ENDING HOMELESSNESS FOR OUR NATION'S VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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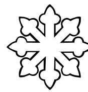

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ENDING HOMELESSNESS FOR OUR NATION'S VETERANS

WEDNESDAY, APRIL 9, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Hall, Rodriguez, Donnelly, Space, Walz, Brown of South Carolina, and Brown-Waite.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning and welcome to the Committee on Veterans' Affairs hearing on Ending Homelessness for Our Nation's Veterans. We have a lot of competition for attendance today. General Petraeus is testifying before the Armed Services Committee and many of our Members share membership with that Committee. And, in addition, one of the parties is holding a caucus meeting at this very moment, so hopefully, they will attend after the caucus is over. Mr. Brown, thank you for being here with us.

I think we all know that homelessness in America is a national tragedy. Few people want to face the issues. Few people want to even look at the homeless. And if that is a national tragedy, the fact of homeless veterans is, I think, a moral disgrace for this Nation.

This is not what we had in mind when we said we would help veterans, both adjust into civilian society and participate in the American dream. There are reasons why that occurs, many of which can be dealt with and prevented. We are going to look at what the U.S. Department of Veterans Affairs (VA) and community organizations are doing, what we should be doing, and how we further the partnerships between the VA and these organizations.

We see already that the current conflicts in Iraq and Afghanistan have produced homelessness. We have figures, I am not sure the reliability of them, but about 1,500 homeless veterans from these conflicts is what is now estimated, although, from what I see, statistics always underestimate the extent of the problem.

We have to do a better job of dealing with these new veterans, and of course, the old veterans. The figures that I see indicate that probably half of the homeless on the street tonight are veterans, mainly from Vietnam. That is 200,000. And that is a disgrace.

Many communities have participated in an annual event called Stand Down. It was started in San Diego, my hometown, in 1987. I was at the first one. And what you saw there was an incredible outpouring of community support and a recognition that dealing with the issue is a holistic, multifaceted problem. Yes, we have to provide housing. And, yes, we have to provide clothes and food. We have to provide medical care and dental support, legal advice, alcohol and drug abuse counseling. All these issues are involved in dealing with the problem.

Stand Down started 20 years ago and as I have said at the last few Stand Downs in San Diego, I am sick of going to Stand Downs, because what we show is that we know how to deal with the problem. For 3 days we bring the resources together and people have a sense of security, they have a sense of support, there is a sense of hope and progress. But it seems to me as a Nation, and what we have a VA for, is to do that 365 days a year. That is what we should be doing for our homeless veterans.

So, I look forward to the panels this morning from the Department of Veterans Affairs, from community groups, from people who have dealt with this for a long, long time. Before the first panel I will recognize Ms. Brown-Waite for an opening statement.

[The prepared statement of Chairman Filner appears on p. 43.]

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman. Every American should have a safe place to live, and unfortunately, that is not always the case. We have a serious problem with homelessness in our Nation. And while this problem is not just specific to veterans, it is deeply troubling that men and women who have served in uniform are over-represented in the homeless population.

I want to thank all of our witnesses who are here today to present their expert views. Without the dedication and strong advocacy of many of you that have taken the time to be here today, we would not have such a successful program like the Maryland Center for Veterans Education and Training (MCVET) to help homeless veterans.

Several research studies have been taken to determine why so many veterans are homeless, although they have been somewhat inconclusive. A number of contributing factors have been identified that contribute to a veteran becoming homeless. First, lack of support upon returning home; substance abuse disorder; inner personal relationships and psychiatric disorders. While psychiatric disorders are considered a contributing factor, I found it noteworthy the Rosenheck Fontana Study found, "No unique association between combat-related post traumatic stress disorder (PTSD) and homelessness." Similarly, a direct connection between military service and homelessness has not necessarily been found.

In 1987, Congress began a nationwide effort to end homelessness among veterans with the enactment of Public Law 100–6. This law provided VA with $5 million for contract residential care and nondomiciliary care for homeless veterans. Since then, VA's homeless programs have expanded and grown. Under the Bush Administration, funding has doubled to an estimated $317 million this fiscal year.

In addition to programs specifically targeted to help them obtain permanent housing, homeless veterans are also eligible for other VA services such as health and dental care. In total, VA estimates that it will spend more than $1.6 billion this year to treat homeless veterans. While actual numbers are difficult to assess, indications are that many of the programs are working. VA's latest estimates show that that number of homeless veterans dropped 21 percent this past year, still it is unacceptable that an estimated 154,000 veterans are on the street on any given night.

With the increasing number of returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans, it is especially important that we ensure that the VA has adequate resources and that it effectively uses those resources to help veterans reintegrate into society and lead productive lives. A superb example of such an efficient and effective program lies just a few minutes here up the I–95 corridor. As I mentioned, Colonel Williams, Executive Director of MCVET is here this morning. MCVET is a very successful program that provides housing, job training, and mental health and substance abuse counseling to homeless veterans. Most participants enter the system through an emergency housing unit and leave with permanent housing and a good paying job.

The program utilizes military order and discipline to help veterans get their lives back on track by taking personal responsibility for their future. In 1997, the Department of Housing and Urban Development (HUD) declared MCVET the national model for seamless transition for homeless veterans.

I believe that for a homeless veteran program to be successful, it must go beyond emergency shelters and free hot meals. We need more programs like MCVET and other programs that we will hear about today.

Solider On, and the Veterans Village of San Diego, strive not only to provide housing and mental health services, but also 21st century job skills.

Mr. Chairman, I too, go to the Stand Downs. And one of the things that we hear in the Florida area is that there are so many homeless veterans living in the National Forest and yet when we have the Stand Downs, I can just share with you that we don't find that many there. As a matter of fact, on almost a biweekly basis, we have a homeless veteran who comes into our Congressional Office in Brooksville. We try to get him services. We try to get him to the clinic. We have the local VSO come over and counsel him. And it is very frustrating that he continues to refuse services. They don't trust government and that is part of the problem. Mr. Chairman, I think you and I can probably agree on that.

I look forward to the testimony of all the witnesses here today and yield back the balance of my time.

The CHAIRMAN. Thank you, Ms. Brown-Waite. I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and that written statements be made a part of the record.

Hearing no objection, so ordered.

The CHAIRMAN. If the first panel will take their seats. We have with us today John Driscoll who is the Vice President for Oper-

ations and Programs at the National Coalition for Homeless Veterans (NCHV). And he is here to discuss the programs in place to help America's homeless veterans.

Libby Perl is an Analyst in Housing at the Congressional Research Service (CRS) and will discuss her recent reports, "Veterans and Homelessness," and "Counting Homeless Persons Homeless Management Information Systems (HMIS)."

And Michelle Saunders is a wounded veteran from Operation Iraqi Freedom who almost became homeless after being discharged from the military.

We look forward to your statements. Your written statements will be made part of the record. And if you can summarize their orally, that would be great. John, thank you for what you do every day.

Mr. DRISCOLL. Thank you, sir.

STATEMENTS OF JOHN DRISCOLL, VICE PRESIDENT FOR OPERATIONS AND PROGRAMS, NATIONAL COALITION FOR HOMELESS VETERANS; LIBBY PERL, ANALYST IN HOUSING, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS; AND MICHELLE SAUNDERS, ARLINGTON, VA (VETERAN)

STATEMENT OF JOHN DRISCOLL

Mr. DRISCOLL. Chairman Filner, distinguished Members of the Committee, the National Coalition for Homeless Veterans is honored to participate in this hearing. This Committee knows all too well that the price of our freedom necessarily includes tending to the wounds of the men and women who reserve some portion of their lives to preserve it.

I would like to begin our testimony by expressing our sincere thanks and gratitude for the continuing their legacy of this Committee. For two decades you have engaged in a noble cause that few others have even wanted to acknowledge. You have asked the tough questions, you have demanded accountability, and you have shouldered this burden before Congress on behalf of the veterans that we represent and you have delivered on your promise. For all that, to us, you stand first among those who made the successes that I will talk about today possible.

The Homeless Veterans Assistance Program that NCHV represents began in earnest in 1990. And I am glad to report that the battle has turned in our favor. This is the first time NCHV has been able to become before this Committee and said that we believe that is the case.

The partnership with the Departments of Veterans Affairs, Labor, Housing and Urban Development supported by the legislation and funding measures championed by this Committee are community service providers have helped reduce the number of homeless veterans on any given night in America by 38 percent in the last 6 years.

The VA has presented an estimate of the wounded veterans, homeless veterans to this Committee every year since 1994. In 2002, that number stood at about 314,000; in 2006 that number had dropped to 194,000. There are two non-government veteran

specific programs serving the men and women who represent nearly a quart of this Nation's homeless population, and these programs are primarily responsible for this reduction in veteran homelessness. The VA's Homeless Providers Grant Per Diem Program and the U.S. Department of Labor's (DoLs) Homeless Veterans Reintegration Program (HVRP) were created in the late eighties to provide access to service for veterans who were unable to get help from federally funded mainstream homeless programs.

The Grant Per Diem Program is the foundation of the nationwide VA and community partnership that funds nearly 10,000 service beds in non-VA facilities in every State. The VA has quadrupled it's support for this partnership since 2002. The purpose of the program is to provide stable housing and supportive services necessary to help homeless veterans achieve self sufficiency to the maximum extent possible. Clients are only eligible for this assistance for up to 2 years and the client progress must be reported to the Grant Per Diem Office quarterly. All programs are required to connect financial and program performance audits annually.

In September of 2007, after a year long review of this program, the U.S. Government Accountability Office (GAO) reported that an additional 11,000 beds are needed to meet the demand presented by the Nation's homeless veterans. The VA concurred with that finding.

We have two recommendations for this program. The first is to increase the annual appropriation to $200 million. The projected $137 million in the President's fiscal year 2009 budget request will increase the number of beds in the program, but not really to the extent that the GAO report has found necessary.

We know that some VA officials would be concerned about the administrative capacity to handle such a large infusion of funding, but we believe that the documented need to do so should drive the debate on this issue.

In 2006, the VA created the position of Grant and Per Diem liaisons to provide additional administrative support. The VA published a comprehensive program to better instruct the grantees on funding and grant compliance issues. They expect to provide intensive training for these liaisons.

Additional funding would increase the number of beds, but it could also increase the level of other services that have been strained by the budget constraints that they have been operating under. We need more money for drop in centers for homeless veterans. This is the first line of defense where veterans who feel they need help and are reaching out to somebody are going to be received and embraced and referred to the people who can help take care of their issues before they are threatened with homelessness.

We need more grants for women who now account for 14 percent of the combat personnel operating in Iraq and Afghanistan. The frail and elderly, which is as the Chairman eluded to the Vietnam veteran generation, we are all getting a little older.

Veterans who are terminally ill and veterans with chronic mental illness need housing supports until the organizations helping them can find other longer-term housing options for them.

The second program is the Department of Labor's Homeless Veterans Reintegration Program, which has been very near and dear

to this Committee's heart. You know that approximately 14,000 to 16,000 homeless veterans are placed into employment every year at less than $2,000 per placement. This program expires at the end of fiscal year 2009, Mr. Chairman. And even though it has been authorized at $50 million a year since 2005, less than half has been appropriated for it. So to whatever extent possible, we would ask that you could apply a little pressure on behalf of those veterans who need that service.

