# EFFECTIVENESS OF FEDERAL HOMELESS VETERANS PROGRAMS

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BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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# EFFECTIVENESS OF FEDERAL HOMELESS VETERANS PROGRAMS

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**THURSDAY, JUNE 24, 1999**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.*

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Brown, Hill, and Evans

## OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. We'll come to order. Good morning, this Oversight and Investigation Subcommittee hearing will examine the effectiveness of Federal Homeless Veterans Programs. This is our subcommittee's first hearing on homeless veterans, and I would like to give a great deal of credit to Ms. Brown, my ranking member of this subcommittee, who is temporarily detained, for her interest and for suggesting this hearing.

According to many reports, a significant number of the homeless are veterans. We see homeless veterans wandering, sleeping and begging for handouts on the streets of almost every city in the country. Some of them are combat veterans with PTSD and many of them suffer from mental illness and substance abuse. Everyone has heard the numbers. According to the Urban Institute Study in 1988, some 600,000 people are homeless in America.

In 1998 a study cosponsored by HUD and HHS reported there were still between 500,000 and 600,000 homeless men and women living on the streets or in shelters. Why has this staggering figure stayed the same for 10 years, and what can be done to help get the homeless off the streets and into jobs so that they contribute to society?

The VA reports that nearly one third of the adult homeless populations are veterans. Certainly it is a fact that we have thousands of homeless veterans, and I am not quite sure anyone knows what the true figure may be.

In fiscal year 1997 VA obligated approximately $84 million on targeted homeless programs. GAO states that in fiscal year 1997 the Department of Education, Health and Human Services, Housing and Urban Development and Labor, Veterans Affairs and Federal Emergency Management agencies obligated approximately $1.2 billion on homeless programs. That is a lot of money.

Today we will hear from the GAO, several community-based homeless programs and a former homeless veteran who has successfully reentered the mainstream of society. We will also hear from HUD, Labor and the VA, and we will hear views of veteran service organizations.

Despite all the government's efforts, many experts tell us that homelessness is still a big problem. That is really causing a question whether the billions of dollars for homeless programs have been effectively spent. We will recognize our ranking member at a later time to give her opening statement, and her statement will be made a part of the record.

And at this time I would like all witnesses to limit their oral testimony—oh, I am sorry. You came in so quietly, Lane, I didn't see you. I would like to yield now to the Ranking Member of the full VA Committee, Lane Evans.

## OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I commend you and Ms. Brown for holding this important hearing on grants to programs that assist homeless veterans. Successful veteran-specific grant programs of both the VA and the Department of Labor permit community-based organizations to offer services that many homeless veterans really need. On the other hand, programs supported by the Department of Housing and Urban Development, a federal agency with major responsibility for programs to end homelessness, too often serve veterans only inadvertently, because they are the homeless.

One-third of this Nation's homeless population deserve focused assistance. HUD's efforts to assist homeless veterans must push beyond happenstance.

I look forward to learn from our witness, Mr. Chairman, and I yield back to you.

[The prepared statement of Congressman Evans appears on p. 47.]

Mr. EVERETT. Thank you very much. And I again apologize, Lane, I was reading from my statement and I didn't see you come in. We certainly are always honored to have you here. I will ask all witnesses to limit their oral testimony to 5 minutes. We will strictly enforce that, because we do have a long list of several panels. And your complete written statement will be made a part of the official hearing record. I would ask the panel to hold the questions until all have testified.

I will now recognize Cynthia Bascetta, Associate Director for Veterans' Affairs and Military Health Care Issues and ask her to introduce her staff.

## STATEMENT OF CYNTHIA BASCETTA, ASSOCIATE DIRECTOR FOR VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY GEORGE POINDEXTER, ASSISTANT DIRECTOR FOR VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE; AND KRISTEN ANDERSON, SENIOR EVALUATOR, GENERAL ACCOUNTING OFFICE

### STATEMENT OF CYNTHIA BASCETTA

Ms. BASCETTA. Good morning Mr. Chairman. Thank you for inviting us to discuss our April report on VA's homeless programs. With me today are George Poindexter and Kristen Anderson.

As you know, homelessness is a complex problem to analyze, starting with estimating the size of the population. The most widely accepted research counts about half a million homeless people. The VA reports that about one-third of them are veterans. Like other homeless people, veterans have high rates of substance abuse and serious mental illness. And the prevalence of these conditions complicates solving the homelessness problem.

Acknowledging the many dimensions of homelessness, VA targeted several programs to augment the core health services it provides. Homeless services vary across VA facilities and may be available through VA directly or through contracts that VA has with community providers. The domiciliary care program is hospital based and primarily housed on medical center grounds. But in contrast, through VA's homeless chronically mentally ill program, medical facilities contract with community providers for time-limited residential treatment services for veterans with psychiatric or substance abuse disorders.

As the program grew, VA leveraged its resources by expanding partnerships with community providers to extend services to even more veterans. For example, VA recently developed the Grant and Per Diem program to establish alternative housing, typically supportive housing, as well as other social services through local government and nonprofit organizations. Some of them are here today and can describe for you the many different interventions that they have.

I would like to focus my remarks on what we know about the results of efforts to reduce homelessness, and I would like to make two key points. First, we should expect modest outcomes in many cases. And second, VA needs better evaluation data so that it can ensure allocating its resources to programs that are most likely to yield positive outcomes over the long run and cut funds to those that may be less effective.

Regarding outcomes, a reasonable goal is stable residence in a setting that allows the highest level of independence an individual can achieve. Some homeless veterans will be able to achieve economic self support and live on their own, but for those with chronic disorders neither full-time work nor independent housing may be feasible. Instead, they may need a more supportive environment such as a group home and residential or transitional housing to ease the way. They may also need episodic intervention with more intensive services at times to prevent relapses.

These outcomes reflect that intervention may often be required over time rather than just once to meet homeless veterans needs. Consequently, VA needs to develop much better data focused on the long-term effects of its interventions. Monitoring short-run effects at discharge provides very limited information for this population.

To determine whether short-term benefits stand the test of time, more rigorous follow up is needed to track whether veterans are still housed and employed as well as successfully dealing with substance abuse or psychiatric illnesses when they recur. For example, VA tracked veterans in the homeless chronically mentally ill program for up to 2 years and veterans in its domiciliary program for up to 1 year.

NEPEC, the Northeast Program Evaluation Center, reported positive post-discharge results, but it also acknowledged two major shortcomings in its methodology that weaken the strength of its conclusions. First, the sample of veterans interviewed was not representative of those treated. Specifically, about 30 percent were not in the follow-up sample and they could have been doing the worst. If so, the findings would overstate any positive effect. And second, because no data were obtained on homeless veterans who did not receive services, VA can't conclude with certainty that the positive effects were attributable to the program.

Even though more rigorous research is challenging and expensive to conduct, without it VA runs the risk of funding programs that may not be as effective as they could be. Homeless veterans could be better served with more solid information on long-term effects and the public could have greater assurance that their tax dollars were funding effective programs.

For these reasons, we recommended that VA conduct a series of program evaluation studies to clarify the long-term effectiveness of its core homeless programs and to figure out how to improve them if necessary.

We are encouraged that VA concurred with our recommendation and plans to supplement NEPEC's budget in fiscal year 2000. This should better position the agency to direct its resources to those efforts with the greatest potential payoff.

Mr. Chairman, this concludes my statement. We are prepared to answer any questions that you or the other subcommittee members may have.

[The prepared statement of Ms. Bascetta appears on p. 49.]

Mr. EVERETT. Thank you very much. Before we get to questioning, as I said at the beginning of the hearing, I don't know anybody in Congress that has more concern for this issue than my colleague, Congresswoman Brown. She has been unavoidably detained, and at this point I would invite her to give her opening statement.

## OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN. Thank you, Mr. Chairman. I thank you very much for having this hearing.

Imagine 17 infantry divisions camped in the streets of America. On any given night, that is how many homeless veterans huddle for warmth in our grate-filled nation. We are going to look today

at government partnerships with community-based organizations that work. Both the VA and the Department of Labor operate grant programs. They allow community providers that are part of the local continuum of care to provide the services that are really needed.

HUD, the federal agency with primary responsibility for homelessness, grants millions and millions of dollars but have done little to support veteran-specific programs. HUD remains unable to provide convincing numbers with regard to veterans or to tell us what is done for veterans other than giving grants to programs which do not exclude veterans.

There is a widespread agreement the veteran-specific programs funded by VA and DOL work. They fill the gap in a continuum that otherwise ignores the specific problems of veterans. They help veterans leave the streets and become full citizens.

Mr. Everett and I decided to hold this hearing to establish on the record what these grant programs do for our homeless veterans and to learn what obstacles they face. And I am looking forward for the rest of the testimony. And for this group may I ask my question now?

[The prepared statement of Congresswoman Brown appears on p. 47.]

Mr. EVERETT. Certainly. And I will follow you.

Ms. BROWN. Oh, that is not correct. Mr. Chairman, you go ahead and I will follow you.

Mr. EVERETT. I do want to compliment my colleague, because she did suggest this hearing. I was more than happy to honor that request.

How valid are the estimates of 250,000 homeless veterans in America? How do we get to that figure? How do we know that figure?

Ms. BASCETTA. Well, in the course of doing our work, verifying that number was not included in our scope and so we reviewed the literature to give the reader a context for the size of the problem. And, as you know, there are a number of estimates in the literature that have used a variety of methodologies, all of which have different sorts of problems. Some are direct counts, a census essentially taken on a single night. Others are probability based samples. Other researchers have used databases that shelters keep to try to determine who is actually in shelters and who may be remaining on the streets. So the basis for that estimate is drawn from a number of techniques, but that estimate has not been verified by us.

Mr. EVERETT. Your April 1999 report states that the VA has little information about the effectiveness of homeless programs. What should the VA do to be able to judge the effectiveness of these programs?

Ms. BASCETTA. We recommended that while the monitoring that VA does of its short-term effects is good and useful, they need to pay much more attention to the impact of their programs over the long term. And in so doing they need to compare their programs. They need to be able to compare the effects of their programs with specific interventions that are tailored toward different sorts of homeless populations, and they need to use control groups so that

they can be more confident that their interventions are in fact making a difference and that improvements wouldn't have occurred in the absence of those programs.

They also need to build, we believe, more on the research of others and to continue their collaborative efforts to work with other federal agencies and with researchers outside of the government. This would give them the benefit of multiple perspectives, diverse disciplines and longstanding experience in the research community in both dealing with these populations and in using sophisticated methodologies for better follow up and tracking.

Mr. EVERETT. Why haven't different agencies and departments come up with the same yardstick to measure the success of outcomes?

Ms. BASCETTA. I think part of the problem is that different agencies are coming at the problem from different vantage points. For example, HUD is most interested in housing, and so they tend to look at the stability of housing as an outcome. The Labor Department is interested in labor force attachment, so their primary focus might be whether or not the person is able to sustain employment. Others might be looking at a substance abuse problem or health care problem to see whether that is being appropriately treated and resolved, but I think that the agencies are interested in working together more collaboratively to come up with a common set, at least a minimum set of outcomes that recognize the diverse and multiple needs of the homeless population. The National Institute of Mental Health, I believe, in fact did propose certain common outcomes that could be used in tracking the progress of homeless populations.

Mr. EVERETT. Which agency has led the effectiveness issue and what can be done to improve the program?

Ms. BASCETTA. Which agency has led?

Mr. EVERETT. Has led, has the best yardstick for measuring.

Ms. BASCETTA. I don't know that we would single out a particular agency at this point.

Ms. ANDERSON. There have been——

Mr. EVERETT. I just wondered if somebody had taken the lead or had a method of measuring outcomes, the effectiveness of the programs, that you would single out as being one of the best.

Ms. ANDERSON. There have been researchers throughout the National Institute of Mental Health and through a variety of other federal agencies that have quite vigorously tackled the question of how best to measure outcomes and are working together to improve the measurement systems. I am not sure that they have devised these yet but are working toward that goal.

Mr. EVERETT. Ms. Brown.

Ms. BROWN. I am just going to pass on this group unless you have any other comments that you want to make.

How can we better improve the coordination of the agencies or how can we get a stronger verification of the number of veterans that have been served, what is the best setting for these programs?

Mr. POINDEXTER. I think during our work at the project level, some of the community-based organizations—and they will follow shortly—they are putting together funds from different federal agencies. And sometimes when one agency's funding ends it would

be interesting to see if there are ways that they could pull together means to look at the homeless person and not the funding streams that exist.

Ms. BROWN. One of the things that stands out is, I have—talked to several veterans groups, particularly those community-based ones that would be interested in participating more, at working with the providers or possible funding sources to, let us say, fix up houses and give them that supportive base. Do we have any programs working with these various groups?

Mr. POINDEXTER. My experience has been that the community-based organizations have done more to figure out the funding streams. In other words, they figure out where they need money, what services are needed, and they figure that part out. I think what we are looking for would be some means of making an assessment of the total effort on an individual veteran or homeless person regardless of where the funds came from.

Ms. BROWN. Well, funding is very important, but what I am trying to figure out is how can we improve what we are doing. How can we broaden it? How can we get more people involved in it?

Ms. ANDERSON. I think part of the problem, as we understand it, is that the outcomes are always measured at the end of a program's participation with the person, and that some coordinated effort to get measurements at the end of treatment, even if the person is moving, would be the kind of information that would be needed in order to understand how best to coordinate these activities.

Ms. BROWN. Okay, thank you.

Mr. EVERETT. Thank you, and I thank this panel for being here today and offering your testimony. As I said earlier, your complete testimony will be entered into the record. Thank you very much.

Ms. BASCETTA. Thank you.

Mr. EVERETT. I would like to recognize panel two, Ms. Linda Boone, Executive Director of the National Coalition for Homeless Veterans; Tim Cantwell, president of the Westside Residential Hall; Colonel Charles Williams, United States Army Retired, the Executive Director of the Maryland Center for Veterans Education and Training, Incorporated; and Ms. Toni Reinis, the Executive Director of New Directions, Incorporated.

While we are waiting for the panel, I want to publicly apologize to our ranking full VA member, Mr. Evans. I saw him get up and walk off and I thought he left the committee room, and I did not give him opportunity to ask questions. And, Lane, I apologize for that. I am sorry. Any questions you may have can be submitted for the record, though.

Ms. Boone, why don't you begin for us.

Ms. BOONE. I would be glad to.

**STATEMENTS OF LINDA BOONE, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS; ACCOMPANIED BY TIM CANTWELL, JR., PRESIDENT, WESTSIDE RESIDENCE HALL; COL. CHARLES WILLIAMS, USA (RET), EXECUTIVE DIRECTOR, MARYLAND CENTER FOR VETERANS EDUCATION AND TRAINING, INCORPORATED; AND TONI REINIS, EXECUTIVE DIRECTOR, NEW DIRECTIONS, INCORPORATED; ACCOMPANIED BY JOHN KEAVENEY, CHIEF OPERATING OFFICER, NEW DIRECTIONS, INCORPORATED; AND LORIN LINDNER, Ph.D, MPH, PROGRAM DIRECTOR, NEW DIRECTIONS, INCORPORATED**

## STATEMENT OF LINDA BOONE

Ms. BOONE. Mr. Chairman, on behalf of the National Coalition for Homeless Veterans, I thank you for the opportunity to present our 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. That is approximately 275,000 men and women who have worn this country's uniforms, been trained at great expense in many of the most advanced technical skills, stood guard over all that we hold sacred and dear, and in some cases incurred physical and psychological injuries.

We have all heard the stories of their descent into homelessness. In many cases the reasons could befall any of us. Some have problems associated with their military experience. Fortunately there are organizations dedicated to helping veterans break the cycle of homelessness. The National Coalition for Homeless Veterans is a coalition of community-based service providers in 43 states and the District of Columbia dedicated to ending homelessness among veterans.

NCHV believes that the need for supportive housing is accelerating as a result of the shift of delivery of health care services by the Department of Veterans Affairs from inpatient to outpatient models of service delivery. The outpatient delivery of neuropsychiatric care, including substance abuse treatment, treatment for post-traumatic stress disorder and other psychiatric services, becomes a real problem for veterans who do not have safe, clean, sober housing.

For most community-based organizations there are three primary resources available for housing to serve homeless veterans, the Department of Veterans Affairs Homeless Grant Per Diem program, the HUD Continuum of Care Grants and the government surplus property. NCHV believes that the VA Homeless Providers Grant Per Diem program needs to be put on a line-item basis with funding by Congress at a level of at least $50 million per year. Currently the amount allocated to this program is an internal decision within the Department of Veterans Affairs.

NCHV also requests removing matching requirements for the per diem portion of the grant and just allow $16 per day per veteran for cost of services provided. The current rate of payment is maximum of 50 percent, $16 per day, and the provider must come up with matching funds, or by adding approval to allow for in-kind donations value to be counted toward the match requirements if match requirement remains. And remove the cap for van purchases. With the increased closure and consolidation of Department

of Veterans Affairs services, vans can provide a valuable link to services for homeless veterans.

Members of the National Coalition for Homeless Veterans expressed frustration about not being able to access HUD's continuum of care funds. Three percent of the total homeless dollars go to veteran-specific programs while veterans are 35 percent of the homeless population. Members cited as the leading reason veteran-specific programs are frequently blocked from inclusion in the local continuum process is that many community-based groups believe the myth that the Department of Veterans Affairs takes care of all homeless veterans.

NCHV strongly recommends that funding be increased to veteran-specific programs in a manner that more reflects the local veteran homeless population needs. These needs should be identified through the Department of Veterans Affairs challenge process that involves providers and advocates in the assessment and service implementation plan. We also want technical assistance to be made available specifically for homeless veteran providers so they can be competitive in their grant proposals.

Under consideration in the Senate is S. 1076 that contains a provision for temporary flexibility processes for disposing of VA property. We have also heard the House is considering a similar proposal. NCHV is concerned about the impact on homeless veteran providers if this provision is passed. Currently surplus property has to be offered to homeless providers before it can be disposed of. Several of our member organizations have acquired property in this manner and are currently running successful programs for homeless and homeless veterans. With surplus they obtain, organizations can leverage the property value to get rehabilitation done, obtain grants, loans and in-kind.

This legislation sends 10 percent of the profits of the property sales to HUD homeless programs. HUD currently underfunds veteran-specific programs now. This means homeless veteran-specific organizations would suffer more under this bill as it is currently written.

The Department of Labor's HVRP program, the Homeless Veterans Reintegration Programs, works with veterans who have special needs and who are shunned by other programs and services, veterans who have hit the very bottom. These veterans require more time-consuming specialized, intensive assessment, referrals and counseling than is possible in other programs that work with other veterans seeking employment. HVRP is virtually the only program that focuses on employment of veterans who are homeless.

Since other sources of funding such as JTPA, that served only 2,052 homeless veterans in fiscal year 1995, that should be available to our member organizations to fund activities that result in gainful employment are not generally available, HVRP takes on an importance far beyond the very small dollar amounts involved. HVRP is an extraordinarily cost-efficient program with a cost per placement of less than $1,500 per veteran entering employment. It is critical that HVRP get appropriated at the amounts proposed in the reauthorization bill.

Mr. Chairman, the National Coalition for Homeless Veterans thanks you and this committee for the opportunity to present our

views on the above matters to you and your distinguished colleagues. Thank you.

[The prepared statement of Ms. Boone appears on p. 57.]

Mr. EVERETT. Thank you very much. Ms. Reinis.

## STATEMENT OF TONI REINIS

Ms. REINIS. My name is Toni Reinis, Executive Director of New Directions, and I thank you very much, Mr. Chairman, Lane Evans, and Ms. Brown, for the invitation and allowing us to speak today.

Los Angeles County has an inordinately large number of homeless men and women. The current figure is as high as 83,000 on any given night. According to the Los Angeles Homeless Services Authority, homeless veterans account for 36 percent of this population, and in some areas it is as high as 40 percent. It is a difficult population known to be the most service resistant of the dispossessed. Years of physical deterioration, psychological problems and undiagnosed post-traumatic stress disorder have increased the need for comprehensive services to this population.

There is a dramatic shortage of substance abuse beds in Los Angeles County. Waiting lists can be as long as 3 to 6 months, and most substance abuse beds are short term and are ineffectual. Years of destructive behavior cannot be cured in 30 to 90 days. Therefore, clients are likely to relapse, creating further costs to society and harm to the individual.

New Directions program is designed to stop the revolving door in which so many homeless veterans are trapped. By providing comprehensive, long-term services in a single location, New Directions helps to ensure that veterans who complete substance abuse programs can go on to become employed at a liveable wage and no longer will be a burden to society. One study has shown that for every one dollar spent on drug treatment there is a four to seven dollar cost savings to society.

The most unique aspect of New Directions is the vocational training program. On-site businesses give the veteran an opportunity to work in a controlled environment and earn money for the transition back to the community. When job training has been completed, the process of job search, interviews and placement can begin. The physical, mental, spiritual and emotional transformation from detoxification to job placement is often quite dramatic.

I have several recommendations based on the Grant Per Diem program. One of my suggestions is that the per diem payment of $16 a day has been an invaluable addition to our budget. However, there should be a range of payments based on a range of services offered to the veteran. Comprehensive services presently receive the same $16 payment as those whose programs provide a bed and food. Although New Directions appreciates the per diem payments having no time limits, when a resident begins to earn a paycheck as a full-time employee, the per diem payment ought to end. Agencies who charge $250 to $350 for rent should not also be eligible for a per diem payment. If the rent does not cover the additional case management, funding through an RFP process ought to be made available for staff salaries. This would be far more cost effective and accountable.

There is a critical need for programs like New Directions that address the needs of veterans with both substance abuse problems and severe and persistent mental illness. It is a population that cannot advocate for themselves, and currently there are few programs that can or will accept dually diagnosed homeless veterans. New Directions recommends that Congress direct funding specifically for services for dual diagnosis programs.

Also New Directions has identified an increasing population of aging veterans who can work part time or occasionally. However, their incomes are not sufficient to rent or maintain housing. Housing subsidies in the form of Section 8 type certificates and affordable housing for seniors is a growing need in our community.

New Directions suggests that Congress appropriate funding for research. This in no way should be taken away from funding that needs to move veterans from homelessness to self sufficiency.

It is hoped the funding for empirical studies would include payments to graduates of the program to come back at 1-year intervals to be evaluated on a number of measures, including sobriety, housing, employment, and social community supports. If funding could include $50 per graduate with an average range of 50 graduates per year, over a 3-year period the cost would only be $7,500 plus another $20,000 to $30,000 for hiring of additional staff to perform these evaluations. It would be helpful to explore the characteristics that make these graduates successful.

In conclusion, on Veterans Day of 1991 the National Coalition for the Homeless released a study entitled "Heroes Today Homeless Tomorrow; Homelessness Among Veterans in the United States." Although many of these issues were highlighted in the report to be critical issues, nearly a decade later they continue to be critical issues. However, there have been significant changes within the Veterans' Administration and HUD on how to address homeless issues.

In West L.A. there is no longer a need to discharge veterans from the hospital to the streets. Creating relationships with community-based organizations has given VA staff a range of housing and service options that did not exist a decade ago. The expensive 30-day revolving door substance abuse programs at the VA have been replaced, thanks to HUD, to long-term comprehensive services and a continuum of care. Veterans can remain in the program for a year or two, address their medical, emotional, legal, educational and economic issues and eventually become self sufficient.

A minimum wage continues to be insufficient to cover housing costs, transportation, jobs, food, clothing and medical care. The issue of illegal drugs has become a multi-billion dollar drain with a disgracefully small amount of funding going to substance abuse.

New Directions continues to search for solutions and looks forward to working with the VA, HUD and the committee to end homelessness in America. Thank you very much for allowing us to testify.

[The prepared statement of Ms. Reinis appears on p. 66.]

Mr. EVERETT. Thank you very much. And I know you had to rush through that, but as I said earlier, all your complete testimony will be here in the record. And we do have the advance written testimony.

Ms. REINIS. Thank you.

Mr. EVERETT. Colonel Williams, we are glad to have you here today. If you would please continue.

## STATEMENT OF COL. CHARLES WILLIAMS

Colonel WILLIAMS. Mr. Chairman, members of the subcommittee, my name is Colonel Charles William, U.S. Army Retired. I am the Executive Director of Maryland Center for Veterans Education and Training, commonly referred to simply as MCVET.

MCVET is a 5-year-old nonprofit organization dedicated to providing homeless veterans, and other veterans in need, with comprehensive services that will enable them to rejoin their communities as productive citizens. MCVET operates a military structured facility. We reintroduce veterans to the military style of discipline that they are already attuned to through their services. The reawakening of the routine military discipline enhances MCVET's ability to stabilize and reorder the lives of these veterans. Each resident is required to attend substance abuse classes and alcohol/narcotic anonymous meetings and work in conjunction with a case manager in the development of an individual service strategy plan, which is a long-range plan used as a tool in remaining drug and alcohol free.

There is zero tolerance for current substance abuse, bad attitudes and bad adjectives. We have instituted the platoon system which utilizes more responsible residents in leadership positions. This is an accountability system in which residents are accountable to each other, their platoon leaders and their fellow platoon people. Peer pressure promotes responsibility for action taken. This system provides order and structure to a group of people whose lives have become unmanageable and unstructured.

MCVET provides veterans in need with an array of services to include day drop-in, emergency, transitional and permanent housing; counseling and housing placement; substance abuse counseling; assistance for physical and mental health issues, including PTSD, job training and placement and education.

The MCVET experience began with the emergency program. This program is not one where a veteran enters in the evening and leaves the next morning. This program requires a 13-week commitment on the part of the veteran. During this time, barriers to recovery are addressed. Issues such as debts, courts, child support, types of discharges, physical, mental issues are addressed. After these issues are considered, veterans are moved to the next level, which is transitional housing where job training and job placement is effected. They can remain in the transitional housing for 2 years before moving on to permanent housing.

MCVET owes its very existence to the federal grants to community-based organizations. We have uniquely married the housing service available from HUD, the medical and social service support available from the Veterans' Administration and the job training education service available from the Department of Labor in order to move homeless veterans into the mainstream as self-supporting, contributing members to their families and to their communities. MCVET has also used grants from FEMA to supplement food costs.

MCVET has received the following federal grants from HUD, Emergency Shelter Grant, $227,000; in 1994 Supportive Housing for over a 5-year period of $7 million; in 1994 Section 8 MOD Rehab SRO for a 10-year period of $3.7 million; from VA in 1994 Building Renovation of $2 million, and we participate in the Grant Per Diem program both in the SRO and in the transitional housing. From the Department of Labor in 1997, a JTPA Title IV-C Fund, we received $78,000.

MCVET used these grants to transform the shelter of an old cup factory and a former house for boys that had been closed for about 50 years into a modern facility comprising approximately 90,000 square feet. This facility programmatically houses a complete continuum of care consisting of a 50-capacity day drop center, 50 emergency bed program, 120 transitional housing program, 80 single-room apartments, complete kitchen, health clinic, learning center, gymnasium and classroom. Thus, a veteran can go from homelessness to permanent housing within the same program while maintaining continuity of counseling and support.

I would be remiss if I did not point out the homeless veteran contribution to the remodeling effort. They laid the tile. They did all the painting and some plumbing and electrical work to enable MCVET to stay within the funding limits. To date the facility can accommodate approximately 300 veterans daily. The $78,000 from the Department of Labor in 1997 enabled MCVET to place 67 residents in colleges and formal training programs.

The federal grants enable MCVET to effectively reorder the lives of that segment of our population who have given a full measure of their bodies and soul to the call of their country. While I cannot say that we have success with every veteran in need that walks through our door, I can say that seven out of every ten veterans that stays with the program for more than 30 days are returned to their families and communities with renewed hope, meaningful jobs that are paying an average salary of $25,000.

On 7 May 1997, HUD declared the program as a national model. To date approximately 1,500 veterans have been associated with the program. Last year alone 15 veterans enrolled in college or formal training, 164 residents registered with job services, 104 residents obtained full-time jobs with a living wage and benefit, 72 residents obtained permanent housing.

In closing, I would like to thank you for the opportunity to share MCVET's story. Homeless veterans are likely to face greater challenges in years ahead as the result of scarce resources that already strain an overburdened service delivery system. I urge you in your deliberation to consider the plight of these young men and women who joined the military service before they can vote or belly up to the bar. They are trained on weapons of mass destruction and sent to defend the ideas of this country. Many of them return home broken of body, mind and soul. This country needs to provide them with a hand up, not a handout, so they can share in the great American dream. I urge you to enhance the grant, the federal grant to community-based organizations.

[The prepared statement of Colonel Williams appears on p. 76.]

Mr. EVERETT. Thank you very much, Colonel. Mr. Cantwell.

## STATEMENT OF TIM CANTWELL

Mr. CANTWELL. My name is Tim Cantwell. I am part of the leadership team of L.A. Vets, a public/private partnership organized to create the conditions for the successful reintegration of the most number of homeless veterans to their highest level of independence as rapidly as possible. It is a venture between Westside Residence Hall, Inc., of which I am president, a development company formed for the purposes of delivering, organizing, financing and managing transitional housing for homeless veterans, and the Los Angeles Veterans' Initiative, a 501(c)(3) service provider intended to manage program development and delivery support of services for those veterans.

Much has transpired since the early 1990s in terms of addressing the needs of homeless veterans in this country. Today I would like to reflect on that a moment, establish the significance of the community-based care provider network in meetings those needs of homeless veterans, take a look at the complexities associated with accessing federal funds, the management and maintenance of servicing those federal funds, the need for program evaluation models, and if we have time, maybe a look at where all this could go.

Tremendous strides have been made. The committee needs to be commended. The VA needs to be commended, and the community-based organizations needs to be commended for having stepped up to the plate. VA has come to recognize not uniformly, but the culture has changed dramatically to recognize the validity and wisdom of partnering with community-based organizations. Likewise, community-based organizations have come to recognize the wisdom of partnering with the VA.

For our own part, in Los Angeles we are part of a continuum of care that includes New Directions, includes Salvation Army, the West L.A. VA Medical Center, several shelter care systems in the skid row area and in the valley of San Fernando and San Gabriel. We currently have provided 460,000 nights of stay since 1993 for homeless veterans. Our resource center serves 300 veterans a week. We are placing veterans in jobs at an annualized rate of 500 a year. The Food service operation delivers 25,000 meals per month. And the outreach efforts through our AmeriCorps funded activities across the country have outreached to 20,000 homeless in the last year, 11,000 of which are veterans.

The community-based organization has arrived. What L.A. Vets is doing is a small part of the entire CBO assisted continuum in Los Angeles. What Los Angeles CBOs are doing is a small part of what the CBO system is doing across the country. To illustrate that point for you, if you roll up the aggregate number of beds available through the Health Care for Homeless Veteran Domiciliary program, the VASH program and the transitional residents attached to CWT in VA across the country, according to the 1997 results in the GAO report there were 3,122 beds. If you simply add up the beds currently in service and under construction in California and Wisconsin together with the first of round of per diem providers currently delivering beds underneath the Grant Per Diem program—put those three components together, and you'll see in excess of 3,000 beds delivered by CBO's—indeed the CBO system has arrived. It is delivering, and as such needs to be recognized as

an integral player partner in the service delivery system for veterans.

The access of funds, something I call *managing the complexity gap* is the process necessary to string together a sensible array of services is a very complex matter. The providers you are hearing from today have solved that riddle for the most part. We all still struggle with it. Many CBOs across the country still struggle with getting accessing the resources available federally. The consolidated plan boundaries which govern the distribution of HUD funds routinely follow lines that do not match up or align at all with the VA hospital catchment areas, much less VISNs areas as the VA moves toward VISN-wide service lines. Again, those consolidated plan boundaries do not match up.

In order to put on a good array of services comprehensively for a veteran, you end up needing to compete in multiple concurrent consolidated plan activities. Not impossible to do. It can be done. Los Angeles Veterans Initiative, Inc. currently is funded through five different consolidated plan boundaries in the greater L.A. area alone. We should probably be in eight in order to completely service the veteran community. I am sure that Salvation Army and New Directions would second that difficulty. Not impossible, doable, but to get there we've needed to make an investment in management and resources to get at the table in those different jurisdictions.

Secondly, once you access those funds the servicing requirements to maintain the relationship from a financial reporting perspective to that funding agency requires a high standard of financial management. Many CBOs struggle with getting the resources to do that completely and appropriately.

The notion of developing an R&D program or program evaluation models are worthy objectives. We would second what you have heard from New Directions. We would second what the GAO said, but we would argue that any evaluation proces needs to be focused on delivering a constant current feedback mechanism to program managers so that in addition to getting long-term evaluation studies we get current information to fine tune programs, enhance the ones that are working well, change the ones that are not, all around managing prudently for the highest rate of return for the invested dollar.

In Los Angeles we can demonstrate absolutely the reduction in inpatient stay days as a result of engaging in transitional Housing at Westside Residence Hall. We can't express exactly what cost savings results, but we know what the reduction in inpatient stay days are when you have intervention strategies like you are hearing from various providers today. We know that dead nut. We can prove it. Most agencies can describe a rate of return on the public balance sheet from income taxes and payroll taxes generated from what you have already heard today. It is not hard to know that these are good things to do.

It is in the system's best interest to invest substantially in modeling and building the capacity for a thinly capitalized community-based provider network. The system must foster the development of research and program evaluation models that can help us collectively manage this process in a way that strives to eliminate homelessness among veterans. A properly constructed R&D program

evaluation could provide the template for the entire country's struggle with high barrier populations.

I am convinced if we stay focused collectively on this effort, solving this issue with veterans will show the way for the rest of the country. Thank you.

[The prepared statement of Mr. Cantwell appears on p. 82.]

Mr. EVERETT. Mr. Cantwell, you are listed as the president of Westside Residence Hall on my sheet here, and I looked down and saw L.A. Vets and I naturally assumed that was Lower Alabama.

Mr. CANTWELL. Naturally.

Mr. EVERETT. Let us start with you, if you don't mind. And this question is for each of you. How do you each define successful outcomes in your individual programs?

Mr. CANTWELL. Well, that depends on the conditions of the veteran when he comes into the facility. Our facility has intervention at the point in time that someone is exiting primary residential treatment for substance abuse or intervention for psychiatric needs. So we look at a measurement that for 75 percent of the population concentrates on obtaining employment, retaining that employment and hitting what we call bench marks, which are conditions precedent, we believe, to increasing the probability for maintaining themselves independently from the means of their own appropriate production. Now for about 75 percent of the vets, that means competitive employment.

I would again second what you have already heard today, that there is a good strong 25 percent out there for whom competitive employment is not a realistic expectation. And the outcome measurement would be different. It probably means independent living organized and managed by themselves through an appropriate funding stream or activity and maintaining sobriety in that setting, functioning and reintegrating to the highest possible level possible for them given what their set of barriers are.

So it will vary, but on the main it is around employment, holding employment. For a substance abuser, relapse prevention, maintaining their sobriety. For a veteran who has dependent children, it would mean making an appropriate adjustment for child support payments. For a veteran that has legal issues, it means fully addressing those legal issues, bringing them out on the table, facing it. For a veteran for whom reintegration with the family is appropriate, developing the parenting skills, making the appropriate rappproachment to the family system. That may not mean raising your hand and saying hey, daddy is back. It depends on how long you have been out of the picture. But appropriate acceptance of responsibility funded by an appropriate means.

Mr. EVERETT. I was not going to put words in your mouth, but in a word, responsibility?

Mr. CANTWELL. Absolutely. And I think that we all come to recognize that the best thing that we can do for someone is allow them the dignity for taking responsibility for themselves.

Mr. EVERETT. Colonel Williams?

Colonel WILLIAMS. I would define success as taking a veteran from underneath the bridges, out of the woods, out of the camps that they have set up to protect themselves because of their issues, return them to their communities as productive citizens with jobs.

And I am not talking about turning hamburgers at McDonalds. If the veteran goes to McDonalds he should be the manager.

Mr. EVERETT. Ms. Boone.

Ms. BOONE. We are not a direct service provider, so I will let my colleagues do that.

Mr. EVERETT. Okay.

Ms. REINIS. I would like to introduce my colleagues that are with me today. This is John Keaveney. He is the COO and founder of New Directions, and Dr. Lorin Lindner, who is our Program Director. We also have with us Mike Gould, who works with our Vocational Training Program. And I would like to refer this to——

Mr. KEAVENEY. Hold on. Let me just say something. First of all, thank you for allowing me to be here today, Mr. Cantwell eloquently explained success. The veterans we deal with primarily have a second diagnosis and are substance abusers. In our program sobriety is the number one way we determine success, secondly being productive and a positive lifestyle and fundamentally staying out of the legal problems. But we have found in recovery that to get to 100 percent lifestyle sobriety usually takes a lot of relapses. It doesn't happen overnight. It can be heart rendering, but what the Colonel said is that, you know, our ideal is to put the commitment forth to our Nation's veterans, whether homeless or substance abusers or formerly incarcerated. And sometimes the success can be the fact that someone has gotten 90 days sober for the first time in 12, 13 years. And the light went on.

Mr. EVERETT. It has a habit of doing that.

Mr. KEAVENEY. I forgot what I said and was going to say.

Mr. EVERETT. I see my time is up, and I now recognize my ranking member, Ms. Brown.

Ms. BROWN. Thank you. I just want to really thank you all. You all are an example of where the rubber meets the road. You know, I know the Federal Government can't do it all, and we really need these community partnerships.

Colonel Williams, I was very impressed with your testimony. How many veterans do you say that you all are serving?

Colonel WILLIAMS. We have the capability to serve approximately 300 veterans a day.

Ms. BROWN. Three hundred a day?

Colonel WILLIAMS. Yes, and since we have been operating for 5 years, there have been about 1,500 veterans that have been associated with the program. I invite you all to come to our program. It is right up in Baltimore.

Ms. BROWN. It is not far, and I am thinking about it.

Mr. Cantwell, would you tell me—I thought I heard you say that you all are providing beds to the veterans cheaper than the HUD partnerships?

Mr. CANTWELL. I don't remember making that point but we can certainly build a case that our system of delivery is extra ordinarilly efficient. We have provided since 1993, when we opened our doors, transitional housing for roughly 2,000 veterans. We can express a unit cost of delivery a variety of ways. If we were to examine the cost of delivery for the entry level residential job program (VIP) in terms of job created, the housing, the food, the case

management, the job development, the placement, works out to about $3,300 per job obtained.

Often when we try to penetrate a new community, which is easier said than done, beyond the nimbiasm that you hear about, there is a bias in most consolidated plans, which is how the HUD funding streams get out there, is for homeless women and children services. It is very difficult to argue to get a piece of support services money when the perceived outcome is to take it away from a women and children program.

But one of the ways we have been able to effectively compete is to characterize the activity not as a housing for homeless activity but an economic development activity that is going to have as its outcome income stream to the local community in the form of payroll taxes and income taxes. Positioning the activity in this way has allowed us to get into the eight different consolidated plan areas that we are now or will soon be operating in.

I would say that without question the community-based delivery system, whichever paradigm you look at, is a fraction of the cost of any paradigm that a direct federal agency can hope to undertake. Now that is not to say at all that we would argue to reduce the activities that the VA is involved in. Not at all. We would just simply ask that you make—you recognize the CBO system for what it is and make a cognitive choice to make an investment in the capacity building of the CBO system. The National Coalition for Homeless Veterans represents it. For example, NCHV could roll it all up. NCHV is in the process of doing that survey right now. It is going to blow your mind. Tens of thousands of homeless veterans are being served every single day. And it is being done with eye drops of money.

Ms. BROWN. Thank you.

Mr. CANTWELL. You bet. I can go on but I won't.

Mr. EVERETT. We have joining our committee Mr. Hill. Mr. Hill, any questions you may have for this panel?

Mr. HILL. Thank you, Mr. Chairman. The task before the agencies that have appeared before us today is complex and must be performed with too few resources against what may be an uphill tide. Your testimony shows that many homeless veterans have serious mental illnesses. Could you elaborate on that?

Mr. CANTWELL. Are you looking at me?

Mr. HILL. Anybody, any member of the panel.

Dr. LINDNER. I would like to comment on that. Thank you. It is true that a majority of homeless veterans that we are seeing do have secondary—primary and secondary diagnoses. And very often in addition to substance abuse you see what we call access two disorders, which are personality disorders, but in addition you have longstanding depression as well as untreated—often untreated post-traumatic stress disorders. And as Toni Reinis mentioned earlier, you also have what is called the dually diagnosed, people who have severe mental illness in addition to substance abuse problems. Those make it—those problems make it especially difficult to treat this population.

Mr. CANTWELL. I would like to jump in on that, as well, and echo that statement and also let you know that housing intervention in a community-based setting has a huge positive impact on the lives

of these individuals however you measure it. And one way to measure it is to examine the reduction in utilization of the inpatient care system for psych beds in the VA medical center. In one 1-year period of time there was a reduction of psych bed usage from 11,059 nights of stay to 2,446 nights of stay in a year after the housing intervention. That is big-time substantial quality of life improvement for the veterans.

It is in the mission of the VA to care for veterans regardless of housing status or income status. And the fact of the matter is there can be tremendous quality of life improvement if you measured it from no other perspective than their reduction on the dependency of the hospital system.

Mr. KEAVENEY. And also, if you don't mind me saying this, $1,100 a day to keep a patient, a veteran in a psych bed, based on the per diem rate of $15 a day and whatever fund they may put together to bring about the services, is a major savings to the taxpayer.

Mr. CANTWELL. From a community-based perspective, for us to collectively respond to that, we have got to go in and noodle it out with HUD. We have got to go in and noodle it out with DOL. We have to noodle it out for non-SHP funded programs and we have to noodle it out with the VA. The CBO system can strategically participate in reducing the cost of care for veterans and improve its quality. And it is happening every day. And it is a very exciting thing. And, please, from my perspective we are not banging on the VA. I think a whole bunch of good stuff has happened.

Dr. LINDNER. And just adding on to that, the VA told me recently that since 1993 they have been able to reduce their inpatient beds from 1,500 to 400 at the West L.A. VA Medical Center. But I have to add that it is critically important to also provide substance abuse treatment for people who need that before you move them on to anything. And one of the things that makes New Directions unique is our vocational training program, because of course, as you know, getting people back to work is a critical component of recovery in ending homelessness and addiction.

Mr. CANTWELL. And it is a real problem across the country as the inpatient substance abuse beds have been shut down. There is not a concommitant provision made for replacing those beds in every jurisdiction. I think because of the work that New Directions and the Salvation Army are doing in Los Angeles on residential treatment pieces, we are seeing some meaningful response to the inpatient shuttering. But that is not uniform across the system. In many VA hospital catchment areas beds are already shut down and the cost for operating have already been reallocated. It is hard to demonstrate why it would be sensible to support an activity that would provide those treatment beds but cost the hospital new dollars.

It can be done. It is being done in a number of VISNs, being done in a number of hospitals. At the Long Beach Naval Station (to be known as Villages at Cabrillo) facility that will be open—it is under construction now and will be open in November, the staging of the shutdown of a 42-bed inpatient program has been aligned with the coming on line of what will be 500 beds of equivalent outpatient space at the villages. Now that is a happy outcome where VA stra-

tegic planning went together with CBO Resource development. The system has got a dilemma in matching up that strategic planning and CBO Resource development jurisdiction by jurisdiction.

