are all in this together. Governor Thompson, you are saying that as a political leader, that this is what we must do, and we need to do that in every state across the country.

(Applause.)

Mr. FILNER. Your leadership says that it is okay to do it, and I really do appreciate it. I wish we all could go around the country and tell everybody, “Yes, this is good politics because this helps everyone and we are all in this together.” So, I hope that people can emulate what you are doing. You are a very popular Governor. I can see why. But it is so important what you are doing, and I so appreciate what you are doing here. Thank you, Governor.

Governor THOMPSON. Thank you, Mr. Filner.

Mr. QUINN. Might I also add, not only that, this gentleman does railroads too. Well, thanks for your help on that stuff too.

Governor THOMPSON. Thank you very much.

Mr. QUINN. You are welcome, Governor. (Applause.)

Ladies and gentlemen, let me just say, as we are finishing up, if you have heard the buzzers and the bells, we have been called to another vote. It is a single vote. We can get over there and back in about 10 or 12 minutes, and we are going to just recess here for no longer than about 10 or 12 minutes, and we will be right back with our third panel.

[Recess.]

Mr. QUINN. Well, good afternoon again. Now it is afternoon. We started out in the morning. Hello, everyone.

I would like to yield to Bob Filner. We just discussed the possibility of changing the order of events here this afternoon because of scheduling problems. Bob?

Mr. FILNER. Well, because of the House votes and the lengthy time, we thought that Panel 4, which has people from all across the country, some of whom have to catch planes, should be next, and we can hear from the people who are really on the frontlines. So if Panel 4 can come forward. And we are going to put Mr. Caouette from the VFW on because he also has a plane to catch. Joe Caouette, if you will come forward also.

Mr. QUINN. Thank you, Bob. And if it is okay with everyone who is involved, we will do the best we can with the schedule. They do not know when we will get called back to a vote. I think we can fit in the rest of our witnesses in this session though. We should not have any problem. I would ask all the witnesses to help us as much as they can, and get their written testimony, which will become part of the record and has been read in most cases by everybody, and then take a few minutes to maybe orally summarize what you have. We will wait until everybody is finished, and then we will get to any questions or comments that Bob Filner, I, or any other members here have.

I am going to pull rank, since we went to—where is Mr. Boland? Mr. Boland was here with the Governor. He is such a good Governor, he probably took him out to lunch, huh? My Governor would probably bill me if we went out to lunch. (Laughter.)

That will probably cost me. I should not say that. Here he is. Mr. Boland. The Governor didn't send any lunch over for the rest of us.

I am going to use the prerogative of the chair again, Bob, if I may, and let my good friend, Doug Haywood from Buffalo, NY, begin the testimony here on Panel 4 this afternoon. And then if it is okay with the rest of the panelists, we will just work our way down the table.

Doug, why don't you go ahead and start?

**STATEMENTS OF DOUGLAS A. HAYWOOD, EXECUTIVE DIRECTOR, WESTERN NEW YORK VETERANS HOUSING COALITION; RAYMOND G. BOLAND, SECRETARY, WISCONSIN DEPARTMENT OF VETERANS AFFAIRS; JOSEPH E. CAOUCETTE, CHAIRMAN, NATIONAL HOMELESS VETERANS COMMITTEE, VETERANS OF FOREIGN WARS; THOMAS R. CANTWELL, MANAGING MEMBER, U.S. VETS; CHRIS NOEL, FOUNDER/EXECUTIVE DIRECTOR, VETSVILLE CEASE FIRE HOUSE, INC.; AND LYNNE L. HEIDEL, CHAIR OF THE BOARD, CENTRE CITY DEVELOPMENT CORPORATION, SAN DIEGO, CA**

**STATEMENT OF DOUGLAS A. HAYWOOD**

Mr. HAYWOOD. Thank you very much, sir. Good afternoon, gentlemen and ladies, members of the committee. On behalf of the staff and residents of the Western New York Veterans Housing Coalition, I would like to thank you for this opportunity to appear before your Committee.

Since its inception in 1987, the Coalition has evolved as a major player in Western New York region in the areas of housing, development, property management, and operation of continuum of care programs for homeless veterans. Currently the Coalition owns and manages 119 residential apartment units in urban Buffalo, and is in the midst of two major housing developments totaling over \$10 million focused on homeless veterans' housing and senior citizen housing.

Our case management team oversees our continuum of care programs in MAYDAY HOUSE, our facility for transitional housing programs for homeless veterans; our PATRIOT HOUSE, which is a facility reserved for formerly homeless veterans who have been successful in the past; and for permanent residents of our properties.

We in the veterans' community need more time to provide the full spectrum of services to homeless veterans in order to empower them to lead relatively independent lives and fulfill their responsibilities to themselves, their families and to this country.

During our first 5 years of existence, the Coalition's VA contracted transitional housing program consisted of a 6-month stay by homeless veterans in a secure, comfortable facility. This time afforded them the best chance for social and economic recovery and independence. Our success rate during this period was about 70 percent, and those who graduated were well equipped to meet life's challenges and go on to succeed in life.

With the arrival of the new administration and the resulting cuts to the VA budget, our 6-month program was suddenly transformed into a 2-month effort, in which our staff, the VA first line care providers who support us, and most of all the homeless veterans and residents, had to really scramble to attain even the most basic requirements before program discharge. Two or 3 months of transitional housing is just not enough time to afford veterans even the modicum of potential for success.

Mr. Peter Collins, who is an army veteran and a current resident of our MAYDAY HOUSE requested that I share an open letter he had written for this occasions. Quote: "This program benefits me as no other, in that I am encouraged to seek and obtain employment

while I am provided food, lodging, and case management services in a clean, safe environment. I am grateful for the months that I have. However, to save enough money for an apartment, furnishings, food, clothing and transportation after securing employment is very difficult. The full 6 months would greatly increase my chances of becoming a self-sufficient member of society once again." Unquote.

Now, time of course is money. However, when one considers the cost of recycling former residents through our program and others, time and time again, simply adding 3 or 4 months to better prepare our veterans for life after discharge is well worth the expense.

The aforementioned budget cuts have also forced the closing or reduced usage of many buildings at VA medical centers. Our Veterans Partnership Initiative will utilize a portion of the Batavia VA Medical Center Campus as a transitional housing facility and as a multi-resource employment and service center for homeless and other veterans throughout New York State.

The VA Western New York Health Care System, the Rochester, New York Veterans Outreach Center, and the Coalition have been working hard on this project for over 2 years, and last year the VA awarded us \$1.4 million for renovation and start-up of this program in 2001. Clearly, we need more programs like this one.

We are also actively involved in providing veterans training, education and employment assistance in addition to MAYDAY HOUSE operations. We are completing our first year of a U.S. Department of Labor Title IVC grant, have been very successful at that, and are optimistic about a renewal of this grant as well as an HVRP grant later on this spring. To date we have assisted over 150 veterans in this program.

The last item I'd like to mention is HUD's Shelter plus Care Program. In 1995, the Coalition was awarded a 5-year HUD Shelter plus Care Program that would go until 29 February of this year. This program was very successful throughout our 5 years, but tragically, our request for renewing this grant was disapproved by HUD last December, as were all other similar requests in Erie County, New York. Such a rejection by HUD of our proposal affects 40 households in our properties, at least 20 of those permanent housing residents that are veterans, and 98 others throughout Erie County. We are in the midst of appealing this HUD decision and have received tremendous bipartisan support from Representative Quinn, and Representative John LaFalce of the House Banking Committee. We are hopeful that this position from HUD will be reversed and that we will be able to continue this valuable program for another 5 years and beyond. If we are not successful, we have 40 households of about 60 people total that could be forced, by their own government no less, back into the same homeless and hopeless position from which they thought they had been rescued the last time they were brought off the street.

We implore Congress to provide the funding necessary to maintain this program and other transitional programs for veterans, so that the VA and not-for-profit care providers may continue to serve those citizens of this country who have done so much and given so much, and are the ones most in need.

Thank you very much for this opportunity to share our concerns with you, and I will be happy to answer any questions.

[The prepared statement of Mr. Haywood appears on p. 83.]

Mr. QUINN. Thank you, Mr. Haywood, and thanks for the work you do up there in Buffalo. Amazing situation that we are talking about, saving homeless veterans, and we could find ourselves in a position to actually throw them back out into the street. It is amazing to me.

Mr. HAYWOOD. That is exactly right.

Mr. QUINN. It is amazing to me we would even get ourselves in a spot like that.

Mr. Boland.

#### STATEMENT OF RAYMOND G. BOLAND

Mr. BOLAND. Thank you, Mr. Chairman, members of the Committee. I too appreciate this opportunity to appear before you, and today to comment on the progress we are making toward ending homelessness among our nation's veterans.

As Secretary of the Wisconsin Department of Veterans Affairs, and as vice president of the National Coalition for Homeless Veterans, I am proud to tell you that we are no longer in the shadows of despair and uncertainty as to how to deal with the homeless veterans issue.

And so today we stand together with this Congress and its leaders on a new threshold of opportunity to realistically pursue the Coalition's policy goal of ending homelessness among our veterans.

Just a few short years ago this Coalition came together to share ideas, and, yes, dreams of how we might make a difference. This week on the occasion of the tenth anniversary of the founding of the Coalition, we are sharing our stories of success, and our plans to duplicate this success throughout the country.

The development of the collaborative community-based continuum of care models is at the heart of this success. We are proving that the funding of programs like this is the best investment that can be made toward ending homelessness.

Two examples of sound investment are the Homeless Veterans Reintegration Program and the VA Homeless Providers Grant and Per Diem Program. These veterans' unique funding streams undoubtedly bring the highest return for investment than any other federal spending for homelessness. We have proved that having programs like this, designed exclusively for veterans, not only makes sense, but produces higher success rates than other models.

This may come as a surprise to some, but there are several reasons why we should have better outcomes. First of all, we have got the U.S. Department of Veterans Affairs' health care system. That unique resource is key for many homeless veterans' ability to gain and hold employment. The collaborative model depends on having a dedicated link to VA health care to be able to deal with whatever physical or mental health issues exist.

The general trend of outreach by the VA is great, but we need to go farther. The VA should formalize its long term strategic plans that will dedicate funding of homeless veterans services. We suggest that the Congress request a reporting by each VA Medical Center of the current level of service and what plans each center

has to build comprehensive service for homeless vets. We also strongly urge that the VA restore its mental health and substance abuse programs that have been so drastically reduced in recent years. Cuts in these services are unacceptable and present a major obstacle to us being able to expand our efforts nationwide.

Another area of potential advantage to veterans is employment. All veterans have experienced employment in settings that required self-discipline, reliability, teamwork, standards, achievement, success, mission accomplishment. They know how to do that. Our task is to retrieve and restore those habits and to enhance their skills through training, and then to try to match the veteran with the appropriate job.

Again, we have to collaborate and integrate this key component of the model. Most of us have networked in one way or another with local State employment offices that house the Veterans Employment and Training Services which are funded by the U.S. Department of Labor. We have found that by bringing this resource into the mix of services we provide, to actually blend it with the rest of the program gives us the best results. I personally find it awkward that job services to veterans, and particularly those who are at risk, is a system that is separate and distinct from the mainstream of other veteran service. Attaining employment for homeless veterans is not a separate issue. It is a central issue to a process that includes these many other components. We have got to bring all these pieces together into one holistic process for the veteran to succeed.

National Coalition for Homeless Veterans is ready to assist community providers in planning and implementing this model. Unfortunately, we do not have the staff resources to do this. Yet, without this help, our providers will continue to struggle with the many challenges they face. Putting this all together is not an easy process, and this is a major reason why homeless veterans are underserved by HUD. In most cases our providers need technical assistance in putting together a program that can compete effectively at the local level in the HUD Grant application process.

To do this the Coalition urgently needs an appropriation of \$750,000 to establish the technical assistance capability we need to build this national network of service providers that gives us the capacity to meet the needs of our veterans. We are the only group that has the established lines of communication needed to do this with grass roots organizations and integration with the appropriate federal agencies.

The National Coalition has accepted the challenge of providing the leadership necessary to launch an all-out assault to end veterans' homelessness. Now we are ready to accept the responsibility of guiding others by providing the technical assistance needed to build local programs. We urge your support to give us this capability.

I also want to take this opportunity today to thank you for the support in giving us the resources we have had in the past to prove that we can make this work.

I thank you so very much for this opportunity to testify.

[The prepared statement of Mr. Boland appears on p. 89.]

Mr. QUINN. Thank you, Mr. Boland. Thank you also for having your governor join us this morning. We appreciate that.  
Mr. Caouette from the VFW.

#### STATEMENT OF JOSEPH E. CAOUCETTE

Mr. CAOUCETTE. Mr. Chairman and members of the Subcommittee, as someone who is committed to assisting homeless veterans, I appreciate this opportunity to participate in today's hearing and share my thoughts on how various veterans' homeless programs may be improved to serve this nation's former defenders who now find themselves in need.

A major concern voiced by six homeless veterans I contacted—and these are people that I work with on a regular basis—is the number of substance abuse and mental health counselors that are being drastically reduced or completely eliminated. A key component in getting veterans off the street and back into society as productive citizens is addressing any substance abuse or mental health problems they may be experiencing. Without any immediate professional help, they cannot be expected to succeed.

In Worcester, the second largest city in Massachusetts, the Central Shelter for Homeless Veterans is having serious problems due to the local Veterans Affairs Medical Center, having no substance abuse or mental health counselors. Three years ago the Medical Center had five counselors. Today there is no direct contact by trained counselors with homeless veterans.

The North Hampton VA Medical Center will not provide one-on-one mental health or substance abuse counseling unless a veteran has been drug or alcohol free for 6 months. Mr. Chairman, these veterans need help immediately, not 6 months from now. The whole purpose of counseling is to help them overcome addictions, not to be on their own during this critical period.

Another problem I am witnessing is the detoxification program. If a veteran is sent to the Brockton VA Medical Center, he will receive 3 to 5 days in detox, and then be released as an outpatient. This is simply not working. At the New England Shelter for Homeless Veterans, of which I am associated, veterans do have access to substance abuse counselors because we have our own, but if they are referred to detox, they only get 5 to 7 days treatment, and unfortunately, that program is being eliminated.

Recently we are noticing an increase in two groups of homeless veterans, World War II veterans and women veterans with dependents. We attribute the increase in World War II veterans to their release from VA Medical Centers of homeless programs, and in many cases their families are not living in the area. As to women veterans, this is simply due to the fact that more and more women are serving in the armed forces. As to their homelessness, there are many contributing factors. I am sure you can appreciate our concern when a woman veteran and her children seek assistance. This presents a whole new set of challenges with limited resources.

Also, in the quest to provide additional single-room occupancy units at closed buildings in the VA Hospitals in Bedford and Brockton, it is a very cumbersome, lengthy problem with an excess of paperwork and loads of red tape. I am glad to see Dr. Murphy has

mentioned the women in her talk earlier today, and hope that that will help.

A lot of these things I said are pretty negative, but we have some good things too.

I would just like to state a couple of cases. We have a gentleman I will call "Mike." His name is Mike. And he came from a large family, and after he got out of the service, he was working for a major company for 10 years, and then he got involved with drugs and liquor and he fell by the wayside. He ended up living under bridges and so on and so forth. We got him into our program—he finally decided he had to make some changes—and today he—well, first of all, he had borrowed from everybody in his family, stolen from them, everything, and then he came to us. We got him cleaned up by the detox program and counseling, and we got him a job working on copiers and fax machines. And he was doing pretty good, but he decided that he wanted to be able to do it himself and work for himself, so he asked for our help. So we set him up with a telephone in a sub-basement room, and said, "Try and start your business. See what you can do." Well, I am proud to say that last year he grossed \$300,000. He has come back to the shelter, volunteering and helping us with other veterans, and he just donated a \$500 copier to our program to raise money to help other veterans. And it is funny, he married a lawyer, and his mother said to me, "He married a lawyer. I have been hiring lawyers for years for all the trouble he was in." (Laughter.)

Then I have one other case that really struck me. I got lost on the way out to a shelter that had been in operation for a couple of years in Averell, Massachusetts. So I stopped and asked a policeman for directions, and he asked me what I was going there for. I said I am the state chairman—at that time I was. And he said, "I will tell you something about that place." He says, "That was in—the house that they are using, they call it 'The Mansion'—it is a big old house." He says, "That was a crack house, and the whole neighborhood was in tough shape." So when they moved in there, even though it was a downtrodden area, the people were saying NIMBY, not in my back yard. They didn't want a homeless shelter, but they did get it in there. And since they have been in there, the whole neighborhood has changed. First of all, they painted up this house and fixed it up, the veterans that were there, and through some of our programs. Then they went around to the neighbors, and they had a lot of paint and everything donated, and they started painting the neighbors' homes. And this is from a policeman. He says, "We don't go down there any more." He says, "That homeless veterans group has changed the whole neighborhood for the good", he says. And this is just an unsolicited thing. I was very proud on that.

I will take any questions. I appreciate the opportunity to appear before you, and allowing me to go on early, because I do have to catch a plane.

[The prepared statement of Mr. Caouette appears on p. 92.]

Mr. QUINN. Thank you, Joe. Thanks very much. We appreciate it.

Ms.—is it Noel or Noel?

Ms. NOEL. Correct.

Mr. QUINN. Noel?  
 Ms. NOEL. Noel.  
 Mr. QUINN. Please continue.

#### STATEMENT OF CHRIS NOEL

Ms. NOEL. Mr. Chairman, thank you and the Committee for allowing me to make several requests on behalf of all homeless American veterans.

The requests I now make of you are based upon my experience and dedication in working in many areas with the military and veterans since 1965.

Most important, I specialize in the work of returning the disabled and homeless veteran back to society by forming and running the homeless veterans shelter of Vetsville Cease Fire House in Florida.

Florida has, according to the National Coalition for Homeless Veterans' 1994 "Report to the Nation", 13,450 homeless veterans, the fourth largest of the states. The homeless veteran is a federal problem, not a local community problem. The men and women of the military had a contract with the U.S. Government.

Homeless veterans have many barriers and complex life circumstances which make them difficult to serve. The men and women watch their dignity fall away as they live day to day, hand to mouth, clinging desperately to the emptiness of their lives. On many occasions I have heard, "Nobody cares about us. We have lost our country."

There are military veterans with the highest military decorations eating out of dumpsters. Why is this allowed to continue?

From my experience, there seems to be a problem by the VA with over medicating for psychological health issues because it makes the veteran easier to control. VA medications sometimes create a temporary zombie effect. When Vetsville attempts to work with social workers and doctors to help the veterans seeking our help, we are ignored, even though the veteran has signed the proper forms of release of information. This lack of cooperation necessitates taking the veteran to a private physician or a hospital. An example. One VA outpatient, 360 sleeping pills from January 1st to February the 28th. In the last 10 days, this particular veteran, taking these pills, OD'd twice.

Homeless veterans need an open channel in order to be heard. They need a watchdog over the VA. Filling out complaint forms at the VAMC merely labels the veteran as "just another disturbed vet." This is a convenient method to avoid his pleas for assistance.

Homeless veterans need dental care. It is difficult to obtain stable employment without front teeth. It is also a health issue since many suffer from malnutrition because they are unable to chew food, or they have infections that go untreated.

Transportation funding is needed to provide access to medical appointment and job search for veterans in community based organizations. Most homeless veterans do not have the mode of transportation to make all the appointments required as an outpatient. When appointments are missed, it can take months for a new appointment, and that can be devastating to a PTSD patient.

Vetsville provides a structured drug and alcohol-free environment for troubled veterans to heal and prepare to re-enter the

mainstream of society. We would greatly benefit from the VA truly becoming our partner to serve the homeless veterans in our community instead of constructing barriers that are difficult to remove. The Vetsville Program works.

Vetsville has applied for federal grants, but has been unsuccessful in obtaining any funding. Grants could greatly aid in the care of homeless veterans by expanding our capacity to serve the large number of homeless veterans in our area. Organizations like ours could benefit greatly from technical assistance if it was available.

Often veterans can only find day-labor jobs because of their work history, and need access to full-time employment in order to be able to live independently. Day-labor does not work to end homelessness. Targeted funding for employment programs specifically for homeless veterans is critical since the veterans have so many barriers to overcome. It takes a special set of skills and knowledge to work with the veterans and potential employers that is not available in mainstream programs. It is not uncommon for very sick veterans to be turned down by the VA for service-connected disabilities 18 to 20 times. Many of these men are too young for Social Security, and full-time employment is not a realistic expectation for them. A fast-track review process could greatly impact the ability of homeless veterans receiving needed services in a timelier manner.

In conclusion, all concerned with Vetsville request that you do the following on behalf of homeless American veterans: support community based organizations that provide for safe housing with food and daily counseling in a cost effective manner specifically for homeless veterans; assure that federal funds allotted for homelessness goes to grass roots programs that specialize in serving the homeless veteran, not to other government agencies; implement an expanded VA dental program that addresses the special needs of homeless veterans; require, require the VA to work with community based providers serving homeless veterans in a meaningful effort to address the local needs of veterans.

I personally want to thank you for your hearts and minds on behalf of all homeless American veterans. Thank you.

[The prepared statement of Ms. Noel appears on p. 93.]

Mr. QUINN. Thank you, Ms. Noel. Mr. Filner.

Mr. FILNER. Thank you, all. I want to introduce Ms. Lynne Heidel, who came all the way from San Diego, and has worked as a member of the board, for quite some time, of the Centre City Development Corporation. I used to serve on the City Council representing downtown, and have very much been involved with trying to deal with the problem for a long, long time, and we thank you, Ms. Heidel, for your efforts.

#### STATEMENT OF LYNNE HEIDEL

Ms. HEIDEL. Thank you. Thank you, Chairman Quinn, Mr. Filner, members of the Committee.

I want to thank you for this opportunity to talk about the new program that we are creating right now, which is called the Special Needs Homeless Program. The program is being developed to address the needs of our urban homeless population, which is comprised of a great number of veterans, as you have heard today.

I am here today, as Mr. Filner said, as the Chair of the Board of the Centre City Development Corporation. The corporation was created in 1975 and operates under the California Community Redevelopment Law, and is responsible for planning and redevelopment areas within the city's 1,500 acre downtown. We are not a social service provider, and we view the issue of homelessness and veterans' homelessness differently, from a different perspective than anyone else here today. But what we do do and what we are expert at is creating public/private partnerships, and we would like to use our money and leverage it with money that is funded to private providers and some of the agencies you have heard from today, to develop programs that could be helpful to the homeless veterans.

Let me explain why a redevelopment agency would be so concerned about this. Perhaps, it is obvious, but it certainly was not obvious in San Diego, and it has taken a lot of persuasion to get people's attention on this.

Over the past 25 years we have invested \$285 million to redefine the city and to eliminate the physical, financial and social blight that existed in the downtown, and as I said, we did this with the formation of public/private partnerships.

Since its creation, CCDC has facilitated development of 4,700 homes, 4,000 hotel rooms, 4 million square feet of Class A office, retail and entertainment complexes, and has spent \$60 million on public improvements in infrastructure, and as a result, our downtown area, which had to be described as blight in the '60s and '70s, has turned into eight distinct neighborhoods that are turning into family desirable areas. Our responsibility has been to provide the appropriate physical environment for economic growth to occur. Naively, we believed that urban problems would be resolved when those two elements were put in place. However, that has not been the case, and I am sure that is not a surprise to any of the speakers here today or to you. Because despite the phenomenal strides in eliminating physical blight, we are still faced with the unacceptable growth of our homeless population.

CCDC has therefore determined that for our redevelopment strategy to be truly successful, we also need to focus on these social issues related to homelessness. By treating the needs of the homeless, we will not only help alleviate the individual suffering that you have heard about today, we will also enhance the physical and economic environment of our downtown area.

The estimates of the homeless population in San Diego's urban center vary, but they are estimated to be as high as 3,750 and about 40 percent of the urban single homeless men are veterans.

Redevelopment dollars can only be a very, very small part of the funds that are needed to address the issues of homelessness, but as I said before, if these funds are leveraged properly and used in conjunction with funds of existing agencies that are dealing with homeless issues, a tremendous benefit to the community can be realized.

To date we have expended \$12 million towards establishment and growth of programs aiding our urban homeless, and our partners have been the respected established social service providers, such as Vietnam Veterans of San Diego—and you Mr. Pavlish [ph]

this morning—and others who receive federal grants to operate their programs.

What we have determined is that—and I was so happy to hear it today, people focusing on the problems that are related to mental illness, chronic inebriation and the dually diagnosed, because we have also found that this is a tremendously under-served portion of the population for veterans and non-veterans. According to local mental health officials, only two-thirds of those suffering from schizophrenia or major depression in the county are receiving treatment. The remaining third have no contact with mental health professionals and receive no prescribed medications. Therefore we initiated creation of a comprehensive continuum of care for the mentally ill homeless and those dually diagnosed with both substance abuse and some form of mental illness.

Downtown San Diego's Special Needs Homeless Program begins with homeless outreach teams. These teams of police officers and social workers daily assist downtown homeless, and they are the ones who have identified the very, very high numbers of veterans who are among the population on the streets in downtown San Diego. In addition, very recently, downtown property owners have agreed to tax themselves to pay in part for these homeless outreach teams, the HOT teams. So the dedication both of our agency—we have been funding it for the last two year, probably a little bit outside the box of what is legal, but we felt it as very important—and now the property owners themselves are willing to contribute to that.

The next element of the program is a centralized system of coordinating services that would follow patients across the continuum of care. A case file for each individual contacted by the HOT team would be created, and these files would be kept in a database that would be accessible to the patient as he or she moves from diagnosis to transitional housing, and finally on to independent living, hopefully.

I see my time is up, and I just briefly summarize. Shall I go on? Thank you.

The third element is the increasing number of transitional and permanent support of housing beds that we are trying to develop. The HOT teams tell us they have no place to take the mentally ill homeless after an initial evaluation and emergency treatment. As a start, CCDC has committed redevelopment funds for the development of four new facilities that could accommodate 25 individuals each for up to 2 years. We are looking to partner with the organizations that are here today to provide that kind of assistance.

And we are also working on the problem of public inebriation, and trying to relocate and improve that system, but again, we need to partner with the agencies that you have heard from today.

None of our programs are revolutionary. But what we do find very exciting for the City of San Diego is that there is a higher level of political will, of collaboration and desire to work on this problem that certainly I, in my 20 years in San Diego, have never seen, and we will be looking to you for you additional assistance so that those providers can work with us in partnership to help address the problems of the homeless veterans in San Diego.

Thank you very much for this opportunity.

[The prepared statement of Ms. Heidel appears on p. 100.]

Mr. QUINN. Well, thank you very much. I think it is a perfect match, by the way, whatever we can do and what you are already doing.

Tim Cantwell, would you like to sort of round out the panel, please?

#### STATEMENT OF TIM CANTWELL

Mr. CANTWELL. That would be great. My name is Tim Cantwell. I am president of Cloud Break Development. Cloud Break Development is a member of U.S. VETS. U.S. VETS is a limited liability corporation made up of United States Veterans Initiative, a 501(c)(3) nonprofit support service provider and Cloud Break Development, which is a for-profit real estate development company.

We wish to commend this committee in its efforts in the past. The huge amounts of new money that have been invested into homeless programs for veterans at the urging of this committee, and we really want to express our gratitude for that. There is no doubt the VA Central Office has been extremely responsive in attempting to move forward the advancement of the homeless grant per diem provider program, as well as additional HCMI contract money throughout the care system. Lots of good things have happened.

The landscape is entirely different today than it was 5 years ago. It is safe to say that at the beginning of the nineties we had very little for homeless veterans. We had very different perspectives on how to respond and meet the needs of those veterans. And as the community-based care provider system comes forward in ways to link up the VA health care system with vets, so too has the VA health care system comes towards the CBO system in getting care and treatment out to vets in the community where they are. We applaud that effort.

For our own part, U.S. VETS' first project, the Westside Residence Hall, has served pretty close to 2,500 homeless veterans since we opened the door in 1993. We are currently serving veterans at the rate of 175,000 nights of stay annually; our food service operation puts out 25,000 meals a month; our outreach team serves 96 different agencies throughout the greater L.A. county care system, referring 1,200 veterans a year into treatment and services; we currently have 100-bed "Back to Work" residential jobs program that is putting vets to work at the rate of about 35 vets a month; our career center is used by 300 vets weekly; there are 26 computer work stations that are online 3,000 hours per year; accessing the network for both job development activities and educational deficiency improvements. We test everyone that comes into the facility for reading and math proficiency. Inglewood Adult School is on campus 4 nights/a week providing reading and math education, as well as computer training.

We have been blessed with an on-campus mental health clinic staffed by the West Los Angeles VA Medical Center. They conduct approximately 37 groups per week on campus for the 400 vets that live on-site. The facility averages, (this is a little staggering) 95-percent sobriety at all times. We will be launching a 32-bed program next week at Westside, which will look like the jobs program

but it is targeting veterans who are noncustodial fathers. We find that 34 percent of the veterans that we see have dependent children. This is a linkage with the District Attorney's Office, with an outcome expectation of employment and appropriate reapproachment to the family, as well as a negotiation on child support payments. We believe that is a barrier to integration into society if a man is not fulfilling his financial obligations in an appropriate way.

We also administer a National Direct AmeriCorps program. It is called National Collaboration for Homeless Veterans annually. Roughly, 400,000 hours of service go into 38 programs in 22 States, outreaching to 20,000 homeless, approximately 60 percent of whom are homeless veterans. That activity has been extremely useful and an "out of the box" source of revenue and human support for the cause of homeless veterans, but it has proved to be very useful.

Our second facility is a 26-acre residential planned community that opened 2 weeks ago called Villages at Cabrillo. That will ultimately serve 921 homeless veterans, families and youth. The Long Beach VA Medical Center has, in its strategic planning process, staged the shutdown of its 42-bed in-patient ward for substance abuse and is shifting 22 full-time equivalents out to the campus at Cabrillo. They will be providing clinical care support to the 500 veterans that will be living at Cabrillo on an outpatient basis and actually conducting the residential treatment component of substance abuse there.

The highly efficient model helps the Long Beach VA Medical Center cash flow under the VERA model while being supportive to homeless veteran needs.

The primary capital financing for these transactions came through Century Housing Corporation, support from the City of Inglewood, the City of Long Beach, and most recently the placing of \$7.2 million of equity capital from a Fortune 500 company purchasing \$9 million of tax credits. We choose not to disclose that at this time in as much as we do not want to queer the deal. It will be a very exciting proposition validating the fact that serving homeless veterans can be a very rational, pragmatic, and economically sound activity.

This summer we are opening a drop-in center in conjunction with the Houston VA Medical Center on the ground floor of the King George Hotel. The 100 rooms will be dedicated to veterans that are moving through the care system in the greater Houston area.

Projects are substantially financed and coming in Las Vegas, NV, a 285-bed facility; 350 beds at Barbers Point in Honolulu; 350 beds at March Air Force Base in conjunction with Riverside and San Bernardino counties.

In each case, we separate out the real estate development and its management from the supportive services. To install the level of supportive services necessary, requires layering in a whole set of Federal resources. Each of these programs that I just delineated have HUD money in them, lots of it. Each of these programs have Labor money in it, significant amounts. Each of these programs have VA support, both in terms of staff on site and per diem, so you can imagine the level of "partnershiping" that is taking place to pull that off in so many locations.

This does not happen in an isolated, fragmented way. Veterans Initiative had been in operation for 4 years before it got a single Federal dollar.

I am out of time. I want to come to closure here. Can I get another minute? Okay.

How did that come about? It came about by doing an analysis of the care system in each of these jurisdictions in which we are operating. Finding ways to demonstrate to that care system how it was in the best interest of that community to develop veteran-specific programs, link all of those parts together and give up a little bit of money from the supportive services dollars they are typically getting from HUD. It is a process. It is complicated, and it is the way the distribution system is working through the HUD consolidated planning areas for a continuum of care. It can be done. It cannot be done without artful negotiation and design on a community-by-community basis.

So I am going to turn my hat around. As president of the National Coalition for Homeless Veterans, I can assure you that a primary gap throughout this care system for meeting the needs of homeless veterans is equipping our veteran community-based service provider network with the capacity to go into a consolidated plan area and successfully compete for Federal dollars that are already allocated and link them up with the VA, with HUD, with DOL and all of the other care providers that are in a community in a way that creates this seamless continuum. It is complicated, it takes staying power, and routinely it might take several bats at the plate.

The concept of providing management and technical assistance will go a long way towards equipping the CBO system to eliminate homelessness of veterans. Now that Congress has made this investment in resources for homeless veterans, we would beseech you to take steps to defend the program money that has been allocated. We are very concerned that the VERA model may reallocate this new money to other purposes before there's been an opportunity to seed any change. We would like to see the money defended.

And lastly, we would like to suggest that this committee consider a discretionary authority to the VA's Homeless Program Office to help sponsor the initiation of new things, that if they prove out, could subsequently be placed into the base funding of VHA.

Mr. QUINN. Your time is up.

Mr. CANTWELL. My time is up.

We appreciate this. We appreciate your interest, and thank you for this hearing today.

[The prepared statement of Mr. Cantwell appears on p. 105.]

Mr. QUINN. Tim, we could talk with you all afternoon, believe me. I do not say that because we—I am serious. That last is a great suggestion. We have talked about it a little bit before and almost as a pilot demonstration type program.

Mr. CANTWELL. Yes. Yes.

Mr. QUINN. It is a great idea.

We thank you all. And we have a problem I want to share with you now, and that is time. Someone else is scheduled to use this room in about 25 minutes. Moving the equipment and everything else out of here would be an absolute nightmare. So we are going

to thank Panel 4, plus a member from Panel 5. We wish you the best to catch your flights.

We are going to ask Al Borrego and Fred Karnas to step forward and start our third panel that is now number four. Thank you.

Mr. FILNER. Mr. Chairman, I would just like to thank everybody for the commitment that they have to these issues and the work they have put in.

I would say to the community folks here that as Congresspeople, we need your help in focusing our attention. You could just see from today's activities we are running hither and yon to votes, and other committee meetings and many members are doing other things.

You all can focus our attention through an outreach program of your own back home. If we looked in every paper in our district and found editorials saying what was said today, if we went into Service Clubs, and PTAs and people asked us "What are you doing about homeless veterans?", if everywhere we went and read, we saw the community asking for action, you would bet action would take place here.

So you all have to not only lobby us, but you have to lobby your whole community. The whole community has to say, yes, we want to do this, and we will get that message here. Congress gets messages from back home very intently. We know what is going on, and we need to hear from our communities. You all could focus your attention on them, too, to help us.

Thank you.

Mr. QUINN. Thank you, Bob.

I want to announce before we begin that the American Legion has submitted written testimony, and it is included in the record. That is for our next panel.

[The statement of the American Legion appears on p. 164.]

Mr. QUINN. Gentlemen, again, with no doing of our own or your own, we are really pressed for time. If we could ask you to summarize in less than 5 minutes, it would be very, very helpful. Mr. Borrego.

**STATEMENTS OF ESPIRIDION "AL" BORREGO, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR, AND FRED KARNAS, JR., Ph.D., DEPUTY ASSISTANT SECRETARY FOR SPECIAL NEEDS PROGRAMS, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT**

**STATEMENT OF AL BORREGO**

Mr. BORREGO. Thank you, Chairman Quinn, Congressman Filner. I always appreciate the opportunity to discuss Labor Department programs to help America's veterans. But I appear today with mixed emotions because the subject is programs to assist America's veterans without homes.

Mr. QUINN. Let me just interrupt for one second, even though we are pressed for time, we do intend to hear what you all have to say. So if you are moving in and out of the room, let us at least try to keep the noise down.

Mr. Borrego, please continue.

Mr. BORREGO. Quite frankly, there should not be any homeless veterans in this land of plenty. Our economy is robust, unemployment is at historic lows. But the problem of veterans without homes persists. This committee has been wise and generous in its support for the Homeless Veterans Reintegration Project. This year we have \$10 million, the most ever allocated. We need every penny of it, and we are using it wisely and economically. Next month, we are awarding our urban grants, totalling more than \$8 million. Later, we will announce our rural grants.

Together, we expect our service providers to help 6,000 homeless veterans. Even though we get good value for our dollar, the number of veterans we directly serve is small. But how do you put a dollar value on dignity, how do you do a cost-benefit analysis on restoring self-respect? Because that is what these programs do. They enable good people to, again, take charge of their lives to become proud, productive members of society.

And just who are these people we serve? We know they are homeless veterans, but we usually only know them by where they have fallen, into a tragic cycle of joblessness, homelessness and aimless wandering on our Nation's streets and alleys. They came from one our Nation's Armed Services. They were soldiers, sailors, airmen and Marines. They served their country with pride and dignity. They protected our homes, our children and our way of life. Perhaps they were skilled trade workers, professionals, administrators, people who made a difference and made a contribution.

Then something happened. It could be many things: Loss of job, sickness, family problems or occurrence of a service-connected disability, something that could very well happen to any one of us. They are not society's losers, they are our wounded comrades in arms, and we have a tradition of not leaving our wounded behind. Secretary Herman has said that to succeed in the economy of the 21st Century, we cannot afford to leave anyone behind. Our programs are designed to make that goal a reality, and it is not unrealistic.

Vets is not going alone. Within the Labor Department, homeless veterans are eligible for a variety of services under the Workforce Investment Act. We are reaching out to the veterans' service organizations, which have always been active in efforts to aid homeless veterans. We are reaching out to faith-based organizations which have a proven track record of service to those in need. We are reaching out to other Government agencies, notably the VA and HUD. Their programs help shelter, feed, clothe and provide medical services to homeless veterans. Our programs which provide employment skills and job placement assistance combine with theirs to break the cycle of homelessness and to put people on the road to self-sufficiency.

For next year, we are asking for \$15 million, our authorized level for homeless veterans. And we will make good use of every penny of it. The need is great, but the potential rewards are even greater.

Thank you for asking me to be here today.

[The prepared statement of Mr. Borrego appears on p. 117.]

Mr. QUINN. Thank you, Al.

Fred, before you begin, I just want to mention that I had a meeting with Secretary Cuomo's assistant, Ms. Glickman, just about 3

weeks ago in my office here and had a list of things to do. But one of the things I talked to her about was this homeless issue for veterans. So as you take this information back from today's hearing, you may want to connect with her.

Please continue.

Mr. KARNAS. I would be glad to.

#### STATEMENT OF FRED KARNAS, JR., Ph.D.

Mr. KARNAS. Thank you very much. I appreciate the opportunity to represent the Department here today. My written testimony has been submitted, and I will try to be very, very brief.