Which brings us to the question of prevention of veteran homelessness. Everything that we have accomplished and all the successes that we have made, necessarily points to the next step in this campaign. The lack of affordable, permanent housing is sited as the number one unmet need of America's veterans according to the VA Challenge Report. We commend the work of the HUD and VA to make up to 10,000 HUD/VA supportive housing (HUD–VASH) vouchers available to veterans with chronic health and disability challenges and another increase in equal measure slated for fiscal year 2009.

But the affordable housing crisis extends far beyond the VA healthcare system and it's community partners. Once veterans successfully complete their Grant Per Diem Programs, many of these veterans still cannot afford fair market rents, most of them will never be able to afford mortgages, even with the VA home loan guarantee. They are still essentially at risk of homelessness.

NCHV supports two measures that would address these issues. The first is a "Veterans Health Care Improvement Act," H.R. 2874, which would provide grants to community and community agencies to provide services to low-income veterans in permanent housing to reduce their risk of homelessness. The services they would be eligible for would be case management, job counseling and training, transportation assistance, and child care needs.

The second measure would make funds available to increase the availability of affordable housing units for low-income veterans and their families. The "Homes for Heroes Act," introduced in both the House and the Senate, addresses this issue and NCHV has been privileged to work with staff in both Houses to support this Congressional action.

In summary, most of the historic achievements of this broad coalition now engaged in the campaign to end homelessness among veterans have occurred in just the last 6 years. I am pretty emotional about this. I have been there for most of them.

We believe the next critical step is to develop and implement a prevention strategy that addresses the health and social and economic needs of OIF/OEF veterans before they are threatened with homelessness.

Never before in the history of this country have we concerned ourselves with preventing homelessness during a time of war for our veterans. For all our collective accomplishments and God willing with your support, I believe this will be our finest hour yet.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Driscoll and the VA Challenge Report appear on p. 45.]

The CHAIRMAN. Thank you, Mr. Driscoll. Ms. Perl, we appreciate your being with us this morning.

STATEMENT OF LIBBY PERL

Ms. PERL. Chairman Filner and Members of the Committee, thank you for the opportunity to testify here today. My name is Libby Perl and I am an analyst at the Congressional Research Service.

As requested, in my testimony I will provide a brief summary of the Federal programs that assist homeless veterans, a brief overview of research regarding homeless veterans and funding levels for those programs. I have submitted a written statement that provides greater detail, for the record.

Comprehensive national research regarding individuals who are homeless that includes detailed information about homeless veterans is rare. So much of the information researchers have relied on dates back to surveys from the 1980s and the 1990s. Despite this, each major study that has attempted to estimate veterans as a percentage of the homeless population has found that veterans are over represented among homeless individuals.

What has been found is that male veterans are between 1.25 and 1.38 times as likely to be homeless as non-veterans and women veterans are estimated to between 2.7 and 3.6 times as likely to be homeless as women who are not veterans. These estimates do not include veterans from the recent conflicts in Iraq and Afghanistan.

Congress has created a number of programs targeted specifically to homeless veterans. There are three major categories of programs for homeless veterans that I will cover. First, permanent supportive housing; second, transitional housing; and third programs that provide services of some kind. I will describe five of these programs.

First, the category of permanent housing. The only program that provides permanent supportive housing specifically for homeless veterans, that is, housing with no time limit together with various supportive services is administered through a collaboration between the VA and HUD called HUD–VASH and John mentioned it in his testimony.

Homeless veterans receive Section 8 vouchers for permanent housing, while VA provides supportive services. With Section 8 vouchers, veterans find apartments or rental units in the private market and pay about 30 percent of their income toward rent. Currently, there are somewhere around 1,000 HUD–VASH vouchers that were made available to veterans back in the early 1990s. However, in the fiscal year 2008 Appropriations Act, an additional $75 million was appropriated for HUD–VASH vouchers which HUD estimates will fund about 9,800 vouchers. And the President has also requested $75 million more for fiscal year 2009 for another 9,800 vouchers.

The next category, transitional housing, is time limited depending on the program. The idea is for individuals in the transitional housing to have some time to get on their feet and find permanent housing. The Homeless Providers Grant and Per Diem Program that John mentioned is the major program for transitional housing for homeless veterans. The Grant and Per Diem Program allows veterans to stay in the housing for up to 24 months and also provides supportive services. The Grant and Per Diem Program typically receives the most funding of any program targeted to homeless veterans and serves more than 15,000 veterans a year.

In the area of healthcare, the VA operates two programs that provide healthcare assessments and treatment for homeless veterans. The two programs, Healthcare for Homeless Veterans and Domiciliary Care for Homeless Veterans, assess and treat a large percentage of veterans who have mental health and substance abuse issues.

In the Healthcare for Homeless Veterans Program, VA Medical Care staff conduct outreach to homeless veterans who don't typically use VA medical services and then they provide clinical assessments and referrals for treatment. In 2006, of the nearly 61,000 Healthcare for Homeless Veterans participants, 82 percent had a serious psychiatric or substance abuse issue.

The Domiciliary Care for Homeless Veterans Program is a little different in that residents live on site while receiving treatment. In fiscal year 2006 veterans stayed in domiciliary care an average of 104 days and of the nearly 5,300 veterans who were admitted to domiciliary care programs, almost 93 percent were diagnosed with a substance abuse disorder, and more than half, about 57 percent, were diagnosed with serious mental illness.

In the area of employment services, the Homeless Veterans Reintegration Program administered through the Department of Labor provides grants to organizations that help homeless veterans find and maintain employment. In fiscal year 2006, HVRP placed about 8,700 veterans in employment, which was 65 percent of those who entered the program.

In 2001, a Demonstration Program through the Department of Labor and the VA was funded to provide job training for veterans who were leaving prison or other institutions. Before the authorization expired in fiscal year 2006, the program helped 1,100 veterans find employment, which was about 54 percent of those who entered the program.

I will conclude briefly with funding levels. There is a table attached to my statement that will provide more detail. In fiscal year 2008, about $317 million is expected to be either obligated or appropriated for these programs that I have described and a few others that I didn't mention. And that does not include the cost of the HUD–VASH vouchers that I discussed and it doesn't include the treatment cost of homeless veterans, such as hospital stays and long term care.

As I mentioned, there is table attached and it will provide breakdowns of funding by program over the years. This concludes my remarks. Thanks, again, for the opportunity to speak here today and I would be happy to answer your questions.

[The prepared statement of Ms. Perl appears on p. 74. The CRS Reports for Congress, authored by Ms. Perl, entitled "Veterans and Homelessness," Updated April 4, 2008, Order Code RL34024 appears on p. 109, and "Counting Homeless Persons: Homeless Management Information Systems," Updated April 3, 2008, Order Code RL33956, appears on p. 130.]

The CHAIRMAN. Thank you, Ms. Perl. Ms. Saunders, we appreciate your being here and it takes some courage to tell personal stories, so thank you for sharing with us.

STATEMENT OF MICHELLE SAUNDERS

Ms. SAUNDERS. Sir, thank you. Mr. Chairman, Members of the Committee, I just want to take this opportunity to thank you all for allowing me to speak about my personal experiences and for the veterans that have come before me and after me.

I am coming from a little bit different perspective. I am not here to talk about how successful our programs are. I am here to basically talk about why they are not successful in my eyes, and why I think there is a lot of systemic issues that are not being addressed. We talk about programs that exist right now for homelessness and there are many issues that happen prior to them becoming homeless. And those, I think, are the issues that we have to address.

My story, basically, is that I was wounded in Iraq in 2004. I spent 22 months at Walter Reed rehabilitating. Through that time, I was promised many different jobs and opportunities and I latched on to that. Maybe I was being a little bit naive, but I thought because I served my country for 10 years that I was going to have a great job when I got out of the military.

The fact of the matter is that it was very, very hard to, especially in this town, to find a job. Being a servicemember that had 10 years of experience, I thought that I wouldn't have a problem at all. After almost 19 months I sat many nights with a loaded gun saying that I wasn't worth anything, because I didn't know who to turn to and I was too prideful to talk to my family about what was going on. I was dealing with a lot of post traumatic stress, a lot of survivors guilt and just didn't know what to do. Didn't know where to go and I just knew that I just wanted to be out of the military and get away from all the bureaucracy that was going on through my transition.

After I retired in May of 2006, I finally I got a job by the grace of God, through the Department of Labor because I had called them every single day, probably about 5 times a day, until they finally said, "Why don't you come down here. We will find you a job."

Ironically, I got a job working as an employment specialist to help other transitioning servicemembers. When I got into that job, I realized that I was really excited to get into the trenches and try to help my brothers and sisters who were transitioning. A lot of things happened. At first I was very excited and then I started to realize that how our successes in our programs were measured were based on numbers, not on quality of service, which was very frustrating to me because you don't measure success on a number. If I have 25 people that I am putting into a database just because I met with them and said, "Okay, fine." That was a success.

There are five major components that have to happen simultaneously that are not happening. And basically, they stem from identifying the servicemembers first. Identifying those who are coming back, informing them. Assessing their issues, assisting them and monitoring them. We have many, many different agencies right now doing multiple duplications of this.

For 6 months while I was at Walter Reed, they had no clue where I was. It took them 6 months to find me after two extensive surgeries and multiple sessions of counseling. Finally, 6 months later, somebody came to me and said, "Where have you been? Why

haven't you been to formation? Well, sir, sorry I was incapacitated. I was in surgery."

I apologize for being all over the board. I have so much to say and sometimes I just get a little overwhelmed. We must ensure that our transition programs are better. Our transition programs right now basically are folks that are going through a transition assistance program are forced to go to a class for 2 days. Most of our men and women that have been wounded are on multiple medications, they are not going to retain a whole lot. They have been in medical treatment facilities for "X" amount of months. All they want to do is go home. They want to be with their families.

Most of them are receiving a Traumatic Servicemembers Group Life Insurance (TSGLI) policy from anywhere to $25,000 up to $100,000 payout. As a 20-year-old kid and $100,000 I don't care who are and how much counseling or how much financial counseling you have had, you are going to misspend that money. You are going to misuse that money.

A lot of our servicemembers are going into debt so they are not thinking that they are not going to have a job when they get out. They got TSGLI, they are drawing Social Security Disability Insurance while they are in the medical treatment facilities. It is the last thing on their mind is getting a job and being able to take care of themselves when they get out. So they are not taking that proactive approach, because they don't know any better.

It is a huge problem. It is a huge problem that our military or our U.S. Department of Defense cannot identify folks because there are multiple databases, are multiple months of information going into databases, and a lot of it is anecdotal so they can't find these folks when they get out. When they leave the military installations and the get put into a temporary retirement status, they put them into CVHCOs which are civilian based health organizations and completely forget about them. That is an issue, because by the time we find them, we are reading about them in the paper or watching them on the news.

So identifying is a really big issue right now. Another big issue that we are running into is the lack of continuum of care through basically the VA and some of the programs. You know, if you are not completely blown up and you don't have a visible wound, then you go to the back of the list. Basically, you are on the bottom of the pile because we can't identify what is wrong with you.

Some of these programs are reactive programs as opposed to proactive programs. Like, for instance, I know that the American Legion hire or not hire heroes, hometown to heroes. In order for them to help you, you have to already be in a homeless situation in order to be able to get provided grant money to help your family through these programs or through these problems you have to literally have to be homeless before they can help you.