Colonel WILLIAMS. MCVET has utilized the services of 12 different VA medical centers. We send our veterans to the appropriate center that can treat the veterans' issues. If the hospital are located in Delaware, West Virginia, Washington, or Richmond, that's where we send them. The Director of Baltimore VA Health Care System is on MCVET Board. This has helped us a lot.

Mr. EVERETT. The chair would now yield to Ms. Brown for additional questions.

Ms. BROWN. Yes, Dr. Lindner, I think, how much do serious mental illness and substance abuse overlap?

Dr. LINDNER. Well, if you actually look at diagnostic criteria, substance abuse is considered a mental disorder. And it certainly needs to be treated before you move on to any other issue. If you are looking at more severe mental illness, there is also quite an overlap. And the use of drugs actually precipitates relapses perpetually in this population. And that is why it is of utmost importance to first treat the substance abuse and then also provide services for the mental illness. You have to be able to treat both of those.

Ms. BROWN. Just a follow-up question. Does your experience suggest a connection to military services?

Dr. LINDNER. I am sorry, can you repeat that?

Ms. BROWN. Does your experience suggest a connection to military services?

Dr. LINDNER. We have certainly seen a connection that people use, begin using in the military sort of as an anesthetic to the pain and to the despair that they see during war time, but very often we are also seeing people who have substance abuse problems particularly before they even enter the military.

Ms. BROWN. Thank you. Anyone else want to respond to that?

Mr. CANTWELL. Go ahead.

Colonel WILLIAMS. Yes, because there maybe a misconception that there is no stress on young men entering military services during peace time, this is not true. I know that you are aware of the fact that bodies of our soldiers are being shipped home from peace time missions frequently. We had a young man in our program whose issues began with being stationed in a submarine 1,200 feet below the Mediterranean Sea and came to port every 30 days for R&R. This is not the normal thing that young men do. Even though there may not be a war, peace time commitment put a lot of pressure on our young men.

Mr. CANTWELL. I think we would say that essentially the same, that predating the homelessness was the loss of a job, predating the loss of the job was substance abuse. The substance abuse may very well have already been in play prior to the military experience. If not, it was certainly fully introduced by then. And it is simply a self medication piece that is designed to deal with what—when you get all the way down to it, the family of origin issues that are very complex to address. And before you can get there, you have got to get by the substance abuse. You need to have some sort of a stable environment that is cost efficient for someone to be in over a long period of time and then develop the treatment pieces

to get at the family of origin issues that created the problem in the first place, often exacerbated by the military experience.

Mr. KEAVENEY. I would like to just say something. Congresswoman Brown, you most eloquently drew the conclusion that in this country there is an equivalence of 13 infantry divisions. Wise men and theologians for countless centuries have been talking about the adverse effects of military service and war upon the human spirit. If there is the equivalent of 13 infantry divisions homeless and they are veterans, I think we can pretty much say that there really is some kind of problem.

Mr. CANTWELL. You bet.

Mr. KEAVENEY. Thank you for letting us speak here today. I really appreciate it.

Ms. BROWN. Once again—did you want to respond?

Ms. REINIS. I will leave these with you, but these are some stories that were in the *Los Angeles Times* of several individuals that are in New Directions presently or are graduates of. Their stories are really quite compelling, and I think you can see that we have both the situation of people having used drugs and alcohol starting at very young ages and those that, as John mentioned or Lorin mentioned, that began in military service. We also have a CD that will be in the office. I hope that you will be able to see it. There are just 3-minute clips. We are going to actually start a national website, a virtual museum for veterans that will tell these incredible stories of veterans before, after and during their recovery.

So I hope not only will you come to visit our program, I would love to entertain you in Los Angeles, but be able to have you meet these veterans who have really come back from adversities. Thank you.

Ms. BROWN. Thank you, again. And you are going to probably get your wish, because I am planning on coming to L.A. very soon.

Ms. REINIS. And we are looking forward to it.

Ms. BROWN. I would like to look at your program.

Mr. EVERETT. Thank you. I can't express enough to you how the committee feels about the written testimony that you have given us and the testimony that you have given us this morning. You certainly have a wealth of knowledge that is doing a great deal for our homeless veterans, and we appreciate your testimony and your appearance here today. We certainly are impressed with the community-based operations that you represent. I can tell you that. So thank you very much. And we will have additional questions. We could keep you here all day, frankly, but we do have a long list of panels. And we will have some additional questions that we will submit to you and ask you to submit answers for the record. Thank you very much.

Mr. CANTWELL. Thank you.

Ms. REINIS. Thank you.

Mr. EVERETT. I would like to now recognize Mr. Roosevelt Thompson, Account Associate for Xerox Business Services, Xerox Corporation. And, Mr. Thompson, if you will be seated, please introduce your panel. If you would now introduce the rest of your panel and then just proceed with your testimony when you get ready.

## STATEMENTS OF ROOSEVELT THOMPSON, JR., ACCOUNT ASSOCIATE, XEROX BUSINESS SERVICES, XEROX CORPORATION; ACCOMPANIED BY MICHELE CAHN, MANAGER OF EXTERNAL AFFAIRS, XEROX CORPORATION; AND CHARLES A. JAMES, JR., MANAGER, BUSINESS DEVELOPMENT PRIVATE SECTOR, XEROX BUSINESS SERVICES, XEROX CORPORATION

### STATEMENT OF ROOSEVELT THOMPSON, JR.

Mr. THOMPSON. Mr. Chairman and members of the committee, I want to thank you for allowing me the opportunity to address you today. I am accompanied by Michele Cahn, who is the Manager of External Affairs for Xerox Corporation and Charles A. James, Jr., the Manager of Business Development for the Private Sector of Xerox Business Services, Xerox Corporation.

I was a little nervous for about a week before I came to this hearing, as I am sure you can understand, but when I read that Chairman Everett was an Air Force veteran like myself, I knew I was in well hands.

Mr. EVERETT. We in the blue stick together.

Mr. THOMPSON. Yes, we do. Absolutely.

Mr. EVERETT. Mr. Thompson, I am going to ask Ms. Brown to take the Chair for a moment. I have an urgent telephone call I need to make, but I will be back in just a couple of minutes. And I have already read your testimony. I must say I am very impressed with it.

Mr. THOMPSON. Thank you, sir.

Mr. EVERETT. But if Ms. Brown would take the Chair now, I will be back as soon as I make this telephone call.

Mr. BROWN (presiding). And you can still be comfortable with me.

Mr. THOMPSON. Absolutely, absolutely. My name is Roosevelt Thompson. I am a Senior System Account Associate with the Xerox Corporation in the XBS division, Xerox Business Services. As my story will highlight, government programs do work and they have worked for me. Therefore, I hope my testimony today will help Congress understand what programs work. I have been the beneficiary of such programs, and I believe they can help others like myself.

I am a native Washingtonian, born and raised in a family of five. At age 19 I enlisted in the Air Force, was sent to Germany, where I was stationed for 2½ years. And very soon after that, I volunteered to go to Vietnam. I served proudly for 1 year until I was given an honorable discharge and sent back home. Vietnam changed me like it changed so many other men my age at that time. I could not fathom some of the sights that I saw, and hence I developed a substance abuse problem while serving that I brought back home with me.

Although I was using substances, I still felt that I was functional. I had a job. I appeared to be managing my life. But soon I felt lacking in focus and moved out of DC to Oakland, California. I lived in Oakland for 11 years until the same feelings that had propelled me to leave out of Washington sent me running back. I didn't realize then that wherever I go I had to take me along with me.

I brought my substance abuse problem back from California. However, despite my problems I was offered a good job at a junior

high school. I enjoyed my job and was liked by many of the students. However, I was in a downward spiral. I was not coming to work on time if I came in at all. Therefore, in 1988 I was asked to resign. I did not work again until 1996.

During this time I lived with my parents in my parents' house, who had passed. However, soon it was sold and the money that was divided among my brothers and sisters and myself, I got me an apartment. But still having the substance abuse problem that I had, the money went to drugs and entertainment. And as you know, if you don't pay your rent you are going to end up out on the street. Hence, I ended up out on the street homeless.

Between 1990 and 1995 I lived on the streets and in shelters. I had lost everything, my self respect, my self esteem. But on December 5, 1995, all this changed when I asked God for help. And as a consequence, my life began to turn around. I had been very ill on that day, December 5, and I called my brother for help. My brother took me to the Community Center for Non-Violence Shelter in Northwest Washington, D.C., where I received medical attention. I was diagnosed with pneumonia in both lungs, a condition I found out later had been known to kill. I hit rock bottom.

CCNV programs placed me upon the path that allowed me my first steps toward reentering society. Their veterans' counselor told me about an outpatient program called SARP, Substance Abuse Rehabilitation Program, at the Veterans Affairs Hospital. My saving grace at that time came from the fact that I could live at CCNV while participating fully in the SARP outreach program. I can say that I have been substance free since that day late in 1995 when my brother took me to CCNV. However, in my opinion I went to an outreach program but an inpatient program would have been, in fact, more successful. But that program had stopped because of lack of funding.

After my successful participation in SARP, I was referred to the Compensated Work Therapy Program, called CWT, associated with the VA Medical Center. And I was placed in a job in a copy center. At the same time, I moved out of the shelter and into a transitional home supported again by the VA department. To move into this home I had to assume several new responsibilities such as saving money, contributing money for my food and buying my own clothes. This arrangement was to last for 1 year to allow me to get into the job market again. I graduated from the program and began my relationship with Xerox.

My life had changed enormously over the year I worked at VA Hospital. I was getting independence, doing the job I truly enjoyed. I had regular contact with the VA social worker that helped me with my job readiness skills. It was in the copy center that I first encountered employees from Xerox. I quickly gained a reputation of being a hard worker and a dedicated employee.

Over the year that I worked, I met several Xerox employees and talked to them about the corporation. From my exposure, I began to gain respect and a liking for the organization, while at the same time individuals from the VA organization were beginning to approach Xerox representatives such as Chuck James, Business Development Manager, about hiring me as part of their new welfare to work initiative. I was introduced to Chuck James and he gave

me the assistance I needed at that time. In addition, Chuck has been what I call my mentor. He has been someone in my life who has really been there for me, walked me all the way through the process of reentering into the job market. And I love the brother for real.

Summed up, I just want to say we have talked about veterans today. I think me being here today is an honor, because we don't have to talk anymore. We can actually talk to a homeless veteran. Being a veteran, being a homeless veteran was a very difficult situation. But it is not a situation that could not change. Hence, I am an example of that.

I am only here today to be able to say that programs from the VA must continue. CWT program, SARP program, these programs must continue, because if they only help someone like myself, I think that is a good thing. So I can only hope that my testimony today could possibly in any way encourage you to look upon these programs as a positive thing. And I just want to say it has been an honor and a privilege to be able to be here today to speak to you. Thank you very much.

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

Ms. BROWN. Thank you, Mr. Thompson. Mr. James, you are recognized for 5 minutes.

## STATEMENT OF CHARLES JAMES, JR.

Mr. JAMES. Thank you. Good morning, my name is Chuck James. I am the Manager for Business Development for the Public Sector of Xerox Business Services. Thank you for the opportunity to deliver some brief remarks on behalf of Xerox. Also, I am going to add a few things as Roosevelt was a little modest in his comments about his contributions to the corporation.

Everyone at Xerox is very proud of Roosevelt's accomplishments. As a matter of fact, he was featured in the 1998 annual report. And it wasn't just because of where he had been, but it was the contributions that he has made on behalf of Xerox to our customers. He has been able to—his maturity has shown and he has been able to help us out well beyond the few dollars that we pay him.

I met Roosevelt over 3 years ago when I was working as the Xerox National Account Manager for the Department of Veterans Affairs. When I learned VA had a candidate they wanted me to meet, was graduating from the CWT program for an opportunity at Xerox, I had no idea it would eventually lead to Xerox establishing a corporate-wide program to identify, hire and train economically disadvantaged candidates for positions in Xerox Business Services, the fastest growing division within Xerox.

Within 3 months of hiring Roosevelt, Xerox Business Services, or XBS, promoted Roosevelt to a full-time status. And since then he has been promoted to a Senior Systems Account Associate at a high production legal site. In his present position, Mr. Thompson is responsible for operating high-speed laser printers. He works with a team of employees receiving and processing electronic documents, retrieving documents from various media and maintaining quality output. And we have other plans for him.

Xerox's experience working with VA and Roosevelt convinced Xerox to make a commitment to establishing a corporate-wide pro-

gram managed through XBS to identify and hire economically disadvantaged adults such as homeless veterans and welfare recipients. We have also employed veterans from the Washington-based CWT program to perform telemarketing tasks. XBS is in constant need of new employees to help grow our facilities management business across the United States. Our number one obstacle to even faster growth has been the ability to identify and hire enough entry-level qualified candidates.

One of our core principles is to behave responsibly as a corporate citizen. So when I was approached by the VA about hiring Mr. Thompson I was quick to respond. The hiring of Mr. Thompson and the subsequent development of the corporate-wide Xerox welfare to work program was instituted to meet a key business objective, insuring a quality supply of labor. Today Xerox has hired and placed over 250 economically disadvantaged adults in XBS with a retention rate of over 76 percent.

Unlike the Federal Government, we do not track the characteristics of our new hires who come through this program, so I cannot tell you how many veterans we have hired. But we do know we have men and women from all walks of life. Mr. Thompson happened to be the first. Today, since Mr. Thompson was hired, Xerox has learned some lessons and developed some best practices to insure every candidate, like Mr. Thompson, has a successful experience at Xerox, specifically extended community partnering. My close partnering with the local VA hospital led Roosevelt to Xerox.

We also make a special effort to work with over 100 community-based organizations from around the country to identify potential candidates who are job ready. We believe that as long as someone is job ready, understands the importance of coming to work on time, dressing appropriately, treating people with respect, then we can teach the skills necessary for a successful Xerox career. We also utilize the total quality management principles as an essential element of success.

Financial incentives, we have found, were not always a primary goal. Other benefits and support are equally important, access to the Xerox Federal Credit Union services for budget planning and bridge loans, setting up a checking account, also continuing education was very important. The participants motivation, attitude and desire to learn are key. Without these, it is unlikely any candidate will succeed. Mentoring was also very important. Everyone needs a mentor, and this is especially true for new hires that may not have had the experience in a large corporate culture. Mentors also provide career advice. Finally, continued proactive outreach to the community and participants is required.

In conclusion, Xerox is proud to be here today and believes the successful elements of this program can be applied to programs for veterans, welfare recipients or any candidate category of disadvantaged adults. Thank you very much, and we would be more than happy to answer any questions.

[The prepared statement of Mr. James appears on p. 94.]

Mr. EVERETT (presiding). We thank you. We thank you for your corporate citizenship that Xerox has shown in this. We thank you greatly. And we thank you, Mr. Thompson, for the courage you had to exhibit so that what Xerox did would be successful. It wouldn't

have been successful without you. And we are very grateful for your story, and I hope that story goes out to other homeless people to recognize that there is a chance, there is hope. I very much appreciate you.

I would like to ask you in your opinion what was most helpful about the government programs that you were in?

Mr. THOMPSON. That is a good question. I think to me one of the most important things was the support and the networking that I built within the program. CWT, for example, the director of that program is in the audience there. Her name is Debbie Jackson, and she was one of the people who, I believe, who stayed with me, you know. When you are coming off of substance abuse, you feel isolated. And one of the things about CWT program, the different activities that it had in the program in terms of teaching me how to go on job interviews for jobs and writing resumes and taking post office tests, it gets you ready for the job market. It is not only just a question of babysitting me, but in fact giving me life skills so I could accept life on life's terms. And that was one of the positive things that I saw out of the CWT program.

Mr. EVERETT. You know, Mr. Thompson, I don't know the exact program that you went through, but let me ask you. We hear a lot about tough love. Did tough love have anything to do with this?

Mr. THOMPSON. Yes, it did. Yes, it did. You know, I hear about tough love, too. Sometimes you need tough love to be able to pull yourself together. You can't just be hearing what you want to hear and just all the time getting a pat on your back, because, I mean, the life that I am living now, I was supposed to have been living the life that I am living now. And we need the love that is built with some kind of consistency, you know. You say tough love. I call it strong love, you know, but it is the same exact thing.

Mr. EVERETT. Better description, probably.

Mr. THOMPSON. But, yes, like, it is a crucial part of the holistic approach that I think is needed in programs.

Mr. EVERETT. I appreciate the word holistic. That is definitely an equation in this. My wife deals with trying to help families come off welfare, and we have noted that she has dealt with various government agencies and tried to pull those agencies together. The problem seems to be—and I don't mean to get off the subject—we have an agency that deals with this, but we have no one to take in that family and look at the holistic needs of that family and then chart a map. And I am very proud of my wife, who set up a family services center in my district that does exactly that. So I appreciate that word holistic.

Lastly, let me ask you what changes in government programs would you like to see take place to better help our homeless veterans?

Mr. THOMPSON. Well, I can speak particularly, and I want to kind of, like, keep it in terms of, like, substance abuse rehabilitation programs in particular. As I said, when I went up to the VA hospital into the SARP program, inpatient program had just stopped when I came up there, so I wasn't able go into the inpatient program. I had to go into the outpatient program, which meant that I go there from 8:00 in the morning till 4:00 in the evening, but then at 4:00 I leave. I have got to go back out here

in the world with the drugs, with the lifestyle where everything is back out there, and hope to hold on until 8:00 that next morning to come back in there to do SARP. An inpatient program would allow a person to be able 24 hours to be in a structured kind of environment where he could be able to recover and rehabilitate within that area and be not exposed to some of the things that he was exposed to in the beginning. Because in your early stages of recovery they say that you need to be away from people, places and things that contribute to your substance abuse. So I would say that if there could be more inpatient programs, I believe that it could be much more successful for a lot of veterans.

Mr. EVERETT. Thank you very much. Ms. Brown.

Ms. BROWN. Mr. Thompson, I think I am pretty tough, but I am sitting up here crying. I am really very touched. I want to salute you and the thousands of formerly homeless veterans like you who have used the programs that we have created to turn your life around. You are a shining example and your story gives us hope that we are doing the right thing here.

And I want to ask Xerox, have you got the best practice award yet? Have you been nominated? Because I think you should.

Mr. JAMES. We have been recognized by the White House, ma'am, for some of the things that we are doing. And a lot of it is we just need good people. We are growing very fast. We need folks that want to come in second shift, making copies all day in the back of a legal firm. And it works very well. And we have also found that we enjoy giving folks an opportunity to go back and get their college degree, maybe, on the first shift to do that.

Ms. BROWN. Well, this is encouraging, because yesterday I met with the Secretary of Labor, and I was questioning some of the dollars that we are doing, giving to welfare to work programs to corporations. And I can see that this is an example of money well spent. Thank you for coming, all of you. Love you. Thank you, Mr. Chairman.

Mr. EVERETT. Again, we thank you very much. I appreciate the corporate citizenship, again, that Xerox has, and please continue it. And, Mr. Thompson, please send more Roosevelt Thompsons to Xerox.

Mr. THOMPSON. I am going to do the best I can.

Mr. EVERETT. Thank you very much.

I would now like to recognize the Honorable Al Borrego, Assistant Secretary of Veterans' Employment and Training, Department of Labor; Mr. Fred Karnas, Deputy Assistant Secretary for Special Needs Assistance Programs, Department of Housing and Urban Development; and Mr. Peter Dougherty, Director of Homeless Veterans' Programs, Department of Veterans Affairs.

Welcome all. We will ask you to please follow the time restraints of 5 minutes. We still have additional panels. And we will hold our questions. Your complete statements will be made a part of the record.

And, Mr. Borrego, I think we will start with you. And I can tell you for a fact that the Secretary of Labor does know that L.A. means Lower Alabama.

Mr. BORREGO. Yes, sir, Mr. Chairman.

Mr. EVERETT. She is a delightful, wonderful lady that has done much for our Nation and much for our state also. If you will, please begin with your testimony.

## STATEMENTS OF HON. ESPIRIDION A. BORREGO, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR; ACCOMPANIED BY FRED KARNAS, JR. DEPUTY ASSISTANT SECRETARY FOR SPECIAL NEEDS ASSISTANCE PROGRAMS, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT; AND PETER DOUGHERTY, DIRECTOR, HOMELESS PROGRAMS OFFICE, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DR. ROBERT ROSENHECK, MD, DIRECTOR, NORTHEAST PROGRAM EVALUATION CENTER, DEPARTMENT OF VETERANS AFFAIRS

### STATEMENT OF HON. ESPIRIDION A. BORREGO

Mr. BORREGO. Yes, sir. Mr. Chairman, Congresswoman Brown, thank you for your invitation to appear before you to testify on the effectiveness of vets HVRP program and the important role played by community-based organizations in providing quality services to homeless veterans.

I have conflicting feelings when I talk about homeless veterans. I am sad that the problem persists and that these talented people are not able to enjoy hearth and home as most of us do. But I am also very glad that our program can, in some small measure, enable excellent community-based service providers to help veterans regain their dignity, get the skills they need to find and keep a good job and to rejoin the mainstream of our growing economy.

I wish we didn't need an HVRP program. It would mean that all veterans were successfully reintegrated into civilian life and contributing to the growth of their families and communities. But reality shows that we need this program as much as ever. You are familiar with the statistics, and they are heartbreaking. But behind those statistics are real people, people who are now productive citizens, just as they were proud and productive soldiers, sailors, airmen and women and marines. I have listened to their stories in shelters across the country. What they said over and over is that they need a fair chance and a good job. That is the promise that HVRP and our community-based partners offer to them.

This year we have $3 million. That has enabled us to fund 23 modest grants. Fourteen of our grantees are community-based organizations, but we had 62 applications. We had to make some difficult choices. Our request for fiscal year 2000 is for 5 million. That would help 3,500 veterans into job. The raw numbers say we are only helping a small percentage of the estimated 275,000 homeless veterans. I say we are getting benefits for our investment far beyond individual veterans being assisted.

First, service providers use VETS modest grants to leverage funding from other state, local, nonprofit and business community sources. Partnerships with community-based organizations provide the fundamental local linkage so important to the continuity of services necessary to move veterans from homelessness to productivity. Second, HVRP is a critical extension of vets training pro-

grams. Grant money is used to help homeless veterans acquire the skills they need to find and hold good jobs.

Secretary Herman has said that we don't have a worker shortage but that we do have a skill shortage. These veterans have what it takes to help bridge that gap and keep our economy growing.

Last but not least, these programs are important because they work. Historically veterans have gotten quality services for less than $1,300 per placement. That is a tribute to how well community-based organizations use our grant money efficiently and effectively. A key to HVRP's success is partnerships with businesses, community-based organizations, with other government agencies like HUD and Veterans Affairs. In the same way, this country has historically formed coalitions to defend freedom around the world, we must now build coalitions to defeat homelessness and expand opportunities for our veterans without homes.

Another key to success is monitoring and accountability. Our state director is the Contracting Officer's Technical Representative (COTR), and our director is responsible for making sure that the grants are working effectively and efficiently. Our goal for the 21st century must be no new homeless veterans.

Two hundred years ago the English poet William Wordsworth witnessed the tragic irony of homelessness in England. He wrote and homeless near a thousand homes I stood and near a thousand tables pined and wanted food. On the eve of the 21st century all America's veterans deserve a more optimistic legacy. It is in this land of plenty. It is within our power to achieve it.

Thank you for the opportunity to appear before you.

[The prepared statement of Mr. Borrego appears on p. 96.]

Mr. EVERETT. Thank you very much. Mr. Karnas.

## STATEMENT OF FRED KARNAS, JR.

Mr. KARNAS. Thank you. Mr. Chairman, Congresswoman Brown, I appreciate the opportunity to testify here this morning on behalf of HUD Secretary Andrew Cuomo.

The Department's efforts to address the needs of homeless veterans can only be understood in the context of the programmatic and policy changes which have taken place as a result of implementing the "Federal Plan To Break the Cycle of Homelessness," called for by President Clinton. At HUD, the plan called for increased resources and the implementation of a new approach to addressing homelessness called the Continuum of Care.

Since 1992, funding for HUD's homeless assistance programs has more than doubled, thanks to the President and Congress, from $404 million to $975 million. And in 1993, HUD implemented the Continuum of Care.

The Continuum of Care approach, which you have heard mentioned several times this morning, made clear that homelessness was more than simply a housing problem, and focused attention on long-term solutions which included housing, as well as job training and drug treatment, mental health services and domestic violence counseling. The Continuum of Care approach recognized that communities were best positioned to know the needs of homeless persons at the local level and the available resources. A winning Continuum of Care grant now is one that focuses on collaborative and

coordinated community-based strategies that emphasize helping homeless people attain permanent housing and self sufficiency to the maximum extent possible.

As a result of the Continuum of Care implementation, several significant changes have taken place, two of which are the fact that the number of persons served has increased dramatically, and the leveraging of non-HUD funds with HUD funds has increased from $38 million in 1992 to $1.8 billion in 1998. Included among the thousands of homeless assistance programs funded by the Continuum of Care, are programs serving homeless veterans, some of which were represented here this morning.

Despite the success of the Continuum of Care approach, the Department has heard from a number of groups over the years saying additional changes were needed to better meet the needs of homeless veterans. In response to these concerns, Secretary Cuomo took several actions. First, in 1996, in consultation with national veterans' service organizations and other federal agencies, he created the HUD Veterans' Resource Center, HUDVET. He named Bill Pittman, a decorated Vietnam era Navy veteran and career federal employee, to direct HUDVET. Bill is with me today.

HUDVET has served as an information resource for veterans and their families by developing and distributing over 10,000 brochures with descriptions of HUD's homeless programs and points of contact as a way of making sure information is available in communities. HUDVET has also produced a directory on human service programs across the Federal Government, and distributed that to VSO National Service Officers all across the country; developed a HUDVET website; again to give people an opportunity to learn about how they can connect with HUD's programs; and worked closely with the Department of Veterans Affairs, the VETS program at DOL to ensure that information on these key agencies and programs was made available.

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. Starting in 1996, the Continuum of Care Notice of Funding Availability, or NOFA, highlighted the need to include veterans in local Continuum of Care. And, in fact, the failure to include veterans' representatives now costs the community points in scoring their application.

The Department also added language to the contracts of every provider that proposes to serve homeless veterans to require they show how they are providing outreach—and describe how they ensure veterans' participation. And to ensure these commitments are monitored, in 1996, the Department included a new section in the Annual Progress Report on service to homeless veterans.

With these changes in place, the Department has reached out to veterans groups to ensure that they are aware of HUD's programs, how they work, and our expectations of providers. In addition to these 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 provides an array of technical assistance resources on such topics as crafting a

Continuum of Care, specific types of programs and program administration. As a result, a number of things have happened that we think are very positive.

In 1997, 657 projects serving homeless veterans were funded, of which 40 were veteran-specific. Funding for these projects totaled nearly $344 million, just under 50 percent of all the dollars available. In 1998, 805 projects ($400 million) serving veterans were funded including 36 veteran-specific project applications which were funded.

It is important to recognize as we hear these statistics, and some of the things that have been said earlier about the percentage of HUD funds going to veteran-specific program, that if we funded every single veteran-specific grant proposal that we received, it still would only be 3 or 4 percent of our total McKinney funding, because we funded almost 50 percent of the veteran-specific application that we received. We funded 40 of 107, for example. I think the real issue here is how we get more veteran-specific applications in the process. And I will talk about that in a moment.

Based on these HUD's efforts, the Annual Progress Reports show that 20 percent of all adult males served in HUD's homeless assistance programs are veterans. Based on this sample, over 50,000 male veterans are served during the course of a year.

We believe we have come a long way in addressing the needs of homeless veterans over the last few years, but we would not suggest that we have done all that needs to be done. It seems there are at least two significant issues remaining, both of which I think have been mentioned this morning.

The first is ensuring capacity. Often grant applications received from groups proposing to serve veterans do not reflect capacity needed to administer federal funds. HUD is committed to improving our technical assistance resources to assist organizations in building that capacity.

The other significant barrier which we have heard about this morning is accessing priorities at the local level. As I have stated, we have put a point system in place that punishes or takes away points from communities that don't receive funding. But we also feel that one of the real issues is that project renewals, and the need to fund existing programs, often gets in the way of new veterans programs. To resolve that problem the President has asked for more resources, $1.929 billion in fiscal year 2000 plus $100 million for vouchers.

The Department will continue our efforts to make communities aware of the needs of homeless veterans and encourage them to include veteran-service organizations and homeless veterans in the local process.

I believe my time is up. I would be glad to answer any questions about this or my written statement, including questions about the Interagency Council for the Homeless.

[The prepared statement of Mr. Karnas appears on p. 99.]

Mr. EVERETT. We would be happy to put all those in the record.

Mr. KARNAS. Thank you.

Mr. EVERETT. I hate to interrupt you, but we do have a vote going on.

Mr. KARNAS. Okay.

Mr. EVERETT. And I am going to have to recess the hearing. It will probably be about 25 minutes, because we have a 15-minute vote followed by a 5-minute vote. And so if you want to take a break, we will try to be back here within the half hour.[Recess.]

Mr. EVERETT. Mr. Dougherty, I believe we are up to you.

## STATEMENT OF PETER DOUGHERTY

Mr. DOUGHERTY. Thank you, Mr. Chairman. I will keep my remarks brief, having been here before. Since our full testimony will be part of the record, let me make some comments in relationship to some things that have been said here today that I think need to be addressed.

One of them is that the VA has the most extensive monitoring evaluation system in the Nation. And while the GAO study did in fact call for us to do further follow up, and we are in fact doing that, I think it is important that it be noted that we are monitoring and looking at those key components that are important to develop and ensure the recovery of a person who has been homeless. We are looking not only at the health care, both the mental and physical health care issues that are involved with that veteran, but housing and employment as well.

We also would like to note that a GAO report that was just recently released, as well, this year is called Homelessness Coordination and Evaluation of Programs Are Essential. In that report they talk about programs that collaborate. Although the Department of Veterans Affairs is only listed as three of the 50 programs included in that report, four of the seven or eight examples that the report cites, are programs that the Department of Veterans Affairs collaborates with others.

There was some discussion earlier about welfare to work, and I clearly understand that the Xerox people consider Mr. Thompson to be sort of a success story out of welfare to work, but I also think we need to be reminded of the fact that Mr. Thompson is not eligible under welfare to work. His veteran status does not exclude him necessarily, but welfare to work is generally available only to TANF recipients. And that excludes virtually all veterans.

I do want to say that the Department of Veterans Affairs, of course, has for more than a decade done lots of things to improve the lives of veterans. We have tried to break out of the mold of how we have done business in the past. I think the panels that you have had here earlier today have expressed that. I think we are moving in the right direction. There was some discussion earlier about compensated work therapy and other programs that are not homeless specific but certainly help homeless veterans.

The Administration's budget for fiscal year 2000 talks about us spending money. I know that sometimes talking about spending money is not necessarily popular, but it is essential. We are spending our money not in building bureaucracy but in putting most of that money in community-based organizations with contract residential care, with increased funding under Grants and Per Diem, and with specialized outreach assistance for women veterans. We think we are going to be able to spread that money in the best way possible.

There are some guiding principles, obviously, that I have mentioned in my testimony that I would like to reiterate. VA has the most extensive system of services for homeless veterans in the Nation, but from the very beginning we have known that we cannot and should not do it alone. Since the late 1980s we have collaborated with communities and community-based service providers.

Second, while there are a number of common patterns, each veteran who has become homeless is like each American who has become successful. Their paths are different and the interventions for rehabilitation must sometimes take multiple attempts and need multiple treatment options to be successfully completed.

Third, we have been aggressive with our involvement with other federal agencies such as those here at the table, state and local governments, native American tribes, veteran service organizations and tens of thousands of volunteers who assist us every year.

Finally, I think there is something that needs to be said here today. America has a long and proud tradition of doing everything possible to bring back those wounded on the battlefield. For many of America's homeless veterans, the battle continues and they are out there wounded, suffering from mental illness, substance abuse disorder. Many carry the scars of the war that we sent them off to fight. We must do everything we can to bring every veteran home.

Our commitment expressed here today continues that tradition. Many homeless veterans on the streets, under the bridges and encamped in the woods of America are hoping that someone is going to bring them home safely. That is our commitment to America's veterans, to bring them home. With your help, the help of this Congress, dedicated staff, veteran-specific service organizations, thousands of volunteers, the community-based organizations that we work with, the AmeriCorps program and others, we will be able to do that. We will be able to bring those veterans back. We will be able to treat them with compassion and assist them to bringing, as Mr. Thompson talked about earlier, to be able to enjoy the bounty of the American dream that he has now had the opportunity to enjoy.

Mr. Chairman, Dr. Rosenheck, who was here for a conference about data collection information and how we would do better, had to leave and is not able to be here. Mrs. Koerber, who is the Associate Chief Consultant of the Health Care for Homeless Veterans Program, and Roger Casey, who is the Program Manager for the Grants and Per Diem Program, are here, if there are specific questions.

Thank you, Mr. Chairman. We appreciate the opportunity to be here and look forward to answering any questions.

[The prepared statement of Mr. Dougherty appears on p. 104.]

Mr. EVERETT. Thank you very much. On the outset let me say that we will have a number of questions for the record for this panel. I want to confine my comments and questions to faith-based organizations. That is not to dismiss community-based, but I want to talk about that a little bit and bring that into the equation also.

Mr. Dougherty, I was also glad to hear that the funding is directed more at the veteran himself than building additional bureaucracies. I think it is well known, and I have said from this

Chair often that there is too much money in the Veterans' Health Administration being spent on bureaucracy—and these are health care dollars that, in my opinion, make it even tougher for some veterans to get the health care they need. So I appreciate the fact that the money is being directed towards veterans rather than putting more layers of bureaucracy on top of bureaucracy on top of bureaucracy.

For all of you, let me ask you to comment. Mr. Karnas, you mentioned that the community-based local level organizations were doing a great job, more bang for the bucks, but more importantly really serving the needs of our veterans. Do you think you could apply that, or have you any experience with faith-based organizations?

Mr. KARNAS. I have been working with homeless people for 16 years and I know that early on it was the faith-based community that was there to help homeless people before anybody else. Over the years they have maintained these involvement—groups like Salvation Army, as well as local churches, and Catholic Charities. One of the things that HUD has done in the last 2 years is create a better connection to the faith-based community. We have always had a connection to local governments and state governments, but we recognized that the community-based organizations were key. Secretary Cuomo created the Center for Community and Interfaith Partnerships to really begin to reach out to faith-based groups to make sure that they understood what they could do with our resources. As you have stated, because they are at the grass-roots level, they can make a significant difference.

Mr. EVERETT. How about DOL and DVA? Do you have any contact with the faith-based organizations?

Mr. BORREGO. Currently, sir, we have two grants out of this latest round of HVRP to the Salvation Army, one in Rochester, NY, another one in New York City. And frequently many of the people that we give grants to will have members from faith-based organizations on their board or as part of the linkages to provide services, because they are very good at locating community resources. And it is a smart thing to do to work with faith-based organizations, so clearly our grantees are reaching out to them. We are funding two right now, and any that submit proposals that make it within the cutoff clearly will be funded.

Mr. EVERETT. Are those demonstration grants?

Mr. BORREGO. No, these are part of our regular HVRP, two of them, except for Salvation Army. The one in Rochester, NY, for almost 114,000, and the one in New York City for a little bit over 124,000.

Mr. EVERETT. And the VA?

Mr. DOUGHERTY. Yes, Mr. Chairman, a number of the grantees under the Grant and Per Diem program are in faith-based organizations. And certainly I would suggest that probably most of the grantees at least are closely connected to faith-based organizations. And, you know, part of the bureaucracy that we do have is we have a couple hundred people who work for us who are full-time clergy, full-time ministers and rabbis and priests and so on. We have a Chaplain Service at the Department of Veterans Affairs. All of our medical centers have people who are very connected to faith-based

organizations, they are working with a lot of these veterans when they are in inpatient and outpatient care programs. I think you will find that most veterans that we have talked to will obviously indicate that there is a degree of spirituality that comes in their recovery process.

Mr. EVERETT. I would like to make for the record make it clear that that is not the bureaucracy I was talking about, and I think you are well aware that——

Mr. DOUGHERTY. I understand that.

Mr. EVERETT (continuing). There is layer upon layer beyond that.

Mr. DOUGHERTY. I understand that.

Mr. EVERETT. Would each of you describe any outreach programs that you have towards these faith-based organizations, or do you have any?

Mr. KARNAS. Well, as I mentioned, at HUD just recently, formed the Center for Community and Interfaith Partnerships, which works regularly bringing faith-based groups together, both at the national level and at the local level, to provide them the information they need to be able to access HUD resources expand the work that they already do already in their communities.

Mr. BORREGO. For us it predominantly occurs at the community-based organization level, those people that we fund from the national office. We don't have any specific outreach to faith-based community.

Mr. DOUGHERTY. Mr. Chairman, we have what we call our CHALENG meetings connected to our local medical centers, our regional offices and VET centers participating. We invite the community, anybody and everybody who is interested and concerned about the issue of homelessness and homelessness among veterans. We have lots of faith-based organizations who participate in that process. We invite them and encourage them to participate.

Mr. EVERETT. Do you have an outreach effort, though?

Mr. DOUGHERTY. I don't say we have a specific office that has outreach to them, but we invite everybody we can find in the local community who is interested, which usually includes a lot of people from the religious communities.

Mr. EVERETT. Well, it is a huge problem, as we have outlined here today on several occasions, and it seems that these folks, as my colleague describes, they are out there where the rubber meets the road. It seems to me that they may be the ones having the most success with these programs, not to belittle VA's efforts. But I now yield to my colleague, Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman. I guess my first question is for HUD. I think this directory, HUDVET directory is nice. I am a supporter of HUD, you know. I think you all really make a difference. But I am concerned as to how can we better account for the veterans that are participating in our programs? How can we work better with the veterans community? Because it really bothers me that one-third of the people on the streets are veterans.

Mr. KARNAS. Well, I think in my testimony what I was trying to show our efforts over the last few years, to put in place the kinds of things that weren't there before in terms of reaching out to homeless veterans. Clearly HUD is concerned that one-third of all homeless men are veterans. And, as result of some of our outreach

efforts through HUDVET, the changes we have made in the Continuum of Care process, and other activities we have gotten part of the way toward meeting the needs of homeless veterans.

As I stated at the end of my testimony, I think there are a couple significant issues which we still need to overcome. One is insuring that the veterans groups have capacity to deliver the services at the local level, and that requires the HUD do a better job, with technical assistance. The other piece is the struggle with the amount of resources available. Despite the relatively large sum of funds that go into the Continuum of Care programs, renewing programs and keeping programs going means that there is oftentimes little room at the local level for new programs. I think that is an area we have to be more creative in getting programs that have been operating for awhile to find other resources so we can help veterans programs and other new programs get on their feet.

Ms. BROWN. Thank you. Okay, for Veterans Affairs I do have one question. I know you heard the person give his testimony just before your panel came up, and he mentioned the inpatient as opposed to the outpatient and that it was a cut in the program. And of course we know the intensity of the program is going to work better. Where are we and what can we do to make sure we have the inpatient type programs? I mean, I think that, yes, you know, you can have the inpatient and then later the outpatient, but initially I think that inpatient at the beginning is very important.

Mr. DOUGHERTY. Ms. Brown, I would certainly concur with Mr. Thompson's assessment, and that is a concern the Department of Veterans Affairs shares. I think what he was referring to a specific program that had changed just before he got there from an inpatient to an outpatient care program.

In my private life I am also a member of a community group called the Metropolitan Washington Council for Homeless Veterans. And one of the things that that group was able to help to do is to secure some HUD funding for homeless veterans so there would be a good residential care placement for those veterans to live in. That doesn't totally answer the problem, but from a practical standpoint what you and what we at the Department have to do, as well, is live within the resources that are available. We need to do a better job of getting creative.

I think Mr. Cantwell and the others in the previous panel were indicating that there are some opportunities for residential services to be provided with support that would be much less expensive than inpatient care. Inpatient care is a very expensive option for us. For many veterans it can be done on an outpatient basis effectively as long as there is a good quality residential care component available.

Ms. BROWN. That is true, but if they don't have anywhere to stay, I mean, if they are living on the streets——

Mr. DOUGHERTY. I absolutely agree with you that that is a problem, and it has been addressed in fairly good fashion in some places and not in good fashion in others. We continue to struggle with trying to make sure that the best option with the most treatment for those veterans is available.

Ms. BROWN. Well, I just think that it is an ongoing problem and——

Mr. EVERETT. Would the gentlelady yield?

Ms. BROWN. Yes, sir.

Mr. EVERETT. Following up on your question on HUD earlier on, have you any method of tracking the veterans you have? We applaud the efforts on helping women and children, but what method do you have for tracking the help you give? You mentioned also creative grant writing.

Mr. KARNAS. In 1996, at the request of veterans groups we included additional language and data collection requirements in our Annual Progress Reports that specifically asked each of our grantees that say they are going to serve veterans (either veterans only, or veterans amongst the other populations that they serve) to keep track of information on veterans served.

Mr. EVERETT. Can you give us any numbers on that?

Mr. KARNAS. The numbers that I mentioned before were that approximately 20 percent of all of the male homeless people that we serve are veterans and that that comes to be about 50,000 homeless veterans a year in our programs.

Mr. EVERETT. How do you validate those figures?

Mr. KARNAS. Those are validated in a couple of ways. First of all, projects submit reports to their local Field Offices. Field Offices are responsible for overseeing those programs and have monitoring responsibility to ensure that projects are securing who they say they are serving. I would say that we are just now 2 years out from putting that into our APRs beginning to get that data. And I think we can agree that—we wouldn't have put it in the air if we didn't believe that we need that kind of information, not only on veterans but on all the populations we serve. I think we are getting closer to getting good data, but we are still a little ways away from what we would really like to have.

Mr. EVERETT. I yield back. Do you have any additional questions?

Again we thank this panel. And as I mentioned at the outset of your testimony, your written testimony will be included in the record. We will have additional questions for you and would hope that you would give us an answer back as soon as possible. Thank you for appearing today.

Mr. KARNAS. Thank you, sir.

Mr. EVERETT. I would now like to recognize Mr. Emil Naschinski of The American Legion and Mr. Rick Weidman of the Vietnam Veterans of America. Gentlemen, welcome. You know the drill. Your limit is 5 minutes and we will have questions for you afterwards. And, Mr. Naschinski, if you will begin, I would appreciate it.

## STATEMENTS OF EMIL W. NASCHINSKI, ASSISTANT DIRECTOR, NATIONAL ECONOMIC COMMISSION, THE AMERICAN LEGION; ACCOMPANIED BY RICK WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

### STATEMENT OF EMIL W. NASCHINSKI

Mr. NASCHINSKI. Chairman Everett and Congresswoman Brown, good morning and thank you very much for inviting The American

Legion to share its views on the effectiveness of federal grants to community-based organizations as a means of addressing the needs of homeless veterans.

While five federal departments and one federal agency administer grant programs, we will only comment on the grant programs of the federal departments that we work with on a regular basis. They are the Departments of Labor, Housing and Urban Development and the Veterans' Administration.