I want to focus on two things; first is where we agree, and then one area which I think we need to work on getting the facts straight.

First, in terms of where we agree. I do not think anybody could argue that they were not moved by Ms. French's comments at the beginning of this session. As a person whose World War II veteran father passed away a few weeks ago, I was moved very much by what she had to say. As a person who for the last 17 years has been an advocate, a provider of homeless services in Phoenix and in Orlando, and released the first report on homeless veterans as the executive director of the National Coalition for the Homeless, I came to Government 5 years ago to join Andrew Cuomo in his efforts to transform the way this Nation addresses homelessness.

I think we all can agree with Mr. Quinn's opening comments that no one should walk out of the door of their homes, whether they are a Congressperson, a person of faith, a person in the community in any way, and not recognize that there are homeless veterans on the street.

Let me now move to clarifying the myth that I have heard several times today. One of the things that Mr. Cuomo has done as Secretary, and as assistant secretary before that, is to implement the continuum of care process. Several people have mentioned that today. That the continuum of care reflects exactly what Mr. Quinn mentioned earlier—an integrated range of services to address homelessness; from outreach, to emergency shelter, to transitional housing, to permanent housing. The result of the implementation of the continuum of care has been a transformation of the way communities serve people who are homeless across the country.

One of the things that we have tried to do is make sure that the continuum of care process responds to the needs of homeless veterans. As my written testimony shows, we have changed. We encourage the local planning process to try to bring homeless veterans groups to the table. The result of our efforts are not that 3 percent of HUD's programs go to serve veteran-specific programs—Although I do not dispute that number—but that over a thousand of the programs that were funded last year target homeless veterans amongst the people they serve. Twenty-eight percent of the people that were served last year by HUD's homeless programs were veterans; 150,000 veterans received services from HUD last year.

There is no doubt there is an incredible amount more that needs to be done. There is no doubt that we have a long way to go in making sure that our programs are as responsive as they should be to homeless veterans. But I think we have to have a debate, not

about numbers, because the numbers show that HUD is responding to the needs of homeless vets, but about what is the appropriate balance between veteran-specific programs versus programs that serve veterans amongst the larger homeless population. I think veterans need both. And, I think it is very important that we have the policy debate based on the facts. HUD is not just putting 3 percent of our money into homeless programs, but over 50 percent and 28 percent of the people that we serve are homeless veterans.

There are some things we do need to do. I have heard people mention technical assistance a number of times here today. Clearly, this is an area where I think we need to work more with groups to make sure that folks get the technical assistance they need to become part of the continuum of care process. The other area that has been raised this morning by Mr. Haywood is the issue of renewals. Renewals are, by law, competitive in the Shelter Plus Care Program, and that is a real problem when we do not have enough dollars, even with a billion dollar budget to meet the need in this country.

We have some proposals on the Hill that were sent up last year that would have moved Shelter Plus Care permanently to the Section 8 program for funding and that would have eliminated problems like Mr. Haywood's this year.

[The prepared statement of Mr. Karnas appears on p. 120.]

Mr. QUINN. Thank you very much. We deeply appreciate the opportunity to have discussions where we need it. And I want to approach it in exactly the same way. Whether it is disagreements or arguments, fine. But I think through discussion we have not heard anybody here today say they did not want to help homeless veterans. That is encouraging. And I think you are right. Secretary Cuomo, and I have a longstanding relationship on other matters, and this is an area where I think we can get together, and we take your offer to continue this discussion in the way that it is offered, and that is constructive, believe me.

Thank you very much.

Mr. FILNER. Mr. Chairman, want to introduce into the record, with your consent, Chapter 11 of a technical report entitled, "Homelessness Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients," prepared by the Interagency Council on the Homeless, dated December 1999.

Mr. QUINN. Without objection, so ordered.

(See p. 126.)

Mr. FILNER. And also the testimony of the American Federation of Government Employees, which will be submitted within a few days.

Mr. QUINN. Without objection, so ordered.

[The statement of the American Federation of Government Employees appears on p. 167.]

Mr. FILNER. Thank you, Mr. Chairman.

Mr. QUINN. Thank you. Thank you, gentlemen.

We would like to have Mr. Harold Schultz, Mr. Richard Schneider and Mr. Calvin Gross come forward now, please.

Mr. Calvin Gross is not going to be with us. Let me begin by apologizing, gentlemen. I seem to always want to do this. We hate

to be as rushed as we are. We have a standing improvement this year to move—I think it is an improvement—to move the VSOs first, but with our guests here this morning, Ms. America, we were not able to do that today.

May I ask you both to take a couple of minutes only to summarize what you have to say.

Mr. Schultz, we will begin with you.

**STATEMENTS OF HAROLD E. SCHULTZ, SUPERVISORY NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS, AND RICHARD C. SCHNEIDER, DIRECTOR OF STATE/VETERANS' AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION**

**STATEMENT OF HAROLD E. SCHULTZ**

Mr. SCHULTZ. Mr. Chairman and members of the subcommittee, I want to first of all thank you for your efforts, first of all, for entertaining this forum today on behalf of homeless veterans, and for your past work and for what work you are going to be slated to do now following the testimony of all of the people here today.

You do have a copy of my testimony submitted for the record. But I would like to, if I can, just go into just a couple of details about what we have done in Syracuse, NY, in reference to setting up a transitional home for homeless veterans in Central New York. This was formed in 1992 through the combined efforts of DAV and the VA. And the Detor House in Syracuse, NY, was set up to try to help those veterans who were transitioning from being homeless to becoming productive members of society.

In that regard, a four-bedroom structure in need of renovation was obtained from the county, Onondaga County, in Central New York, in Syracuse. Through the help of many volunteers, some of whom were homeless veterans themselves, the home was renovated, and the renovations were paid for through a massive fundraising campaign with the DAV, the VFW, the Legion and other service organizations contributing dollars to help make that effort successful.

The home now known as the Detor House is conjointly managed now by the Disabled American Veterans and the Syracuse VA Medical Center. The medical center is responsible for the screening, selecting and counseling of the residents. And since its inception, the house has assisted 23 veterans transitioned from homelessness to again becoming productive members of society.

The majority of the residents have obtained full-time or part-time employment in community jobs or at the VA Medical Center since their becoming residents of the transitional home. Those with a history of substance abuse have remained compliant with the recovery programs, and they have all shared responsibilities and demonstrated the ability to live cooperatively with each other.

The Detor House is an innovative strategy which demonstrates that private sector organizations, such as the DAV, can create special cooperative partnerships helping homeless veterans regain self-sufficiency and success in society. We have shown that a community can address the needs of homeless veterans through efforts in both public and private sectors. The Detor House has been a major

step towards accomplishing that goal in Syracuse. We have obtained an additional home as well on the grounds adjacent to Detor House and hope to now raise the necessary funds to begin renovation of this home to assist even more veterans in Central New York.

Mr. Chairman, the DAV is so concerned by the problem of combatting homelessness in our veteran population that we continue to encourage departments and chapters to get involved at their local levels. Since 1989, the DAV's charitable service trusts, grants and allocations for homeless veterans totals nearly \$815,000. There is no question that with the proper assistance homeless veterans can improve their situations to begin to transition once again and become a productive part of mainstream America, the very ideals they served and fought to preserve for all Americans.

Mr. Chairman, this concludes my statement. I appreciate your interest in resolving this national problem of homelessness among veterans and the opportunity to discuss Detor House in Syracuse.

Thank you.

[The prepared statement of Mr. Schultz appears on p. 154.]

Mr. QUINN. Thank you, Mr. Schultz.

Let me just ask one very—I meant to ask Ms. Noel this question before. She was from West Palm Beach, FL, and it is a related remark to what Bob Filner talked about twice earlier this day.

I happen to know in Syracuse, NY, your Congressman is Jim Walsh. He has got part of Syracuse.

Mr. SCHULTZ. That is correct.

Mr. QUINN. To what extent was he involved in this effort?

Mr. SCHULTZ. Jim Walsh's office has been very supportive of all of the efforts that we have done throughout Central New York.

Mr. QUINN. My point then in saying that, I suppose I posed the question wrong, who would say he was not, right? But I guess if we piggyback on what Bob is trying to point out, wherever we are involved in these individual success stories across the country, if we are going to come back to some folks who make decisions on this, not all of them, but some of them, we need to get them involved, to know the success story and to know the problems before you turn it into a success story so they can become cheerleaders for us here and can help us do what has got to be done here.

Mr. Schneider.

#### STATEMENT OF RICHARD C. SCHNEIDER

Mr. SCHNEIDER. Thank you very much, Mr. Quinn, Mr. Filner. I appreciate the opportunity to be here. Our formal statement is submitted for the record, so I will not dwell on that. And I know time is short, and the only thing standing between us and everybody going out that door is me. (Laughter.)

I will just address about three things that I think are critically important.

Number one, we talk partnership, and partnership has got to be the way we go. But we also need to recognize the lack of funds supporting homeless veteran programs. We would like to see the increases in both the VA, and to HUD and anywhere else that Federal funds are available.

We believe McKinney funds should be proportional to the numbers of homeless in the community that are on the street on any given night. More than that, in the partnership, in the community partnership, we believe that the representation on the community council ought to be equivalent and representational of the proportion of number of veterans on the street in that community. We think our veterans are badly represented by having only one advocate, possibly two on these community councils. People on the outside of the council trying to yell over the shoulders and bring attention to veteran homelessness doesn't work. It would be good if HUD grant processes would focus attention to increase the size of the community representation of veterans.

VA medical health care is great. Outpatient care is great. But the problems of homelessness is long term. Mental health is long term. Substance abuse is long term. We see people coming through the pipeline, but they do not come through it via a series of outpatient visits. They normally come through it because they have been treated in an inpatient resident program. And we call upon you to call upon VA to relook that issue very strongly, and by God open some of those wards and bring the veterans back so that they can get the inpatient abuse treatments that they need.

I think the other thing I would say is that we have so many great programs as evidenced by this morning's crowded hearing room. If you look at the great programs discussed in this room today, a number of leaders have emerged, who have got the welts on their back, who have been beaten up, and still had the fortitude to overcome then obstacles to create dynamic programs. We need to share their stories. And I think one of the things that we can really do is to take HUD's LVER and DVOP representatives to every place where there are community collaborations to further the collaboration to inform communities because there is unevenness, and access to care is not the same across America.

We need to have the successful homeless programs of today emulated across the country. We need an organization like the National Coalition of Homeless Veterans to have appropriated seed money to begin the process to further educate and to provide the awareness across this country of how to organize, fund, and execute homeless veteran initiatives.

I would publically have commented to Al Borrego, who has left, the thought I shared this with him the other day that employment representatives, LVERs and DVOPs, when they are meeting the needs at VA for vocational rehabilitation and training, when they are meeting the needs at vet centers across America, when they are meeting the needs of reintegration programs, when they are meeting those needs, time is running out. There is not enough people.

I think it is time we look at providing some contract employment representatives or let people bid so that these big homeless centers can, in fact, have their on-site employment representatives not only talking to the veterans, but going into the community, spurring on training programs and spurring on the opportunity for employment.

The thing that will end homelessness is employment. To get a veteran to employment, we need to break the substance abuse, we need to break the chains that are holding them back, we need to

provide both shelter and the full continuum of care. But at the end of the tunnel, we need to be focused on a job, and we need to have LVER/DVOP representation working in every community facility. I do not denounce what Labor has done. But I would say that the ocean is bigger than their boat, and they need to provide further assistance to make that program go. Homelessness will ultimately be broken by jobs.

Thank you.

[The prepared statement of Mr. Schneider appears on p. 158.]

Mr. QUINN. Thank you, Mr. Schneider. And thank you both for your patience with us here today.

We want to thank everyone who has joined us and the panelists here. Mr. Filner and I have a lot to look at, a lot to report back to the subcommittee and the full committee. If there is no other further business to come before the subcommittee today, we stand adjourned.

Mr. SCHNEIDER. Mr. Quinn?

Mr. QUINN. Yes, sir?

Mr. SCHNEIDER. Could I make one other comment.

Mr. QUINN. You better hurry.

Mr. SCHNEIDER. It was a stroke of genius for you to bring Ms. America to this hearing. (Laughter.)

I wish that you would recommend that she appear before the Appropriations Committee and let her tell the story at Appropriations.

Mr. QUINN. Good idea. (Laughter.)

Mr. SCHNEIDER. Thank you.

Mr. QUINN. Thank you.

[Whereupon, at 1:46 p.m., the subcommittee was adjourned.]

## APPENDIX

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### PREPARED STATEMENT OF CONGRESSWOMAN CHENOWETH-HAGE

I'd like to thank Chairman Quinn and Chairman Stearns for holding this important hearing. I'd also like to thank Heather French, Miss America 2000, and the other panelists for taking time out of their busy schedule to testify before this committee. It is good to know that we are working together to help improve the lives of our homeless veterans.

As many of you know, homeless veterans are often our most forgotten veterans. We honor our World War II veterans, Gulf War veterans, veterans who receive Purple Hearts, and veterans who have served long and distinguished careers in the military. There are ceremonies, parades, and public recognition for these veterans, but what about our homeless veterans? What happens to these forgotten heroes?

The Clinton/Gore Administration continues to make it difficult for our veterans to achieve self-sufficiency. When veterans file for benefits such as a home loan, the VA buries them under paperwork. When veterans attempt to receive treatment at a VA Medical Center, they may be subjected to a six month wait. In short, this Administration's neglect has caused many veterans to be homeless.

Despite the Clinton/Gore Administration's lack of concern, I am glad to report that local communities pulled together to help Idaho's homeless veterans. Last year, Boise held Stand Down '99 to help our neediest veterans. Stand Down provided Idaho's homeless veterans with a hot meal, clothing, warm shower, medical treatment, and assistance in obtaining employment for our veterans. Boise sent the Clinton/Gore Administration a message: "don't forget our neediest veterans!" With the help of many caring people, Stand Down '99 showed the Administration that our veterans must never be forgotten. I hope we can continue this wonderful community program for our veterans.

While local communities pull together, we on the House Veterans' Committee have also helped our homeless veterans. During the first session of this Congress, this Committee passed Veterans' Millennium Health Care Act. This legislation, which was eventually signed into public law, extended authorization for VA and Department of Labor programs to help assist homeless veterans. In addition, this bill awards grants for building and remodeling of State veterans' homes and also provides grants for homeless veterans. I would like to commend my colleague, Representative Cliff Stearns, for his relentless work on improving opportunities for our homeless veterans.

Thank you Chairman Quinn and Stearns for giving me this opportunity to present my statement.

**Statement of Congressman Luis Gutierrez  
House Committee on Veterans' Affairs  
Subcommittee on Health and Subcommittee on Benefits  
Joint Hearing on Homeless Veterans  
March 9, 2000**

Thank you, Mr. Chairmen. I am pleased that we are holding this joint subcommittee hearing on the very important topic of homeless veterans. I welcome all of our guests here today and I look forward to hearing from our panels and witnesses to learn about their perspectives on this issue.

The statistics regarding homeless veterans are troubling. There are estimates which suggest that as many as four-hundred thousand veterans may be homeless at any given time. One-third of all homeless men in the United States are veterans. Half of all homeless veterans report chronic health problems. Three-fourths of all homeless veterans have a drug, alcohol or mental health problem, and approximately nine out of ten have experienced such a problem at some point in their lives. Contrary to what many may believe, homelessness is not just a problem that is found in our most populated American cities. However, it is not uncommon to visit a place like Chicago or New York City and see a person with a sign that reads "Homeless veteran. Please help. God bless

you.” I believe that we must work diligently to get to the root of these problems and reduce these figures.

Federal policy toward veterans recognizes the importance of their service to the nation and the effect that service may have on their subsequent civilian lives. The Department of Veterans Affairs runs the majority of federal programs that assist our men and women after completion of their military service. I am pleased that VA’s Fiscal Year 2000 budget increased funding for specialized services for homeless veterans by \$50 million. VA expects to spend almost \$144 million this year on programs for homeless veterans and the budget for these programs is expected to increase for fiscal year 2001. I should also note that the Department of Labor and the Department of Housing and Urban Development have many programs that benefit our nation’s veterans. I am eager to hear from the representatives of these departments who have joined us today.

Mr. Chairmen, thank you again for holding a hearing on this important issue.

STATEMENT OF  
LANE EVANS  
RANKING DEMOCRATIC MEMBER  
COMMITTEE ON VETERANS AFFAIRS

Hearing on Homeless Veterans' Issue  
March 9, 2000

Good Morning. Msrs. Chairmen, I am pleased that you have called this very important hearing today. I ask that a statement by AFGE be included in the hearing record.

Homeless veterans represent about a quarter of the people living on America's streets. This is a national disgrace. Former VA Secretary Jesse Brown recognized this tragedy and made addressing homelessness a fifth mission of the VA. While we have done much to improve VA's services for homeless veterans, this effort to eliminate homelessness has many fronts. It is clear to anyone who has passed a city grate on a frosty night that we have far more to do.

While there is much to be done, there is great hope that much will be done. Much of this hope is due to our current Miss America 2000, Heather Renee French, a compassionate and articulate advocate for our nation's homeless veterans. Miss French, I want to offer my heartfelt thanks to you today, not just for what you will accomplish on behalf of our veterans during your reign, but for bringing thousands of veterans hope in making Americans aware of their plight. As a veteran and as an advocate for veterans, I thank you for your recognition of this tremendous problem. Too many young Americans have lost sight of the contributions veterans have made to our way of life. You give us hope that young and not so young Americans who are made to understand the sacrifices that have been made on their behalf will be eager to stand for veterans in their hour of need.

The last Clinton/Gore budget proposed a \$50-million initiative targeted at programs to assist homeless veterans. This initiative includes expanded outreach and community-based contract residential care, including projects specifically directed to homeless women veterans. It allows creation of new community-based beds and will allow per-diem payments to fund care in organizations that have not received grants. In addition, it identified spending for compensated work therapy, "stand downs", and distribution of excess equipment and clothing.

I was pleased that the Administration proposed this comprehensive and multi-faceted approach. However, I was also concerned that the initiatives lacked multi-year funds so VA could start and continue these important programs. Last fall, I wrote the VA with seven other Democratic Members of this Committee to ask VA if it planned to continue to identify the funding for these initiatives in future years. Unfortunately, VA responded that it would not offer a multi-year budgetary commitment to fulfill the initiatives beyond fiscal year 2000. How many of us would accept the challenge of developing a program to address such a vulnerable part of the veteran population without knowing where our next dollar would come from? I am eager to hear VA explain to those who receive these funds the plans that are in place to assure an ongoing commitment from VA to support the new programs that will just begin operating by the end of fiscal year 2000 when their funding runs out.

I also want to join Miss French in calling on our appropriators to earmark \$750,000 of The Department of Housing and Urban Development (HUD) homeless programs budget for veterans programs. The funding would take the form of a line-item appropriation to provide technical assistance to community-based homeless services providers and would allow them to expend their capabilities for homeless veterans. The funding would be provided to the National Coalition for Homeless Veterans (NCHV), a nationwide non-profit organization with ten years' experience aiding such groups.

A new survey released by HUD Secretary Andrew Cuomo, *Homelessness: Programs and the People They Serve*, was recently made public by HUD. It indicates that while veteran-specific programs funded by VA [the Department of Veterans Affairs] and the Department of Labor have had a significant effect, more is needed. It is time for HUD to step up to the plate. Veteran-specific efforts are barely mentioned in the HUD report. Less than 3 percent of HUD homeless grant money goes to veteran-specific programs. With 23% of the homeless being veterans, scarcely 5 percent of the permanent housing programs *will not* meet veterans' needs. The numbers aren't much better for transitional housing or emergency shelter programs. Clearly HUD needs to do more to meet the needs of homeless veterans.

VA can provide excellent care to homeless veterans, but it cannot meet the need alone. VA's efforts seem to work best when it brings together a variety of VA, other federal programs and community services. Just a couple of months ago, one of my staff members related her experience at the Little Rock VA Comprehensive Homeless Center to me. This program is a good example of what

the term “One VA” is all about. The Center provides hot meals, clothing, shower and laundry facilities, some primary care, linkages to housing and vocational rehabilitation programs, and benefits counseling to veterans. Vets don’t live in the Center, yet it gives them a place to re-group and a launching pad from which to establish a more stable life. I think when you hear Estella Morris’s testimony you’ll agree that we need to have this sort of center in at least 20 of our major metropolitan areas. Estella Morris is the director of the Little Rock Comprehensive Homelessness Center. She, as well as Dr. Henrietta Fishman are with us today and I look forward to their testimony about the innovative treatment their programs offer.

I have the utmost respect for the important work VA does in the area of homelessness. Yet, without a viable acute and chronic psychiatric system to support their efforts, I believe this valuable work will be compromised. In the last few years, VA’s inpatient psychiatric programs, which include programs for treatment of substance abuse and post-traumatic stress disorder, as well as other mental illnesses common to the homeless population, have literally been decimated. I am not well assured by VA’s claim that it has “maintained the capacity” of these programs as required by law.

I am in the process of reviewing a report from the General Accounting Office (GAO) that examined trends in VA treatment for veterans with dual diagnoses, that is, generally, veterans with substance abuse and mental illness, among others with chronic conditions for which treatment has been labeled a “special emphasis program” within the Veterans Health Administration. I asked GAO to determine if they could confirm whether VA was maintaining capacity in its special emphasis programs. I am yet not at liberty to release GAO’s findings as the agency has not yet had an opportunity to comment upon them, but I hope they will be the subject of future hearings. VA will tell you accessible mental health programs, in VA or in Vet Centers, are often the “hook” for veterans to use other health care services and benefits. If we want homeless veterans to resume their lives as productive citizens, they must have access to good mental health programs. So strong mental health programs are the foundation for strong homeless programs in VA; I believe they are so closely linked that to compromise one is to compromise the other.

I am also firmly convinced of the value of case management for people who are homeless and for people with serious chronic mental illness. If I believed that veterans who had been discharged from inpatient programs had been placed in intensive psychiatric community case management programs, I would be pleased.

A program that assigns someone to look out for a particular veteran whether that veteran needs a pension, a hot meal, fresh clothes, a bed, or a new start on life has a lot better chance of helping that veteran overcome the hurdles of multiple bureaucracies that can often frustrate him or her and to help that veteran successfully re-integrate into society. But many of the VA's mental health officials will readily admit that the closure of inpatient beds has significantly outpaced VA's ability to develop a strong community-based infrastructure, and where community resources are also lacking there are now real gaps in the safety net. At best it appears veterans find a highly variable mix of mental health programs available to meet their needs around the system.

We know that there is no single solution to solve the issue of homelessness. It will require a multi-faceted approach with many participants. As a resource for veterans, who are sadly such a large part of this population, VA should play a major role. But we must also ask other federal, state, local, and private agencies to lend a hand. When it comes to helping our fallen comrades, we should draw on all of our resources.

Thank you. I will look forward to hearing our expert witnesses today.

**STATEMENT**

**of**

**Heather French  
Miss America 2000**

**before the**

**Subcommittees on Benefits and Health**

**of the**

**Committee on Veterans Affairs  
United States House of Representatives**

**The Honorable Jack Quinn  
and  
The Honorable Cliff Stearns  
*Chairmen***

**March 9, 2000  
Washington, DC**

Chairmen Quinn and Stearns, I thank you for the opportunity to present my views here today. On any given night there are the equivalent of 17 infantry divisions on the streets of this great nation with no place to call home. These are men and women who served our nation during its greatest times of need and now live without shelter or food or medical care. They are the once young men and women now aging who we sent abroad to defend our country but cast aside upon their return. They are our country's forgotten heroes those who at one time may have been awarded a Medal of Honor or Purple Heart.

Today as Miss America 2000 I serve as a national role model and advocate for our homeless veterans. I care about our veterans because, first and foremost beyond the crown, I am the daughter of a disabled Vietnam veteran whose struggles have changed my life forever. I had my first experience with the plight of our veterans when my father began taking me to the VA Medical Center with him at the age of four. At that time appointment at the VA was an all day event. They used to have a light board from the number 1 to 1,000 and it always seemed my father received number 999!

I would wait in the VA lobby for hours waiting for my father's turn to receive treatment. During that time I was able to hear the most intriguing stories of trauma and victory from the veterans that surrounded me. That was the first time I learned to listen...not just with my ears but also with my heart. Through the eyes of my father, I have seen challenges that face our nation's homeless veterans everyday: the pain of psychological trauma, especially Post Traumatic stress disorder resulting from perils of war; the struggle to overcome drug and alcohol addiction; the heartache of rejection from potential employers, landlords, neighbors, friends and sometimes even family.

As the first Miss America of the new millennium I have chosen to do so as a bold spokesperson and advocate for our nation's homeless veterans. I have dedicated, not just my year of service, but also my life to creating unprecedented awareness surrounding this issue. I will travel over 20,000 miles each month speaking to as many citizens as I possibly can about the needs of these heroes. And I will continue to do so and ask the news media to join me in a partnership that informs and educates young and old alike because I believe their stories deserve to be heard. The story of our veterans is one of ultimate sacrifice, the greatest of love stories, because these soldiers were once willing to lay down their lives for our nation.

Since becoming Miss America in mid-September, 1999 I have been visiting homeless veteran programs all over the nation from VA programs, to community-based nonprofit organizations, to Stand Downs which are community events by many organizations and government agencies for outreach to veterans. I have been able to hear countless personal stories of veterans and observe first hand different community-based programs serving the needs of these forgotten heroes.

Homeless veterans want to be able to regain personal pride by taking personal responsibility to remove the barriers that have prevented their transition to productive citizenship. In order to do this they need access to substance abuse recovery and mental health programs, affordable housing, and employment opportunities. During my travels I have seen first hand programs that are helping in a significant and meaningful way to reconstruct lives and reunite families. Every visit connects me with successful stories from the streets, men and women who were formerly homeless now with careers, a reconnected family, a home, and a new outlook on life. These veterans are now able to live a part of the "American Dream" that they were promised but were denied for so long.

It is very clear to me that it takes a network of partnerships to be able to provide a full range of services to homeless veterans. No one entity can provide this complex set of requirements without developing relationships with others in the community.

Community-based nonprofit organizations are most often the coordinator of services because they house the veteran during his transition. These community-based organizations must orchestrate a complex set of funding and service delivery streams with multiple agencies that each play a key critical role.

We look to the Department of Veterans Affairs to take the lead in providing health care and benefits for homeless veterans. Community-based organizations recognize the tremendous improvements that have been made in the last ten years within the Department of Veterans Affairs. Recognition by the VA that they can share in the successful reintegration of homeless veterans with other members of the communities they serve by forming alliances has made a positive change in reaching more homeless veterans. In talking with community-based providers these are the improvements I would suggest:

◆ **Require the DVA to setup and Homeless Veterans Advisory Committee** under the Office of Intergovernmental Affairs that would provide an unfiltered and unrestricted channel of information to the DVA Secretary concerning the issues affecting homeless veterans.

◆ **Require the DVA to Measure, Report, and Implement System-wide Services to Homeless Veterans.**

A mission to serve the needs of homeless veterans, written into VA's strategic plans for the long term, would secure the place of these forgotten men and women. VA needs to dedicate funding of homeless veteran services not just on a year-to-year basis that does not allow for long-term focus or results. The State Veteran Home Program would be a comparable model.

Currently it is unclear what the staffing and funding levels in each medical center are dedicated to homeless services. We suggest that Congress request a reporting, by each medical center, the current level of service and what plans each center has to build comprehensive services for homeless veterans.

The DVA Director of Homeless Services should be used as a consultant on all DVA policy decisions relating to services for homeless veterans. The Director has the opportunity to provide unique insight into the working relationships of community-based organizations and the DVA.

◆ **Fund the VA Homeless Providers Grant and Per Diem at \$50 million**

In the FY 1999 Appropriations Bill, Congress allocated \$14 million for VA's homeless grant program, and another \$6 million for its homeless per diem program. These programs, begun in 1992 to fund the development and operation of transitional housing programs for homeless veterans who are free of drugs and alcohol, have made over 4,000 beds available with only \$41 million over those years. Like Department of Labor, Homeless Veterans Reintegration Program, the money activates the genius of community-based organizations with veteran-specific programs.

Congress needs to make the per year allocation to VA's Homeless Providers' Grant and Per Diem Program a line item appropriation at *\$50 million in FY 2001 through FY2005*. VA continues to play -- and *must* continue to play -- a key role in providing health care to homeless veterans, both through its own facilities and direct care programs, and through contracts with community-based providers whose unique programs and locations and understanding of homeless veterans make them better fit to meet specific needs.

In addition, half a dozen years of experience show that VA's regulations for its Homeless Providers Grant and Per Diem Program need revisions to allow:

- Providers to use in-kind contributions to count toward the matching funds they must provide for operational expenses.
- Give priority to proven effective organizations serving veterans.

◆ **Develop a formal nationwide expedited claims process for homeless veterans.**

Veterans become homeless while waiting for their VA claims to be processed and often a resolved claim can provide the means for a homeless veteran to get into housing. It is unconscionable that a veteran would be forced to live in homelessness while waiting months or years for a claim to be resolved. There are several model DVA Regional office programs that provide exemplary models that should be developed into a national DVA model, with sanctions for not complying.

**Employment** -- having and keeping a job with a routine and decent pay and benefits -- is the key to ending homelessness. Having a job at the end of the tunnel is often the difference between success and failure for vocational rehabilitation and substance abuse treatment. Employment is central to keeping homes and families together.

◆ **Appropriations at authorized level for the Homeless Veterans Reintegration Program**

The capstone of employment efforts for homeless veterans has been the *Homeless Veterans Reintegration Program (HVRP)* of the Department of Labor (DOL), which has been authorized at \$15 million for FY2001.

Members of the House Veterans Affairs Committee were true veteran advocates in the last session of the 106<sup>th</sup> Congress by reauthorizing HVRP at increased levels through FY2004 and by influencing the appropriators to provide full funding of the authorized level in FY2000 for the *first time in the history* of this program. That is a record that should be continued and your leadership is appreciated.

**Housing**

Community-based organizations express the need for safe, clean, sober housing for veterans as being one of the most pressing needs in their efforts to assist veterans, if indeed not the most pressing need.

◆ **Ensure that Veterans Receive an Equitable Portion of HUD Resources Nationwide**

One of the biggest frustrations I have heard in talking with community-based organizations is that homeless veteran specific programs receive such a small percentage of the Housing and Urban Development (HUD) homeless funding. While veterans are 23% of the total homeless population and 33% of the male homeless population, veteran specific homeless programs receive less than 3% of HUD funding.

Congress should take all necessary steps to ensure that homeless veterans are in the process of resource allocations in every state and in all 900 plus areas for distribution of HUD homeless funds, as full partners in the process. State and community boards must include veteran representation in creating and distributing grant proposals and funding. NCHV urges Congress to require that *HUD report to Congress* annually:

- Veteran community-based providers participation in fund allocation at every level.
- What funds veterans receive for any purpose at every level.
- A customer satisfaction survey to veterans who are potentially eligible for or who actually receive HUD-funded services.

◆ **Allocate \$750,000 in FY2001 to the National Coalition for Homeless Veterans (NCHV) for technical assistance to homeless veteran service providers.**

The appropriations would be for NCHV to provide technical assistance to build the capacity of service providers to meet the needs of veterans to help them transition out of homelessness.

Currently NCHV does not have the resources to expand capacity to meet the needs of community-based providers. The Department of Veterans Affairs is not able to provide that technical assistance and HUD does not address the specific needs of veterans.

NCHV is the only group that has direct lines of communication *already established* with grassroots organizations providing direct services to homeless veterans (and other local organizations), veteran service organizations, the VA, HUD, DOL (and other federal agencies), and a myriad of national and local homeless organizations.

Community-based organizations are where the rubber meets the road. They are responsible for services delivered and they have stated that *they need help* leveraging their resources, getting funding and finding solutions to inadequate funding.

Veteran specific providers want to be competitive within HUD and other federal, state and local agencies grants programs, as well as within the private sector. NCHV can be the bridge that helps each veteran arrive back home. Veteran-specific programs can more

effectively target homeless veterans, who comprise one-third of the homeless male population in the United States.

♦ **DVA provide changes to policy of loan guaranty for manufactured housing.** Veterans' choices would be enhanced if they could more easily choose to finance their manufactured home as either real or personal property. The current The Department of Veterans Affairs (VA) regulations do not allow that. The VA could study the value of changing it regulations by working with community-based providers to amend the VA regulations as necessary for this pilot project – using manufactured homes as a source of affordable housing for homeless veterans.

The VA loan guaranty program has a component that allows the VA to guarantee loans on personal property manufactured homes. The program has seen very little volume for a number of years for a couple of reasons. The program for personal property manufactured homes requires a minimum down payment of five percent. Conventional lending programs (non-government guaranteed or insured) generally offer similarly low down payment loans without the paperwork required in a VA-guaranteed loan.

The VA loan guaranty program for homes that are financed as real estate requires no down payment from the veteran. It does, however, require that the home be installed on a site-built foundation and that the home and land be treated as a single real estate transaction under state law. The site-built foundation requirement often eliminates a traditionally installed manufactured home from consideration for a VA loan, even though the home may be installed in a manner that is just as safe and secure as if it were on a site-built foundation. Converting a manufactured home from personal to real property under state law is often not a simple transaction. Mortgage lenders, furthermore, often avoid financing manufactured homes as real estate for fear that adding this complication to the transaction could endanger their security interest in the home.

VA's program for guaranteeing loans on personal property manufactured homes requires only that the home be installed in accordance with the manufacturer's installation instructions. This transaction also would not require that the home become a fixture to the land or that the home and land be treated as a single real estate transaction. Unfortunately, lenders are discouraged from offering and veterans are discouraged from pursuing VA-guaranteed loans on personal property manufactured homes. It could not hurt to examine if this can be remedied.

As my year of service continues I will share my personal encounters with these forgotten heroes that I have met. I have seen in their faces the face of my own father and I can tell you that the most beautiful faces in this nation are not those whose heads are adorned with crowns but those who have borne the battle...our veterans.

Looking in the eyes of men and women who were once decorated with medals only now to be replaced with broken spirits I encourage this committee to implement policy changes that will finally end homelessness among veterans.

Thank you for this holding this hearing and for your commitment to all our nation's veterans.

**VITAE**  
**Heather French**  
**Miss America 2000**

***Education:***

University of Cincinnati  
 Pursuing Master's Degree in Fashion Design & Illustration  
 Bachelor's Degree in Fashion Design  
 Recipient of more than \$80,000 in Miss America Scholarships

***Ambition:***

To complete a Master's degree. Also to complete fashion illustration textbook for college-level design students. To pursue a career as a designer of women's career wear.

***Platform:***

The Forgotten Heroes: Honoring Our Nation's Homeless Veterans

**STATEMENT OF  
FRANCES M. MURPHY, M. D., M. P. H.  
ACTING DEPUTY UNDER SECRETARY FOR POLICY AND MANAGEMENT  
DEPARTMENT OF VETERANS AFFAIRS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS, SUBCOMMITTEE ON HEALTH AND  
SUBCOMMITTEE ON BENEFITS  
U. S. HOUSE OF REPRESENTATIVES**

**March 9, 2000**

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Mr. Chairmen and Members of the Committees

I appreciate the opportunity to discuss homelessness among veterans and the VA's efforts to address homeless veterans' needs. Accompanying me this morning are Ms. Estella Morris, Program Manager of the Comprehensive Homeless Center of the Central Arkansas Veterans Health Care System, Ms. Henrietta Fishman, Manager of the Network 3 Homeless Veterans Treatment Programs Service Line and Mr. Peter Dougherty, Director, Homeless Veterans Programs. Mr. Angel Caban, a formerly homeless veteran, who now serves as a supervisory social worker for the VISN 3 Mental Illness Research, Education and Clinical Center (MIRECC), is also with us today.

VA has developed a wide range of programs and services to address homeless veterans needs. These programs operate in partnership with community-based organizations and service providers and other federally funded programs. With the additional funding made available in the FY 2000 budget we will be significantly expanding our homeless programs this year and we plan to initiate new program evaluation efforts as required by the Millennium Act. While many special programs have been designed to address the special needs of homeless veterans, they do not function in isolation. These programs are integrated with other VA healthcare and benefits services. In addition, VA relies heavily on its federal, state and community based partners to assure a full range of services for homeless veterans.

**Homeless Veteran Population**

In 1996 the Federal Interagency Council on the Homeless (ICH) designed and the Census Bureau conducted the "National Survey of Homeless Assistance Providers and Clients." The survey was conducted in the 28 largest metropolitan areas, 24 randomly selected small and medium sized areas and 24 randomly selected groups of rural counties. Approximately 12,000 service providers were contacted and 4,200 consumers of homeless services were interviewed. Survey findings and a technical

report written by the Urban Institute were released in December 1999. Survey findings related to homeless veterans were as follows:

- 33% of homeless males and 23% of homeless adults are veterans while 31% of adult males and 13% of all adults are veterans;
- 33% of homeless veterans report being stationed in a war zone;
- 28% of homeless veterans report being exposed to combat;
- 67% of homeless veterans reported serving 3 or more years in the military;
- 32% of veterans compared to 17% of non-veterans reported that their last episode of homelessness lasted more than 13 months; and
- 57% of homeless veterans reported using VA health care services at least once.

The Urban Institute issued a press release in February 2000, estimating that between 2.3 million to 3.5 million Americans may have experienced an episode of homelessness during 1996. Extrapolation from this estimate would suggest that between 322,000 – 491,000 veterans might have experienced homelessness during that time period.

#### Homeless Veterans Served by VA

In FY 1999, staff in VA's Health Care for Homeless Veterans (HCHV) Program had contacts with over 39,000 homeless veterans. Approximately 29,000 homeless veterans were given formal intake assessments to determine their clinical, housing and income status. Data from these intake assessments provides VA with detailed information about the demographic and clinical characteristics of the homeless veterans served by VA. We would like to share some of these findings with you today:

- Approximately 97% of homeless veterans contacted by program staff are men and 3% are women.
- The mean age of these veterans was 46.
- Approximately 48% of the veterans served in the military during the Viet Nam Era while nearly 4% served during the Persian Gulf era.
- Approximately 50% of these veterans were African Americans and 6% were Hispanic.
- 60% of homeless veterans report part-time, irregular employment or no employment; 73% of homeless veterans report not having worked at all during the 30 days prior to the intake assessment.
- 68% of homeless veterans reported living in emergency shelters or outdoors at the time of the intake assessment.
- 81% of homeless veterans were determined by HCHV clinicians to have a serious psychiatric or substance abuse problem -
  - 43% had a serious psychiatric problem,
  - 69% were dependent on alcohol and/or drugs,
  - 31% were dually diagnosed with psychiatric and substance abuse

disorders.