The criteria for some of these programs is completely backward and we are working in a vacuum and we are putting it basically, "a band-aid on a sucking chest wound." And so I guess I am here more to talk about the systemic issues and to try to prevent homelessness as opposed to cleaning up the mess that is already out there and it is getting worse.

And so that is kind of what I have to say.

[The prepared statement of Ms. Saunders appears on p. 82.]

The CHAIRMAN. Thank you. Thank you for sharing that with us. It gives a lot of information.

Mr. Rodriguez, you have dealt with this issue in the civilian world and as a Congressman. We thank you for your leadership. And you have 5 minutes to address the panel.

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. I just had the Secretary of the VA over to San Antonio to visit us. We took him to one of the few homeless shelters that we have there through the American GI Forum and they seem to be doing a pretty good job. But it is a small program in comparison to the need that is out there.

I wanted to ask a couple of things. Ms. Saunders, thank you very much for your testimony. You talked about how there is a need for us to do some prevention in advance and not after, picking up the person after they become homeless. I was wondering, Mr. Driscoll, if the VA is engaged in home healthcare, where we reach out and work with the family in any way at the present time?

Mr. DRISCOLL. Well, I am sure that they can fill you in better than that. What I do know is the VA Readjustment Counseling Centers Vet Centers, their purpose is to help be that first line of defense for combat veterans who feel strains, need help finding what access to whatever services they need, whether it is educational, whether it is housing supports.

Mr. RODRIGUEZ. But we do not provide any home healthcare that you are aware of? Because I know we provide it under Medicare, Medicaid, Medicare Advantage. And I am just talking about that because I just had a group of home healthcare professionals come over, and it seems like it might be a program that might be able to reach out before that person gets thrown out or finds himself out of the picture.

Mr. DRISCOLL. Right. I am not aware of anything in that regard.

Mr. RODRIGUEZ. Okay. You mentioned the drop in centers. How many do we have, throughout the country? Do we know?

Mr. DRISCOLL. Well, formally I could not answer that. I know that members of NCHV almost all of them to some degree have an open door policy. You come in and we will help you. You know, a lot of the communities where those organizations operate, the word gets around. Homeless people talk to other homeless people. VA used to fund those through the Grant and Per Diem funding on a higher level, and I may be misspeaking so I do not want to do that. But I do know that on the last few grant cycles for the Grant and Per Diem they have not been able to increase funding for the drop in centers.

Mr. RODRIGUEZ. The drop in centers?

Mr. DRISCOLL. Right.

Mr. RODRIGUEZ. Ms. Perl, I know you mentioned jails, and I was glad because I never hear those comments and sometimes I feel like I am the only one who is mentioning this issue. I do not have any statistics to show this, but I think that a lot of our Vietnam veterans in the process of trying to deal with their post traumatic stress, self-medicated and found themselves taking illegal drugs and found themselves in jail. You mentioned a program that was working with them. Can you tell me a little bit about that?

Ms. PERL. There are a couple programs that I mentioned. The Domiciliary Care for Homeless Veterans Program is run onsite at VA Medical Centers and veterans are able to stay there, not in the hospital but in residential care and receive treatment while living in the facilities for substance abuse issues or mental healthcare. As I mentioned, veterans stay in those facilities generally a little over 100 days based on the most recent estimates that I have from the VA.

And the other one, Healthcare for Homeless Veterans, is more of an outreach program to try to find those veterans who are out there who are not coming into the VA maybe for the treatment of substance abuse issues and mental healthcare. And the VA does outreach, brings them in, does clinical assessment, and then refers for treatment.

Mr. RODRIGUEZ. I know, and I think it was indicated that we do not have good research to identify homeless veterans. There are questions as to the numbers that are out there based on the new way of determining who is homeless and who is not and how many are out there. And I recall very distinctly, because I taught a class in community mental health, the largest number of people, because I used to take people to the private sector, the public sector, and one of the things I taught my students is that the largest number of the mentally ill were in our prisons. And I presume that is still the case, in some of those areas. But there has got to be a way of not only dealing with the ones that are in there now as they are released. Maybe coming up with some programs, Ms. Saunders, where we can reach out so that it does not happen in the first place. I do not know if you want to comment on that.

Ms. SAUNDERS. Yes sir, I do, actually. The way, the problem is that, and this is from my perspective, and I am part of this generation. And I think anybody that has been, who has ever served can attest to, we have the same exact issues as we did when folks came back from Vietnam. The problem is that there was never a place to go after they leave the gates of the installations. There was not an environment created for them to go to be able just to breathe.

A lot of people do not realize that when you go through a traumatic event like that, especially if you have a family, when you come home you are expected, you know, you get a pat on the back and you are expected to go out there and, you know, be productive in society. But what happens is when you go through something traumatic like that, we live in a society where murder is not normal, where killing is not normal. And so when you see things like that and you commit things like that, whether it is time of war or not, your spirit is broken. Your whole family as a unit is broken. And people are not understanding that. So when you come back you are forced to go out and find a job, go out and find a job, go out and find a job in order to take care of your family. But you cannot do that because you are stuck. You are stuck in a place where you are just broken and you do not know how to heal.

So you just continue to shove it down, and shove it down, and shove it down, because you have other responsibilities to take care of, meaning your family, or you have to be productive in society because there are those things called bills that we have to pay. And so when you stuff all that down inside, it comes out of you. It sur-

faces later on and severe things happen. You fall into severe depression. You turn to alcohol, you turn to drugs because that is the only thing you know how to do, is to be numb because you do not want to feel. So there is not an environment created yet out there for that after you leave the gates of the installation. And it is the last stop for the next 10,000 miles and a lot of people get lost in that.

I am in the process of developing a program right now. I started a foundation started Veterans Moving Forward. And what we do is we want to provide that continuum of care, that rehabilitation, that drug and alcohol counseling, but also have that educational component attached to it. Because when something like that happens you lose your self-worth. You do not know what you are worth anymore because the only thing you knew is what you did in the military. And you wore that uniform and you wore it proud. So when you lose that you are completely stripped of all your pride. So to rehabilitate is key, but we have to create that environment first. And that goes with transitional housing, rehabilitation, drug and alcohol, and education to give them another skill.

Mr. RODRIGUEZ. Thank you very much. I do want to just thank the whole panel. And Mr. Chairman, if I can, I know one other item that was brought up and it keeps bothering me. The fact that we have had a good 3,000 that have committed suicide while in the military just recently. And a good number, or higher, outside of the military. And when they commit suicide, and that just came to mind in terms of what you experienced when you were at night by yourself with the depression that you talked about. Having that gun and, and sometimes playing with it, we really need to look at how we treat the veterans that, the soldiers I should say, that have committed suicide while in the military.

I had a young lady who committed suicide, or supposedly committed suicide, while she was in Iraq. And she got treated by our veterans and by the system extremely rudely. The family gets no benefits whatsoever. And I would hope that, when they commit suicide, afterward it is a different situation, but it is still the same. And so we really need to, I do not know what the answer is, look into this and how we can come to grips with it because we do not want to encourage that treatment while they are in the military. But at the same time we need to see how we can deal with it in a manner that is more just, to both those that are in the military as well as those that are out of the military in terms of the benefits that they might be entitled to and other things. And now I am talking more in terms of the family, also, that are left behind. And thank you very much. Yes ma'am.

Ms. SAUNDERS. May I address that? Is that possible?

Mr. RODRIGUEZ. If the Chairman would allow.

The CHAIRMAN. Yes.

Ms. SAUNDERS. Again, going back to some of the systemic issues I know we went through that being at Walter Reed. There is a real inability for the services, the service components, all of them, to admit that post traumatic stress is an issue. Coming from a battalion commander down or a brigade commander down, if that commander stands in front of his trooper and says, "Hey look it is okay to go through what you are going through right now. What you saw

was not normal." That message is not being put out. And until that message is put out there is going to be a stigma. And my brother and my sister to the left and right of me are going to look at me different if I bring that to the surface.

So again, you hide it. You do not want your peers to know, especially if you are going to be retained on active duty, because you are going to look at as, oh, as one of those. That is a huge, huge problem. And until our military stands up and addresses that as an issue, that will never, ever go away.

The CHAIRMAN. Thank you. Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman. I agree, Ms. Saunders, you know we have really got some problems in getting this thing sorted out. I believe very strongly, I am the Ranking Member on the Economic Opportunity, and a lot of these problems can be averted if we can get people where they can make a living wage along with solving the other problems that you are talking about. But you mentioned the Transition Assistance Program (TAP), and that is a pretty good program. You know, we worked hard and the people that administer that are good people and they are working hard to try to give good information. But it is difficult. You mentioned that they do not, you know, that they want to go home. You know, they are not really interested in getting the information. So, I mean, I think everyone would be willing to work with different ways of delivering that information, perhaps. But it really is a challenge.

You mentioned the fact that a person gets a large sum of money. And, again, that is a problem whether you win the lottery, it is a problem if you are an athlete and all of a sudden you are successful, or a movie star, or whatever. You know, those really are core problems that are difficult to solve. So like I said, I guess I would be very interested in, rather than doing the 2-day TAP Program, how would we do that differently?

Ms. SAUNDERS. I actually am in the process of implementing a program, a pilot program at Walter Reed, a three-phase program to facilitate those needs. Again, like I said, you know, we are dealing with a different population right now in terms of, for the first time in our history of any war the American people are pushing back and saying, "What is going on? Why are we not taking care of our veterans?" And the fact of the matter is, we are. It is just there are so many out there that have already fallen through the cracks and now we are working in a vacuum.

We are in a position where we are dealing with servicemembers who have been severely wounded, both emotionally and physically. Their time and stay in the military treatment facilities are, you know, a tremendous amount of months. Again, I was there for 22 months. There are folks that are still there today when I was there. Again, the last thing on their mind is finding a job. Especially if they are, and I hate to say this, and a lot of them are entitled to some of the monetary grants and funds that they are receiving right now. But when you are sitting in an outpatient room and you are drawing VAH and you are drawing Social Security Disability Insurance, and you are drawing traumatic group life insurance, and you are drawing any kind of grant that you can get your hands on because there are multiple programs out there that will give

money, grant money, based on what their physical disability or emotional disability is, I sit there and I say, "Well, I am making $6,000, $7,000 a month. Why the heck would I want to work right now?" That is a huge problem. There is a lot of push back because of that. And that is our generation, that we have to take care of. I mean, there is a societal need right now to take care of them because we are giving them handouts. We are not giving them hand ups. I would rather show somebody the way than take them there.

Mr. BOOZMAN. I do not disagree. I mean, the reality is, is how do you do that? And I am the guy that would like very much as they rehabilitate physically, and mentally, and the other stuff, but you know, to get them busy starting their education, almost immediately. You know, doing things like that. But again, along with that you do have to figure out how to get the person themselves to want to do that. That is our challenge. And I think that is really what you are saying.

Ms. SAUNDERS. Well, that is what I have, I have been working very, very hard on trying to pilot this program. And basically what it is, the phase one starts out as a corporate immersion. I have over 200 companies across the country, most of them are Fortune 500 companies, that are willing to work with these guys. And I drive home to them, I say, "Look, this is a mentorship. We have to mentor these folks. We cannot just create jobs for them and put them in a job where they are not going to grow. We have to mentor them and show them that they are worth something and they are able to grow." So that phase one is actually at the military treatment facility. And my ultimate goal is to be able to incorporate that as part of the TAP program. To get these guys stimulated, to get them out of their rooms, to get them out there and engaging in the communities. And that is where it is going to happen, is at the community levels. Because like I said, once they leave the gates of the installation, that is it.