Mr. Chairman, most individuals who work with homeless veterans agree that the key to breaking the cycle of homelessness lies in assisting the veteran to become job ready and then assisting that person in finding and maintaining suitable employment. Unfortunately very few homeless veterans programs offer an employment component. The Homeless Veterans' Reintegration Act, or HVRP as it is better known, is operated by the Department of Labor. It is the only federally funded program that is focused strictly on preparing homeless veterans for employment and on successfully placing them in meaningful jobs.

Recently Congressman Filner of California introduced H.R. 1484. The name of that bill is the Authorizing of Appropriations for Homeless Veterans Reintegration Projects. That bill will extend the HVRP program from fiscal year 2000 through 2004. It will also raise HVRP's funding level from $10 million to $50 million per year. The American Legion fully supports that legislation.

The Department of Housing and Urban Development operates the largest federal grants program. The problem here, as Mr. Karnas mentioned, is that veterans are currently only receiving approximately 3 percent of that agency's Stewart B. McKinney dollars.

The VA operates the Homeless Providers' Grant and Per Diem Program. It provides grants to community-based groups who construct or renovate existing facilities that will be used to provide transitional housing or supportive services for homeless veterans. VA recently reported that during the program's first 6 years 127 grants were made to 101 different care providers in 39 states and the District of Columbia. Those grants resulted in the creation of 2,700 new community-based transitional beds for homeless veterans and the creation of 14 independent homeless service centers, five mobile service center units and the purchase of 20 vans for outreach to homeless veterans.

The American Legion does not believe it has enough information to objectively determine whether or not these programs are successful and effective. However, through our association with the National Coalition on Homeless Veterans and the Veteran Organization's Homeless Council, we have had an opportunity to talk with many community-based providers. The bulk of the anecdotal reports we have been given have been very, very favorable on both HVRP and the Grants and Per Diem Program.

While the HUD grant program may be effective in meeting the needs of some homeless, the sad fact is that veterans programs are being underfunded. Recently Congressman Metcalf introduced H.R. 1088, which will require HUD to make 20 percent of its McKinney dollars available for veteran-specific programs. The American Legion supports this bill because the VA is—because while the VA

has several good programs to assist homeless veterans, it cannot help all veterans.

Mr. Chairman, that concludes our comments. Again, thank you.

[The prepared statement of Mr. Naschinski appears on p. 113.]

Mr. EVERETT. Thank you very much. Mr. Weidman.

## STATEMENT OF RICK WEIDMAN

Mr. WEIDMAN. Thank you, Mr. Chairman. On behalf of Vietnam Veterans of America I thank you and Ms. Brown for inviting us to share our views here today. I would like to just have unanimous consent that a written statement be submitted in the record and then talk beyond that, if I may, sir.

Mr. EVERETT. Absolutely.

Mr. WEIDMAN. Inadvertently one of the witnesses from the agencies said, in good faith, I believe, but used a phrase that is in fact indicative of the problem when it comes to dealing with the problems of homeless veterans when he said that they did great work in some small measure to meet the overwhelming need. It is those words in small measure that really sum up the core of the problem both in terms of policy and coordination and in terms of resources that are made available to the community-based and faith-based organizations who really understand the needs of the individual veterans on the street and how to help those folks regain their self respect and return to the greatest degree of self sufficiency and humanness, if you will, possible.

There are a number of things that I could detail, but I will just touch on a couple of the remedies that we had already noted in our written statement. The first is H.R. 364, which if I understood correctly, Mr. Coyne agreed to take up in the Committee on Benefits, which is a Veterans' Bill of Rights for Employment, Training and Related Services, which would ensure that each and every federal agency identifies veterans and meets the special needs, gives priority to veterans in the provision of all services that would be related services, which include meeting barriers to employment. Certainly being homeless is the overwhelming barrier to employment, and there are other reasons that lead people to be homeless.

The other is H.R. 1008, which my colleague from The American Legion spoke of, introduced by the Honorable Jack Metcalf of Washington. I would certainly urge the two of you and your distinguished colleagues on this committee to get on that bill as a cosponsor.

There is much that we have heard from HUD over and over and over again about how deeply concerned they are from the Secretary on down with the needs of homeless veterans. When pointed out in the written statement that in addition to a special focus on homelessness among veterans HUDVET has become a recognized source of information on other HUD and related federal programs. Well, that may well be true, but I would just point out that Vietnam Veterans of America along with most of the other national veteran service organizations are part of the National Coalition for Homeless Veterans. HUDVET helpline, when they have a tough question, they refer it to NCHV. This is not a recognized resource when they have to turn to a tiny not-for-profit in order to answer the

tough questions coming in from either service providers or from individual homeless veterans.

Secondly, on page 4 of the HUD statement where it notes all continuum of care grantees are required to submit an annual progress report, et cetera, et cetera, et cetera, and they review it, well, to what end. What action takes place subsequent to that? The answer is nothing. The answer is nothing. There are no incentives and no rewards and no sanctions that are taken on anybody who does not give proper service or discriminates against veterans in a provision of services.

Last but not least is on page 5 there where they talk about and where Mr. Karnas in his verbal statement talked about the fact that if there were only more veteran service providers who would submit a reasonable application we would fund more. Well, in point of fact unless you are certified by one of those 900 local areas, you can't submit a grant. And the problem is that our folks are aced out and blocked because they are not certified by one of those 948 local areas. It is a catch 22 where national organizations at the national office of HUD says that if only we had qualified applications, but you can't have a qualified application if you can't get to the table and get certified by the folks at the continuum of care coordinating group at the state or the local level. So this is disingenuous when they say that there isn't the expertise to provide specialized services to homeless veterans. And it is just somewhat maddening. It is, in fact, a modern day catch 22 in the civilian sector.

Last but not least on that has to do with the veteran identifiers that was discussed here in a question that you asked, Mr. Chairman. In response to that question, they talked about how they tried to identify the number of services delivered to homeless veterans. And that is an estimate.

A year and a half ago in March of 1998 in a public meeting here in Washington I asked Mr. Karnas, well, you seem to be saying that you don't do anything because the Congress won't let you do it, why cannot Secretary Cuomo go through the process of the public rule making, use the public rule making process in order to put a veterans and disabled veterans identifier into a requirement on every single HUD and HUD funded program. And he pledged that he would explore that and take the next steps on that. And in fact, they could do it. They do have the legal authority.

And the answer back on that, incidentally, at first blush was, well, you know, the Congress can always overturn this public rule making process. Whereupon I started to laugh. I cannot imagine the Congress turning around to Secretary Cuomo and saying my gosh, you are doing too much for disabled vets. I don't believe that would happen, Mr. Chairman.

So I wanted to comment on those things on HUD and then move on and touch on two other quick things, if I may. One of the principal problems is that the coordination you mentioned at the faith-based and the community-based organizations understand the problems in general that are generic, if you will, with homeless veterans and homeless persons, and they also understand how their community works, which is also important that you understand the particular area in which you are working. And they are the ones

who can best and most efficiently and most effectively deliver the services if they have the resources and if they have the knowledge.

You heard this morning from many community-based organizations from around the country who are the creme de la creme in terms of sophistication and understanding how to do the coordination from the bottom up, because there is no good way, not through HUD, not through VA, not through any other way, to access all of those little pools of money that might be available and how to put them together into a seamless continuum of care on the part of a community-based organization or organizations working within a given community. That leads back to a lack of overall federal policy and a failure thereof for coordination.

There was in the late 1970s under President Carter a thing called the White House Veterans Federal Coordinating Committee. Later on in the early 1990s there was a thing created, the Interagency Homeless Coordinating Committee, which has fallen pretty much dormant. I would suggest to you that there is certainly a need for strong executive leadership. And in lieu of that, since that may not be coming, is that the Congress create some sort of mechanism that will force the coordination of policy overall in some kind of systematic way between VA, HUD, HHS, Labor, SBA and Agriculture to address the needs of both rural as well as urban homeless veterans.

Last but not least on one personal note, if I may, Mr. Chairman, and I know I have got the red light there, is in this room talking about this issue of HVRP last week inadvertently I left the impression with staff that I was decrying the actions or lack of actions on the part of former Deputy Secretary of Labor Katherine Higgins in regard to HVRP's request. It was not against Ms. Higgins. Ms. Higgins is one of the finest veterans advocates we have ever had at the Department of Labor, Schedule C or permanent person. But rather the fact that Office of Management and Budget turned around and asked for a cutting in half of the authorization for HVRP.

HVRP is the most cost effective, cost efficient program run by the Department of Labor, and it is nothing short of shameful that OMV and the Domestic Policy Council sent Mr. Borrego and the VA folks up here and asked for a cutting in half of the authorization for a program that truly works and that brings taxes back into the treasury more than it costs to have the job placement within the same fiscal year.

So that is—I wanted to correct that for the record, Mr. Chairman, and just say that we need to focus on coordination and on accountability of GBRA. And the way to do that is with an overall comprehensive federal policy. And that can only come out of something like the White House Federal Coordinating Committee or another entity that is designed in a piece of legislation carried by this committee to enactment.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Weidman appears on p. 116.]

Mr. EVERETT. Well, thank you. And you bring up an interesting dilemma. I don't know if you were available when I talked earlier about the fact that—I will get a little personal, too—my wife has a family services center down in my district. The problem she

had—it took her 2 years to do it—she knew that the HR, job skills, the various mental health and various other agencies were not serving their constituents. They admitted that. They couldn't get to them.

Well, she came in with the idea of a one-stop shopping center where the family services center would evaluate the holistic needs of the family and then chart them out a map. I mean, if you are a single mother and you don't have transportation and nobody makes that transportation available to you or you need care for your children, then there is not much you can do. Plus the fact that the government agencies, under the setup she has put there, are now in the same building. And it has just been a great success. And that success spent no additional federal dollars.

But the problem she had for 2 years was to convince those people in a very local area in a very easy way that she has of talking to people to get past the turf battles. It took her 2 years simply in one county to get back past the turf battles in eight or nine organizations.

I agree that we probably need what you mentioned, an overall policy from the executive branch or from the Congress. The fear I have is that if we do that we will simply create another bunch of bureaucrats that will take health care dollars from our veterans and we still will have that same problem with turf battles. I come out of private business, 33 years, and had never been in politics. And it was amazing to me what I saw when I got up here 7 years ago about turf battles, not only in the bureaucrats, but frankly in the Congress also. Sometimes we have to go through three or four different committees of jurisdiction just to get what you would think would be a simple bill passed.

So I just wanted to comment on that. I certainly agree with it that it is needed. I don't know if we could do it. I don't know if it would work if we tried to do it. Perhaps it would.

But let me get past that and just ask each of you to describe what you think agencies are doing right for homeless veterans and what is the number one thing they should change or initiate. Mr. Naschinski, we will start with you.

Mr. NASCHINSKI. Well, I think, Congressman, that possibly one of the biggest problems is that it is very difficult to measure the success of these programs. The GAO report on VA's homeless programs pointed out that that was the major problem there. And they are currently working on developing some tools to more effectively determine exactly what they are doing right and what they are doing wrong. I would say that would probably be one of the major needs.

Mr. EVERETT. I am sorry. Would you repeat that, the last sentence?

Mr. NASCHINSKI. What I was saying is that the GAO report that was submitted recently on VA programs noted that one of the problems was that it really was not measuring the success of those programs. And it suggested that VA develop tools to more accurately assess success. They are currently working on those tools, and I think that is a real problem throughout these programs. It is just very difficult to measure first of all, and second of all, there just aren't enough tools to do it at this point.

Mr. EVERETT. Mr. Weidman, I don't mean to anticipate your answer, but would you agree with that assessment?

Mr. WEIDMAN. Yes.

Mr. EVERETT. I think that one of the things this hearing is all about, first of all, is to highlight the problems which my colleague very much wanted us to do. But in addition to that, you know, we had 600,000 homeless veterans, according to estimates 10 years ago, and the latest figures that we see, we have still got 600,000 veterans. And we have spent billions of dollars out there.

Mr. WEIDMAN. If I might suggest, Mr. Chairman, that when you talk about homeless veterans it is not a generic group of people. They are veterans whose problems have become so acute that they find themselves homeless. And you have heard VVA, my organization, testify up here continually, and we continue to have dialogue with the top VHA officials about shifting VA hospitals to a much more consciously wellness policy in the way in which they do business. It begins with a complete military and medical history. They don't do that. They do not do that, Mr. Everett. You tell people outside of our little world that they don't ask when you walk into the VA hospital what did you do in the war, dad, and what happened to you, and they just look at you like you are crazy, because the public believes that that is what VA does, that that is what it is there for, to care for he who had borne the battle or for she who had borne the battle. And it doesn't start at the right place.

Some folks down at VHA are starting to agree with us and certainly some of the staff here is starting to understand what we are talking about. You have got to begin from that place, particularly when you're dealing with people whose problems are very complicated, as are most of the folks whose problems have become so acute that they are living on the street or in a shelter that is worse than the street in many cases.

So when you—in terms of what they are doing right, some of VA's treatments in many of their facilities, because you have seen one VA, you have seen one VA hospital, but in many of the facilities they are much better when it comes to neuropsychiatric care in terms of the models. The problems are that the neuropsychiatric care, more than any other part of VA, has been decimated in terms of resources. And it comes right back to where some of us believe we have got to bust the cap or change the cap for veterans.

Congress and the Administration made a Custer decision on flatlining veterans health care budget for the next 5 years beginning in 1997. And let us not be like George Armstrong Custer and refuse to change a Custer decision until it is too darn late and you can't get out of the Little Bighorn. Let us not wait until the veterans hospital system crashes before we change that.

And that would be the number one recommendation that we would have if you want to meet the needs of homeless veterans, is to make the VA system more accountable and more focused on the wellness model, which would include veterans who are homeless, but it also would help veterans whose problems have not become so acute they are on the street. And secondly is provide adequate resources for doing so.

I might add that the HVRP program is dynamite. It is a great program, but it is just not enough of it. It is, as Mr. Borrego said,

some small measure of a help. And that is not his fault. The problem is there just aren't enough resources in it.

Last but not least, I would just like to make this comment. The line that runs through all the success stories that you have heard today is this. Every one of them depends on a local faith-based or community-based organization at the service delivery point. If you provide the resources, and think of FEMA, I might suggest, Mr. Chairman, as a model, which is tiny, tiny administrative entity. Puts the money out in the field with incentives and with sanctions on a competitive basis, but has certain requirements that people go through. And if people do a good job, they get more resources the next year. If they do a lousy job, they get less or they get none. That is the way to do it and not create another bureaucracy.

The problem that your wife encountered at the county level, if I might suggest, sir, is there were no rewards and incentives based on performance like there are in business. That is exactly what Mr. Kwen and the committee staff and Mr. Stump had been struggling towards when it comes to employment programs, is have rewards and sanctions. Last time I looked, the men and women who served in the American military over the last 50 years won a cold war against communist and state planning on behalf of the free enterprise system, which is essential to democracy. Let us reap the fruits of it by building those kinds of free enterprise incentives in the government programs to assist those men and women to be able to earn their piece of the American dream.

Mr. EVERETT. I see my time is out, but for the record let me correct a statement I made. I said that 600,000 homeless veterans. I meant total of 600,000. About a third of those are veterans.

You said an awful lot there, a lot of which I agree with, but the foundation, it seems to me, goes back to something that, well, I started as Chairman working on in the 104th Congress. And that is information. VA's computer system and, for instance, DOD's computer system where a lot of this information is, can't even talk to each other. And here we are 5 years later and we are no better off than we were 5 years ago. It seems to me we have to have that progress to serve these veterans.

Having said that, let me yield to my ranking member.

Ms. BROWN. Thank you, Mr. Chairman. Mr. Weidman, you mentioned something that I was very interested in, and I would like for you to say more about it. The problems that veterans organizations get in being at the local level participating, you said they are not on the boards that, I guess, just give out the monies, the grants?

Mr. WEIDMAN. Actually on several counts. One is that just simply getting to the table of the 900 local entities in the continuum of care model that HUD uses for dispensing McKinney Act monies, veterans often can't—in more cases than not cannot literally get a seat at the table, even—I'm sorry.

Ms. BROWN. Yes, I just want to be clear about this. You are saying that groups that serve veterans, they can't apply for these dollars? I thought you only had to have a 501(3)(c).

Mr. WEIDMAN. You have to have certification from the continuum of care group within that area in order to be able to submit.

Ms. BROWN. And they don't have that?

Mr. WEIDMAN. Well, you have to get to the table to get built into the local plan. And what I am saying is that they can't get to the table to get built into the local plan. Mr. Lazio, who has supervision, is chair of the committee that has supervision over the McKinney Act monies on the Banking Committee of the Congress, finally understood what we were talking about when we had him meet with John Lynch and the folks from Veterans Place and Suffolk County Veterans United and was astonished to find out that they—it had taken them 5 years to get to the table and they still weren't getting any money out of it. Now Mr. Lazio knew this group, had visited this mostly privately, now, financed group in Suffolk County on Long Island, knew what great work they were doing and was absolutely astonished they couldn't get any of the McKinney Act money because they, one, couldn't get to the table, and then even after they did they didn't get any of the resources.

Ms. BROWN. Well, I personally would like to further look into that and get more information on that.

Mr. WEIDMAN. Be glad to help, Ms. Brown.

Ms. BROWN. I have a few more minutes. Is there anything else you want to share with us?

Mr. WEIDMAN. Well, I just want to once again reiterate and echo all of the folks who have spoken before about how grateful we are to you, Mr. Chairman, and to you, Ms. Brown, for having this hearing focusing on the needs of homeless veterans and federal contracts with homeless veterans. I would reiterate something that I said a little while ago. If you provide the resources, the community-based organizations and the faith-based organizations in a locality can make it work and can, in fact, partner with VA.

The crux of the issue is the let them eat cake syndrome that those local entities run into. What I mean by that is this. They go to HUD. They go to the local JTPA entity to try to get employment monies, which will soon be succeeded by WIB. They go to the social services. They go everyplace else and they—those folks say go to VA. And VA says we want to partner but we don't have any money but we want to partner with our community groups. Whereupon the community groups say partner with what. With what? Because everybody says go back to the VA, but in most cases there is the Grant and Per Diem Program but beyond that there are no service dollars.

So it is a very sticky conundrum. And it takes somebody like Colonel Williams, who is extraordinarily well connected and had tremendous help from the political leadership in Baltimore and I am very familiar with that operation. My last commanding officer in the military at Wilson Army Hospital is on Colonel Williams' board, so I had heard about MCVET for a long time from Colonel Nesbitt, who I am still in touch with. And it takes that kind of sophistication and that kind of years perseverance and luck in order to be able to put together a continuum of care from the bottom.

Now you can argue that that is stronger, but it is not universal. It is not universal, and it only—it doesn't reach enough people in enough places in America. None of us served under the flag of Maryland when we went to Vietnam or to the Gulf or anyplace else. We served under the United States of America's flag. And we need to do what we can to create a national system.

And once again, I come back to what I mentioned to the Chairman a moment ago, Ms. Brown. And that is a system of rewards and sanctions and competition for some of these resources. And the community-based organizations can do it if we will only make the resources available to those who can get the job done most effectively and most efficiently for these most deserving of citizens who have earned this right.

Ms. BROWN. Many of the people in the audience were nodding their heads as you were speaking, so let me just thank everybody for coming. This information has been very valuable to me and to our committee. And we are going to do our part to get our colleagues to come forward and do what we can to continue to forge a better working relationship for our veterans and more cooperation, because we really need to—as we go toward the 21st century, we need to make sure that we don't leave our veterans behind, because they have done so much for us. So thank you again.

Mr. EVERETT. I want to thank all the witnesses for appearing today, particularly Mr. Roosevelt Thompson for sharing his very personal experiences of being a homeless veteran. With help, he was able to overcome many obstacles, developing crucial skills and confidence to become self sufficient and a contributing member of our society. We wish Mr. Thompson well in all his future endeavors.

Homelessness among veterans is still a very serious and complex problem. As we have seen here today, it has no easy solutions. The VA, and other departments and agencies, have made some progress addressing the homeless veteran issues, but there is still much to be done.

I intend to ask the GAO, the independent investigative arm of the Congress, to report on how effectiveness of federal homeless programs for veterans can be uniformly measured. We need to ensure that departments and agencies all use a consistent yardstick to measure what successful outcomes really are. To find resources the departments and agencies must be able to identify the most successful programs and ensure that these programs receive the appropriate funding. Programs that cannot demonstrate successful outcomes should be terminated so that the money can be put to the effective programs. I have been in Washington long enough to know that that is easier said than done, as I discussed a little bit earlier.

Finally, I can assure everyone this subcommittee is going to continue its interest in how to most effectively address homelessness among veterans. And because Ms. Brown has such an outstanding interest in this, if she would like to make any additional remarks.

Ms. BROWN. Thank you, Mr. Chairman, for really calling this hearing, because I think it is one that we really needed to have. And we need to take this information that we have learned back to the full committee and continue our work for the homeless veterans. And thank you again.

Mr. EVERETT. I thank my colleague for her interest in this. The hearing is adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

# APPENDIX

## PREPARED STATEMENT OF CONGRESSWOMAN BROWN

Thank you, Mr. Chairman.

Imagine 17 infantry divisions camped in the streets of America. On any given night, that is how many homeless veterans huddle for warmth in our grate-filled Nation. This quarter million men and women were not lost when the armed forces released them. Few would survive the decades of homelessness that would represent. Rather, they are a constantly changing mix of people with problems—veterans with problems.

For some, of course, homelessness is the simple result of short-term difficulties with employment. For a great many, if not most homeless veterans, their problems have a service connection. Post-traumatic stress disorder (PTSD) or other mental health trials can be chronic problems that stay sufficiently buried for years to allow a semblance of a normal life, before surfacing and taking over. Self-medication with alcohol or drugs can keep the lid on for a long time for some veterans, until retirement or thoughts of one's own mortality recall war-time experiences that lead to a downward spiral. So while some may ask how long these veterans will go on without being "readjusted," the better question is when will the readjustment problems occur, and how quickly can we intercept them?

We are going to look today at government alliances with non-government providers—community-based organizations (CBOs)—that have worked. While we want to know what problems there are, it is at least as important that we share best practices in treating homelessness among veterans. Over the past few years, both the Department of Veterans Affairs (VA) and the Department of Labor (DOL) have operated grant programs. They allow community providers that are part of the local continuum of care to provide the services that are really needed.

At the same time, the federal agency with lead responsibility for homelessness grants, the Department of Housing and Urban Development (HUD), worth millions and millions of dollars have done little to support veteran-specific programs. HUD remains, after years of discussion, unable to provide convincing numbers with regard to veterans, or to tell us what it does for veterans other than give grants to programs which do not exclude veterans.

There is widespread agreement the veteran-specific programs funded by VA and DOL work. They fill the gaps in a continuum that otherwise ignores the special problems of veterans, and they help veterans to leave the streets and become full citizens. Today we are here to learn from them, and to see what they need. I look forward to today's testimony.

## PREPARED STATEMENT OF CONGRESSMAN EVANS

Thank you, Mr. Chairman. I commend you and Ms. Brown for holding this hearing today on grants to programs that assist homeless veterans. In part, this hearing will examine the lessons that can be learned from the successful veteran-specific grant programs of both the Department of Veterans Affairs (VA) and the Department of Labor (DOL). These relatively small grants permit community-based organizations (CBOs) to tailor programs that fill the gaps in the local continuum of care.

Community-based providers offer services that many homeless veterans really need. DOL and VA grant programs differ because they seek to address different needs in the continuum of care. DOL's Homeless Veterans Reintegration Projects (HVRP) grants provide funds to CBOs working on employment issues—training, job readiness, presentation and resume skills. VA's Grant and Per Diem program and Compensated Work Therapy (CWP) programs are part of the Veterans Health Administration (VHA), and fit into the matrix of VA health care efforts.

I am pleased that yesterday the full Veterans' Affairs Committee passed H.R. 2280, the Veterans' Benefits Improvement Act of 1999. This legislation includes authorizing step increases in the funding for the Homeless Veterans Reintegration Program beginning at $10 million in fiscal year 2000 and increasing to $30 million in fiscal year 2004. We have worked hard, and for several years, to keep this highly effective program funded. This new authorization is a major step.

The Department of Housing and Urban Development (HUD), the federal agency with major responsibility for programs to end homelessness has been invited to participate in this hearing. For the most part, HUD grants are of a vaster scale, aimed at cities rather than individual programs. Here, I think, we are less concerned with grant recipients providing veteran-specific programs than with making sure the CBOs with such programs are allowed to reach the table locally.

Too many communities have long-standing networks of organizations that serve veterans only inadvertently, because they are a third of the mix that walks in the door. One-third of the Nation's homeless population needs to receive focused assistance. HUD's efforts to assist homeless veterans must push beyond happenstance. Veteran-specific CBOs need technical assistance, and HUD must push communities to bring veterans to the table. I have seen no evidence to suggest that HUD cares whether veteran providers are part of the continuum of care, despite the massive numbers of homeless veterans in our communities. HUD needs to get beyond lip service and directories.

We will also hear today from the National Coalition for Homeless Veterans (NCHV) and several community-based providers who are familiar with the programs we are evaluating. In addition, several of the Nation's veterans service organizations (VSOs) have been invited because of their expertise, both as advocates and as providers of services to homeless veterans. We are particularly pleased to welcome as a witness a veteran who has been homeless and who can tell us how community-based programs have made a positive difference in his life.

I commend Chairman Everett and Ranking Member Brown for holding this hearing today, and I look forward to what we can learn from it. Thank you.

GAO

United States General Accounting Office

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Thursday, June 24, 1999

# HOMELESS VETERANS

# VA Expands Partnerships, but Effectiveness of Homeless Programs Is Unclear

Statement of Cynthia A. Bascetta, Associate Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-150

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our recent report on VA's homeless programs.[1] Homelessness is a complex and difficult problem. The exact number of homeless is unknown, but on any given night an estimated 500,000 to 600,000 homeless people live on the streets or in shelters.[2] The Department of Veterans Affairs (VA) reports that approximately one-third of the adult homeless population are veterans, and these homeless veterans suffer about the same relatively high rates of psychiatric and substance abuse disorders as the general homeless population. Over the past decade or so, VA has established several programs to address the special needs of homeless veterans; these targeted programs supplement the health care services provided through VA's medical facilities. In fiscal year 1997, VA obligated approximately $84 million to these programs targeted to homeless veterans. Other federal departments and agencies have also developed programs to assist the homeless. In fiscal year 1997, the federal government, including the Departments of Education, Health and Human Services (HHS), Housing and Urban Development (HUD), Labor, and VA, and the Federal Emergency Management Agency, spent approximately $1.2 billion on targeted homeless assistance.[3]

Federal agencies serving the homeless, including VA, have begun to coordinate their activities with each other and with community-based service providers. These collaborative efforts are intended to minimize barriers to service, avoid unnecessary duplication of services, and enhance service provision. The development of these programs and the investment in them have generated questions about their effectiveness. As you requested, my remarks today will focus on (1) VA's programs to address homelessness, including efforts made in partnership with community-based organizations, and (2) what VA knows about the effectiveness of its homeless programs. To develop this information, we conducted work at VA headquarters and VA's Northeast Program Evaluation Center (NEPEC) in West Haven, Conn., and reviewed reports from federally funded research programs. We visited VA and community-based homeless programs in Little Rock, Ark.; Denver, Colo.; Washington, D.C.; Los Angeles and San Diego, Calif.; and New York, N.Y.

In brief, we found that in addition to the need for housing, homeless veterans typically have multiple problems, which may include medical and mental health problems, limited work skills, and long-standing social isolation. Research suggests that effective interventions for the homeless involve comprehensive, integrated services to address their multiple needs. VA provides medical, mental health, and substance abuse treatment to homeless veterans through its health care facilities. In addition, VA's targeted homeless programs address a variety of nonmedical needs by providing services such as case management, employment assistance, and transitional housing. To leverage its efforts, VA has developed partnerships with other federal departments, state and local government agencies, and community-based organizations. While much activity has occurred and many millions have been spent, VA has little information about the long-term effectiveness of its homeless programs. VA has conducted some research over the years to identify program outcomes, but methodological weaknesses in those studies have limited the extent to which they can be used to assess program effectiveness. As a result, little is known about whether veterans served by VA's homeless programs remain housed or employed, or whether they instead relapse into homelessness. For this reason, we recommended that VA initiate a series of program evaluation studies designed to clarify the effectiveness of its homeless programs. VA concurred with this recommendation. It has one study of outcomes for veterans judged ready for permanent housing under way and plans several more on its new homeless initiatives.

**Background**

Veterans constitute about one-third of the adult homeless population in the United States on any given day. They form a heterogeneous group and are likely to have multiple needs. Many homeless veterans need treatment for medical or psychiatric conditions in addition to housing and other supportive services. Although many questions remain about how to treat homelessness, a series of research initiatives launched in 1982 and funded primarily by HHS suggests that effective interventions for the homeless involve

[1] Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness Is Unclear (GAO/HEHS-99-63, Apr. 1, 1999).

[2] Martha R. Burt, "Demographics and Geography: Estimating Needs," paper presented at the National Symposium on Homelessness Research: What Works, cosponsored by the Department of Housing and Urban Development and the Department of Health and Human Services, Oct. 1998.

[3] Homelessness: Coordination and Evaluation of Programs Are Essential (GAO/RCED-99-49, Feb. 26, 1999) provides an inventory of targeted and nontargeted federal programs that assist the homeless.

comprehensive, integrated services. These initiatives also suggest that a range of housing, treatment, and supportive-service options needs to be available to the homeless, and that flexibility is needed to appropriately match services to the individual needs of homeless people.

Although meeting the most basic needs of a homeless person for food, clothing, and shelter is a first step, it is rarely sufficient to enable a person to exit homelessness. Instead, progress in achieving housing stability requires comprehensive attention to the full range of a homeless person's needs. VA estimates that approximately one-half of homeless veterans have a substance abuse problem, approximately one-third have a serious mental illness (and of those, about half also have a substance abuse problem), and many have other medical problems. Some homeless veterans need assistance in obtaining benefits, managing their finances, resolving legal matters, developing work skills, or obtaining employment. Supportive services such as transportation or child care may also be needed. Problems in any of these areas can interfere with progress. As examples, untreated mental illness may interfere with a person's ability to retain housing, and lack of transportation may limit access to medical appointments or job interviews.

Research suggests that positive outcomes are promoted by integration of services, as well as by comprehensive services. Attempts to address the needs of a homeless person sequentially, or simultaneously but without coordination, seem less effective than strategies that involve integrated efforts to address multiple needs. For example, homeless people who have both a mental illness and a substance abuse problem have been found to benefit more from integrated treatment programs than from programs that approach these problems separately. Similarly, the effectiveness of employment and training programs for the homeless is enhanced by linkage to housing assistance and supportive services. Integration is needed in part because of fragmentation of the homeless service-delivery system, which involves different organizations that address different needs. Case managers can facilitate integration by helping the homeless obtain services in ways that complement rather than conflict with one another. In addition, organizations that serve the homeless can collaborate to promote integrated, comprehensive service provision.

Experts suggest that in terms of housing, the goal of homeless assistance programs should be stable residence in a setting that allows the highest level of independence each person can achieve. For some homeless veterans, independent housing and economic self-support are reasonable goals. But for others, including many seriously mentally ill homeless people, neither full-time work nor independent housing may be feasible. Instead, for these individuals, residence in a supportive environment, such as a group home, may be the most reasonable outcome. In addition, transitional housing may be necessary before a more permanent housing arrangement can be achieved. Thus, efforts to assist the homeless require a range of housing options (including emergency shelter as well as transitional and permanent housing); treatment for medical, mental health, and substance abuse problems; and supportive services such as transportation and case management. This spectrum of options is referred to as the continuum of care. Because the homeless have diverse needs and local resources vary, flexibility in arranging partnerships among organizations optimizes the development of a continuum of care at the local level.

**VA Provides Key Services, Builds Capacity Through Partnerships**

VA provides key services to homeless veterans through its mainstream health care programs. In addition, VA has established several programs specifically targeted to homeless veterans, providing veterans at some VA facilities services such as case management, work rehabilitation, or residential treatment for mental illness or substance abuse. Because it does not have sufficient resources to address all the needs of homeless veterans, VA has expanded its partnerships with community-based providers. Thus, VA is working with other agencies to identify and prioritize gaps in service availability and to develop strategies for meeting those needs–that is, to develop a continuum of care for homeless veterans.

Many homeless veterans receive medical, mental health, and substance abuse services through VA's mainstream health care programs. Although VA does not know the extent to which its annual health care appropriations are spent on medical care and other treatment services for homeless veterans, recent estimates suggest the amount is substantially greater than the level of funding for VA's targeted homeless programs. VA's

targeted homeless efforts include additional services, such as outreach to identify homeless veterans, case management to assess the needs of homeless veterans and link them with appropriate VA or community-based service providers, job counseling and placement assistance, and referral to residential treatment programs to address clinical disorders.

Since establishing its targeted homeless programs, VA has worked with other service providers and expanded its relationships with community-based organizations. This commitment to partnering is reflected in annual meetings among VA homeless program staff and other homeless service providers and organizations. These meetings are intended to promote a collaborative effort to assess, plan for, and address the needs of homeless veterans. VA has acknowledged that it alone cannot meet all the needs of homeless veterans. Not only are its resources insufficient, but VA's homeless programs are not available in all locations. By partnering with other providers, VA increases its potential for stretching its resources to provide needed services to homeless veterans and ensure better coordination of services.

The specific services available to homeless veterans vary across VA facilities and may be offered through VA or through arrangements made by VA with community-based service providers. Through VA's Homeless Chronically Mentally Ill (HCMI) program, 62 VA medical facilities contract with existing community-based providers to provide time-limited residential treatment to mentally ill or substance abusing homeless people. For example, some homeless veterans seen at San Diego's VA Medical Center are referred to the Veterans Rehabilitation Center operated by Vietnam Veterans of San Diego. This facility specializes in treating substance abusing homeless veterans with post-traumatic stress disorder or serious depression. As another example, some homeless veterans with substance abuse problems or mental illness receive convalescent medical care at Christ House through a contract with the VA medical center in Washington, D.C. Veterans served through these contracts receive case management from VA staff and may receive some of their medical or mental health treatment through VA.

As part of VA's effort to expand its partnerships with community-based providers and increase the availability of transitional housing, VA developed the Homeless Providers Grant and per Diem (GPD) program. In contrast with the HCMI program, which involves contracting with existing community-based residential treatment facilities, the GPD program awards grants and per diem payments to public and nonprofit organizations that establish and operate new supportive housing and services for homeless veterans. When grants awarded during this program's first 5 years (1994 through 1998) become fully operational, VA estimates that over 2,700 new community-based transitional housing beds will be available for homeless veterans. Moreover, VA has indicated its intention to continue expanding this program. To date, a heterogeneous group of programs has been funded. In some cases, veterans who have completed a residential treatment program through VA's HCMI contract program move on to a GPD facility, which offers transitional housing in conjunction with supportive services. As an example, at the West Los Angeles VA Medical Center, homeless veterans may first be referred for residential substance abuse treatment and then, once they have completed such a program, be referred to L.A. Vets' welfare-to-work program, where they receive housing and assistance in obtaining and maintaining employment through a GPD program. In a few instances, VA has awarded GPD funds to programs with more unique missions. For example, the Veterans Hospice Homestead in Leominster, Massachusetts, provides housing and support for terminally ill homeless veterans.

In addition, the Veterans Programs Enhancement Act of 1998 (P.L. 105-368) authorized VA to guarantee up to $100 million in loans to construct, rehabilitate, or acquire land for multifamily transitional housing projects for homeless veterans.

**Effectiveness of VA Homeless Programs Is Unclear**

VA's NEPEC monitors and evaluates VA's homeless programs. Although NEPEC collects extensive descriptive data, it has only limited information about the effectiveness of VA's homeless programs. Homeless program sites routinely submit data to NEPEC, but this information is generally used for monitoring program activities rather than for evaluating program effectiveness. That is, the data routinely collected by NEPEC are used primarily to provide program managers with information about aspects of specific homeless program sites, such as characteristics of the veterans served and length of stay in treatment. This information is used for comparison with other program sites or with

standards established by legislation or VA policy. Research designed to evaluate program effectiveness requires more rigorous and costly data collection methods than those NEPEC routinely uses for monitoring purposes. For example, NEPEC collects some data about program participants upon discharge from a homeless program, including information about housing and employment status and changes in substance abuse and mental health problems. These data are of limited use, however, in assessing program effectiveness, because the measures are relatively imprecise and do not indicate what happens after a veteran is discharged from treatment. As a result, VA cannot use this information to determine whether veterans served by its homeless programs remain employed or stably housed over the long term. NEPEC has conducted several studies in which additional data, sometimes collected on follow-up, were obtained from program participants. Results of these studies led NEPEC to conclude that veterans served by VA's major homeless programs, the HCMI and Domiciliary Care for Homeless Veterans (DCHV), derived substantial benefit from their participation. We found, however, that methodological shortcomings in that research prevent firm conclusions about program effectiveness.

Program Data Focus
on Descriptive Characteristics,
Status at Discharge

NEPEC collects and analyzes a wide range of descriptive information regarding program structure, veteran characteristics, program processes, and veteran status at discharge for specific sites. Program managers use this information to monitor and compare program sites. These data would indicate if programs failed to conform to intended guidelines. For example, by monitoring diagnostic information, NEPEC can determine whether programs designed for homeless mentally ill veterans are serving that population.

When discharged from a VA homeless program involving transitional housing or residential treatment, a veteran's reported housing and employment status are recorded. In addition, participants are rated for changes in alcohol, drug, and mental health problems, but the rating system that VA has been using has allowed case managers, at most, to indicate that the problem has worsened, remains unchanged, or has improved.[4] These assessments are made at the time that the veteran is discharged from a DCHV program or at the time that VA stops paying a per diem fee to a contract residential treatment facility or a GPD facility. If VA pays for only part of a veteran's course of treatment, and the veteran remains in treatment with a community-based provider after discharge from VA's homeless program, then the veteran's status upon completion of treatment (which may occur some time later) is not captured in NEPEC's data.

In fiscal year 1997, about 8,500 veterans were discharged from VA's two largest and oldest residential treatment programs, the DCHV program (in which homeless veterans receive rehabilitative services while occupying dedicated beds at VA medical centers) and the contract-based HCMI program. NEPEC reported that of the homeless veterans served through the DCHV program, 62 percent successfully completed the program (that is, the veteran and clinician agreed that program goals had been met). It also said that 57 percent of DCHV veterans were housed at discharge, and 52 percent reported full- or part-time employment at discharge. NEPEC reported that of those served through the HCMI program, 52 percent successfully completed the program. It further said that 39 percent of HCMI veterans reported having their own apartment, room, or house at discharge, and 43 percent reported full- or part-time employment at discharge. About three-fourths of participants in each program were rated by VA as improved in drug, alcohol, and mental health problems. How to interpret these ratings, however, is not entirely clear. Almost all participants who were deemed to have completed a program successfully were rated as improved in these domains. It is difficult to interpret a rating of "improved" with regard to drug or alcohol use when that assessment is made at the end of a program that requires participants to avoid alcohol and drugs (as VA residential treatment programs do), especially when the only alternative ratings are "unchanged" or "worse."

During fiscal year 1997, over 1,000 veterans were discharged from VA's GPD program. Reported outcomes were less favorable for these veterans; in particular, the proportion of unsuccessful discharges from GPD programs was high. As VA noted, however, the GPD program is relatively new, and early data may not provide a clear basis for evaluation. For example, veterans who were benefiting from their placements might not have been

[4]NEPEC has indicated its intention to begin using a 5-point rating scale to assess changes in alcohol, drug, and mental health problems.

discharged from the GPD program yet, so no information about them would have been included in the data.

Limited Information Available About Program Effectiveness

Although outcome research can be difficult and costly, VA has acknowledged the need for program evaluation and includes such efforts in its strategic plan under the Government Performance and Results Act of 1993. In addition to routine monitoring of homeless programs, NEPEC has conducted studies that suggest that veterans served through VA's homeless programs are better off after receiving program services than before admission. Methodological shortcomings in that research, however, prevent strong conclusions regarding program effectiveness. NEPEC does not typically collect or examine data in a way that clarifies the long-term effectiveness of its programs, the effect of specific interventions in comparison with alternative treatments, or which interventions work for specific populations. We noted in our April report that program effectiveness could be clarified by additional evaluation research.

To identify the benefits associated with program participation, NEPEC conducted pilot follow-up projects at a sample of its homeless program sites between 1987 and 1990, using more detailed outcome measures than VA typically collects from program participants. Follow-up is needed to determine whether veterans are still employed, housed, or successfully dealing with substance abuse or mental health problems after program completion. NEPEC concluded that, compared with their status at admission, veterans showed improvements in housing, employment, mental health, and substance abuse problems 6 months after discharge from DCHV treatment and that, with the exception of alcohol use, these improvements remained evident 1 year after discharge. Similarly, veterans who participated in the HCMI program were assessed from 1 month to 2 years after their initial contact with VA homeless staff. On average, these veterans were last interviewed 8.3 months after their first contact. About two-thirds were admitted to residential treatment; of these, some were still in residential treatment when last interviewed. NEPEC concluded that veterans who participated in VA's HCMI program (including both those who were and those who were not provided with contract residential treatment) showed improvements in terms of housing, employment, psychiatric problems, and substance abuse upon follow-up relative to initial contact.

These follow-up studies represented a major undertaking in terms of resources and effort, and they suggest that the DCHV and HCMI programs are worthy of further investigation. However, these studies had two major shortcomings that NEPEC acknowledged in its reports and that limit the extent to which firm conclusions can be drawn about program effectiveness. First, post-program outcome data were not obtained from a substantial number of veterans. As a result, interview data were not collected from a fully representative sample. Follow-up interviews were conducted with only 72 percent of the veterans who agreed to participate in these studies. Although the status of those veterans who were not reinterviewed is not known, it is possible that the veterans who were doing the poorest were also less likely to be reinterviewed. As a result, the data from those who were reinterviewed could suggest more positive outcomes than would be true for the program as a whole. Second, no data were obtained from veterans who did not participate in the DCHV or HCMI programs. Data from such groups would have allowed an estimate of the degree of improvement attributable to the DCHV or HCMI programs. It is possible that some of the improvements noted among those veterans who were reinterviewed would have occurred in the absence of DCHV or HCMI treatment. Other research suggesting that some improvement over time may occur among the homeless, even in the absence of intensive treatment, highlights the importance of comparison data. Without data from an appropriate comparison group of veterans who were not served through VA's homeless programs, VA cannot determine how much veterans benefited from those programs.

In addition, NEPEC analyzed data from small subsamples of participants in the HCMI follow-up study to examine relationships between measures of program participation and improvement. These analyses suggested that certain aspects of participation in the program, such as longer stays in residential treatment, were associated with greater improvement. Again, these findings are promising, but NEPEC acknowledged that strong conclusions could not be reached because of methodological limitations. Research designed to clarify the processes that make interventions effective, or what aspects of treatment are associated with positive results for different clinical groups (for example, those with serious mental illnesses or those with a substance abuse disorder), can yield information relevant to efforts to improve programs or to optimize program outcomes.