### **Programs and Services Provided by VA**

VA is the only federal agency that provides substantial hands-on assistance directly to homeless persons. Although limited to veterans, VA's major homeless programs constitute the largest integrated network of homeless assistance programs in the country, offering a wide array of services and initiatives to help veterans recover from homelessness and live as self-sufficiently and independently as possible.

VA, using its resources or in partnerships with others, has secured more than 8,000 transitional and permanent beds for homeless veterans throughout the nation. These include:

- beds in VA's Domiciliary Care for Homeless Veterans (DCHV) program;
- beds in VA's Compensated Work Therapy/Transitional Residence (CWT/TR) program;
- beds supported through the Health Care for Homeless Veterans (HCHV) program;
- the VA Supported Housing (VASH) program;
- the joint HUD-VA Supported Housing (HUD-VASH) program; and
- the Homeless Providers Grant and Per Diem Program.

With new initiatives that will be started this year, VA expects to add approximately 9,000 more transitional beds for homeless veterans over the next 4 years.

In addition to these special initiatives, VA provides a wide range of services to homeless veterans through its mainstream health care and benefit assistance programs. To increase this assistance, VA has initiated outreach efforts to connect more homeless veterans to both mainstream and homeless-specific VA programs and benefits. These programs strive to offer a continuum of services including:

- aggressive outreach to veterans living on streets and in shelters who otherwise would not seek assistance;
- clinical assessment and referral to needed medical treatment for physical and psychiatric disorders including substance abuse;
- long-term sheltered transitional assistance, case management and rehabilitation;
- linkage and referrals for employment assistance, linkage with available income supports; and assistance in obtaining housing.

### **Homeless Veterans-Specific Programs**

VA's FY 2000 budget increased funding for specialized services for homeless veterans by \$50 million. Of this increase, \$39.6 million was included in the medical care appropriation and the remainder is available to guarantee loans made under the Multifamily Transitional Housing for Homeless Veterans Program. VA expects to spend \$143.8 million on specialized programs for homeless veterans this year and is

projecting a budget of \$150.6 million for these programs in FY 2001. The following provides an overview of the types of programs VA has developed to meet the multiple and varied needs of homeless veterans:

**VA's Health Care for Homeless Veterans Program (HCHV)** operates at 76 sites where extensive outreach, physical and psychiatric health exams, treatment, referrals, and ongoing case management are provided to homeless veterans with mental health problems, including substance abuse. As appropriate, the HCHV program places homeless veterans needing longer-term treatment into one of its 200 contract community-based facilities. During the last reporting year, this program assessed more than 29,000 veterans, with 4,000 receiving residential treatment in community-based treatment facilities. The average length of stay in community-based residential care is about 70 days and the average cost per day is approximately \$39.00. **VA is committing \$18.8 million to the expansion of the HCHV program in FY 2000. This includes the activation of new sites and expansion of existing programs. When new staff and new programs are fully operational, it is expected that 12,000 additional homeless veterans will be treated. Approximately one third of these veterans will be provided contract residential treatment. In FY 2000, VHA will commit an additional \$3 million to establish 10 programs that will be dedicated to homeless women veterans. These programs are expected to serve 1,500 homeless women veterans per year.**

**VA's Domiciliary Care for Homeless Veterans (DCHV) Program** provides medical care and rehabilitation in a residential setting on VA medical center grounds to eligible ambulatory veterans disabled by medical or psychiatric disorders, injury or age and who do not need hospitalization or nursing home care. There are 1,751 operational beds available through the program at 35 VA medical centers in 26 states. The program provided residential treatment to some 5,530 homeless veterans in FY 1998. The domiciliaries conduct outreach and referral; admission screening and assessment; medical and psychiatric evaluation; treatment, vocational counseling and rehabilitation; and post-discharge community support.

**Special Outreach and Benefits Assistance** is provided through funding from VA's Veterans Health Administration to support 12 veterans benefits counselors from the Veterans Benefits Administration (VBA) as members of VA's Health Care for Homeless Veterans Program and DCHV programs.

**Acquired Property Sales for Homeless Providers Program** makes available properties VA obtains through foreclosures on VA-insured mortgages. These properties are offered for sale to homeless provider organizations at a discount of 20 to

50%. To date, 116 properties have been sold, and 58 have been leased to nonprofit organizations to provide housing for the homeless.

**Drop-In Centers** provide homeless veterans who sleep in shelters or on the streets at night with safe, daytime environments. Eleven centers offer therapeutic activities and programs to improve daily living skills, meals, and a place to shower and wash clothes. At these VA-run centers, veterans also participate in other VA programs that provide more extensive assistance, including a variety of therapeutic and rehabilitative activities. Drop-In Center staff also coordinates with other programs to provide veterans with long-term care services.

**Compensated Work Therapy (CWT) and CWT/Transitional Residence Programs** have had dramatic increases in activity during the past few years. Through its CWT/TR program, VA offers structured therapeutic work opportunities and supervised therapeutic housing for at risk and homeless veterans with physical, psychiatric and substance abuse disorders. VA contracts with private industry and the public sector for work to be done by these veterans, who learn new job skills, re-learn successful work habits and regain a sense of self-esteem and self-worth. The veterans are paid for their work and, in turn, make a monthly payment toward maintenance and upkeep of the residence.

The CWT/TR program includes 49 community-based group home transitional residences with more than 400 beds. Nine program sites with 14 houses exclusively serve homeless veterans. The average length of stay is approximately six months. There currently are more than 100 individual CWT operations connected to VA medical centers nationwide. Nearly 15,000 veterans participated in the programs in 1999, an increase of more than 5,000 over 1996. CWT programs developed contracts with companies and agencies of government valued at a national total of \$43.8 million. Increased competitive therapeutic work opportunities are occurring each year. At discharge from the CWT/TR program 44% of the veterans were placed in competitive employment and 7% were placed in training programs. **VA has committed \$2.3 million to the activation of new CWT programs and other therapeutic employment initiatives for homeless veterans. When these programs are fully operational, it is expected that they will be able to serve an additional 1,600 veterans annually.**

Intradepartmental programs also support the CWT programs for homeless veterans. VA's National Cemetery Administration and Veterans Health Administration have formed partnerships at 20 national cemeteries, where more than 100 formerly homeless veterans from the CWT program have received therapeutic work opportunities while providing VA cemeteries with a supplemental work force.

**HUD-VA Supported Housing (HUD-VASH) Program**, a joint program with the Department of Housing and Urban Development (HUD), provides permanent housing

and ongoing treatment services to the harder-to-serve homeless mentally ill veterans and those suffering from substance abuse disorders. HUD's Section 8 Voucher Program continues to renew 1,780 vouchers for \$44.5 million, designated over a ten year period, for homeless chronically mentally ill veterans, and VA staff at 35 sites provide outreach, clinical care and case management services. Rigorous evaluation of this program indicates that this approach significantly reduces days of homelessness for veterans who suffer from serious mental illness and substance abuse disorders.

**VA's Supported Housing Program** is like the HUD-VASH program in that VA staff provides therapeutic support and assistance to help homeless veterans secure low-cost, long-term transitional or permanent housing and provide ongoing clinical case management services to help them remain in housing. It differs from HUD-VASH in that dedicated Section 8 housing vouchers are not available to homeless veterans in the program. As part of VA's clinical case management services, staff work with private landlords, public housing authorities and nonprofit organizations to find therapeutically appropriate housing arrangements. Veterans service organizations have been instrumental in helping VA establish these housing alternatives nationwide. In 1998, VA staff at 26 Supported Housing Program sites helped 1,700 homeless veterans find transitional or permanent housing in the community.

**Joint Social Security Administration (SSA)/VA Pilot Project** provides benefits and services to homeless mentally ill veterans at four sites – New York City, Brooklyn, Dallas, and Los Angeles. HCHV and DCHV staff coordinate outreach and benefits certification with SSA staff to locate and assist homeless veterans in obtaining SSA benefits.

**Comprehensive Homeless Centers** place a variety of VA's homeless programs into an integrated organizational framework to promote coordination of VA resources and non-VA homeless programs. VA currently has eight comprehensive homeless centers connected to medical centers in Anchorage, Brooklyn, Cleveland, Dallas, Little Rock, Pittsburgh, San Francisco, and West Los Angeles.

**Stand Downs** are 1-3 day safe havens for homeless veterans that provide a variety of services to veterans and opportunity for VA and community-based homeless providers to reach more homeless veterans. Stand downs provide homeless veterans a temporary place of safety and security where they can obtain food, shelter, clothing and a range of community and VA-specific assistance. In many locations, VA provides health screenings, referral and access to long-term treatment, benefits counseling, ID cards and linkage with other programs to meet their immediate needs. VA participated in 136 stand downs run by local coalitions in various cities during 1999. Surveys showed that more than 25,000 veterans and 8,000 members of their family and others

in need of assistance attended these events. More than 17,000 volunteers contributed to this effort. The Secretary has identified stand downs as VA's White House Millennium Project for 2000. **In FY 2000, VA is committing \$1.5 million to support stand downs. VA expects to participate in 200 stand downs and to provide services to 100,000 homeless veterans at these events.**

**VA Excess Property for Homeless Veterans Initiative** provides for the distribution of federal excess personal property, such as clothing, footwear, socks, sleeping bags, blankets and other items to homeless veterans through VA domicillaries and other outreach activities. In less than six years, this initiative has been responsible for the distribution of more than \$80 million worth of materiel and currently has more than \$8 million in inventory. A CWT program providing a therapeutic work experience for formerly homeless veterans has been established at the VA Medical Center in Lyons campus of the VA New Jersey Health Care System, to receive, warehouse and ship these goods to VA homeless programs across the country.

**The Homeless Providers Grant and Per Diem Program** is a dynamic component of VA's homeless-specific programs. It provides grants and per diem payments to assist public and nonprofit organizations to establish and operate new supportive housing and service centers for homeless veterans. Grant funds may also be used to assist organizations in purchasing vans to conduct outreach or provide transportation for homeless veterans. Since the first year of funding in FY 94, VA has awarded 178 grants to nonprofit organizations, units of state or local governments and Native American tribes in 42 states and the District of Columbia.

Total VA funding for grants has exceeded \$41 million. When these projects are completed, approximately 4,000 new community-based beds will be available for homeless veterans. Nearly 1,500 homeless veterans are being cared for through these programs today and supported by VA per diem payments to service providers.

**VA is committing \$11 million in additional funding for the Grant and Per Diem Program. For the first time VA is providing "Per Diem Only" awards to non-VA organizations that have not received grants. VA announced the availability of \$5 million for Per Diem Only awards on February 11, 2000. VA will also announce a new round of grants later this month and has committed \$12 million for the seventh round of funding. We estimate that 20,000 homeless veterans will receive services funded through the grant and per diem program in FY 2000.**

**Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans** is a nationwide initiative. VA medical center and regional office directors work with other federal, state and local agencies and nonprofit organizations. They assess the needs of homeless veterans, develop action plans to

meet identified needs, and develop directories that contain local community resources to be used by homeless veterans.

More than 10,000 representatives from non-VA organizations have participated in Project CHALENG initiatives, which include holding conferences at VA medical centers to raise awareness of the needs of homeless veterans, creating new partnerships in the fight against homelessness and developing new strategies for future action. As a result of recent Project CHALENG activities, 19 new homeless coalitions have been formed, 95 new interagency service agreements have been signed and 53 new sites were identified for outreach to homeless veterans.

**Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans** is currently being implemented as authorized by P. L. 105-368. This program will allow VA to guarantee loans made by lenders to help non-VA organizations develop transitional housing for homeless veterans. VA awarded a contract to Birch and Davis Associates, Inc., and their subcontractors, Century Housing Corporation, to assist with the development of this pilot program. VA plans to guarantee 5 loans in the next two years, with a total of 15 loans guaranteed over the next 5 years. It is expected that 5,000 new transitional beds for homeless programs will be created through this program.

### **Mainstream VA Programs Assisting Homeless Veterans**

The Veterans Benefits Administration (VBA) administers a number of compensation and pension programs: disability compensation, dependency and indemnity compensation, death compensation, death pension and disability pension. Vocational rehabilitation and counseling assist veterans with service-connected disabilities to achieve independence in daily living and to the extent possible become employable and maintain employment. In the Fiduciary or Guardianship Program, the benefits of veterans who are determined to be incapable of managing their funds are managed by fiduciary.

VBA regional offices at 57 locations have designated staffs who serve as coordinators and points of contact for homeless veterans through outreach activities. In FY 1999, VBA staff engaged over 23,000 homeless veterans through outreach activities. These VBA staff made 2,753 shelter visits and 4,721 agency visits.

The Readjustment Counseling Service's Vet Centers have homeless coordinators who provide outreach, psychological counseling, supportive social services and referrals to other VA and community programs. Each year approximately 140,000 veterans make more than 800,000 visits to VA's 206 Vet Centers. During the winter months, approximately 10% of Vet Center clients report being homeless.

A substantial number of homeless veterans are served by VHA's general inpatient and outpatient mental health programs. For the past five years VA at its Northeast Program Evaluation Center (NEPEC), has conducted an End-of-Year Survey of hospitalized homeless veterans in VA health care facilities. On September 30, 1999, 17,258 veterans were being treated in acute medical surgical and psychiatric beds, acute substance abuse beds, psychosocial residential rehabilitation and treatment program (PRRTP) beds and domiciliary beds. A total of 4,811 veterans (27.9%) were homeless at admission. Nearly 20% were living on the streets or in shelters before admission and 8% had no residence and were temporarily residing with family or friends.

A total of 4,376 veterans were being treated in VA mental health beds. Approximately one-third of these veterans were homeless at admission and another 6%, while not homeless when admitted, were at high risk for homelessness if discharged on the day of the survey. The following is a break out of the type of mental health bed section veterans occupied:

- 23.1% of 2,715 veterans in Acute Psychiatry beds were homeless at admission.
- 46.7% of 255 veterans in Acute Substance Abuse beds were homeless at admission.
- 48.5% of 1,406 veterans in PRRTP beds were homeless at admission.

VA has also collected information on homeless veterans seen in outpatient mental health programs. For FY 1999, a total of 664,340 veterans were treated in outpatient mental health programs. Approximately 62,000 (9.3%) of these veterans were identified as homeless on VA encounter forms. Over 70% of homeless veterans were treated in

VA's specialized programs for homeless veterans and the remaining 30% were treated in general mental health outpatient programs.

### **Homeless Veterans Program Monitoring and Evaluation**

VA has the Nation's most extensive and long-standing program of monitoring and evaluating data concerning homeless individuals and the programs that serve them. In 1987, we initiated a three-fold evaluation strategy for what was then an unprecedented VA community collaborative program – the original HCMI veterans program.

Under this evaluation plan: (1) all veterans evaluated by the program were systematically assessed to assure that program resources were directed to the intended target population (now almost 30,000 under served homeless veterans per year); (2) housing, employment, and clinical outcomes were documented for all veterans admitted to community-based residential treatment, the most expensive component of the program; and (3) a detailed outcome study documented housing and employment outcomes after program termination was initiated.

The VA study showed 30% to 40% improvement in psychiatric and substance abuse outcomes, employment rates doubled, and 64% exited from homelessness at the time of program completion. When these veterans were re-interviewed 7.2 months after program completion, they showed even GREATER improvement. A similar effort was mounted for the Domiciliary Care for Homeless Veterans program with similar long-term post-treatment results. These data have been published by NEPEC in leading medical journals.

After establishing the effectiveness of these standard programs with extensive follow-up studies, VA developed several enhancements to the core program in several areas. These areas include compensated work therapy (CWT), outreach to assure access to Social Security Administration (SSA) benefits, and a collaborative program with HUD that joins VA case management with HUD section 8 housing vouchers. Outcome studies demonstrated the long-term effectiveness of the CWT/TR program at reducing substance abuse and increasing employment. The Joint VA-SSA outreach effort conducted in New York City, Brooklyn, Dallas, and Los Angeles almost doubled the percentage of SSI awards made to veterans from 7.19 % to 12.4 % of the veterans contacted during the outreach effort.

An outcome study showed that, compared to a control group that did not receive benefits, SSA beneficiaries had improved housing and overall satisfaction with life as a result of their receipt of benefits. The outcome of the study also showed no increase in substance abuse, with the exception of tobacco use for SSA recipients. A follow-up study of the HUD-VA supported housing program shows that the benefits of this program, especially housing stability were sustained three years after program entry. This is one of the longest follow-up studies conducted on any homeless population anywhere.

All of our homeless initiatives and programs receive rigorous evaluation. VA uses a consistent set of clinical measures for the Homeless Providers Grant and Per Diem Program as with all other VA homeless veterans programs to assure that valid comparisons can be made. VA performance measures provide consistency in evaluating homeless programs.

In FY 2000, VA is expanding its evaluation of homeless veterans programs to more thoroughly determine the effectiveness of these programs. Sec. 904 of the Veterans Millennium Health Care and Benefits Act (P. L. 106-117) requires VA to conduct evaluations of its homeless veterans programs. This is to include measures to show whether veterans for whom housing or employment is secured through one or more of VA's programs continue to be housed or employed after six months. The General Accounting Office (GAO) made a similar recommendation in its April 1999 Report entitled, Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness is Unclear. GAO's single recommendation to VA was to conduct ... "a series of program evaluation studies to clarify the effectiveness of VA's core homeless programs and provide information about how to improve those programs."

Through these ongoing and new program evaluation efforts, VA expects to increase our knowledge about the effectiveness of services that are provided to assist homeless veterans. Information will be used to modify and improve our programs for homeless veterans.

### Conclusion

VA health care services and other benefits programs form the core elements for the wide range of medical, work therapy, rehabilitation, transitional housing and benefits programs, VA offers to homeless veterans. With assistance from community-based service providers and veterans service organizations, we are bringing thousands of veterans off the streets and into a continuum of care that offers them the health care and support services they need to resolve their health, housing and vocational problems.

The Department of Veterans Affairs is proud of its past contributions to homeless programs and is committed to enhancing the Nation's understanding of risk factors which contribute to this problem, to work towards reduction of homelessness among veterans and to providing high quality programs for homeless veterans.

I would be pleased to answer any questions the committees have at this time.

**Statement of  
Estella Morris, LCSW  
Program Manager, VA Comprehensive Homeless Center  
Central Arkansas Veterans Healthcare System  
Little Rock, Arkansas  
Before the  
Committee on Veterans' Affairs, Subcommittee on Health and  
Subcommittee on Benefits  
U. S. House of Representatives**

March 9, 2000

Mr. Chairmen and Members of the Committees

The Health Care for Homeless Veterans (HCHV) Program in Little Rock is one of 43 original Homeless Chronically Mentally Ill (HCMI) Programs implemented by VA in 1987. Since that time, we have expanded our services to address the myriad of physical, social, vocational and psychological problems that plague the population of homeless veterans in the state. In 1995, we were named one of eight Comprehensive Homeless Centers (CHC). The CHC in Little Rock includes HCMI street and shelter outreach and case management, Housing and Urban Development (HUD)-VA supported housing, HCMI supported housing, community residential contract treatment, domiciliary care, Compensated Work Therapy Therapeutic Residence (CWT/TR), VA benefits linkage, and a drop-in day treatment center. The Day Treatment Center is the newest component of Little Rock Homeless Programs. It has been the location for all Health Care for Homeless Veterans Programs since it opened March 15, 1996. The Center is in an accessible community-based location where homeless veterans can receive psychosocial and health assessments, participate in group activities, obtain donated military and civilian clothing, receive personal hygiene items, and use laundry and shower facilities.

The primary goal of the CHC is to expedite the transition of homeless veterans from a state of instability to one of physical, mental, vocational and social constancy. Methodologies for achieving this goal include outreach, referrals for acute and residential treatment in permanent housing and supported aftercare with clinical follow-up. In 1997, our innovative approaches to achieving this vision earned us the distinction of being named one of the first six Clinical Programs of Excellence for treatment of homeless veterans in the VA system. We received this two-year designation again in 1999.

We use a Social Treatment Model that focuses on the strengths of our veterans. After twelve years of operation, we take pride in knowing that we have consistently

provided services of exceptional quality that adhere to the "highest standards of clinical care, patient satisfaction, resource utilization, teaching and research."

In FY 99, we completed 474 intakes with 7,214 visits to 1,065 separate individuals. Of this number, 96.62% were males and 3.3% were females. Ninety five percent reported history of alcohol abuse, 84% reported history of drug abuse, 49% mental illness, 43% reported a medical illness and 62% admitted social or vocational skill deficits. Of that number 57.60% were African-Americans, 40.51% were Caucasians, 0.84% were Hispanic and 1.05% were other. The periods of service represented were Vietnam era, 47%, with 5% being between Korea and Vietnam, 1.05% being Korean, 0.42% pre Korean, 0.63% WWII, 43% Post Vietnam and 3.00% being Gulf War. Twenty-four percent reported combat exposure. We show that 45.57% were divorced, 22.57% were separated, 3.8% widowed, 6% married and 21.73% never married. Of the veterans seen in Little Rock, 41% indicated having been homeless more than one year compared to a national average of 26.94%. This reflects a greater degree of chronicity among homeless veterans in Arkansas.

In addition to a higher degree of chronic homelessness among veterans in Arkansas, the veterans appear to be much sicker. Eighty-one percent of veterans report hospitalization for a psychiatric or substance abuse problem compared to 66.97% for all other sites. To further complicate the picture, a population-based study by Dr. Rosenheck and others found that, VISN 16 had the second highest number of veterans with incomes below \$10,000. Despite the fact that our veterans are *sicker*, more *chronically homeless* and *poorer*, clinical outcome measures from VA's Northeast Program Evaluation Center (NEPEC) show that veterans discharged from residential treatment in Little Rock were consistently above the VA national average in improvements shown for all diagnostic categories. NEPEC data demonstrates that in 1998, 75.6% of veterans discharged from the HCHV program at Little Rock showed improvements regarding alcohol abuse compared to 67.9% nationally. In the area of drug abuse, 82.6% showed improvements compared to a national average of 66.7%. Improvement in mental health status was 85.7% for Little Rock compared to 62.9% nationally. In the social/vocational arena, we showed 84.5% improvement compared to the national average of 60%. Finally, we had 85.7% improvement in medical problems compared to 64.8% nationally.

We make referrals to the medical center for acute treatment in cases where veterans are actively abusing alcohol or drugs, in need of mental health follow-up or medical screening. In addition, we have taken several other actions to improve the health of the homeless veteran population outside of the medical center. We conduct health screenings, provide flu shots and TB screening for veterans in shelters, at soup kitchens and at the Drop-In Center. In 1997 and 1998, we saw a significant number of

veterans diagnosed with hepatitis C. This has resulted in targeted training during our health care prevention education groups at the Drop-In Center. During flu season, we undertake a significant outreach effort including making announcements at the shelters and soup kitchens and generally, "put the word out on the streets" when we receive the flu vaccine. This effort helps reduce the incidence of influenza in veterans on the streets, thus reducing the cases of emergency room visits or medical admissions.

We ensure the overall operating efficiency of the HCHV Program by closely monitoring admissions and discharges. This increases the probability of veterans taking advantage of the services of the program to improve their homeless status. This means assessing their motivation for treatment and testing to ensure that veterans going into residential treatment are not abusing alcohol or drugs. It also means discharging veterans abusing the drug and alcohol free environment of the treatment setting. This minimizes instances of veterans being admitted to treatment who are not sincere about maintaining their sobriety or working on mental health stability. In addition, we monitor the clinical capability of staff employed by the treatment facilities as a means of insuring that veterans are receiving the services that we are contracting for, rather than just maintenance services. Finally, we have weekly clinical case management conferences to insure that all staff are aware of clinical needs of veterans and to insure that those needs are addressed. We use these sessions to monitor progress of veterans in following their treatment plans, maintaining required savings and taking appropriate actions in working with VA Supported Housing and Supported Housing staff for locating permanent housing. We also invite clinical staff from our residential treatment facilities to participate in case conferences and provide monthly reports of program participants. The overall goal of these conferences is to insure continuity of care and to insure that all is being done that can be done on the part of the clinician and the veteran.

To improve veteran's accessibility to our program we moved to a community location in March 1996. In our opinion this was a productive move. This location increased convenience for both customers and staff. It also allowed us to increase the number of services that are readily available to veterans. Many veterans come to the Drop-In Center for screenings and referrals rather than going to the medical center, because the waiting time is much shorter. We make an effort to insure that veterans needing services have to wait no longer than 15 minutes before being seen by a case manager; most are seen within five minutes. Several years ago, we increased our hours to cover twelve-hour periods Monday - Thursday. This allows workers to provide individual and group clinical services to veterans in the evening. We also provide services that they are unable to get at other locations, i.e., laundry and shower services, coffee, snacks for breakfast and lunch, lockers, clothing, recreational facilities, and a place to call their own. We allow them to have input into the services provided and often engage them in assisting with various chores around the center. We assign

veterans frequenting the center to individual case managers for assistance with achieving stability. We have implemented a customer satisfaction survey that helps us monitor customer satisfaction with services. This helps to keep us aware of any need for targeted improvements or changes.

We place an average of 85 veterans annually in residential treatment with an average length of stay of 61 days. We seek to improve the overall standard of care for residential treatment facilities by identifying areas where gaps in services exist. CHC visit the treatment facilities 3-4 times per week and monitor documentation of staff treatment practices monthly. We also ensure continuity of care of patients discharged from residential care. In 1998, we scheduled follow-up treatment for 97% of veterans discharged from residential treatment, compared to 80.7% nationally. We scheduled 97.4% of veterans with a history of drug abuse for follow-up while 81.6% were scheduled for follow-up nationally. We had 98.4% scheduled for medical follow-up locally with 84.4% being scheduled for follow-up nationally. We have consistently remained above the national average in improvement and scheduling of follow-up care for all clinical areas since 1993.

Four years ago, we entered into an agreement with VA substance abuse staff to provide in-house treatment sessions to veterans in residential placement. This eliminated the problem veterans were having due to lack of city transportation in the evenings, discontinuance of weekend groups and problems with job scheduling.

We have consistently maintained a per diem rate in the contract residential care program well below the national average. Our overall cost for services is further reduced through use of non-VA resources when appropriate. This includes our collaboration with one non-profit homeless provider for a full time vocational case manager and a contract job counselor through the HUD Continuum of Care Grant and with another non-profit provider for a HUD Emergency Shelter grant to help cover expenses and provide food at the Drop-In Center.

We base our standards for success of the residential care program on the number of individuals in permanent housing at discharge. We use this measure, because the ultimate goal of HCMI Residential Treatment is permanent housing placement. Of veterans in HCMI residential treatment, 57.52 % were discharged to their own apartment, compared to 32% nationally. We believe one of the reasons for success in this area is the fact that we ensure that veterans have adequate funds saved that would allow them to remain in housing. Quantifiable evidence is seen in the improvements in permanent housing placement from 1991 to 1998. Our Domiciliary Program had 71% discharged to permanent housing, compared to 58% nationally. We

also show that 70% of veterans discharged from the Domiciliary were employed, compared to 54% nationally.

Veterans without disability payments require 90 days on the average to save adequate money for an apartment and housing start-up items. In addition, veterans leaving the program are not allowed to return within a six months period. We will, however, assist them in getting into community programs with the understanding that they can again return to our program in six months. This has been an incentive for veterans to use the services for the purposes for which they were designed.

The Homeless Veterans and Families Program funded through the HUD Continuum of Care is one example of an innovative program that is coordinated by HCHV. This program provides a full-time (40 hours/week) vocational case manager and a contract job placement counselor that are available on site to assist veterans with employment. This is a collaborative program with Volunteers of America (VOA).

Our focus is on meeting the homeless veterans where they are and helping them to address their needs in an environment that is conducive to their lifestyle. We strive to be non-judgmental in our manner and supportive in our services, without fostering dependence. This is especially important in housing as we believe the individuals at greatest risk of homelessness are those who have been homeless in the past. Maintaining an awareness of this helps to keep us attentive to the needs of veterans in permanent housing. Their satisfaction and continued success means that we have achieved some level of success in and understanding of what we do to move veterans from the streets to permanent housing.

My appreciation of the value of VA homeless programs extends far beyond my experience over the past 13 years as a Program Manager for the exemplary VA Homeless Program that we have in Little Rock. I am the second oldest of 14 children, 6 sisters and 7 brothers, 10 of us have served in the military. I have a younger brother who completed the VA Homeless Program in San Diego, under the clinical Management of Elizabeth Pinner, 12 years ago. He experienced a traumatic head injury while completing a tour of duty in Germany. As a result he experienced migraine headaches and severe sleep disorders. He turned to alcohol as a means of self-medication. He was one of the first graduates of that program and has now been stable and in permanent housing for 12 years. He is currently completing a two-year Associate Degree Computer Training Program. I also have a younger sister who became homeless and moved into a shelter as a result of her involvement in a co-dependent relationship. She received assistance from the VA Homeless Program in Atlanta and now continues to maintain full-time employment and has now been in stable housing for approximately 4 years. I deeply appreciate the VA programs and clinicians

that helped my brother and sister. Their progress and the progress of the homeless veterans seen at the Central Arkansas Comprehensive Homeless Center are vivid examples of the value of directly addressing the needs of homeless veterans.

This concludes my statement. I will be pleased to respond to the Committee's questions.

Statement of  
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Before the  
Committee on Veterans' Affairs, Subcommittee on Health and  
Subcommittee on Benefits  
U.S. House of Representatives

March 9, 2000

Mr. Chairmen and Members of the Committees

It is an honor to be here as the Manager of the Network 3 Homeless Veterans Treatment Programs Service Line. This is the first homeless veterans programs service line in the Veterans Health Administration. It includes all of the specialized interdisciplinary programs aimed at providing treatment and assistance to homeless veterans. The continuum encompasses outreach throughout southern New York and New Jersey, including shelters, prisons and areas where the homeless congregate; inreach to homeless veterans in VA acute and longterm beds; case management; drop-in centers; day treatment programs; domiciliary residential treatment programs; contract residential care; Compensated Work Therapy and Veterans Industries; transitional supported housing; and long-term housing with case management through the HUD-VASH Program. In addition, the comprehensive range of our community partnerships has enriched services and the lives of the veterans served.

Why did we establish a service line, given the range of other options possible? In announcing the designation of the service line, Mr. James J. Farsetta, Network Director, stated that "Helping homeless veterans move from streets and shelters to productive lives in the community is a priority in Veterans Integrated Service Network (VISN) 3." First and foremost, the top leadership in VISN 3 was committed to providing a single standard of care for homeless veterans. The concept of 'one VA' is particularly relevant. When programs are medical-center based, instead of integrated as a network, there always is the possibility that veterans will not have access to the full compliment of specialized programs. Moving from a medical-center-based perspective to a network focus, positions the homeless programs to serve as resources for *all* homeless veterans in the Network, wherever they are located. The service line organization provides a venue for standardizing policies and procedures and criteria for admission. Inconsistencies in resources, staffing, treatment outcomes and productivity can be monitored and appropriately addressed. The goal is to improve homeless veterans' access to the right type of treatment at the right time and in the right place.

As a service line we are able to minimize the 'administrative layering' which can significantly compromise the timeliness, effectiveness and creativity necessary to forge community alliances. While the VA neither can nor should meet all of the complex needs of

homeless veterans, we cannot form effective service partnerships with the community unless we can speak with one voice and as one VA. By minimizing the horizontal and vertical layers for input and approval at each medical center, we are able to come to the table to negotiate with the community for the priorities established by the network. This enhances the ability of the VA to build bridges to the community, working together as members of one team to provide quality, effective and efficient services to homeless veterans.

The VISN 3 Homeless Veterans Treatment Programs Service Line is based on a matrix management model, with oversight provided by an Executive Council comprised of site managers from each facility. In addition, the chair of the Consumer Council, which is composed of homeless and formerly homeless veterans, is a member; as is the chair of the Consortium, which includes representatives from all of the VA's homeless veterans programs. This service line formalizes structures which have operated informally for a number of years. The Consortium, which was initiated in 1991, won the Hammer Award in 1995 and the Public Employees Roundtable Award for the Federal Government for Excellence in Public Service in 1998. In developing and coordinating the Consortium, it was a never ending challenge and a privilege for me to work with a uniquely talented and dedicated team of staff representing all the VA homeless programs throughout the metropolitan area, Vet Center and Veterans Benefits Administration (VBA) to create a network of client-centered, innovative services.

The VA Consortium grew from a need to coordinate the VA homeless programs across medical center lines so that we could speak with one voice with city, state, federal and nonprofit agencies in advocating for homeless veterans' needs and in developing services within the VA as well as between the VA and the community. Homeless veterans often fall between the cracks among the overwhelming numbers of homeless in this area. Working in tandem with homeless and formerly homeless veterans, the Consortium took leadership in creating models of service delivery which have been successfully replicated throughout the country. There was precedent for this as Project TORCH, VA's first drop-in, day treatment program for homeless veterans, was developed in 1987 at the Brooklyn VA campus of what is now the New York Harbor Health Care System. Some of the initiatives developed by the Consortium include:

- Establishing reception centers for homeless veterans at New York City shelters
- Establishing a transportation system of vans driven by formerly homeless veterans to transport homeless veterans from shelters to VA services
- Distributed Department of Defense surplus clothing and supplies to homeless veterans throughout New York and New Jersey
- Conducted multimedia outreach campaign utilizing posters, public service announcements, billboards and bilingual palm cards with referral information
- Established a toll-free hot line operated 24 hours a day, 7 days a week to link homeless veterans to services

- Designed and staffed a mobile medical care van to bring services directly to veterans
- Implemented as lead agency, a Memorandum of Understanding with city, state, federal and not-for-profit agencies to provide treatment, rehabilitation, intensive case management, vocational services and supportive housing to seriously mentally ill homeless veterans from the streets and shelters—the first partnership of its kind in the VA
- Facilitated a Homeless Veterans Advisory Council to plan the agenda of 'action items' to address in the first CHALENG meetings in the metropolitan area
- Initiated Project PRIDE to provide restorative work therapy, case management and job placement for Long Island homeless veterans on Public Assistance in lieu of Workfare—a partnership involving state, county, and federal agencies and the VA
- Developed a wide range of consumer-led services, including a HIV-Peer Counseling Program
- Created a VISN-wide AmeriCorps program which has received national recognition
- Encouraged community agencies to apply for the Grant and Per Diem Program, resulting in a total of 121 new transitional beds provided by five different agencies throughout the Network

A number of activities have taken place or are ongoing within our new service line. They include:

- Expansion of outreach to underserved areas within the VISN, using AmeriCorps members, volunteers from the Consumer Council and staff
- Initiation and/or expansion of contract residential care funding for homeless veterans at every medical center in the Network
- Creation of a Job Resource Center staffed by VA, Partnership for the Homeless, Project HELP and the US Department of Labor to provide pre-vocational job readiness training, counseling, job development and on-the-job coaching for homeless veterans
- Establishment of a Law Clinic, with a local law firm providing *pro bono* legal services for homeless veterans; this will be replicated throughout the Network
- Participation of Miss America for 'Make a Difference Day' to recognize the contributions of a large number of formerly homeless veterans who are making a difference in their communities through volunteer work
- Improvement of program efficiency and performance through data integration and standardized data collection and validation throughout the Network
- Activation of specialized housing, vocational and case management services to meet the needs of special populations such as women veterans and families

While we are very proud of the accomplishments of our staff and the homeless and formerly homeless veterans who are valued members of our team, much work remains to be done. An accurate count of the number of homeless veterans in our VISN often depends on which data base and what definition is being used. However, some numbers invite attention. The FY 98 End-of-Year Survey of Homeless Veterans in VISN 3 compiled by NEPEC indicated that 24% of the 1227 veterans in acute beds, domiciliaries and PRRTP programs were homeless at admission. However, the residence of an additional 19% of the veterans at admission was in an institution. It is likely that these veterans also were homeless, which suggests that 43% of the veterans surveyed were homeless. An additional data source, using the Social Security numbers of veterans receiving outpatient treatment services in FY99, indicated that 4,345 homeless veterans were treated in VA clinics in this VISN.

An accurate count of homeless veterans within the New Jersey/southern New York area is not available. However, the New Jersey Department of Military and Veterans Services states that there are 7,000 homeless veterans in their state. The Coalition for the Homeless estimates that there are approximately 100,000 homeless individuals in the New York metropolitan area. If 23% are veterans [Findings of the National Survey of Homeless Assistance Providers and Clients, Interagency Council on the Homeless, December, 1999], then there could be as many as 23,000 homeless veterans. Our colleagues in Long Island and the southern New York counties report similarly high numbers. While these numbers are staggering, it is critical that we continue to approach the complex problems underlying the symptom of homelessness with all the hope, skill and compassion that we can muster. In our programs, we treat one veteran at a time, one day at a time, because each homeless veteran is unique, with his or her own needs, values and strengths. Lives are being saved by these programs; and large numbers of formerly homeless veterans have achieved goals that they would not have thought possible when we first met them on the streets and in shelters. We must never grow complacent about homelessness! And we never can accept that our streets have become "home" for countless veterans who served our country so that we could have safe homes.

The solutions to the problem of homelessness are as complex as the causes. While it is clear that homeless veterans need and want jobs and affordable housing, and that these things are critical for their recovery and healing, we must not lose sight of the big picture. The ongoing availability of case management, as well as medical, psychiatric and substance abuse treatment services is a major factor in veterans' maintaining stability in the community. Our Consumer Council has urged that case management services be provided, as needed, to formerly homeless veterans after they obtain housing. They point out that this is the time when veterans are most vulnerable to relapse. The HUD-VASH program in our Network - which provides long-term case management - has demonstrated that over 68% of the veterans referred during a five-year period successfully completed the program and are leading productive lives in the community.

Some current trends have been noted. Extensive pre-vocational remedial skills building is needed by the majority of the homeless veterans we're seeing, many of whom are not ready for Compensated Work Therapy. The number of veterans leaving domiciliary care programs on disability or retirement status has increased dramatically. For many, this increase appears to be based on the acuity of their medical and psychiatric problems; for others, there are very real barriers to employment faced by middle-aged and older veterans. Additional barriers to housing and employment are faced by the large numbers of African-American and Hispanic veterans in this Network's homeless programs. Homeless veterans have been on the streets for longer periods of time than in earlier years, generally as the result of several episodes of homelessness. They are sicker than veterans seen in the past, with a number of serious medical and psychiatric diagnoses. With shorter lengths of stay in the VA hospitals, and the transition in mental health from a maintenance treatment philosophy of to that of recovery, there is growing demand for the specialized homeless treatment programs. Homeless veterans often are stabilized in the psychiatric and medical units and transferred to the domiciliaries to develop the skills necessary to transition to the community. Many of these veterans are unable to live independently. Discharge planning involves helping the veteran accept that he or she needs to live in a supervised environment in the community to prevent relapse into illness and homelessness. Given the high percentage of homeless veterans in our hospitals, domiciliaries and residential care facilities are major resources in the continuum of care.