So if we can do that as a phase one, and then the phase two being a week-long mentor program. I have already started it. It is called Operation Real Transition, to take them out of that environment again, work them in the team environment with peers that are going through exactly the same things that they are going through. So that they can talk and they have mentors there at any time that they need to talk. Go through, we do mock interviews, we do the right questions to ask during, an interview and basically what it is like to be in the corporate environment, what it is like to get out there and work. And then once they find out, "Wow, I could do this." Or, "Wow, I did not know that I had this ability or these skill sets." Then they say, a light goes on and they say, "Oh, okay, now I am motivated and I want to work."

And then obviously the phase three would be the facility, the transitional housing facility, if they want to work but they want to go to school at the same time. Or they just want to go to school and continue their care and rehabilitation. Give them a skill, make them marketable, for the 21st century workforce.

Mr. BOOZMAN. Can I ask one more thing, Mr. Chairman? I know I am running over the clock again. You are a bright gal that presents yourself very well today. You mention that you have been in the military for 10 years and you really had a tough time finding

a job. And what was, what do you feel like was the reason for that? I mean, were you in an age group, or this or that, or did you not have the skills that you needed that they were looking for? Was it the fact that you had been injured or been in the military? Or, I mean all of those things, you know when I talk to corporate America, many of those things are a plus. I mean, they are, you know, but what in your particular case, how could we have prepared a 10-year person like yourself to be more employable?

Ms. SAUNDERS. Personally, I was scared. I was scared to go to an employer and, granted I sent my resume out there, but I was scared to go interview because I did not know, I had the hard skills but I did not have the soft skills. And that is what corporate America is looking for. They are looking for the soft skills. The hard skills are easy. You know, there are training curves and learning curves, but it is the soft skills that are really, really hard. And that is the whole intent and purpose of mentoring these guys and girls, is to show them what it is like to be in a corporate environment. You know, you cannot say certain things in a corporate environment that you would to your buddy sitting in your uniform. And it is that simple. It is such a simple, simple thing. But that is honestly the biggest step, over that threshold. Folks are just scared. They are very intimidated. They do not know the right questions to ask. They do not know how to act. So that it is up to us as veterans, ambassadors, to help them through that process.

Mr. BOOZMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Donnelly, do you have any questions?

Mr. DONNELLY. Thank you, Mr. Chairman. One of the concerns that I have is the number of OEF/OIF veterans that are already starting to show up at the homeless shelters. And what I am wondering, if any of you can help, is what are the steps you think we need to take now to try to provide for the veterans so they do not reach that point where they come to the homeless shelters? What are the things we are missing that have caused these veterans to arrive?

Ms. SAUNDERS. Can I answer that?

Mr. DONNELLY. Wide open.

Ms. SAUNDERS. I think that is basically what I have been saying, you know, for the past 10 minutes or so. It is we have to be proactive, or we have to get them before they get out of the gates. What is happening is, is that they are falling through the cracks. And after they leave the military we cannot catch them. Some of them do not want to be found. As Ms. Brown-Waite said earlier, you know, there are folks out there that they do not want to be approached. They are so bitter they just do not know how to be. So they become numb, and they get into this really, really dark place. And so I think that we need to back up and somehow collaborate with the military or the Department of Defense and in the Transition Assistance Program. It cannot just be a 2-day class. There is a lot that has to happen and 2 days is just not cutting it.

We need to start mentorships, we need to get interns, we started that with Operation War Fighter, where we got Federal agencies involved with the servicemembers that are rehabilitating at Walter Reed right now. We get them out of their rooms, we get their minds stimulated, we get them engaged, we get them active in the

community within the agency where they learn that, "Wow, I can have some pride in what I am doing right now." That is such a huge, huge key and it is such a huge part of their rehabilitation. And so by backing up before they leave the military, I think, is where we need to hit that head on.

Mr. DRISCOLL. I would like to add something here. And one of my concerns, especially with OIF/OEF, is that it is appropriate to place the spotlight on this young veteran returning population. But I think we have to do it with respect to the greater population. Just as was the case after Vietnam, it is a tiny, tiny minority of troops that come home after Iraq and Afghanistan that immediately go and seek assistance outside of their families, outside of their communities. And I can only really speak to my own personal experience, just as you do. I really appreciate hearing your testimony.

When I got home from Vietnam, I was decorated. It was the first time in my life I ever really thought that I amounted to anything. And I went to Walter Reed, worked on the surgical intensive care unit and, I mean, I was the man. But it was not until about 3 years later, I was home with my adopted family at Christmas, when Dr. Hake in all his wisdom took me aside and said, "You know John, no matter how much I agree with you and I usually do, you have an intensity that scares people." And of course I thanked him, gave him a hug, and went outside and had a good cry because he had said basically what I knew all the time up to that point, is that as long as I am in that clinical environment, and life and death, and blood and guts up to my elbows, I am fine. But I could not walk out of that hospital and laugh and feel good having a, you know, pounding down a beer with my buddies.

So I would say that there is no singular answer. Everybody has his own baggage, and everybody has his own way of responding. I think what we are seeing in the early going, because it still is in the early going for this cohort, is people who do not have those family support networks, those circle of friends, that real sense of purpose when they get home, they go through the anxiety of separation. Military is oftentimes the only family some of these young people have. And when they leave it, they are vulnerable. And even if they do not act like they are vulnerable, inside they feel they are vulnerable.

This is why I alluded to the fact that the VA Readjustment Counseling Centers, that needs to be public, it is a huge resource but a lot of veterans do not realize it because, as my colleague said, when you are ready to go home, you are ready to go home. You do not need anybody telling you what you think you might need, or where to turn 4 or 5 years down the road. It is not until it all catches up with you. That is when you need to know that there is a VA Readjustment Counseling Center, or there is a community-based organization that no matter what your problem is and the reasons you have it, you will not be judged. You will not be turned away. And that is why these community-based organizations need to continue getting that funding. That is why the VA needs to really spruce up, I believe, the VA Readjustment Counseling Centers. But they have to publicize that so the veterans coming home, that do not have the family supports, know there is a lot of help out

there. I think most of the time veterans who need help just do not know where to turn to get it. And there is a lot of help out there.

Mr. DONNELLY. Thank you very much for your service. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman. First of all, Ms. Saunders, I want to thank you for your service. Ten years of service and you are still obviously serving and trying to help others by being here today.

In your written testimony, and also your oral testimony, you spoke about being an Employment Coordinator, and then you also mentioned that you have a foundation. Are you still an Employment Coordinator with the Department of Labor?

Ms. SAUNDERS. I am a consultant for the Department of Labor.

Ms. BROWN-WAITE. Oh, okay.

Ms. SAUNDERS. So I am not a General Schedule employee. So there is really, it is not a conflict of interest, ma'am.

Ms. BROWN-WAITE. No, no, no. That was not——

Ms. SAUNDERS. No, I know, I know.

Ms. BROWN-WAITE [continuing]. In any way, shape or form what I was alluding to, please do not think that. It is just when you jumped to the foundation I just was not sure if you were still——

Ms. SAUNDERS. I am, I am still affiliated with the Department of Labor as an Employment Consultant. However, again, stepping back, there are so many programs out there that do not really have a lot of substance. And I got frustrated one night, I had a *Jerry Maguire* moment at 3:00 in the morning, and basically wrote out what I thought and how I would approach the problem, and how I could put my arms around it. So I built a program based on education training, rehabilitation, and transitional housing to create that environment. And we are in the process of developing that facility right now.

Ms. BROWN-WAITE. Thank you. You had also mentioned that you did not have the soft skills, and that helping veterans coming back in employment interviews is absolutely necessary so that they have those skills. Have you been able to attract any corporate individuals who would help in that? Or corporate foundations, even, that would be able to send individuals to help the veterans to do that?

Ms. SAUNDERS. Yes ma'am, I have. I have over, like I said, over 200 companies, most of them which are Fortune 500 companies. One of my biggest advocates is OSI, Outback Steakhouse, Incorporated.

Ms. BROWN-WAITE. Whose original headquarters was in Tampa.

Ms. SAUNDERS. There you go. And they have been a huge advocate. And basically, we just had a very successful Operation Real Transition mentorship program a month ago in Tampa, Florida, actually, where I had multiple employers come out, HR folks come out, and basically spent the week out on a ranch with, we had 39 servicemembers, wounded servicemembers, that came out. We flew them in from all over the country. And——

Ms. BROWN-WAITE. Was that the event at Chinsegut?

Ms. SAUNDERS. Yes. Yes, ma'am.

Ms. BROWN-WAITE. I heard about it at the very last minute——

Ms. SAUNDERS. Yes.

Ms. BROWN-WAITE [continuing]. And I could not get there but my District Director did.

Ms. SAUNDERS. That is exactly——

Ms. BROWN-WAITE. I wish I had known about it before, because I would have been there.

Ms. SAUNDERS. Yeah——

Ms. BROWN-WAITE. But——

Ms. SAUNDERS. Well, I will be sure to invite you to the next one, ma'am.

Ms. BROWN-WAITE. Thank you for having it. It really, you know, a lot of good information was disseminated there.

Ms. SAUNDERS. Mm-hmm.

Ms. BROWN-WAITE. How do we, and any one of the three of you, how do we get to the veterans like the one I described who is in my office every other week, who does not trust government, and we even tried to get him to a not-for-profit homeless shelter that works with men. Most of the men have substance abuse problems, be it alcohol or drugs, and it is a really good program. Even then, he will not go. And I am using my constituent as an example. I am sure everyone here, every Member of Congress has many, as I do. But this one makes a point of coming to my office. So in a way, he is trying to get help. But when it is offered, there is a pull back. How do we get to the homeless veteran? You know, Ronald Reagan once said the most feared words are, "I am from the Federal Government. I am here to help." So we can overcome that fear of the government help? Mr. Driscoll. Or anyone.

Mr. DRISCOLL. Well, one of the things that I have learned the hard way, I suppose, over the last 7 years at NCHV is no matter what is there an available, no matter how much of a perfect fit it is for the veteran in crisis, until he is ready to recognize, "There is a big problem inside of me," that help is not going to reach him. And we have a 1–800 vet help line. So first of all, ma'am, I would invite you to hand your visitor a card that has our number on it.

Ms. BROWN-WAITE. I did that.

Mr. DRISCOLL. Oh, okay, well and maybe I have talked to him because there are several that call over and over again, and, you know, I mean I am like my friend over here. I respect, no matter what your issue is, you are a veteran, you call, I respect you. I will listen to you. But after about the third or fourth call, I do not have a problem saying, "Why do you keep calling me?" You know? I mean, I want to help you but you have to help yourself. And that is a very touchy thing to do. I do not do it with everybody. But you develop a rapport, and just a veteran helping veteran assistance programs are extremely successful for veterans in crisis. But the bottom line is, until they are ready to receive the help that is available they are not going to. I do not know what else I would say.

Ms. SAUNDERS. Can I piggyback on that? Ma'am, may I ask how old this person is? Is he younger or older?