NEPEC officials have occasionally conducted such analyses, which require them to supplement their data files with additional information (for example, about treatment approaches). Clear conclusions about what treatment strategies are most strongly associated with achieving housing stability, and about which strategies work best for which veterans, require more rigorous and costly research methods than NEPEC has typically employed.

NEPEC officials stated that they have not conducted additional evaluation research on VA's core HCMI and DCHV programs because obtaining follow-up information on this hard-to-serve population is difficult and expensive. A NEPEC official estimated that if it were to conduct another follow-up study, the cost would be about $60,000 per site per year, and noted that multiple sites would be needed to ensure generalizability. Total cost would thus depend on the number of sites sampled and the length of the follow-up interval.

NEPEC is not currently conducting evaluation research on its largest residential treatment and transitional housing programs (the DCHV, HCMI, and GPD programs). It is, however, studying some of VA's other programs. Follow-up data are being collected from participants in one of VA's smaller programs called the Housing and Urban Development-VA Supported Housing program. In this program, intensive case management and vouchers for permanent, subsidized housing are made available to homeless veterans through a cooperative arrangement between VA and HUD. To evaluate this program, NEPEC has collected follow-up information from a sample of program participants, as well as from a comparison group of veterans who were considered appropriate candidates for permanent housing but who were randomly assigned to receive either intensive case management without a housing voucher or more traditional case management through VA's HCMI program, again without a housing voucher. In addition, veterans who have participated in the Compensated Work Therapy/Transitional Residence and VA Supported Housing programs are also reinterviewed periodically.[6] VA has recently indicated its intention to initiate three new homeless programs and to evaluate each of those programs using follow-up procedures similar to those it has used in the past. These new initiatives involve using a promising case management strategy called Critical Time Intervention, developing programs for homeless women veterans, and implementing a vocational service called Therapeutic Employment, Placement and Support. A NEPEC official acknowledged that to minimize the cost of these evaluative efforts, the methods used to evaluate Critical Time Intervention and the homeless women programs are likely to be less rigorous than would be ideal.

In our April report, we recommended that a series of program evaluation studies be conducted to clarify the effectiveness of VA's core homeless programs and provide information about how to improve those programs. We concluded that this series of studies should address long-term effects, processes associated with positive outcomes, and program impact. Thus, VA could design follow-up studies to examine, for example, the stability of housing and employment in the year or two after discharge from transitional housing or residential treatment. VA could also undertake outcome evaluations designed to assess program processes to better understand the factors that produce desirable outcomes and how they could be replicated. Such studies could also identify aspects of treatment that are associated with positive outcomes for veterans with different conditions. Finally, VA could estimate how program outcomes differ from outcomes that would be likely in the absence of the program. For example, results observed for a sample of homeless veterans who received a particular kind of treatment could be compared with results for a control group who did not receive that treatment. We also recommended that, where appropriate, VA should make decisions about these studies (including the type of data needed and the methods to be used) in coordination with other federal agencies with homeless programs, including HHS, HUD, and Labor.

Even though evaluation research can be difficult and expensive to conduct, we concluded that such studies are necessary to ensure that VA directs its resources to those efforts with the greatest potential for beneficial effects. VA concurred with our recommendation and described plans to initiate evaluations of several new homeless projects and to supplement NEPEC's budget with $600,000 from the additional $50 million VA requested for its homeless programs in its fiscal year 2000 budget.

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[6]In addition, a small sample of veterans who participate in the GPD program are being surveyed within a few months of their discharge from that program, but the questions focus on verification of the services received, rather than on outcomes.

In summary, VA provides medical, mental health, and substance abuse treatment to homeless veterans through its mainstream health care programs, and it offers additional specialized services for homeless veterans at many of its medical centers and through partnerships with community-based service providers. As VA facilities attempt to develop a continuum of care for homeless veterans, variations in local needs and resources will result in different patterns of involvement for VA and its partners. Because homeless veterans differ from one another in their needs, no single treatment program can serve all veterans with equal effectiveness. Local programs designed to serve groups with different needs are likely to be important components of any continuum of care for the homeless. VA has obtained some information about outcomes for veterans who have participated in its programs, but methodological shortcomings of that research prevent clear conclusions about program effectiveness. Further research on program effectiveness could provide the information needed to make decisions about how to direct VA's limited resources and improve its homeless programs.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

**GAO Contact and Acknowledgments**

For future contacts regarding this testimony, please call Cynthia A. Bascetta at (202) 512-7207. Individuals making key contributions to this testimony included George Poindexter, Kristen Anderson, Timothy Hall, Jean Harker, and Deborah Edwards.

(406172)

# STATEMENT

**of**

**Linda Boone**
***Executive Director***

**of the**

**NATIONAL COALITION *FOR* HOMELESS VETERANS**

**before the**

**Subcommittee on Oversight and Investigations**

**of the**

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

**The Honorable Terry Everett**
***Chairman***

**June 24, 1999**
**Washington, DC**

Mr. Chairman, on behalf of the **National Coalition *for* Homeless Veterans (NCHV)**, I thank you for the opportunity to present our views here today. We have learned a great deal concerning what is working to reconnect homeless veterans, and what is not and look forward to sharing these with the committee. 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. That is approximately 275,000 men and women who have worn this country's uniforms, been trained at great expense in many of the most advanced technical skills, stood guard over all that we hold sacred and dear, and in some cases, incurred physical and psychological injuries.

We have all heard the stories of their descent into homelessness. In many cases, the reasons could befall any of us, the death of a loved one, the loss of a job, prolonged medical disability and a variety of other triggering events. Some have problems associated with their military experience, the lack of transferable skills to the civilian labor market, PTSD, the difficulty of transitioning from military to civilian life.

Fortunately there are organizations dedicated to helping veterans break the cycle of homelessness and hopelessness. The National Coalition for Homeless Veterans (NCHV) is a coalition of community based service providers in 43 states and the District of Columbia dedicated to ending homelessness among veterans.

The National Coalition for Homeless Veterans is a nonprofit 501(c)(3), established by seven homeless veteran service providers in 1990 to educate America's people about the extraordinarily high percentage of veterans among the homeless.

These seven providers, all former military men, were concerned that people did not understand the unique reasons why veterans become homeless and the fact that these veterans, men and women who defended America's freedom, were being dramatically under served in a time of personal crisis. In the years since its founding, NCHV's membership has grown to 244 organizations in 43 states and the District of Columbia.

The current mission of NCHV is to champion the quality of life for homeless veterans by shaping public policy, educating the public, and building the capacity of service providers to meet the needs of homeless veterans.

The majority of NCHV's members provide front line housing and supportive services to homeless veterans and their families. Services fall within the full continuum of care system including street and rural area outreach, drop-in centers, soup kitchens, benefits and legal counseling, emergency shelters, residential substance abuse treatment, transitional supportive housing, job development, placement and retention services, permanent housing, and a plethora of other supportive services.

To prepare for this hearing NCHV sent letters to all its members requesting information on the federal grant programs and how effective the members perceived them to be. We asked for specific enhancements they would like to see and also what worked well in the current process. You will see their comments throughout this testimony in quotes and italics.

At NCHV we are conducting an in-depth survey of our member organizations that will be completed in September. It will capture the demographics of their client base and the resources used to serve these veterans. We plan to release this information in the fall to give a clearer picture how community based organizations are providing services to homeless veterans throughout the nation.

**How many homeless veterans are there?**
In May 1994, NCHV released "Report To the Nation" providing a reasonable estimate of homeless veterans by state and major geographical locations within the state. We estimated the total homeless veteran population to be 271,750. Eight states accounted for 47% of the homeless veteran population, California, New York, Texas, Florida, Illinois, Ohio, Pennsylvania, and Michigan. No other national estimate has been conducted since that time.

NCHV would like to see a requirement that all organizations that federal homeless assistance funding be required to collect minimal data on the veteran status of the clients they serve. This would enable some trend analysis to be developed that could result in more targeted resource allocation. Senator John McCain has introduced S312 that would require that the grantee identify veterans in all federally funded emergency shelter programs and connect the veterans with Department of Veterans Affairs for counseling on veteran benefits. A similar bill should be introduced in the House.

**The myth**
The DVA estimates there are at least 275,000 veterans who are homeless on any given night of the year, with more than double that number homeless at some point during the year (i.e., more that 500,000 veterans homeless at some point during the year). The *highest estimate* is that DVA has some contact with about *38,000 homeless veterans* during the course of the year. For veterans one of the **biggest myths is that the Department of Veterans Affairs takes care of all veterans for all things**. Community groups whether they realize it or not are serving veterans that the DVA is not able to.

The DVA myth gets enhanced because the DVA does a wonderful public relations job about how many programs they have to serve homeless veterans. What gets left out of the message is the number they don't serve and how much communities have to make up the difference. Although the DVA has increased their partnerships with community-based organizations, most communities still believe that the DVA will take care of every veteran in need.

NCHV believes that many members of Congress believe this also. The introduction of HR566 with 84 cosponsors is a case in point. This bill would require the DVA to hold a Stand Down event in every state to address the needs of homeless veterans in that state. NCHV is opposed to this legislation since it assumes the DVA should be the lead agency in an activity that began in 1988 in San Diego as a grassroots activity from veterans themselves to address the needs of the homeless veteran. Stand Down type events have now grown annually to over 100 throughout the nation *based on the needs of each specific community.* Communities (all organizations and advocates, including the DVA) should decide what the outreach activities should be in that community not the DVA as mandated from Congress.

Congress passed PL 105-114 and previous legislation requiring the DVA to annually make an assessment of how homeless veterans' needs were being met in every VA Medical Center catchment area. The intent was to draw a variety of community providers and advocates together to work on meeting the unmet needs within that specific community. This is a wonderful theory and is indeed working in several VAMC catchment areas. However, in many medical centers this activity receives low priority and a prime opportunity to unite a community into addressing the needs of homeless veterans is not realized.

**Why are veterans homeless?**
There are many individual situations that triggered the entry into homelessness by veterans and others. Most often the reasons are grouped into these main areas:

. Employment
- Lack of jobs paying living wage.
- Lack of job skills.

Housing
- Affordable housing unavailable.

Health issues
- Substance abuse
- Mental health
- Other health issues that prevent employment

Sometimes an underlying factor for veterans is related to their military experience. No matter what the cause or variety of causes, NCHV believes that **veterans have earned** special preference for their service to our nation.

In "Priority: Home! The Federal Plan to Break the Cycle of Homelessness" (1994) states that: "Veterans are disproportionately represented (among the homeless)" and "approximately 20-45% of the entire adult male homeless population have served their country in the armed services". Yet today veterans continue to receive an unbalanced share of Federal homeless funding. NCHV members, as grassroots homeless providers, have discovered that **specific legislation is necessary** to make federal entities honor their responsibilities to our nation's veterans.

**Delivery of Services to Homeless Veterans**
Most of NCHV member organizations were founded by veterans wanting to help their brother and sister veterans that had befallen a personal tragedy so great that they had become homeless and were not receiving assistance through "the system" in place to help veterans.

Some of our members serve veterans because there are federal grants available for veteran specific programs that will help them expand their operations by serving veterans.

The majority of our membership consist of new organizations formed in the last 10 years that lack the business acumen of larger more traditional homeless providers. Most have very small staffs use a high number of volunteers and are "*innovating their way from one operational issue to the next and as a result are learning and growing the hard way*".

"*If Congress has concerns about the quality of services being provided or is interested in a better system of reporting the outcomes of veteran services, the best way to address these issues is to put a structure in place that assures a common level of training and service expectations that can be tracked by existing reporting procedures.*" Pennsylvania member

**Health Care**
The transmutation of the Veterans Health Administration of the United States Department of Veterans Affairs from a traditional hospital facility-based system into a "services oriented" system that is organized into the 22 "Veterans Integrated Services Networks" (VISNs) has produced significant reductions in services needed by many veterans, particularly homeless veterans.

The reductions and curtailment of services that concerns NCHV are the drastic reduction in neuro-psychiatric care. Inpatient care for Post Traumatic Stress Disorder (PTSD) has been drastically reduced in both duration and availability. ***Many mental health and substance abuse treatment programs have been eradicated, effectively eliminated, or dramatically truncated.*** For example in VISN 1 (New England area), an inpatient substance abuse program went from 21 days to an outpatient 5 day, 8 hours per day program.

We request establishment of specific requirements or expectations for each VISN to participate in homeless veteran initiatives. The February 7, 1996 NEPEC report *FY95 End-of-Year Survey of Homeless Veterans in VA Inpatient and Domiciliary Care Programs*, found that "23% of all inpatients had been homeless at the time of their admissions". Currently, with the exception that each medical facility have a homeless

coordinator, participation of homeless initiatives by individual VAMC is voluntary. This seems to neglect almost one-fourth of the patients within the VHA. Additionally as further noted in the NEPEC report, this population is "more likely to need inpatient admission to get their treatment started".

The continuing process of ostensibly decentralizing decision making authority within the *Veterans Health Administration* (VHA) by transferring authority for some decisions to each of the twenty-two VISNS is having the effect of precluding VHA from even maintaining the capacity to produce any standardized reporting on a National basis. This makes it difficult to obtain a clear picture of the rapid changes in both the amount and the types of medical care and services being provided at facilities across the United States. In a recent report, the Senate correctly pointed out that virtually all systemic quality control/quality assurance programs have been in effect eliminated or debilitated by the kaleidoscopic changes, both at the VISN level and at the DVA Central Office level. NCHV holds that perhaps it would be most efficient and effective if authority as to how best to accomplish the mission(s) of VHA were decentralized. However, the responsibility for setting the mission(s), and holding the VISNs and each DVA facility accountable for how well that mission is being accomplished has been given to the Secretary of Veterans' Affairs and to the Undersecretary for the *Veterans' Health Administration*. NCHV strongly believes in the military principle of "You may delegate authority; you may *NOT* delegate responsibility." This principle is certainly applicable to these two officials. The DVA must do a better job of standardizing reporting, and in re-instituting meaningful and effective quality assurance systems.

*"We all know that the VA has been forced to do over the past few years and we want to be part of the solution. The substance abuse and PTSD programs have been cut in a time frame or cut completely while being a homeless veteran is just a symptom of a much larger problem that needs to be addressed."*

*"We are turning to more and more of a citizens Armed Forces while still making it harder and harder for those in arms to qualify as veterans when it comes to receiving aid from the VA. If the VA does not wish to provide the services, I believe the veteran should receive a VA Insurance card which can be used at a facility of their choice."* Indiana member

NCHV has a national toll free telephone line that is used by our members and other providers to receive technical and advocacy information. It has also been publicized in a variety of publications that homeless veterans have access to in Vet Centers and VA Medical Centers. When we receive theses calls from homeless or at risk veterans we do a type of homeless triage to determine what avenues and local referral recommendations to make to each veteran. **I am astonished at the number of calls we receive from inside VA Medical Centers where the VA Homeless Coordinator has given our number to the veteran so we can tell them where to go locally.** It is obvious there is no commitment at those VA Medical Centers to learn where local resources are that can serve homeless veterans, instead they move them to someone else's plate.

With significant cuts occurring throughout the nation we urge Congress to examine the strategy of "reinvestment" of the "savings" achieved through the reordering of the way the health care services are delivered. Specifically we would like to see language to ensure that a portion of those resources saved are reinvested to ***meet unmet needs***, not simply reassigned to some other type of care. We believe a required percent reinvestment should be set forth from the program dollars that have been and will be cut in each VISN.

Many community based organizations (CBOs) have a strong record of performance in the delivery of services to veterans in the most vital need, and could do a great deal more inpatient care if the resources were available to meet those unmet needs of veterans. CBOs are a vital link in any continuum of care chain, particularly in an era when there is such concern toward finding the most cost effective means possible for meeting the vital needs of veterans in each community, while preserving the highest standards of quality care.

Traditionally, DVA has been reluctant to contract out any delivery of health care services, except with Medical Schools. However, it is clear that the old paradigms do not apply in this rapidly changing environment. No longer can the DVA be all things to all veterans, fulfilling every role. The DVA must do what it does best, providing front line clinical support, and channel resources to the CBOs to do what they can do best.

The US Department of Health and Human Services (HHS) is not traditionally thought of when discussing the needs of homeless veterans. However, two programs in HHS provide services within communities and are treating veterans particularly those who are not eligible to receive DVA services or where the DVA does not have the capacity.

Health Care for the Homeless program assures access to primary health and other related services, is in the FY2000 budget for $945 million. Veterans are not enumerated in any of the subprograms so no specific data is available. PATH, Projects for Assistance in Transition from Homelessness, is a program targeting homeless individuals with mental illness. It is in the FY2000 budget for $31 million. For the last several years they have reported about 14% of their clients are veterans.

Currently HHS does not have any targeted funding for the homeless with substance abuse problems although unfunded authority exists to do so. With the movement of HUD towards permanent housing and away from providing supportive housing services using McKinney homeless grants, the role of HHS in providing supportive services takes on a new urgency. Currently veterans are not viewed as a client group

within HHS and have no significant advocacy relationships with the agency. This relationship takes on significant importance as DVA continues to cut services that need alternative resource streams.

**Housing**
NCHV members and others 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.

NCHV believes that the need for such housing is accelerating as a result of both the shift of the delivery of health care services by the Veterans Administration from inpatient to outpatient models of service delivery, as well as the system wide pressures on VA to "save money."

The outpatient delivery of neuro-psychiatric care, including substance abuse treatment, treatment for Post Traumatic Stress Disorder (PTSD), and other psychiatric services becomes a real problem for veterans who do not have safe, clean, sober housing.

NCHV has much anecdotal evidence to indicate that the diminishment or virtual elimination of adequate quality substance abuse treatment and other neuro-psychiatric treatment services is a significant problem in virtually every major city. General McAfferty has testified that nationally only 13% of the substance treatment need is met. In some cases the inpatient resources devoted to these purposes have *not* been shifted to delivery of similar services on an outpatient basis. In other cases the lack of safe, clean, sober housing for veterans while in outpatient treatment or participating in partial hospitalization programs destroys any effectiveness that the treatment might provide toward rehabilitation and recovery of the homeless veterans affected.

For most community based organizations, there are three primary resources available for housing to serve homeless veterans, DVA Homeless Providers Grant and Per Diem Program; HUD Homeless Continuum of Care Grants, and government surplus property process.

NCHV believes that the *VA Homeless Providers Grants and Per Diem Program* needs to be put on a "line item" basis, with funding by the Congress at least at the level of $50 Million per year. Currently the amount to be allocated to this grant program is an internal decision within the DVA.

NCHV also requests:

- Removing matching requirements for the per diem portion of grant and just allow payment of $16 per day per veteran for cost of services provided. Current rate of payment is maximum of 50% ($16 per day) and the provider must come up with matching funds.
- Adding approval to allow for in-kind donation value to be counted toward match requirement, if match requirement remains.
- Remove the cap for van purchases. With the increased closure of DVA services and location of other services vans can provide valuable link of services for veterans living in transitional housing.

*"I have some major concern in the timing of the NOFAs on the street and the actual time we agencies are awarded the monies. There is a huge lapse of time between receiving the award and actually getting the money. For example: The DVA Homeless Provider's grant – we were presented the fake check on October 27, 1997, and received the run around for one year and finally received the monies one year and one month later."* South Carolina member

One of our member organizations comments…
*"The competitive awards form DVA and DOL/HVRP both veteran specific programs that make the awards to the awardee directly, have been handled efficiently and effectively. Conversely, the HUD Continuum of Care process is quite different. The local umbrella organization serves as the conduit for the receipt and disbursement of government grant funds. It is through this organization that the homeless providers must submit their applications.*

*The disadvantage of this process is if homeless providers are not aware of this and if they are not a part of the network, they are essentially excluded form the HUD application process and any chance of participation for HUD funding.*

*This current process is complicated, confusing, political, and intimidating for those not familiar with the process.*

*There is an apparent misconception among homeless providers and other funding agencies that the DVA should be the primary source of funding for homeless veteran programs. Those who provide services to homeless veterans know that this is simply not true. Veteran specific programs never have received a fair share and if the funding application process here is similar to the processes in other states, then the apparent inequity of funding for veteran specific programs will remain."* East Coat member

When asked about the discrepancy in awarding Continuum of Care funds, HUD's staff responded that they do not receive many veteran-specific applications, and it is impossible to fund what they do not get.
In 1997 only 107 (3%) of the 3,415 applications received for Continuum of Care funds were submitted by organizations proposing to **serve primarily homeless veterans.**

During this year's annual conference, members of NCHV expressed frustration about not being able to

access HUD's Continuum of Care funds. Members cited as the leading reason veteran-specific programs are frequently "blocked" from inclusion in block grants that many community-based groups believe the myths that "homeless veterans have the exact same problems as all other homeless and, anyway, the Department of Veterans Affairs takes care of all veterans."

NCHV member comments about the HUD process:
*"Make application process as simple as possible. We maintain a minimum staff capable only of meeting the immediate needs of our residents and do not have the excess to dig through cumbersome governmental regulations."* Mississippi member

*"We are not well-known to HUD, the DOL or other federal agencies. What we see year after year is the same old huge nonprofit agencies getting more money. The new guys don't have a chance, except for programs like the DVA Grant and Per Diem program. Please do everything in your power to get equal consideration for small programs with big hearts, even if that means that the larger programs can't add to their inventories."* New York member

*"HUD gave a very high priority to permanent housing. With so many renewals receiving a high priority, new transitional housing for homeless veterans is often a low priority for the HUD application."* California member

*"I am concerned about how the HUD funds are handled for the rural type areas. This is the third year that I have attempted to get funded. What is it that we have to do to see that these funds from HUD are fairly distributed, without having to know someone personally. Please inquire as to why there is so much red tape to get funded and why all of the papermill process."* California member

*"Another problem experienced as the director of a small organization is the lack of time to adequately prepare federal grant requests. I have recently submitted under the VA Grant and Per Diem, the HUD SuperNofa grant, local and state grants, all within a couple of months. The timelines for submissions are extremely tight, offering no room for error, very little time for preparation and to still conduct normal daily operations.*

*Most federal grants do not allow for operating or maintenance costs and for very little administration costs. These costs seem to be the biggest part of my budget, and the hardest to gain funds for from any source."* Utah member

*"HUD Continuum of Care – what seems to be good intentions doesn't work for us locally. The process is slow and a burden on small non-profits with having to come up with a 20% cash match for any supportive service projects. If we had this kind of cash match then we wouldn't need this grant. Furthermore, they will not award in monies for homeless prevention. Leave it to the bureaucracy who would rather spend monies after the fact than giving us small nonprofits the monies to prevent someone from losing everything they own."* South Carolina member

*"There is no program in this area to help veterans and this is something that is needed desperately."* Florida member

NCHV strongly recommends that funding be increased to veteran specific programs in a manner that more reflects the local veteran homeless population needs. These needs should be identified through the DVA CHALENG process that involves providers and advocates in the assessment and service implementation plan.

NCHV supports Rep. Metcalf's bill HR1088 that mandates that 20% of HUD Continuum of Care funds be made available to specifically serve homeless veterans, since HUD has not developed an effective alternative.

Under consideration in the Senate is S1076 that contains a provision for a "temporary flexibility" process for disposing of VA property. We have also heard the House is considering a similar proposal. NCHV is concerned about the impact on homeless veteran providers if this provision is passed. Currently surplus property has to be offered to homeless providers before it can be disposed of. Several of our member organizations have acquired property in this manner and are currently running successful programs for homeless and homeless veterans.

With surplus property they obtain, organizations can leverage the property value to get rehabilitation done, obtain grants, loans, in-kind, etc.

VA surplus property is usually located close to VA Medical facilities that allow veterans to get needed support services easily. Additionally since the property is already in use for veterans that can aid in overcoming NIMBY issues.

With the Senate legislation the homeless organizations would only receive 10% of value where now they receive 100%. Finding available and appropriate alternative property could be a problem due to costs and locations.

This legislation sends 10% of the profits of property sales to HUD Homeless programs. HUD under-funds veteran specific programs now (3% of total homeless dollars go to veteran specific programs, while

veterans are 35% of homeless population). This means homeless veteran specific organizations would suffer more under this bill.

Alternative scenarios are abundant but must include assurance that homeless veterans would directly receive benefits from the sale of veteran properties.

**Employment**

**Work is the key to helping homeless veterans rejoin American society.** As important as quality clinical care, other supportive services, and transitional housing may be, the fact remains that helping veterans get and keep a job is the most essential element in their recovery and reintegration.

The Homeless Veteran Reintegration Program (HVRP) is a job placement program begun in 1989 to provide grants to community-based organizations that employ flexible and innovative approaches to assist homeless, unemployed veterans reenter the workforce. Local programs offer employment and job-readiness services to place these veterans directly into paying jobs. HVRP provides the key element often missing from most homeless programming, job placement.

Through HVRP funds veterans gain access to civilian assistance, ex-military benefits and entitlements, education and training opportunities, legal assistance, whatever is needed to begin the rebuilding process towards employment.

HVRP programs work with veterans who have special needs and are shunned by other programs and services, veterans who have hit the very bottom, including those with long histories of substance abuse, severe PTSD, serious social problems, those who have legal issues, and those who are HIV positive. These veterans require more time consuming, specialized, intensive assessment, referrals, and counseling than is possible in other programs that work with other veterans seeking employment.

The HVRP is virtually the only program that focuses on employment of veterans who are homeless. Since other sources of funding that should be available to our member organizations to fund activities that result in gainful employment are not generally available, HVRP takes on an importance far beyond the very small dollar amounts involved.

The keys to veterans' success are: finding stable housing or shelter; having a place to go where they feel comfortable and can enhance their self-esteem; and, being allowed the opportunity to pursue and be supported in their efforts for seeking employment. Service providers are committed to helping veterans overcome past failed attempts in employment. When veterans recognize the benefits and are motivated, they can be successful in obtaining employment and become a productive member of the community.

The problem is that the state and local agencies that distribute Federal resources for employment, training, and other vital services feel that "veterans are a Federal problem." Unless veterans are specifically and explicitly "written in" to laws, regulations, and appropriations by the Congress, then veterans will be explicitly "read out" of any program at the state and local level. *HVRP* is a program that has assumed an importance far beyond the relatively small amounts of funds involved because it is so difficult or in many cases impossible for veterans' services providers to access other funds that should be available to serve the employment needs of veterans who are homeless. Even though VA and Department of Housing and Urban Development acknowledge that at least 30% of homeless adults are veterans, only 3% of HUD funds pursuant to the McKinney Act go to programs designed to meet the 'special needs' of veterans.

In a similar vein, only 7.2% of all participants who completed a program under Title IIA of the Job Training Partnership Act, designed to assist economically disadvantaged adults were reported to be veterans in Program Year 1995 (the most recent reports available). The number of these who received services directed to meeting their "special needs" as veterans, and building on their special strengths as veterans, were virtually negligible. Even more telling, only 1,353 *homeless veterans* were served by Title IIA in PY 1995, and only 699 *homeless veterans* were served under Title III in that same period according to the SPIR data base maintained by the United States Department of Labor.

***HVRP* is an extraordinarily cost efficient program, with a cost per placement of about $1,250 per veteran entering employment for the years 1989-1995.** This is less than 25% of the cost of JTPA programs, which do not meet the special needs of homeless veterans, even in the rare instances where homeless veterans can secure such services. In at least some measure this is because *HVRP* is primarily a placement program and not a lengthy training program. ***HVRP* is a very inexpensive and extraordinarily cost effective program in comparison to all of the JTPA programs.**

Due to the very small appropriations for this program, $3 million for the past two years, only twenty-two programs in eleven states have received grants. For FY2000 the President's budget is only asking for $5 million to be appropriated. The Department of Labor estimates being able to place approximately 3,500 veterans in unsubsidized jobs with this $5 million for about $1430 per placement cost, still significantly lower than most job placement programs.

NCHV supports the recent markup authorization recommendations of the Subcommittee on Benefits of the House Veterans Affairs Committee at $10 million for FY2000; $15 million for FY2001; $20 million for FY2002; $25 million for FY2003; and, $30 million for FY2004. Our further expectation is that the entire Veterans Affairs Committee and House will support this recommendation and follow through with matching appropriations.

**Other assistance**
Homeless funding also is disbursed through FEMA Emergency Food and Shelter Program that provides no specific enumeration of the number of homeless veterans served. Assistance typically goes to families, not single males. A few years ago the national board of the Emergency Food and Shelter Program used $75,000 of the $100 million appropriations to provide assistance to Stand Down events being held across the nation for homeless veterans.

Transportation is a critical need for veterans in transition from homelessness for medical and counseling appointments, job search and early employment periods.

*"Homeless veterans do not have the mode of transportation to make all the appointments required as an out patient, which are required more and more."* Indiana member

*"Once an incidental expenditure, the current reality is that each veteran may consume $200-$300 of transportation support and that diminishes the dollars available for supportive services."* Pennsylvania member

**Prevention**
An area that is rarely discussed is how to prevent homelessness among veterans. Our coalition spends most of its resources trying to deal with the current disproportionate number of veterans that are now homeless, and prevention issues are deferred.

HR606 is the legislation that deals with the *Congressional Commission on Servicemembers and Veterans Transition Assistance* recommendations. The recommendations under the section addressing the TAP, Transition Assistance Program, are supported by NCHV. This strengthened program is critical in providing the first step for servicemembers with a means of controlling their transition to civilian life, which has often lead to homelessness.

Incarcerated veterans most often are released without a transition plan and swell the ranks of homeless and place a burden on providers. In a very small number of prisons both federal and state, pre-release case management is occurring. Prisons are mainly warehousing people for punishment and do not provide rehabilitation programs to develop needed education and other skills to rebuild their lives once released. We would support a plan to provide pre-release preparation for incarcerated veterans.

Mr. Chairman, the **National Coalition *for* Homeless Veterans** (NCHV) thanks you for the opportunity to present our views on the above matters to you and your distinguished colleagues. We thank you for your leadership in struggling to meet the vital needs of veterans, particularly homeless veterans, in these austere times.

> **Yesterday**, America's veterans served our country in peacetime and in war, with pride and with honor, because America needed them.
>
> **Tonight**, at least 275,000 veterans live an endangered existence in a war zone at home.
>
> **Tonight**, 275,000 seek shelter in the alleys and doorways of America's cities.
>
> **Tonight**, 275,000 sleep without hope in barns and lean-to's in America's countryside.
>
> **Tonight**, 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.
>
> **Today**, they deserve better.

## CURRICULUM VITAE

Linda Boone, Executive Director, National Coalition for Homeless Veterans took over the management of this national organization in April 1996. Although she is a native of Oregon, she came to DC after two years in Little Rock, Arkansas as executive director of a statewide association of nonprofits.

Linda's efforts for veterans' issues started in 1969 as a volunteer in her local community. In 1990 she became aware of the growing crisis of homeless veterans and began her advocacy for these veterans. In September 1993 Linda completed a year as National President of the one million member American Legion Auxiliary.

The National Coalition for Homeless Veterans was founded in 1990 by a group of veteran service providers when they became frustrated with the growing numbers of homeless veterans that were coming into their facilities and the lack of resources to adequately provide services.

The organization opened a Washington, DC office in 1993 to raise the homeless veteran issue at a national level to obtain resources to resolve issue. It is a nonprofit 501c3, membership organization. Funding is from donations, grants and membership fees.

The current mission of NCHV is to champion the quality of life for homeless veterans by shaping public policy, educating the public, and building the capacity of service providers to meet the needs of homeless veterans.

## FEDERAL GRANT OR CONTRACT DISCLOSURE

The National Coalition for Homeless Veterans received $36, 016 Federal funding in FY99 (Oct. 1, 1998-Sept. 30, 1999) to provide targeted marketing for the Work Opportunity Tax Credits.

The National Coalition for Homeless Veterans received $60,000 Federal funding in FY98 (Oct. 1, 1997-Sept. 30, 1998) to provide targeted marketing for the Work Opportunity Tax Credits.

**U.S. House of Representatives**
**Committee on Veterans' Affairs**
**Subcommittee on Oversight and Investigations**
**June 24, 1999**

Los Angeles Times Article, May 1999
**Paul, age 46**

**Paul had already been an alcoholic for four years before joining the Navy at age 17. Six months before his 18th birthday in 1970, the West Los Angeles native was shipped off to Vietnam, where he worked for 18 months as a hospital corpsman caring for the injured and dead. He was also sent deep into enemy territory as part of a "hit team."**

**"Seeing all that blood and death was traumatic and terrifying for someone as young as I was," he said. "The first thing I did when I got there was find out where the drugs were. To ease the pain, I would self-medicate. It made me not care and not feel the fear that I did when I was sober."**

**Over the years, Paul said he tried a number of drug rehabilitation programs for the wrong reasons. Now, having been at New Directions since February, Paul said the comprehensive, long-term approach to rehabilitation is the only way he can turn his life around.**

**"Now I've got clothing, shelter, medical and dental. This is the best thing that ever happened to me", he said. "I'm looking inside and bringing to the surface the things I'd tried to bury."**

**William, age 53**

**At age 18 he joined the Marine Corps so he could move to California. In 1966, shortly before he was scheduled to be shipped out to Vietnam, William's mother called him and told him that her boyfriend had "messed with" her niece.**

**William went home to confront the boyfriend and instead was shot repeatedly and was in serious condition. Months later, William left for Okinawa. His body had healed but his emotions had not.**

**In 1967, William landed in Da Nang amid some of the fiercest fighting of the war. He was horrified. "We'd wake up every morning to artillery (fire). You'd be talking to some guy and the next minute part of his brain would be gone."**

**William was 25 when he got out of the military. After years of drugs and alcohol he tried a 30-day drug rehabilitation program at the VA. To celebrate his 30 days he "got a big ol' rock of cocaine."**

**William spent more than 10 years living on the streets. His body had almost completely shut down by the time he arrived at New Directions. Despite being clean and sober for 14 months, 25 years of addiction has taken its toll on William's health. He probably won't be able to work full-time again.**

**"I feel loved and cared for," he said. "I never have loved myself, but now I do. I am somebody."**

**"If not for New Directions, I would have gone into a diabetic coma and ended up in the graveyard. I'm sure I would have died in the streets".**

**New Directions deals with life and death issues, giving veterans one more chance at life. No promises are made, just the commitment of taking one day at a time. Over time, lives change..... dramatically.**

**The Problem**

Los Angeles County has an inordinately large number of homeless men and women; the current figure is as high as 83,000 people. According to the Los Angeles Homeless Services Authority, homeless veterans account for 36% of this population. It is a difficult population, known to be the most service resistant of the dispossessed. Years of physical deterioration, psychological problems and undiagnosed post -traumatic stress disorder (PTSD) have increased the need for comprehensive services for this population..

There is a dramatic shortage of substance abuse beds in Los Angeles County. Waiting lists can be as long as three to six months, and most substance abuse beds are in short-term programs that are ineffectual. Years of destructive behavior cannot be cured in 30 to90 days. Therefore, the clients are likely, to relapse-creating further cost to society and harm to the individual.

**A Solution**

New Directions' program is designed to stop the revolving door in which so many homeless veterans are trapped. By providing comprehensive long-term services in a single location, New Directions helps ensure that the veterans who complete its substance abuse program can go on to become employed at a livable wage and no longer be a burden on society. One study has shown that: "Best estimates are that for every $1 spent on drug treatment, there is a $4 to $7 return in cost savings to society."(Los Angeles Times, 6/11/99, Alan I. Leshner, Director, National Institute on Drug Absuse at the National Institutes of Health).

The most unique aspect of New Directions is the vocational training program and on-site businesses that give the veteran an opportunity to work in a controlled environment and earn money for the transition back into the community. When job training has been completed, the process of job search, interviews and placement can begin. The physical, mental, spiritually, and emotional transformation from detoxification (detox) to job placement is dramatic.

The New Directions seamless approach provides free, long-term transitional housing, food, clothing, job and life skills training, remedial education, professional and peer counseling, a structured substance abuse program, permanent housing placement, legal services, job placement and job retention. Through the New Directions program, medical services are offered to the veteran at the nearby VA hospital, including a pysyco-social evaluation, and TB, HIV, and hepatitis testing. Other medical and surgical services are available to veterans who qualify. The VA nursing staff provides education and information to New Directions residents on issues of personal health and hygiene as well as a smoking cessation.

A resident can stay in the program for up to two years unless, in addition to chronic substance abuse, there is a medical or psychological determination that would prevent him from working in full-time employment. That resident would be eligible for the Shelter Plus Care Program (HUD) and could stay at New Directions for five years, working part-time (with medical approval).

**The Program**

New Directions is a comprehensive drug and alcohol treatment and vocational rehabilitation center working to permanently alter the chemically dependent lifestyle of the chronically recidivistic homeless veteran population. The program is licensed by the State of California Department of Drug and Alcohol Programs as a duly recognized drug and alcohol treatment facility with qualified, experienced addiction and vocational counselors. Since opening the 156 bed facility it has steadily increased its numbers to capacity.

New Directions' clients come from throughout Los Angeles County. They range from 24 to 77 years of age; the median age is 45. Approximately 70% are African-American, 10% Hispanic, and 20% are Caucasian. These homeless male veterans have chronic substance abuse problems. The typical resident has had a long history of treatment failures, is treatment resistant, and is diagnosed as a chronic polysubstance abuser. The majority has concomitant diagnoses of one or

more personality disorders and a history of self defeating, maladaptive behaviors with repeated occupational, academic, and social/interpersonal failures as well. Very often they have had some experience with the criminal justice system; often spending years behind bars for addiction related crimes.

New Directions overarching goals for the residents are remaining clean and sober, finding and maintaining full time employment and affordable housing, money management, creating community supports, and reunification with family or other loved ones. All of these goals are typically met within 9-12 months of treatment in the program. Although the program is designed for up to two years of treatment, veterans are not expected to stay for that entire time. The first year is comprised of substance abuse treatment and vocational training; the last year is for supportive aftercare and fellowship. This time frame is significantly different from that reported in the April 1999, GAO Report to the Chairman, Committee on Veterans' Affairs, US Senate.

The program begins with extensive outreach measures through which veterans are taken from the streets into detoxification (detox) for 3-12 days. For those who are screened into the program, they then receive 3-5 months of substance abuse treatment. This constitutes the First Phase of the treatment program.

During the First Phase, the resident also receives remedial education from the L. A. Unified School District (LAUSD), a community partner providing services on the premises. Initially, all residents are evaluated to determine if they meet the minimum state standards for reading, writing and mathematics literacy. This innovative class is conducted four days a week and utilizes substance abuse recovery-oriented materials..

A large percentage of the men entering the program need help resolving problems with the legal system. Therefore, local attorneys and law students (sponsored by Public Counsel) provide legal clinics. New Directions also works closely with the local drug courts. Parenting classes are also offered and some of the residents are court-ordered to this component of the program. Family reunification groups are held by our trained counseling staff every week as a large number of the men we serve are fathers, who have not seen their children in years.

New Directions believes that an important part of encouraging veterans in their recovery from homelessness and chemical dependency is to help develop a life worth living through meaningful employment. After the resident stabilizes in treatment, which is determined by a multi-disciplinary staff on an individual basis, the opportunity to enroll in one of several training programs is provided. This component of treatment can last another 4-6 months and begins the Second Phase of the program. It is well documented that vocational training is a critical part of the recovery process from homelessness and addiction. (For example, see "Work and Identity in Substance Abuse Recovery", in the Journal Of Substance Abuse Treatment, Vol. 15, No.1, pp.65-74, 1998 by Joshua Room and the Alcohol Research Group, Berkeley, CA)

Two vocational training programs are conducted on site through the State of California's Employment Development Department's Job Training Partnership Act (JTPA). The Culinary Arts Training is taught by Los Angeles Trade Technical College and is a complete multi-module program that awards certificates of training well recognized by potential employers. Additionally, handiworker training is provided at the facility by Los Angeles Unified School District through JTPA. This includes instruction in basic carpentry, painting, plumbing and electrical skills. The State Department of Vocational Rehabilitation also offers job training and education funding and services to the residents on site.

Chrysalis, an employment agency for homeless and at risk populations, offices at New Directions with staff that provides services including resume preparation, mock interviews, job counseling, job search assistance and employment placement. Chrysalis works with employers interested in hiring veterans checking with both employer and employee to make sure the relationship works.

Nearly 90% of New Directions residents are in need of dental care. A simple smile helps in building self-esteem and confidence. However, unless a veteran has a dental problem that is service connected, dental services are not available to them.

**Replicating the program**

There continues to be a need for veteran specific programs throughout the country. There are also vacant buildings and underused veteran facilities. The only component missing is individuals with the passion to help veterans. The staff at New Directions would be honored to share this unique program with communities across the country.

New Directions is funded by a combination of funding sources. Since the West Los Angeles VA is surrounded by four cities, they were all asked to contribute to the building rehabilitation cost of $5.4 million. Los Angeles County, HUD, the VA, Congressional Special Purpose Grant, and AmVets all joined together to complete the funding package.

Program an operating funding is a result of grants primarily from HUD and the VA Grant and Per Diem program. A combination of EDD/JTPA (State Veteran-Title 4) and HUD provide the job training and job placement funding. Foundation grants, donations and contributions help with capital purchases and support activities not covered by grants.

The two phases of the program are highly structured and are easy to replicate because of the concrete steps leading to completion of each phase. As a result, this program is easily exportable to other communities wishing to serve homeless veterans. The measures of success are definitive and easily quantifiable. Of course, in a program that is so diverse there are numerous measures of success.

New Directions provides a successful alternative to inpatient care for the VA. In 1992, the WLA VA had 1,500 acute inpatient beds, now it has about 400 beds. Not only has New Directions made a significant difference in the quality of life of homeless veterans, it has been a major factor in making the VA more efficient.

**Facts**

The GAO report states that in fiscal year 1997, homeless veterans received an average of 73 days of treatment. The average stay in New Directions from January to June 1999 is 175 days (not including detox). The total number of days abstinent from chemicals that is typically considered necessary for treatment success for chronic substance abusers is 90 (see June 1999 issue of Archives of General Psychiatry).

**Men's program**

**Some statistics from the program January 1, 1999 to June 14, 1999:**

209 veterans came into detox
43% of those accessing detox entered the program
31% successfully completed detox and were referred to transitional or permanent housing
71% of veterans entering treatment this year, reside at New Directions and continue to progress.

96% of veterans exiting detox and treatment left clean and sober
61% exiting detox and treatment moved to transitional or permanent housing
52% of those entering the program successfully completed the substance abuse and vocational treatment program with an average of more than one year clean and sober, employed, trained in money management, and moved to permanent housing in the community, with resolved criminal issues.

**Women Program**

The women's program operates out of two homes in the community. The women who enter the program have all of the multiple disorders and problems the men in the program have with even greater numbers of abuse. Eighty percent of the women have been abused/assaulted and some are homeless as a result of abuse. All have very low self-esteem and it is not uncommon for some to have used their bodies in order to purchase drugs or alcohol. The women range in age from 28 to 54 years of age.

**RECOMMENDATIONS**

1. New Directions has twice received funding from the VA Grant and Per Diem Program for construction. The first grant was for $400,000 which was a portion of the $5.4 million needed to rehabilitate the 60,000 square foot facility which is today the New Directions Regional Opportunity Center. The second grant was $28,000; a portion of the funding for the culinary training classroom recently completed. It is my understanding that few agencies applied for construction funding this year. Since HUD is in the business of housing construction, VA homeless funds may be better spent providing services to veterans, since that is the mission of the VA. It is my recommendation that Congress dedicate needed VA funding for comprehensive services for homeless veterans and leave building construction to HUD.