A major focus in our service network is empowering homeless veterans to take an active role in their own recovery from homelessness. They work as partners with staff in setting and prioritizing goals for their lives, progressing at their own pace. Many veterans, sometimes while still homeless, begin to volunteer in the programs, leading self-help groups, and mentoring fragile peers. Our vision is to create a supportive community of veterans helping veterans which can be transferred to the community outside the VA's walls. "...what appears to be most central to the reparation of the veterans' broken spirit is the development of hope in the real possibility of connecting to others and belonging in the world." [Amelio A. D'Onofrio, Ph.D., "On the Psychology of the Homeless Veteran"].

Within VISN 3, a Mental Illness Research, Education and Clinical Center (MIRECC) clinical demonstration project will provide peer-assisted case management services to seriously and persistently mentally ill homeless veterans. Formerly homeless veterans will be employed as counselors to offer supportive services to these veterans in community settings. The goal is to enhance their quality of life, community tenure and treatment compliance as a result of the interventions and activities provided by their peers. Clinical services will be provided and supervised by professional staff. The social worker who will mentor and supervise the peer counselors is a formerly homeless veteran who graduated from the Domiciliary Care Program at the Brooklyn campus of the VA New York Harbor Health Care System. Mr. Angel Caban is a Vietnam Era Air Force veteran who recently was awarded the Master of Social Work degree from Hunter College in New York. He is here with us today.

This concludes my statement. I will be happy to respond to any questions from the Committees.

**STATEMENT  
OF  
DOUGLAS A. HAYWOOD, EXECUTIVE DIRECTOR  
WNY VETERANS HOUSING COALITION  
TO THE  
HOUSE VETERANS AFFAIRS COMMITTEE  
SUBCOMMITTEES ON BENEFITS AND HEALTH  
UNITED STATES HOUSE OF REPRESENTATIVES  
WASHINGTON, D.C.**

**9 MARCH 2000**

Mr. Chairman, Representative Quinn, Members of the Committee, Ladies and Gentlemen.

On behalf of the Staff and Residents of the WNY Veterans Housing Coalition, thank you for this opportunity to add our views to those of many others in support of homeless programs for Veterans.

The Coalition is a not-for-profit organization founded in 1987 by a group of Vietnam Veterans to search and develop innovative ways to improve housing opportunities for Veterans and "Continuum of Care" programs for Homeless Veterans and "Special Needs" populations.

Since that time, the Coalition has evolved as a major player in the Western New York region in housing development, property management, and operation of "Continuum of Care" programs for "Special Needs" households (about half of whom are headed by Veterans).

Currently, the Coalition owns and manages 119 residential apartment units in seven properties in urban Buffalo, New York, including two commercial tenants.

In addition, we are in the midst of two major developments totaling over \$10 Million for Homeless Veterans and senior citizens.

A key element of our organizational structure is our Case Management Team, which oversees "Continuum of Care" programs in "MAYDAY HOUSE" (our appropriately named transitional housing element for Veterans), "PATRIOT HOUSE" (another appropriately-named facility for formerly Homeless Veterans), and for permanent Residents of our properties (again, about half those households are headed by Veterans).

Napoleon Bonaparte, arguably the most brilliant of the “Great Captains” the world has ever known, once remarked to his subordinate commanders: *“You can ask me for anything – EXCEPT time.”*

Well, this morning, I am asking you for just that – *TIME* ... and, more.

First, TIME: We in the veterans community need more time to provide the full spectrum of services to Homeless Veterans to empower them to lead relatively independent lives and fulfill their responsibilities to themselves, their families, and their country.

During about its first five years of existence, the Coalition’s VA-contracted transitional housing program consisted of a six-month stay by Homeless Veterans in a secure, comfortable facility that was staffed with dedicated Case Managers. This time afforded Homeless Veterans the best chance for social and economic recovery and independence. Our success rate during this period was about 70% and those who graduated were relatively well equipped to meet life’s challenges and succeed.

With the arrival of the new administration and the resulting cuts to the VA’s budget, our six month Homeless Veterans transitional housing program was suddenly transformed into a two month program in which our Staff, the VA’s first line care providers who supported us, and most of all the Homeless Veterans in residence had to really scramble to attain even the most basic requirement before program discharge.

Recently, a month has been added to the stay of 12 Veterans entering our program under the VA’s “Health Care for Homeless Veterans” program. However, the nine Veterans enrolled in our transitional housing program under the VA’s “Substance Abuse” program (most of whom are also Homeless Veterans) still are allowed only a maximum of two months before they must leave the facility.

Two or even three months of transitional housing is just not enough to afford the Veteran of even a modicum of potential for success.

Mr. Peter Collins (an Army Veteran and a current Resident of “MAYDAY HOUSE”), requested that we share an open letter he had written for this occasion:

*“This program benefits me as no other in that I am encouraged to seek and obtain employment while I am provided food and lodging in a clean, safe environment. I am grateful for the months I have, however, to save enough funds for an apartment, furnishings, food, clothing, and transportation after securing employment is difficult the full six months ... greatly increases a Veteran’s chances of becoming a self-sufficient, productive member of society once again.”*

Time, of course, is money. However, when one considers the costs of “recycling” former residents through the program again and again and/or to other treatment programs at other agencies or municipalities, adding three or four months to the transitional housing program in order to better prepare the Veteran for “life after discharge” is well worth the expense.

The second item I’d like to address is the use of vacant or under-utilized VA facilities for *Veterans Transitional Housing Programs*.

The aforementioned budget cuts have forced the closing or reduced usage of many VA facilities, particularly buildings at VA medical centers. Utilizing a portion of those facilities for Veterans transitional housing programs is very appealing for a variety of reasons:

- The buildings are in good shape and still must be maintained, whether occupied or not;
- While they require renovation to meet the requirements of a residential facility, any improvements enhance the value of the facility itself;
- As part of a VA medical center, its proximity of the transitional housing program to clinics and the like makes treatment opportunities more accessible to program Residents;
- Additional vacant facilities can be utilized as “Multi-Resource Employment Centers” for Veterans’ skills, education, employment, and small business training experience utilizing the Department of Labor-administered “*Homeless Veterans Reintegration Project*” funds.

One of our development operations is called the “Veterans Partnership Initiative”, which will utilize a portion of the Batavia New York VA Medical Center campus as a transitional housing facility and a “Multi-Resource Employment & Service Center” for Homeless and other Veterans from throughout NY State.

The VA’s WNY Health Care System, the Rochester New York Veterans Outreach Center, and the Coalition have been working on this project for over two years and last year the VA awarded \$1.4 Million for renovation and start-up of the program in 2001.

We are hopeful that this is the only the beginning of VA and private sector partnerships to improve housing and employment programs for Veterans.

A third major effort in which the Coalition is actively involved is that of providing Veterans training, education, and assistance in securing employment. We are completing our first year of a Department of Labor (VETS) "Title IVC" grant and are optimistic about not only a renewal of this grant, but approval of a "Homeless Veteran Reintegration Project" grant proposal for the above Batavia activity. To date, we have assisted over 150 Veterans under this program.

The last point I would like to address is HUD's "Shelter + Care" program. The Coalition was awarded a five-year \$640,000 "Shelter + Care" program grant in March 1995. To date:

- It has provided housing subsidies and case management services to over 100 homeless households (at least half headed by formerly Homeless Veterans);
- Our Case Management Staff has coordinated for almost \$2 Million in services for these households as matching funds;
- The failure rate of residents in our program is less than 25% (over 5% less than the national average of 30%);
- About 20% these households have moved on to a higher standard of living;
- And, more than 50% have retained their current housing in good standing

Tragically, our request for renewing this program grant (as well as all such requests from other groups in Erie County, New York) was disapproved by HUD last December. *In fact, the Erie County grant proposal rejections ALONE equal 10% of all renewal applications that were rejected by HUD for the entire Nation!*

Such a rejection by HUD of our renewal proposal affects 40 households in Coalition properties and 98 others throughout Erie County.

We are in the midst of appealing this HUD decision and have received tremendous bi-partisan support from Representative Quinn of this committee and Representative John LaFalce of the House Banking Committee. We are hopeful that HUD's position will be reversed and that we'll be able to continue this valuable program for another five years.

If we are not successful, 40 of the Coalition's households (20 headed by Veterans) could be forced (by their own government, no less) back into the same homeless –and hopeless situations from which they thought they had been rescued years ago.

We implore the Congress to provide the funding necessary to maintain the above programs that will continue to allow the VA and not-for-profit care providers to serve those citizens of this country who are most in need.

Thank you again for this opportunity to share our concerns and hopes with you in this important area.

**CURRICULUM VITAE**

DOUGLAS A. HAYWOOD  
95 DeKalb Street

**Tonawanda, New York 14150**

(716) 693-4377

**Summary:** Experienced manager and leader of diverse populations; mission-oriented professional; Vietnam Combat Veteran.

**Employment**

<b>Experience:</b>	1992 – Present	WNY Veterans Housing Coalition, Inc. Case Manager, Property Manager, Executive Director
	1989 – 1992	American Protective Services Site Supervisor, Senior Field Supervisor
	1986 – 1988	Realty World Central Lakes Real Estate Agent
	1986	Alexander's Retail Department Manager
	1983 – 1986	United States Army Civilian Employee (Public Affairs, GS-12)
	1969 – 1983	United States Army Commissioned Officer (Commander, Staff Officer)
<b>Education:</b>	1997	Certified Occupancy Specialist Course
	1993	Registered Apartment Manager's Course
	1969 – 1983	Various U.S. Army Infantry & Armor Schools
	1965 – 1969	Pennsylvania Military College (B.A. History)

**Military Awards:** Bronze Star Medal w/"V" Device (2<sup>nd</sup> Oak Leaf Cluster)  
Purple Heart  
Meritorious Service Medal  
Combat Infantryman Badge  
Parachutist Badge  
Ranger Tab

Funding received for programs or projects cited in the above testimony are:

- Veterans Transitional Housing Program (VA-Contracts): \$ 528,890
  - Title IVC Grant Program (DOL-Contracted): 96,655
  - Veterans Partnership Initiative (VA Grant & Per Diem) 1,495,000
  - "Shelter + Care" (HUD-Contract) 303,160
- TOTAL for FY 98 & 99 = \$2,423,705

**STATEMENT BY**  
**RAYMOND G. BOLAND**  
**SECRETARY**  
**WISCONSIN DEPARTMENT OF**  
**VETERANS AFFAIRS**

**BEFORE THE**  
**SUBCOMMITTEE ON BENEFITS IN CONJUNCTION WITH**  
**THE**

**SUBCOMMITTEE ON HEALTH**  
**COMMITTEE ON VETERANS' AFFAIRS**  
**UNITED STATES HOUSE OF REPRESENTATIVES**  
**JOINT OVERSIGHT HEARING ON HOMELESS**  
**VETERANS' ISSUES**

**9 MARCH 2000**

Mr. Chairman, members of the Committee, I appreciate this opportunity to appear before you and comment on the progress we are making toward ending homelessness among our nation's veterans. As Secretary of the Wisconsin Department of Veterans Affairs and as Vice President of the National Coalition for Homeless Veterans (NCHV) I am proud to tell you that we are no longer in the shadows of despair and uncertainty as to how to deal with the homeless veterans' issue. Today we stand together with this Congress and its leaders on a threshold of new opportunity to realistically pursue the NCHV policy goal of ending homelessness among America's veterans.

Just a few, short years ago, our Coalition members came together to share ideas and dreams of how we might make a difference. This week, on the occasion of the tenth anniversary of the founding of NCHV we are sharing our stories of success and our plans to duplicate this success throughout the country. Literally from coast to coast, we have achieved a track record of success that proves our belief that helping homeless veterans is not mission impossible. It can be done, we are doing it, and the time is at hand to build upon this record.

The development of collaborative, community based, continuum of care models is at the heart of the success of each of our members' programs. We are proving that the funding of programs like this is the best investment that can be made toward ending homelessness.

Two examples of sound investment are the Homeless Veterans Reintegration Program (HVRP) and the VA Homeless Providers Grant and Per Diem Program. These veterans' unique funding streams undoubtedly bring the highest return for investment than any other federal spending for homelessness. Grantees are able to make the best of both worlds by blending these federal programs into the collaborative community-based model. The outcomes that result come at a fraction of the cost of independent, non collaborative programs such as the Job Training Partnership Act (JTPA) and VA domiciliary treatment.

We have also proved that having programs like this designed exclusively for veterans not only make sense, but they also produce higher success rates than other models. This may come as a surprise to some, but there are several reasons why we should have better outcomes.

First, and most important, is the Department of Veterans Affairs' (VA) health care system. This unique resource is key for many homeless veterans' ability to gain and hold employment. Sustaining employment is the difference between success and failure. The collaborative model depends on having a dedicated link to VA health care to be able to deal with whatever physical or mental health issues exist. The recent trend of outreach by the VA is the most positive development we've seen. But we need to go farther. The VA should formalize long-term strategic plans that will dedicate funding of homeless veterans' services. We suggest that Congress request a reporting by each Medical Center the current level of service and what plans each Center has to build comprehensive services for homeless veterans.

We also urge the VA to restore mental health and substance abuse programs that have been drastically reduced in recent years. Cuts in these services are unacceptable and are a major obstacle to being able to expand our efforts nationwide.

Another area of potential advantage to veterans is employment. All veterans have experienced employment in settings that required self-discipline, reliability, teamwork, standards, achievement, success, mission accomplishment. They know what it takes to be a winner—they were trained for that. Our task is to retrieve and restore these habits, to enhance skills through training programs and to try to match the veteran with appropriate job placement. Again, there is a need to collaborate, and activate this key component of the model. Most of us have networked with local state employment offices that house the Veterans

Employment and Training Service (VETS), which are funded by the U.S. Department of Labor. We have found that by bringing this resource into the mix of services we provide, and to actually blend it with the rest of the program, gives us the best results. I find it odd that this critical service to all veterans and particularly those at risk is a stovepipe delivery system that is separate and distinct from the mainstream of other veterans' services. Attaining employment for homeless veterans is not a separate issue. It is a central issue to a process that includes many other components. We have to bring all of these pieces together in a holistic manner for the homeless veteran to succeed.

The National Coalition For Homeless Veterans is poised to assist community providers in the planning and implementation of the collaborative model by sharing its knowledge and experience. Unfortunately we do not have the staff resources necessary to do this, yet without this help, providers will continue to struggle with many difficult challenges. Pulling it all together is not an easy process. This is one of the reasons why homeless veterans are underserved by HUD. In most cases our providers need assistance in putting together a veterans' program proposal that can compete effectively at the local level in the HUD grant application process.

NCHV urgently needs an appropriation of \$750,000 to establish the technical assistance capacity needed to build a national network of service providers that creates the capacity to meet the needs of our veterans. NCHV is the only group that has the established lines of communication needed to do this, with grassroots organizations as well as all the appropriate federal agencies, veteran service organizations and a myriad of other national and local homeless organizations.

We have accepted the challenge of providing the leadership necessary to launch an all-out assault to end veterans homelessness. We are prepared to accept the responsibility of guiding others by providing the technical assistance needed to build local programs. I urge your help to give us this capability and I sincerely thank you for all of the support and resources you've provided us in the past that gave us the chance to prove this can work.

Once again, I am grateful for this opportunity to testify on behalf of my fellow veterans. Many of them are missing in action among the battlegrounds of our society. It is our duty to try to assist them.

STATEMENT OF  
JOSEPH E. CAQUETTE, CHAIRMAN  
NATIONAL HOMELESS VETERANS COMMITTEE  
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEES ON BENEFITS AND HEALTH  
COMMITTEE ON VETERANS AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

HOMELESS VETERANS' ISSUES

WASHINGTON, DC

MARCH 9, 2000

Mr. Chairmen and Members of the Subcommittees:

As someone who is committed to assisting homeless veterans, I appreciate this opportunity to participate in today's hearing and share my thoughts on how various veterans' homeless programs may be improved to better serve this nation's former defenders who now find themselves in need.

A major concern voiced by six homeless shelters I contacted is that the number of substance abuse and mental health counselors are being drastically reduced or completely eliminated. A key component in getting veterans off the streets and back into society as productive citizens is addressing any substance abuse or mental health problems they may be experiencing. Without immediate professional help, they cannot be expected to succeed.

In Worcester, the second largest city in Massachusetts, the Central Shelter for Homeless Veterans is having serious problems due to the local Veterans Affairs Medical Center having no substance abuse or mental health counselors. Three years ago the Medical Center had five counselors, today there is no direct contact by trained counselors with homeless veterans. The North Hampton VA Medical Center will not provide one-on-one mental health or substance abuse counseling unless the veteran has been drug or alcohol free for the past six months. Mr. Chairmen, these veterans need help immediately, not six months from now. The whole purpose of counseling is to help them overcome addictions, not to be on their own during this critical period.

Another problem area I am witnessing is the detoxification program. If a veteran is sent to the Brockton VA Medical center they will receive 3-5 days in detox, and then be released as an outpatient; this is simply not working. At the New England Shelter for Homeless Veterans, of which I am associated, veterans do have access to substance abuse counselors, but if they are referred to a detox unit they will only receive 5-7 days of treatment and unfortunately, that program is being eliminated.

Recently we are noticing an increase in two groups of homeless veterans - World War II veterans and women veterans with dependents. We attribute the increase in World War II veterans to their release from VA Medical Centers or homeless programs and, in many cases, their families not living in the area. As to women veterans, this is simply due to the fact more and more women are now serving in the Armed Forces. As to their homelessness, there are many contributing factors. I am sure you can appreciate our concern when a woman veteran and her children seek assistance. This presents a whole new set of challenges with limited resources.

In closing Mr. Chairmen, again I appreciate the opportunity to appear before your Subcommittees. I look forward to a continuing dialogue and will be happy to respond to any questions you have.

**STATEMENT**

of

**Chris Noel**  
**Founder/Executive Director**  
**Vetsville Cease Fire House, Inc.**

before the

**Subcommittees on Benefits and Health**

of the

**Committee on Veterans Affairs**  
**United States House of Representatives**

**The Honorable Jack Quinn**  
and  
**The Honorable Cliff Stearns**  
*Chairmen*

**March 9, 2000**  
**Washington, DC**

Mr. Chairmen, thank you for allowing me to make several requests on behalf of all homeless American Veterans.

The requests I now make of you are based upon my experience and dedication in working in many areas with the military and veterans since 1965. Most important, I specialize in the work of returning the disabled and homeless veteran back to society by traveling throughout America speaking on veterans issues at the request of veterans organizations; also by forming and running the homeless veterans shelters of Vetsville Cease Fire House in Florida.

Florida has according to the National Coalition for Homeless Veterans' 1994 "Report to the Nation" 13,450 homeless veterans, the fourth largest of the states. I believe those numbers are increasing due to the attraction of a new VA Medical Center and the mobile homeless veteran population.

The homeless veteran is a federal problem, not a local community problem. The men and women of the military had a contract with the United States government. Seeking the "geographical cure", many veterans have become transients. They are the "hobo's" of today.

Please understand why so many American Veterans are homeless. Many of the military dependents are receiving food stamps. This is where today's problem starts. If these military families are not treated honorably now, they will become the "new homeless". The United States Government trains, feeds, clothes and houses troops for specific jobs or as warriors. They are totally taken care of, paid salaries and are required to do what they are told to do. When they leave the service, all of a sudden, they have to drop all training and learn different survival skills in an urban setting without proper debriefing.

Homeless veterans have many barriers and complex life circumstances which make them difficult to serve. These men and women watch their dignity fall away as they live day-to-day, hand-to-mouth, clinging desperately to the emptiness of their lives. On many occasions I have heard "Nobody cares about us, we have lost our country."

Veterans by definition are Americans who have fought and served to protect the very freedoms that American society enjoys today. Why then, is it that so many of them are in dire need of benefits from the society, which they served and protected?

There are military veterans with the highest military decorations eating out of dumpsters. Why is this allowed to continue?

From my experience there seems to be a problem by the VA with over medicating for physiological health issues because it makes the veteran easier to control. VA

medications sometimes create a temporary “zombie” effect. When Vetsville attempts to work with social workers and doctors to help the veteran seeking our help, we are ignored, even though the veteran has signed the proper forms for release of information. This lack of co-operation necessitates taking the veteran to a private physician or hospital.

Many veterans are emotional time bombs. When a veteran goes to the VA to be helped, instead of helping the veteran deal with the emotions through therapy, or by talking to the veteran about the problem and acknowledging his problem, the veteran is first put into a lock-up ward that can create a tremendous resentment.

Veterans hate to be in defeat because they were trained to be undefeated. Those that have never taken an illegal drug are now labeled drug addicts because the VA has made them that way. Then they hide from society in a shack, the woods, under bridges or anywhere so that they don't have to suffer from the anxieties of trying to communicate with others. Once these people become accustomed to homelessness, it then becomes very difficult to change.

I continually hear, “Let the VA take care of them”. Let's face it, many Vietnam and Gulf War veterans don't trust the VA system or find it too bureaucratic.

Homeless veterans need an open channel in order to be heard. They need a “watchdog” over the VA. Filling out complaint forms at the VAMC merely labels the veteran as “just another disturbed vet”. This is a convenient method to avoid his pleas for assistance.

One of the most pressing needs we have experienced that the VA has minimal capacity to provide is dental care. It is difficult to obtain stable employment without front teeth. It is also a health issue since many suffer from malnutrition because they are unable to chew food or they have infections that go untreated.

Transportation funding is needed to provide access to medical appointment and job search for veterans in community-based organizations. The cost of maintaining our vehicles, insurance and fuel can significantly impact our operating budget and it is a difficult item to find funding for. Most homeless veterans do not have the mode of transportation to make all the appointments required as an outpatient. When appointments are missed it can take months for a new appointment that can be devastating to a PTSD patient. Transportation is critical for the veteran searching for employment, and traveling to and from the job site.

I formally requested assistance for homeless veterans in our hospital catchment area in a letter to Secretary of Veterans Affairs. I begged for his help with the local VA. I never received a response. A phone conference was held without Vetsville participation in the

West Palm Beach VA Medical Center Directors office with VA staff only in attendance. The outcome was that the hospital homeless coordinator was doing a good job because they were active on local community boards. There was no measure how the treatment of homeless veterans in the hospital catchment area. Maybe good public relations for the new VA, but not in delivering services to homeless veterans. The VA with their public relations receives the credit while community-based organizations do the majority of the work. Why in this area does the VA not work more with the community-based organizations to expand the services to homeless veterans?

The Vetsville Program works! Vetsville provides a structured, drug and alcohol free environment for troubled veterans to heal and prepare to re-enter the main stream of society. We could greatly benefit from the VA truly becoming our partner to serve the homeless veterans in our community instead of constructing barriers that are difficult to remove.

Vetsville has applied for Federal grants but has been unsuccessful in obtaining any funding. Grants could greatly aid in the care of homeless veterans by expanding our capacity to serve the large number of homeless veterans in our area. Vetsville is in this community providing the much-needed services of safe, clean, sober housing for veterans. In Palm Beach County, this grass root, nationally recognized agency does as much if not more than the VA for homeless veterans. Our organization does not have the capacity or the expertise to search for funding sources and complete all the necessary paperwork for each proposal. Organizations like ours could benefit greatly from technical assistance if it was available. We would be able to increase our capacity to serve homeless veterans and measure the outcomes more specifically.

The VA Homeless Provider Grant and Per Diem program process is complicated, confusing, political and unrewarding. Its pages too long, too detailed and not clear. Here's a quote from an attorney who helped write our grant; "Anyone who even files this paperwork deserves a grant". Vetsville never knew why we were never awarded a grant from the VA process. A clear explanation would have been instrumental for the future. Why won't the VA help us? Often the grant money will be awarded to a government agency instead of community-based organizations. Why do government agencies receive funding from another government agency?

Often veterans can only find day labor jobs because of their work history and need access to fulltime employment in order to be able to live independently. Day labor does not work to end homelessness! Most employers hire only manual labor as day labor. Many veterans cannot lift. Day labor also depends upon good weather.

Veterans are considered a liability to society that makes it's difficult to find a good job or housing. How many employers are willing to allow a person time off during work hours

to go to the VA for appointments? Many veterans suffering from post-traumatic stress disorder (PTSD) also have a chemical imbalance that needs continual monitoring through hospital visits.

Many PTSD veterans have a total inability to hold a permanent job. However, at Vetsville they have an opportunity to work part time. Some of them only work well at night. These vets are great workers. They work with pride and diligence. We talk with them, we listen, and we support them. The veteran's self-esteem grows. Sometimes their medicines are lowered. The veteran is stronger.

Targeted funding for employment programs specifically for homeless veterans is critical since the veterans have so many barriers to overcome. It takes a special set of skills and knowledge to work with the veterans and potential employers that is not available in mainstream programs.

It's not uncommon for very sick veterans to be turned down by the VA for service-connected disabilities 18 to 20 times. Many of these men are too young for social security and full time employment is not a realistic expectation for them. A fast track review process could greatly impact the ability of homeless veterans receiving needed services in a timelier manner.

Incarcerated veterans are warehoused for punishment and return to society homeless. A report released in January 2000 by the Bureau of Justice Statistics, US Department of Justice "Veterans in Prison or Jail" states there are 225,700 veterans in Federal prisons and local jails. Veterans makeup 14.5% of the Federal jail population and about 12 % of state and local jails. Pre-release counseling is needed to insure that these veterans are able to return to a productive life after release and not become homeless. Many of these veterans show up in community-based organizations directly from incarceration without having being treated for alcohol or substance abuse or their mental health issues so they consume additional resources for issues that should have been addressed prior to release.

In conclusion, all concerned with Vetsville request that you do the following on behalf of homeless American veterans:

- Support community-based organizations that provide for safe housing with food and daily counseling in a cost effective manner specifically for homeless veterans.
- Assure that federal funds allotted for the homelessness goes to grass roots programs that specialize in serving the homeless veteran, not to other government agencies.
- Implement an expanded VA dental program that addresses the special needs of homeless veterans.

- Require the VA to work with community-based providers serving homeless veterans in a meaningful collaborative effort to address the local needs of veterans.

I personally want to thank you for your hearts and minds on behalf of all homeless veterans.

### Curriculum Vitae

Chris Noel is Founder and Executive Director of Vetsville Cease Fire House, West Palm Beach, Florida and Nashville recording artist. Chris Noel hosted her own radio program on the U.S. Department of Defense Armed Forces Radio and Television Service from 1966 to 1971. Chris entertained GI's at firebases and remote areas, throughout South Vietnam. She has been caught in sniper fire, and has crashed in a helicopter. Because of her morale building the Viet Cong enemy put a \$10,000 price on her head. Chris Noel is the author of "Matter of Survival", a book which has become a favorite with Vietnam Veterans, their families and therapists. Chris's latest book is "Vietnam, Till I Die?"

Chris has co-starred in the movies with Elvis Presley, Dennis Hopper, Don Johnson, and Burt Reynolds and is a dedicated patriotic singer and speaker for our Vietnam Veterans throughout America.

Chris Noel and Reid Moore founded Vetsville Cease Fire House, Inc., in February 1993.

Vetsville, a 501(C)(3) nonprofit corporation continuously for the past seven years, has provided clean, safe, sober housing for disabled and homeless U.S. Military veterans. We provide 35 beds a night and 105 meals a day. Vetsville has three separate residential facilities Boynton Beach, Riviera Beach, and West Palm Beach, Florida. These shelters are in immediate proximity to the new VA Medical Center. Funding comes from donations, fundraisers and grants. Currently the staff consists entirely of all volunteers.

The mission of Vetsville Cease Fire House, Inc. is to help disabled and home less American Veterans by providing supportive residential lodging, food, clothing, access to medical treatment, and employment opportunities regardless of race, creed, color, sex or age. To provide referral to other human service agencies, and coordinate with these agencies to help our clients to return to the community as responsible, productive self sufficient citizens.

Vetsville accepts referrals from other agencies, treatment centers and several hospitals in the community.

Vetsville is an affiliate or member of the following organizations, which aid homeless veterans:

The National Coalition for Homeless Veterans  
The National Vietnam and Gulf War Veterans Coalition  
The Homeless Coalition of Palm Beach County  
The Daily Bread Food Bank of Palm Beach Co. Agency  
USDA Commodities Recipient Agency  
Homeless Outreach Team (Division of Human Services)  
The Center for Information and Crisis Services Agency

Approved eligibility in the Federal Surplus Property Utilization Program

Vetsville is a sub site for an AmeriCorps Education Awards Program through US Vets putting education vouchers in the hands of veterans and other volunteers in exchange for service to homeless veterans.

**Federal Grant or Contract Disclosure**

None

**TESTIMONY OF LYNNE L. HEIDEL  
CHAIR OF THE BOARD  
CENTRE CITY DEVELOPMENT CORPORATION  
SAN DIEGO**

**Joint Oversight Hearing on Homeless Veterans' Issues**

**Subcommittee on Benefits and Subcommittee on Health of the Committee  
on Veterans Affairs, U.S. House of Representatives**

**10:00 a.m., Thursday, March 9, 2000  
Cannon Caucus Room  
345 Cannon House Office Building**

Good morning, Chairmen Quinn and Stearns and members of both the Subcommittee on Benefits and the Subcommittee on Health. Thank you for giving me the opportunity to share San Diego's story about mentally-ill veterans, who comprise a great percentage of our urban homeless population.

I am here today as Chairwoman of the Board for the Centre City Development Corporation, the single-purpose public agency created by the City of San Diego in 1975. The Corporation operates under California's Community Redevelopment Law, and is responsible for planning and redevelopment efforts within the 1,500-acre downtown. For 25 years, we have been in the business of forging successful public/private partnerships.

We have invested \$285 million in mostly tax increment funds to further the cause of redefining what – back in the late 1960s – was described as a physically, financially and socially blighted downtown. Those dollars have leveraged \$2 billion in development value and 20,000 jobs through projects such as the highly successful Horton Plaza retail/entertainment complex and the San Diego Convention Center. In addition, we have facilitated 4,700 homes, 4,000 hotel rooms and four million square feet of Class A office space, and we have spent over \$60 million on public improvements and infrastructure. The eight neighborhoods of downtown San Diego are fast becoming desirable family-friendly places.

Yet, day in and day out we are faced with the unacceptable situation of a growing homeless population. The issues related to homelessness are challenging. As a redevelopment agency, CCDC's responsibility has been to provide the appropriate physical environment for economic growth to occur. It was always our thought that social issues would be solved with those two elements in place. However, that has not been the case.

CCDC, therefore, determined that for our redevelopment strategy to be truly successful, we would also need to focus on social issues such as the homeless. Residents, businesses and homeless people alike could not continue to endure conditions as they existed then. Residents encountered substance abuse and its residual effects of theft and litter daily. Businesses endured vandalism and their storefronts being used as toilets. Homeless individuals suffered despair at the inability to find help, housing and services.

Estimates of the homeless population in San Diego's urban center vary, but range as high as 3,750. A study of this population, and the services available, indicates that there is a dire need for additional and better coordinated facilities for those with special needs, such as the mentally ill.

About 40 percent of San Diego's urban single homeless men are veterans. A great many homeless veterans suffer from some form of mental illness. Their average age in our city is 40. Substance abuse is common: 80 percent reportedly have drug and alcohol-related problems. Overall, there are 54 shelter beds in the county directed to serving the special

needs of San Diego's homeless veterans.

San Diego's transitional shelter for veterans is addressing some of the need for diagnosis, therapy and counseling. It was funded, in part, by downtown tax increment funds. Clients are mostly single veterans, many with mental disorders.

We determined that redevelopment resources alone could not solve the problems of homelessness, but if leveraged properly and used in conjunction with other agencies that already existed and dealt with homeless issues, a tremendous benefit to the community's residents, businesses and homeless individuals could be realized. To date, we have expended \$12 million towards the establishment and growth of programs aiding our urban homeless.

CCDC coordinated the creation of downtown's Social Issues Strategy, designed by redevelopment professionals, business people, property owners, residents and social service providers. Since its adoption by the San Diego City Council, it has served as the policy direction for dealing with challenging issues. The strategy complements and supports the efforts of social service providers who apply comprehensive 24-hour programs that address the core issues of homelessness.

Mental illness often accompanies homelessness. Not only can homelessness be a consequence of mental illness, but a homeless life may trigger and exacerbate emotional instability. CCDC, in conjunction with Downtown Partnership, has turned it's attention to the needs of these individuals. The PBID - property owners are taxing themselves to address this issue.

There are about 1,900 severely mentally ill homeless people in San Diego. More than half are white; 70 percent are male veterans. A few head families, but most are single adults. Their average age is 30. Most have completed high school, and many have some college education. Many are episodically homeless. According to local mental health officials, only two-thirds of those suffering from schizophrenia or major depression are receiving treatment. The remaining third have no contact with professionals nor receive prescribed medication.

In order to respond to the needs of the mentally ill homeless population, we initiated a comprehensive continuum of care program in downtown San Diego that we hope to more fully develop this year. Our Special Needs Homeless Program, as it is called, was created following a needs assessment and study of available services. It addresses what we found to be the unmet need of a portion of downtown's urban homeless population, those individuals suffering from mental illness, chronic inebriation, drug addiction. Most have dually diagnosed conditions.

Approximately 25%, or roughly 950 homeless people - veterans and non-veterans - in

downtown San Diego, suffer from severe mental illness and need medication and a supportive housing environment. There are currently only 63 beds available that offer appropriate housing and treatment programs for the severely mentally ill homeless; they are scattered and the provision of services is not well coordinated.

An even larger number of the homeless – about 40% or roughly 1,500 people – are addicted to or abuse drugs and/or alcohol, or are dually diagnosed with both substance addiction and some form of mental illness. There are currently 440 beds available in treatment programs downtown and nearby for homeless drug and alcohol abusers.

The City's Homeless Outreach Team (HOT), a successful collaborative program between the city and county, has identified the lack of detoxification and treatment facilities for homeless alcoholics as one of the biggest obstacles to dealing effectively with this highly visible and difficult population.

Costs associated with the development of programs to assist the Special Needs Homeless are staggering. Estimates provided by the HOT program indicate that during a one-year period, 10 chronic inebriates required public funding totaling \$1.5 million to cover costs associated with law enforcement, hospitalization, incarceration, etc. – dollars that could be better spent to implement fully the Special Needs Homeless Program.

Downtown San Diego's multi-faceted Special Needs Homeless Program grew from knowledge obtained from data collected by the Homeless Outreach Team as these police officers and social workers daily assisted downtown's homeless. The teams identified a significant number of veterans among the downtown homeless population.

I cannot stress enough the importance of treating each homeless individual as a patient is treated by doctors and hospitals. We must first establish a case file for each. In San Diego, we want to create these files in a computer data base that is accessible as the patient moves from diagnosis to transitional housing and care, and finally on to independent living or permanent supportive housing.

The immediate need of each of these individuals is a place to go that is off the street, and a clear diagnosis is needed of the mental and/or abuse problems involved. This understanding is necessary in order to properly place the individuals in existing programs that could follow up with the specific care needed. The first element of the Special Needs Homeless Program is the creation of this centralized system of coordinating services that would follow patients across the continuum of care.

State and federal funding is being sought to cover start-up costs, including evaluation, referral, case management and initial critical services. Such a centralized and coordinated system does not now exist, but would greatly improve the opportunity for real assistance to individuals who are not being reached today.

Increasing the number of transitional and permanent supportive housing beds is the second step of the program, and this effort is underway.

Downtown redevelopment efforts would develop four new facilities that could accommodate 25 individuals each for up to two year stays, with the first two to be sited and funded by December 2000 and the second two by December 2001. The City and CCDC are currently working with social service providers to identify sites in the downtown area close to public transit and other needed services.

Increasing permanent supportive housing by 100 units for the severely mentally ill will provide shelter for those who complete the transitional program and are not capable of independent living. This type of housing can be blended with other low income housing or built separately. Case management and other services would be included to assure that these formerly homeless mentally ill people have the chance to lead stable and productive lives. The goal is to site and fund 25 units by December 2000 and 75 additional units by December 2001. The San Diego Housing Commission has accepted the responsibility for this element of the program.

San Diego's Special Needs Homeless Program goes further than just housing and services. We hope also to improve the application of state and local laws. And we want to facilitate the relocation and expansion of the Volunteers of America Alcohol & Drug Detoxification program, allowing for increased stays and better evaluation of substance abuse and mental conditions. Armed with this knowledge, VOA can move people into comprehensive detox or mental health facilities that already exist. An additional 80 beds would be added by December 2000 in both long and short-term treatment programs, many reserved for the dually diagnosed.

We understand that federal funding of over \$1 billion is currently being provided for homeless assistance. However, as all of us in this room know, the homeless population continues to be under served. San Diego's Special Needs Homeless program is the right approach. It is comprehensive and inclusive, and blends public and private resources, as well as local, state and federal funding. It is needed today to alleviate the suffering that exists, as well as to address the soaring costs to the public of continued neglect.

The opportunity to share these thoughts and San Diego's comprehensive program with you is appreciated. Thank you.

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**STATEMENT**

of

**THOMAS R. "TIM" CANTWELL  
MANAGING MEMBER, U.S. VETS  
and on behalf of  
U.S. VETERANS INITIATIVE, INC.  
EXECUTIVE DIRECTOR STEPHANI HARDY**

before the

**Subcommittees on Benefits and Health**

of the

**Committee on Veterans Affairs  
United States House of Representatives**

**The Honorable Jack Quinn  
and  
The Honorable Cliff Stearns  
*Chairmen***

**March 9, 2000  
Washington, DC**

US VETS, formerly known as LA VETS, is a partnership between United States Veterans Initiative, Inc (a 501(c)(3) non-profit corporation) and Cloud Break Development, LLC (a for-profit California limited liability company.) The mission of US VETS is the successful reintegration of the greatest number of homeless veterans to their highest level of independence as rapidly as possible.