Ms. BROWN-WAITE. I do not——

Ms. SAUNDERS. From OIF/OEF, or——

Ms. BROWN-WAITE. No, no. Late Vietnam.

Ms. SAUNDERS. Late Vietnam? What I have found, and this is just from a personal standpoint, there are many of us who do not want to talk to somebody in a suit. We do not want to talk to some-

body who does not share the same backgrounds as we do. I have been able to break through to some veterans that many of my colleagues are like, "I cannot get through to this person," just because I have been there and done that, and have the credibility to walk up to that person and throw my arm around them and say, "Hey, what is going on? What is happening?" It just, being in the same age group is such a huge deal. A lot of the Vietnam veterans, they do not want to talk to these younger guys. They want to talk to them about war stories, but they do not want to talk to them about their stories.

So I guess it is a tough nut to crack because some of them really do not want to be, they do not want the help. They do, but they are too prideful to ask for it. And then when you try to drive it home, they say, "No, thanks but no thanks." So I do not think there is really an answer to that. I mean, that is tough.

Mr. DRISCOLL. Yeah, but especially in Tampa, I mean, it just, you know, I wish we were all in Tampa. And we get those veterans——

Ms. BROWN-WAITE. Well——

Mr. DRISCOLL. Yes, ma'am, absolutely. But more to the point, for veterans in crisis, because there are some tremendous programs there, that is the cradle of the Grant and Per Diem Program. And I think that it is incumbent upon us to recognize, and I say this to a lot of families. Do not assume responsibility for the choices of your loved one. But guide them to the opportunities that exist. If we in the service provider network, and particularly in partnership with the VA, because even in the most stressful times the military mind knows VA is there. They may not act like it, but they know. But all we can do, really, is make sure the opportunities are there. We cannot push them into the door. We can put our arms around their shoulders and try to nudge them in.

Mr. RODRIGUEZ. May I ask you to yield?

Ms. BROWN-WAITE. Yes, I yield.

Mr. RODRIGUEZ. Let me tell you what Mr. Driscoll has just indicated, unless a military person takes ownership, it is just like any society or any community. If they take ownership of the problem, they can deal with it. If they do not take ownership they cannot. I had people come in and tell me, "Mr. Rodriguez, I want to go to college." A year later they are telling me, "Mr. Rodriguez, I want to go to college." You finally have to tell them, "Look, do not tell me that anymore unless you register for school." Like with the alcoholic, until they realize that they have a problem, then they can deal with it. So they have to take ownership of that situation.

Ms. BROWN-WAITE. Well, obviously he realizes, the particular gentleman realizes he has a problem because he will come in and indicate he wants help. But he goes just so far and he cannot go any further. But Mr. Chairman, thank you for indulging the overtime and I yield back.

The CHAIRMAN. Thank you. And again, thank you for what you are doing. Mr. Driscoll, you said something about somebody estimated the need is 11,000 beds. Did I hear that right?

Mr. DRISCOLL. Yes, sir. The Government Accountability Office, that was reported in September 2007 after a year long report——

The CHAIRMAN. Yes, I know, I do not understand where they get this stuff.

Mr. DRISCOLL. This was actually information they received from the Department of Veterans Affairs.

The CHAIRMAN. No, I understand. I mean, in San Diego we need a few thousand right in San Diego, so——

Mr. DRISCOLL. Oh, oh, I get your point.

The CHAIRMAN. We seem to continually underestimate the problem because it is going to take some effort and some money to deal with it. In the Grant and Per Diem Program, that only goes to institutions that are providing services to a group where at least 75 percent are veterans. Is that right?

Mr. DRISCOLL. There are two components, sir. For the capital, which is for the billing, construction, renovations, an organization has to have 75 percent of their clients as veterans. But the funding will only go to 65 percent of the capital costs. So it is actually, it is fair to say that is primarily a veterans. As far as the Per Diem, if you are a program that has 75 percent clients and you are qualified for Per Diem, you can get that if you have 75 percent veterans. But every Per Diem dollar has to be spent for a veterans, not for a non-veteran.

The CHAIRMAN. Right. I mean, it would seem to me that, I do not know why we have this 75 percent requirement.

Mr. DRISCOLL. In this day——

The CHAIRMAN. We should follow the veteran.

Mr. DRISCOLL. Right. But in this day and age, it is very important, with all of the citizen soldiers we have right now, Guardsmen, Reservists, if you do not have capacity to bring in spouses and children, dependent children, then you are breaking up families, basically, by having an exclusive treatment option.

The CHAIRMAN. Yes, what I am saying is the Per Diem Grant ought to follow the veteran and not just the institution. Do you agree with that?

Mr. DRISCOLL. I would, well, as an individual. I cannot speak to NCHV because I have not heard that. But as an individual I would have a concern with that, and it is because, and I hope you will back me up on this, veterans need more than just a cot and a check. I think that is the message that I heard from my colleague there.

The CHAIRMAN. I understand that. But, I mean, we have shelters in San Diego that serve anybody.

Mr. DRISCOLL. Right.

The CHAIRMAN. They are always strapped for funds. If they are serving veterans in an emergency situation, why not help them? I mean, the Per Diem is not that great, as you pointed out.

Mr. DRISCOLL. Correct. Correct.

The CHAIRMAN. I do not know, is it $31 a day or something?

Mr. DRISCOLL. But I feel that the need is more comprehensive than just shelter——

The CHAIRMAN. I understand. But in an emergency, why should they not be given that help?

Mr. DRISCOLL. Well——

The CHAIRMAN. I mean, I understand the comprehensiveness but, you are just talking about basic shelter for a night.

Mr. DRISCOLL. No, actually I am talking just the opposite.

The CHAIRMAN. No I mean, if somebody needs basic shelter, and you are telling me, "We have a bed here," or, "We would give you a bed but we are not comprehensive enough." That seems to me rather cruel right there. What am I missing here?

Mr. DRISCOLL. Maybe it is just a difference of perspective. Most people who walk into the community-based organizations that we represent are going to be given a needs assessment. They are not going to be just thrown in a corner and kicked out like shelters do in the morning. They are going to be referred to the services that they need, whether that is through the VA or whether that is through their own onsite service providers, or——

The CHAIRMAN. Look, there are not enough beds in any city. And if somebody can get a bed for that night, why shouldn't our Federal Government help them? That is all I am saying.

Mr. DRISCOLL. I agree, sir.

The CHAIRMAN. Let me just make a suggestion. Ms. Saunders, if you could just react quickly, we have a couple of other panels here. It seems to me, when we send you, as a soldier, into the—were you in the Army?

Ms. SAUNDERS. Yes, sir.

The CHAIRMAN. You went through boot camp.

Ms. SAUNDERS. Yes.

The CHAIRMAN. In 12 weeks you learned how to be a soldier, and the kind of thinking, unit cohesion, and the psychology. But, when you get out we do not have a de-boot camp.

Ms. SAUNDERS. Correct, sir.

The CHAIRMAN. Or a basic un-training. I think that as part of active duty, we should take 10 or 12 weeks, the same amount as boot camp, with the cooperation of VA and the Department of Defense to provide a de-boot camp. Take a company of soldiers so you have that cohesion and allow the family to participate, which is important in both diagnosis and treatment. Make sure everybody gets a professional evaluation for PTSD and traumatic brain injury (TBI), because virtually everybody in my estimation has it, and you have to prove to me you do not rather than come in and we prove you do. We would use that information for an immediate, diagnosis without any stigma. Early treatment is vital with the support of the family, comrades from the company. Then, address these other issues of education and vocational training, certification, and other options. Make it part of your active duty. I mean, everybody wants to get home but the last 10, 12 weeks. It could be utilized to address the problems our transitioning servicemembers may have.

Ms. SAUNDERS. Sir, you are so dead on. That is exactly what I am trying to do right now. And I do not care if it just takes me driving the bus I will make that happen.

The CHAIRMAN. All right.

Ms. SAUNDERS. That is what I want.

The CHAIRMAN. We are going to get the money and you are going to do it, okay?

Ms. SAUNDERS. Write me a check, sir, I will take care of it tomorrow.

The CHAIRMAN. You know, it just seems——

Ms. SAUNDERS. It makes sense. It makes perfect sense. You know, we spend so much money on getting people in the military. And then you turn around and say, "Well, thanks, here are a couple of medals." I have medals on my wall and I am like, "Wow, that is great."

The CHAIRMAN. You can be in Baghdad yesterday——

Ms. SAUNDERS. Exactly.

The CHAIRMAN [continuing]. And taking your kids to soccer——

Ms. SAUNDERS. Exactly.

The CHAIRMAN [continuing]. The next day. And you are going to respond to them in the way that you have been doing for the last——

Ms. SAUNDERS. Exactly.

The CHAIRMAN [continuing]. Twelve months, right?

Ms. SAUNDERS. And they are spending tons and tons and tons of money on sign on bonuses, but what are they doing for them on the way out the door? And that is exactly the plan that I have. I would love for a military, for anybody to go into the military, and sign on, you know, sign their agreement. Okay, a three-year enlistment. At that 2½ year mark, that last 6 months, or that last, whatever, 3 or 4 months, they have to go through a transitioning program where they can go into an internship or they can go into some sort of training program so that we give them the proper skills. We give them the proper education on the way out the door so that we set them up for success. We do not set them up for failure.

The CHAIRMAN. Right. And it has got to take some time, as you said.

Ms. SAUNDERS. Absolutely.

The CHAIRMAN. I mean, I have been to TAP classes and everybody, including the instructor, is asleep. And, you know, it is not the most effective——

Ms. SAUNDERS. It really is not.

The CHAIRMAN. You have to keep the support system there with your soldiers and your family. Mr. Hall, you had a question.

Mr. HALL. Yes, please. Thank you, Mr. Chairman. I just have one and I am sorry for being late. But I will read all of your testimony, your written testimony. I wanted to ask Ms. Saunders relative to a hearing we are having later this week in the Subcommittee on Disability Assistance and Memorial Affairs, and to your testimony about PTSD. Do you believe that service in Iraq in particular, or that in a combat zone in general, should be considered an automatic stressor for presumption of PTSD?

Ms. SAUNDERS. One hundred percent, sir.

Mr. HALL. Okay. Ms. Perl.

Ms. PERL. No position on that.

Mr. HALL. And Mr. Driscoll.

Mr. DRISCOLL. I think there should be a presumption until proven otherwise.

Ms. SAUNDERS. It is just like anything else, sir. Regardless of if you are, in any traumatic event, if you see, if you are in a car accident or if you lose somebody in your family, you are going through very similar things. You are feeling some very similar feelings. You are having the same reactions. A lot of people do not know how to

deal with death. When you see something that traumatic, or when you go through a traumatic event, again, it breaks the soul. Especially if you have to point a gun and shoot at women and children just to get out of a kill zone. Something happens there. And you are going to have residual effect. I do not care who you are. And if you do not, you are completely insane.

Mr. HALL. I agree with you. And I am glad to hear your corroboration. I mean, just the fact that, I mean I, a protected, privileged Congressman slept one night in the Green Zone in October on a visit to Iraq in one of Saddam's pool houses. What I understand last week, or a couple of days ago when they were taking so much incoming——

Ms. SAUNDERS. Yes.

Mr. HALL [continuing]. Rocket and mortar fire they were telling people, "Sleep in your helmet and your body armor."