2. The Per Diem ($16 per day) has been an invaluable addition to our budget. However, there should be a range of payments based on the range of services offered to the veteran. Comprehensive services receive the same $16 payment as those who provide a bed and food. Although New Direction's appreciates the per diem payments having no time limits, when residents begin to earn a paycheck (as a full-time employee), the per diem payment ought to end. Agencies who charge $250 to $350 for rent should not be eligible to claim Per Diem payments. If the rent does not cover the cost of the additional case management, funding through an RFP process ought to be made available for staff salaries. This would be far more cost effective and accountable.

3. There is a critical need for programs, much like New Directions that address the needs of veterans with both a substance abuse problem and a severe and persistent mental illness. It is a population that cannot advocate for themselves and currently there are few programs that can or will accept dually diagnosed veterans. New Directions recommends that Congress direct funding specifically for services for dual diagnosis programs.

4. Also, New Directions has identified an increasing population of aging veterans who can work part-time or occasionally. However, their income is not sufficient to rent or maintain housing. Housing subsidies in the form of Section 8 type of certificates and affordable housing for senior veterans are growing needs.

5. There is great interest in the effectiveness of veteran specific programs and the use of funding. As the GAO report suggests, the funds provided by both the VA and HUD grants are for program and operational costs. HUD provides 12% for administrative costs which hardly begins to address the aspect of a comprehensive study or data collection to determine effectiveness. Also, most social service agencies rely on the expertise of The Rand Institute, local colleges and universities or VA's Dr. Rosenheck to determine what aspects of a problem need to be researched and how the study will be conducted. New Directions suggests that Congress appropriate funding for research. This in no way should take away critical funding that is needed to move veterans from homelessness to self-sufficiency.

6. It is hoped that funding for empirical research would include payments to graduates of the program to come back at one year intervals to be evaluated on a number of measures (such as sobriety, housing, employment, social/community supports). If funding could include $50 per graduate with an average of 50 graduates per year, over a three year period the total cost would only be $7,500 with another $20-30,000 for the hiring of additional staff to perform these evaluations. It would be helpful to explore what characteristic makes these graduates successful. Do they build more of a social support network the longer the stay in the program? Does the job training provide them with greater employment and, thus, housing stability? There are many other questions to examine.

7. The GAO report also claims that "Among the homeless, highly structured programs tend to have somewhat higher drop out rates than other strategies." It appears that this statement may be based on research conducted on non-veteran populations (especially since the GAO claims that the data is not available on these kinds of strategies for veterans). The highly structured military-style team-based approach, with which veterans are very familiar, appears to work better with this population than with non-veterans. Again, this should be an area of study.

**Conclusion**

On Veterans Day, November 1991, the National Coalition for the Homeless released a study entitled, "*Heroes Today, Homeless Tomorrow?: Homelessness Among Veterans in the United States*." Although many of the issues that were highlighted in that report continue to be critical issues nearly a decade later, there have been significant changes within the Veterans Administration in how to address homeless issues.

In West LA, there is no longer a need to discharge veterans from the hospital to the streets. Creating relationships with community based organizations has given the VA staff a range of housing and service options that did not exist a decade ago.

The expensive 30 day revolving door substance abuse programs at the VA have been replaced (thanks to HUD) by long term comprehensive services and a continuum of care. Veterans can remain in the program for a year or two, address their medical, emotional, legal, educational and economic issues and eventually become self-sufficient.

The frustration, fear and distrust veterans were experiencing at the VA in the early 1990s has been replaced by positive contacts and *willingness* by veterans to use the many services offered at the VA.

Although today there are many more veteran specific programs, and programs to assist homeless people, the number of homeless people continues to be shamefully high. There is still a serious shortage of affordable housing and programs that address mentally ill and dually diagnosed people. While upper class incomes have increased dramatically, the gap with those in society's lower rungs is ever widening. Minimum wage continues to be insufficient to cover housing

costs, transportation to jobs, food, clothing and medical care. The issue of illegal drugs has become a multi-billion dollar drain with a disgracefully small amount of funding going to substance abuse treatment.

New Directions continues to search for solutions and looks forward to working with the VA, HUD and the Committee to end homelessness in America.

Toni Reinis, Executive Director
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TESTIMONY OF

CHARLES WILLIAMS
COLONEL, U.S. ARMY (RET.)
EXECUTIVE DIRECTOR
MARYLAND CENTER FOR VETERANS EDUCATION AND TRAINING, INC.

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JUNE 24, 1999

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, MY NAME IS COLONEL CHARLES WILLIAMS, U.S. ARMY (RETIRED) AND I AM THE EXECUTIVE DIRECTOR OF THE MARYLAND CENTER FOR VETERANS EDUCATION AND TRAINING INC.: COMMONLY REFERRED TO SIMPLY AS "MCVET".

MCVET IS A FIVE-YEAR-OLD NON-PROFIT ORGANIZATION DEDICATED TO PROVIDING HOMELESS VETERANS, AND OTHER VETERANS IN NEED, WITH COMPREHENSIVE SERVICES THAT WILL ENABLE THEM TO REJOIN THEIR COMMUNITIES AS PRODUCTIVE CITIZENS. MCVET OPERATES A MILITARILY STRUCTURED FACILITY. WE REINTRODUCE VETERANS TO THE MILITARY STYLE DISCIPLINE THAT THEY ARE ALREADY ATTUNED TO THROUGH THEIR SERVICE. THE REAWAKENING OF THE ROUTINE MILITARY DISCIPLINE ENHANCES MCVET'S ABILITY TO STABILIZE AND REORDER THE LIVES OF THESE VETERANS. EACH RESIDENT IS REQUIRED TO ATTEND SUBSTANCE ABUSE CLASSES AND ALCOHOLICS/NARCOTICS ANONYMOUS MEETINGS, AND WORK IN CONJUNCTION WITH A CASE MANAGER IN THE DEVELOPMENT OF AN INDIVIDUAL SERVICE STRATEGY PLAN, WHICH IS A LONG-RANGE PLAN USED AS A TOOL IN REMAINING DRUG AND ALCOHOL FREE.

THERE IS ZERO TOLERANCE OF CURRENT SUBSTANCE ABUSE, BAD ATTITUDE AND BAD ADJECTIVES. WE HAVE INSTITUTED THE PLATOON SYSTEM WHICH UTILIZES MORE RESPONSIBLE RESIDENTS IN LEADERSHIP POSITIONS. THIS IS AN ACCOUNTABILITY SYSTEM BY WHICH RESIDENTS

ARE ACCOUNTABLE TO EACH OTHER, THEIR FELLOW PLATOON MEMBERS AND THE DESIGNATED PLATOON LEADER. PEER PRESSURE PROMOTES RESPONSIBILITY FOR ACTION TAKEN. THIS SYSTEM PROVIDES ORDER AND STRUCTURE TO A GROUP OF PEOPLE WHOSE LIVES HAVE BECOME UNMANAGEABLE AND UNSTRUCTURED.

MCVET PROVIDES VETERANS IN NEED WITH AN ARRAY OF SERVICES TO INCLUDE:

**DAY DROP-IN, EMERGENCY, TRANSITIONAL & PERMANENT HOUSING

**COUNSELING AND HOUSING PLACEMENT

** SUBSTANCE ABUSE COUNSELING

**ASSISTANCE FOR PHYSICAL & MENTAL HEALTH ISSUES, INCLUDING PTSD

**JOB TRAINING AND PLACEMENT

**EDUCATION

THE MCVET EXPERIENCES BEGIN WITH THE EMERGENCY PROGRAM. THIS PROGRAM IS NOT ONE WHERE A VETERANS ENTERS IN THE EVENING AND LEAVES THE NEXT MORNING. THIS PROGRAM REQUIRES A 13 WEEK COMMITMENT ON THE PART OF THE VETERAN. DURING THIS TIME, BARRIERS TO RECOVERY ARE ADDRESSED: ISSUES SUCH AS DEBTS, COURTS, CHILD SUPPORT, TYPES OF DISCHARGES, PHYSICAL/MENTAL HEALTH ISSUES ARE ADDRESSED. AFTER THESE ISSUES ARE CONSIDERED, VETERANS ARE MOVED TO THE NEXT LEVEL WHICH IS TRANSITIONAL HOUSING WHERE JOB TRAINING AND JOB PLACEMENT IS EFFECTED. THEY CAN REMAIN IN TRANSITIONAL HOUSING FOR TWO YEARS BEFORE MOVING ON TO PERMANENT HOUSING.

MCVET OWES ITS VERY EXISTENCE TO THE FEDERAL GRANTS TO COMMUNITY BASED ORGANIZATIONS PROGRAMS. WE HAVE UNIQUELY MARRIED THE HOUSING SERVICES AVAILABLE FROM HUD; THE MEDICAL AND SOCIAL SERVICE SUPPORT AVAILABLE FROM THE VETERANS ADMINISTRATION; AND THE JOB TRAINING/EDUCATION SERVICES AVAILABLE FROM THE DEPARTMENT OF LABOR IN ORDER TO MOVE

HOMELESS VETERANS INTO THE MAINSTREAM AS SELF-SUPPORTING, CONTRIBUTING MEMBERS TO THEIR FAMILIES AND THEIR COMMUNITIES. MCVET HAS ALSO USED GRANTS FROM FEMA TO SUPPLEMENT FOOD COST.

MCVET HAS RECEIVED THE FOLLOWING FEDERAL GRANTS:

FROM HUD:

| | |
|---|---|
| EMERGENCY SHELTER GRANT | $327,000 |
| 1994 SUPPORTIVE HOUSING (OVER 5 YEARS) | $7,090,000 |
| 1994 SECTION 8 MOD REHAB SRO (OVER 10 YEARS) | $3,705,000 |

FROM VA:

| | |
|---|---|
| 1994 BUILDING RENOVATIONS | $2,000,000 |

GRANT PER/DIEM PROGRAM (BASED ON ELIGIBILITY OF "SELECTED VETERANS" $16.00 PER DAY SRO. $35.00 PER DAY FOR TRANSITIONAL)

FROM DEPARTMENT OF LABOR:

| | |
|---|---|
| 1997 JTPA TITLE IV-C | $78,000 |

MCVET USED THESE GRANTS TO TRANSFORM THE SHELL OF AN OLD CUP FACTORY AND A FORMER "HOME FOR BOYS" THAT HAD BEEN CLOSED FOR FIFTY YEARS INTO A MODERN FACILITY COMPRISING APPROXIMATELY 90,000 SQUARE FEET. THIS FACILITY PROGRAMMATICALLY HOUSES A COMPLETE CONTINUUM OF CARE CONSISTING OF:

- 50 CAPACITY DAY DROP IN CENTER
- 50 EMERGENCY BED PROGRAM
- 120 BED TRANSITIONAL HOUSING PROGRAM
- 80 SINGLE ROOM APARTMENTS (SRO)
- COMPLETE KITCHEN, HEALTH CLINIC, LEARNING CENTER, GYM AND CLASSROOMS.

THUS, A VETERAN CAN GO FROM HOMELESS TO PERMANENT HOUSING WITHIN THE SAME PROGRAM WHILE MAINTAINING CONTINUITY OF COUNSELING AND SUPPORT.

I WOULD BE REMISS IF I DID NOT POINT OUT THE HOMELESS VETERANS CONTRIBUTIONS TO THE REMODELING EFFORTS. THEY LAID

THE TILES, DID ALL OF THE PAINTING AND SOME PLUMBING AND ELECTRIC WORK TO ENABLE MCVET TO STAY WITHIN THE FUNDING LIMITS. TO DATE, THE FACILITY CAN ACCOMMODATE APPROXIMATELY 300 VETERANS DAILY.

THE $78,000 FROM THE DEPARTMENT OF LABOR IN 1997 ENABLED MCVET TO PLACE 67 RESIDENTS IN COLLEGES AND FORMAL TRAINING PROGRAMS.

THE FEDERAL GRANTS ENABLE MCVET TO EFFECTIVELY REORDER THE LIVES OF THAT SEGMENT OF OUR POPULATION WHO HAS GIVEN A FULL MEASURE OF THEIR BODIES AND SOULS TO THE CALL OF THEIR COUNTRY. WHILE I CANNOT SAY THAT WE HAVE SUCCESS WITH EVERY VETERAN IN NEED THAT WALKS THROUGH OUR DOORS, I CAN SAY THAT SEVEN OUT OF EVERY 10 VETERANS THAT STAY WITH THE PROGRAM FOR MORE THAN 30 DAYS ARE RETURNED TO THEIR FAMILIES AND COMMUNITIES WITH RENEWED HOPE AND MEANINGFUL JOBS PAYING AVERAGE SALARIES HAS BEEN $25,000.00.

ON 7 MAY 1997, HUD DECLARED THE PROGRAM A NATIONAL MODEL.

TO DATE, APPROXIMATELY 1500 VETERANS HAVE BEEN ASSOCIATED WITH THE PROGRAM. LAST YEAR ALONE:

*15 RESIDENTS ENROLLED IN COLLEGES OR FORMAL TRAINING PROGRAMS

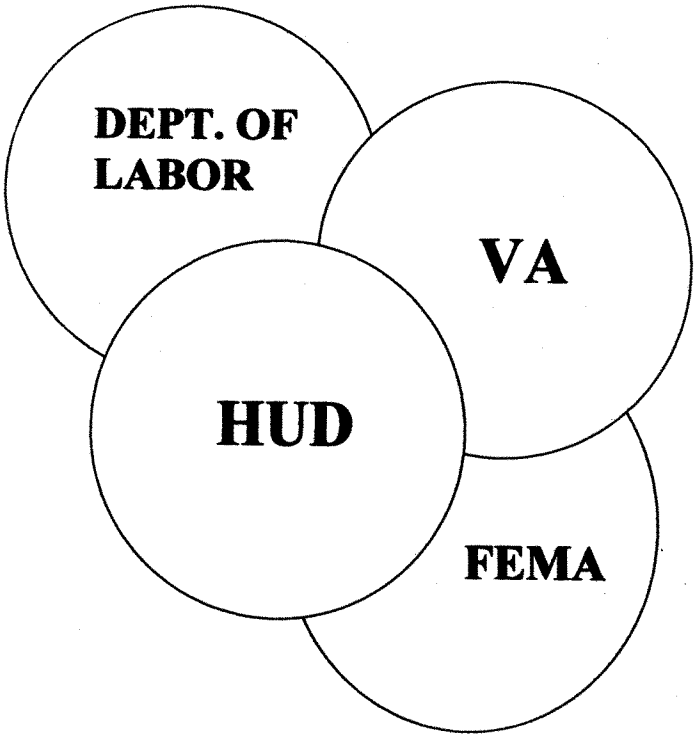
*164 RESIDENTS REGISTERED WITH JOB SERVICES

*104 RESIDENTS OBTAINED FULL TIME JOBS WITH A LIVING WAGE AND BENEFITS.

*72 RESIDENTS OBTAINED PERMANENT HOUSING

IN CLOSING, I WOULD LIKE TO THANK YOU FOR THIS OPPORTUNITY TO SHARE MCVET'S STORY. HOMELESS VETERANS ARE LIKELY TO FACE GREATER CHALLENGES IN THE YEARS AHEAD AS SCARCE RESOURCES STRAIN AN ALREADY OVERBURDENED SERVICE DELIVERY SYSTEM. I URGE YOU IN YOUR DELIBERATION TO CONSIDER THE PLIGHT OF THOSE YOUNG MEN AND WOMEN WHO JOINED THE ARMED SERVICES BEFORE THEY COULD VOTE, OR BELLY UP TO A BAR, TRAINED ON WEAPONS OF MASS

DESTRUCTION AND WERE SENT TO DEFEND THE IDEALS OF THIS COUNTRY. MANY OF THEM RETURNED HOME BROKEN OF BODY, MIND AND SOUL. THIS COUNTRY NEEDS TO PROVIDE THEM WITH A HAND-UP SO THEY CAN SHARE IN THE AMERICAN DREAM. I URGE YOU TO ENHANCE FEDERAL GRANTS TO COMMUNITY BASED ORGANIZATIONS.




THE CONCENTRIC CIRCLES INDICATE THE MARRIAGE OF SERVICES BY FEDERAL AGENCIES THAT HAVE BEEN KEY IN THE BRICKS & MORTAR PHASE AS WELL AS THE PROGRAMMATIC DEVELOPMENT OF MCVET. IN MY OPINION, **HHS** SHOULD ALSO BE A PART OF THESE CIRCLES.

# TESTIMONY OF TIM CANTWELL

**before the**

**U.S. House of Representatives**
***Subcommittee on Oversight and Investigations***

**regarding**

## THE EFFECTIVENESS OF FEDERAL GRANTS TO COMMUNITY BASED ORGANIZATIONS

**Washington, D.C.**

June 24, 1999

L.A. VETS is a joint venture between Los Angeles Veterans Initiative, Inc. (a 501(c)(3) non-profit corporation) and Westside Residence Hall, Inc. (a single purpose for-profit California Corporation). The mission of L.A. VETS is the successful reintegration of the greatest number of homeless veterans to their highest level of independence as rapidly as possible. (For a history of the formation of LA VETS, see EXHIBIT A)

Members of the committee, I want to commend your continued interest and intellectual and emotional investment in coming to grips with the issue of homelessness among veterans. Since we first started walking these halls in 1993, much has been accomplished through your efforts, the Department of Veterans Affairs, and community-based organizations spread throughout the country. Tremendous strides have been made towards getting 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 administrates, 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. As we stand before you, there are many programs configured under a variety of paradigms serving homeless veterans across the country. Even as we sit in the room today, collaborations are being birthed. And much of the animosity and conflict that littered meeting rooms have been set aside as we collectively focus on what's good for veterans.

We think it's safe to say that there's growing unanimity of opinion among homeless veteran service providers and VA that a self-determination format embracing the concept of hand up, not a hand out, is not only clinically correct and cost efficient for the taxpayer, but most importantly empowering for the veteran. In the end it is the individual who has to want to help himself/herself. There are many parts to the process...for an individual to obtain adequate self- esteem to move the ball. At first, maybe it's just a sandwich or a blanket. Later, maybe it's an entry level job along with basic literacy work or undergraduate/graduate level school then a better job. But, there's little doubt that as soon as clinically practical an individual needs to be given the dignity of making his/her own way by the means of their own (appropriate) production, participating in the financial cost of their path.

It's a truth that needs to be told, and it's a truth that is applicable for non-veterans as well. We can and should impact on the public policy of this country as leaders among the homeless provider community. Because what we've discovered and have practiced for years is about building dignity through individual responsibility, supported with as many services as we can muster.

For our own part, LA Vets' first project, the Westside Residence Hall and the LA-based team in collaboration with the West LA VAMC have:

- Currently provided nearly 460,000 nights of stay since the fall of 1993.
- Currently houses nearly 400 formerly homeless veterans (4% are female) in long-term, clinically supported transitional housing, and will ultimately house over 500.
- Our food services operation produces more than 25,000 meals per month
- Conducts over 30 groups per week (everything from cognitive awareness & parenting skills to cash and anger management).
- The Education and Career Center services nearly 300 different veterans weekly.
- Stimulates over 12,000 Internet access hits per week by these Education and Career Center users.
- Legal Clinic has provided service to 73 veterans since January 1999.
- The Center is placing veterans in work at an annualized rate of 500 per year.
- Literacy & Math Computer tutorial is utilized by 92 veterans weekly.

The National Collaboration for Homeless Veterans, an LA Vets AmeriCorps program is now in its 5th year of operation:

- Fifty thousand homeless individuals (of which 20,000 were veterans) have been served by this program. Today 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 30 community partners. In the last two years we have expanded this opportunity with an AmeriCorps Education Awards Only program to over 38 programs in over 22 different states. Combined these AmeriCorps members deliver nearly 400,000 hours of service annually.

**The Villages at Cabrillo is currently under construction and is LA Vets' second facility. The nearly 1,000 bed residential plan community for the homeless born out of a collaboration between the following private sector and non-profit sector:**

- The City of Long Beach
- The Department of Veterans Affairs
- The Department of Defense
- The State of California
- Los Angeles County
- The Salvation Army – Family Transitional Housing
- Catholic Charities – Family Shelter
- WomenShelter of Long Beach – Domestic violence transitional housing
- 1736 Family Crisis Center – Youth transitional housing

- Comprehensive Child Development – Child Care
- Long Beach City College – Skills training and learning center

The resulting therapeutic community at Villages at Cabrillo promises to usher in a new era for provision of services to homeless people. By coordinating existing support service agencies, and combining them with transitional housing, Villages at Cabrillo offers a powerful solution to the pervasive problem of homelessness in America.

Developments on the board include:

- In 1999 we will open a 235-bed facility in Las Vegas, Nevada in the year 2000
- 300-bed facility in Riverside, California,
- Currently negotiating to open facilities in Ventura County, California; Honolulu, Hawaii; and Washington, D.C.

We are only a small part in this effort to meet the needs of homeless veterans. Currently in Los Angeles, our outreach coordinates intimately with detox and long-term substance abuse treatment beds available through New Directions, Inc. The Salvation Army's HAVAN program refers a variety of veterans who are discharged to Westside Residence Hall. Westside Residence Hall then discharges them to an aftercare component of the HAVEN, and as such the Salvation Army outplaces staff to Westside Residence Hall. Veterans came to Westside Residence Hall from a total of 57 different agencies and across the country what is being done in Los Angeles, California represents only a small portion of community based service delivery for homeless veterans.

In 1990 seven homeless veterans' service providers established the National Coalition for Homeless Veterans (NCHV) to educate America's people about the extraordinarily high percentage of veterans among the homeless. These seven providers we consider to be the 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 veterans, men and women who defended America's freedom, were being dramatically under served in a time of personal crisis. In the years since its founding, NCHV's membership has grown to 244 organizations in 43 states and the District of Columbia.

The majority of NCHV's members provide the front line housing and supportive services to homeless veterans and their families. Services fall within full continuum of care system including drop-in centers, emergency shelters, transitional supportive housing and permanent housing.

**The community based service delivery system has truly arrived.** To illustrate this point, according to the GAO's report the 1997 total number of beds delivered by CWT-TR (152 beds of transitional residence), HUD-VASH (1383 Section 8 vouchers with case management) and DCHV (1,587 beds of set-aside domicillary care for homeless veterans) is 3,122. By contrast (perhaps startling to some) in California and Wisconsin alone, beds currently installed and under development together with the first 1005 beds of now operating per diem service providers exceed 3,000...A very similar scale but reflective of only a small portion of the CBO delivery system represented by NCHV.

Honorable members of this committee, don't you believe it's time that Congress, the Department of Veterans Affairs, the Department of Defense, and the Department of Labor recognize the community based care provider system as an integral part of service delivery for veterans, and as such be treated as an equal partner. Over the last five years much has occurred to change the community delivery system and VA has had a substantial hand in making this possible. One could say they've been priming the community...some might argue the community has been priming the VA. However you look at it, it's a good thing and the near future looks very promising. Much has been accomplished...and much remains to be done.

On March 16th of this year, I had the privilege of testifying before the House Banking & Finance committee around the McKinney Act Re-authorization. Startling to me in that hearing room was the frame of reference most of the Members and testifying parties held. It seemed clear that substance abusers (which make up the bulk of the homeless veterans population at least) are considered victims. A point of view that substance abusers by virtue of their substance abuse are disabled and that they are victims, reflects a philosophy that is frightening from a recovery perspective. It runs the high risk of furthering a codependent societal relationship within the population. Furthermore, it ultimately strips someone of the dignity to take responsibility for themselves. We would argue that in the end all of us would be best served if we focus our attention where we have some medicine of influence...over our own lives. As a society interested in helping others, the focus needs to be in helping others to help themselves...not inserting our collective energies and taxpayer dollars into setting-up systems that haven't as its objective equipped people to compete for themselves.

A mandated performance measure would require a HUD/SHP funded housing provider to *not* discharge a program participant to the street. Our data, and that of many veteran homeless providers, and many who are involved in residential treatment for substance abuse have experienced diametrically opposed conclusions. We believe to continue to extend housing and services without a concomitant modification of behavior is simply enabling for the individual and harmful to them. It dramatically reduces the rate of return on public investment. Furthermore, and perhaps most importantly, it puts those attempting to maintain their sobriety at grave risk.

So while, on the one hand, we have learned the benefits of rewards and consequences, it would seem that the largest piece of funding for support services for homeless is wrapped-up in an ideology that is not only enabling but harmful. Another disturbing thesis is the notion that HUD/SHP funds shouldn't be used for support services but limited for housing (HHS is expected to pick-up the slack). Not surprisingly, 5 of 7 continuum of care plans in which we competed this year ranked permanent housing as the number one need. While the symmetry of HUD Funding Housing and HHS Funding Services is appealing, the fact remains: HHS wasn't so and isn't so; HUD stepped in. No bounty exists for either but there *are* options for funding capital improvements. There are virtually *no* options for funding services.

**The Complexity Management Gap**. The distribution system for funds from the McKinney Act follows consolidated plan boundaries which are regularly contrary to how a veteran gets his clinical care needs met. The VA catchment areas rarely align with the consolidated plan boundaries which artificially abstract limitations on support services dollars for a veteran service provider to extend services to veterans. Routinely, they are required to compete concurrently in multiple consolidated plan jurisdictions to obtain HUD funds in order to install an array of services available to veterans accessing the local VAMC catchment area. This becomes even more pronounced as many VISNs are appropriately moving toward VISN-wide service lines.

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 Greater Los Angeles County, LA VETS is part of 5 and should arguably be part of 8 such planning areas). And then if awarded, separate reimbursement efforts for drawdown of the grant as well as different financial reports are required for each of the administrating agencies.

To make matters more confusing, logical funding streams for a veteran service provider includes: JTPA funds (block granted through states), non-SHP/HUD funds (typically block granted through counties). 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, Los Angeles Veterans Initiative submitted 13 grants in 9 different agency jurisdictions.

The point here is not to complain about the process (it is what it is)...only to underscore the ***complexities*** involved in successfully responding to the streams of funding available and necessary to combine together adequate funds in a sufficient 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, many of which are members of the National Coalition of Homeless Veterans, struggle to respond to this system of distribution of federal funds.

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 cost more than the $10,000 that would be allowed, leaving general administration cost unfunded.

The community based organizations system has a dilemma of a capacity gap around managing this complexity in order to respond successfully to the distribution system to access funds and then the resources to pay for management and financial reporting systems to properly service those funds.

To illustrate this point, even though LA Vets has a business culture and a high standard of financial reporting, let me assure you that we underestimated the necessary commitment to fully respond and maintain the requirements of fund accounting associated with the federal grants. Because of our partnership structure, we were able to commit additional resources to close the gap. Few homeless veteran service agencies have resources to which they can turn in order to be in a position to manage this complexity.

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 the 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.

Even though LA VETS (many homeless veteran providers can make the same claim) has been able to determine conclusively that in-patient care usage is reduced dramatically for at least a period of one year following discharge (see Exhibit B); and even though many homeless veterans service providers are able to demonstrate a rate of return on public investment by virtue of employer paid payroll taxes and employee paid income taxes as a result of veterans (the employee) returning to work, we would concur with the general tenet of the GAO's conclusion around the need for research on program effectiveness.

We would hope an emphasis is placed on setting the evaluations up in a way to provide continuous feedback to managers for constant modification of programs to achieve the best possible results.

It would be regrettable if GAO recommended funding for these evaluations were limited to VA funded programs given that the bulk of activities for homeless veterans is not funded by the VA at all. We would like to see a percentage of the money that the VA intends to set aside for developing program evaluations for use in stimulating evaluations in non-VA funded programs run by homeless veterans service providers as well as those done in collaboration with the VA.

The purpose of all of this is to serve veterans. While it's crucial to manage scarce resources prudently, we mustn't setup an expectation that a high barrier population is going to be cured. That would be setting us all up for failure. It may also take our focus off what's good for the veteran. The veteran is entitled to healthcare and it's in the mission of VHA to deliver it, regardless of a veteran's housing or income status. We collectively all want the best delivery system possible with the best programs that yield the highest quality of life for every veteran and should take every measure to achieve it.

As we said at the onset, the recognition of the needs of homeless veterans has grown. The investment in meeting those needs has grown. The intellectual knowledge of how to accomplish meeting those needs has grown. For this we should all be grateful.

VA and other agencies must make an increased investment in minimizing the capacity gap for managing the complexity. This country needs to strengthen its community-based organizations. The VA needs to place its resources on the frontline in the form of medical and clinical support or in dollars to purchase those services from the community. The VA must continue to foster a culture that allows the community board system to flourish not compete with it. The Department of Labor needs to place its resources with community-based providers that can efficiently deliver jobs. HUD needs to recognize that veterans get or could get their care needs met through a health care system that doesn't neatly align with their consolidated plan boundaries. HUD should make provisions in its distribution of SHP funds for the Regional medical/clinical care service delivery system of the VA. HHS needs to come out of the woods and put some resources on the table that are accessible.

And finally, while longitudinal studies can play a crucial role in improving quality of services to veterans, we must not become overly focused on them as an end themselves. What we are collectively learning is light years ahead of what is known about the general homeless population. HUD is unable to say how many veterans have been served, much less what has happened to them. A properly constructed R&D program could provide the template of leadership for the entire country's struggle with high barrier populations.

It's in the system's best interest to invest substantially in modeling and building the capacity for a thinly capitalized community-based provider network. The system must foster the development of research and program evaluation models that can help us collectively manage this process in a way that strives to eliminate homelessness among veterans. If we stay focused this collective effort for veterans will show the way.

The discovery of reduced demand for inpatient treatment by Westside residents appears to contribute to the reduction of bed days of care at the affiliated Greater Los Angles West LA Health Care Center (see Figure 2)

**Figure 2. Decrease in Mental Health Bed Days of Care for WLA VAMC. Dates Parallel Potential Impact of Westside on the Number of Bed Days of Care.**

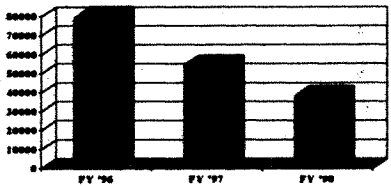



Table 1 provides a comparison of hospital utilization data for 3 groups of veteran patients (14): 323 veterans from Westside Residence Hall, 341 from a non-profit located on the hospital grounds (Comparison #1) and 311 admitted to substance abuse inpatient treatment services (all patients were then offered outpatient treatment) at the West Los Angeles VA Medical Center (Comparison #2). The data appear to demonstrate that while at Westside and for up to one year after leaving the facility, veterans required/sought inpatient psychiatric and medical health care at the VA Medical Center significantly less than they did before entering Westside. The window of assessment was 1994-1998 with veterans for each program compared for 1 year prior to admission to the respective program and 1 year post discharge from the program. The most significant caveat of this comparison is that those veteran patients may represent different populations of patients or similar populations of patients but at different stages in their treatment history. For example, Westside requires that veterans have 90 days of sobriety prior to entering their program. This was not the case for the other two programs. This and other factors may bias the Westside clients towards a more favorable outcome. However, the pre/post program differences in inpatient health care utilization between Westside and the other two programs is striking. Future studies would benefit from the utilization of a prospective design and, if at all possible, random assignment to Westside or comparison programs. Four types of "beds" are described: the Domiciliary, Substance Abuse, Psychiatry, and Medical/Surgical. Figures 1 and 2 summarize the number of medical center admissions while Figure 3 summarizes pre and post medical center bed days of care for patients with psychiatric disorders at Westside.

**Figures 1 and 2. Number of Admissions to the Medical Center per year per veteran 1 year before Entering Westside vs. 1 year after Exiting Westside**

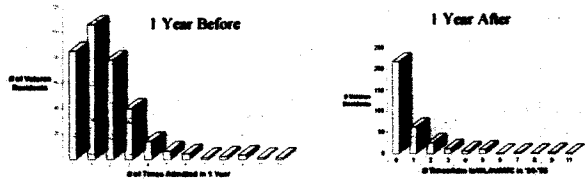
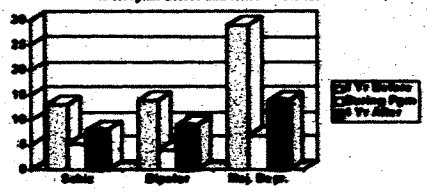



**TABLE 1. Hospital Bed Days of Care for Westside and Two Comparison Programs**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Westside (n=32)** | | | | | | | | |
| | *BH00 (# yr Pre)* | *BH00 (# yr Post)* | *SA (# yr Pre)* | *SA (# yr Post)* | *Psych (# yr Pre)* | *Psych (# yr Post)* | *Med (# yr Pre)* | *Med (# yr Post)* |
| Bed Days of Care | 17604 | 4366 | 4871 | 598 | 11059 | 2406 | 1301 | 304 |
| BDD/Admit | 52.64 | 12.00 | 12.60 | 4.04 | 34.20 | 7.57 | 3.41 | 0.94 |
| %Change | 75.9% decrease | | 85.4% decrease | | 77.9% decrease | | 72.4% decrease | |
| **Comparison Group #1 (n=30)** | | | | | | | | |
| | *BH00 (# yr Pre)* | *BH00 (# yr Post)* | *SA (# yr Pre)* | *SA (# yr Post)* | *Psych (# yr Pre)* | *Psych (# yr Post)* | *Med (# yr Pre)* | *Med (# yr Post)* |
| Bed Days of Care | 3813 | 13764 | 2636 | 3247 | 5891 | 5828 | 856 | 1633 |
| BDD/Admit | 11.10 | 40.36 | 7.73 | 9.52 | 17.28 | 17.12 | 2.51 | 4.79 |
| %Change | 264% increase | | 23.2% increase | | 1% decrease | | 90.8% increase | |
| **Comparison Group #2 (n=30)** | | | | | | | | |
| | *BH00 (# yr Pre)* | *BH00 (# yr Post)* | *SA (# yr Pre)* | *SA (# yr Post)* | *Psych (# yr Pre)* | *Psych (# yr Post)* | *Med (# yr Pre)* | *Med (# yr Post)* |
| Bed Days of Care | 2857 | 5593 | 1126 | 2210 | 819 | 4894 | 1071 | 1001 |
| BDD/Admit | 8.22 | 16.22 | 3.02 | 7.13 | 2.57 | 12.87 | 3.44 | 3.22 |
| %Change | 97.2% increase | | 97% increase | | 400% increase | | 6.5% decrease | |

**Figure 3. Number of Veterans with Mental Illness Admitted to Hospital Before and After Westside**



**Federal Funding Sources for Los Angeles Veterans Initiative, Inc.**
**(Currently reorganizing to U.S. Veterans Initiative, Inc.)**

| Funding Source /Date | Purpose | Amount |
|---|---|---|
| *Los Angeles, California:* | | |
| HUD-SHP 1995 | Supportive Services | $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 | $ 300,000 |
| VA Homeless Providers Grant | Tenant Improvements (Father's Project) | $ 30,000 |
| *Long Beach, California:* | | |
| HUD-SHP 1995 | Supportive Services | $1,000,000 |
| VA Homeless Providers Grant - 1996 | Tenant Improvements | $ 357,500 |
| VA Homeless Per Diem – annual | 100 beds of Residential Treatment | $ 540,000 |
| HUD-SHP 1996 | Supportive Services (treatment) | $ 840,000 |
| HUD-SHP 1996 | Shelter Plus Care (disabled vets) | $ 270,000 |
| HUD-SHP 1998 | Supportive Services (Welfare to Work) | $ 655,000 |
| DOL - California 1998 | JTPA | $ 300,000 |
| *Ventura, California:* | | |
| HUD-SHP 1996 | Supportive Services | $ 595,875 |
| VA Homeless Providers Grant - 1997 | Tenant Improvements | $ 327,000 |

**Federal Funding Sources for Los Angeles Veterans Initiative, Inc.**
**(Currently reorganizing to U.S. Veterans Initiative, Inc.)**

| Funding Source /Date | Purpose | Amount |
|---|---|---|
| *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 |
| *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 |
| 1997-99 | Education Awards Program | $ 248,478 |

CURRICULUM VITAE

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 that 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 low income sector of the greater Pasadena area for businesses in general 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, 10 and 13 respectively.

## PREPARED STATEMENT OF ROOSEVELT THOMPSON, JR., ACCOUNT ASSOCIATE, XEROX BUSINESS SERVICES

Members of the Committee, thank you for allowing me the opportunity to address you today. My name is Roosevelt Thompson, Jr. and I am here today to tell you my story of being a homeless veteran. Today, after a twenty-five year journey, I am proud to say I am a Senior Systems Account Associate with the Xerox Corporation in the Xerox Business Services division. As my story will highlight, government programs can work—they worked for me. Therefore, I hope this hearing will help Congress understand what programs work. I have been the beneficiary of such programs and I believe they can help others like me.

I am a native Washingtonian who was born and raised in a family of five children. At age nineteen I left home to pursue a career in the military. I enlisted in the Air Force for a 4-year term. For the first 2½ years of my duty I was based in Germany. Soon, I felt the compulsion to serve my country in the Vietnam War. I was proud to serve in Vietnam. The Vietnam War changed me, as it changed so many men my age. The Vietnam War era was a traumatic stage in my life, for, at age twenty, I could not fathom the horrendous sights that I saw in Vietnam. I found myself not knowing or understanding what was going on right before my eyes. It was in Vietnam that I began using substances, substances I would later abuse. I felt that these substances were the only vehicles I had for maintaining my sanity. By the time I left Vietnam with an honorable discharge I had begun to misuse substances.

Although I brought my substance problem back to Washington with me, I still believed that I was a fully functional person. I had a job, which I was keeping up while managing to make it through. However, soon I found myself to be lacking focus due to my experiences in the war and substance abuse problems. Between 1971 and 1974, my lack of focus infiltrated into my life and caused me to take actions such as switching my job regularly. I did everything in this period from selling vacuum cleaners door to door to being a clerk-typist for the Federal Government. Soon Washington began to overwhelm me and I truly believed my lack of focus was due to my location, not my personal demons. Therefore, I packed myself up and moved to Oakland, CA. In California, I attended a Junior College where I took classes in broadcasting. After attending school, I got a job. I worked for 6 years but I still felt the inner turmoil that plagued me in Washington. I refused to see that it was problems within me that caused my lack of focus and concluded it was Oakland. I moved back to Washington.

Unfortunately, I brought my substance abuse problem from California back with me. I was literally running from my problems. Despite the shape I was in mentally, I was offered a good job at a junior high as a computer instructor. I enjoyed my job and was well liked by the students. However, I was in a downward spiral. I was not coming to work on time, if I came at all. Therefore, about 1988 I was asked to resign. I did not work again until 1996. After being forced to resign, my life went further downhill.

During this time I was living in a house my parents had left to my siblings and me. Soon thereafter, we sold the house and divided the money from the sale among the children in my family. At this time I was living, unemployed, in an apartment off the money I made from the sale of my family's home. However, my money went quickly. Instead of saving, I spent my money on drugs and entertaining. As a consequence, I lost my apartment and was forced onto the streets. Between 1990 and 1995 I lived on the streets and in shelters. I had lost everything my job, my self-respect, and my health. On December 5, 1995, I asked God for help and as a consequence my life began to turn around.

I had been quite ill and on December 5 I called my brother to give me the assistance I so needed. My brother took me to the Community Center for Non-Violence (CCNV) shelter in northwest Washington where he knew I could receive medical attention. I was diagnosed with pneumonia in both lungs, an illness that I later would find out has been known to kill. I had hit my bottom, mentally, physically, and spiritually. I thought I was going to die. The shelter sent me to George Washington hospital where the pneumonia was cured. On December 5, the directionless stage of my life ended and I began to rebuild my life.

The programs that CCNV offered placed me upon the path that allowed the first steps towards reentering society. CCNV had a veteran's counselor who gave me information about an outpatient substance abuse program called SARP, the substance abuse and rehabilitation program, at the Veterans Affairs Hospital in northwest Washington. My counselor told me at that time that the inpatient program had been suspended due to inadequate funding but I had the option to participate in the outpatient program. My saving grace at this time came from the fact that I could live

at CCNV while participating fully in the SARP outpatient program at the VA hospital. I was given money for transportation and lunch. During this period I met regularly with social workers and medical professionals designed to help me build my life skills. These services enabled me to stick with my recovery. I can say now that I have been substance free from the day, late in 1995 my brother took me to CCNV for the first time, until the present. However, in my opinion, the most beneficial programs are those which are inpatient and allow around the clock treatment for your problems. After successfully completing and participating in the SARP, substance abuse and rehabilitation program, I was referred to the Compensated Work Therapy Program (another government funded program) associated with the Veterans Affairs Medical Center where I was placed in the copy center at the VA hospital. The job in the copy center gave me a sense of purpose and responsibility. At the same time, I moved out of the shelter and into a transitional home supported by the Veterans Department. I made that move into a transitional home and with it took on several new responsibilities. To live in the home I had to begin saving money at a rate of one hundred dollars a month. The money I saved was placed into savings for me so that eventually I was able to move out on my own. In addition to the $100, I also had to contribute money for food and buy my own clothes and other necessities. This arrangement was supposed to last 1 year and prepares you for the job market. Therefore, after 1 year, I graduated from the program and began my relationship with the Xerox Corporation.

During my year of work at the VA hospital my life was continuously changing. I was gaining more and more independence, doing a job that I truly enjoyed. I had regular contact with a VA social worker that helped me with my job readiness skills and self-confidence. I was assigned to work in the copy center at the hospital, which was the first place I encountered employees of the Xerox Corporation. I quickly gained a reputation with my coworkers as being hard-working and dedicated to my job and was therefore given an amazing amount of responsibility. It was the first time in years that the woman who worked in the center felt no remorse leaving on 2-week vacations because she knew I could handle the job. The center was filled with Xerox machines and therefore we often had Xerox technicians at the site. Over the year that I worked there I got to know several Xerox employees. I remember asking them questions about their job, such as, whether they enjoyed it, wages, etc. From my exposure I began to gain a respect and liking for the Xerox Corporation while at the same time people from the VA were approaching Xerox salesperson Chuck James, encouraging him to hire me on as part of their new welfare-to-work initiative. I was introduced to Chuck James and he gave me the assistance I needed at that time of my life. In addition to advice Chuck helped me write my resume, operate machinery, and introduce me to all elements of the Xerox Corporation. Chuck became my mentor and he walked me through the entire process. He schooled me in the skills that are often forgotten, those which teach you how to function in a working environment. He practiced interviewing skills with me and got me in contact with the Xerox hiring manager Beverly Smith by setting up an interview for me. The day of the interview Chuck gave me a ride there, continuing his support and guidance that he had offered since the first day I knew him. I felt prepared, and, frankly, was prepared to interview for a position with Xerox. I was introduced that day to Beverly Smith who interviewed me and made another ally. I was hired as a Xerox temp for 90 days at which time my status would be reevaluated. Beverly held my hand through this and as a consequence I am now a Xerox employee with full benefits such as health care, profit sharing, and paid vacations. Later on, I moved out of the transition house to a group home run by the Presbyterian Church where I lived for a few years and just last week I moved into my first apartment.