Members of the committee, I want to commend your continued interest and investment in coming to grips with the issues of homelessness among veterans. Since we first started walking these halls in 1993, much has been accomplished through your efforts, through the Department of Veterans Affairs, and through the work of community-based organizations throughout the country. Tremendous strides have been made towards getting jobs, housing and services to homeless veterans.

There can be no question as to the resolve of the VA central office, the programs it sponsors and administers, and the work of countless VA staff throughout the system. As the VA has moved towards understanding the importance of collaborating and partnering with community organizations as well as other federal agencies, so have community-based organizations come to understand the wisdom of partnering and collaborating with the VA. Much of the animosity and conflict that previously littered meeting rooms has been set aside as we collectively focus on what's in the best interest of serving veterans.

I think it is safe to say that there is growing unanimity of opinion among homeless veteran service providers and VA programs that a self-determination model, embracing the concept of "a hand up, not a hand out", is not only clinically correct and cost efficient for the taxpayer, but, most importantly, empowering for the veteran. There's little doubt that as soon as clinically practical an individual needs to be given the dignity of making his or her own way by the means of their own production, participating in the financial cost of their path in whatever way is appropriate. This restoration of dignity instills hope, which in turn gives an individual the fuel they need to address the multitude of issues that keep them perpetually homeless.

The results speak for themselves. The following numbers reflect what has been accomplished at U.S.VETS' first project, the Westside Residence Hall in collaboration with the West Los Angeles VA Medical Center:

- 500,000 nights of stay from the fall of 1993 – end of 1999, serving more than 2,000 homeless veterans, and expect that we'll provide more than 145,000 nights of stay for this calendar year.
- Currently houses nearly 400 formerly homeless veterans (4% are female) in long-term, clinically supported programs and transitional housing, and will ultimately house 500 providing 175,000 nights of stay annually.
- 100 of these beds are an entry-level "back to work" program, Veterans in Progress (VIP), that has an 85% success rate in getting veterans employment within 3 days.
- 32 more "Back to Work" beds will open on March 15, 2000 targeting non-custodial veteran fathers and include child support payment negotiations with the LA County District Attorney's office. Transitional support is directed towards appropriate rapprochement with the family.
- The West LA VAMC has on-site a food service operation produces more than 25,000 meals per month.
- The West LA Vamp's clinical staff together with US Veterans Initiative staff conducts 37 groups each week (including cognitive awareness, relapse prevention, anger management, and a variety of 12 step groups).
- Our on-site career center serves nearly 300 veterans each week, and includes computer training, literacy and math classes by Inglewood Adult School, a full time DVOP, money management, and legal services. Veterans log more than 60,000 hours/year in the center on 22 computer workstations.

- Our Outreach Team serves 96 agencies throughout Los Angeles County each year assessing over 1200 individual homeless veterans for service needs.
- Transitional Housing at the Westside Residence Hall averages 95% sobriety at all times.

United States Veterans Initiative also administers a national direct AmeriCorps program called the National Collaboration for Homeless Veterans. This program is now in its 6<sup>th</sup> year of operation and serves close to 20,000 homeless individuals each year...at least 60% are veterans. Full operating sites exist in Los Angeles, Long Beach, Ventura, Houston, and the Washington, D.C. Metro area, providing direct service to the homeless through more than 40 community partners. Two years ago we expanded this opportunity with an AmeriCorps Education Awards Only program to over 38 programs in 22 different states. Combined, these AmeriCorps Members deliver nearly 400,000 hours of service annually.

U.S.VETS' second facility, the Villages at Cabrillo, is a 26-acre planned residential development on the former Cabrillo/Savannah Naval Housing Base in Long Beach. This first phase is just now opening following \$16 million of improvements. The nearly 1000 bed residential planned community for homeless veterans, families, and youth, was born out of a collaboration among the following:

- United States Veterans Initiative
- Transition Point, LLC
- Century Housing Corporation
- City of Long Beach
- Long Beach VA Medical Center
- Department of Defense
- State of California
- County of Los Angeles
- The Salvation Army - Family Transitional Housing
- Catholic Charities - Family Shelter
- 1736 Family Crisis Center - Youth Transitional Housing & Family Residential Treatment
- Comprehensive Child Development - Child Care
- Long Beach City College - Skills Training & Learning Center
- Long Beach Unified School District - school for homeless children
- South Bay Private Industry Council through the One Stop Center
- Department of Labor through state EDD, DVOP and LVER representatives.

This therapeutic community promises to usher in a new era for provision of services to homeless by coordinating existing supportive services and combining them with transitional housing. The Villages at Cabrillo offers a powerful solution to the pervasive problem of homelessness in America.

Primary debt financing for both the Westside Residence Hall (\$5.6 million) and the Villages at Cabrillo (\$8.3 million) has been provided by Century Housing Corporation together with local municipality support from the City of Inglewood for Westside Residence Hall, and the City of Long Beach for Cabrillo. Furthermore, Cabrillo benefits from \$7.2 million of limited partnership capital being provided through a private placement of \$8.7 million in tax credit allocation for the first phase.

In early summer, United States Veterans Initiative will be opening a homeless veteran employment center in downtown Houston, Texas. This project will include a community drop-in-center, mental health clinic, and career center on the ground floor of a renovated historic 100-unit hotel. This effort, a collaboration with the Houston VAMC, Houston Housing Corporation, AmeriCorps, and United States Veterans Initiative, Inc. will have set aside access to up to 80 units of this project based Section 8 hotel for long term veteran housing.

Additional developments under way for which property has been identified and substantial funding has been secured include:

- Las Vegas, Nevada - a 235 bed facility including substance abuse treatment, a Veterans In Progress Employment Program and long-term transitional housing for veterans

The distribution system for these McKinney Act funds follow a devolution policy that organizes priorities for allocation of formula share \$s at a local level within a continuum of care. The Continuum of Care prescribes a planning process built on a community-by-community model. Within each community, a planning process takes place in which advocates and service providers describe the problem, access the current resources available, and decide what needs to be done using the "targeted" McKinney programs, which total \$1.2 billion annually. Overall federal funding to assist the poor is about \$215 billion annually and is not synchronized with targeted homeless assistance funds. So, they are accessed differently.

Until such time as a homeless veteran provider is able to convince the local continuum of care that its in THEIR best interest to juggle their \$s in a way to allow a veteran provider to the table, a veteran program typically gets ranked out of the money (assuming they get ranked in the continuum at all). In our experience, it takes several years of analysis, networking, program/funding design, and negotiations to be able to show that giving a high priority to a relatively small piece of HUD SHP \$s for a veteran provider is in the community's best interest. A veteran provider can access support service money and a clinical care system (VHA) available for veterans only. This leverages resources that can off load the community care system of the veterans currently occupying beds and free up capacity that then becomes available for women, children and other special needs population. At one level, this is the market economy operating at its best...but it is complicated to say the least.

Adding to the challenge of utilizing HUD SHP funds is that they are allocated within consolidated plan boundaries which regularly run contrary to service areas where veterans get clinical care needs met (See attached Chart B). The fact that VA catchment areas rarely align with HUD consolidated plan boundaries places artificial limitations on support services' dollars available to extend services to veterans. Routinely, we are required to compete concurrently in multiple consolidated plan jurisdictions to obtain HUD funds in order to install the necessary array of services to veterans in a single VAMC catchment area. This conundrum becomes even more pronounced as more VAMC's move toward VISN-wide service lines that cross consolidated plan jurisdictions.

While not impossible, the degree of difficulty is high, requires vigilance in order to be at the table in each of these planning areas, and requires separate grant applications. For example, for Greater Los Angeles County, U.S. VETS is part of 5 and should arguably be part of 8 such planning areas! And then if grants are awarded, separate monthly reimbursement efforts for drawdown of grant funds typically requiring as many different financial statement report formats as there are administering agencies.

Once receiving the federal funds, the financial reporting requirements have standards that are not size appropriate to the grantees. Most grants limit administration cost to 5% of the grant money. On the lower end of the funding scale (say \$200,000), the required program audit and quarterly financial statement reports alone costs more than the \$10,000 that would be allowed, leaving general administration, program evaluation, as well as new design and program development costs largely grasping for unrestricted funds

The community-based organization system faces a capacity gap around managing this complexity in order to respond successfully to the distribution system for accessing funds and then if awarded the resources to pay for management and financial reporting systems to properly service those funds.

The point here is not to complain about the process (it is what it is, until it's changed)...only to underscore the complexities involved in successfully responding to the streams of funding available and necessary to combine together adequate budgets in a sufficiently broad geographic area to put on a reasonable array of services for homeless veterans. Our experience is not unique. Most community-based organizations throughout the country struggle to respond to this system of distribution of federal funds.

Although this continuum of care for homeless veterans in Los Angeles is very impressive, it represents only a portion of the community based service delivery for homeless veterans throughout the country. In 1990, seven homeless veteran service providers established the National Coalition for Homeless Veterans (NCHV) to educate America's people about the

- Riverside, California (March Air Force Base) – The first phase of a 350 bed program on 24 acres will include residential treatment, Veterans In Progress employment program, long-term transitional housing for veterans, and serviced enriched permanent housing.
- Honolulu, Hawaii (Barbers Point Naval Air Station) – 350 beds on 5 acres including residential treatment, Veterans In Progress employment program, programs for dually-diagnosed and mentally ill veterans, and long-term transitional housing for veterans, and serviced enriched permanent housing.
- Ventura County, California – 60- bed Veterans In Progress employment program and long-term transitional housing for homeless veterans.

In Los Angeles, we are part of a very effective continuum of care for homeless veterans. The Westside Residence Hall has a unique collaboration with the Salvation Army's Haven program. The final phase of this residential treatment program for homeless veterans is actually the first phase of our Veterans In Progress employment program at Westside. This creates a seamless continuum for the veteran and increases the effectiveness of both programs. Our outreach team refers veterans in need of detox and long-term substance abuse treatment to the New Directions program. As mentioned earlier, 96 agencies from throughout Los Angeles County are referring homeless veterans into the programs at the Westside Residence Hall each year. All of these activities are supported through the West LA VAMC Homeless Program and nine FTEs out stationed in their satellite mental health clinic located at West Side Residence Hall.

#### Complexity Management Gap

There are a wide variety of Federal funds that Veteran Service providers are eligible for in the course of serving Homeless veterans. The challenge is in accessing them. United States Veterans Initiative (formerly doing business as Los Angeles Veterans Initiative) was in operation for nearly 4 years before it was able to position itself to successfully compete and receive ANY federal, state or local agency funds except AmeriCorps. Today, the budget FYE 6/30/2000 includes approximately \$5million in such funds. Adding together the commitments in Houston, Honolulu, Riverside/San Bernardino, Ventura, and Las Vegas, another \$4.5 million is secured for nearly \$10 million in committed annual federal support service funds.

The attached Chart A describes logical funding streams for a veteran service provider which includes DOL JTPA funds now being retooled through work-force development boards (block granted through states to local boards). Non-SHP/HUD funds (typically block granted through counties), VHA homeless veteran grant and per diem programs, and other VA HCMF contracts (national, but administered through local VAMC's, but potentially subject to VERA modeling caps.) National Service Corporation funds (largely block granted through state commissions and capped national competitions), and as yet, a largely mystifying process for accessing HHS funds. As an example, in one 40-day window just completed, United States Veterans Initiative submitted 13 grants in 9 different agency jurisdictions.

The current prevailing public policy of devolution, increases likelihood that Federal \$'s are ultimately allocated through a ranking process subject to local viewpoints. At a local level the common perception is that veterans are taken care of by the VA. Some are, yet most are not, but the perceptions can be a barrier to homeless veterans service providers' access to funds. This perception is a reality that must be reckoned with in order to compete successfully.

When a local group is forced into priority recommendations that choose between needy men, women, and women and/or their children, it's a challenge to argue for displacing the funding for women and children in favor of a man (who's a veteran the VA is taking care of anyway). Sometimes a homeless veteran has his family still together, but it's the exception.

Consistently at nearly \$1 billion annually, the biggest piece of funding currently on the table is available from targeted HUD funds through the Super NOFA for Supportive Housing Programs. In the absence of other major funding streams targeted to homelessness, we applaud the availability of these funds.

extraordinarily high percentage of veterans among the homeless. These seven providers we consider to be true original warriors for the cause. All former military men, they were concerned that people did not understand the unique reasons why veterans become homeless and the fact that these men and women who defended America's freedom were being dramatically underserved in a time of personal crisis. In the years since its founding, NCHV's membership has grown to 235 in 43 states and the District of Columbia.

We urge this committee to consider finding ways to get capacity building services into the hands of the community-based care provider group attempting to serve veterans. It's squarely within the mission of NCHV to help formulate this capacity. And while NCHV has been doing this, it's been done in a limited way without the benefit of any federal funds. We ask you to consider the following:

- Allocate \$750,000 in FY2001 to NCHV to build capacity of the veteran service provider network. The goal would be to significantly increase access to the federal funding streams already appropriated and to enhance the efficiency of utilization for those currently accessing these streams.
- Give the Department of Veteran Affairs discretionary grant making authority (as most other Federal agencies already possess) under the Homeless Veterans Program office so that when new and innovative proposals surface the VA could sponsor their initiation. If the activity demonstrates value, VHA could put the activity into its base-funding budget or seek other long term program funding.
- We are concerned about funds Congress has encouraged VHA to set aside for Homeless Veterans are at risk of being converted to other uses. Per Diem and allocated homeless program dollars can be re-allocated if subjected to VERA modeling. Please defend these dollars by making certain they are not converted to other uses, unless it's clear the need they were intended meet has been satiated.

The march has just begun as we head into the new millennium. We look to an era where the CBO system is recognized fully as the integral part of service delivery system that is has been. We believe that it is possible to install programs and facilities sufficient to eliminate homelessness among veterans. We will seek to gain public investment in this system that will strengthen for the long-term existing organizations and new ones developing programs for homeless veterans. Let us together develop the management capacity to position this system and its sources for adaptive restructuring over time to meet the needs of our aging veteran population.

**THOMAS. R. CANTWELL, JR.**

THOMAS R. CANTWELL, JR. is President and a Director of Cantwell-Anderson, Inc., a real estate development company. Mr. Cantwell is a licensed general contractor, and since 1979 has directed the company in the area of acquisition, finance, renovation, development, construction and management of condominium, apartment and commercial real estate projects totaling over \$138,000,00. Currently, the company manages a \$17 million mixed use and mixed income residential project it developed in 1986. It retains a limited partner interest in La Vina, a \$150 million residential planned community currently under construction and will build out a 500 student K-8 school. The concept, land assembly, acquisition planning and discretionary public approvals were substantially completed under its leadership.

Many of Cantwell-Anderson Inc. projects have been for sale and rental housing targeted to low income households, mixing below market financing from various state and local agencies, tax-exempt mortgage bond funds as well as market rate commercial lenders and equity investors. Utilizing similar financing techniques, the company is packaging land, building and financing for use in meeting the housing requirements of the southwest's substantial number of homeless and special needs populations.

Mr. Cantwell is the President of Westside Residence Hall, Inc., (formerly Los Angeles Veterans Education and Training Services, Inc.), an operation dedicated solely to the purpose of delivering 500 beds of affordable transitional housing to homeless veterans. The 150,000 square foot Westside Residence Hall combines a variety of social and economic programs designed to assist each veteran resident to their highest level of independence and individual responsibility. The development concept is grounded in the belief that a homeless veteran committed to leaving life on the streets can be a bankable consumer if the conditions can be brought to bear that allows realization of their human resource potential. They pay their own rent from the means of their own production.

Mr. Cantwell designed the concept of a joint venture with a non-profit service provider whose mission was to develop and coordinate the necessary supportive services to provide the highest probability for a homeless veterans to successfully reintegrate into society. Mr. Cantwell served as the Acting Executive Director of this non-profit partner, Los Angeles Veterans Initiative, Inc., a 501(c)(3) for a 3 year formative period beginning October 1993, during which time the organization's annual operating budget grew from \$40,000 to over \$1,200,000. Efforts begun under his tenure has placed the non-profit in the position of serving homeless veterans in 8 counties located in 5 states with a combined budget in excess of \$5,000,000. Still retained as a consultant, he provides among other duties, strategic planning and program development consultant for the National Collaboration for Homeless Veterans, a L.A.VETS AmeriCorps Program, which will provide more than 300,000 hours of service annually to homeless veterans across the country.

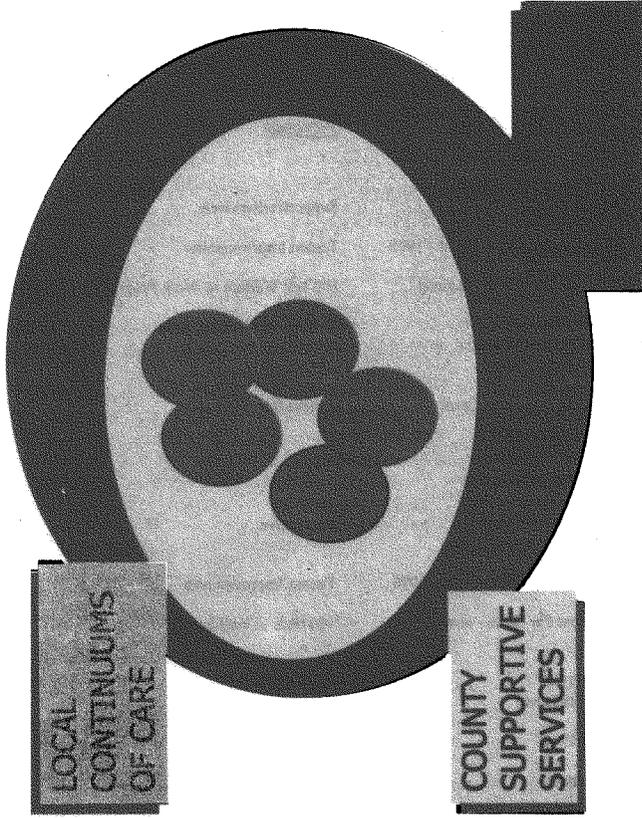
Currently, Mr. Cantwell is President of the Board of Directors of the National Coalition for Homeless Veterans representing nearly 250 agencies across the country, whose mission is legislative advocacy, public education, management and technical assistance for Homeless Veteran Service Providers.

Mr. Cantwell currently serves on the honorary board of two other non-profit entities; Pasadena Development Corporation and the Pasadena Enterprise Center. These corporations manage revolving loan funds of over \$3,000,000 and a small business incubator facility providing technical support for 31 businesses. Both strategies are designed to stimulate job formation in the and particularly for women and minority-owned business enterprises. Much of the growth of these organizations occurred during Mr. Cantwell's 15 years of volunteer service on the Board of Directors of which the last 10 years as their President.

Mr. Cantwell is the proud father of Ryan and Dawn, 11 and 14 respectively.



CHART B



**Federal Funding Sources  
for United States Veterans Initiative, Inc.**

<u>Funding Source /Date</u>	<u>Purpose</u>	<u>Amount</u>
Los Angeles, California:		
HUD-SHP 1995	SupportiveServices	\$1,500,000
VA Homeless Providers Grant - 1995	Tenant Improvements	\$427,000
VA Homeless Per Diem - Annual	100 bed Welfare to Work Program	\$540,000
HUD-SHP 1996	Welfare to Work Program	\$819,487
DOL - California 1998	JTPA	\$525,000
VA Homeless Providers Grant (Father's Project)	Tenant Improvements	\$30,000
Long Beach, California:		
HUD-SHP 1995 Services	Supportive	\$1,251,189
VA Homeless Providers Grant - 1996	Tenant Improvements	\$357,500
VA Homeless Per Diem - annual Treatment	100 beds of Residential	\$540,000
HUD-SHP 1996 Services (treatment)	Supportive	\$840,000
HUD-SHP 1996  (disabled vets)	Shelter Plus Care	\$270,000
HUD-SHP 1998 Services (Welfare to Work)	Supportive	\$655,000
DOL - California 1998	JTPA	\$525,000
Ventura, California:		
HUD-SHP 1996	Supportive Services	\$595,875

VA Homeless Providers Grant - 1997	Tenant Improvements	\$327,000
Glendale, California:		
HUD - SHP 1997	Outreach	\$124,194
El Monte, California:		
HUD - SHP 1997	Outreach	\$96,000
Houston, Texas:		
VA Homeless Providers Grant - 1998	Tenant Improvements	\$208,000
Washington, D.C./Baltimore, Maryland:		
DOL - HVRP 1998	Training & Placement with Marriott Corporation & VA Compensated Work Therapy	\$67,000
Las Vegas, Nevada:		
VA Homeless Providers Grant - 1999	118 bed Transitional Housing	\$380,085
Riverside, California:		
VA Homeless Providers Grant - 1999	118 bed Transitional Housing	\$397,000
Oahu, Hawaii:		
VA Homeless Providers Grant - 1999	118 bed Transitional Housing	\$565,223
National Collaboration for Homeless Veterans an L.A. VETS AmeriCorps Program		
operating site only:		
1994-95	Los Angeles	\$103,724
1995-96	Los Angeles	\$102,764

as parent organization of the national direct program:

1996-97	Expanded LA Site & Houston	\$827,672
1997-98	Expanded LA Site Houston & Metro D.C.	\$1,359,071
1998-99	Expanded. LA Site Houston & Metro D.C	\$1,332,147
1999-2000	Expanded LA Site Houston & Metro D.C.	\$1,164,990
1997-99	Education Awards Program	\$252,509

**STATEMENT OF**  
**ESPIRIDION "AL" BORREGO**  
**ASSISTANT SECRETARY OF LABOR FOR THE**  
**VETERANS' EMPLOYMENT AND TRAINING SERVICE**  
**BEFORE THE**  
**SUBCOMMITTEE ON BENEFITS AND**  
**SUBCOMMITTEE ON HEALTH**  
**OF THE HOUSE VETERANS' AFFAIRS COMMITTEE**  
**U.S. HOUSE OF REPRESENTATIVES**  
**MARCH 9, 2000**

Chairman Quinn and Chairman Stearns, Members of the Subcommittees:

Thank you for the opportunity to appear before you today to talk about issues facing America's homeless veterans, and the Department of Labor's efforts to serve these veterans.

As you know, America's economy is strong. Over the past seven years, more than 20 million new jobs have been created and the unemployment rate is at its lowest level in 30 years. Most of our citizens, including many of whom prosperity had previously left behind, are doing better than ever. Unfortunately, despite many Federal, State, and local -- public and private -- efforts to reduce homelessness among our Nation's veterans, an estimated 322,000 to 491,000 veterans experienced homelessness during 1996, for example. Our challenge is to reduce these numbers and to restore dignity -- through gainful and lasting employment -- to our Nation's homeless veterans, who all too often must first overcome multiple barriers to employment, including mental health problems and alcohol and drug abuse.

One of Secretary Herman's highest priorities is to ensure that the promise of America's prosperity is shared by our Nation's veterans. Today, I want to talk about the nature of this challenge, by first focusing specifically on the efforts of the Veterans' Employment and Training Service (VETS), and, secondly, speaking of the Department's efforts to serve homeless veterans in general.

**Homeless Veterans Reintegration Program (HVRP)**

On behalf of the Secretary, let me begin by thanking you for your support of VETS' Homeless Veterans Reintegration Program (HVRP), and particularly for supporting its reauthorization. The Secretary has often said that "Veterans' issues are America's issues." Perhaps no other veterans' issue touches our hearts as the plight of homeless veterans. We at the Department are very proud of the services we provide to veterans under the HVRP and other programs.

HVRP was the first Federal program to focus on placing homeless veterans into jobs. It is intended to augment our overall veteran employment program by focusing coordinated services from multiple providers, thus expediting the reintegration of homeless veterans into the labor force so that they may achieve financial independence. Once these homeless veterans are job ready, our veterans' employment representatives are available to assist with job placement. The goal of this program is to place a veteran in a job -- and not just any job, but a job that he or she can keep. In addition to VETS' three month follow-up, HVRP grantees will now be required, under the reauthorization of this program passed last fall, to determine the job status of their clients six months after the initial placement. This will allow us to better track our success in reintegrating homeless veterans into the mainstream economy.

HVRP is a successful program which has been broadly supported by local community groups and Veterans Service Organizations. Since its inception, this program has been a partnership with local agencies and other State and Federal programs. Indeed, partnerships are a fundamental requirement for applicants for these grants. As part of the competitive process, applicants are required to identify the entities with whom they will partner, such as the

Departments of Housing and Urban Development (HUD) and Veterans' Affairs (VA), Workforce Investment Act (WIA) grantees, the State Employment Security Agencies (SESAs), State and local governments, and local groups. Grant applicants also must identify the services to be provided by their partners, such as housing assistance, sustenance and medical support, job training, mental health services and substance abuse treatment. Applicants are required to address these issues in their application, and their responses are evaluated as part of the grant award process.

The quality of these supplemental services is assessed and evaluated at the same time that the performance of the grantee is reviewed. HVRP grantees also utilize former homeless veterans as outreach coordinators. This has proven to be a successful method for encouraging veterans to accept assistance.

From Fiscal Years 1989 through 1994, the \$19 million spent on HVRP provided a variety of services to 19,516 homeless veterans; 9,808 of whom were placed in jobs. During this six-year period, homeless veterans entered employment at a cost of \$1,937 per veteran. As you know, the program was not funded for Fiscal Years 1995, 1996, and 1997.

Funding for this program was resumed in Fiscal Year 1998. VETS' Fiscal Year 1998 Solicitation for Grant Application to operate the HVRP program drew many applications, mostly from urban areas. Applications were submitted from State and local public agencies, Private Industry Councils, and nonprofit organizations.

On April 1, 1999, VETS awarded \$3 million in Fiscal Year 1998 funding to 20 different grantees to administer 23 grants in urban and rural areas. The grants varied in size between \$100,000 and \$125,000. As is customary, the urban grants included an option for VETS to re-fund for a second year if the grantee performed in accordance with the grant agreement's performance measures. Rural grants were awarded for one year only. At the end of Fiscal Year 1999, these grantees enrolled and served 3,783 homeless veterans and placed 1,843 veterans in jobs.

Fiscal Year 1999 funding also provided \$3 million for second-year funding to those urban Fiscal Year 1998 grantees whose performance was satisfactory, and for another competition for those rural areas which did not have the option of extending an additional year. Preliminary results indicate that so far 1,703 homeless veterans have been provided a variety of services. Moreover, 928 veterans were placed in jobs. We expect to receive final reports for this program year after June 30, 2000.

Due to support from Congress and the homeless veteran community, this year's Fiscal Year 2000 grant program -- funded at \$9.6 million -- is the most ambitious since the inception of the program. Essentially the program is funded at its full authorized level. We believe that this investment reflects Congress's confidence in the quality of services and our track record.

For Fiscal Year 2000, VETS is announcing two separate competitions. The first Solicitation for Grant Application (SGA) to operate an HVRP program is targeted to the Nation's 75 largest cities, where the need is the greatest. This SGA was published in the Federal Register on February 7, 2000. The second SGA competition will solicit applications from entities serving rural areas. At a conservative estimate, we expect that about 6000 homeless veterans will receive a variety of services. In addition, we expect that 4000 will be placed in jobs.

For Fiscal Year 2001, President Clinton's budget requests the full authorized level -- \$15 million -- for HVRP funding. This increased funding would enable VETS to compete funds with fewer limitations, such as the maximum size of the grant or the number of grants funded, while simultaneously increasing the efficiency and effectiveness of the HVRP. At this funding level, we estimate that 17,400 homeless veterans would be enrolled in HVRP programs. We also estimate that 8,700 would be placed in jobs.

#### **Homeless Veterans and the Labor Department's Employment & Training Administration**

In addition to HVRP, homeless veterans are eligible to participate in Employment and

Training Administration (ETA) programs. For example, veterans currently participate in Job Training Partnership Act (JTPA) programs. Based on preliminary data for the last full program year of JTPA, seven percent of those completing the Adult program and 11 percent of those completing the Dislocated Worker program were veterans. Eight percent of the veterans in the Adult program were homeless.

JTPA will be replaced by the Workforce Investment Act (WIA) on July 1, 2000. WIA will be administered at the local level by Workforce Investment Boards that include representatives of veterans' organizations and veterans' employment programs as members. A cornerstone of WIA is the One-Stop service delivery system, which includes veterans employment programs as required partners. This means that veterans, including homeless veterans, will literally have "One-Stop" access to employment and training and related services, including job placement services specifically tailored to veterans. These services include assessment, job training, employability training, job search assistance, support services for low income, unskilled or low skilled adults and youth.

Homeless veterans are also eligible for services provided by the public Employment Service, which is funded and administered by the Department, and operates through the States. The Employment Service provides labor exchange and labor market information services at no charge to the public. Local Veterans Employment Representatives (LVERs) and Disabled Veterans' Outreach Program specialists (DVOPs) are available at local Employment Service offices. LVERs provide some direct service to veterans and ensure that they receive appropriate employment services and DVOPs provide staff-assisted job search and placement services for qualified veterans. A total of 1.7 million -- or 10 percent of job seekers registering with the Employment Service in program year 1998 (July 1, 1998 through June 30, 1999) -- were veterans. The Employment Service does not collect data on homeless job seekers.

#### **Other Departmental Efforts to Serve Homeless Veterans**

In addition to our efforts through programs authorized by this Committee, the Secretary and I have met with Veterans Service Organization (VSO) leaders to discuss the problem of homelessness among our veterans. We have attended national VSO conferences to describe DOL's role in responding to their concerns about this important issue. VETS participates in VSO national service officer and other homeless advocate training activities to develop strategies to respond to homeless issues. We also work with the Veterans Organization Homeless Council (VOHC) and the Homeless Veterans Foundation, as well as the National Coalition for Homeless Veterans. Recently, the Secretary convened a meeting with representatives of faith-based organizations in order to make them aware of DOL programs, including HVRP, and to seek stronger partnerships with these organizations.

VETS' staff also work with the Department of Housing and Urban Development (HUD), the President's Committee on Employment of People with Disabilities, the Department of Veterans Affairs (VA), and other Federal agencies to pool informational resources and educate providers about the full range of DOL community based services available to veterans and their families. In addition, DOL participates on the Veterans Task Force of the Interagency Council on the Homeless and on VA's Town Hall Meetings on Homeless Veterans. This interagency effort and cooperation has resulted in the establishment of the HUD Veteran Resource Center (HUDVET) and the recruitment of a combat disabled veteran to be its director. VETS works closely with HUDVET. Essentially, the Department of Labor acts as a catalyst to leverage the support of other Departments toward support of homeless veterans.

I appreciate this opportunity to testify before the Subcommittee and look forward to working closely with you and the veterans' community to further reduce homelessness among our Nation's veterans. I would be happy to take any questions you may have at this time.

**Statement of**  
**Fred Karnas, Jr., Ph.D.**  
**Deputy Assistant Secretary for Special Needs Programs**  
**U.S. Department of Housing and Urban Development**  
**before the**  
**Subcommittee on Benefits and Subcommittee on Health**  
**Committee on Veterans' Affairs**  
**U.S. House of Representatives**

March 9, 2000

Mr. Chairman, members of the Subcommittee, I appreciate the opportunity to appear before the Subcommittee today. It is my honor to represent the Department of Housing and Urban Development (HUD), Secretary Andrew Cuomo and Assistant Secretary Cardell Cooper before you today.

The fact that current estimates suggest that on any given night there may be as many as 275,000 homeless veterans in the U.S. is not only tragic -- in this time of significant economic prosperity it is unacceptable. For this reason, addressing homelessness has been a high priority for the Department since the first day of President Clinton's administration, and it is why over that past three years, HUD has provided over \$1.1 billion to fund nearly 2,500 programs targeting homeless veterans as one of the primary groups they are serving.

HUD's efforts to address the needs of homeless veterans must be understood in the context of the programmatic and policy changes which took place as a result of implementing *Priority Home! The Federal Plan to Break the Cycle of Homelessness*. The Federal plan was developed by direction of President Clinton in 1993, and involved input from a variety of federal agencies and thousands of organizations and individuals working to address homelessness.

At HUD, the plan called for increased resources and the implementation of a new approach to addressing homelessness called the Continuum of Care. It must be clear that HUD's mandate is to seek to address the housing and service needs of all homeless persons -- families with children, persons living with HIV/AIDS, those suffering from alcohol or drug dependence, persons experiencing mental illness, and veterans. It is HUD's special challenge to ensure, to the degree possible, that communities have the tools necessary to craft programs and policies to meet the complex needs of all of these groups.

This morning, I would like to highlight how the Department has successfully expanded its efforts to support community approaches to addressing homelessness broadly, and then more specifically focus on our efforts to target the needs of homeless veterans.

**Resources**

Significantly increased resources have been key to HUD's ability to support the efforts of communities to address homelessness in recent years. Since 1992, thanks to the President's initiative and Congressional support, funding for HUD's homelessness assistance programs has nearly tripled from \$450 million to over \$1 billion in 1999. And, because the need continues to exceed the resources, President Clinton is seeking to make even more funding available in his FY2001 budget proposal, which includes \$1.2 billion for HUD's competitive and formula homeless assistance programs, as well a funding for 18,000 Section 8 vouchers to assist homeless persons move from transitional to permanent housing.

### **The Continuum of Care Policy**

In 1993, under the leadership of then Assistant Secretary Andrew Cuomo, HUD's Office of Community Planning and Development recognized homelessness was more than simply a housing problem. The Department restructured its homeless assistance programs focusing attention on long-term solutions which included housing, but also included job training, drug treatment, mental health services, and domestic violence counseling, among other things. The new homeless assistance policy was called the Continuum of Care.

Besides changing the thinking about how HUD's homeless assistance programs should work, the Continuum of Care approach also restructured the relationship among Federal, state and local governments, nonprofits, and other community stakeholders. It did so by engaging citizens in a common planning process to craft a comprehensive system of housing and services to meet the complex needs of homeless persons. In so doing, HUD recognized that communities were best positioned to know the needs of homeless persons at the local level, and the existing resource infrastructure. In order to obtain funding, communities were asked to submit a comprehensive plan to HUD, which included local priorities for funding.

In addition to calling for a new approach and additional funding, HUD sought to ensure that taxpayer funds directed to address homelessness were used effectively and efficiently by imposing performance as a criteria for continued funding. A successful Continuum of Care includes (1) outreach; (2) emergency shelter; (3) transitional housing; (4) permanent housing or permanent housing with supportive services. While not all homeless people need access to each component, all four must be present and coordinated within a Continuum. A winning application is one that focuses on a coordinated community-based strategy that emphasizes independence and self-sufficiency to the maximum extent possible.

As a result of the implementation of the Continuum of Care approach to addressing homelessness, several significant changes have occurred in the nation's response to homelessness. First, according to a 1995 report by the Barnard-Columbia Center on Urban Policy, the number of persons served has increased at least 4 times and perhaps as many as 14 times depending on the number of persons receiving multiple services. This significant increase reflects both the additional resources and the efficiencies gained from a comprehensive and coordinated process. Second, leveraging of non-HUD funds by HUD funds increased from \$38 million in 1992 to \$1.8 billion in 1999 providing significantly more resources to address homelessness at the local level.

By 1999, over 83% of the U.S. population (646 cities and 1,860 counties) lived in areas covered by Continuums of Care, and the Barnard-Columbia University Center on Urban Policy study revealed that communities across the nation felt that the Continuum process has significantly improved their ability to address the needs of homeless people.

Reflecting the significance of the impact of HUD's policy changes, the Department received a Hammer Award from National Performance Review, and, in 1999, was named one of 10 winners (out of more than 1,400 nominees) for the prestigious Harvard-Ford Foundation Innovations in Government Award.

### **Targeting the Needs of Homeless Veterans**

Despite the success of the Continuum of Care approach overall, the Department heard from a number of groups serving homeless veterans that additional changes were needed to better meet the needs of homeless veterans. Thus, we undertook the efforts outlined below.

### **HUDVET**

In response to these concerns, on March 19, 1996, HUD Secretary Andrew Cuomo created the HUD Veteran Resource Center (HUDVET). Established in consultation with national veteran service organizations, and other Federal agencies, specifically the Department of Labor's Veterans Employment and Training Service, the Department of Veterans Affairs, and The President's Committee on Employment of People with Disabilities, HUDVET's first and major goal was educational. HUD recognized the need to provide veterans, their families and their service organizations and advocates information on HUD's community based programs and services.

The Department believed that equipped with this knowledge, veterans and their service organizations could become more involved in local planning and decision-making around homelessness assistance. HUD also envisioned that by working together the various Federal agencies and working groups could increase veteran utilization of services and local resources, as well as related Federal programs.

In addition to a special focus on homelessness among military veterans, HUDVET has also become a recognized source of information on other HUD and related Federal programs available to serve veterans at the community and state levels. With the educational mission in mind, HUD worked together with VSO staff and other veteran advocates to develop the HUDVET brochure and the HUDVET Directory of Resources. The brochure provides point of contact numbers for all HUD's Federal homeless program colleagues, as well as providing a brief review of selected HUD programs.

In addition to providing an excellent overview of HUD programs and services, our 400 page HUDVET Directory contains a first of its kind listing of all Federal, state and local human development planning and service programs available to veterans and their families.

Working with VSO's, HUD has mailed copies of the Directory to every single VSO National Service Officer in the United States. In fact, to date, HUD has distributed over 10,000 copies of the HUDVET Brochure and several thousand copies of the HUDVET Directory.

Working with VSO's, and in particular the Veterans Organization Homeless Council (VOHC) chaired by Bob Piero of the Vietnam Veterans of America and the Homeless Veteran Foundation (HVF) chaired by Harold Russell, HUD developed the HUDVET Web Site which contains information and links to federal, state and local veteran services, including the House Veterans' Committee website.

As part of HUDVET's efforts, the Department has also worked closely with the Department of Veterans Affairs, and the Department of Labor's VETS program, sharing information, educating community groups regarding the range of services available to veterans and their families.

The success of HUDVET is due, in no small way, to the appointment of Bill Pittman to head the office. Mr. Pittman is a highly decorated combat disabled Vietnam veteran and career Federal employee. Bill served in the U.S. Navy from 1965-1971. He saw duty with the First Marine Division in Vietnam. His decorations include the Navy and Marine Corps Medal for Heroism, two Purple Hearts, the Navy Combat Action Ribbon, the US Army National Guard Distinguished Service Medal and the Republic of China Medal of Honor.