Ms. SAUNDERS. Mm-hmm.

Mr. HALL. And whether you are driving a truck from the airport to town, or whether you are flying low in a helicopter low over certain areas on the way out to Ramadi, Iraq, or whatever, you do not know from whence the attack might come. It is a situation where there is no front and no rear. And so for that reason alone I, you know, and I have heard this from so many veterans in my district who have come to our office for help. I am just trying to get one more, and I thank you for your answer, one more corroboration of that. Thank you, Mr. Chairman.

The CHAIRMAN. We thank the panel and we look forward to working with you to end this scourge on our Nation. Thank you so much.

Mr. DRISCOLL. Thank you.

Ms. SAUNDERS. Thank you.

The CHAIRMAN. If panel two will step forward, we have representatives from different programs that seem to be working and we want to hear from them as to how and why. John Downing from Soldier On is with us; Charles Williams from the Maryland Center for Veterans Education and Training; Phil Landis from the Veterans Village of San Diego (VVSD); and William D'Arcy from the Catholic Charities Housing Development Corporation. Mr. Downing, if you will start? Again, your written statements will be made a part of the record and if you would summarize that statement, your oral testimony, that would be great.

STATEMENTS OF JOHN F. DOWNING, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SOLDIER ON (UNITED VETERANS OF AMERICA); COLONEL CHARLES WILLIAMS, USA (RET.), EXECUTIVE DIRECTOR, MARYLAND CENTER FOR VETERANS EDUCATION AND TRAINING, INC.; PHIL LANDIS, CHIEF EXECUTIVE OFFICER, VETERANS VILLAGE OF SAN DIEGO, CA; AND WILLIAM G. D'ARCY, CHIEF OPERATING OFFICER, CATHOLIC CHARITIES HOUSING DEVELOPMENT CORPORATION, CHICAGO, IL

STATEMENT OF JOHN F. DOWNING

Mr. DOWNING. Thank you. Chairman Filner, Members of the Committee, on behalf of the hundreds of homeless veterans whom

we serve every year at the United Veterans of America, I am honored by your invitation to be here today testifying on behalf of the homeless veterans of U.S. military service. I have the privilege of serving as President and CEO of the United Veterans of America, doing business as Soldier On. Based in Leeds, Massachusetts, with facilities serving homeless veterans in Pittsfield and Leeds, Soldier On serves upwards of 250 homeless veterans every day. We run at 111 percent of capacity every day, 365 days a year.

Our program is based on a continuum of care ranging from the treatment of trauma and mental health issues to substance abuse counseling, shelter, food and other necessities, job training and permanent housing. Our partners include the U.S. Department of Veteran Affairs, the U.S. Department of Labor, HUD, and many State and local agencies. Shelter, treatment, and hope are the cornerstones of what we do every day.

Soldier On hosts 145 men and women in transitional living on site at the VA Medical Center in Leeds, Massachusetts, a section of North Hampton, Massachusetts. We rent cottages from the VA Hospital. We use the cottages for housing for female veterans and frail and elderly male veterans. We pay HUD's fair market rents to the VA for the privilege of housing these men and women, which means for a three bedroom, half of a cottage, I pay $750 a month to the local VA out of money given to me to serve homeless veterans. Sixty more vets live in transitional housing at our Berkshire veteran's residence in Pittsfield, Massachusetts, which opened in September 2004.

There are ten new studio apartments funded through HUD in that facility and they provide permanent housing for homeless veterans with disabilities at that site. The turnover in those apartments in the 3 years that we have operated is, we had one individual who, unfortunately, died in our care and another individual whose wife was put into assisted living and he became eligible for public housing. Those are the two openings that I have.

So we know that permanent, affordable housing with services works for formerly homeless veterans. Soldier On serves veterans primarily from the northeast of the United States of America. A few were referred to us from across the country. The average age of someone in our population is 54, but the mean age is trending younger as we see more veterans of Operation Enduring Freedom and Operation Iraqi Freedom. Approximately 88 percent of our vets suffer mental health and/or substance abuse disorders. Some 10 percent are elderly at age 65 or older. Five percent of our veterans are women. More than 25 percent of our veterans have been diagnosed with post traumatic stress disorder. Twenty-eight percent are on parole or probation and 42 percent of our veterans are minority. I could go on but I invite you to take a look at our Web site at www.wesoldieron.org and to learn more about our program. I am supported by a dedicated staff, a tremendously committed board of directors, and I enjoy a strong, collaborative relationship with our VA Medical Center and the VA Headquarters here in Washington, D.C.

I think it is significant that I can sit in front of you after doing this work for 6 years and sometimes in a very adversarial position and still consider Pete Dougherty a friend. So I want to make that

clear. It really does work and the VA has worked hard to build relationships with our program and understand that we are constantly pushing the limits of what we think they should do to accomplish the task for the people we think should be served.

Currently, we are in the pre development stage of a 39-unit limited equity cooperative to be built on our site in Pittsfield, Massachusetts. The development will be owned and managed by formerly homeless veterans. Now, one of the things that makes our program unique is that our program is entirely run by formerly homeless veterans and the professional staff that works there, it is our job to serve them. So every facility, each building is managed by a team of formerly homeless vets that is self selected by the veterans in the living facility and they develop their own rules and own system.

So our women's program, Building 6, Building 26, the Pittsfield facility, all have different teams of veterans that run them, all have some different rules and it is our job to support those rules and figure out ways for those who are so consistently labeled failures in their lives to be successful at managing their lives and learning how to respond also to the lives of the people in their care.

So to give you an example of how that really operates, every facility that we operate has its own budget. The vets manage that budget. We cut the checks where they tell us to cut them. Our job is to work with them to be successful. Any money that is given to us for gifts goes into gift funds that they operate. We execute the checks. They tell us how the gifts will go.

They decide tonight, if somebody in one of our buildings relapses, we do not have automatic penalties. The team of veterans decides what they think after they listen to the veteran would be the best outcome for them. And then it is our substance abuse counselors, our psychologists, our team of people come in and we execute that with them.

So that when you fail with us, you do not leave. Failure is never final. We do not believe that pushing people out of the community makes them better. We believe that it is our job to continuously engage you and figure out ways to serve you so you want to stay with us. So what happens to us is that veterans who used to trickle back and forth between the community ricochet from one place to another are now settled down in programs long term with us. What we found was that the ricocheting system, the merry-go-round of services that used to exist does not work and that what our people needed was just what Michelle Saunders said earlier here, when she testified on the first panel, that the community of veterans becomes the family most veterans identify with, feel most secure with, and want to be a part of the rest of their life.

One of the issues facing all of us is this horrible issue of homelessness in America and homelessness of veterans, but we need to frame up the problem with an understanding of what is really going on. In a capitalistic society, okay, there are some social statistic analysis that we must do on income to understand who are the people we serve.

Those individuals who live at the poverty level or below in our society appear four times, are more likely to appear in negative social statistics than people in the same group above the poverty

level regardless of gender or social origin. Now we take that same group at the poverty level or below and we add one overwhelming factor, single-parent families, and we almost double that number again. So what we need to see is that the people who are in our care, okay, in my facility, last night, 64 percent of them were raised in single-parent families, and most of them from families that were marginal economically and this is by verbal memory of many of the individuals we work with.

So what we found out was that when we got a homeless vet and 54½ years old, they came in our door with eleven open prescriptions. Eighty-eight percent were addicted. We are feeding them medicine on prescriptions. There is a clever idea, huh? How to keep you permanently homeless and then we ask them to come in and change, and what we found was we had to say not only do we want you to come in and change, but we will stand and be here for you. You will not have to leave again. You cannot fail here. We need to help you become successful.

So when somebody chooses to leave us, our conversations with them is, how did we fail you? What could we do different? And so as a result of that process, what we became aware was we needed to have safe, affordable housing that was permanent that these folks could live in and succeed in.

Last fall, the national alliance to end homelessness released a comprehensive report on the status of homeless Veterans. I know you all received that report and I really commend you to read it. You will read about poverty and unemployment among veterans. You will read about veterans with disabilities who are further burdened by severe housing costs especially among veterans who are renters and sadly you will read about veterans who fall into more than one high-risk category.

The CHAIRMAN. Mr. Downing, we need you to conclude your testimony.

Mr. DOWNING. Okay. Yes, sir. I would just say that I think that the other thing that I would like to do in closing then is add that we need to do a couple of things that really will effect what we do for homeless veterans. We need to amend the Fair Housing Act to include veterans of the U.S. Military Service as a protective class. I mention this because if we are successful in creating permanent housing for veterans, we run the risk of violating fair housing laws by giving veterans priority. Again, a catch 22 which I am sure is unintentional and which I am sure can be fixed. Other technical fixes are within our grasp as well.

For instance, the VA's payment system is a nightmare. Good people in Congress working with good people of the VA passed legislation that changed the payment system last year but that legislation never made it to a final bill. If I could go out and raise money to improve service to homeless veterans, the VA is forced to reduce, as a result of the Office of Management and Budget circulars, it's payment to us. So our per diem rate falls when I am more successful in capturing other funding.

So I am asking you to really look at that. I am asking you to also realize that I believe we want to welcome home the veterans of both OEF and OIF but our veterans deserve a system of care that

is anchored in safe, affordable, permanent housing with services. Thank you.

The CHAIRMAN. Thank you, sir. I am sorry to have to——

Mr. DOWNING. That is okay.

[The prepared statement of Mr. Downing appears on p. 85.]

The CHAIRMAN. I mean we appreciate your passion and we need to hear it. Colonel Williams.

STATEMENT OF COLONEL CHARLES WILLIAMS, USA (RET.)

Colonel WILLIAMS. Oh. Yes, sir. Mr. Chairman, Members of the Committee, my name is Charles Williams, Colonel, U.S. Army retired, and I am the Executive Director of the Maryland Center of Veterans Education and Training, also known as MCVET. MCVET was established to provide homeless veterans and other veterans in need with comprehensive services that will enable them to rejoin their communities as productive citizens.

We meet veterans where they are when they enter our program and through a smooth continuum of service, we reorder their lives. This also means partnering with Federal, State and local resources to provide the veterans with services they need to become productive. MCVET has about 15 years hands-on experience in dealing with homeless veterans with various issues such as drugs, alcohol, mental, physical health and, of course, under that come PTSD and TBI. MCVET owes its very existence to the Federal grants, to community-based organizations.

We have uniquely married the housing services available from HUD, the medical and social services available from Veterans Affairs, and the job and training and education services available from the Department of Labor in order to move veterans into the societal main stream as supporting and contributing members to their families and their communities. Veterans returning from Afghanistan and Iraq face problems that can be overcome through the Veterans Affairs system. Many problems occur from an ineffective readjustment period after transitioning from the war zone.

If the veteran is not connected to comprehensive services, then other problems take place, i.e., drugs, crime, and homelessness will surface. A unified service delivery system should be developed with Federal agencies that would address the major issues facing the returning veteran in a timely manner and I repeat timely.

Over the years, MCVET has progressed to the point that it is considered a national model in reordering the lives of veterans with issues of homelessness. We have partnered with the Veterans Affairs Medical Centers who have placed medical staff at our facility and this staff includes but they are not limited to psychologists at the doctoral level and social workers.