My story is of a holistic experience where each event and stage is connected to the next. Therefore, it is inappropriate to look at Xerox as the whole story. I was given housing, which allowed me a safe place to live, a social worker to help me confront my problems and people, and experiences that helped prepare me for work. Through these experiences I was taught honesty and openness which further helped me to take the steps towards the life I enjoy now. Each one of the veterans programs I participated in put me more and more into a proper state of mind. As a result of my experiences I have ambition. I attend every type of management training Xerox offers and look forward to building on my career at Xerox. As a consequence I have already helped manage the copy and reproduction centers at law firms such as Arnold and Porter, Akin, Gump, Strauss, Hauer, and Feld, and Steptoe and Johnson. I am proud to say that I have already been promoted to a Senior Account Associate. Aside from career ambitions, I also recognize the importance of giving back and regularly return to the streets I used to live on to encourage others to follow in my steps. I am also affiliated with the Reach our Men, Reach

our Sons community-based organization which is designed to get Afro-American men involved in community volunteer services such as mentoring and family interactions to continue to further enhance our community. As you can see from my life journey, each one of the government-funded programs I participated in (SARP, Veterans Affairs, and CWP) played a very important role in my ability to develop critical life skills, such as self-esteem, self-confidence, reliability and work skills. These government programs combined with the helpful people and supportive atmosphere at Xerox have allowed me to become completely self-sufficient and a taxpaying and contributing member of society. I am now in the fortunate position of being able to help my former colleagues, the homeless, veterans and those who just need a boost in life. I hope Congress is able to continue to support and fund the programs that have helped me become a success.

## PREPARED STATEMENT OF CHARLES A. JAMES, JR., MANAGER, BUSINESS DEVELOPMENT PRIVATE SECTOR, XEROX BUSINESS SERVICES, XEROX CORPORATION

Good Morning, my name is Chuck James, Manager for Business Development Private Sector, Xerox Business Services. Thank you for the opportunity to deliver some brief remarks on behalf of Xerox Corporation.

First, I would like to share my pride and the pride of everyone at Xerox in the accomplishments of Roosevelt Thompson, Jr. In fact, to demonstrate just how proud Xerox is of Mr. Roosevelt, he is featured in the Xerox 1998 annual report. I first met Roosevelt over 3 years ago when I was working as the Xerox National Account Manager for the Department of Veterans Affairs. When I learned the Veterans Department had a candidate they wanted me to meet for a potential job opportunity in Xerox, I had no idea at the time that it would eventually lead to Xerox establishing a corporate wide program to identify, hire and train economically disadvantaged candidates for positions in Xerox Business Services, the fastest growing division within Xerox.

Within 3 months of hiring Roosevelt, Xerox Business Services promoted Roosevelt to full time status and since then he has been promoted to a Senior Systems Account Associate at a high production legal site. In his present position, Mr. Thompson is responsible for operating high-speed laser printers. He works with a team of employees receiving and processing electronic documents, retrieving documents from various media, and maintaining quality output.

Xerox' experience working with the Veterans Department and Roosevelt Thompson convinced Xerox to make a commitment to establishing a corporate wide program managed through XBS to identify and hire economically disadvantaged adults, such as homeless veterans and welfare recipients. XBS is in constant need of new employees to help us grow our facilities management business across the United States. XBS' number one obstacle to even faster growth has been the ability to identify and hire enough entry-level qualified candidates.

One of Xerox' core principles is to behave responsibly as a corporate citizen, so when I was approached by the Veteran's Department about hiring Mr. Thompson I was quick to respond. The hiring of Mr. Thompson and the subsequent development of the corporate wide Xerox welfare to work program was instituted to meet a key business objective: ensuring an adequate supply of labor. Today Xerox has hired and placed over two hundred fifty economically disadvantaged adults in XBS with a retention rate of over 76 percent. Unlike the Federal Government, Xerox does not track the characteristics of our new hires who come through this program, so I can not tell you how many veterans we have hired, but we know we have men and women from all walks of life. Mr. Thompson happened to be the first. Today since Mr. Thompson was first hired Xerox has learned some lessons and developed some best practices to ensure every candidate like Mr. Thompson has a successful experience at Xerox. Specifically:

- Extended community partnering is essential. My close partnering with the local Veterans Hospital led Roosevelt to Xerox and this small-scale example has now been replicated across the company. Xerox now makes a special effort to work with over 100 Community Based Organizations from around the country to identify potential candidates who are job ready. At Xerox we believe as long as someone is job ready, understands the importance of coming to work on time, dressing appropriately, treating people with respect, then we can teach the skills necessary for a successful Xerox career.
- Utilizing Xerox' total quality principles are also essential for success. Xerox' total quality management practices serve as the framework for how we operate and manage any Xerox program, including our welfare to work program.

This means the welfare to work program just like any other operation in Xerox must plan for quality, organize for quality and monitor for quality and most importantly there must be 100 percent total customer satisfaction. Using these metrics ensure we know how well we are meeting both the requirements of the new hire and the customer.

- Financial incentives are not always the primary goal. Other benefits and support are also equally important. Access to the Xerox Federal Credit Union services for budget planning and bridge loans to help get someone on their feet are essential as well.
- The participant's motivation, attitude and desire to learn are key. Without these, then it is unlikely any candidate will succeed.
- Mentoring throughout the employment experience at Xerox is critical. Everyone needs a mentor and this is especially true for new hires who may have had not experience in a large corporate culture. Xerox has now formalized our mentoring program so each new hire has someone to turn to for even the most basic questions and does not need to feel embarrassed or uncomfortable. Mentors also provide essential career advice.
- Finally continued proactive outreach to the community and participants is required.
- In conclusion, Xerox is proud to be here today and believes the successful elements of this program can be applied to programs for veterans, welfare recipients or any category of disadvantaged adults.

I would be happy to answer any questions you may have.

**STATEMENT OF**
**ESPIRIDION "AL" BORREGO**
**ASSISTANT SECRETARY OF LABOR FOR THE**
**VETERANS' EMPLOYMENT AND TRAINING SERVICE**
**BEFORE THE**
**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**
**OF THE HOUSE VETERANS' AFFAIRS COMMITTEE**
**U.S. HOUSE OF REPRESENTATIVES**
**JUNE 24, 1999**

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before you today regarding the Veterans' Employment and Training Service's (VETS) Homeless Veterans Reintegration Program (HVRP). As requested in Chairman Everett's letter, the subject of this testimony will be the effectiveness of Federal grants to community based organizations as a means of addressing the needs of homeless veterans. Since 14 of VETS' 20 grantees to assist homeless veterans are to Community Based Organizations (CBOs), the vast majority of help for homeless veterans under this grant program is provided by CBOs.

Mr. Chairman, I wish to begin by thanking you and the House Committee on Veterans' Affairs for your past support of the HVRP. We at the Department have worked hard and are very proud of the help provided to veterans under the HVRP through the many local groups participating in this program. HVRP is intended to augment our general veteran employment program by 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.

This has been a very successful program that has been broadly supported by local community groups and Veterans Service Organizations (VSOs). From its inception, this program was meant to be a partnership with local agencies and other State and Federal programs. These partnerships are a fundamental requirement of providers, and applicants for these grants are required to identify the entities with which they shall create linkages, such as the Departments of Housing and Urban Development (HUD) and Veterans' Affairs (VA), Job Training Partnership Act (JTPA)grantees, the State Employment Security Agencies (SESAs), State and local governments and groups. These grant applicants also must identify the types of services provided through such linkages, such as housing, sustenance and medical support, job training, and other related services.

VETS also works with VSOs and organizations that represent homeless providers. The Department of Labor has worked to establish its linkages with other Federal Agencies. At the specific request of Secretary Herman, VETS has made a special effort to work with VSOs and our Federal partners to enhance their understanding of DOL community-sponsored programs and services for homeless veterans. The Secretary and I have met with VSO leaders to discuss this national problem and we have attended national VSO conferences to address DOL's role in responding to their concerns about this important issue. The VETS Deputy Assistant Secretary and I have participated in VSO national service officer and other homeless advocate training activities that focus on development of strategies to respond to homeless issues. We also participate in VSO-sponsored homeless focus committees such as the Veterans Organization Homeless Council (VOHC) and the Homeless Veterans Foundation (HVF) as well as the National Coalition for Homeless Veterans.

VETS' staff work with HUD, the President's Committee on Employment of People with Disabilities (PCEPD), the VA and other Federal agencies to share informational resources and educate homeless-continuum-of-care-providers about the full range of DOL community based services available to veterans and their families. DOL participates with the Interagency Council on the Homeless -- Veterans Task Force, and VA's Town Hall Meetings on Homeless Veterans. I am pleased to say that one result of this interagency effort and our cooperation with VSOs has been 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 not only

because it is important to expand use of our SESA partners by HUD's homeless grantees, but also because our grantees need to become more knowledgeable and involved in HUD's work for the homeless.

From Fiscal Years 1989 through 1994, cumulatively, 19,516 homeless veterans were served by the HVRP and 9,808 were placed in jobs. The total funding for the program during that period was $19 million. The program was not funded for Fiscal Years 1995, 1996 and 1997.

Fiscal Year 1998 funding was $3 million and grants were awarded on April 1, 1998. As of March 31, 1999, results thus far show 3,783 homeless veterans served, of whom 1,843 have been placed in jobs. The final reporting period for this program year's funding ends June 30, 1999.

VETS' Fiscal Year 1998 Solicitation for Grant Application (SGA) to operate the HVRP program drew 53 urban applications and 9 rural applications for a total of 62 applications for funding. Applications are accepted from CBOs, State and local public agencies, Private Industry Councils, and nonprofit organizations. Applicants are encouraged to utilize, through subgrants, experienced public agencies, private nonprofit organizations, and private businesses which have an understanding of the unemployment and homeless problems of veterans, a familiarity with the geographic area to be served, and the capability to effectively provide the necessary services. This information is included in the grant application and these capabilities are evaluated as part of the grant award process.

For Fiscal Year 1998, VETS financed 19 urban and 4 rural area grants. There are 20 different grantees, since some grantees have both urban and rural grants. In the SGA, applicants were encouraged to apply for funding in the range of $100,000 and $125,000. As is the custom in HVRP, the urban grants included an option to be refunded for a second year if the grantee performed in accordance with performance measures established at the time of the initial award or otherwise required pursuant to the terms of the grant agreement. Rural grants were for one year and are now in the process of being awarded through another Solicitation for Grant Application (SGA).

In accordance with the grant award, each grant is monitored by the VETS Director (DVET) of the respective state. The Director is officially the Grant Officer Technical Representative (GOTR). As part of the GOTR's function, each program's quarterly report is reviewed in accordance with the VETS' system-wide "Grants Monitoring Guide." In addition, each site is visited at least once a year; however, the site is actually visited more often if the required GOTR's quarterly review shows that the grantee is not meeting planned goals.

While I believe most everyone in this hearing room has visited a homeless veterans program and met veterans benefitting from HVRP, I would like to take the opportunity to tell you about two special veterans.

Charles Harvey is sober and on the job. But that wasn't true for most of the time since Charles was discharged from the Army in 1986. For almost a decade, he was part of another army, an army of homeless veterans. Charles spent most of his days fruitlessly searching for work in Pittsburgh and Atlanta; he spent his nights drinking to ease the pain of joblessness. He hit rock bottom in 1993 when his grandmother, with whom he had been living, died. After a year in prison, Charles sought help from the Vietnam Veterans Leadership Program (VVLP), a Pittsburgh-based organization dedicated to helping veterans move from dependency to self-sufficiency.

VVLP got Charles into a treatment program at the Domiciliary in Butler, PA, a move that changed his life. After a year in treatment, the VVLP helped Charles find a job. He is working at the Lemington Nursing Home in East Liberty. He has his own car, membership at a local gym, and attends church regularly. He returns regularly to VVLP to offer encouragement to other veterans facing the problems he knows all too well.

Chris Riley was just one of hundreds of homeless men and women lined up outside the New England Shelter for Homeless Veterans, out of a job, out of money, and just about out of hope.

Chris' story has a happy ending. Thanks to the work of shelter staff, he received emergency housing, training, and job search counseling. After a 16-week course in the shelter's culinary arts program, Chris began a new chapter in his life. He is a productive member of society, learning the fundamentals of French cuisine as a chef-in-training in a major Boston hotel.

I mention these stories simply to illustrate how important, and successful, the HVRP program can be in improving the lives of veterans and their families.

The Administration has requested $5 million for HVRP funding for Fiscal Year 2000. This is an increase of $2 million over Fiscal Year 1999 funding, and will enable VETS to compete funds with fewer limitations and increase the efficiency of the program. At this funding level, VETS' latest estimates are that 5,100 veterans who are homeless would be enrolled in programs and more than 3,500 would be placed in jobs. In addition, the Administration supports a 5-year reauthorization of HVRP for such sums as necessary for years beyond Fiscal Year 2000. This would provide stability and continuity for the program.

As I mentioned earlier in my testimony, the HVRP effort is part of the goal of bringing homeless veterans back into the mainstream of American life by making their economic independence possible.

HVRP provides a ray of hope as veterans overcome homelessness and its causes. HVRP provides jobs and, when needed, job training. VETS is providing this assistance at a current national average cost per placement of $1,295, but costs will not be completed until the end of the program year. As I mentioned earlier in my testimony the program was not funded for Fiscal Years 1995, 1996 and 1997. The placement rate for the current Program Year, the first year since the restart of this program is 48%. For the final funding period preceding 1995, the placement rate was 55%. It takes time to deal with the problems of the veteran homeless population. Our program experience indicates that Fiscal Year 1999, as the second year of a two-year grant cycle, will exceed the placement rates of the current program year.

We recognize that the job of addressing the plight of homeless veterans is not finished. In spite of the many Federal, State, and local efforts to reduce homelessness among our Nation's veterans, some estimate that as many as one-third of the homeless males are veterans -- another study found that 275,000 veterans are homeless at any one time. We must continue our work.

Mr. Chairman, I appreciate this opportunity to testify before the Subcommittee and look forward to working closely with you and the veterans' community in resolving homelessness among our Nation's veterans.

**Statement of Fred Karnas, Jr.**
**Deputy Assistant Secretary for Special Needs Programs**
**U.S. Department of Housing and Urban Development**
**before the**
**Subcommittee on Oversight and Investigation**
**Committee on Veterans' Affairs**
**U.S. House of Representatives**

**June 24, 1999**

Mr. Chairman, members of the Subcommittee, I appreciate the opportunity to appear for 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. I serve as Deputy Assistant Secretary for Special Needs Programs at the Department, with responsibility for HUD's homelessness assistance programs, and housing programs for persons living with HIV/AIDS. I have also served as acting executive director of the Interagency Council on the Homeless (ICH) since 1995.

Addressing homelessness has been a high priority for the Department since the first day of President Clinton's administration. Soon after his inauguration, the President issued an executive order calling for the development of a plan for addressing homelessness in this nation. The effort to craft this plan was carried out by the Interagency Council on the Homeless which was chaired by HUD. The result of this effort was the publication of *Priority Home!: The Federal Plan to Break the Cycle of Homelessness.*

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 the Federal plan. At HUD, the plan called for increased resources and the implementation of a new approach to addressing homelessness called the Continuum of Care.

In terms of the resources, since 1992, thanks to the President's initiative and Congressional support, funding for HUD's homelessness assistance programs has more than doubled from $404 million to $975 billion in 1999. And, in 1993, HUD implemented the Continuum of Care policy. The Continuum of Care approach made clear that homelessness was more than simply a housing problem, and focused 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 Continuum of Care approach also restructured the relationship among Federal, state and local governments, nonprofits, and other community stakeholders 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 local 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, 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 1998 providing significantly more resources to address homelessness at the local level.

By 1999, over 80% of the U.S. population (646 cities and 1,860 counties) lived in areas covered by Continuums of Care, and a 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 NPR, and was named one of 25 finalists (out of more than 1,200 nominees) for the prestigious Ford Foundation Harvard Innovations in Government Award in both 1998 and 1999.

Included among the thousands of homeless assistance programs funded by the Continuum of Care, many of which serve homeless veterans along with other sub-populations of homeless persons, are a number of exceptional programs specifically for veterans, such as the Los Angeles Veterans Initiative, Swords to Plowshares in San Francisco, and the Vietnam Veterans Workshop in Boston. Despite the success of the Continuum of Care approach, the Department heard from a number of groups serving homeless veterans that additional changes were needed to better meet the needs of homeless Veterans.

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 it's 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 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.

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 language to the contracts of every provider that proposes 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.

Finally, 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, Deputy Chief of Staff for Programs and Policy 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.

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.

The Department is currently in the process of enhancing our technical assistance efforts through a national assessment of technical assistance needs in our various Continuum of Care programs. When completed we will be able to better target technical assistance resources to projects and communities with special needs – including better serving homeless veterans.

We believe all of these efforts have resulted in positive changes. In 1997, 107 applications out of the total pool of 3,415 Continuum of Care project applications were submitted for veterans specific projects. Of those 107 applications submitted, 40 projects were funded. In the same year, 617 additional projects targeting homeless veterans, but not serving only veterans, were funded. Overall, for 1997 the success rate of funding for all awarded projects serving veterans was 42 percent compared to 41% for all projects.

In 1998, HUD received 93 veteran specific project applications, of which 36 were funded. When including all projects proposing to target veterans, the share of successful applications reached 52% (805 projects) compared to the success rate of all applications which was 56%.

We are pleased that the percentage of winning proposals from homelessness assistance organizations seeking to serve veterans is almost equal to that of other applicants overall. It is very important to understand that when statements are made that only 1% of HUD's funding goes to veterans specific programs, that even if HUD funded 100% of the 1998 veteran specific applications it would only total 3.5% of HUD's Continuum of Care funding. Thus, if the goal is to get more veteran specific programs funded, the real issue is how to get more veteran specific applications submitted.

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 50,000 male veterans are served during the course of the year.

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 two significant issues remain. The first is 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 in few weeks we will be releasing additional resource materials on the Continuum of Care process. In addition, HUDVET provides an array of technical assistance resources that are readily available through the Internet and via our 1-800 number. And finally, we will be strengthening our College of Experts to ensure that sufficient qualified technical assistance consultants are available.

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 cost communities points. 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 new resources. The President is asking for $1.029 billion in FY2000 plus $100 million for vouchers to assist homeless persons in

moving from transitional housing to permanent housing. The Department will also continue to make communities aware of the needs of homeless veterans and to encourage veterans service organizations to regularly participate in local planning efforts to educate the community on the special needs of homeless veterans.

In closing, let me briefly mention the role of the Interagency Council on the Homeless (ICH). We are aware that issues have been raised about the effectiveness of the ICH. First, it should be stated that the ICH can not and should not be measured against the standard developed before it was defunded by Congress in 1994. With funding from HUD, the ICH continues to serve a coordinating and information sharing role with a significantly smaller staff and limited resources. The Council no longer has a formal legislative mandate.

The ICH policy group of senior policy staff from the 18 agencies which make up the Council does, however, continue to meet on a bi-monthly basis to address problems, share information on new initiatives, and consider joint efforts. The Council also has a number of ad hoc working groups, including a Veterans Task Force convened by the Department of Veterans Affairs, which focus on specific issues or sub-populations of the homeless persons. These ad hoc work groups share information on projects, legislative proposals, and policies. In the coming months, ICH's major project for the past few years will come to fruition. The National Survey of Homeless Assistance Providers and Clients will be released. This survey, funded by 11 Federal agencies and conducted by the U.S. Census Bureau, is the first major national survey on homelessness since 1987. It addresses a number of questions regarding homeless veterans which will help us understand the current status of programs serving homeless veterans, provide a profile of homeless veteran clients, and help the Federal government shape future policy to better address the needs of homeless veterans.

Thank you for the opportunity to talk about HUD's efforts to address homelessness. The Department is proud of the impact we have made in addressing this American tragedy, but we, like many Americans, are appalled that any of our nation's veterans, who have sacrificed so much to benefit us all, should find themselves homeless on the streets of our cities and towns. We at HUD, therefore, commit ourselves to continuing our work with this committee, veterans service organizations, and other concerned groups to improve our efforts to ensure that the needs of homeless veterans are met.

**Statement of**
**Peter H. Dougherty**
**Director, Homeless Veterans Programs**
**U.S. Department of Veterans Affairs**

**Before the**
**House Committee on Veterans Affairs**
**Subcommittee on Oversight and Investigations**

**June 24, 1999**

Mr. Chairman and Members of the Subcommittee, I want to thank you for your continuing interest in the issue of homelessness among veterans and your efforts to support a variety of assistance programs to improve their lives. Accompanying me this morning is Dr. Robert Rosenheck, VA Director of the Northeast Program Evaluation Center and Professor of Psychiatry and Public Health at Yale University. Also in attendance is Ms. Gay Koerber, Associate Chief Consultant Health Care for Homeless Veterans, and Mr. Roger Casey, Program Manager, Homeless Grant and Per Diem Program, is case there are specific questions the subcommittee needs them to address.

We understand that the focus of this oversight hearing is to gather information on the effectiveness of federal grants to community based organizations as a means of addressing the needs of homeless veterans. In accordance with your wishes, we will limit much of what we say to the specific topic of this hearing. However, we do want you to know that we believe we have a number of highly effective programs and partnerships that assist many of the estimated quarter million veterans who find themselves homeless in America. Much of that information is included in an attachment, which we ask be made a part of the record.

We want the Committee to recognize the diverse efforts and substantial internal and external collaborations VA has made to improve the lives of those veterans who are homeless. VA medical care and supportive services are offered to homeless veterans with significant collaboration from community service providers. Innovative programs have made more than 175 foreclosed properties available at deep discounts or leased for $1 per year for homeless service providers. A great internal partnership has been established between the Compensated Work Therapy Program (CWT) and the nation's national cemeteries that assists many homeless veterans on the journey

back to employment with therapeutic work experience at some of our Nation's most hallowed ground.

VA has one grant program that is specifically designed to assist homeless veterans. The Homeless Providers Grant and Per Diem Program is our effort at bringing the strengths of community-based service providers, state and local governments, native American tribes and veterans service organizations and VA together to work to improve the lives of our Nation's veterans. This program is viable in the Nation's largest urban centers and in it's smallest towns and villages.

The Homeless Providers Grant and Per Diem Program began in this Committee nearly seven years ago when your committee approved legislation authorizing the program. The Department of Veterans Affairs believes that this program enables thousands of veterans each year to improve the quality of their lives in ways that were unattainable at the beginning of this decade. This program is bringing thousands of veterans to gainful employment, stable housing, reunification and renewed financial and emotional responsibility with families, and significantly improved health. All these factors make this program worthwhile. In an era in which taxpayers' investments in government functions are being closely followed, the work of this program is one of the best investments America is making.

As of October 1998, VA awarded 127 grants to 101 different entities in 39 states and the District of Columbia. We have committed approximately $26 million in grant funding during the past five years, and the President's FY'2000 Budget funds this program at $31 million. We appreciate the increased funding for this program this fiscal year. When all current grantees complete their acquisition, renovation and/or rehabilitation of their property we expect more than 2,700 transitional housing beds for homeless veterans will be created in communities across the Nation. Twelve independent homeless service centers, five mobile service center units which will provide medical care and/or counseling services for homeless veterans, and twenty vans to address transportation needs, have or will come into community service as a result of our grant program.

This Congress is considering whether to reauthorize the Homeless Veteran Service Providers Grant and Per Diem Program, and whether to lift the cap on the number of vans that providers can procure using grant funds. Allowing community groups to be awarded funding for vans is a great way to improve access to services without creating more costly accessible community services. VA supports extension of the program and lifting the cap on use of funds to acquire vans.

Tonight, more than 1,000 veterans will put their heads on pillows in one of nearly three dozen locations across the country at quality facilities supported by VA per diem payments. These community-based programs span our Nation in large cities and small towns. Once many formerly homeless veterans went without hope; now, many are able to return to their highest functional level in independent living arrangements and are

once again becoming employed. VA pays providers $16 per day for the care and treatment of our homeless veterans. This modest investment is giving us a great opportunity to improve the lives of these veterans. Our homeless service providers are committed to an extremely difficult task with little financial reward.

As you know, the General Accounting Office recently conducted two reviews of homeless programs: "HOMELESSNESS Coordination and Evaluation of Programs Are Essential" [GAO/RCED-99-49] and "HOMELESS VETERANS VA Expands Partnerships, but Homeless Program Effectiveness is Unclear" [GAO/HEHS-99-53]. We believe that those reports generally showed that the programs offered by VA are highly collaborative in their approach and effective in their results. GAO told us that no single treatment program can serve all veterans with equal effectiveness. We agree and believe our programs offer diverse delivery options to provide veterans with the best treatment setting available. These treatment options are essential components in our ability to be effective.

GAO recommended in the latter report that VA initiate a series of program evaluation studies to address the long-term effects. That recommendation was to review positive outcomes and program impact with enhanced follow-up of those veterans who have been through our programs. We concurred. Prior to this recommendation being presented we were taking steps at selected sites to improve our information on long-term program effectiveness. We hope to present information on this topic to the committee in the future.

**VA Involvement with other Federal Agencies**

VA has been an active participant on the Federal Interagency Council on the Homeless (ICH). The ICH is a working group of the White House Domestic Policy Council housed within the Department of Housing and Urban Development (HUD). ICH's role is to coordinate the activities of the various Federal agencies and improve our collective response to homelessness in America. ICH is committed to breaking the cycle of homelessness and we are very supportive and involved in its work. The Secretary of Housing and Urban Development (HUD) serves as chair, the Secretary of Health and Human Services (HHS) and the Secretary of Veterans Affairs (VA) serve as co-vice chairs.

One of the most important projects recently undertaken by the ICH is the "National Survey of Homeless Assistance Providers and Clients." The survey conducted by the Census Bureau should be released this summer. We hope this report will answer a number of questions about service availability and utilization and give us rich information about who are the homeless, how often and how long have they been homeless, and what programs and activities were most helpful in getting them out of homelessness. VA has actively participated in the design of the survey and will work with the extensive data that is released from the more than 4,000 individuals who were interviewed.

VA has worked to improve communications with other Federal programs that assist veterans.

The largest programs to assist homeless persons conducted under the McKinney Act are HUD's Homeless Assistance Programs. These programs that award homeless assistance grants for emergency, transitional and permanent housing and supportive services under local continuums of care established at the city or county level in more than 900 jurisdictions. While these programs have worked well in many instances, we are continually working with HUD to improve program coordination.

As a result of a number of discussions with local community organizations and veterans service organizations, we believe it is very important to maintain a high degree of collaboration and exchange of information regarding need, accessibility of services and eligibility of persons to be served by the local community.

The U.S. Department of Labor (DoL) has long been a VA ally in assisting homeless veterans. DoL's HVRP (Homeless Veterans Reintegration Projects) Program awards small grants to non-profit organizations to assist veterans with training, employment and transportation needs faced by (unemployed) homeless veterans.

DoL requires its grantees to meet with local VA staff so that each may be aware of the capabilities and limitations of the other and to develop some ways to achieve increased cooperation to benefit the veterans both seek to serve.

The Department of Health and Human Services (HHS) has a number of programs that assist homeless veterans. Our Department has strong working relationships with their Substance Abuse and Mental Health Services Administration. HHS's Projects for Assistance in Transition from Homelessness (PATH) provides grants to states that develop comprehensive strategies to address homelessness among persons with mental illnesses in the respective states.

The Public Health Service Act, Part C, Section 522(d) requires the Secretary (of HHS) in making grants using PATH appropriations, to be sure each State in its application gives special consideration to entities with a demonstrated effectiveness in serving homeless veterans. I have served for several years as a PATH application reviewer. There has been some excellent cooperation with some states; but other states show little understanding of the services and programs offered by VA and the opportunities to have PATH grantees work more closely with veterans.

We at VA are working closely with staff at HHS to improve communications at the national, state and local levels. We believe this information dissemination at multiple levels is necessary to have the beneficial effect on those veterans who need assistance.

In addition, we have good relationships with the Federal Emergency Management Agency (FEMA) and the Department of Agriculture. Both of these agencies provide food assistance to homeless persons and we have enjoyed the opportunity to exchange ideas regularly. Our community assessments have found food needs that are generally been met. We believe this is, in large part, a result of the collaborative efforts of both agencies.

**VA and Community Partnerships**

For five years, VA has conducted Community Homelessness Assessment Local Education and Networking Group CHALENG meetings to determine the needs of homeless veterans, establish and update local resource directories and develop local action plans. More than 10,000 persons have attended these meetings and many have worked diligently to improve the lives of veterans in their communities. We shared the information gathered at these meetings with HUD regional managers and encouraged its use by local communities.

VA's Millennium Project is called: "Stand Down 2000." These community-based efforts strive to offer homeless veterans and family members an entry into a community-wide continuum of services. Based on our past experience, we anticipate that most veterans participating in stand downs will be men (only three to four percent are women). The vast majority of veterans attending stand downs are single, and most come from poor, disadvantaged backgrounds. Homeless veterans tend to be older and more educated than homeless non-veterans are. About 45% of homeless veterans have a serious psychiatric disorder and slightly more than 70% suffer from alcohol or other drug abuse problems. More than half are African American or Hispanic.

VA will support community efforts to hold stand downs and assistance fairs in every state. We hope as that many as 100,000 veterans and their family members will be assisted. This will be done with, hopefully, the help of more than 40,000 volunteers during November 1999 through December 2000. VA has, for more than a decade, been a partner with Veteran Service Organizations, community-based, non-profit service providers and state and local governments to reach out to homeless veterans. VA will continue to work with these groups in coordinating stand downs in the hope that more than 25,000 veterans will access mental and physical health care services for the first time at these stand downs.

We have worked with all major veteran service organizations, as well as the Veterans Organization Homeless Council, the National Coalition for Homeless Veterans, the National Alliance to End Homelessness, the National Law Center on Homelessness and Poverty and other national organizations and offices in an effort to improve the continuum of services for veterans. VA serves as the lead agency to bring the resources of the community to better understand the capability and availability of services for veterans. We do this at meetings with those organizations and with other

Federal agencies actively involved in assisting homeless person, including homeless veterans.

**VA Activities Under Title V of the McKinney Act**

VA surveys all VA medical care facilities and regional offices twice each year to identify unutilized and underutilized property that might be made available to non-profit organizations to serve the homeless.

In January 1999, VA identified 67 unutilized and underutilized properties of which 29 were determined to be suitable for use by homeless providers. The process of identifying Federal properties for use by homeless service providers has been in place, with some modifications, since 1987.

A specific McKinney Act transaction involved a former VA property at North Little Rock, AR that had been reported as excess to the GSA. GSA negotiated a permit with HHS for a homeless provider to use part of this property and VA, as former landholder, agreed to the terms. Ultimately that deal fell through. We have found the McKinney Act requirements and procedures are administratively burdensome and there is more incentive for VA to directly lease its unutilized property to homeless groups that serve veterans rather than relinquish property under the McKinney Act.

VA medical centers (VAMC) have entered into several successful partnerships with non-profit organizations that are providing programs and services for homeless veterans. VAMCs have provided properties to non-profit organizations, under short-term leases and sharing agreements in an effort to expand services for homeless veterans. Examples include VAMCs at Northampton, MA; Northport, NY; Coatesville, PA; Hampton, VA; Richmond, VA; Martinsburg, WV; Chillicothe, OH; St. Louis, MO; Minneapolis, MN; Portland, OR; and West Los Angeles, CA.

In addition, non-profit organizations have received grants pursuant to VA's Homeless Providers Grant and Per Diem Program to renovate VA properties to serve as supportive housing for homeless veterans. Under VA's Homeless Providers Grant and Per Diem Program, VA also provides these non-VA organizations with per diem payments (currently $16 per day) to help offset the costs of operational expenses.

**VA Conducts Extensive Program Monitoring**

VA has the Nation's most extensive and long standing program of monitoring and evaluating data concerning homeless veterans and the programs that serve them. In 1987, at the request of this Committee, the Northeast Program Evaluation Center

(NEPEC) initiated a three-fold evaluation strategy for what was then an unprecedented VA community collaborative program – the original HCMI 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 underserved 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 NEPEC study showed 30% to 40% improvement in psychiatric and substance abuse outcomes, employment rates doubled, and 64% exit 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. Both of these studies have been published in leading medical journals.

After establishing the effectiveness of these basic 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 (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 percent to 12.4 percent of the veterans contacted during the outreach effort.

A recent 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 were sustained THREE YEARS after program entry. This is the longest follow-up study conducted on any homeless population anywhere.

In addition, VA is a leader in documenting the substantial additional costs of treating homeless veterans with mental illness and in tracking the expenditure of every program dollar to assure maximal efficiency and accountability. Several additional program improvements are planned for implementation during the next the next year. These included transitional housing services for homeless inpatients, and a special outreach program for homeless female veterans.

Each of these efforts will receive the same scientifically rigorous evaluation that has characterized all components of VA's homeless initiatives for the past 12 years. Furthermore, NEPEC uses the same clinical measures with the Homeless Grant and Per Diem Program as with all other VA homeless specific programs to assure monitoring consistency. This has allowed us to create a common measuring stick for all of our homeless programs.

**VA's Commitment to Assisting Homeless Veterans Continues**

The Department of Veterans Affairs has worked diligently for more than a decade to improve the lives of our Nation's homeless veterans. The Administration's budget shows how serious we are at attempting to break the cycle of homelessness among veterans. This budget seeks wide opportunities to address the solutions with a variety of treatment options. Most of the money will be spent with community service providers by doubling the amount of funding under our contract residential care program; providing special programs for homeless woman veterans; expanding our therapeutic work experience under our CWT program; increased support for stand downs; increased program monitoring and evaluation; increased funding for our grants and per diem program.

We have learned some lessons that have guided us to date:

First. While VA has the most extensive system of services for homeless veterans in America, we cannot and should not try to do it alone. Since the late eighties, we have collaborated with communities and community based homeless service providers.

Second. While there are a number of common patterns, each veteran who has become homeless is like each American who has become successful: their paths are different and the intervention for rehabilitation may take multiple attempts and need multiple treatment options prior to successful completion.

Third. Aggressive involvement with other Federal agencies, state and local governments, Native American Tribal governments, veterans service organizations and tens of thousands of volunteers makes a difference.

Finally, something needs to be said and remembered here today: America has a long and proud tradition of doing everything possible to bring back those wounded on the battlefield. For many of America's homeless veterans, the battle continues, and they are out there wounded, suffering from mental illness, and substance abuse disorder. Many carry the scars of the wars we sent them off to fight.

We must do all we can to bring every veteran home—our commitment expressed here today continues that tradition. Many homeless veterans on the streets, under

bridges and encamped in the woods are desperately hoping that someone is coming to bring them back to safety—to bring them home. That is our commitment to bring all of America's homeless veterans—home.

With your help and with the help of dedicated staff, veteran specific service providers, veterans service organizations, thousands of volunteers, including a number of AmeriCorps members, we will continue to bring back those in greatest need, treat them with compassion and assist them in enjoying the bounty of the American dream.

Thank you,

**STATEMENT OF EMIL W. NASCHINSKI, ASSISTANT DIRECTOR**
**NATIONAL ECONOMIC COMMISSION**
**THE AMERICAN LEGION**
**BEFORE THE**
**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**
**COMMITTEE ON VETERANS' AFFAIRS**
**UNITED STATES HOUSE OF REPRESENTATIVES**
**ON**
**FEDERAL GRANTS FOR HOMELESS VETERANS' PROGRAMS**

**JUNE 24, 1999**

Chairman Everett and distinguished members of the Subcommittee:

The American Legion is pleased to have this opportunity to share its views on the effectiveness of federal grants to community-based organizations as a means of addressing the needs of homeless veterans. While five federal department and one federal agency administer grant programs, we have confined our comments to the grant programs of the federal departments that The American Legion works with on a regular basis. They include: the Departments of Labor (DoL), Veterans Affairs (VA) and Housing and Urban Development (HUD).

Experts on homelessness estimate that on any given night there are 750,000 homeless persons in this country. Of that number, they believe that at least one-third are former members of our Armed Forces. They further estimate that the percentage of veterans in the homeless populations of most major cities is upwards of fifty percent.

While The American Legion is deeply disturbed by these estimates, we are equally disturbed by the fact that they are the same figures we were using 10 years ago. Despite the efforts of Congress, federal agencies, private sector organization and a host of community-based groups, it does not appear that we have had significant success in ending homelessness among veterans.

We are not inferring, Mr. Chairman, that the veterans who are homeless today are the same veterans who were homeless a decade ago. Many of the men and women who were homeless 10 years ago received the assistance they needed and are no longer homeless. Unfortunately, many others are now deceased.

According to the VA, veterans who become homeless generally start showing up in homeless programs 10 years after their discharge. If that is true, it might explain why a large and growing number of homeless veterans served in the military during the past decade.

The American Legion believes there are several reasons for our lack of success in ending homelessness among veterans. The first reason, and the saddest, is that 10 years ago one of this country's priorities was to end homelessness in America. Unfortunately, that goal fell by the wayside before it was achieved. To make matters worse, because homelessness is so prevalent, many Americans have become apathetic and desensitized to the plight of the homeless.

The second reason is that while there are many good homeless veterans' programs, too many concentrate on getting the veteran off the street rather than on using a holistic approach to address all of the veteran's needs. Unfortunately, many community-care providers have neither the resources nor the technical capacity to address all of the veteran's needs.

Mr. Chairman, most individuals who work with homeless veterans, and/or who advocate for them, agree that the key to breaking the cycle of homelessness lies in assisting the veteran to become job ready and then assisting that person in finding and maintaining suitable employment. Unfortunately, very few homeless veterans' programs offer an employment component.

One program that has been successful in placing homeless veterans in jobs is the Homeless Veterans Reintegration Project (HVRP). It is operated by DoL and is the only federally funded program that is focused strictly on preparing homeless veterans for employment and on successfully placing them in meaningful jobs. Through this program, grants are awarded to community-based organizations and private sector contractors that assist homeless, unemployed veterans in finding and sustaining employment. According to DoL statistics, the average cost per placement is between $900.00 and $1500.00.

In order to find suitable employment, homeless veterans must overcome significant and real barriers. Those barriers can include such things as not having the proper training to compete for certain jobs, not having appropriate clothing for a job interview, or not having the tools to ply one's trade. HVRP addresses these types of issues and helps homeless, unemployed veterans get off the welfare dole and onto the 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 usually recoups his investment within a year.

Despite the fact that Congress authorized a funding level of $10 million per year for HVRP, the program has not received an appropriation of more than $5 million per year in the past 7 years. In fact, during two of those years, the program received no money. For FY 98 and FY 99 the program received a mere $3 million per year. The American Legion salutes Congress for establishing the HVRP program. Having said that, however, we must also point out that Congress must take full responsible for not providing the appropriations this program needs to reach its full potential.

Recently, Congressman Filner (CA) introduced H. R. 1484, *Authorization of Appropriations for Homeless Veterans Reintegration Projects.* That bill will extend the HVRP program from Fiscal Year (FY) 2000 through FY 2004. It will also raise HVRP's funding level from $10 to $50 million per fiscal year. Because of HVRP's past success in placing homeless, unemployed veterans in meaningful jobs, The American Legion fully supports this legislation.

Mr. Chairman, another problem is that while veterans constitute a significant portion of the homeless population, veteran specific programs currently receive less than three percent of HUD's Stewart B. McKinney dollars. We believe there are two reasons for this underfunding.

First, many individuals who serve on the local boards that determine which homeless program their community will fund are not veterans. As a result, they are less likely to be aware of the needs and problems of veterans who become homeless.

Second, many of the individuals who serve on local boards mistakenly believe that all veteran issues and programs are handled by VA. As a result of that misunderstanding, local boards are less likely to fund veteran specific programs with HUD grant dollars.

In 1987, Congress responded to the growing number of homeless veterans by requiring VA to establish programs to meet the needs of those veterans. Today, VA operates a wide variety of programs that are tailored to meet the diverse needs of its homeless clientele.

Because VA realizes that it does not have the resources to meet the needs of all homeless veterans, it has established numerous partnerships throughout the country with community-based care providers and private sector organizations. The purpose of these partnerships is to develop a continuum of care and improve services to homeless veterans by customizing those services to meet the needs of the veterans in those communities.

Only one of those programs, however, is a grant program. The VA's Homeless Providers Grant and per Diem (GPD) program provides grants to community-based

care providers who construct or renovate existing facilities that will be used to provide transitional housing or supportive services for homeless veterans.

VA recently reported that during GPD's first six years, 127 grants were made to 101 different care providers in 39 states and the District of Columbia. Once the current grantees complete their construction or renovation projects, VA believes the GPD program will be responsible for the creation of 2,700 new community-based transitional beds for homeless veterans. The program is also responsible for the creation of 14 independent homeless service centers, five mobile service center units and the purchase of 20 vans for community outreach to homeless veterans.

In April of this year, the General Accounting Office (GAO) released a report entitled, *Homeless Veterans, VA Expands Partnerships, But Homeless Program Effectiveness Is Unclear* (GAO/HEHS-99-53). It concluded, and VA management agreed, that there is not enough data on which to accurately evaluate the effectiveness of GPD and VA's other programs for homeless veterans. GAO's single recommendation was that VA initiate a series of program evaluations to clarify the effectiveness of VA's core homeless programs and to provide information on how to improve those programs. VA concurred with that recommendation and is in the process of remedying that situation.

Mr. Chairman, if GAO and VA's top management have been unable to assess the effectiveness of the GPD program, it would be ludicrous for The American Legion to offer an opinion. We do, however, support continuation of the GPD program. According to one VA official, GPD's funding for FY 2000 will be increase by a total of $15 million. Of that money, $11 million will be used for grants and the remaining $4 million will go to the per diem portion of the program.

The American Legion is a member of both the National Coalition for Homeless Veterans and the Veteran Organizations' Homeless Counsel. Because of our relationship with those groups, we have had an opportunity to talk to numerous community-based care providers. The bulk of their anecdotal reports on GPD have been favorable. A number of them, however, recommended that GPD could be improved by eliminating the cap on the purchase of vans for outreach. Currently that cap is set at 20 vans and that limit was reached in the program's first year. Also, several of those care providers suggested that Congress either eliminate the $16.00 per day, per veteran requirement, or allow in-kind contributions to be used as an off-set.

Mr. Chairman, in closing, The American Legion wants to publicly thank you and the members of the Subcommittee for the concern you have demonstrated for America's homeless veterans. Because combating homelessness is expensive, additional resources are need. Nonetheless, we do appreciate the support you and the Subcommittee have given to the programs that assist those veterans in becoming productive citizens again.

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*A Not-For-Profit Veterans Service Organization Chartered by the United States Congress*

**STATEMENT**

**OF**

# VIETNAM VETERANS of AMERICA

**BY**

**RICHARD F. WEIDMAN**
**DIRECTOR OF GOVERNMENT RELATIONS**
**VIETNAM VETERANS OF AMERICA**

**BEFORE THE**

**HOUSE VETERANS AFFAIRS**
**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION**

**REGARDING THE EFFECTIVENESS OF FEDERAL GRANTS TO COMMUNITY BASED ORGANIZATIONS AS A MEANS OF ADDRESSING THE NEEDS OF HOMELESS VETERANS**

**JUNE 24, 1999**

**Vietnam Veterans of America** **House Subcommittee on Oversight and Investigations**
**June 24, 1999**

Mr. Chairman, my name is Rick Weidman, and I am Director of Government Relations at Vietnam Veterans of America (VVA). On behalf of the officers and members of VVA, I thank you for the opportunity to appear here today to present our views on the effectiveness of federal grants to community based organizations as a means of addressing the needs of the homeless veteran. Let me note that VVA is grateful for your continued leadership on these and other issues of vital interest to America's veterans.