#### **Changes in the Continuum of Care Process to Better Serve Homeless Veterans**

In addition to the establishment of HUDVET, the Department made a number of policy and operational changes to the Continuum of Care process to further encourage and make possible full participation by organizations serving homeless veterans. The need to include groups representing veterans in local Continuum of Care planning was first highlighted in the 1996 Continuum of Care Notice of Funding Availability (NOFA) and

continues to be an important factor in our review of project applications. The NOFA specifically states:

*The community process used in developing a Continuum of Care system must include interested veterans service organizations with specific experience in serving homeless veterans, in order to ensure that the Continuum of Care system addresses the needs of homeless veterans.*

In addition, the NOFA indicates that high scores result from having maximum participation by various nonprofit providers, among which veterans service organizations are included as an example. Thus, in scoring applications, communities which have not reached out and included groups representing veterans are scored lower than those who have brought them into the process. This point is underscored by a section of the "Questions and Answers" document which accompanies the Continuum of Care application and which includes basic information on including veterans and the organizations representing them in the Continuum of Care process.

The Department has also added a condition to the award of grants to providers that propose to serve homeless veterans in their HUD funded housing and service programs which requires them to describe how outreach will be conducted to the veterans population. The grantee must also describe the methods that will be used to ensure veterans' participation including information on specific site locations and referral networks. And, since Assistant Secretary Cooper has made monitoring of HUD's projects a high priority, Field Office staff are in a better position to ensure that the commitments of our grantees to address the needs of homeless veterans are met.

In the last funding cycle, we added language to our conditional grant letters directing those programs which have stated that they will target homeless veterans either primarily or as part of their target population to inform their local VA entities that their services are available to veterans.

In addition, all Continuum of Care grantees are required to submit an Annual Progress Report (APR) containing program narrative, budget, client and accomplishments data on the past year's activities. In 1996, the Department included a new section in the APR focusing on service to homeless veterans. APRs are reviewed and program sites are monitored regularly by HUD's Field Offices.

With these changes in place, the Department has reached out to veterans' service organizations, the National Coalition for Homeless Veterans, and other groups concerned about the plight of homeless veterans to ensure that they are aware of HUD's programs, how they work, and our expectations of providers. Secretary Cuomo, Assistant Secretary for Community Planning and Development Cardell Cooper, Acting Chief of Staff Jacquie Lawing, Mr. Pittman, myself, and other senior HUD staff have led sessions at conferences, attended special meetings, and held briefings with these veterans groups in recent years to highlight HUD's homelessness assistance programs.

### **Technical Assistance**

In addition to the program and policy changes, the Department makes available an array of technical assistance resources. Although the HUD Reform Act prohibits HUD staff or consultants from assisting with the development of a specific grant application, the Department can provide general information on programs and clarification of program requirements. National technical assistance providers can work with groups and communities to improve the Continuum of Care process, or to enhance the inclusion of homeless persons in the process. Local technical assistance providers can help with an array of programmatic questions, as can HUD's College of Experts, which includes individual consultants with knowledge of programs for homeless veterans.

### **Results**

We believe all of these efforts have resulted in positive changes. In 1997, the Department funded 657 projects targeting homeless veterans. Overall, for 1997 the success rate of funding for all awarded projects serving veterans was 42 % compared to 41% for all projects. In 1998, HUD funded 805 projects serving homeless veterans. The success rate for 1998 projects proposing to serve veterans was 54% compared to 56% for all applicants. By 1999, over 1,000 projects serving homeless veterans were funded, with a success rate of 62%, the same as for all applicants.

As a result of HUD's efforts to better focus on the needs of homeless veterans, over \$1.1 billion dollars has been made available for projects serving homeless veterans in just the past three years. These funds have gone to fund excellent projects operated by organizations such as U.S. Vets, Maryland Homeless Vets, and the New England Shelter for Homeless Veterans.

But, application data only tells part of the story. The real issue is what happens when the projects are implemented. As mentioned previously, the Department requires the submission of Annual Progress Reports (APRs) which provide a snapshot of what is happening with funded projects. A recent sample of APRs shows that 28% of all adult males served in HUD's homeless assistance programs are veterans. This figure is proportionate to the rate of homeless males who are veterans (about 33%). Based on this sample, over 150,000 male veterans are served during the course of the year.

### **There is Still Work to be Done**

We believe we have come a long way in addressing the needs of homeless veterans. We would not suggest, however, that we have done all that needs to be done. It seems that at least two significant issues remain.

#### **Capacity**

Often grant applications received from groups proposing to serve veterans do not reflect the capacity needed to administer Federal funds. HUD is committed to improving our technical assistance resources to assist organizations in building capacity. I previously mentioned our efforts to assist existing grantees, and last summer we published new technical assistance materials on the Continuum of Care process and on developing Safe Haven programs for persons experiencing mental illness. In addition, HUDVET provides an array of technical assistance resources that are readily available through the Internet and via our 1-800 number.

In the coming year, we are considering ways we might improve the Department's outreach to veterans' groups regarding the availability of these resources, and ways that we might develop veterans specific TA resources.

#### **Access to the Continuum of Care Process**

The other significant barrier to groups seeking funding to assist homeless veterans is at the local level. We have heard from a number of groups who claim that the interests of homeless veterans are not a priority in local planning processes. As mentioned previously, the Department has crafted the application in such a way that ignoring the needs of homeless veterans will affect the community's score in the Continuum of Care competition. However, having said that, there is one significant reality which cannot be ignored, that is the renewal of existing projects. In some communities, the reason that new groups proposing to serve homeless veterans are not prioritized highly is that the renewal demand for existing projects is so high that to include a new program as a priority would require the closing of an existing project. HUD's response has been to seek additional resources to meet the continued need. As mentioned earlier, President Clinton is seeking a significant increase in HUD's homelessness assistance budget in FY2001. Passage of this appropriation will help address the renewal problem and make additional funding available for new programs in most communities.

The Department will also continue to make communities aware of the needs of homeless veterans and encourage veterans service organizations to regularly participate in local planning efforts to educate the community on the special needs of homeless veterans.

#### **Closing**

Thank you for the opportunity to talk about HUD's efforts to address homelessness. Homelessness among our nation's veterans continues to be an American tragedy. The Department of Housing and Urban Development is proud of the strides we have made in addressing this crisis, and the thousands of homeless persons who, through our programs, have returned to self-sufficiency. However, we, like many Americans, continue to be appalled that even one of our nation's veterans, who have sacrificed so much to benefit us all, should find himself or herself homeless on the streets of our cities and towns. Therefore, we at HUD commit ourselves to continuing our work with this committee, veterans service organizations, and other concerned groups to ensure that the needs of homeless veterans are met.

# **HOMELESSNESS:**

## **Programs and the People They Serve**

### **Findings of the National Survey of Homeless Assistance Providers and Clients**

#### **Technical Report**

Prepared for:  
Interagency Council on the Homeless

Andrew Cuomo, Chairperson  
Secretary of Housing and Urban Development

Donna E. Shalala, Vice Chairperson  
Secretary of Health and Human Services

Togo D. West, Jr., Vice Chairperson  
Secretary of Veterans Affairs

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**December 1999**

## CHAPTER 11 VETERANS<sup>1</sup>

### *Highlights: Homeless Male Veterans and Non-Veterans<sup>2</sup>*

- Homeless male veterans are more likely than their non-veteran counterparts to be white (46 versus 34 percent) and age 45 or older (46 versus 20 percent).
- 32 percent of homeless male veterans report that their last homeless episode lasted 13 or more months, compared to 17 percent of male non-veterans. Only 34 percent of homeless male veterans say their last homeless episode lasted three months or less compared to 43 percent of their non-veteran counterparts.
- Homeless male veterans report a median income over the past 30 days of \$250. This is only slightly higher than the \$212 median income of homeless male non-veterans.
- 49 percent of homeless male veterans report having no medical insurance, compared to 68 percent of other homeless men. This large difference occurs because many homeless veterans receive VA medical care (32 percent).

### *Highlights: Currently and Formerly Homeless Male Veterans Compared*

- Currently and formerly homeless male veterans are from similar racial/ethnic groups: the largest shares are white non-Hispanic and black non-Hispanic.
- 31 percent of currently homeless male veterans have experienced 4 or more periods of homelessness, compared to 16 percent of formerly homeless veterans. For 49 percent of formerly homeless veterans, their most recently completed episode of homelessness lasted less than four months, compared to 34 percent of currently homeless veterans.
- Formerly homeless male veterans' median income over the past 30 days is over twice that of currently homeless male veterans (\$511 versus \$250).

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<sup>1</sup> Analyses in this chapter are based on *male* NSHAPC clients, since 98 percent of the veterans in NSHAPC are men.

<sup>2</sup> Unless noted specifically in the text, all comparisons are statistically significant at  $p = .10$  or better, and all percentages presented by themselves have a 90 percent confidence interval no larger than  $\pm 6$  percentage points. A confidence interval of  $\pm 6$  percentage points means that if the reported percent is 60, 60 is the estimate of the value and the probability is 90 percent that the value falls between 56 and 64 percent. Confidence intervals greater than  $\pm 6$  percentage points will be noted in a footnote as: 90% C.I. =  $\pm X$  percentage points.

- Currently homeless veterans are more likely than formerly homeless veterans to be without medical insurance (49 versus 34 percent).
- 25 percent of currently homeless veterans report three or more food problems, compared to 11 percent of formerly homeless veterans.

## INTRODUCTION

That some veterans are homeless is particularly ironic in the eyes of many Americans. Might their military experiences have contributed to their vulnerability to homelessness? Combat experience has often been considered in this regard, because of the traumatic stress that it produces and the use of drugs and alcohol to counter this stress. Some studies by Rosenheck and colleagues (Rosenheck et al., 1996) have reviewed the experiences of homeless and non-homeless veterans and found few differences in their exposure to war-zone service or combat, or in the prevalence of war-related post-traumatic stress disorder. As with other Americans, poverty, ADM problems, and social isolation are documented as the primary risk factors for homelessness among veterans (Rosenheck et al., 1996). This study provides the opportunity to explore further the issue of military service and homelessness.

## HOMELESS VETERANS

Twenty-three percent of all homeless clients are veterans. Ninety-four percent report service in the Armed Forces of the United States and 2 percent report service in the Reserves or National Guard (Appendix table 11.A2). In addition, 4 percent say that they were in the military at the time they were interviewed for this study.

Forty-seven percent of homeless veterans served in the Vietnam Era (August 1964 through May 1975), and 32 percent served from May 1975 to August 1980. The next most common periods of service are September 1980 to July 1990 (17 percent) and before the Vietnam War—February 1955 to July 1964 (15 percent). Sixty-seven percent of homeless veterans served three or more years in the military, 21 percent served two years, and 7 percent served one year. Thirty-three percent report being stationed in a war zone, of whom most report that they were exposed to combat (28 percent). Finally, 11 percent of homeless veterans report they did not receive an honorable discharge from military service.

The use of veteran-specific services by homeless veterans was a focus of this study. Fifty-seven percent have used a medical facility operated by the Department of Veterans Affairs for some type of long or short-term medical care. Also, 25 percent of homeless veterans have participated in programs specifically for homeless veterans, the most common of which are shelters for veterans (14 percent), domiciliary programs (11 percent), and compensated work therapy (8 percent).

## HOMELESS MALE VETERANS AND NON-VETERANS

Among homeless men, 33 percent report being veterans, and a very high proportion (98 percent) of homeless veterans are men. Therefore, the remainder of this chapter looks at homeless *male* veterans and compares them to homeless *male* non-veterans. Focusing on homeless *male* clients rather than all homeless clients allows one to examine differences due to veteran status rather than confounding these with gender differences.

### *Demographic Characteristics*

Several interesting differences emerge when examining the differences in demographic characteristics between homeless male veterans and non-veterans (table 11.1). Homeless veterans are more likely than their non-veteran counterparts to be white non-Hispanic (46 versus 34 percent) and less likely to be Hispanic or Native American (9 versus 26 percent). Homeless veterans are more likely to be older; 44 percent are between the ages of 45 and 64 compared to only 20 percent of homeless non-veterans (figure 11.1). Also, 85 percent of homeless veterans have completed high school or have received a GED, compared to 56 percent of homeless non-veterans.

The two groups also differ in their marital status. However, they are equally unlikely to be in family households (2 percent of homeless male veterans and 4 percent of homeless male non-veterans). Sixty-seven percent of homeless veterans and 41 percent of their non-veteran counterparts report that they are married or have been married in the past and the veteran group is more likely to be divorced (38 versus 19 percent). Among homeless veterans, the largest proportion reside in central cities (79 percent), with smaller proportions in suburban (16 percent) and rural areas (5 percent).

### *Homeless Experiences*

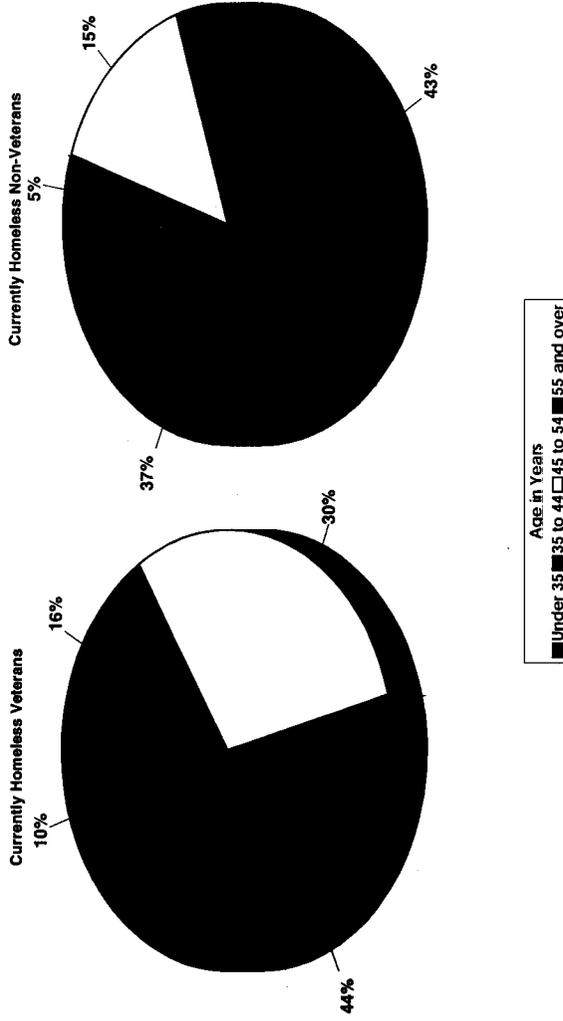
Currently homeless veterans and non-veterans do not differ in the number of times they report having been homeless. However, they do report having been homeless for different lengths of time (figure 11.2). Nearly half of each group say they are in their first homeless episode (table 11.2). Homeless non-veterans, however, are more likely to report that their current episode has lasted three months or less (28 versus 18 percent). The same pattern emerges when studying the length of previous episodes. Homeless veterans are more likely to report their most recent

Table 1.1. Basic Demographic Characteristics of Male NSMPC Veterans and Non-Veterans, by Homeless Status

	Currently Homeless Veterans (N=183)	Non-Veterans (N=159)	Formerly Homeless Veterans (N=129)	Non-Veterans (N=189)
Race/Ethnicity				
White non-Hispanic	48%	51%	54%	58%
Black non-Hispanic	45	46	48	46
Hispanic	5	13	2	3
Native American	4	1	1	0
Other	1	1	*	1
Age				
Under 18	0	*	0	1
18 to 21 yrs.	*	6	0	8
22 to 24 yrs.	1	4	3	3
25 to 29 yrs.	9	27	2	10
30 to 34 yrs.	3	4	3	18
35 to 39 yrs.	4	15	16	12
40 to 44 yrs.	30	15	34	16
45 to 49 yrs.	14	5	17	9
50 to 54 yrs.	2	*	10	8
55 or more yrs.				
Unaffiliated States				
Central Cities	79	71	69	77
Suburban/Urban Fringe	16	17	22	13
Rural	5	12	9	11
Education/Highest Level of Completed Schooling				
Less than high school	15	44	16	52
High school graduate/G.E.D.	40	34	53	29
More than high school	45	22	29	19
Marital Status				
Never married	33	59	31	56
Married	7	2	6	7
Widowed	3	2	1	1
Divorced	35	19	44	18
Separated	19	13	9	19
Living Situation				
Chart 17 to 24				
In families	*	1	0	*
Women	0	0	0	0
Men	0	0	0	0
Single clients	1	10	3	4
Women	0	0	0	0
Men	0	0	0	0
Chart 25 or older				
In families	2	3	6	5
Women	0	0	0	0
Men	0	0	0	0
Single clients	97	98	91	96
Women	0	0	0	0
Men	0	0	0	0
Other Services Users				
Veterans (N=54)				
Non-Veterans (N=189)				
Insufficient N				

Source: Urban Institute analysis of weighted 1998 NSMPC client data. \* Denotes values that are less than .5 percent but greater than 0. Note: Percentages do not sum to 100% due to rounding. Insufficient N signifies that sample size was too small for data to be reported.

Figure 11.1  
**Age of Homeless Male Clients, by Veteran Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

completed episode lasted over 13 months (32 versus 17 percent) while their non-veteran counterparts are more likely to report that it lasted three months or less (46 versus 34 percent).

#### *Current and Lifetime Use of Homeless Assistance Programs*

The living situation on the day they were interviewed for this study is very similar for veteran and non-veteran homeless clients (table 11.3). One difference does exist in their use of homeless assistance programs over the prior week. Forty-two percent of homeless non-veterans report using a soup kitchen over the past week compared to 34 percent of homeless veterans. When the day of the interview is included along with the last seven days, the percentage of veterans (44 percent) that report using a soup kitchen is still smaller than the percentage of non-veterans (53 percent).

During the course of their lifetime, a similar proportion of homeless veterans and non-veterans report using emergency shelters and soup kitchens. However, a larger percentage of homeless veterans (42 percent) have used food pantries in their lifetime than have homeless non-veterans (33 percent).

#### *Income, Income Sources, and Employment*

Very few differences exist in current income, income sources, and employment characteristics of veteran and non-veteran homeless clients (table 11.4). Veterans report a median income over the past 30 days of \$250, which is only slightly higher than the \$212 median income of homeless non-veterans. Looking at sources of income helps explain why these amounts are so similar. For example, similar proportions of homeless veterans and non-veterans report working for pay in the last thirty days (49 versus 51 percent). One expected difference, however, is receipt of veteran-related benefits: 6 percent of homeless veterans receive veterans disability payments and 2 percent receive a veteran's pension.

#### *Health and Nutrition*

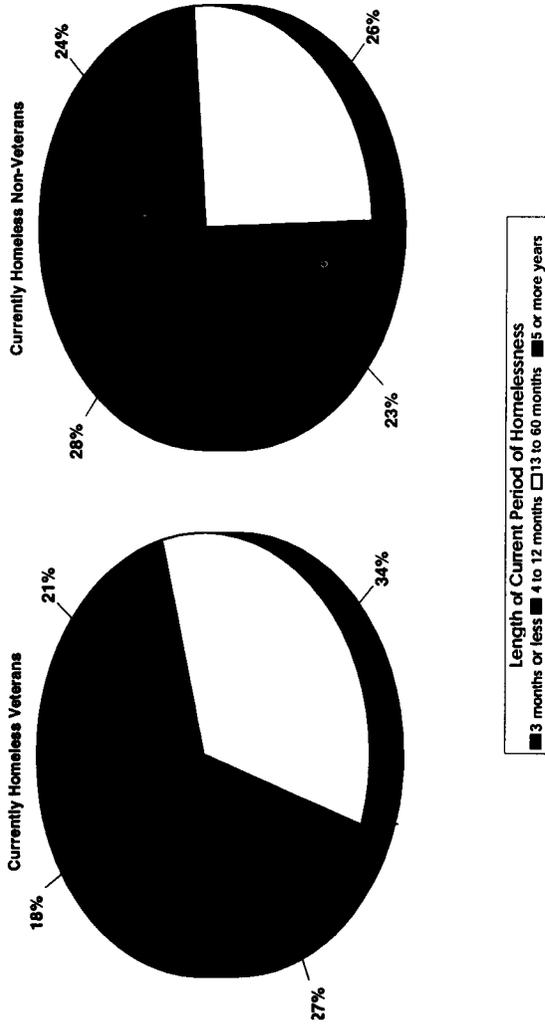
While physical health, medical needs, and health insurance coverage of homeless clients vary by veteran status, the general types of health-related conditions reported by both groups are quite similar (table 11.5 and figure 11.3). Twenty-five percent of veterans and 24 percent of non-veterans report having one or more acute infectious conditions. Likewise, 8 percent of both groups report one or more acute *non*-infectious conditions, and 52 percent of veterans and 44 percent of non-veterans report having one or more chronic health conditions. The most common medical conditions reported by homeless veterans are arthritis, rheumatism or other joint problems (32 versus 21 percent of homeless non-veterans) and high blood pressure (23 versus 12

Table 11.2  
**Length and Number of Homeless Episodes of Male Veterans  
 and Non-Veterans, by Homeless Status**

	Currently Homeless Veterans (N=632)	Currently Homeless Non-Veterans (N=1353)	Formerly Homeless Veterans (N=129)	Formerly Homeless Non-Veterans (N=271)
<b>Number of Times Homeless or Without Regular Housing for 30 Days or More</b>				
1	47(%)	47(%)	43(%)	34(%)
2	12	17	30	25
3	10	12	6	11
4-10	22	20	14	22
11 or more	9	4	2	5
<b>Among Currently Homeless Clients</b>				
<b>Length of Current Period of Homelessness</b>				
< 1 week	3	6	Not Applicable	Not Applicable
>= 1 week and < 1 month	5	8	Not Applicable	Not Applicable
1-3 months	10	14	Not Applicable	Not Applicable
4-6 months	10	10	Not Applicable	Not Applicable
7-12 months	17	13	Not Applicable	Not Applicable
13-24 months	20	17	Not Applicable	Not Applicable
25-60 months	14	9	Not Applicable	Not Applicable
5 or more years	21	24	Not Applicable	Not Applicable
<b>Spell History and Current Spell Length</b>				
First time homeless	13	17	Not Applicable	Not Applicable
6 months or less	34	30	Not Applicable	Not Applicable
more than 6 months	17	20	Not Applicable	Not Applicable
Not first time homeless	36	32	Not Applicable	Not Applicable
current spell 6 months or less				
current spell more than 6 months				
<b>Among Currently or Formerly Homeless Clients With at Least One Completed Homeless Episode</b>				
<b>Length of Last Complete Period of Homelessness</b>				
< 1 month	12	14	16	7
1-3 months	22	32	33	37
4-6 months	14	15	19	10
7-12 months	20	23	8	23
13-60 months	21	13	16	19
5 or more years	11	4	9	4

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding. \* Denotes values that are less than .5 percent but greater than 0.

Figure 11.2  
**Length of Homeless Male Clients Current Period of Homelessness,  
by Veteran Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

Table 1.3  
Current Housing & Use of Homelessness Assistance Programs by Male Veterans and Non-Veterans, by Homeless Status

Type of Place Lives Now (Today)	Currently Homeless Veterans (N=1532)		Formerly Homeless Veterans (N=129)		Other Service Users Veterans (N=54)	
	N (%)	300%	N (%)	0%	N (%)	0%
Emergency shelter	21	23	0	0	0	0
Transitional shelter/housing	1	1	0	0	0	0
Car or other vehicle	2	5	0	0	0	0
Abandoned building	2	5	0	0	0	0
Transportation site (e.g., bus station)	5	1	0	0	0	0
Place of business (e.g., church)	11	12	0	0	0	0
Homeless shelter (not transitional prog.)	8	2	15	9	28	3
Hotel/motel/sortory hotel (not transient)	10	13	85	91	72	87
House/apartment (transitional prog.)	6	7	0	0	0	0
Other place	8	2	0	0	0	0
<b>Type of Program Use Within Last Seven Days or on Day of Interview</b>						
Shelter*	38	41	0	0	0	0
Shelter*	65	72	1	1	45	4
Soup kitchen*	44	35	3	3	45	46
Other	28	26	71	61	62	48
<b>Programs Used Within Last Week</b>						
Emergency shelter	25	29	0	0	0	0
Homeless housing	2	24	0	0	0	0
Shelter*	2	5	0	0	0	0
Permanent housing	3	2	11	15	0	0
Shelter vouchers	2	1	0	0	0	0
Soup kitchen	34	42	31	48	17	26
Food pantry	5	6	4	7	5	5
Job training program	5	6	10	4	1	1
Outreach	5	7	1	6	5	5
Drop-in center	9	11	8	10	12	6
<b>Programs Also Used</b>						
Emergency shelter	67	66	67	66	0	0
Transitional housing	42	38	27	22	0	0
Permanent housing	9	7	14	30	0	0
Shelter vouchers	18	14	15	13	0	0
Soup kitchen	73	70	85	79	42	43
Food pantry	24	23	22	17	15	13
Job training program	24	22	22	17	5	5
Outreach	16	18	8	14	32	10
Drop-in center	30	30	33	25	22	12

Source: Urban Institute analysis of weighted 1999 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding. \* Denotes values that are less than .2 percent but greater than 0. Note: Percentages may not sum to 100% or other total due to rounding. † This includes clients who reported staying in the streets or other places not meant for human habitation (e.g., abandoned buildings, vehicles) on the day of the NSHAPC interview or during the seven days prior to the interview. ‡ This includes clients who reported staying in the streets or other places not meant for human habitation (e.g., abandoned buildings, vehicles) on the day of the NSHAPC interview or during the seven days prior to the interview, or clients who were selected for the study at one of these programs. ‡ This includes clients who reported using a soup kitchen during the seven days prior to the interview, or clients who were found and interviewed for NSHAPC at a soup kitchen. ‡ This includes clients who reported using an other program (food pantry, mobile food, outreach, drop-in center and/or permanent housing) during the seven days prior to the interview, or clients who were found and interviewed for NSHAPC at one of these programs. ‡ This includes clients who did not report staying in an emergency shelter, transitional shelter, permanent housing, or voucher program over the last seven days but said yes to question 6.6 that they received food over the last seven days in the shelter where they live.

Table 11.4  
Income Levels, Income Sources, and Employment of Male Veterans  
and Non-Veterans, by Homeless Status

	Currently Homeless Veterans (N=32)	Non-Veterans (N=153)	Formerly Homeless Veterans (N=129)	Non-Veterans (N=271)	Other Service Users Veterans (N=54)	Non-Veterans (N=188)
Mean Income from All Sources (Last 30 Days) <sup>a</sup>	\$298	\$524	\$644	\$453	9488	9476
Median Income from All Sources (Last 30 Days) <sup>b</sup>	250	212	511	447	720	470
Income from All Sources Over Last 30 Days						
None from \$100	11(%)	16(%)	1(%)	4(%)	Insufficient N	4(%)
\$100 to 200	20	30	6	7		12
\$200 to 400	22	30	7	10		12
\$400 to 600	15	16	24	32		14
\$600 to 800	11	13	28	16		10
\$700 to 799	3	5	6	9		12
\$800 to 899	4	5	9	7		7
\$1000 to 1,199	7	2	2	1		2
\$1200 or more	7	4	7	4		5
Did Any Paid Work At All in Last 30 Days	48	51	48	40	37	27
Source of Earned Income in Last 30 Days						
Job lasting 3 or more months	17	11	20	12	32	12
Job expected to last 3 or more months	5	8	13	8	6	6
Temporary job, firm work	6	9	5	12	2	8
Temporary job, non-firm work	2	5	•	1	0	•
Day job or pick-up job	18	20	8	6	1	9
Freelancing	5	2	1	3	0	•
Received Money/Benefits from Government Sources in Last 30 Days	•	4	0	1	0	2
Aid to Families with Dependent Children (AFDC)	8	10	18	16	2	12
General Assistance	10	11	11	37	14	21
Supplemental Security Income	8	7	16	19	7	14
SSI	5	2	11	7	39	23
Social Security	6	0	14	0	23	0
Veteran's disability payments	2	0	1	0	16	0
Veteran's pension (not disability related)	1	0	1	0	16	0
Food Stamps	33	29	30	42	16	26
Received Means-Tested Government Benefits <sup>c</sup>	41	37	45	74	23	48
Any, including food stamps	17	22	35	61	20	40
Any other than food stamps						
Other Sources of Income Over the Last 30 Days						
Pensions	5	10	6	4	2	6
Dividends	8	12	5	4	2	6
Interest	5	10	2	6	1	•
Aiding for Money on the Street						

Source: Urban Institute analysis of weighted 1998 NISHAPC client data. Note: Percentages do not sum to 100% due to rounding. <sup>a</sup>Denotes values that are less than .5 percent but greater than 0. <sup>b</sup>In an income range was reported by client, mid-point of range was used in calculating mean. <sup>c</sup>AFDC, GA, SSI, Food Stamps, housing assistance. Insufficient N signifies that sample size was too small for data to be reported.

percent). Many of these health status differences may be the result of the age differences reported earlier in this chapter.

Forty-nine percent of homeless veterans say they have no medical insurance compared to 68 percent of non-veteran homeless men (figure 11.4). This large difference is due to many homeless veterans receiving VA medical care (32 percent compared to less than 1 percent of non-veterans).

It is also interesting to examine measures relating to food and hunger by veteran status (figure 11.5). A slightly higher percent of homeless veterans report having no food problems over the last 30 days (43 versus 36 percent), but similar proportions of both groups report having one to four problems acquiring sufficient food (57 versus 63 percent).

### *Special Needs*

The incidence of alcohol, drug, or mental health (ADM) problems is very similar for veteran and non-veteran homeless clients (table 11.6 and figure 11.6). The overwhelming majority of both groups have experienced past-month ADM problems (76 and 68 percent, respectively), with alcohol difficulties being the most frequently reported (49 and 43 percent).

When the time frame is expanded to the past year, 58 percent of veterans and 53 percent of non-veterans report an alcohol-related problem. The corresponding lifetime rates are 77 and 70 percent, respectively. Overall, 93 percent of veterans and 88 percent of non-veterans report an ADM problem at some point in their lives.

### *Service Needs*

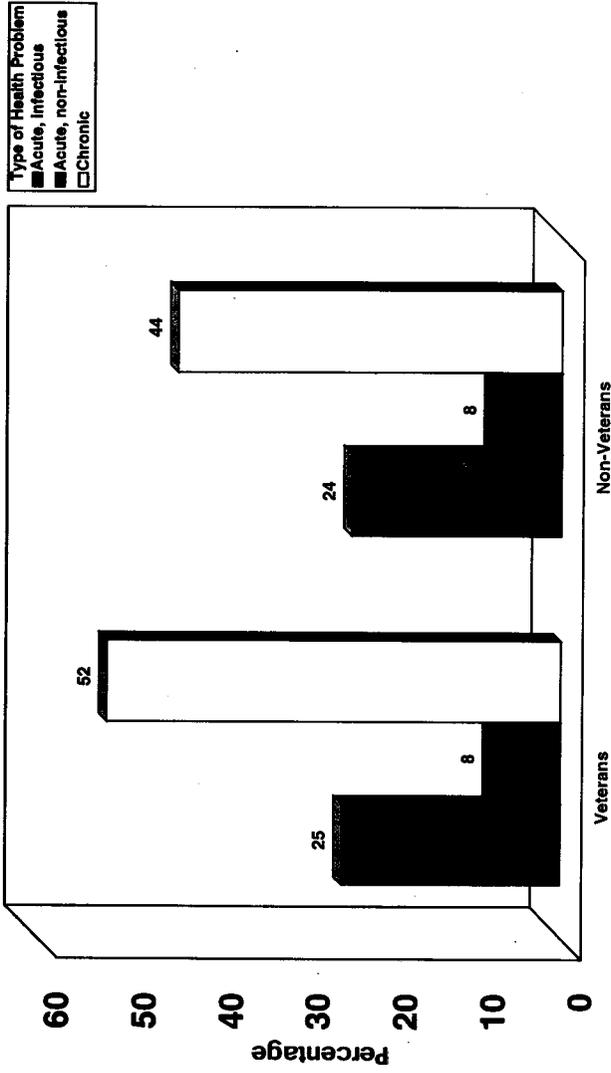
Currently homeless veterans and non-veterans report similar service needs and requirements for leaving homelessness (table 11.7). When asked "what are the three things you need the most now?" the top two choices for homeless veterans and non-veterans alike are finding a job (45 and 47 percent, respectively) and finding affordable housing (37 and 39 percent, respectively). In addition, insufficient income and a lack of a job or other employment are the overwhelming choices when homeless veterans and non-veterans are asked what has kept them from leaving homelessness.

Table 11.5  
Physical Health and Nutrition Status of Male Veterans  
and Non-Veterans, by Homeless Status

	Currently Homeless Veterans (N=632)	Currently Homeless Non-Veterans (N=1353)	Formerly Homeless Veterans (N=129)	Formerly Homeless Non-Veterans (N=271)	Other Service Users Veterans (N=54)	Other Service Users Non-Veterans (N=198)
<b>Type of Reported Medical Conditions</b>						
Acute infectious conditions (1 or more)	25(%)	24(%)	15(%)	32(%)	45(%)	19(%)
Acute non-infectious conditions (1 or more)	8	6	7	6	12	1
Chronic conditions (1 or more)	52	44	56	65	78	53
<b>Four Most Common Medical Conditions</b>						
Arthritis, rheumatism, joint problems	32	21	34	36	54	32
Chest infection, cold, cough, bronchitis	23	18	15	20	55	17
Problem walking, foot/limb, other handicap	18	13	20	30	38	28
High blood pressure	23	12	13	27	48	37
Needed but Not Able to See Doctor or Nurse in Last Year	18	25	13	23	15	14
<b>Type of Current Medical Insurance</b>						
Medicaid	17	25	32	52	18	54
VA Medical Care	32	0	30	0	28	0
Private Insurance	4	4	8	4	3	4
No insurance	49	68	34	34	42	34
Other	9	6	11	14	34	22
<b>Best Description of Food Situation</b>						
Get enough of kinds of food wanted	40	36	38	38	57	48
Get enough but not always what wants	33	34	35	36	33	37
Sometimes not enough to eat	18	16	15	14	10	13
Often not enough to eat	9	12	11	15	0	2
<b>Current Food Problem(s)</b>						
None	43	38	46	47	82	64
One	18	21	29	22	16	28
Two	14	18	14	17	2	3
Three	18	15	6	9	2	6
Four	7	9	5	5	0	0

Source: Urban Institute analysis of weighted 1998 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding. \* Denotes values that are less than .5 percent but greater than 0% conditions listed include: diabetes, anemia, high blood pressure, heart disease/stroke, liver problems, arthritis/rheumatism, chest infection/cold/bronchitis, pneumonia, tuberculosis, skin diseases, lice/scabies, cancer, problems walking/other handicap, STDs (other than AIDS), HIV, AIDS, intravenous drugs, and other. #Problems include 1) normalness or often not having enough to eat, 2) eating once or less per day, 3) in the last 30 days client was hungry but did not eat because could not afford enough food, and 4) in the last 30 days client went at least one whole day without anything to eat. Insufficient N signifies that sample size was too small for data to be reported.

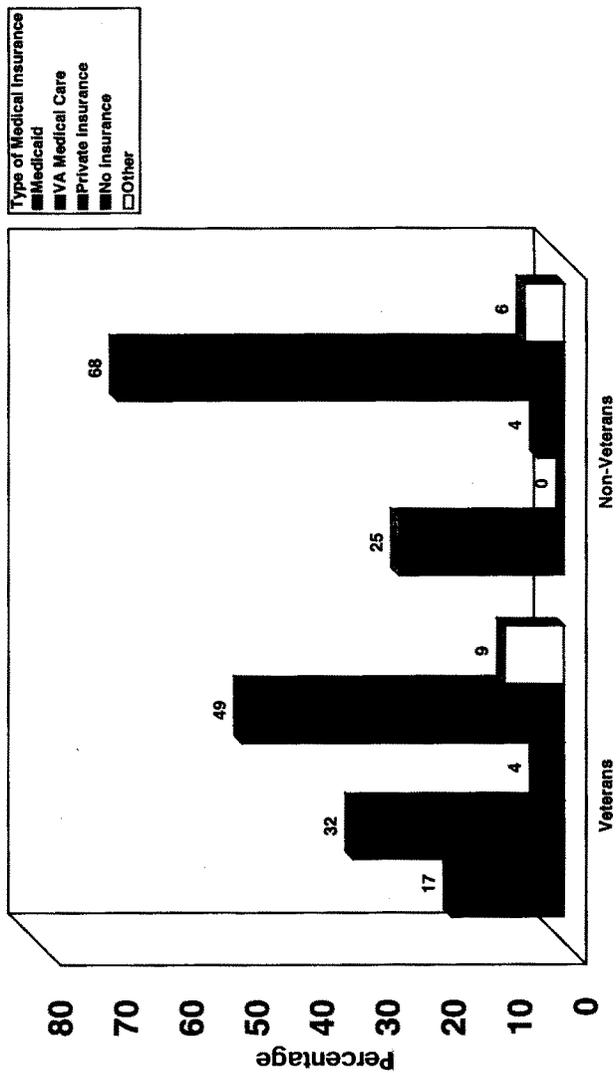
Figure 11.3  
**Health Problems Reported by Homeless Male Clients, by Veteran Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

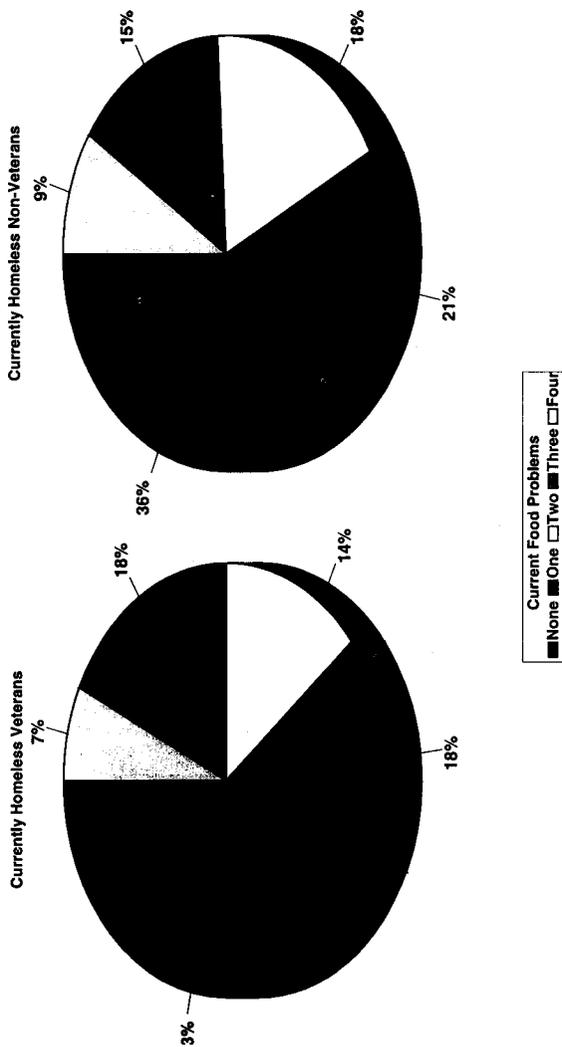
11-13

Figure 11.4  
**Type of Medical Insurance for Homeless Male Clients, by Veteran Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

Figure 11.5  
**Food Problems of Homeless Male Clients, by Veteran Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Numbers may not sum to 100% or other total due to rounding.