Additionally, a liaison person from the Grant Per Diem program is in our facility twice a week. These VA personnel assist in the admission process for veterans who are in immediate need of mental health services and are key in determining the level of care needed. Our students are able to access mental health services within 1 week of entering our program; this is the speed at which these people enter treatment.

Also, psychosocial assessments are conducted at the agency within the first week in an effort to identify the level of mental health

services that should be given to each student. Without the assistance of the VA medical health profession, the admission process becomes time consuming with a distinct possibility of losing a veteran to the street. Veterans Affairs has adequate resources to treat mental health issues once the veteran is admitted.

MCVET also has partnerships with Johns Hopkins, University of Maryland Healthcare System, the Greater Baltimore Healthcare System, and Mercy Hospital in providing necessary treatment for the homeless veteran population. The key to reduction and/or elimi-Nation of homelessness among veterans is grounded in the speed and the effectiveness of access to treatment.

So in closing, I would like to say thank you for the opportunity to appear before you and to share the MCVET story. Homeless veterans are likely to face greater challenges in the years ahead as scarce resources strain the delivery system that is already overburdened. I urge you in your deliberation to consider the plight of these young men and women who have been sent to defend the ideals of their country and many of them are returning home broken of body, mind and soul and this country needs to provide the resources so that these people too can share in the American dream, send their kids to school, and live where they choose to live. Thank you.

[The prepared statement of Colonel Williams appears on p. 88.]

The CHAIRMAN. Thank you, Colonel. Mr. Landis, thank you for being here.

STATEMENT OF PHIL LANDIS

Mr. LANDIS. Chairman Filner, Members of the Committee, thank you for the opportunity to share a few of my views with you and a little something about the organization that I am so humbled to be a part of. My name is Phil Landis. I am the current Chief Executive Officer of Veterans Village at San Diego. I have been a board member with that organization for 11 years and as of September of last year I have had the truly unique and wonderful opportunity to head this organization.

VVSD was formed 27 years ago by a small group of Vietnam combat vets who were struggling with their own issues and searching for ways in a desert, if you will, to develop means by which they can come to grips with their own demons and, hence, Vietnam Veterans of San Diego was born in that time. We have since changed our name to Veterans Village of San Diego because we truly are a village of all veterans. We currently have a veteran from World War I, formerly homeless, and he is 88 years old. We have 130 other homeless veterans who are currently residing with us at our early treatment facility. Of those 131, eight are women, six are OIF/OEF veterans, and one of those six is female.

In listening to some of the testimony earlier, it struck me at how the issues that we are struggling with today are the same issues that I and my fellow veterans of the Vietnam conflict struggled with for so long. One of the primary and significant differences between now and 40 years ago is a plethora of services available and the will, politically and economically, to support the OIF/OEF veterans. For that matter, all veterans of the Global War on Terrorism era that we are involved in now.

I would like to talk a little bit about numbers. Veterans Village was the founder of Stand Down which is now replicated at some 200 locations around the country. In the late '90s, we saw the number attending Stand Down begin to dribble down. Starting about 3 years ago, it is beginning to dribble up.

Last year, we had almost 800 in attendance at our 3-day event. That is about 60 more than we had the previous year. The population has changed to younger. We have more families attending Stand Down. These are veteran families with children attending Stand Down. We had 74 children aged under 16 at Stand Down last year. One of the commonalities between generations of servicemembers seems to be true at this time as it has in the past. You know, PTSD as we call it today, in the Civil War, they called PTSD soldier's heart and that is what gets broken in combat along with the soul and a lot of folks have difficulty with that and it is a long road home.

One of the commonalities that all combat veterans—well, I would not say all. Many combat veterans have anger, addiction, disillusionment, despair, all of the catch words that lead to suicide, that lead to homelessness. I have been fortunate enough to sit in groups of our current group of homeless veterans, Iraq primarily. It is the same. It is the same message then that I hear from them that I heard in the groups that I was involved in when I was going through counseling for many, many years at our local Vet Center.

My time is running short but quickly, what do we do? We have identified an outreach program which has recently been funded, which we call Warrior Traditions. Warrior Traditions will go into the communities with qualified facilitators and create atmospheres whereby these veterans can, amongst themselves, in an environment that is facilitated towards a helpful and progressive end begin to deal with some of these issues.

So we are outreaching into the community. That is not our core mission but we find that it is significant to do that or they are going to fall through the cracks. The name of it is prevention and in closing, if I were to wish for anything, I would wish for more beds. I would wish for funding for more permanent housing. I would wish for funding for more transitional housing.

If we had enough money, we would throw supportive services at it but the first element that we need is to get the folks off the street and get them into a bed, and then develop the services that go with that. Thank you for hearing my testimony.

[The prepared statement of Mr. Landis appears on p. 90.]

The CHAIRMAN. Thank you. Mr. D'Arcy.

STATEMENT OF WILLIAM G. D'ARCY

Mr. D'ARCY. The rents that we collected paid for the property management but not the social services. Social services at St. Leo Residence are provided to chronically homeless and mentally ill veterans primarily from the Vietnam era. And Catholic Charities provides nine employees, more than originally planned, at a cost of $500,000.

At the Auburn Gresham Clinic, the VA provided services to 1,185 veterans in the first 9 months. And the Department of Labor as-

sisted 312 veterans with job searches and 45 of them obtained employment.

So what did we learn? The clinic was built with a public and private partnership that was extensive. Catholic Charities engaged seven governmental agencies and six private partners. And we learned that these partnerships are necessary, they are quite complicated, and they require a considerable time commitment.

The second thing we learned was about financing. Ten layers of funding were assembled and six of them were from government agencies. The VA committed the first funding and that opened the door for all the funders.

The State of Illinois awarded $10 million in Federal tax credits and Catholic Charities procured more than $4 million in grants and donations to fill the funding gaps.

We learned that a simpler financing method must be found and we request an opportunity to renegotiate the terms of our VA loan.

Operating revenue came from housing vouchers that provided only 35 percent of the funding. Plus, low rents collected from veterans provided 65 percent. Such a small revenue budget cannot pay for both property management and social services. We learned that more housing vouchers and/or grants are needed or this project will fail.

And regarding social service outcomes, 79 percent of the residents obtained employment. That was nearly 50 percent in the first year. And nearly all veterans at St. Leo Residence are receiving benefits.

We learned that Catholic Charities had to increase its staff to work with this challenging population in order to achieve these positive outcomes.

Last, community response has been favorable and we learned that being in a neighborhood near public transportation is very important because ongoing support from local groups is critical to helping veterans.

In conclusion, we at Catholic Charities believe that our country needs more housing to address the problem of homelessness among veterans. The St. Leo Residence and the Auburn Gresham Clinic have made a real contribution because formerly homeless veterans are becoming viable contributors to our society again.

Mr. Chairman, we are willing to work with any group you designate to review this pilot project in order to make the next project even more successful. I urge the Congress to promote this program, to simplify its implementation, and to provide financial support for continued operations and social services.

Thank you.

[The prepared statement of Mr. D'Arcy appears on p. 92.]

The CHAIRMAN. Thank you. Thank you all for what you are doing each and every day for our veterans.

Mr. Rodriguez, do you have any comments?

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

Let me also just thank you for the services that you are providing out there.

Based on the figures, even if we have a disagreement over them, if we have 11,000 so-called individuals out there, what is the duration of time that they spend in your facilities? I know that it is dif-

ficult, but right now based on how much time we keep them, if we felt that we needed to transition them and allow that opportunity for them to get a job, say that it is a year, what is the cost that we are looking at overall, if that is the maximum number that are out there? What is the cost for any one of you right now for an individual at your place?

The CHAIRMAN. Well, Mr. Rodriguez, I was going to ask for the operating budget for each agency. I was just trying to figure out——

Mr. RODRIGUEZ. Yes.

Mr. DOWNING. Excuse me. My operating budget is approximately $4 million a year.

Mr. RODRIGUEZ. And that comes out to how much per veteran?

Mr. DOWNING. It would probably average out around $80,000 a veteran.

The CHAIRMAN. And you are serving about 250?

Mr. DOWNING. Yes, sir.

Mr. RODRIGUEZ. Per year?

Mr. DOWNING. Per year, but that number would be a total. In a total year, that would be about 900 veterans.

Mr. RODRIGUEZ. Okay.

The CHAIRMAN. Four million dollars. Okay.

Colonel Williams.

Colonel WILLIAMS. My budget is about $3.6 million a year, but that is not the full story because we get our people jobs. Our average salary runs about over $13 an hour now.

Because of the money that we get from HUD, not from HUD, but from the Department of Labor, we send our people to colleges, universities, and tech schools. And some of the jobs that we have been able to secure for them is master fitness trainer, web designer, and that web designer is making more money than I make. So he can afford to pay his rent. Okay.

The CHAIRMAN. How many people do you serve per year?

Colonel WILLIAMS. We run about 240 people a day. In the report that we sent in earlier, it has those numbers in it. And I keep thinking that we are going to run out of people, but they keep coming.

But one of the keys to this whole thing is that we put people in a position to fend for themselves. About 2 or 3 years ago, we decided that we were going to take a look at the number of people who left the program and what they were doing. We found out that over 500 had purchased their own home and some of them had moved down to South Carolina or in Georgia and had little, small mansions out there with ponds in the back.

So these people are not throwaways. These people, once you give them the tools to get on their feet, they can make it. They are different from the other population of homeless veterans because at one time, these people had been successful in their lives. At one time, they had aspirations and because of their experience in war, they may have lost some of it. But if you put them back on track, they can become very, very self-sufficient and, you know, they can help other veterans on their way up.

And we do have that because we have people with their own businesses and they come back to the organization and they hire their fellow veterans and take them out to their businesses.

The CHAIRMAN. Mr. Landis, your annual budget?

Mr. LANDIS. Yes, sir. Six point three million dollars. I was just thinking how to put a number to the veterans that we do serve if we include Stand Down.

And we have a winter shelter that we have been providing for the City of San Diego for 8 years. This year alone, we had over 400 documented different Social Security numbers that we worked with.

We operate out of seven different locations. We have transitional housing facilities in some of those locations as well. I would say conservatively 1,500 to 1,700 veterans a year.

The CHAIRMAN. And, Mr. D'Arcy, you said it was $20 million to build the facility?

Mr. D'ARCY. Right. But to operate——

The CHAIRMAN. Social services is what?

Mr. D'ARCY. Was $500,000 cost. But, Mr. Chairman, our operating budget is $1.7 million, which comes out to $12,000 per veteran.

The CHAIRMAN. How many people are in the——

Mr. D'ARCY. 141.

The CHAIRMAN. Okay. I am sorry, Mr. Rodriguez.

Mr. RODRIGUEZ. No. Thank you.

Excuse me. I am trying to get a feel in terms of what might be needed in terms of serving. Mr. Landis.

Mr. LANDIS. Yes, sir. If I may expand just a moment. The most critical component of what Veterans Village provides is our drug and alcohol treatment. That is our core mission. That is the most expensive component of treatment that we offer. It costs approximately $60 a day to treat the men and women that are in that facility.

As you know, the Per Diem rates are $30 a day, which means we struggle to find the differential. And the differential is widening. It is not coming closer together. So we struggle with that as well.

Mr. RODRIGUEZ. So just to provide them housing, you are looking at what, $30 to $50 a day just for housing?

Mr. LANDIS. Well, if I was providing transitional housing only, at $30 a day, sir, I would make a profit.