In twenty (20) states, there are thirty-nine (39) loosely coordinated programs for homeless veterans, funded by the VA Homeless Veterans Grant & Per Diem program, not including the currently fashionable "STAND DOWN" events. In most, there is a semblance of coordination; or, to use the contemporary euphemism, "continuum of care" between state and federal agencies and/or the veterans services organizations. The National Coalition *for* Homeless Veterans (NCHV) has contact with more than 600 providers of service in 43 states and the District of Columbia. There are undoubtedly more efforts taking place than anyone in Washington is aware, and others who would respond to the challenge if there were any hope that resources to do the basic work might become available.

It is well beyond the time for demanding that all levels of government get serious about homelessness. At the federal level, government began relatively serious attempts at dealing with the homeless about fifteen (15) years ago. It is now time to demand that those of us involved in assisting the homeless, especially the homeless veteran, demand much more accountability from Federal funding agencies for their action, and take the neccesary steps to get programs that are effective, and that address the needs of veterans in a truly 'holistic' manner, that focuses on returning veterans to the highest degree of autonomy possible.

A "continuum of care" is an integrated combination of programs, ranging from immediate aid such as food and shelter, to job training and transitional housing, to preparation for permanent jobs and permanent housing. The steps from intake to graduation will differ with each case; but moving on successfully is the measure of effectiveness. This model derives from the notion that there is a job to be done, a goal to be reached. "Three hots and a cot" are not enough. Most non-VA programs assisting homeless veterans are geared to changing the lives of homeless veterans, to helping overcome their addictions and a myriad of other problems. No homeless veteran has small problems and no single step will make things right for them. WE HAVE TO HELP THEM CHANGE THEIR LIVES.

A typical "continuum of care" program, a carefully orchestrated network of not-for-profit and government programs, will offer the homeless veteran a menu of services. Following stabilization and sobriety, these programs will offer transitional housing (three (3) meals a day, clean clothing, a safe place to sleep and the company of fellow veterans) coupled with the real changes; an array of assistance aimed at mental health and addiction problems, coupled with job counseling and jobs training. Approaching graduation, the veterans will be offered placement services, for both employment and housing. In a few cases, continuous, on-going aftercare will be needed. In all cases, successes are predicated on four (4) factors: good program design, dedication of staff, a "continuum of care" and adequate funding.

What makes veteran-specific programs succeed where others fail is that they are targeted toward a special needs population -- they are designed not for some sort of generic homeless people, but for homeless veterans. Make no mistake; homeless veterans are not your typical "garden variety" homeless person who just happens to have served in the Armed Services of the United States. Most are homeless because they are veterans and because their problems are uniquely different than the rest of the needy in the streets.

**WHY ARE THEY DIFFERENT?** Statistics suggest the answer. Homeless veterans come from every ethnic group, but they are overwhelmingly men and their median age is 45. Most served during the Vietnam War, although some post-Vietnam and Gulf War veterans tend to lower the median age. A 1987 study conducted by The Research Triangle Institute found the highest correlations to be between combat service and PostTraumatic Stress Disorder (PTSD). Not war but the nature of the Vietnam War -- explains why homeless veterans tend to be disproportionately from the Vietnam era and why they are so unlike anybody else.

Let us step back for a moment and offer a clearer view. Most Americans, by the age of 30, watch a hundred or more western movies. Almost all of these films feature lonely wanderers, men so unadapted even to frontier society that they roam the badlands alone; yet few of these pictures mention that the period that they describe was the first two decades after the American Civil War, this nation's only other divisive. Like Vietnam, it was brutal war after which many veterans found no place that felt like home. The two (2) World Wars united this nation, but Vietnam was a second civil war. That sort of aftermath worsens PTSD in combat veterans.

Untreated PTSD is a major cause of homelessness in veterans, stemming directly from the combat experience. Nobody who has not gone through a similar experience can imagine how savage the nightmares are, how terrifying the flashbacks that close in on you. Most veterans with severe PTSD find that substance abuse -- alcohol, drugs or both -- will dull the unbearable symptoms, so they "self medicate" But substance abuse is not a cure. Quit, and the horror returns! Imagine trying to hold a job while carrying the burden of a serious mental health problem and a major addiction. Imagine trying to keep your home or your family. Most homeless veterans live alone, afraid to trust anyone. They've tried job after job, always failing because of what will ultimately be determined to be a dual

diagnosis, the addiction and the PTSD; trying to get "clean and sober" only to have the war return every night; tried PTSD programs and got thrown out for drunkenness. There are programs -- though not enough -- that treat the PTSD and the addiction simultaneously, but programs aimed at the generic homeless don't know this. Generic homeless programs expect to find mental health issues complicated by substance abuse, but not PTSD. If you don't look for PTSD, you won't find it. Every homeless man must be asked if he is a veteran; and, it wouldn't hurt to ask the women as well.

Access to homeless veterans begins with trust and they find it hard to trust anyone who doesn't understand where they've been and how they got where they are now. The everyday world seems shallow and false. Arrogance is often a defense against the terror of being alone in hostile territory. For such men, panhandling is not easy work. They will trust other veterans and because of program staff's deep personal commitment, are on the threshold of reaching out to and assisting those who are ready to make a change in their life.

Over that past several years, we have proposed to the federal government that it needs to fundamentally recognize that homeless veterans are a distinct special needs group. Homeless veterans comprise 35-40% of the overall population of homeless adults; but, they do not receive, by any stretch of the imagination, a fair and equitable share of monies allocated to the homeless.

Homeless veterans are a group that can be served for far less money per person than the generic homeless; but, is one that goes largely unidentified. The failure to identify and assist homeless veterans is a costly one. It means that otherwise well-constructed efforts and messages are meaningless to a third or more of those that they are intended to reach. That's similar to administering the wrong serum to a third of the sick during an epidemic.

We have no expectation that this narrative will be greeted enthusiastically outside the veterans' community. There is a notion that veterans, having long ago given whatever thing of value that was theirs to give, have ever since whined for gifts and set-asides as a payback. While this notion is not wholly incorrect, it is for the most part wildly exaggerated. But, the blunt facts of the overall homeless effort makes a different case here. Homeless veterans are so clearly a special needs population -- one that is large (particularly throughout the Northeast) and difficult to reach yet eminently treatable using the services designed, the continuum of care.

This fair and equitable share concept, both in funding and operational structure, is not an attempt to wheedle resources for an important constituency group. Rather, it is an eyes-open conclusion about who is in the streets. Most of those ragged men with signs that read, "PLEASE HELP -- VETERAN" are just what they claim to be. And, lest it has been forgotten, let us recall the

NUMBER ONE priority of the last three (3) administrations: HOMELESS VETERANS and what this nation intends to do about the approximately 275,000 homeless veterans have been identified as existing in the United States.

**H.R. 1008**

Vietnam Veterans of America (VVA) strongly favors early enactment of H.R. 1008, The Robert Stodola Homeless Veterans Act of 1999. This proposed legislation, sponsored by the Honorable Jack Metcalfe of Washington, would set aside 20% of the Stewart McKinney funds available through the Department of Housing and Urban Development (HUD). Currently only about 1 to 1.5% of these funds go to programs designed to meet the *special needs* of veterans despite the act, as noted above, more than 30% of homeless adults are veterans. VVA urges you, Mr. Chairman, and your distinguished colleagues on this Committee to co-sponsor this important measure, and to join with Mr. Metcalf in pushing for speedy passage of this measure by the House, and enactment before the end of this session.

**Veterans Identifiers and H.R. 364**

Last week, your distinguished colleague, the Honorable Jack Quinn, Chairman of the Subcommittee on Benefits, appeared to be ready to take up H.R. 364, the Veterans Bill of Rights for Employment, Training, And Related Services. This proposal, if strengthened, would go far toward restoring veterans priority in programs that will assist veterans to get jobs, as well as the important process of overcoming barriers that can be classified as "barriers to employment." One of the biggest problem is trying to identify veterans served by any of the many general programs operated by HUD, HHS, Labor, or other agencies. The first step toward equity will be identifying veterans, as defined in Title 38, United States Code, and forcing the heads of agencies to report on services to veterans to the Congress each year.

At HUD, I asked Deputy Secretary Karnas why HUD did not instigate action through the public rule-making process to put veteran identifiers on all services delivered by HUD and HUD-funded programs. He stated, in public at the NCHV annual meeting in Washington in March of 1998, that he would start the process toward making this happen. That is the last that I have heard about this.

The VA, until very recently did little to help the homeless veteran. That bleak picture has changed a great deal over the past five (5) years, but much remains to be done.

Homelessness, for a great many veterans who suffer it, is a service-connected disability. PTSD, though a major contributing factor, is not its only cause. Last summer, one of our members spoke with a homeless veteran in north central New Jersey whose Cold War service was in missile silos, who says that constant preparations demanding a willingness to destroy all life on earth ruined his sanity. And, the lowering of entry standards mid-way through the Vietnam War brought into the

stressful world of the wartime military a group of men previously -- and correctly -- considered unfit to bear such stresses.

And a great many of the veterans who are admitted to these veteran-specific programs likely already have or will shortly after intake qualify for service-connected VA entitlements. Others will have or will qualify for SSI benefits. Most programs call for the veteran with an income, no matter the source, to contribute 30% of his gross monthly income towards room and board.

In trying to fund these non-VA programs, most grantees have access to only two (2) federal programs with any real dollars that are competitively sought. They are HUD's *Supportive Housing Program* and the *VA Homeless Providers Grant and Per Diem Program*. VVA would argue that the key missing element here is enough funding available to most local programs access to the Homeless Veterans Reintegration Program (HVRP), which is the most cost effective, cost efficient program administered by the United States Department of Labor.

It has been our experience over the past eight (8) years that HUD will fund successful applicants for up to 50% of construction/renovation/purchase of a property up to a specific amount, limited to the ceiling set by the local HUD field office. As an example, in the northeast, all programs there are in the 175% high-cost area. That means that HUD will fund up to $400,000 of a construction/ purchase or rehab of a property that may cost $800,000 in total. HUD will also pay 100% of all supportive services costs over the life of the grant; and, 75% of the 1st year's operating costs, 75% of the 2nd year's operating costs and 50% of the 3rd year's operating costs. Once a prospective grantee determines the total of all costs, HUD permits the addition of 5% of that total to the application for administrative costs (record-keeping, reporting costs, etc.).

Beginning in 1994, the *VA Homeless Providers Grant and Per Diem Program* began funding projects requesting construction /renovation/purchase funds – up to 65% of the total cost, with no limitation on the total amount. Five years ago, this was a fairly straightforward process and HUD was the agency asking for a lot of useless information. Now, the reverse is true. VA will also only fund proposals that *create new beds*, not expansions of existing programs. VA also administers the per diem program for which new rules are about to be published.

Mr. Chairman, that concludes our joint remarks. We would be pleased to answer any questions. Again, Vietnam Veterans of America appreciates the opportunity to appear here today and thanks you for your leadership on these important issues.

*Vietnam Veterans of America*
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*A Not-For-Profit Veterans Service Organization Chartered by the United States Congress*

**VIETNAM VETERANS OF AMERICA**
**Funding Statement**
**June 24, 1999**

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Director of Government Relations
Vietnam Veterans of America.
(202) 628-2700, extension 127

STATEMENT OF

PARALYZED VETERANS OF AMERICA

FOR THE RECORD OF THE

HEARING OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

CONCERNING

FEDERAL GRANTS TO AID HOMELESS VETERANS

JUNE 24, 1999

Good morning Mr. Chairman and members of the Subcommittee. On behalf of the Paralyzed Veterans of America (PVA), it is a pleasure to present our views on the effectiveness of federal grants to community based organizations as a means of addressing the needs of homeless veterans.

According to the latest VA estimates, at least 275,000 veterans are homeless on any given night throughout the United States, and more than 500,000 veterans are homeless at some point during the year. The reasons for these staggering figures vary from veteran to veteran, however it is a well documented fact that veterans at highest risk for becoming homeless include those with disabilities, chronic illnesses, low incomes, lack of family and community support, and histories of mental illness and substance abuse.

Indeed, veterans just like anyone else may experience catastrophic illness or disability, loss of employment or benefits, or a host of other problems that leave them unexpectedly homeless.

In an effort to address this ever growing problem, consistent outreach, case management, community-based residential treatment and prevention are mandatory. Quality outreach to those most vulnerable veterans, those in shelters and on the streets, will provide the opportunity to give relief to those in need of care. Proper case management and community-based residential treatment can provide veterans with safe, clean, and sober settings for treatment and transition back to their communities. The ultimate goal for all veterans should be the path to employment, which will maximize treatment programs effectiveness. Prevention and follow-up for at-risk veterans can greatly reduce the likelihood of veterans losing their homes. All of these aspects are vital links in the continuum of care necessary to address the causes and effects of homelessness.

The Veterans Health Administration (VHA) must assume special responsibility for homeless veterans, however, it cannot address the problem alone. The VHA case managers must work with other government and private agencies to assist veterans enabling them to draw on all available social service resources. The assumption that veterans are a Federal problem presents a critical obstacle to VHA's ability to collaborate with providers of services for homeless veterans. There is also an apparent reluctance on the part of local community boards to support veterans specific programs and allow representatives of Veterans Service Organizations (VSO) on local boards. It is clear that programs designed to meet veterans' special needs are prevented from receiving funding from local entities that disperse Department of Housing and Urban Development (HUD), Department of Labor, Department of Health and Human Services (HHS), and other Federal funds. These agencies claim to provide services to homeless veterans, but few have any method of tracking the number served. Often these claims are based on the assumption that because veterans are part of the homeless population, they are provided services. This may very well be the case, however, there are also instances of veterans being turned away from

programs and sent to the VA. An example of one homeless provider's veterans' services was to provide the veteran a bus ticket to the VA.

PVA believes that the key to success in returning homeless veterans to the mainstream of life is through employment. While transitional housing, clinical services, and proper case management are also critical to the overall process, helping the veteran obtain and sustain employment must prevail.

Community-based providers must be prohibited from denying or delaying services to veterans. Congress must specifically address homeless veterans in all legislation designed to assist homeless individuals and include workforce development or employment in all such legislation.

We are pleased with the introduction of H.R. 1484, which, if enacted, would authorize a five-year increase in the Labor Department funding for community-based programs to find jobs for homeless veterans. It would double the current authorization to $10 million in FY 2000 and increase that amount by $5 million per year until it tops out at $30 million in FY 2004. PVA would like to thank Representative Bob Filner for his efforts in this area and urge the adoption of this measure during full committee markup.

PVA believes that Congress should create a structured method to ensure collaboration among federally funded efforts to ensure that more effective services are delivered to veterans. As indicated in the *Independent Budget*, creation of a White House Veterans Federal Coordinating Committee, co-chaired by the Domestic Policy Advisor and the Secretary of Veterans Affairs and reporting directly to the Vice President would be a positive step toward improving such collaboration.

DEPARTMENT OF VETERANS AFFAIRS
PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR CONGRESSIONAL AFFAIRS
WASHINGTON DC 20420

August 27, 1999

The Honorable Terry Everett
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are the Department's responses to post-hearing questions you submitted in your letter of July 29, 1999, concerning the June 24, 1999, hearing on the Effectiveness of Federal Homeless Veterans Programs.

If we can be of further assistance, please have your staff contact me or Nurit Erger at 202-273-5828.

Sincerely,

Sheila Clarke McCready

Sheila Clarke McCready

Enclosure
SCM/rth

**Post-Hearing Questions**
**Concerning the June 24, 1999, Hearing**

**for**
**The Department of Veterans Affairs**

**from**
**The Honorable Terry Everett**
**Chairman, Subcommittee on Oversight and Investigations**
**Committee on Veterans' Affairs**
**U.S. House of Representatives**

**1. How does VA plan to maximize its increased funding for homelessness?**

VA will maximize its increased funding by expanding many of its highly successful current programs for homeless veterans. For more than a decade VA has partnered with community-based service organizations, state and local governments, veterans service organizations, and native American tribal organizations to provide high-quality residential care and other supportive services to homeless veterans.

Our FY 2000 budget will allow us to expand services to many communities who need but do not have medical care and supportive services today. The additional resources will allow us to double contract residential care with community providers, allow modest expansion of our compensated work therapy, create ten new programs specifically for homeless women veterans, improve outreach in hundreds of communities and improve program monitoring and evaluation.

**2. One problem is that there seems to be little hard data on the numbers of homeless veterans. How many homeless veterans do you think there are in America? How do you get your numbers?**

There have been no systematic efforts to count the number of homeless people in America since 1987. Since there is no evidence that the numbers have declined, these somewhat dated estimates are used by most scholars and policy analysts. A careful study of survey data on homeless men suggested that in 1987 40 percent of homeless men were veterans, which results in an estimate of from 200,000 to 250,000 homeless veterans on any given night. Estimating the numbers of homeless Americans is methodologically difficult and controversial. Regardless of the precise numbers, there are clearly too many homeless veterans, and VA has taken action to assist them.

**3. How can local continuums of care do a better job in addressing the needs of veterans?**

In FY 98 there were 2,332 persons who participated in our Community Homelessness Assessment, Local Education and Networking Group (CHALENG) meetings for

veterans. The vast majority of participants were from community organizations or other Federal, state or local governments. One-quarter (553) were employees of the Department of Veterans Affairs. These meetings continue to be held and focus on the met and unmet needs of homeless veterans in the areas served by local VA medical centers, create or improve local resource directories, and develop local action plans to address the unmet needs of the homeless within their communities. These meetings are significantly enhanced by the high level of participation from individuals and organizations outside of this Department.

Our CHALENG meetings have been very helpful in many communities to develop local action plans to address the needs of homeless veterans. Unfortunately, these meetings are not considered in some community planning forums. We continue to work with representatives from Federal, state and local governments, community service providers and other interested parties to improve our meetings and to get the information collected there into the larger community planning to address the needs of homeless veterans.

**4. Sometimes it appears that there is little hope that situation with tens or even hundreds of thousands of homeless veterans will get better. Will it? What needs to happen?**

While VA's homeless assistance programs constitute the Nation's largest integrated system of services for homeless, securing more than 7,000 beds with supportive services, the number of veterans who have become newly homeless keeps the total number of homeless high. With the support of Congress and with improved integration and collaboration with community service providers, we believe the future is brighter.

As a result of targeted actions to get assistance directly to the veterans we serve, we hope between 35-40,000 veterans will be assisted in one or more of the programs VA supports under its homeless initiatives.

**5. GAO conducted two studies that involved homeless services, one specifically regarding homeless veterans. GAO recommended VA take some specific actions regarding long-term follow-up, what are you doing in response to the GAO recommendations?**

We have planned several new studies that will provide long-term follow-up on veterans treated in specialized VA homeless programs. New initiatives in work therapy, outreach services for female veterans and Critical Time Intervention for hospitalized homeless veterans will all include longitudinal outcome assessment. In addition, three-year outcome data from the VA Supported Housing (VASH) program and a comparison sample of homeless veterans treated in the standard Health Care for Homeless Veterans (HCHV) program will be available in the next year.

**6. One of the programs that we hear good things about is Compensated Work Therapy (CWT). I understand that many CWT veterans end up in VA jobs. Is that true? Is there a good reason for VA to grow this program rather than contract or grant it out to CBOs?**

Compensated Work Therapy (CWT) is a program providing an opportunity for participating veterans to strengthen vocational identity and maximize work potential based on skills, abilities, and therapeutic rehabilitation needs. VA began providing therapeutic work after World War II. We believe that this particular benefit is one of the best ways for a veteran disabled by mental illness and handicapped by his or her homelessness to develop a positive identity in our society.

Approximately 50 percent of CWT participants were homeless when last living in the community. In 1990 there were 49 programs nationally, and the value of work performed was $4.2 million dollars. In FY 98, 15,000 veterans, including those in our CWT/Transitional Residence Program, were treated at 100 programs, earning $34 million dollars. The variety of therapeutic-related Transitional Work Experience opportunities generated by almost 5,000 agreements with private companies, Federal, state and municipal agencies, has resulting in high levels of satisfaction among participating veterans. CWT has shifted from the therapeutic train-and-place workshop model to a community-based therapeutic Transitional Work Experience, reflecting developments in the field. Increasingly, therapeutic Transitional Work Experiences have proven to be a bridge to future competitive employment for participating veterans. CWT staff will receive training in community placement techniques from the National Veterans Training Institute (NVTI) in Denver to further develop their skills in providing therapeutic work.

Approximately 30 percent of the 9,000 veterans leaving the program last year received therapeutic-related Transitional Work Experiences within the Veterans Health Administration and the National Cemetery Administration, and approximately 38 percent subsequently obtained competitive employment. Program evaluation does not distinguish among the veterans who, after being discharged from CWT, were subsequently hired by VA and those who were subsequently hired by private-sector employers. We do know that a cross referencing of VA personnel conducted more than three years ago showed that approximately 750 VA employees had previously been treated in VA's homeless specific programs.

We believe that the continued growth of CWT is essential for the substantial number of veterans who as yet remain unserved by this normalized approach to therapeutic work, which focuses in part on the development of employment opportunities in the community. As an increasing body of research on work therapy for individuals with serious mental illness becomes available, it is apparent that many more veterans are appropriate for participation in work-based programs as part of their treatment, and many veterans receiving such treatment are able to thereafter achieve successful vocational outcomes. CWT has the experience and clinical expertise to enhance work skills and behaviors, to serve as an intermediary with employers on behalf of the

individual, and to develop access to opportunities that would otherwise be unavailable to veterans with serious mental illness. Therefore CWT will increase access to the more than 100,000 veterans in treatment each year for Schizophrenia. Additional studies and evaluations are indicating the strength of CWT as a valuable component in the reduction of drug and alcohol abuse during participation. These analyses are leading us to expand CWT for veterans in treatment for substance abuse disorders.

The effort to link with Community Based Organizations (CBOs) is important for CWT because of the benefits that result for the participating veteran. First, the veteran remains closely connected to the VA health care system. Clinical literature suggests that successful vocational outcomes are achieved more frequently when both the rehabilitative and medical aspects of care necessary to address serious mental illness so often found among the homeless are closely aligned and readily available, as they are within VA.

Secondly, partnerships between CWT and CBOs add value to the efforts of both organizations; it brings resources together in support of the needs of the veteran without additional costs to either organization, increases outreach to those in need of services, and can streamline the process of community integration.

We consistently promote the value of such partnerships to our CWT programs. Over 130 CWT staff from around the country attended the annual conference of the International Association of Psychosocial Rehabilitation Services (IAPSRS) where they met with community-based organizations operating rehabilitation programs for people with serious mental illness. CBOs that have demonstrated excellence in the delivery of vocational or residential services through compliance with recognized accreditation organizations, as most of them will, most effectively augment VHA's clinical and therapeutic-work services.

The tremendous value of real work in the treatment of mental illness is such that we must make every effort to provide such opportunities to any veteran who is not participating in some form of remunerative program of therapeutic-work. CWT is an effective and efficient approach that is available by legislative authority within the Veterans Health Administration. We intend to provide modest expansion of these services next year and will continue to work closely with community-based organizations.

**7. What can you tell me about how these grant programs meet the needs for both standards of performance and verifying their accountability?**

Providing accountable and quality services for homeless veterans through the Homeless Service Providers Grant and Per Diem Program (GPD) is a "process" that begins in the early stages of the program time-line. Program management controls are in place to ensure each stage, from the initial announcement of funding to the inspection of completed projects and eventually the ongoing operational monies, is guided by objective and unbiased procedures that maintain high standards with awardee

responsibility for the funding provided by the agency.

The Homeless (GPD) programs that receive ongoing per diem support participate in a national evaluation conducted by NEPEC. This evaluation is similar in design to those of other VA homeless program evaluations, and consists of three parts: documentation of client characteristics, program processes and client outcomes. Documentation of client characteristics shows whether or not GPD programs are serving the intended population (homeless veterans with psychiatric or substance abuse problems). Documentation of program processes such as average length of stay and cost provides feedback to the VA on how GPD funds are being spent. Random samples of veterans are conducted following discharge to verify dates of stay and to gather client feedback on services. Documentation of client outcomes such as housing and employment status at discharge gives a preliminary indication of program effectiveness.

Below are the controls established within various stages of the Grant/Per Diem program implementation continuum.

**Under Homeless Grants**

Function: Availability, amount, and specifics of funding for Homeless Providers Grant and Per Diem Program funds are announced in a Notice of Fund Availability (NOFA) and published in the *Federal Register.*

> Management Controls: Publication of *Federal Register* information is reviewed by VA offices of Operations, Intergovernmental Affairs, General Counsel, and the Under Secretary for Health before requesting OMB approval.

Function: Those entities considered for Homeless Providers Grant and Per Diem Program grant awards must be eligible entities to receive funds for approved purposes. The application (and the application process) is fair, objective, and unbiased.

> Management Controls: 1) Programs considered for funding are reviewed by program officials for initial threshold criteria. Threshold criteria are defined by 38 CFR § 17.701. These include: form, time, and adequacy; applicant eligibility; eligible population to be served; eligible activities; and audit findings. 2) Multi disciplinary teams are assembled to ensure adequate verification of eligible status as defined by 38 CFR §17.701 and review applicants meeting threshold. Review criteria and scoring is in accordance with Public Law 102-590 and rules and regulations as set forth in 38 CFR §§ 17.709 through 17.714; 3) Grant applicants' second submissions are reviewed by VA Office of Facilities Management and General Counsel, in accordance with VA policies and procedures and 38 CFR § 17.700. The balance payment of grant monies is contingent on final inspection and the facility meeting all applicable codes, standards, and regulations of the Department of Veterans Affairs.

**Under Per Diem**

Function: Those entities eligible to receive a grant are eligible to receive per diem payments under the Homeless Providers Grant and Per Diem Program and meet the eligibility requirements established by the Department of Veterans Affairs.

> Management Controls: A system of inspections by local VAMCs and VA Headquarters staff ensures that programs receiving per diem payments meet the rules, regulations, and standards as defined in 38 CFR §§ 17.715 through 17.716. These inspections are performed minimally on a yearly basis or as needed.

Function: The per diem amount paid to eligible entities under the Homeless Providers Grant and Per Diem Program is currently set at $16.00 per day per veteran. This amount cannot exceed one half of other costs of the veterans' care in that program.

> Management Controls: VA Headquarters in conjunction with local VA Medical Centers monitors per diem expenditures. Per diem expenditures are verified with information collected through program surveys by VA North East Program Evaluation Center (NEPEC).

Function: Per diem payments under the Homeless Providers Grant and Per Diem Program are made only for veterans that have been approved by VA.

Management Controls: The Homeless Providers Grant and Per Diem program, with local VAMCs, authorizes payments for only those veterans determined to be eligible for VA services by Headquarters or local field offices of Information Management Service, Section of Eligibility Determinations.

**8. Why is it important that programs be veteran-specific?**

There are several reasons why our programs are targeted to veterans. The laws under which this Department operates almost always require that only eligible veterans can participate in programs supported by appropriated funds. While the Homeless Service Providers Grant and Per Diem program has some leeway (75 percent of program participants must be veteran eligible), all of our contracted residential care and all of our per diem payments are made only to support services for veterans eligible for care as defined by the Congress.

VA estimates that on any given day approximately 250,000 veterans are homeless. The VA healthcare system plays a critically important, but largely unrecognized, role as a healthcare "safety net" for poor and disadvantaged veterans needing care. In FY 97, 29 percent of all VA medical center inpatients were either homeless at admission or lost their housing while they were under VA care. At 17 medical centers homeless veterans made up approximately one-half or more of all inpatients.

There are two important additional reasons to support veteran-specific programs. Many service providers believe that the common military experience allows a more effective way to reintegrate these veterans back into societal mainstreams of housing and employment. Programs that serve veterans also allow VA to use its limited resources in an efficient manner. Larger programs with greater concentrations of homeless veterans allow us spend our time and money more efficiently.

DEPARTMENT OF VETERANS AFFAIRS
PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR CONGRESSIONAL AFFAIRS
WASHINGTON DC 20420

September 29, 1999

The Honorable Terry Everett
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are the Department's responses to post-hearing questions you submitted in your letter of August 27, 1999, concerning the June 24, 1999, hearing on the Effectiveness of Federal Homeless Veterans Programs.

If we can be of further assistance, please have your staff contact me or Nurit Erger at 202-273-5628.

Sincerely,

Sheila Clarke McCready

Sheila Clarke McCready

Enclosure
SCM/rlh

**Follow-up Questions**
**Concerning the June 24, 1999, Hearing**

**for**
**The Department of Veterans Affairs**

**from**
**The Honorable Terry Everett**
**Chairman, Subcommittee on Oversight and Investigations**
**Committee on Veterans' Affairs**
**U.S. House of Representatives**

**1. How are potential community partners recruited or made aware of the VA need and upcoming grant awards?**

Community partners are made aware of the VA need and of upcoming funding through a number of methods. VA's Community Homelessness Assessment, Local Education and Networking Groups (Project CHALENG) for veterans requires VA staff to work with providers in the community to assess the needs of homeless veterans. There is a CHALENG point of contact at every VHA facility. These points of contact host a CHALENG meeting at least once a year with community providers to ascertain homeless veteran needs in their particular communities and exchange ideas on how to best aid the homeless veteran. This exchange leads to recruitment of community providers to work in conjunction with all of VA's Homeless Veteran Initiatives.

Notices of Fund Availability are published in the *Federal Register* announcing the recruitment of community partners for VA's Homeless Providers Grant and Per Diem Program. In addition, VA medical and benefit staff and VISN level Homeless Coordinators provide information about the Grant and Per Diem Program through regular contacts with community groups. VA provides regular contact with press and media outlets advising the public about this program. VA also features its Homeless Veteran Initiatives on its Internet Web site. The Grant and Per Diem Program page on the site provides information, offers hyperlinks to successful Grant and Per Diem recipient programs and offers information downloads such as the program application and the applicable rules and regulations. Finally, the Grant and Per Diem program has a toll free number that is disseminated in a variety of ways e.g., the web site, program application, and other program documents.

**2. Prior to awarding grants, what criteria are used in determining which providers are best suited to partner with VA in a particular locality? Is the provision of performance data a factor or requirement in awarding grants?**

The criteria used in determining the suitability of providers to partner with VA in the Grant and Per Diem Program is outlined in 38 CFR 17.700 through 17.731. Applications for funding are reviewed by a panel of subject matter experts and are scored as outlined in the CFR. In addition, applicants are required to complete, to the extent applicable, OMB's Application for Federal Assistance, Standard Forms 424, 424C and 424D.

The provision of performance data in and of itself is not a requirement for the award of a grant. However, the applicants must demonstrate the "Ability to develop and operate a project" (38 CFR 17.711(c)(3)). The applicant is requested to include past performance data from their program. That information is taken into account under our selection criteria.

**3. Once grants are awarded, how does VA track performance and outcomes? What specific measures are required of the grantees?**

Once the grant is awarded and the provider is within 90 days of completing the grant component (acquisition, renovation, or construction), a VA liaison is assigned from the

local medical center to aid the provider in completing the per diem inspection, setting up a mechanism for billing, and training the provider regarding the Northeast Program Evaluation Center (NEPEC) performance measurement component. The per diem inspection by the liaison ensures the provider is providing the housing and services as outlined in the original grant application, has the ability to provide these services, and reviews site safety issues.

The NEPEC performance measurement component is extensive and includes all of the information needed to ensure successful measurement of VA's homeless veterans programs. NEPEC requires verification and documentation of all homeless veteran clients who are admitted to and discharged from the provider program. In addition, a clinical evaluation is accomplished on participants with a follow-up component. This data is sent monthly to NEPEC for program monitoring and evaluation and is included in its reports. Providers are required to complete specific documentation as outlined in NEPEC's Training Manual for Grant and Per Diem Performance Measurement.

**4. Is all of the above data comparable, allowing for aggregate outcome determinations? If not, how do you propose such determinations be made?**

The data that is collected is comparable across all programs and allows for comparison of programs based on the outcome measures used.

Chairman Everett to Cynthia A. Bascetta, Associate Director, Veterans' Affairs And Military Care Issues, United States General Accounting Office

**Enclosure** **Enclosure**

## Responses to Questions submitted for the record by Chairman Terry Everett

- **How valid are the estimates of 250,000 homeless veterans in America? What other methods could better estimate the number of homeless veterans?**

We did not estimate the number of homeless American veterans as part of our work for our April 1999 report.[1] GAO has, however, previously reported on the difficulties of determining the size of homeless populations.[2] Estimates vary depending on, for example, the definition of homelessness (e.g., whether the person is literally homeless or not), the time frame under consideration (e.g., homeless on a given night or during a given interval), and the method used for deriving the estimates. Possible methods include full counts at selected sites, probability-based extrapolations from samples, database tracking, and surveys; each of these methods has strengths and weaknesses. Consequently, estimates of the size of homeless populations vary, but a precise count the number of homeless persons – or any subgroup of the homeless, such as veterans – is virtually impossible.

Experts at the Urban Institute who are familiar with the difficulties of counting the homeless estimate that from 500,000 to 600,000 persons are literally homeless on any given night. That number is a projection made by the Urban Institute in 1987 based on a systematic random sample of homeless people in cities with a population of more than 100,000. The Department of Veterans Affairs (VA) estimates that approximately one-third of the homeless – up to 200,000 by this reckoning – are veterans, a number that is consistent with findings of several large surveys of the homeless conducted during the 1980s.

- **Are there potential savings on acute/inpatient delivery for VA, by offering community-based care and transitional housing to homeless veterans?**

Offering appropriate community-based care and transitional housing to homeless veterans does appear to offer potential savings through reduced need for acute inpatient treatment. The homeless often use expensive health care alternatives, including emergency and inpatient services. The reasons are complex, but include the results of violence; problems in obtaining appointments for, or transportation to, medical appointments; and difficulty negotiating the health care system. Access to appropriate housing with supportive services can minimize the risk of victimization and facilitate access to timely, lower cost health care.

Moreover, substantial proportions of homeless veterans suffer from serious mental illness, substance abuse, or medical disorders. In many cases, these problems are ones that are most likely to recur or worsen in the absence of an appropriate and stable environment. The need for acute inpatient treatment for the homeless is likely to be reduced by strategies that allow stabilization or improvement in medical, psychiatric, or substance-related problems.

Convalescent care facilities illustrate the potential cost savings of providing or subsidizing supportive housing for the homeless: Medical problems are common among the homeless, with rates of illness and injury estimated at two to six times higher than among those who are housed. Typical conditions of homelessness — poor nutrition and hygiene; fatigue; and exposure to the elements, violence, and communicable diseases – contribute to poor health and make recovery from illnesses more difficult. For example, persons with homes can typically deal with acute respiratory infections or chronic disorders such as hypertension or diabetes through a combination of medications, diet, and rest. Those living on the street or in shelters, however, may lack access to appropriate meals, safe storage facilities for medications and medical supplies, or the opportunity for adequate rest. As a result, health may deteriorate, and resultant long-term medical complications may force expensive hospitalizations and further interfere with the person's ability to exit homelessness. Access to an appropriate supportive housing facility (whether community-based or VA-operated) can allow stabilization or recovery, thus minimizing the risk of medical deterioration and hospitalization.

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[1] Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness Is Unclear (GAO/HEHS-99-53, Apr. 1, 1999).

[2] Homeless Mentally Ill: Problems and Options in Estimating Numbers and Trends (GAO/PEMD-88-24, Aug. 3, 1988); Counting the Homeless: Limitations of the 1990 Census Results and Methodology (GAO/T-GGD-91-29, May 9, 1991).

The seriously mentally ill homeless provide another example: For many homeless veterans with chronic mental illnesses, relative stability can be achieved with the help of medications and psychosocial treatment. Homeless people, however, are often resistant to treatment, and noncompliance with treatment (and with medications in particular) is frequently associated with worsening symptoms, deterioration of mental health, and a resultant need for acute psychiatric hospitalization. Supportive housing arrangements for the seriously mentally ill can facilitate treatment compliance, for example, by having appropriately trained staff dispense and monitor medications and ensure transportation to appointments. Thus, suitable community-based supportive housing can help reduce the incidence of acute psychiatric episodes, which would require inpatient hospitalization.

Thus, offering appropriate community-based residential treatment or supportive housing to homeless veterans does have the potential to reduce VA's costs for acute/inpatient health care. Further research is needed to identify which programs are best suited to particular subgroups of the homeless (such as those with serious mental illness or those who abuse substances) and which aspects of programs (such as case load or duration of treatment) are most strongly associated with positive outcomes.

- **GAO believes the sort of homeless veterans programs it has evaluated do successful work, and that further examination such as 6-month follow-up might be expected to confirm such positive outcomes. Is that right?**

No, our work indicated that little is known about whether veterans served by VA's homeless programs remain housed or employed, or whether over the long term they instead relapse into homelessness. VA has conducted some research over the years to identify program outcomes, but methodological weaknesses in those studies have limited the extent to which they can be used to assess program effectiveness. For this reason, in our April report, we recommended that VA initiate a series of program evaluation studies designed to clarify the effectiveness of its core homeless programs and provide information about how to improve those programs. We further recommended that, where appropriate, VA should make decisions about these studies (including the type of data needed and the methods to be used) in coordination with other federal agencies with homeless programs, including the Departments of Health and Human Services, Housing and Urban Development, and Labor.

Specifically, we concluded that this series of studies on VA's core homeless programs should address (a) long-term effects, (b) processes associated with positive outcomes, and (c) program impact. Thus, VA could design follow-up studies to examine, for example, the stability of housing and employment in the year or two after discharge from transitional housing or residential treatment. (Research outside of the VA has indicated that 6 months may not be a sufficient interval to determine whether residential stability has been achieved.) VA could also undertake outcome evaluations designed to assess program processes to better understand the factors that produce desirable outcomes and how they could be replicated. Such studies could also identify aspects of treatment that are associated with positive outcomes for veterans with different conditions. Finally, VA could estimate how program outcomes differ from outcomes that would be likely in the absence of the program. For example, results from a sample of homeless veterans who received a particular kind of treatment could be compared with results for a control group who did not receive that treatment.

- **Your April 1999 study shows at least one-third of homeless veterans to have serious mental illness. Could you elaborate?**

Determining the proportion of homeless veterans who have a serious mental illness is complicated not only by the difficulties already discussed (such as how homelessness is defined and which methods are used to count the homeless), but also by issues surrounding diagnosis. Experts estimate that one-third of homeless adults have serious mental illnesses. VA reports that of the homeless veterans who were seen by a member of its Health Care for Homeless Veterans (HCHV) staff, a higher proportion – 45 percent – suffer from a serious mental illness, defined as including psychosis, mood disorder, or Post-Traumatic Stress Disorder (PTSD). Because the HCHV program emphasizes service to mentally ill and substance abusing homeless veterans, VA's sample may overrepresent those with serious mental illness.

- **Does your evidence suggest a connection to military service?**

We did not examine the connection (if any) between military service and homelessness. The Interagency Council on the Homeless noted that rates of PTSD are higher among homeless veterans than among other homeless people, but the appropriate interpretation of that finding is not clear. For example, some research suggests that the veterans most at risk for homelessness served during non-wartime eras.

- **Your study also shows about half of homeless veterans have a substance abuse problem, whether the cause or a consequence of homelessness.**

Experts estimate that one-half of homeless adults have substance abuse problem. VA reports that more than 70 percent of homeless veterans who were seen by a member of its HCHV staff suffer from a substance abuse problem, defined as alcohol or drug dependency. Because the HCHV program emphasizes service to mentally ill and substance abusing homeless veterans, VA's sample may overrepresent those with a substance abuse problem. The data do not indicate whether substance abuse causes homelessness, homelessness causes substance abuse, or some third factor causes both.

- **How much do serious mental illness and substance abuse overlap?**

Experts estimate that one-fifth of the homeless have both a substance abuse problem and a serious mental illness, with 50 to 70 percent of those with a serious mental illness having a co-occurring substance abuse disorder. VA reports that more than 33 percent of homeless veterans who were seen by a member of its HCHV staff are dually diagnosed, that is, suffer from both a serious mental illness and a substance abuse problem. Again, because the HCHV program emphasizes service to mentally ill and substance abusing homeless veterans, VA's sample may overrepresent dually diagnosed homeless veterans.

- **Why is it important that programs be veteran-specific?**

We did not evaluate the importance of tailoring programs to veterans. The community-based programs that we visited included some that were limited to veterans and some that were not. For example, the Veterans Rehabilitation Center, run by Vietnam Veterans of San Diego, is designed to serve veterans. Its founders suggest that part of that program's success is attributable to the sense of community it fosters among its residents, a sense that they believe is promoted by their shared identity as veterans. Another of the programs we visited, Critical Time Intervention, is not limited to veterans. Both of these programs have been studied, and results suggest favorable outcomes in both cases.

Chairman Everett to Hon. Espiridion (Al) Borrego, Assistant Secretary for Veteran's Employment and Training, U.S. Department of Labor

QUESTIONS AND RESPONSES
Resulting from Hearing on
June 24, 1999
before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs

1. *What contacts has VETS had with faith-based organizations that rehabilitate homeless veterans regarding employment opportunities?*

The 1400 Disabled Veterans Outreach Program specialists (DVOPs), funded by the Veterans' Employment and Training Service (VETS), who are located in local employment service offices and out-stationed at homeless shelters, Veterans Administration medical services and similar sites around the country, assist all homeless veterans seeking employment. There are no current national programs that target faith-based organizations as a source of jobs for veterans, but DVOPs look at all possible avenues of employment for their veteran clients. DVOPs work to find employment for all homeless veterans, whether or not the homeless veteran is receiving housing, job training and other assistance from a VETS' grantee.

2. *Has VETS conducted any outreach efforts to faith-based organizations regarding homeless veterans?*

VETS currently has given two grants to the Salvation Army, one in Rochester, New York and one in New York City. However, in the past, VETS has not conducted any specific outreach efforts to faith-based organizations regarding homeless veterans. VETS has asked the director of the Department of Labor's public liaison office to help VETS reach out to this group. Our plans are to meet in Washington with representatives of the larger faith-based organizations so that we can advise them of VETS' services and programs, and to send our field staff to meet with smaller local organizations.

3. *How does VETS measure outcomes and success in sustained employment?*

The HVRP grantee is required to follow-up with the veteran client 60 days and again 90 days after the veteran begins a job. The results of these follow-ups are reported to VETS in the grantee's quarterly report. VETS has asked all grantees to keep records on its clients for at least one year so that VETS may do further follow-ups if it so elects. While VETS does not require prospective grantees to state for what jobs the veterans would be trained, the grant does require that the wages at placement be equal to or exceed the applicable State's wage rates set forth in Titles II and III of the Job Training Partnership Act. VETS' grantees generally set a goal of placing about 50% of the previously homeless in jobs, and HVRP as a whole has reached this goal.

4. *Is outreach to faith-based organizations in your strategic plan?*

No, it is not. However, as indicated above, VETS intends to reach out to such organizations.