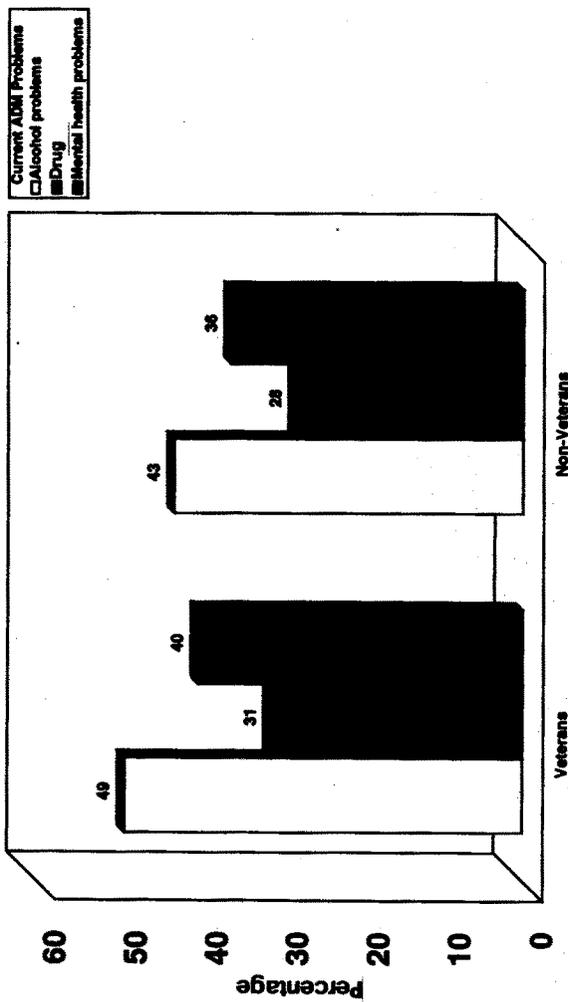
Table 11.6  
Alcohol, Drug, and Mental Health Problems Among Male Veterans  
and Non-Veterans, by Homestead Status

Problems in Past Month	Currently Homeless (N=1352)		Formerly Homeless Veterans (N=129)		Other Service Users Non-Veterans (N=186)	
	Veterans (N=632)	Non-Veterans (N=720)	Veterans (N=129)	Non-Veterans (N=171)	Veterans (N=54)	Non-Veterans (N=132)
Alcohol Problems	48(%)	43(%)	53(%)	57(%)	43(%)	25(%)
Drug Problems	11	23	19	25	5	3
Mental Health Problems	40	36	29	32	16	18
Specific Combinations						
Alcohol problem only	17	18	Insufficient N	14	Insufficient N	20
Drug problem only	8	7		7		4
Mental health problem only	12	13		17		10
Alcohol and drug problems	11	7		11		3
Alcohol and mental health problems	17	17		11		3
Drug and mental health problems	6	5		2		6
Alcohol, drug, and mental health problems	5	9		5		*
No ADM problems	24	32		36		55
Problems in Past Year						
Alcohol Problems	58	53	36	43	43	28
Drug Problems	40	43	22	32	5	17
Mental Health Problems	46	43	29	39	17	20
Specific Combinations						
Alcohol problem only	15	15	Insufficient N	14	Insufficient N	18
Drug problem only	8	7		9		4
Mental health problem only	10	10		15		10
Alcohol and drug problems	14	13		10		5
Alcohol and mental health problems	10	9		10		1
Drug and mental health problems	7	7		9		3
Alcohol, drug, and mental health problems	11	18		9		5
No ADM problems	17	23		29		53
Problems in Lifetime						
Alcohol Problems	77	70	65	62	67	51
Drug Problems	60	66	50	53	17	35
Mental Health Problems	54	54	49	52	26	25
Specific Combinations						
Alcohol problem only	12	11	Insufficient N	9	Insufficient N	26
Drug problem only	7	6		6		6
Mental health problem only	2	4		15		9
Alcohol and drug problems	20	18		21		15
Alcohol and mental health problems	19	6		12		3
Drug and mental health problems	7	6		5		6
Alcohol, drug, and mental health problems	20	12		20		9
No ADM problems	7	12		12		27

Source: Urban Institute analysis of weighted 1996 NSHAC client data. Note: Percentages do not sum to 100% due to rounding.

\* Denotes values that are less than .5 percent but greater than 0. Insufficient N signifies that sample size was too small for rates to be reported.

Figure 11.8  
Past-Month ADM Problems of Homeless Male Clients, by Veteran Status



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

11-17

Table 11.7  
**Service Needs Reported by Male Veterans and Non-Veterans, by Homeless Status**

	Currently Homeless Veterans (N=632)	Currently Homeless Non-Veterans (N=1353)	Formerly Homeless Veterans (N=129)	Formerly Homeless Non-Veterans (N=271)	Other Service Users Veterans (N=54)	Other Service Users Non-Veterans (N=168)
<b>Top Responses Clients Provided to "What Are the (three) Things You Need the Most Now?"</b>						
Obtaining food	15(%)	19(%)	25(%)	30(%)	30(%)	29(%)
Finding a job	45	47	31	30	19	27
Finding affordable housing	37	39	24	20	13	19
Assistance with rent, mortgage, or utilities for securing permanent housing	32	27	14	16	15	6
Other <sup>a</sup>	21	22	40	22	28	38
<b>Single Most Important Thing Keeping Client from Getting Out of Homelessness<sup>b</sup></b>						
Insufficient income	26	28	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Lack of job/employment	25	27	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Other	14	14	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Addiction(s) to alcohol or drugs	13	10	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Lack of suitable housing	9	11	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Physical condition or disability	5	3	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Mental health condition	3	2	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Insufficient education/skills/training	2	3	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Family or domestic instability	2	1	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Insufficient services or service information	1	1	Not Applicable	Not Applicable	Not Applicable	Not Applicable

Source: Urban Institute analysis of weighted 1995 NSHAPC client data. <sup>a</sup>Refers to needs other than assistance getting food, assistance getting clothing, transportation assistance, help with legal issues, help with parenting, child care services and payment of costs. <sup>b</sup>Question only asked of clients who are currently homeless.

### CURRENTLY AND FORMERLY HOMELESS MALE VETERANS COMPARED<sup>3</sup>

As in prior chapters, this section examines variations in veterans' characteristics across homeless status. However, the categories of other service users are not discussed due to potential biases.<sup>4</sup>

#### *Demographic Characteristics*

Currently and formerly homeless veterans have equivalent demographic characteristics (figure 11.7). Both groups have similar race/ethnicity distributions with the largest proportions being white non-Hispanic (46 and 54 percent of currently and formerly homeless veterans, respectively). In addition, their urban/rural distributions do not differ statistically, with the majority residing in central cities (79 and 69 percent, respectively). The only difference between the two groups with regard to marital status is that currently homeless veterans are more likely to be separated than formerly homeless veterans (19 versus 9 percent). They also report higher educational attainments than their formerly homeless counterparts (45 versus 29 percent have at least a high school diploma).

#### *Homeless Experiences*

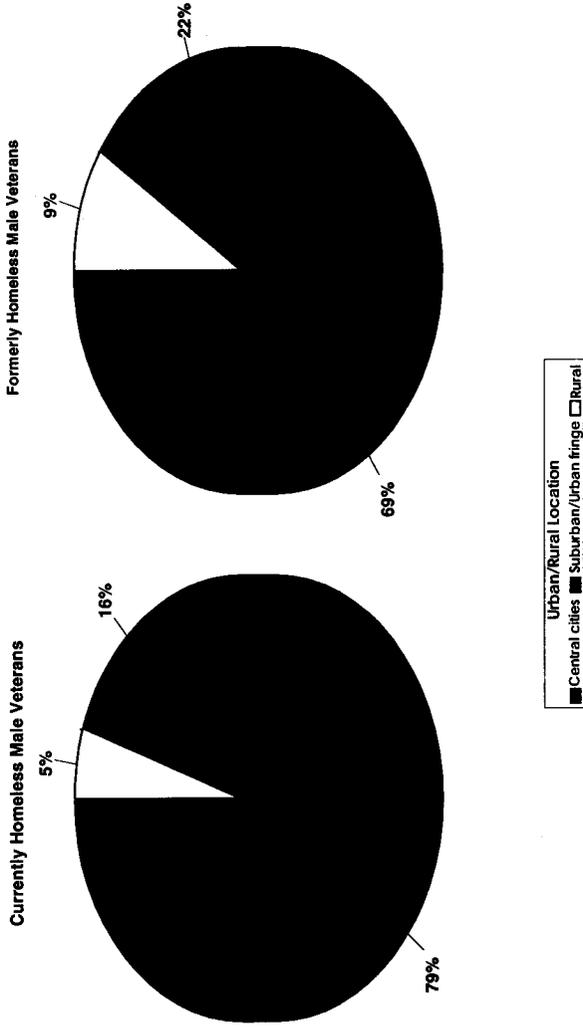
There are some interesting differences in the homeless experiences of currently and formerly homeless veterans. Currently homeless veterans have more episodes and longer periods of homelessness. Thirty-one percent of currently homeless veterans have experienced four or more periods of homelessness compared to 16 percent of formerly homeless veterans. By contrast, formerly homeless veterans are more likely to have two or fewer episodes than currently homeless veterans (73 versus 59 percent). The length of the last period of homelessness also varies, with currently homeless veterans less likely to report shorter durations of homelessness. Almost half (49 percent) of formerly homeless veterans report that their most recent complete episode of homelessness lasted less than four months compared to only one-third (34 percent) of currently homeless veterans.

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<sup>3</sup> All C.I.'s for formerly homeless veterans in this section are less than  $\pm 11$  percentage points.

<sup>4</sup> The unweighted sample of other service users who are veterans (N=54) comprise a very small share (only 9 percent) of the unweighted sample but a much larger share (38 percent) of the weighted sample (i.e., the sample weighted in such a way as to represent the national population of clients of NSHAPC programs). Consequently estimates based on this weighted sample may be biased and may produce misleading results. In addition, the subsample is too small to divide by age as has been done in other chapters. The tables report information about all other service users who are male veterans.

Figure 11.7  
**Urban/Rural Location of Male Veteran Clients, by Homeless Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

### *Current and Lifetime Use of Homeless Assistance Programs*

Since a person's current housing situation was a factor in determining homeless status, it is not surprising to find that currently homeless veterans are more likely to use shelter programs than formerly homeless veterans over the past week (table 11.3). About one-quarter of currently homeless veterans report using either an emergency shelter or transitional housing program in the seven days before being interviewed. By contrast, a larger proportion of formerly than currently homeless veterans have used a permanent housing program over the past seven days (11 versus 3 percent).

Over the course of their lifetime, a similar proportion of currently and formerly homeless veterans have used emergency shelters, permanent housing programs, voucher programs, food pantries, mobile food programs, outreach programs, and drop-in centers. However, because such programs first appeared in the late 1980s, currently homeless veterans are more likely than formerly homeless veterans to have used a transitional housing program in their lifetime (42 versus 27 percent). A larger proportion of formerly homeless veterans, however, have used a soup kitchen at some point in their lives (85 versus 73 percent).

### *Income, Income Sources, and Employment*

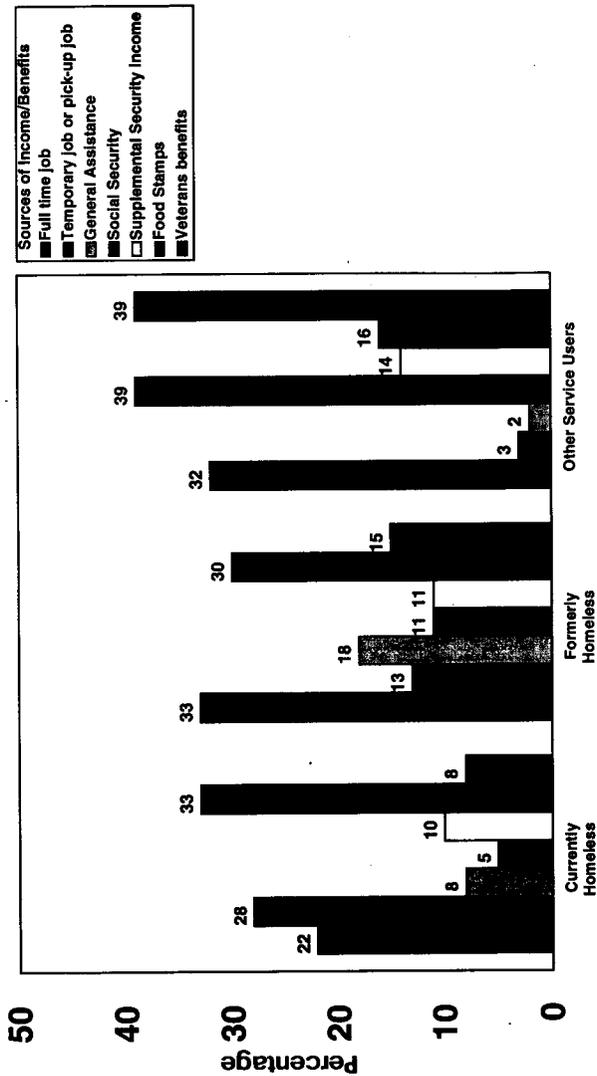
Although similar proportions of currently and formerly homeless veterans undertook some form of paid work in the last 30 days, the income distribution of the two groups are quite different. While the majority of currently homeless veterans had incomes less than \$300 (53 percent), 76 percent of formerly homeless veterans had incomes greater than this amount. This discrepancy corresponds to a more than \$250 difference in the median incomes of the two groups (\$250 and \$511 for currently and formerly homeless veterans, respectively).

Some of the variations in incomes can be explained by contrasts in the type of employment held and government benefits received by the two groups (figure 11.8). In the past 30 days, twenty-two percent of currently homeless veterans have held a job lasting or expected to last three or more months, compared to 33 percent of formerly homeless veterans. In addition, currently homeless veterans are more likely than formerly homeless veterans to have earned income from peddling or a day job (23 versus 9 percent). Currently homeless veterans are also less likely to have received General Assistance (8 versus 18 percent) or Veteran's Disability payments (6 versus 14 percent).

### *Health and Nutrition*

Health and nutrition status also vary by the homeless status of male veteran clients. Although comparable proportions of both groups report one or more acute *non-infectious* conditions, currently homeless veterans are more likely than formerly homeless veterans to indicate having

Figure 11.8  
**Sources of Money/Benefits Received by Male Veteran Clients in Last 30 Days, by Homeless**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

one or more acute infectious problems. In addition, 23 percent of currently homeless veterans report having high blood pressure, compared to 13 percent of formerly homeless veterans. However, similar portions of both groups indicate having joint problems, chest infections, and problems walking.

Sources of medical insurance also vary by homeless status. While both groups are equally likely to have access to VA medical insurance, currently homeless veterans are much less likely to have Medicaid (17 versus 32 percent). Instead, currently homeless veterans are much more likely to have no health insurance at all (49 versus 34 percent).

Equal portions of both populations indicate they get enough of the kinds of food they want to eat (40 and 38 percent for currently and formerly homeless veterans, respectively). Equal proportions of each group also indicate at least one food problem in the last 30 days (57 and 54 percent—figure 11.9). However, currently homeless veterans are more likely than formerly homeless veterans to report three or more food problems (25 versus 11 percent).

### *Special Needs*

A number of significant variations in ADM problems are evident by homelessness status (table 11.6 and figure 11.10). Currently homeless veterans are more likely than formerly homeless clients to have an alcohol problem in the past month (49 versus 33 percent). However, formerly homeless veterans are less likely than currently homeless veterans to have a past-month mental health problem (28 versus 40 percent).

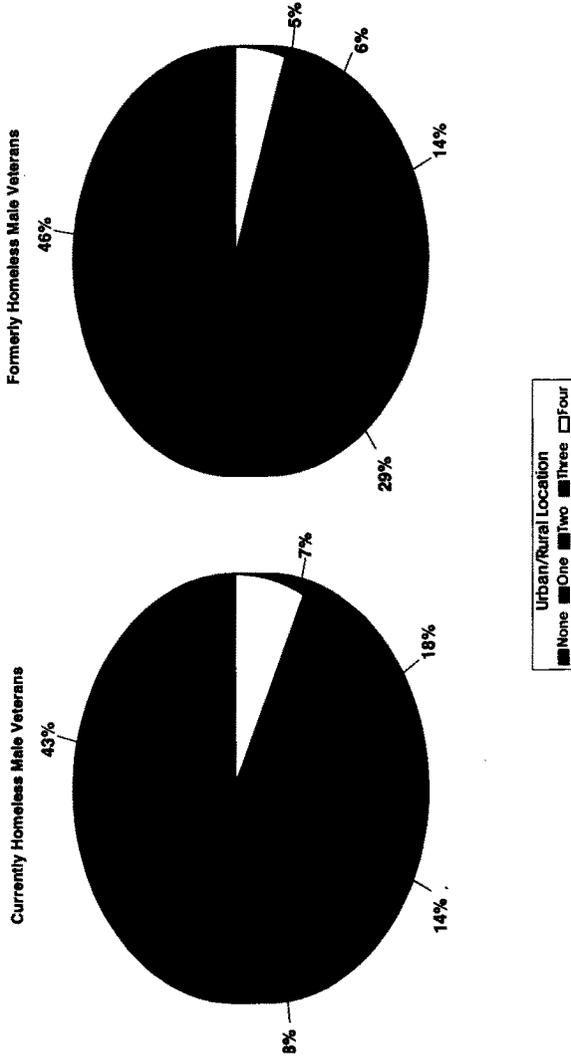
### *Service Needs*

The service needs reported by currently and formerly homeless veterans vary considerably. When asked “What are the three things you need the most now,” currently homeless veterans gave finding a job as their top choice followed by finding affordable housing and securing permanent housing (45, 37, and 32 percent, respectively). Formerly homeless veterans report as their most important need some need “other” than the 28 specific ones asked about on the survey (40 percent). The next most important needs for formerly homeless male veterans are finding a job (31 percent) and obtaining food (25 percent).

## APPENDIX 11

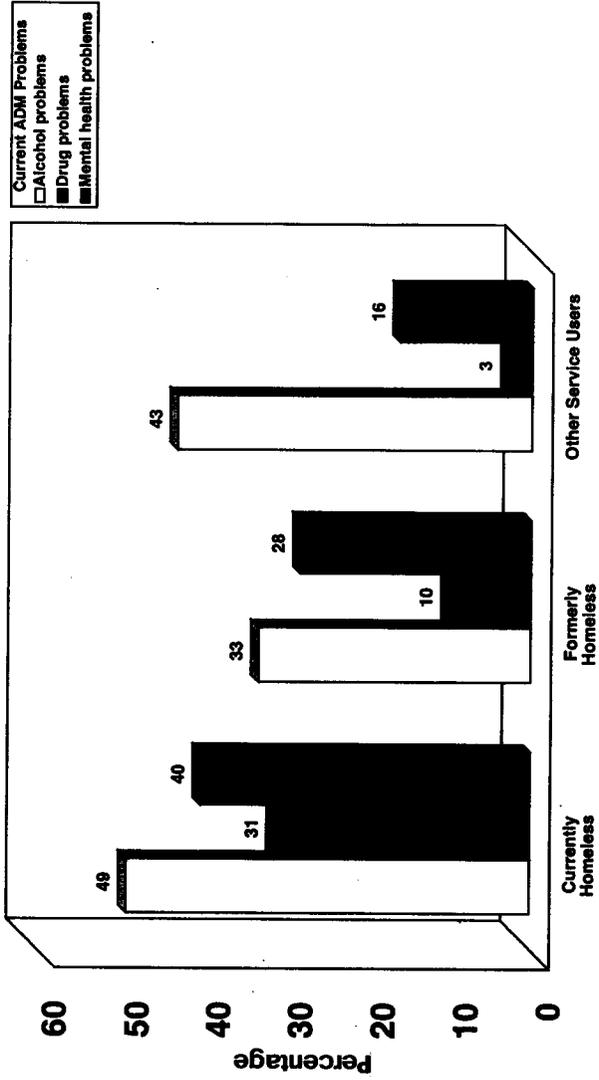
For readers interested in the military experiences of NSHAPC veterans, Appendix tables 11.A1 and 11.A2 provide information about type, timing, and length of service, combat experience, type of discharge, and use of programs designed specifically for veterans.

Figure 11.9  
**Food Problems of Male Veteran Clients, by Homeless Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

Figure 11.10  
**Past-Month ADM Problems of Male Veteran Clients, by Homeless Status**



Source: Urban Institute analysis of weighted 1996 NSHAPC client data.

Appendix Table 11A1  
Military and Veterans' Characteristics  
of Homeless Veterans, by Standard Grouping

	Living Situation			ADJN Post Discharge			Race/Ethnicity		
	Currently Homeless Veterans (N=29,939)	Family Homeless Veterans (N=2,571)	All Other Homeless Veterans (N=2,425)	With ADJN (N=2,425)	Without ADJN (N=2,571)	White Non-Hispanic (N=2,571)	Black Non-Hispanic (N=2,571)	Hispanic (N=2,571)	Native American (N=2,571)
Types of Military Service	4%	Insufficient N	4%	4%	1%	3%	2%	Insufficient N	Insufficient N
Active duty military service in the armed forces of the United States, now in the United States	94	2	84	93	96	96	95	Insufficient N	Insufficient N
Active duty military service in the armed forces of the United States, in the past	2		3	3	1	2	3		
Service in Reserve or National Guard only	8		7	8	5	8	6		
Armed Forces (Including Reserve or National Guard)	17		18	15	24	14	20		
September 1980 to July 1990	32		32	31	34	34	36		
July 1990 to August 1990	47		48	51	34	54	34		
September 1990 to August 1995	15		15	12	23	18	11		
February 1955-July 1964	4		4	2	0	3	4		
Korean conflict (1950-1953)	4		4	2	0	3	4		
World War II (1940-1947)	1		1	1	0	1	1		
Any other time	1		1	1	0	1	1		
In Total, Number of Years of Active-Duty Military Service (Including Reserve or National Guard)	7	Insufficient N	7	8	Insufficient N	5	11	Insufficient N	Insufficient N
Time	21		22	23	24	24	17		
Year	26		26	26	26	25	27		
Farther than 100 miles	19		19	19	19	12	23		
Far to far	4		4	3	3	5	2		
Even or more	4		4	3	3	5	2		
Over stationed in War Zone	33	Insufficient N	33	31	38	32	35	Insufficient N	Insufficient N
During Military Service, Ever in or Exposed to Combat	28	Insufficient N	28	27	30	28	28	Insufficient N	Insufficient N
(Items Below Are Limited to Credits in Active Duty in Past or Service At Reserves or National Guard)									
Received an Honorable Discharge	89	Insufficient N	89	80	87	82	88	Insufficient N	Insufficient N
When Discharged from Military Service									
Ever Used a Medical Facility									
Operated by the VA for Overnight Hospital Care, Community Care, or Admissions for Long-Term Care	57	Insufficient N	57	59	50	58	57	Insufficient N	Insufficient N
Participated in Programs Specifically for Homeless Veterans	25	Insufficient N	25	29	13	28	25	Insufficient N	Insufficient N
Participated in the Following Programs									
Compensated work therapy program	8	Insufficient N	8	11	4	15	2	Insufficient N	Insufficient N
Community care program	11		12	14	4	15	5		
Homeless shelters for veterans not run by the VA	14		15	18	7	17	13		
Veterans Center drop-in program	4		4	4	3	4	3		
Shard down	5		5	4	3	2	4		

Source: Urban Institute analysis of weighted 1995 NSVAFC claim data. Notes: Percentages do not sum to 100% or other total due to rounding. \* Denotes values that are less than .5 percent but greater than 0. † ADJN = Alcohol, drug, or mental health problem in the past month.

Appendix Table 11.A2  
**Military and Veteran Specific Program Use Characteristics, by Homelessness Status**

	Homelessness Status			
	Currently Homeless Clients (N=676)	Formerly Homeless Clients (N=140)	Other Service Users Under Age 65 (N=46)	Other Service Users 65 and Older (N=12)
<b>Types of Military Service</b>				
Active duty military service in the armed forces of the United States, now	4(%)	0(%)	0(%)	0(%)
Active duty military service in the armed forces of the United States, in the past	94	98	92	100
Service in Reserves or National Guard only	2	2	9	0
<b>When Served on Active-Duty in the U.S.</b>				
<b>Armed Forces (Including Reserves or National Guard)</b>				
August 1990 or later	8	9	2	0
September 1980 to July 1990	17	15	30	0
May 1975 to August 1980	32	14	19	0
Vietnam era (8/64-4/75)	47	53	38	0
February 1955- July 1964	15	18	20	0
Korean conflict (8/50-1/55)	4	8	30	39
World War II (9/40-7/47)	1	6	0	65
Any other time	1	*	2	0
<b>In Total, Number of Years of Active-Duty Military Service (Including Reserves or National Guard)</b>				
One	7	4	3	3
Two	21	22	26	37
Three	25	26	27	8
Four	19	16	17	47
Five to ten	19	27	20	4
Eleven or more	4	1	3	0
<b>Ever Stationed in War Zone</b>	33	27	26	24
<b>During Military Service, Ever in or Exposed to Combat</b>	28	28	16	12
<i>(Items Below Are Limited to Clients in Active Duty in Past or Service in Reserves or National Guard)</i>				
<b>Received an Honorable Discharge When Discharged from Military Service</b>	89	93	98	0
<b>Ever Used a Medical Facility Operated by the VA for Overnight Hospital Care, Outpatient Visits, or for Nursing Home, Convalescent Home, or Admissions for Long-Term Care</b>	57	52	75	83
<b>Participated in Programs Specifically for Homeless Veterans</b>	25	11	14	0
<b>Participated in the Following Programs</b>				
Compensated work therapy program	8	2	0	0
Dom Program (domiciliary care program)	11	1	0	0
Homeless shelters for veterans not run by the VA	14	7	12	0
Veterans Center drop-in program	4	8	2	0
Stand down	4	1	0	0
Other	3	2	*	0

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% or other total due to rounding. \*Denotes values that are less than .5 percent but greater than 0.

**STATEMENT OF  
HAROLD E. SCHULTZ  
SUPERVISORY NATIONAL SERVICE OFFICER  
DISABLED AMERICAN VETERANS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEES ON BENEFITS AND HEALTH  
UNITED STATES HOUSE OF REPRESENTATIVES  
MARCH 9, 2000**

Messrs. Chairmen and Members of the Subcommittees:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, I am delighted to provide you with testimony on DAV's efforts to address the needs of homeless veterans.

As an organization committed to building better lives for America's disabled veterans and their families, one of the DAV's top priorities is to help America's homeless veterans break the cycle of poverty and move from the streets to self-sufficiency.

Our goal is to help veterans living in places not ordinarily meant for human habitation or in emergency shelters connect with social services that can help them get their lives back on course.

In a recently released report, designed and funded by 12 federal agencies—"Findings of the National Survey of Homeless Assistance Providers and Clients"—it was reported that:

- almost 25 percent of homeless people are veterans; a third of the male homeless are veterans
- almost all homeless veterans are males—two percent are females
- 57 percent have used VA health care services
- almost half of the homeless veterans served during the Vietnam era
- 33 percent of the male veterans served in a war zone, and 28 percent were exposed to combat

The report went on to state that, when homeless people get housing assistance and other needed services, about 76 percent of those living along with their families and 60 percent of those living alone improve their living situation. Such services include health care, substance abuse treatment, mental health services, education, and job training.

Reducing homelessness among veterans requires greater government commitment and more federal resources. Veterans who are homeless deserve a better deal than what they are receiving from our government—in many cases, it is nothing more than lip service.

Messrs. Chairmen, I can tell you that DAV is making a difference in the lives of many homeless veterans across this nation.

The issue of homelessness is a serious, long-term matter of concern for the DAV and will require a long-term commitment. Supported by our Charitable Service and Colorado Trusts, DAV's Homeless Veterans Initiative enables our network of volunteers to provide food and shelter, and medical, vision and dental aid to homeless veterans.

The VA estimates 275,000 veterans are homeless on any given night, and 500,000 experience homelessness annually. The problem is not limited to big cities where the issue is most obvious; many homeless veterans are subsisting in rural areas or wandering in wilderness areas. The experience of DAV's service programs tells us that mental illness rooted in or worsened by military service is a key factor.

The DAV Homeless Veterans Initiative is our program to assist those veterans who find themselves living on the streets. Our motto—"We Don't Leave our Wounded Behind"—is more than a clever slogan, it is a principle, a rule, and a promise we need to keep—all of us, including our government.

Distressed by this shocking situation, the DAV's Homeless Veterans Initiative continues its ongoing activities on behalf of homeless veterans and their families. In many instances, grants are permitting the expansion of services local VA medical centers offer homeless veterans who suffer mental illness and substance abuse.

Serving veterans in Massachusetts and the New England region, the DAV Homeless Veterans Initiative supports an innovative, specialized transitional housing program that serves homeless veterans who are diagnosed with either HIV/AIDS or other terminal illnesses and are no longer able to care for themselves. The Veterans Hospice Homestead, financially supported through the DAV Homeless Veterans Initiative, is the only "veteran-specific" program in the country to help these veterans. The DAV Homeless Veterans Initiative is providing funding to help give a comprehensive mix of supportive services to either assist the terminally ill veteran in finding appropriate housing and services or to assist the veteran in his or her final transition to death. This includes specialized counseling, medical services, mental health counseling, food service support, and supportive service planning.

Additionally, our Homeless Veterans Initiative is helping fund a low-cost, subsidized transitional housing project for homeless veterans in DePere, Wisconsin, which has helped return veterans to productive lives. The housing facility in DePere, the Armitage, named in honor of a young Marine killed in Vietnam, was purchased to serve as both a transitional housing facility and an information and assistance center for homeless and at-risk veterans.

With the help of local veterans' groups and the business community, the Armitage provides single-room occupancy housing with communal meals at a cost that allows residents to transition into their own permanent housing and employment. Veterans who are unemployed or do not have the financial means are not charged.

It is estimated that there are as many as 2,000 homeless and at-risk veterans in northeastern Wisconsin. Homeless veterans represent about 42 percent of the individuals housed in local shelters.

Last year, Ford Motor Company donated six 1999 Windstar vans to our Homeless Veterans Initiative programs operating in Colorado, Connecticut, Indiana, Maryland, Massachusetts, and Wisconsin. DAV is very proud to have Ford as part of our Homeless Veterans Initiative's efforts to bring food, clothing, meals, and shelter to veterans.

In New York, the Syracuse VA Medical Center was one of 43 sites selected by the VA in 1987 to implement a program for homeless veterans under Public Law 100-6. This law mandated providing outreach, physical and mental health evaluation, referral, case management follow-up, and contracted care and shelter at a residential facility for up to six months. The program staff, however, soon realized that after six months, a portion of these veterans would have to return to the streets if appropriate interim shelter was not available.

In an attempt to confront this issue, Mr. Raymond Deter, a service-connected disabled World War II veteran and life member of DAV began working with Mr. Timothy Kohlbecker, VA Homeless Program Coordinator in November 1991. A public plea was issued and it was answered by Onondaga County Executive Nicholas Pirro, who offered the use of county-owned property for \$1.00 per year.

A four-bedroom structure badly in need of renovations was located, and \$35,000 was needed to start the program. A massive fund-raising effort was begun. Ray Deter and members of DAV Chapter 167 applied for and received a grant from the DAV national organization. Other funds from the DAV Department of New York were received, as well as from many local DAV chapters and from other veterans service organizations. Following these efforts, the county legislature approved a lease, and the renovations began in the summer of 1992.

The renovations were done with the assistance of numerous volunteers, some of whom were homeless veterans themselves. These renovations included electrical and plumbing repairs and modifications, painting, cleaning, and landscaping. Through the collective efforts of the DAV and many other volunteers, including VA employees, Boy Scouts, and the county, the first group of homeless veterans moved into the home in October 1992. Many local businesses provided supplies, furnishings, and tools needed to make this home a reality. A grand opening ceremony took place in November 1992.

The home, known as "Detor House," is managed by the DAV and the VA Medical Center. The Medical Center is responsible for screening, selecting, and counseling residents.

Since its inception, the Detor House has assisted 23 veterans transition from homelessness to again become productive members of society. Many of the residents are Vietnam-era veterans, divorced or separated, with periods of homelessness ranging from one month to two years. Most suffer from adjustment problems, mental health problems, substance abuse, lack of family support, and periods of unemployment.

The majority of residents have obtained full- or part-time employment in community jobs or at the VA Medical Center. Those with a history of substance abuse have remained compliant with their recovery programs. They all share in household responsibilities and have demonstrated the ability to live cooperatively with their peers at the house. The VA staff and the DAV Housing Coordinator evaluate each veteran's status regularly. Monthly meetings are held at the house and are attended by both residents and staff. These meetings provide an opportunity to discuss personal issues and group living concerns.

The Detor House is an innovative strategy, which demonstrates that private sector organizations such as the DAV can create special cooperative partnerships helping homeless veterans regain self sufficiency and success in society. We have shown that a community can address the needs of homeless veterans through efforts in both the public and private sectors. The Detor House has been a major step toward accomplishing that goal in the Syracuse area.

We have obtained an additional home on the grounds adjacent to Detor House. We hope to raise the necessary funds to begin renovation of this new home to hopefully expand upon the success of the Detor House and provide transitional assistance to many more veterans.

The VA's Homeless Providers Grant and Per Diem program promotes the development, acquisition, and renovation of new facilities for homeless veterans by encouraging private sector groups and service organizations to apply for funding. Twice, funding for this additional home was requested through the VA Homeless Providers Grant and both times refused. The first refusal was due to a technicality. After completing the 45-page application, Marvin Triggs, the adjutant of DAV Chapter 8, was advised that the application was denied because he was a VA employee and this was a conflict of interest. Mr. Triggs, a staunch advocate for veterans in Syracuse, is a janitor at the VA Medical Center. How can this be construed as a conflict of interest? It is hoped that this process can somehow become more veteran friendly by making the application process easier for those dedicated individuals who devote their time and effort to assisting the needs of homeless veterans.

As a nation, we must remain steadfast in our efforts to fulfill our promise to veterans by ensuring that no veteran who honorably served his or her country is ever without adequate living quarters. The DAV will remain true to our commitment to ensure that we make every effort to assist our fellow veterans and their families in obtaining appropriate assistance for their needs, including obtaining adequate housing.

Messrs. Chairmen, the DAV is so concerned by the problem of combating homelessness in our veterans' population that we continue to encourage our departments and chapters to get involved on the local level. We encourage groups to apply for grants from our Charitable Service Trust and Colorado Trust to continue and expand local services and activities on behalf of homeless veterans and their families.

Since 1989, DAV's Charitable Service Trust grants and allocations for homeless projects total \$814,764.00.

There is no question that with the proper assistance—including health care, substance abuse treatment, mental health services, education, and job training—homeless veterans can improve their situations and begin the transition to once again become productive and a part of mainstream America; the very ideals they served and fought to preserve for all Americans.

Messrs. Chairmen, this concludes my prepared statement. We appreciate the Subcommittees' interest in resolving this national problem of homelessness among veterans and the opportunity to discuss Detor House. I am available to answer any questions that you or other members of the Subcommittees may have.



Non Commissioned Officers Association of the United States of America

225 N. Washington • Alexandria, Virginia 22314 • Telephone (703) 549-0311

**STATEMENT OF**

**RICHARD C. SCHNEIDER  
DIRECTOR OF STATE/VETERANS AFFAIRS**

**BEFORE THE**

**SUBCOMMITTEE ON BENEFITS  
AND  
SUBCOMMITTEE ON HEALTH**

**COMMITTEE ON VETERANS AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES**

**ON**

**HOMELESS VETERAN ISSUES**

**MARCH 9, 2000**

*Chartered by the United States Congress*

**DISCLOSURE OF FEDERAL GRANTS AND CONTRACTS**

The Non Commissioned Officer Association of the USA (NCOA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts.

**INTRODUCTION**

The Non Commissioned Officers Association of the United States of America (NCOA) is most grateful for the opportunity to appear today and address concerns on homeless veteran issues. Despite current federal funding of over \$1 billion, it is clear to NCOA that homeless veterans continue to be under served. This hearing, as the new Century begins, is an important signal of your commitment to reverse what is inarguably a national tragedy.

There are countless statistical and demographic reports on the homeless veteran population. Although less than 10 percent of the total national population, tragically, veterans constitute between 25 and 35 percent of the total known homeless population. The conclusion of all data trails is that veterans are represented at a disproportionately high level among the nation's homeless population.

At this point Mr. Chairman, NCOA considers it appropriate to recognize the reigning Miss America, Ms Heather Renee French. The Association publicly salutes Ms French for her decision to choose "Homeless Veterans" as her platform issue during her tenure. Through her extensive travel, *hands-on* participation in homeless veteran Stand Downs, visits to employment training, soup kitchens, and living facilities in both federal and state communities, Miss French, perhaps more so than any other individual, has brought this issue to the forefront of society's awareness. She also has promoted work training opportunities and employment issues with leaders in the corporate world. NCOA is deeply grateful to Miss French for efforts that clearly will have long-term, positive results.

**NCOA GRANT ASSISTANCE  
TO  
HOMELESS VETERAN PROGRAMS**

NCOA has been involved in homeless veterans' issues for many years through The NCOA National Defense Foundation. Over the years, The Foundation has provided numerous grants to enhance the quality of life of homeless veterans and to assist in efforts that would strengthen the homeless veteran's relationship with family members. The Association is proud to report the following financial grants in support of homeless veteran initiatives made during 1999.

Grants	Number	Amount
VAMCs	18	\$13,510.87
Vet Centers	29	\$21,750.00
State Home	1	\$650.00
Totals	48	\$45,910.87

NCOA is a proud member of the Veterans Organizations Homeless Council (VOHC) Executive Committee representing nationally recognized veteran organizations, and the National Coalition for Homeless Veterans. These organizations collaborate on legislative recommendations and policy issues at the national level to help end the vicious cycle of homelessness among veterans. They also serve as referral organizations attempting to provide emergency assistance to locate shelter and continuum of care services for homeless veterans across the country.