5. *One of the problems seems to be that there is little hard data on the number of homeless veterans. How many homeless veterans do you think there are in America? How do you get your numbers?*

The Department of Veterans Affairs (VA) estimates that veterans comprise one-third of America's homeless population. This estimate means that between 300,000 and 500,000 veterans are homeless at some time in any given year. VETS historically has used VA's count of homeless veterans. The International Union of Gospel Missions conducts surveys of its 133 shelters across

the country. It estimates that one in three homeless men seeking refuge is a veteran. However, we have not seen an estimate by the International Union of the total number of homeless in America.

6. *How can local continuums of care do a better job in addressing the needs of veterans?*

Local providers often serve as the "hub of the wheel" of services provided within their communities. They must be more dedicated to serving homeless veterans, because veterans often have multiple problems that contribute to their homelessness. Veterans tend to have more psychological and chemical abuse-related problems than non-veterans. Non-veteran providers must also work harder to overcome homeless veterans' perception that non-veterans cannot relate to veterans' problems. Experience has shown that homeless veterans are more receptive to services from dedicated veteran staff who can identify and be responsive to veteran client needs. Finally, local service providers must shake off the perception that homeless veterans are the Federal government's problem, rather than the States' and local communities' problems. The Federal government alone cannot care for the hundreds of thousands of homeless veterans.

7. *Sometimes it appears that there is little hope that the situation with tens or even hundreds of thousands of homeless veterans will get better. Will it? What needs to happen?*

Yes, the situation is going to get better, but not without increased funding. Other Federal programs simply provide shelter and will continue to do so. These programs will need to continue as long as there is no emphasis on jobs and job training. Unless veterans' military training and experience are more highly regarded by civilian society, and unless those who need skills receive appropriate training for 21st Century jobs, veterans will need to remain in shelters or subsidized living arrangements rather than be able to realize full economic security and independence. There needs to be a sustained, cooperative effort at all levels of government, and among non-profit, faith-based and other community groups to end homelessness among our Nation's veterans.

The best antidote I know to homelessness is a good job. That is why any assistance to aid homeless veterans must include providing the skills necessary to succeed in the civilian job market. The organizations receiving VETS' homeless grants provide both technical and employment preparedness skills so that veterans can fairly compete for the good jobs being created by our flourishing economy. One of my goals for the 21st Century is no new homeless veterans. VETS is marshaling its other resources to ensure that all separating service members enter secure occupations. If we succeed at this, we can concentrate our homeless program on the existing homeless veteran population.

8. *What can you tell me about how these grant programs meet the needs for both standards of performance and verifying their accountability?*

Grantees submit a quarterly technical performance report comparing actual accomplishments to established goals for the reporting period and respond to any findings related to VETS' monitoring efforts. If established goals have not been met, a grantee provides a detailed narrative explanation including a corrective action(s) which will be taken, as well as a timetable for accomplishment of the corrective action plan. VETS staff serve as the Grant Officer's Technical Representative (GOTR) who monitors performance by the grantee. During the grant period, it is required that the GOTR conduct quarterly desk reviews and at least one on-site monitoring visit to validate information reported by the grantee. If there are discrepancies found by the GOTR, additional on-site visits will be scheduled as necessary.

9. *Why is it important that programs be veteran-specific?*

Men and women who wear the uniform of our armed forces make a compact with the citizens of this Nation to protect and defend our way of life. As veterans reintegrate into civilian life after their years of dedicated service, the Federal government should make the same compact with them. Congress created the Veterans' Employment and Training Service to make sure that the employment and training services provided to veterans would not be subsumed into more broadly based programs designed for other groups.

Veterans have needs that other programs' operations do not address. Their special characteristics, especially for those veterans that have been in conflict or combat situations, require specialized attention from service providers that understand the nature of their problems. Mainstream programs are not set up to adequately address these needs. Most homeless veterans have multiple problems that contribute to their unemployment, such as alcohol and/or drug abuse, medical and/or physical and mental trauma of wartime, lack of skills or education and a poor employment history. Some veterans suffer from post-traumatic stress disorder (PTSD) that is often unrecognized by the general homeless service provider. Additionally, many veterans have military experience that can translate to a comparable civilian occupation, but most service providers do not have knowledge of military occupational specialities and ratings. Further, the veterans service provider can seek assistance from veteran service organizations and community-based organizations, thus increasing the opportunity for homeless veterans to receive treatment for barriers to their employment.

**Post-Hearing Questions**
**Concerning the June 24, 1999 Hearing**

**for**
**The Department of Housing and Urban Development**

**from**
**The Honorable Terry Everett**
**Chairman, Subcommittee on Oversight and Investigations**
**Committee on Veterans' Affairs**
**U.S. House of Representatives**

***(NOTE: Questions have been numbered in the order presented for reference purposes).***

**1. The Interagency Council authored a report: *Priority Home: The Federal Plan to Break the Cycle of Homelessness.* In Part IV, "Recommendations for New Policy Initiatives and Agency Action Steps," there were a number of items that seem to have a direct impact on agency coordination and veterans. Have there been any substantial efforts made under those recommendations? Does the Interagency Council on the Homeless review or benchmark the activities conducted in support of those activities?**

It is important to remember when discussing the current role of the Interagency Council on the Homeless (ICH), that the Congressional decision to eliminate all funding for the ICH in FY 1993 has had a very significant impact on the Council's ability to aggressively continue the work it was implementing or planning to implement. ICH continues today only because HUD stepped forward to fund a portion of the Council's previous workload, but staff and resource levels are significantly below those contemplated at the time of the release of the *Priority Home* report.

Despite significant reductions in staff, the Council regularly stays abreast of ongoing agency activities to implement the principles contained in *Priority: Home* through the bi-monthly meetings of its staff-level Policy Group. Also, in October 1995 the Interagency Council issued an interim report (copy enclosed) on the progress made in implementing the key recommendations in *Priority:Home.*

**2. In particular, on pages 94-95 of the report there is discussion of the ICH sponsoring two meetings a year with Governor-appointed State Homeless Contacts and McKinney and non-McKinney Homeless Assistance Program Managers to encourage state and local coordination. How many of those meetings have been held? Have representatives from the Departments of Labor and VA attended those meetings? If not, why not?**

Although the Council has no resources to hold meetings with the Governor-appointed State Homeless Contacts recently, it corresponds with them regularly to keep them apprised of funding deadlines, regulatory changes and the availability of surplus Federal property in their areas.

**3A. While we have heard that VA has held several national meetings and conferences on homelessness and has invited and had participation from veteran service organizations, has HUD as the lead agency on this issue held or sponsored any national meetings on homelessness and invited VSOs to participate (see page 95)?**

Each year, shortly after the Continuum of Care Notice of Funding Availability (NOFA) is published, HUD conducts interactive national satellite training broadcasts to inform potential applicants of that year's application process, highlight program requirements and suggest approaches to ensure the development of competitive applications. The announcement of both these national broadcasts and specialized local HUD field office training opportunities is made using the extensive mailing lists compiled by the national Community Connections clearinghouse service, HUD's field office mailing lists and HUD's Internet website. Over each of the last four years local veterans service organizations, federal, state and local government veterans agencies, and persons indicating an interest in serving veterans have been included in both the national and field office mailing lists and are, thereby, notified of all national and local training sessions. Moreover, any veterans group can ask for one-on-one technical assistance from local HUD staff or technical assistance contractors prior to announcement of each year's NOFA.

In addition, HUD program staff and HUDVET staff participate in numerous meetings on homelessness each year, providing training on HUD's homeless programs and obtaining input on program operations from persons working on the front lines of service delivery. Many of these meetings are sponsored by VSO, and even more include veterans groups among the attendees.

**3B. One of the problems the Committee has heard from veterans is that the local continuum of care plan creates few opportunities for specific service providers to be successful in securing funding. According to what we heard, very few communities even mention the need to address homeless veterans in their local plans. Can you tell us how many or approximately what percentage of local continuum of care plans reflect the need to address homeless veterans in their communities?**

To determine to what extent communities include veteran participation and assess the needs of veterans we examined 25 randomly selected Continuum of Care (CoC) applications. Overall the analysis confirms that virtually all continuums are concerned about and seek to address the needs of veterans. Specific findings follow:

- All but two of the 25 reviewed CoCs had veterans' representation in the development of the CoC plan and 21 discussed how veterans would be specifically reached or planned to be reached in the CoC plan.
- All except one of the 25 CoC plans provided estimates of the met and unmet needs of veterans. That one continuum area indicated that it felt veterans needs were contained in the other estimates of subpopulations and did give a priority ranking of medium for veterans needs.

- Sixty-eight percent of continuums ranked serving single veterans as a high or medium priority. In a number of the continuums not giving a medium or high ranking, there were very few veterans relative to the number of persons represented by other sub-populations, especially in rural or suburban areas. In other cases lower priority ratings were justified by the level of existing special programs addressing veteran needs.

In sum, it is clearly not correct that very few local Continuums of Care either address homeless veterans' needs in their plans or fail to give opportunities for service providers wishing to address homeless veteran needs the opportunity to be funded.

**4A. According to information the Committee has, the Department of Health and Human Services for at least most of this decade has reported the number of veterans its local grantees (mostly non-profit organizations) have served. Can you tell us how many veterans are served under HUD funds? Why not?**

In recognition of the need for more systematic information on veterans served by HUD's homeless assistance programs, the Department added a veterans' section to the annual report that grantees are required to submit to HUD. Based on a sample analysis of all the reports received to date, 31% of all single adult males served by HUD's competitively-awarded homeless assistance programs were veterans. In 1999, it is estimated that approximately 150,000 veterans will be served in HUD's competitively-awarded homeless assistance programs.

**4B. The Interagency Council on the Homeless supported an effort to review programs and services for homeless persons, including homeless veterans. Can you tell us how soon that report will be released?**

VA, HUD and ten other Federal agencies co-sponsored the *National Survey of Homeless Assistance Providers and Clients* to provide information about the providers of homeless assistance and the characteristics of homeless persons who use services. The survey asked service users a number of questions about their previous active-duty military service, participation in programs for homeless veterans, receipt of benefits, health status and other issues. The report is scheduled to be released in September or October 1999.

**5. The Veterans Organization Homeless Council (a group made up of most of the national VSOs) has requested a meeting be held to look at the lack of access to**

**housing, employment and health care services for homeless veterans. Has the meeting been scheduled? Do you have any plans established?**

The Veterans Organization Homeless Council (VOHC), in conjunction with the Homeless Veterans Task Force (HVTF), is jointly sponsoring an all day conference on September 14, 1999 on this important topic. Both HUD and the Interagency Council on the Homeless (ICH) are active and enthusiastic participants in this session. Assistant Secretary for Community Planning and Development Cardell Cooper, Deputy Assistant Secretary Fred Karnas, who also serves as Acting Executive Director of ICH, and several members of their top staff, are all planning to attend the conference. Both Assistant Secretary Cooper and Deputy Assistant Secretary Karnas will also be formally addressing the session regarding the commitment of HUD and ICH to work in conjunction with the VOHC and the HVTF in overcoming the barriers that currently are preventing full access for homeless veterans to housing and supportive services.

**6. Is there any policy on the number of persons who sit on the local continuum of care boards?**

HUD does not have a required structure for local Continuum of Care boards, however the Department strongly encourages the active participation of representatives of all segments of the community in the local Continuum of Care planning bodies. As stated in the Continuum of Care application documents, the Department views the participation of interested veterans' service organizations, especially those with experience in serving homeless veterans, as highly important to applicants when developing their Continuum of Care plans. Further, both the annual Notice of Funding Availability (NOFA), as published in the Federal Register, and the annual Continuum of Care application form itself, identify the participation of veterans service organizations as an important factor in achieving a high rating in the Continuum of Care funding competitions administered each year by HUD.

**7. In previous years there has been significant push for veterans' representation on local continuum of care boards. Former HUD Secretary Ciscernos wrote a letter supporting veteran representation on local boards a few years ago. Has HUD's position changed.**

HUD continues to show its support for meaningful veteran representation in planning processes for all jurisdictions through its application requirements and through its competitive scoring of continuum of care plans. For the past several years, veterans participation has been highlighted in several areas of continuum of care plan development. As noted immediately above, applicants have been informed that high scores can only be achieved by a broad-based planning process that includes veterans as one of the key homeless groups. If evidence of veteran participation is not found in the continuum of care development process, communities are informed in later debriefings that this is an area of concern that needs to be addressed to receive higher competitive scores for funding. In addition, the continuum of care plan must address how each

component (outreach/intake/assessment, emergency shelters, transitional housing, supportive services, permanent housing and permanent supportive housing) is reaching or will reach special homeless sub-populations, including veterans. Lastly, the Continuum of Care includes veterans as one of the six sub-populations that must be addressed in the Gaps Analysis section of the plan.

**8. VA holds meetings at most of its medical centers each year to look at the met and unmet needs of homeless veterans and to develop local action plans. Is there any coordination between the agencies at this table and those reports?**

HUD field staff participate in many of VA's Community Homelessness Assessment, Local Education and Networking Group (CHALENG) meetings to discuss the needs of veterans in the areas served by VA medical centers. HUD and VA staff are currently identifying additional ways in which the two agencies can share data and improve program coordination.

**9. Labor's HVRP (Homeless Veteran Reintegration Projects) seems to call upon its local grantees to inform the local VA about its program and activities. Does HUD have any similar requirements for its grantees, especially those that check the box indicating veterans can participate in their program?**

It is important to state that the check boxes in the Continuum of Care application form referenced in this question (also see answers to Questions 10 and 11 below) do not indicate whether or not homeless veterans can participate in the homeless assistance programs. Rather, the check boxes identify only whether veterans are either the primary target population or a target population among others. We are not aware of any circumstance where veteran's status is used as a disqualification for a SHP program. Moreover, we would consider the disqualification of an otherwise qualified person for a program because of veteran's status to be highly inappropriate and a very serious matter requiring correction.

HUD does not require grantees implementing homeless assistance projects that serve veterans to inform the local VA office about the project and activities. However, the Department would be very willing to share whatever information would be helpful about approved projects that have targeted veterans for assistance with the local and national VA offices.

**10. Are there any programs offered by your agencies that veterans cannot participate in?**

There are no HUD programs that specifically restrict participation by veterans. The eligibility requirements of a variety of HUD programs, as established by the statutes authorizing each of the Departments programs, may restrict the participation of individuals who happen to be veterans because they do not otherwise qualify as an eligible participant in the program. As an example, many of the homeless assistance

programs enacted under the McKinney Act that are administered by HUD restrict participation to only those individuals that meet the strict definition of homelessness as established by the statute. Therefore, an individual who may be a veteran but does not meet the criteria established by law as homeless would not be eligible to participate in these programs.

**11. It appears less than half of your grantees check the box saying veterans can participate in their programs. Why do so many exclude veterans? Why are so few of your grantees aware veterans can take part and should be encouraged to participate in their programs.**

In the Continuum of Care application, each program has a section entitled Homeless Veterans that contains two questions about the level of "targeting" to homeless veterans for that project. The questions and the response rate from the 1998 competition grantees are:

Q. Are veterans the primary target population of your proposed project?

A. 36 projects ( 2.4 percent ) responded yes.

Q. Are veterans among the homeless subpopulation(s) your project specifically intends to serve?

A. 769 projects (52 percent) responded yes.

The lack of response of 683 projects (45.6 percent) to answer either level of targeting question should not be construed to mean that they are excluding veterans. It only means that veterans are not being specifically targeted as a sub-population in that project. For example, a rural domestic violence shelter for women is likely to consider that there are too few female veterans to constitute a significant homeless sub-population to target. Therefore, such a project would not answer yes to either question. However, that would not mean the project would exclude homeless women with veteran status suffering from domestic violence if she applied for assistance.

**12. VA in its testimony says that its monitoring and evaluation is consistent with all its programs that assist homeless veterans. Are your monitoring and evaluation programs similar to VA's? Are your monitoring and evaluation programs consistent with other programs within your own agency?**

The monitoring and evaluation policies of all Federal government agencies must fully conform with the Office of Management and Budget (OMB) uniform procedures as established in the applicable OMB Federal Management circulars (see OMB Circular A-110, Attachments A, B, C, D, F, I, N and O and 24 CFR Part 85). Therefore, the monitoring and evaluation procedures of VA and HUD share the same basic framework. Policies on which awarded projects and how many projects are monitored may differ between the two agencies. Within HUD, the same monitoring and evaluation policies are

common among all of the grant programs administered by the Assistant Secretary for Community Planning and Development.

**13. One of the problems seems to be that there is little hard data on the number of homeless veterans. How many homeless veterans do you think there are in America?**

There is no methodologically sound data on the number of homeless people in general, or, more specifically, homeless veterans. The best estimates come from the only published national study on homelessness which was conducted in 1987, and thus is seriously outdated. Fortunately, the Interagency Council on the Homeless and its member agencies, which include HUD and VA, did develop and fund a forthcoming national study of homeless persons and providers. While this new study was not designed or conducted to produce an estimate of homeless persons, the survey does provide valuable information on homeless assistance programs and the clients who use them. An entire section of the survey was devoted to veteran status of clients. This study will make a significant contribution to our understanding of homeless veterans.

**14. Some have suggested (such as Mr. Metcalf R-Wash) that a percentage of HUD's funding should be set aside to assist homeless veterans. What do you think of such proposals?**

HUD would strongly oppose proposals to establish specific homeless funding set-asides under the McKinney Act programs administered by the Department for any group of individuals or families, including veterans. Such a proposal would seriously undercut the entire Continuum of Care planning process. Under that process, communities come together as a whole to make local determinations concerning the highest priority needs for all homeless sub-populations living in the community and the most appropriate resources to address those needs. Clearly, representatives of the other sub-populations of the homeless (i.e. the mentally ill, victims of domestic violence, youth) would rightfully demand similar status if one sub-population group was afforded automatic funding. Any proposal that would have the effect of splintering the community-wide Continuum of Care process and establishing one homeless sub-group as of higher priority than the others would be destructive of community-wide collaboration, an essential ingredient in a viable Continuum of Care system.

In addition, the establishment of one or more funding set-asides in the distribution of relatively scarce McKinney Act funds would diminish the level of available resources for the national homeless assistance competition required under the McKinney Act and undercut the intent of the Act to ensure the selection of only the highest quality projects on a national basis.

**15. How can local continuums do a better job in addressing the needs of veterans?**

Many local continuums do an excellent job in addressing the needs of homeless veterans. An increasing number have taken steps to ensure that representatives of homeless veterans and homeless veterans themselves are active participants in the local Continuum of Care planning process. A significant number of projects either proposed by veterans organizations or otherwise intended to primarily serve homeless veterans are identified as high priority projects for funding each year and are, in fact, funded. Importantly, many projects not proposed by veteran-specific organizations commit to specifically targeting veterans among the populations they will reach out to and serve.

Regardless of their current level of accomplishment in addressing homeless veteran assistance needs, all local continuums can still strive to improve their efforts in the future. Improvements can specifically be made in: outreach to homeless veterans, assessments of the unique needs of homeless veterans, providing services tailored to homeless veteran needs, and, evaluating the strengths of programs serving homeless veterans. HUD encourages each local Continuum of Care system to make such improvements in addressing veterans and all other sub-populations through its application rating procedures, its technical assistance resources and its training efforts.

**16. Sometimes it appears that there is little hope that the situation with tens or even hundreds of thousands of homeless veterans will get better. Will it? What needs to happen?**

HUD's Continuum of Care approach has been recognized by a variety of respected, objective sources as making a significant impact in moving formerly homeless Americans into permanent housing and in achieving self sufficiency . Hundreds of thousands of formerly homeless individuals and families, including formerly homeless veterans, have been assisted in finding shelter and in addressing their individual supportive service needs. In many cities across the nation there is concrete evidence that the numbers of homeless people living on the streets has substantially declined.

The problem of homelessness in America, including veterans' homelessness, has not disappeared but neither can it fairly be characterized as hopeless. To a growing degree, communities are rationally addressing the causes and effects of homelessness and are using the resources that are available more effectively than ever before. It is equally clear, however, that the underlying causes of homelessness (e.g. high housing costs, low wage jobs, lack of mental health services, and inadequate substance abuse treatment resources, among others) are still very prevalent in American society and that additional resources and attention toward preventing persons from becoming homeless will be necessary.

**17. (Question addressed to the Department of Veterans Affairs)**

**18. Is there a data collection system that all programs could use that could assure clarity and confidence?**

As mentioned earlier, the ICH and its member agencies recently conducted a national survey. To ensure accurate and representative data, the study was conducted by the Bureau of the Census and the study selected a sample of 76 geographic areas to ensure the findings are nationally representative. The findings of the study are expected to significantly improve our understanding of the prevalence of veterans among the homeless population and the characteristics and needs of homeless veterans. The data will also serve as a baseline for future evaluation of the effectiveness of programs and policies focused on addressing homelessness.

Interagency Council on the Homeless

October 1995

INTERIM REPORT

IMPLEMENTATION OF *PRIORITY: HOME!*
*THE FEDERAL PLAN TO BREAK THE CYCLE OF HOMELESSNESS*

BACKGROUND

The Clinton Administration's policy on homelessness was articulated in a May 1994 report entitled *Priority: Home! The Federal Plan to Break the Cycle of Homelessness*. *Priority: Home!* was prepared by the Interagency Council on the Homeless, a working group of the White House Domestic Policy Council. The Interagency Council is comprised of the heads of 18 Federal agencies with programs and other resources that can be used to assist the homeless. There was unprecedented consultation with representatives of State and local governments, service providers, public interest and advocacy organizations, and other concerned individuals in writing the report.

*Priority: Home!* includes a thorough analysis of the nature and causes of homelessness and a comprehensive overview of Federal and local assistance and relief efforts. It acknowledges the importance of two broad and sometimes overlapping classes of problems--"crisis poverty" and chronic disabilities--which can interact and result in large-scale homelessness.

*Priority: Home!* proposes the development of a seamless system of housing and services called the "continuum of care," a concept which encompasses early assessment, transitional housing and services, and permanent housing to promote long-term independence and self-sufficiency, as well as short-term emergency needs.

Other key recommendations include doubling the HUD McKinney homeless assistance budget, improving the mental and physical health systems, increasing Federal housing subsidies for homeless families, fighting illegal discrimination, and exploring the use of tax incentives to assist low-income households with housing costs.

To prevent future homelessness, *Priority: Home!* cites the need to increase education, job training, and employment opportunities while increasing accessibility to social services and affordable housing for homeless people.

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IMPLEMENTATION STEPS

*Priority: Home!* recommends a number of initiatives and agency actions to assist those who are currently homeless or at risk of homelessness through long-term "structural" changes and cross-cutting agency actions. Shortly after the publication of *Priority: Home!*, the Interagency Council established work groups to recommend specific action steps for implementing the various recommendations. The work groups were formed around the following topical areas: (1) making prevention equal to remediation in policy planning; (2) integrating the services system for homeless persons with mainstream programs so that it no longer operates as a parallel system; (3) expanding and enhancing access to long-term, affordable housing; (4) improving the delivery of mental health and substance abuse services for those who need them; (5) increasing access to health care and nutrition services; (6) addressing special needs in rural areas; and (6) improving interagency coordination.

The work groups were directed to take necessary steps to implement the recommendations in *Priority: Home!* The adequacy of current Federal efforts in these areas was assessed, and additional steps that Federal agencies could take to improve, build upon, or otherwise enhance this strategy were identified.

SIGNIFICANT ACCOMPLISHMENTS TO DATE

While some of these actions require legislative changes, others can be acted upon administratively. There have been numerous changes in Federal policies and programs since the May 1994 publication of *Priority: Home!*, and the Administration and Congress are currently reviewing proposals for major revisions to key support programs such as welfare and Medicaid in connection with the F.Y. 1996 budget. However, there has been major progress in implementing the principles and recommendations in *Priority: Home!* Highlights include the following accomplishments:

Increased Funding

- The Administration was successful in doubling the HUD budget for targeted homelessness assistance programs under the McKinney Act from $571 million in FY 1993 to $1.12 billion in FY 1995.

- The Administration has strengthened the support network for homeless veterans by doubling the VA budget for homeless veterans from $32 million in FY 1992 to $76 million in FY 1995.

- The Administration reaffirmed its commitment to improved outreach by approving $6.4 million in FY 1995 for the

continuation of 35 SSI Outreach Demonstration grants. These grants either target homeless people or populations which include homeless people.

Program Improvements

- DoD and HUD have worked with Congress to enact the Base Closure Community Redevelopment and Homeless Assistance Act of 1994 to improve the process for making surplus property on closed military bases available for homeless assistance while allowing local reuse committees to balance homeless assistance needs with other economic and community development needs.

- HUD developed a legislative proposal to consolidate all five of its McKinney homeless assistance programs into a single Homeless Assistance Grant Program to enhance local flexibility in designing effective programs and filling local gaps in the continuum of care. The proposal initially submitted to Congress in 1994 is still pending.

- HUD awarded $900 million in homeless assistance funds to 818 projects in 228 communities in 1995 through a consolidated and streamlined competition designed to foster community planning. These projects are key components in specific communities' continuum of care strategies to break the cycle of homelessness.

- HHS has proposed consolidating its mental health, substance abuse and primary health care programs to provide greater local flexibility, encourage more comprehensive approaches and improve program administration. Grant recipients will be encouraged to address the needs of homeless persons in their plans.

- USDA is evaluating the results of $2.8 million in small demonstration grants to 26 community organizations in 10 States to test innovative ways of providing outreach and enrollment assistance to homeless persons and other hard-to-reach groups in connection with the Food Stamp Program.

- HHS has proposed consolidating three programs for runaway and homeless youth into a single, comprehensive program for this population.

- Many of the Administration's proposals for the reauthorization of the Education for Homeless Children and Youth Program were adopted in the Improving America's Schools Act of 1994 (IASA), including a new requirement that homeless children and youth must have access to the education and other services they need to meet the same challenging academic standards to which all students are

held. The IASA also makes all homeless children and youth eligible for Title I, the largest Federal compensatory education program serving disadvantaged children.

- VA has awarded more than $11.5 million to 63 projects in 25 States and the District of Columbia to expand the VA continuum of care to homeless veterans through partnerships with nonprofits and public entities under the Homeless Grant and Per Diem Program.

- To ensure that the housing needs of persons with HIV/AIDS are met, HUD established a new Office of HIV/AIDS Housing. The office administers the Housing Opportunities for Persons with AIDS program, assists persons with AIDS in accessing other HUD programs for which they may be eligible and provides technical assistance to service providers. A working group consisting of housing providers and persons living with HIV/AIDS meets regularly to provide first-hand perspectives on ways to improve the programs and operations of HUD in this area.

- The Social Security Administration (SSA) received the distinguished Hammer Award for developing the plan to redesign the disability claims process. SSA is committed to implementing a new disability determination process that will deliver significantly improved service to the public, including homeless people.

Improved Data

- Under the auspices of the Interagency Council on the Homeless, 12 Federal agencies are co-sponsoring a National Survey of Homeless Assistance Providers and Clients to provide current information on the providers of homeless assistance and the characteristics of homeless persons who use services. The Census Bureau is conducting the survey on behalf of the sponsoring agencies between October 1995 and February 1996.

- The Census Bureau is testing methods to ensure that homeless persons are included in the national decennial census in 2000.

- HUD and HHS are collaborating with the University of Pennsylvania and the Fannie Mae Foundation to develop and test a uniform community-level homeless data system to guide local policy and program planning.

- HHS is restructuring its national Head Start information system to include information on homeless children.

- HUD developed and is implementing a computer mapping

software program as a tool to assist localities in comprehensive, consolidated community planning and development. Computer mapping enables localities to use technology to outline areas of need by Census tract block groups down to the street level. It also pinpoints existing and planned projects, including continuums of care for homeless families and individuals.

- VA conducted a one-day hospital census of its patients to determine homeless veterans' access to VA medical care services.

Provision of Technical Information and Other Assistance

- USDA's Office of Rural Economic and Community Development sponsored three regional interactive workshops and a national conference to obtain information on the special nature of homelessness in rural areas and recommendations on ways to combat it. FEMA, VA, other Federal agencies and local homeless coalitions provided support by hosting special workshops at these meetings. USDA will publish a conference report by December 1, 1995 that includes regional highlights and strategies for addressing rural homelessness.

- Through its CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans initiative, VA has undertaken a nationwide assessment of the needs of homeless veterans through a series of VA-hosted mini-summits on homelessness at each of its 171 medical centers. All of the relevant agencies in each medical center catchment area are brought together at these meetings to energize community-wide efforts to improve assistance to homeless veterans and develop new strategies to address identified needs.

- HUD is offering in 40 cities a nationwide series of technical assistance workshops to help service providers develop an effective continuum of care in their community to help homeless persons gain self-sufficiency to the extent possible.

- HHS sponsored a national conference, "A Call to Action", to mobilize the mental health and substance abuse communities to become involved in community homeless assistance planning efforts.

- The Department of Labor (DOL) required grantees under the Job Training for the Homeless Program to "partner" with and provide technical assistance to at least one Job Training Partnership Act (JTPA) administrative entity. This partnership would implement strategies likely to prove effective in increasing the number of homeless persons

served by JTPA and enhancing the services that this mainstream program offers them.

- As part of a major technical assistance effort focused on "mainstreaming" services to homeless people through the JTPA system, DOL conducted workshops at national and regional conferences of key employment and training organizations, including the National Association of Private Industry Councils, the National Association of Workforce Development Professionals and the Western Job Training Partnership Institute. These workshops have included instructions for grantees in the use of Internet to improve their access to information and the provision of services to the homeless. As a result of these technical assistance efforts, more than half of the Job Training for the Homeless Demonstration Program grantees have secured State or local funding resources to provided employment and training and other supportive services to homeless individuals.

- HHS has offered a series of workshops for Health Care for the Homeless providers and developed a self-assessment tool and other technical assistance materials to help providers to continue to be viable in a managed care environment, and thereby continue to be able to provide health care services to homeless persons.

- VA has continued its support of Stand Downs and Homeless Veterans Programs to provide homeless veterans with clothing, food and linkages to programs and benefits. VA supported over 40 Stand Downs and Benefit Fairs in FY 1994, assisting over 16,000 homeless veterans. Since 1993 VA has distributed more than $16 million worth of excess clothing and personal supplies to homeless veterans.

- HHS sponsored a training institute to advance models of working with homeless persons with mental illnesses and substance abuse disorders. Participating communities, which had to send at least one representative from the mental health and substance abuse service systems, developed strategies for implementing programs in their communities.

Miscellaneous Actions

- The White House formed an interagency task force on veterans, including VA, HUD and other key agencies, to improve the coordination of Federal programs for veterans. In response to the special needs of homeless veterans, a Task Force on Homeless Veterans, chaired by VA, has been established under the Interagency Council on the Homeless.

- FEMA is working to encourage the 2,500 local boards and 11,000 agencies under the Emergency Food and Shelter

National Board Program to incorporate prevention activities into their local plans.

- The Corporation for National and Community Service has created a partnership with HUD to match some of HUD's funds for the Supportive Housing program with human resources available through AmeriCorps and VISTA volunteers to assist local, community-based organizations. VA's AmeriCorps project, "Collaboration for Homeless Veterans" focuses on improving the lives of homeless veterans through a collaboration of community-based providers, VA medical centers and regional benefit offices.

- The Department of Justice filed an amicus brief on behalf of overturning a Santa Ana, California, ordinance that clearly targeted the homeless community by prohibiting sleeping in public with a blanket.

- Transfers of Federal surplus real and personal property have continued under the authority of Title V of the McKinney Act. For example, GSA has transferred 45 sites valued at more than $84.4 million to homeless providers under this program.

- HHS is leading an interagency group including representatives of HUD, VA, Justice and other agencies to develop an effective discharge planning process for persons with mental illnesses or substance abuse disorders.

- Because it administers key benefits that assist homeless people, the Social Security Administration was made a full member of the Interagency Council on the Homeless.

- SSA and VA continue to operate a joint pilot project that provides benefits and services to homeless mentally ill veterans at 11 sites. SSA staff coordinate outreach and benefits certification with VA staff to locate and assist homeless veterans in obtaining SSA benefits.

Chairman Everett to Charles Williams, Executive Director, Maryland Center for Veterans Education & Training, Inc.

**QUESTIONS SUBMITTED FOR THE RECORD BY CHAIRMAN TONY EVERETT**

**1. HOW DO YOU EACH DEFINE SUCCESSFUL OUTCOMES IN YOUR INDIVIDUAL PROGRAMS?**

The Maryland Center for Veterans Education and Training, Inc. (MCVET) provides a continuum of care that consists of a Day Drop-in program, an Emergency Shelter program, a Transitional or Comprehensive Recovery and Treatment program, a Single Room Occupancy facility (SRO) and a Follow-up program. Each of these programs has clearly identifiable outcome measures that define our success. We have developed a Program Logic Model that identifies our program inputs, activities, outputs and outcomes. The outcome portion of the logic model documents our success by identifying the number of program participants who remain drug/alcohol free, who are placed and remain in permanent housing, who are processed for educational services and who maintain steady employment. In addition, these outcome measures identify those program participants who remain in appropriate supportive services and those program participants who have not returned to homelessness. Our statistics show a direct correlation between the length of time a program participant stays in our program and their chances of remaining drug/alcohol free. A successful outcome is determined by a program participant's return to society as a productive member of society who remains drug free and does not return to a state of homelessness.

**2. HOW DO EACH OF YOU TRACK YOUR OUTCOMES?**

The agency has on staff a full time Follow-up Counselor whose primary mission is to track former program participants and report outcome measures to the appropriate source. This unique tracking program consists of making an attempt to locate and report on every program participant who has been through the doors of MCVET since its inception. This is being accomplished by establishing partnerships with the Baltimore City Department of Social Services Homeless and Environmental Unit, various transitional housing programs throughout the area and the three Baltimore Veteran Affairs Medical Centers. In addition, the follow-up counselor conducts outreach in the city, making contacts on the street with former program participants and veterans who may benefit from our program. One other method of tracking former program participants entails conducting an annual reunion picnic. This provides us with the opportunity to meet annually with our former residents and to see how they are doing. Once a former participant is located, a determination is made as to whether or not this person needs further assistance. A connection is established through this method even though they are no longer actually at MCVET. They are provided access to some of the same benefits and resources that they enjoyed when they were enrolled in the program. Outcome measures are then identified and recorded and an annual report is provided to our funding sources.

**3. WHAT IS YOUR ESTIMATE OF UNMET DEMAND FOR HOMELESS SERVICES IN THE COMMUNITY AMONG THOSE WHO ARE VETERANS?**

Normally, there are over 500,000 homeless veterans over the course of one year on America's streets (Source: US Government, 1993). In Baltimore, Maryland, approximately one third of individuals living in emergency shelters, transitional housing or on the streets are veterans. Statistics from the Maryland Department of Human Resource publication in 1997 show 507,898 total bed nights provided to homeless individuals while 16,000 were refused service because of lack of funds or lack of space.

The veteran specific demand for services target female veterans and veterans with discharges that are Other Than Honorable. Services for female veterans are virtually non-existent in the community other than the possible medical attention that they can

receive at the Veteran Affairs Medical Centers. This leaves gaps in the services for emergency and supportive housing, accessing food, as well as family assistance.

Veterans with discharges that are Less Than Honorable pose another challenge to the community resources. These are veterans who may have served years in the military but for various reasons, often due to substance abuse or psychological deterioration, were unable to successfully complete their military duty. These veterans cannot access medical or psychological resources through the VA although their medical or psychological problems may have been a direct result of their military service.

Other concerns that arise when examining the needs of the Baltimore veterans include the inconsistency of the soup kitchens. Both of two main food lines in Baltimore are located in East Baltimore which makes it difficult for the hungry individual without funds to travel from other areas of the city. Many churches operate soup kitchens but only when they have food available and not more than one or two days per week.

Another community problem involves area shelters that are beginning to charge an overnight fee. A homeless individual without money cannot access those services. In addition, because the length of stay at area shelters is limited and the wait for permanent housing is often in excess of a year, many homeless individuals are forced to move around frequently without a stable contact address. Thus making it even more difficult to be notified when permanent housing is available.

Even for veterans who can access the Veteran Affairs Medical Centers, there are gaps in service. The VA does not provide non-service connected veterans with dental services or vision correction. This leaves thousands of veterans without routine dental examinations and care. For the homeless veteran population, who have poor nutrition and often no regular cleaning regimen due to a lack of running water, the problem is exacerbated because they have to deal with serious infection and loss of teeth as a rule. Although the VA will provide ophthalmologic examinations to veterans, it does not provide corrective lenses or glasses. This can make reading and basic tasks necessary to employment and functioning very difficult for veterans who are trying to reorder their lives. Veterans without an Honorable Discharge cannot access this service, although they may have a family history of serious eye disease or deterioration that could have been caused by diabetes or glaucoma.

**4. YOUR TESTIMONY SHOWS MANY HOMELESS VETERANS HAVE SERIOUS MENTAL ILLNESS. COULD YOU ELABORATE?**

Serious mental illnesses can be observed both in our residential population and among those homeless veterans who have not yet become residents in our facility. There are many that we do not see because they are unable to make a conscious decision to involve themselves in treatment. Studies show that approximately 41% of all homeless veterans suffer from some form of mental illness (Source: Struening, e.L., Pittman, J., & Rosenblatt, A. 1998, New York State Psychiatric Institute). This is a percentage that is captured in the data. Many of the seriously mentally ill are the ones who do not come to our attention because outreach efforts are not identifying them. Most of the applicants applying for admission to the MCVET facility present with multiple psychosocial problems on intake. Researchers found Attention Deficit Hyperactivity Disorder (ADHD) to be high among homeless veterans. They suggest that clinicians working with homeless veterans should be better trained in recognizing the various manifestations of ADHD. Many Vietnam veterans report experiencing Post Traumatic Stress Disorder (PTSD). A great number of Vietnam veterans express a need for psychotherapy and anger control therapy. Some Veteran Affairs Medical Centers (VAMC) have found it affective to have after hours crisis intervention programs offering medication consultation, family interventions and referrals to outpatient services. The VAMC's reports to have reduced inpatient psychiatric admissions by 34% (Lambert M., 1995, Psychiatric Services 46 (3): 283-284).

**5. DOES YOUR EXPERIENCE SUGGEST A CONNECTION TO MILITARY SERVICE?**

MCVET is of the belief that there is a direct correlation between homelessness, substance abuse and/or mental illness as a result of military service. It cannot be said categorically that in all cases of homelessness and substance abuse/mental illness is linked to veterans who served in the military. However, this program does serve as a substantial percentage of veterans who began abusing drugs and alcohol while serving in the military as a result of Vietnam and/or other combat service, or that they incurred some traumatic experience as a result of military service.

A percentage of the women veterans in this program have experienced sexual trauma while in the military and that is the source of their current problems. Women veterans have often been the victims of sexual harassment and/or sexual trauma and were reluctant to report it while they were on active duty. Some women experienced childhood sexual trauma that perpetuated their chances of becoming victims of sexual trauma in the military. As a result of childhood and/or military related sexual trauma, they did not seek out adequate treatment that perpetuated their use of substances and contributed to their homelessness. For the woman veteran, most of the substance abuse and homelessness issues they experience are directly to some type of emotional, relational or sexual trauma.

A substantial number of MCVET's male residents are veterans of Vietnam combat service which is where they began to experiment with drugs and alcohol. The use of narcotic substances and alcohol, subsequently, has led to mental illness and homelessness. Many of the male veterans have revealed that their substance abuse began in Vietnam because of the trauma and situations incurred while serving in a combat zone. When they returned to the United States, they were ridiculed by the American public and further isolated into despair. The military indoctrinates its men and women with strong values of independence, pride and leadership skills and many are reluctant to ask for help when they have suffered trauma.

I want to emphasize that not all veterans are drug addicts or homeless as a result of serving in a combat zone. There are those veterans who, during peacetime, were deployed aboard ships, on submarines or in duty stations in remote countries where they were separated from friends and family for long periods of time. These veterans were responsible for multimillion-dollar equipment or were in high-pressured situations where they had to perform complex duties at a young age.

**6. YOUR TESTIMONY ALSO SHOWS MANY HOMELESS VETERANS HAVE A SUBSTANCE ABUSE PROBLEM, WHETHER THE CAUSE OR A CONSEQUENCE OF HOMELESSNESS.**

Applicants to our program generally present with many psychosocial stressors at intake. A large number suffer with mental illness and the majority has a substance abuse problem. The majority of our residents who are suffering from a mental illness also abuse alcohol or illicit drugs. Veterans often substitute the use of alcohol and drugs for acceptable behavior while on active duty. They later use these substances inappropriately to cope with psychosocial stressors. On the other hand, mood and affective disorders may be substance induced. Addiction is a problem whose onset is not definitive. Certainly, addiction can bring about problems (marriage, family, employment, etc.,) that might lead to homelessness. Additionally, homelessness has it's own set of stressors that may further aggravate an existing condition.

**7. HOW MUCH DO SERIOUS MENTAL ILLNESS AND SUBSTANCE ABUSE OVERLAP?**

Nearly 80% of all patients admitted for inpatient psychiatric treatment are experiencing or have experienced substance abuse problems. Prior to seeking professional help, they have attempted to self medicate. In some cases, psychiatric disorders are substance induced.

## 8. WHY IS IT IMPORTANT THAT PROGRAMS BE VETERAN-SPECIFIC?

Homeless veterans represent a unique and challenging group of people. Each soldier, whether male or female, enlisted or officer, is trained and schooled to efficiently use deadly weapons. The misuse of these weapons, whether during war or peacetime, can lead to serious injury or death. They are trained to enter areas that may be contaminated by weapons of mass destruction. They are ordered in "peacekeeping, conflicts, and above all- **WAR** situations. They cannot say "ANY" with serious repercussions.

As was evidenced during the Vietnam War with the spraying of the defoliant Agent Orange over vast area of jungle, the recent Persian Gulf Conflict, which had the ever present threat of biological, chemical warfare, uranium depleted shells, monstrous oil fires with toxic fumes, placed the serviceman at a graver risk both in the present as well as 20 to 30 years into the future when chronic effects begin to become evident.

Today, the VA is still adding illnesses, diseases, etc. to the ever growing conditions for which they will grant service connection from Agent Orange exposure. The Persian Gulf Veteran is still likely to be on active duty. There are those veterans who were in combat and those who had to "clean up the mess" afterwards that have already or will eventually experience the psychologically overwhelming pictures of death and destruction, seeing the death or wounding of friends, etc., on a horrific scale and feel an enormous sense of guilt and responsibility as the survivor.

The noted author and former homeless alcoholic and Vietnam veteran John Mulligan stated in a national forum conducted in March, 1999 that the fastest growing population of homeless veterans are from the Persian Gulf War. There are still many others on active duty, unregistered with the VA or Department of Defense who have yet to experience medical or mental health issues. The long-term effects of the "Gulf War" syndrome are still in the very early phases of research, application and, finally, service connected benefits.

We have alluded to the fact that part of the reason we believe that there should be veteran specific programs is because they have some different characteristics that are based upon their military service. Also, they have higher standards and generally higher education levels that can help them transition out of homelessness. They have a comradely from the military so sometimes an all veteran environment can help them recover (Source: National Coalition for Homeless Veterans).

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