Additionally, NCOA chapters and members across America are participants in countless community based and Department of Veteran Affairs programs designed to assist homeless veterans. The \$1 billion of federal funds is leveraged considerably by all volunteers, organizations, private foundations, and corporate America to provide those types of activities and services not typically authorized by congressional appropriations.

## **Federal Efforts To Maximize Veterans Usage Of Homeless Assistance Programs That Are Available In The General Population**

NCOA believes substantial progress has been made through community-based block grants to provide shelter, health care, and case management for all homeless individuals. Unfortunately, there remains a misconception all across the country, fostered by cost consciousness, that VA is responsible for taking care of homeless veterans. Consequently, homeless veterans are often screened out of community-based programs and referred to Department of Veteran Affairs health care or other types of facilities. Often times, these referrals are to distant VA facilities and are made without regard to the fact that the homeless veteran is without private transportation or access to public transportation. Federal VA-sponsored programs that limit service to honorably discharged veterans further blur the distinction between homeless categories (veterans and civilians). VA refers civilian homeless to other community-based providers; hence, the misperception of who takes care of whom is clouded further.

While there has been increased communication between federal and community homeless leaders, there is still a pressing need to expand the relationship between agencies and providers. There is the continued need for community councils that prepare federal funding grant requests to have broader representation in the process to develop local action plans to support homeless people, both veterans and non-veterans. Veteran type community-based homeless providers are all too often not represented on these community-based councils. This again reflects a lack of direct council advocates for the largest segment of the population, homeless veterans.

## **EMPLOYMENT**

NCOA believes that the entire continuum of care and case management for all homeless veterans programs should be targeted toward gainful and meaningful employment outcomes. The complete cycle of care and services must work toward this goal. Employment provides the means for homeless to become productive citizens in the society.

**Homeless Veterans Reintegration Program (HVRP):** This DOL program is an effective tool for providers to take veterans through varied monitored and controlled services freeing them of substance abuse, complex histories of combat related post traumatic stress disorder (PTSD), and establishing their trust and confidence as adult citizens. HVRP is a significant success story in the effort to end homelessness among program participants. Grant recipients have been able to place hundreds of veterans in good jobs. The success is documented in the employment retention record, which exceeds expectations. HVRP provider cost is \$1,250. per placement. The cost return in taxable income of these formerly homeless veterans makes this a highly effective cost productive program when the alternatives are considered.

HVRP is a highly competitive grant program among nationwide community providers. A total of \$10 million was appropriated for the current year, \$8 million for direct grants and \$2 million for discretionary homeless employment programs. It is expected that DOL will award 33 grants to support an estimated 4,000 veterans in provider programs. Grant guidelines were announced in the Federal Register (February 7, 2000) with a submission date required within 30 days. Communication would be enhanced from community councils through the entire bureaucracy if the grant guidelines were made available earlier.

Funding for HVRP is proposed at \$15 million for FY2001. NCOA urges you to meet that amount and believes the majority of funds should be provided directly to support community-based HVRP programs.

**DOL Veteran Employment Counselors:** NCOA recognizes that more and more veteran homeless providers are utilizing the resources of the DOL Veterans Employment and Training Service (VETS), specifically the services provided by Local Veterans Employment Representatives (LVER) and Disabled Veteran Outreach Program (DVOP) specialists. These DOL programs regrettably are not uniformly available or accessible. Where effective, the LVER/DVOP representatives are active participants in their local community based homeless veteran provider employment training programs.

It is understandable that these DOL representatives have neither the time nor resources to actively meet the homeless requirement without jeopardizing other veteran clients. HVRP programs do not have the staff to actively manage this type of direct individual employment counseling and

developing corporate relationships to refer program graduates for employment. NCOA believes DOL should consider a unique expansion of VETS to allow community based providers who are effectively utilizing resources of the HVRP program to compete for funds. In NCOA's view, this would permit VETS to employ a full time employment specialist to participate in the case management of homeless veterans.

**Employment Tax Credit Recommendation:** NCOA fully supports the National Coalition for Homeless Veterans recommendation that a Veterans Work Opportunity Tax Credit (V-WOTC) be established. That proposal would provide priority to employing homeless veterans and other potential "homeless-at risk" low income veterans whose income is below the poverty line. The creation of such a *Veterans Work Opportunity Tax Credit (V-WOTC) Jobs Program* would provide the employer a federal tax credit. To receive the tax credit employers could hire any US military veteran or their immediate family member in the eligibility category specified. It is estimated that there are 1.5 million veterans who fall below the poverty line and may be at risk to becoming homeless. The proposed private sector federal hiring tax credit would provide employers with :

- 50 percent of their first year's wages (to a maximum of \$10,000 per family member)
- Provide a second year's retention credit equal to 25 percent of the second year's wages (to a maximum of \$4,000 per family member)

## DEPARTMENT OF VETERANS AFFAIRS

**VA Homeless providers Grant and Per Diem Program:** These programs originally implemented in 1992 to fund the development and operation of transitional housing programs for homeless veterans who are free of drugs and alcohol now provide over 4,000 beds. The current program is successful but needs to be expanded beyond current limits. The 2000 budget authority provides \$24 million for the VA Grant Program and \$7 million for its homeless per diem program. VA working with community providers and veterans organizations is able to leverage these dollars into expanded programs of job training and placement. The budget for the VA Grant and Per Diem Program must be increased for budget years

**Veterans Health Administration** is further able to coordinate the health care for veterans participating in the grant and Per Diem Program through its health care facilities and direct care on site visits. Declining availability of inpatient substance abuse and mental health programs have adversely impacted homeless veterans.

Homeless veterans who are inpatients at VA health care facilities must have a realistic discharge plan prepared before their discharge from the facility. Social workers and case workers need to be identified as part of the case management team as the "homeless" veteran again becomes part of a sheltered or transitional housing community. The Undersecretary for Health should establish inpatient discharge planning of homeless veterans as a measurable goal of VISN Directors. VA medical facilities must be held accountable for the role they have in veteran's reintegration into community provider programs.

## HOUSING AND SHELTER

NCOA supports the following legislation and recommends adoption:

- HR 1008, The Robert Stolda Homeless Veterans Assistance Act, introduced by Representative Metcalf (R-WA) that would direct that 20 percent of HUD McKinney Homeless Funds be directed to programs that provide for homeless veterans.
- S.312, introduced by Senator McCain (R-AZ) to require entities that operate homeless shelters to identify and provide certain counseling to homeless veterans, including employment assistance programs. Entities would be required to consult with VA to offer other services and failure to comply would result in ineligibility for additional grants.

HUD grant programs make available considerable fiscal resources to community based homeless providers. Veterans organizations represented in the Veterans Organization Homeless Council have never been fully satisfied that specific veteran service providers have adequately been represented in the community grant process. The veteran organization specific program representative(s) is most often outnumbered in the council process competing with and against every other community provider and their specific program efforts. The veteran provider representative lacks proportional representation on their respective council relative to the number of homeless veterans within the local homeless population.

NCOA believes that lacking enactment of HR 1008, a number of veteran specific homeless programs will never compete adequately at the community bargaining table for HUD Grant resources. All grant applications routinely check off a program block signifying that their community request includes specific activities for homeless veterans. NCOA and the VOHC questions the reality of all programs being equally accessible by veterans in view of the continuing mass referral of homeless veterans to VA.

NCOA believes that the Secretary of HUD should report annually to Congress to:

- validate that homeless veterans are represented in resource allocations for specific programs to every state, and
- report the number of homeless veterans and their percentage of the total homeless population served by HUD grant allocations

## CONCLUSION

It has been a pleasure for the Non Commissioned Officers Association to appear before this joint hearing to address its concerns on behalf of America's Homeless Veterans. It will take the concerted action of federal agencies and community partnerships to begin to break the homeless path of some America's veterans. In the journey ahead, Congress must provide the program dollars and enable community and veteran coalitions to set in motion those programs that take the homeless through the continuum of care into the ranks of the employed and self-sufficient. The Association is fully prepared to join the effort to resolve the issue of homelessness.

In January 2000, the Department of Justice released its report (Veterans in Prisons or Jails) concerning incarcerated veterans. The report tragically documents that in the year prior to arrest, 23 percent of those veterans incarcerated were in fact homeless veterans. It is the judgement of this Association that we as a Nation can do better. There is no doubt that programs like the DOL Homeless Veteran Reintegration Program and VA's Grant and Per Diem Program can turn many of veterans now in jeopardy into productive – and tax paying – citizens. We cannot, by default, reduce homelessness in America to incarceration.

Thank you for the opportunity to testify.

**STATEMENT OF  
EMIL W. NASCHINSKI, ASSISTANT DIRECTOR OF ECONOMIC  
THE AMERICAN LEGION  
TO THE  
SUBCOMMITTEE ON BENEFITS  
COMMITTEE ON VETERANS AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
ON  
HOMELESS VETERANS**

**MARCH 9, 2000**

The American Legion appreciates the opportunity to submit its views for the record on the status of public and private sector initiatives to end homelessness among veterans.

The American Legion's views on public sector attempts to assist homeless veterans are well documented in the records of numerous other Congressional hearings. Therefore, while we will not dwell on that subject, we must, nonetheless, again voice our concern over the past reluctance of Congress to fund one federal program that has a proven track record of assisting homeless veterans in breaking the cycle of homelessness.

Like most other groups that work with homeless veterans and/or who advocate for them, The American Legion firmly believes that the key to ending homelessness among veterans lies in assisting those veterans in becoming job ready and then in assisting them in finding suitable employment. Unfortunately, very few homeless veterans' programs offer an employment component. As a result, veterans all too often remain homeless when a small investment in their futures would provide the hand up necessary for them to once again become productive members of society.

Title IV (c) of the Job Training Partnership Act (JTPA), which is operated by the Department of Labor (DoL), does place homeless, unemployed veterans in jobs. However, another DoL program, the Homeless Veterans Reintegration Project (HVRP), is the only federally funded program that is focused strictly on preparing homeless veterans for employment and on successfully placing them in jobs.

Through HVRP, grants are awarded to community-based organizations and private sector contractors that assist homeless, unemployed veterans in finding and sustaining employment. During FY '99, DoL statistics indicate that the average cost per placement was between \$900.00 and \$1500.00. In view of the fact that placements under HVRP are approximately 25 percent of what they cost under JTPA, this is a very cost-effective program.

In order to find suitable employment, homeless veterans must overcome significant and real barriers. These barriers often include such things as not having the training needed to compete for certain jobs; not having the proper clothing for a job interview; or not having the tools to ply their trade. HVRP addresses these types of issues and helps homeless, underemployed veterans get off welfare rolls and onto tax rolls.

In other words, HVRP is not a handout, but rather, it is an investment in the veteran and an investment in this country's economy. Considering the average cost per placement, Uncle Sam generally recoups his investment within a year.

Since its inception, HVRP has been authorized \$10 million per year. However, between FY 1992 and FY 1999 it never received an appropriation of more than \$5 million. Furthermore, during two of those years, the program received no funding at all. During the past two fiscal years, HVRP received a mere \$3 million per year.

HVRP received a significant increase in funding for this fiscal year—slightly over \$9 million—and we understand that the President has requested \$15 million for FY 2001. The American Legion urges Congress not to allow any slippage in next year's funding

for HVRP. With proper funding, HVRP can begin to reach its full potential of being a cost effective tool for ending homelessness among veterans.

With respect to private sector initiatives, The American Legion is proud to report that many of our Posts, American Legion Auxiliary Units and Sons of The American Legion Squadrons are conducting a wide variety of homeless veterans' projects and programs. Although we just used the words "many" and "wide variety," we are not trying to be vague. The truth is that we simply do not know the true extent of our organizations' efforts to assist homeless veterans and their families.

All too often American Legion Posts, Units and Squadrons do not report their efforts on behalf of homeless veterans to our National Headquarters. That is because they do not feel that their projects and programs are special or noteworthy. They believe they are just doing what they should do to assist homeless veterans in making a successful transition back into mainstream society.

An example of that occurred in 1992 when, quite by accident, our National Headquarters staff learned of a veterans home in Gallatin, Tennessee that was owned and operated by the John T. Alexander American Legion Post 17.

The Post, which is located in a renovated building that was formerly a movie theater, raised enough money through its weekly Bingo games to purchase a piece of property directly across the street from it. That property, which consisted of a dilapidated "no-tell" motel and a diner, cost the Post \$87,000. Post 17 then invested \$78,000 in renovating the two buildings. They are now known as the Stars and Stripes Diner and the Sumner County Veterans Home.

The diner was the first to be renovated. When it was completed it was opened to the public. The Stars and Stripes Diner, which is self-sustaining, charges the home's residents a minimal amount for meals.

Today the Sumner County Veterans Home provides housing for 40 formerly homeless veterans, as well as disabled and elderly veterans who have nowhere else to go. While there are some differences in the size and layout of the rooms, all are furnished and have private baths. They also are equipped with color TVs, microwaves, refrigerators and telephones. The rent from the residents pays for the utilities, furniture usage, a weekly cleaning service and cable TV fees. Residents pay for their own telephone service.

It is also worth mentioning that while the members of Post 17 considered applying for a grant from the Department of Housing and Urban Development (HUD) they ultimately chose to finance the project without federal dollars. As one Legionnaire noted, "Federal money comes with federal strings attached."

Another American Legion initiative eventually became known as the Cypress Street Project. It quickly received national attention and has served as a basis for many similar projects in the Pittsburgh area and throughout the country.

In the late 1980s, a social worker at the Highland Drive VA Medical Center in Pittsburgh saw the need for transitional housing for homeless veterans who had completed inpatient treatment and had no place to go after discharge. That insight, and subsequent discussions with the leadership of the Pennsylvania American Legion, led to a unique partnership between the Legion and the medical center.

In 1988 The American Legion of Pennsylvania formed the American Legion Housing for Homeless Veterans Corporation. Once established, the corporation purchased four town houses on Cypress Street in Pittsburgh. Those houses had been repossessed by the VA who in turned sold them to the corporation at a discount price.

The concept of the Cypress Street Project is very simple—provide a safe, clean, stable environment for the resident as he/she completes schooling, job training and becomes adequately self sufficient to seek permanent housing in the surrounding community.

Each resident is expected to take part in cleaning the house, cooking and maintaining the jointly used facilities. They are also responsible for keeping their own assigned area clean and for doing their own laundry. The corporation maintains the buildings and the medical center is responsible for placing veterans in the homes, and for providing medical, psychological, financial and spiritual counseling.

Since its humble beginnings with the Cypress Street Project, the Pennsylvania American Legion's Housing for Homeless Veterans Corporation has continued to grow, expand and to build on its strong relationship with the Highland Drive Medical Center. In 1995, the corporation purchased another home in Allegheny County. With the help of local veterans and others, the corporation was the first group to place a female veteran and her three children in transitional housing. She has since obtained a college degree and has purchased her own home. That same year the corporation expanded its operation to the Philadelphia area. Through the support of Legion members, the corporation signed a lease/purchase agreement contract with HUD for a three bedroom home in Philadelphia. Its residents are serviced by the Philadelphia VA Medical Center.

The corporation's newest addition is a home it purchased in 1998 in Ephrata, Pennsylvania. The house still needs many repairs, furnishings and a lot of hard work. But corporation members are confident that with the continued support of Legionnaires, civic organizations and other interested parties, the home will quickly take shape once work begins. When completed, it will provide stable transitional housing for five veterans in the central Pennsylvania area.

Again, The American Legion appreciates having this opportunity to share its views on public and private sector initiatives to assist homeless veterans and their families. We respectfully request that this statement be made a part of the permanent record of this hearing.

Statement by Bobby L. Harnage, Sr., National President, American Federation of Government Employees, AFL-CIO

**Chairman Quinn, Chairman Stearns and Members of the Subcommittees:**

My name is Bobby L. Harnage. I am President of the American Federation of Government Employees, AFL-CIO (AFGE). I appreciate the opportunity to offer our concerns regarding the issues facing homeless veterans. AFGE is the nation's largest federal employee union, representing some 600,000 employees, including some 125,000 employees in the Department of Veterans Affairs (DVA).

AFGE's testimony focuses on the care of homeless veterans in the Veterans Health Administration's (VHA's) general inpatient and outpatient programs. AFGE is concerned that the budget proposal for FY2001 may undermine treatment of homeless veterans in these programs. AFGE is concerned that VHA's increasing reliance upon contractors to deliver veterans with health care coupled with the dramatic decrease in VHA's in-house capacity for inpatient services and transition to community based outpatient clinics may inadvertently lessen the access of care homeless veterans receive.

About 45 percent of homeless veterans suffer from mental illness and, with considerable overlap, slightly more than 70 percent suffer from alcohol or other drug abuse problems. Nearly forty percent of the veterans being treated in VHA mental health beds were homeless or at high risk of homelessness.

VHA's proposes for FY 2001 to *reduce* the number of psychiatric care patients it treats by 13,800. (See Volume 2, page 2-42 of the Department of Veterans Affairs FY 2001 Budget Submission.) VHA also proposes to *cut* 1,200 full-time employees who work in psychiatric care in FY 2001. (See Volume 2, page 2-47 of the Department of Veterans Affairs FY 2001 Budget Submission.)

Adequate numbers of well-trained staff are essential to manage workloads, prevent potentially harmful delays in care, avert medical errors, and improve services.

VHA also proposes to reduce its domiciliary care beds by 759 from FY 1999 levels. (See Volume 2, page 2-102 of the Department of Veterans Affairs FY 2001 Budget Submission.) That is a 15 percent cut in a program designed to provide

medical care and rehabilitation in a residential setting to eligible ambulatory veterans who do not need hospitalization or nursing home care. These beds are critical to homeless veterans suffering from substance abuse and/or mental illness and essential to the Domiciliary Care for Homeless Veterans program.

AFGE strongly believes these reductions in in-patient care staff and VHA domiciliary beds will seriously worsen homeless veterans' access to needed psychiatric care.

Chairman Stearns, we urge you to continue to press the VHA for answers on how these cuts in staff and patients treated will help homeless veterans who suffer from severe mental illness. It is our understanding that most of the psychiatric staffing cuts will come from support staff – the Nurses Assistants, Licensed Practical Nurses and other lower graded health care staff. Without adequate support and administrative staff, Registered Nurses would have to devote more of their time to paperwork, maintaining hospital cleanliness, feeding, bathing and transporting patients.

VHA proposes to increase its use of community based outpatient clinics (CBOCs) and contracted psychiatric care. Are mentally ill homeless veterans served well by these initiatives?

A study by Dr. Robert Rosenheck, of VHA's Northwest Program Evaluation Center (NPEC), examining veterans access to medical care from FY 1995-1997 concluded that CBOCs do *not* improve access to specialty mental health care for either the general population of veterans or among veterans who received compensation for psychiatric disorders. (See, *Impact of Primary Care Satellite Clinics on Access to General Health Care Services and Mental Health Services.*)

The February 1999 CBOC Performance Evaluation Project report suggests that contractor operated CBOCs are less equipped to care for homeless veterans. For example, only 63 percent of contractor CBOCs versus nearly 90 percent of DVA-staffed CBOCs have available public transportation access (bus, subway or Disabled American Veterans voluntary transportation). Mental health services were provided at a higher percentage of DVA-staffed CBOCs (roughly 54 percent) than

contractor CBOCs (18 percent). DVA-staffed CBOCs serve veterans almost exclusively while veterans were only a small part of the workload in contractor CBOCs. Will contractors whose profits are based largely on serving non-veterans encourage and welcome homeless veterans into their waiting rooms?

AFGE urges you to press VHA to demonstrate that contractor CBOCs will serve homeless veterans as well as DVA-staffed CBOCs. AFGE asks that you direct VHA to study whether and how contractor-operated CBOCs increase or decrease homeless veterans' access to needed health care.

With regard to contracted psychiatric inpatient and community based care, AFGE is concerned that VHA does not have adequate staff or resources to assure that veterans are provided with quality care and that these services are not subject to waste, fraud and abuse by contractors. VHA is proposing to use roughly 200 contract community-based facilities to provide an additional 4,000 homeless veterans longer-term medical treatment. The success of these contracts hinges upon active VHA staff involvement and monitoring of the quality of care and treatment in provided by contractors.

Of the veterans in the Little Rock residential treatment program, 57.52 % were discharged to their own apartments, compared to 32% nationwide in the VHA homeless programs. Homeless veterans in the Little Rock program showed higher improvement regarding alcohol abuse (75.6 % compared to 67.9% nationally), drug abuse (82.8% showed improvements compared to a national average of 66.7%), and in mental health status (85.7% compared to 62.9% nationally.) AFGE believes the difference between Little Rock and other VHA programs nationwide is attributable to the active oversight and monitoring of the contractor performance by Little Rock's clinical care staff.

VHA employees at Little Rock vigorously monitor the clinical capability of staff employed by the treatment facilities as a means of insuring that veterans are receiving the services that we are contracting for, rather than just maintenance services. VHA staff visit contractor sites 3-4 times a week and have weekly clinical case management conferences. VHA staff use these sessions to monitor the

progress of veterans in following their treatment plans.

Such contractor oversight and active involvement of VHA staff is critical nationwide to ensure that the additional millions of dollars spent on contract residential care for homeless veterans will truly help these veterans make the transition into permanent living arrangements.

AFGE asks that you direct VHA to study how oversight by VHA clinical staff of contractor performance affects the treatment outcomes for homeless veterans.

This concludes my statement. Thank you for the opportunity to offer AFGE's views on the treatment of care of homeless veterans.

## WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

**Post-Hearing Questions  
Concerning the March 9, 2000, Hearing**

for  
**Dr. Frances Murphy**  
Acting Deputy Under Secretary for Policy and Management  
Veterans Health Administration, Department of Veterans Affairs

from  
**The Honorable Lane Evans**  
Ranking Democratic Member, Veterans Affairs' Committee  
U.S. House of Representatives

**Question 1: Dr. Murphy, I understand that VA is using performance measures to ensure that VA fulfills its commitment to homeless veterans. But if you are confident that these measures will indicate that VA is maintaining its commitment to its homeless veterans, why the hesitancy to commit multi-year funding to the programs in VA's own budget request for FY 2000?**

**Answer:** VA has made a multiyear commitment of budget support for homeless veteran programs. The President's FY 2001 budget request continues funding support for new homeless initiatives that are being funded with increased FY 2000 funding identified for specialized homeless veterans initiatives. FY 2000 funds for homeless veterans programs are being distributed by using a population based distribution model to expand outreach, case management and contract residential treatment for homeless veterans with the expectation that some existing Health Care for Homeless Veterans (HCHV) Programs will receive augmented funds and some of these resources will be placed at VA medical centers so that these kinds of services can be established as new programs. In addition, Requests for Proposals (RFPs) are being used to invite VA medical centers to apply for funding to establish new programs for homeless women veterans, new therapeutic employment initiatives and new intense, but time limited case management services for hospitalized homeless veterans. The FY 2000 medical care budget also identified resources to enhance VA's Homeless Providers Grant and Per Diem Program, Stand Downs, the Excess Property Distribution Program and the Northeast Program Evaluation Center (NEPEC's) program monitoring and evaluation efforts. These funds are also being used to support the new Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans Program. In FY 2001 these resources will be distributed as general medical care funds through the Veterans Equitable Resources Allocation (VERA) model. It is the expectation of VA leadership, that funding levels identified in FY 2000 for new homeless veterans program activities or program expansions will be sustained by VISN Directors and VA medical center directors for multiple years. Monitoring systems are in place to provide oversight of the utilization of resources for homeless veterans programs.

**Question 2: Dr. Murphy, I share Mr. Filner's concern raised at the hearing that VA has significantly downsized its mental health programs —enough so that they could severely compromise the effectiveness of programs that they should be supporting, like those available for homeless veterans. If VA had replaced inpatient care with intensive community-based care programs that would be one thing, but that doesn't appear to be the case. In fact, the Northeastern Program Evaluation Center that you have stated VA relies upon for outcomes indicates that the number of veterans with "dual diagnosis" (a diagnostic label applied to many of the homeless) that VA treated has dropped. Would you care to comment?**

**Answer:** The NEPEC data does not account for additional mental health programs provided by contract. Data from NEPEC indicates that the number and percentage of veterans treated with dual diagnoses has only dropped slightly

over the last few years. In the first six months of 1996, VA treated and discharged 39,434 veterans with a dual diagnosis. In the first six months of 1999, VA treated and discharged 35,136 veterans with a dual diagnosis. In 1996, 41.9% of all inpatient psychiatric discharges were related to treatment of veterans with dual diagnosis. In 1999, 40.8% of all inpatient psychiatric discharges were related to treatment of veterans with dual diagnoses.

**Question 3: Dr. Murphy, I was recently informed that, as required by the Veterans Millennium Health Care and Benefits Act, by June 2000, VA plans to distribute an additional \$15 million to its PTSD and Substance Use Disorder Treatment programs. As you know these programs are crucial to many homeless veterans' recovery. There is a specific requirement in the law that these funds be distributed in consultation with the Committee on Seriously Chronically Mentally Ill Veterans. Has the Committee been consulted in this matter? Has VA received proposals from programs that plan to enhance their programs?**

**Answer:** The Committee on Care of Severely Chronically Mentally Ill Veterans has been and continues to be consulted on this project. At this time, committee members are reviewing the draft Request for Proposals document before release to the field. The goal of this project is to fill gaps in existing services based on a population based needs assessment and an assessment of existing specialized programs for PTSD and Substance Use Disorder care. In some cases where gaps in the continuum of care are identified, VISNs will be specifically requested to develop such programs.

**Question 4: Dr. Murphy, will you comment on Ms. French's proposal to establish a VA Homeless Advisory Committee.**

**Answer:** While VA does not currently have a Homeless Advisory Committee, VA receives advice from and consults with a number of groups on homeless veterans issues. VA staff meet with and receive input on homeless veterans issues from the following external groups:

- The Veterans Organizations Homeless Council (VOHC). This group has members from all interested Veterans Service Organizations and meets on a quarterly basis. VA staff meet with the VOHC regularly to provide updates on programs, to respond to questions and address concerns.
- The Homeless Veterans Task Force of the Federal Interagency Council on the Homeless is chaired by VA and consists of representatives from other federal agencies that have programs that serve homeless veterans. The purpose of the Veterans Task Force is to assure coordination of all federal efforts to address the needs of homeless veterans.
- The Women Veterans Advisory Committee is attentive to the special issues that face homeless women veterans. VA staff involved with homeless veterans programs have met with the Women Veterans Advisory Committee and have responded to recommendations contained in the Committee's reports.
- The National Coalition for Homeless Veterans (NCHV) has representatives from State and local governments and non-profit organizations that serve homeless veterans. VA staff meet with NCHV on a regular basis.

In addition to the external groups identified above, for more than a decade VA has held monthly meetings of the Working Group on Homelessness. This internal group, with representation from VA's staff and administration offices, meets to coordinate and communicate VA's efforts to assist homeless veterans. This effort is the longest and most sustained federal effort to assist homeless

persons by any department of government. VA homeless program staff regularly meets with VA's internal Committee on Care of Seriously Chronically Mentally Ill Veterans. VHA also has a Council of Network Homeless Coordinators, made up of appointed representatives from each VISN that advises VA headquarters staff concerning homeless programs. Many of the VISNs have established working groups to address homeless veterans issues and many of these working groups have established their own advisory committees that include homeless veterans. Information from VISN working group meetings is routinely discussed during Council conference calls and meetings. We believe that the broad-based input obtained from these committees and groups substantively address the recommendation that VA get external advice on its homeless programs.

**Question 5: Will you comment on the National Coalition on Homeless Veterans' proposal to convert VA Homeless Providers Grant and Per Diem Program to a program akin to the Grants for State Extended Care Facilities? What would the merits and drawbacks of using such an approach rather than the current process be?**

**Answer:** There are many similarities between VA's Homeless Providers Grant and Per Diem Program and VA's Grant Program for State Extended Care Facilities and, at the same time, there are important distinctions.

These programs are similar in that they have components common to most Federal grant programs. Both utilize an application, specific award criteria, review processes, conditional and final selection processes, compliance review processes, and fund disbursement processes.

The programs differ in that they are designed to address the needs of very specific and different clientele. One is the homeless population and the other being an extended care geriatric population. Each of these populations has very specific needs that differ from each other and as a result of this difference in needs the goals of the program are specifically targeted to the customer population. Both of the grant programs have taken the similar components involved in grant management and structured them to best meet these needs of these two diverse populations.

As to the merits and drawbacks of VA's Homeless Providers Grant and Per Diem Program using the same approach as VA's Grants for Extended Care Facilities Program as suggested by the National Coalition for Homeless Veterans (NCHV), the Department of Veterans Affairs can not respond in any detail to the suggestion by the NCHV since the Department does not have the details of the suggested changes and they were not included in the testimony.

However, the Department of Veterans Affairs welcomes the opportunity to work with the Coalition and encourages them to make the specifics available to the Department in an effort to review and evaluate the proposed changes along with their implications and externalities as they apply to the service delivery to homeless veterans and the Grant and Per Diem Program.

**Question 6: I have some real concerns about what we can realistically hope to achieve with a population of chronically ill, aging veterans. There needs have been neglected for so long that many have reached an age where they would normally be considering retirement and may not ever be able to work. What can we reasonably expect to achieve for them?**

**Answer:** The aging, chronically ill homeless veteran presents special challenges to VA. Aging homeless chronically ill veterans, many of whom suffer from mental illness, substance abuse disorders and a wide range of medical illnesses, receive appropriate outreach and treatment, and assistance in maximizing their ability to live as independently as possible. While returning to work may be an appropriate goal for some, VA recognizes that this is not a realistic goal for all homeless veterans. Staff associated with VA's homeless veterans programs tailor

treatment and services to each individual veteran. They conduct assessments to determine the bio-psycho-social needs and capabilities of each homeless veteran they contact through outreach and then work with each veteran to develop a treatment plan. VA's integrated health care system gives us the capability to provide a continuum of services to homeless veterans including acute inpatient and outpatient health care, mental health and substance abuse treatment programs, rehabilitation, and long-term care. VA staff refer homeless veterans to appropriate VA and non-VA services and provide case management to make sure that each veteran receives the care and support services that he or she needs.

**Post-Hearing Questions  
Concerning the March 9, 2000, Hearing**

for  
**Ms. Estella Morris**  
Program Manger, VA Comprehensive Homeless Center  
Veterans Health Administration, Department of Veterans Affairs

from  
**The Honorable Lane Evans**  
Ranking Democratic Member, Veterans Affairs' Committee  
U.S. House of Representatives

**Question 1: In your view, what are the critical components of a successful comprehensive approach to working with the homeless?**

**Answer:** In my view, the critical components of a successful comprehensive approach to working with the homeless would involve the use of a well organized case management system that gives attention to insuring that needs are met in the following areas in the order listed:

- a). A case management system for identifying and directing service delivery to homeless individuals in an easily accessible non-threatening environment;
- b). The availability of a free standing community based facility that may serve as a safe haven, for homeless individuals during the waking hours, with provisions for meeting the basic needs for shelter, food, personal hygiene, and laundry services;
- c). Outreach to identify and engage homeless individuals who have limited knowledge of resources and difficulty negotiating social welfare systems;
- d). Identification of and referral for social, medical and mental health service needs;
- e). The availability of resources for addressing mental health, social, and medical maintenance concerns;
- f). Referrals for treatment or nighttime shelter needs;
- g). Pre-employment training in a broad range of areas that will be transferable to jobs in the community and emphasis on direct services for permanent employment placement; and
- h). Motivation on the part of the client to change.

**Question 2: I have some very real concerns about what we can realistically hope to achieve with a population of chronically ill, aging veterans. Their needs have been neglected for so long that many have reached the age where they would normally be considering retirement and may not ever be able to work. What can we reasonably expect to achieve for them?**

**Answer:** While it is true that our veterans are getting older and some have extensive medical and/or psychiatric problems, I remain optimistic that we can still make a real difference in their lives. What we have found to be true in our work with this particular group is that primarily they want an opportunity to be heard, and to receive services that will foster independence. In an effort to meet the changing needs of this population, we have developed an "assertive" case management style. This involves assessing the needs of clients and providing some tangible services relative to their stated needs within a short time frame. We have successfully worked with this population by building coalitions with the VSO's, SSD and community homeless service providers. For the veterans that

we see who have a medical and/or psychiatric condition that preclude them from working, we have successfully assisted them with gaining disability income. For those who are looking for employment, we partner with our local Employment Security Division. Veterans with limited work skills and have not been in the work force for quite some time are referred to our Compensated Work Therapy Program. We are not miracle workers, but with clinical staff, adequate resources, and the right "mind set", there is always "something" we can do. My response then, to your question is that for many, we give hope, for most, we give life.

**Post-Hearing Questions  
Concerning the March 9, 2000, Hearing**

**for  
Ms. Henrietta Fishman  
VISN 3, Homeless Veterans Treatment Programs  
Veterans Health Administration, Department of Veterans Affairs**

**from  
The Honorable Lane Evans  
Ranking Democratic Member, Veterans Affairs' Committee  
U.S. House of Representatives**

**Question 1: Dr. Fishman, will you explain the role of your consumer council in overseeing the management of your homeless service line? Also, tell us a little more about the peer support services referenced in your testimony.**

**Answer:** The purpose of the Consumer Council (developed by Council members) is: to enhance communication between VA staff and veteran consumers; to give feedback to staff about the special needs and issues of homeless veterans; to provide guidance about locating and engaging homeless veterans; to make recommendations about program development; and to assist in educating VA and community providers about the experience of homelessness. The chair of the Consumer Council reports to the Executive Council quarterly, or sooner if necessary. Currently, the Consumer Council is working in concert with the Executive Council to identify underserved areas and to plan new outreach initiatives which will involve consumers and professional staff. The Consumer Council takes an active role in the CHALENG process.

Creating a supportive community of veterans helping veterans is central to the VISN 3 homeless veterans treatment programs. As they become stabilized, homeless veterans lead support groups, work as volunteers (sometimes as part of pre-vocational training), are "mentors" to new veterans in the programs, and assist at every level of program involvement. This helps homeless veterans develop self-confidence, skills, and a sense of belonging within the community. Some of these veterans do outreach into the community, working side-by-side with staff as members of the team. These veterans provide orientation to newly homeless veterans, telling them about VA services, introducing them to staff, and being a "big brother." Programs also have active Veterans Advisory groups. Many formerly homeless veterans are members of AmeriCorps and they provide supportive services to homeless veterans. A MIRECC clinical demonstration project at the NY Harbor Health Care System's Comprehensive Homeless Center will employ formerly homeless veterans who have graduated from specialized VA programs as peer counselors. Under professional clinical supervision, these peer counselors will be assigned to work with seriously mentally ill formerly homeless veterans as they transition to living in the community. The goal is to increase their community tenure, improve their quality of life, help them maintain substance-free lifestyles and assist them with productive activities such as vocational rehabilitation, attending day treatment programs, etc.

**Question 2: In your view, what are the critical components of a successful comprehensive approach to working with homeless veterans?**

**Answer:** There are many components to a successful comprehensive approach to working with homeless veterans. First, there must be a commitment from top management to the value of these services, and the organizational "will" to ensure that homeless veterans receive the same standard of care as other veterans in the system. A continuum of services is necessary: from outreach to

treatment, rehabilitation and case management to transitional and permanent housing and employment. All homeless veterans do not need to move through all aspects of this continuum. The availability of these services is important so that veterans can be linked to the right service and level of care to meet their needs, which will change over time. An essential part of this continuum involves active partnerships with the community, working with them as a team. And a key member of the team must be the homeless veteran, who has his or her own distinct needs, preferences, strengths and abilities.

**Question 3: I have some very real concerns about what we can realistically hope to achieve with a population of chronically ill, aging veterans. Their needs have been neglected for so long that many have reached an age where they would normally be considering retirement and may not ever be able to work. What can we reasonably expect to achieve for them?**

**Answer:** It is true that many of the homeless veterans leaving VA treatment programs now are middle-aged or older and many have formidable health problems which mitigate against working in most settings, if at all. Others may not be as disabled, but face age-related job discrimination. There are many avenues to pursue, all with the goal of a meaningful, productive life for the veteran. It is important that disabled veterans obtain the benefits necessary to allow them to live in the community, and VA programs actively pursue whatever benefits and services are available for this population. For veterans unable to work, there are activities which can be planned, from volunteering to involvement in church and community activities to hobbies such as painting and ceramics. For older veterans who need special assistance to be able to work, the challenge is to forge partnerships with the community to provide a moveable feast of options to prepare veterans for employment and to provide job development, job placement and job coaching. An example is the newly developed Veterans Vocational Resource at the CBOC in downtown Brooklyn (part of NY Harbor Health Care System). VA and four community agencies provide "one-stop" vocational services which include assessment, training, and placement for homeless veterans, with extensive services for the seriously mentally ill. While we cannot and do not expect miracles, we believe that aging formerly homeless veterans have the right to have a satisfactory quality of life in the community with the supports they need to live with safety and dignity.

Congressman Evans to Non Commissioned Officers Association

**Joint Oversight Hearing on Homeless Veteran's Issues  
Follow-up Questions for:**

**Mr. Richard C. Schneider  
Director of State Veterans Affairs  
Non Commissioned Officers Association**

1. I want to thank all of your organizations for the good work you do on behalf of homeless veterans. I think in the future we will need ever more strong leadership from veterans. Do your organizations participate on local planning boards to prioritize funding requests to HUD?

**NCOA Response:** No. Participation on local planning boards is a concern of this Association. NCOA believes that veterans, comprising 25-30 percent of the homeless population, should be represented by a proportionate number of designated voting members on any local planning board. The key here is collective representation from veteran organizations/provider programs as opposed to demanding an individually designated "veteran" seat on the table the local planning council.

2. Do you support Ms. French's call to establish a VA Advisory Committee on Homeless Veterans?

**NCOA Response:** NCOA strongly supports a VA Advisory Committee on Homeless Veterans, as Ms. French suggested, within the Intergovernmental Affairs office of the Department of Veterans Affairs. Further, the Association recommends similar representative advisory committees on homeless veterans be established within every Veteran Integrated Service Network.

It is imperative to develop these enhanced partnerships and communication channels to better integrated programs serving homeless veterans and maximize limited resources in both VA and community initiatives. The key to success is providing improved communication channels in which collaborative partners can join forces and work in the best interest of the homeless veteran population from both a national and local perspective.