Mr. RODRIGUEZ. Okay.

Mr. LANDIS. No question. When you couple that with supportive services, the costs go up. When you add to that drug and alcohol treatment, especially if you are doing it in the way that we choose to do it, which is all encompassing and very holistic, it is very expensive.

So we struggle. In fact, our treatment facility which we call the VRC, Veterans Rehabilitation Center, every year runs at a slight loss.

Mr. RODRIGUEZ. Do we have any program that is looking at the veteran coming out of the prison system that is picked up? I know it was mentioned. Go ahead.

Mr. LANDIS. Yes, sir. We have a large component of our men and women in a treatment facility that come straight from prison.

Mr. RODRIGUEZ. Okay.

Mr. LANDIS. We also are involved in a pilot program called Optional Sentencing. So a judge has an opportunity, if they choose to, to sentence somebody, if you will, to our treatment facility as opposed to putting them in prison.

Mr. RODRIGUEZ. Okay. That is good.

Mr. DOWNING. Twenty-eight percent of our people come out of prison on parole or probation. And we have a person who visits all the prisons in our region every week. I have an outreach person. That is all he does, visits all the shelters and all the prisons and we bring them in that way.

Mr. RODRIGUEZ. And I gather most of, I am stereotyping, but I gather most of the offenses have been drug-related?

Mr. DOWNING. Drug or violence. You know, a number of our veterans are also men that batter women, adjustment disorders under which post traumatic stress disorder falls. There is a number of behaviors that seem to be pretty consistent with that.

Colonel WILLIAMS. Sir, we coordinate with the prison system of Maryland and believe it or not, the veterans in the prison system have fundraisers for us. And once they get out, they come into the program.

But we do not have people sentenced to us because that means that we have to account for their behavior and we have to account for their presence. But once they turn them loose, in most cases in the court, if they know that they are with us or coming to us, they will, instead of imprison them, will send them to us. We have a good relationship with them.

And we have also met with the Chief of Police in Baltimore and was trying to arrange a meeting between the psychologist and psychiatrist to tell their people about the type of people that they are going to see coming back from Iraq so that they do not get involved with shooting these people for their behavior. And we are going to continue that.

And also in dealing with the other problems, health and that sort of thing, we partner with Johns Hopkins who come in. All our men that are over 40, they give them prostate screening. And we are working on a plan now to get our females their mammograms because we found out that these people not only have problems with drugs and alcohol, but they have medical problems because of their stay on the streets and that sort of thing.

And it really takes the community to help a veteran heal, so we go to the community and all of the hospitals cooperate with us in what we are trying to do.

The CHAIRMAN. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

I would like to ask two questions and if each of you could answer.

The first question is, how do you verify the veteran status of an individual who is participating in the programs that you run? And the second question would be, how do you define a successful outcome for the individuals that you are helping?

And we can start on either end.

Mr. DOWNING. Okay. First of all, DD–214, everybody has a DD–214. We get them and we work to get them. The St. Louis Center is very good. We get them back in 24 hours.

And the VA hospital does what they call a "hink" and they can run that for us immediately. And most of the time, that will show somebody who has been in the system and is VA eligible. So we do that.

And then we have a number of people, especially a lot of our returning folks, who come back with bad paper because they were discharged for less than honorable, especially after violent activity or drug activity. And so those folks, we bring in and they are eligible for Per Diem and then we immediately start a process of appealing their paperwork and work with the various service groups to get them eligible for full VA services. So we do that.

Secondly, a successful outcome for us is somebody who stays with us that is sober and safe, okay, and has developed some responsibility for their life.

If you ask me today, I could say this to you. About 23 percent of the people that come in my door today will be with me 2 years from now. I cannot tell you who they will be. I can tell you that. Okay?

I mean, it is a very difficult process, but what we are looking for is stable behaviors, people who stay within the disciplines for their medical treatment, their psych treatment, and stay with the supportive services.

The more services we provide, the busier we keep them, the more we stay in touch, the longer they stay. The average stay of a person in our program now is 17 months.

Ms. BROWN-WAITE. Let me follow-up on one of the comments——

Mr. DOWNING. Yes, ma'am.

Ms. BROWN-WAITE [continuing]. That you made. If the individual coming out of the military has a less than honorable discharge——

Mr. DOWNING. Yeah.

Ms. BROWN-WAITE [continuing]. And you are simultaneously working to try to get that changed, are you offering them assistance during that period?

Mr. DOWNING. Yes, ma'am. Oh, yeah. We say no to nobody, okay, even if we do not get reimbursed for them. We feel if you come in to us and you have had military service, even if you have a DD–214 with less than honorable, we are going to start to work with you.

If at the end of that 3-month, 4-month period we find out that we cannot get it changed and it is not going to change, then we have to start to look for alternative long-term treatment facilities for you and we do that. Okay?

Ms. BROWN-WAITE. Thank you.

Colonel WILLIAMS. Ma'am, our mission is to provide services so that people can rejoin their communities as productive citizens. We have a very sophisticated system of accounting for the people. I can tell you where some of our people, the first 20 people that we took in 14 years ago, I can tell you what they are doing.

We do know that 71 percent of the people who stayed with us longer than 30 days, because 30 days is key, they bind to the pro-

gram. We are returning 71 percent of those people to their communities with jobs and we are also dealing with families.

We did a random study in which we pulled 50 records from the years we have been open to find out what those people were doing. We found out of the 50, 41 of them were still in a recovery program with jobs. But more important than that, 21 of them had reunited with their families, who had been separated from their families, had reunited with their families.

Now, we have programs to encourage family reunification because we believe that if we can reunite these people with their families and get that connection, chances of them returning to the street is minimum.

Now, I know when I came back from Vietnam, one of the things that probably saved me was a family who would not let me be by myself to think about this, but kept me moving. And we believe that.

We have days when we bring the family in, the mother, the children, and especially things like Christmas and picnics and that sort of thing to sort of force that family unit so that the people will not return back to the streets.

Ms. BROWN-WAITE. And your verification process is that the individual you are dealing with is a veteran?

Colonel WILLIAMS. Oh, yes. We check that out with the DD–214 and at one point, we had people from the Federal building coming down. And as we interviewed people, we checked the status.

Ms. BROWN-WAITE. Thank you.

Mr. Landis.

Mr. LANDIS. Yes, ma'am. We also have access through the VA Regional Office and the VA hospital to determine eligibility or veteran's status within 1 day.

We do see a lot of forms DD–214. However, our experience has led us to verify beyond that and that is what we do on a regular basis. So we know within 24 hours if the person we are dealing with is, in fact, a veteran.

I mean, how do you determine success? Success if you are in our treatment program for drug and alcohol addiction is determined by the fact that you are clean and sober and you have a job and that you are an economic functioning part of society once again.

The latest study that we had conducted determined that 6 months after graduation from that program, we still had 72 percent of our alumni clean and sober, no nights in jail, and economically employed.

Mr. D'ARCY. The way we verify is also with the DD–214, plus we are in contact with the VISN 12 office at Hines, Illinois. And then the Jesse Brown VA Medical Center official oversees the clinic, which is across the street. And so we use them. So we have, like Mr. Landis here, we have good access to the VA data.

And how do we determine outcomes? Well, we were pleased that in the first year, we had 14 percent move on to permanent housing.

The goal of our project is the veteran has to commit to seeking and obtaining and maintaining employment. They have to pay rent and they have to agree to live in a drug-free environment.

So our case managers are working with people on a weekly basis. We only had seven move out in the first year because they did not

want to comply with the program. So 23 moved on. They got better jobs. They got financially stable and they moved out to permanent housing.

Ms. BROWN-WAITE. Thank you.

And I thank the Chairman for indulging me a little extra time.

The CHAIRMAN. Thank you.

When you were telling me the budget figures, I was doing some calculations to see, if we had everybody in your program that we think are homeless, how much it would cost this Nation.

And I do not know what estimates have come to you. I get, in the order of $3 to $4 billion a year.

Now, offhand, that sounds like a little bit of money. That is about 2 weeks of the War in Iraq, maybe less. So I am going to arrange to stop the war 2 weeks earlier and we are going to fund all to end the homeless situation.

So, I mean, everything is relative, you know. This country has the money to solve this issue. It is a question of priorities. And if we can borrow hundreds of billions of dollars for war, we can borrow a few billion to deal with this, which is a moral crisis for America.

I would say 90 percent, 95 percent or 98.6 percent—you cannot help every single person, but you can provide the conditions for virtually everybody to achieve success in the way each of you defined it.

So your every-day work will recommit us to making sure you continue and we put in the money that is necessary to solve this issue.

When Pete Dougherty from the VA comes up, he is offering $4 billion. I want you to solve this problem in a year. Okay?

Thank you all again for what you do.

And, we will now have the VA Director come forward.

Pete, there are not a lot of people who come up from the VA where everybody says they love you—we heard at least one testimony. I did not ask the other three. I did not want to get you in trouble. But you are well known around the Nation.

I took from this second panel that you have your finger in a whole lot of things that are successful. And I think that is a testament to you and what you are doing. So we appreciate you being here today.

STATEMENT OF PETER H. DOUGHERTY, DIRECTOR, HOMELESS VETERANS PROGRAMS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. DOUGHERTY. Thank you, Mr. Chairman.

I probably should say that I learned all those good traits by being a staff member of the House Veterans' Affairs Committee many years ago.

It is my pleasure to be with you today. I appreciate the opportunity to come and to testify on behalf of the Department's programs and services that are helping homeless veterans.

VA, as you know, is the Nation's largest single healthcare provider and we provide healthcare to more than 100,000 homeless veterans each year. We are making unprecedented strides to expand current and to create new partnerships in service with others.

We aggressively reach out and engage veterans in shelters, in soup kitchens, on streets, and under the bridges. We connect them with a complement of VA healthcare and benefits assistance.

Our objective is to help these veterans receive coordinated care with VA benefits which in turn further enhances their opportunity to live independently and to gain gainful employment. Thousands of these veterans are returning to independent living each year.

With your support, we have continued to make significant investments in provisions of services to homeless veterans. This year, we expect to spend over $2 billion in both veterans, homeless veterans' specific programs and healthcare services for veterans who are homeless.

VA under the Veterans Benefits Administration has expedited over 21,000 claims from homeless veterans and, therefore, given thousands of veterans an income support and other eligibilities they may not otherwise have.

We believe the best strategy to prevent homelessness is early intervention. Veterans returning from the present conflict in Iraq and Afghanistan have 5 years of eligibility for healthcare. We believe this eligibility policy allows our clinical staff to identify additional health problems that may, if left untreated, contribute to future homelessness.

During the past 3 years, 556 veterans who served in Iraq and Afghanistan have been seen and served in residential treatment programs that we either run and operate or are run in partnership with us such as the panels that you have had here earlier today. Our best option is to reach these veterans early and to serve them early.

Last year, we had over 9,000 people attend our community homeless assessment meetings across the country. We host those meetings at every VA medical center. They are called our challenge meetings. Those meetings help us to identify the met and unmet needs of homeless veterans. It also is one of the things that we use to get an estimate of the number of homeless veterans. Our 2007 report estimated the number of homeless veterans is going down. It is down to 154,000. That is a reduction, but we do not claim any great success. We are confident that our continued efforts will achieve our goal of ending chronic homelessness among veterans.

It has been mentioned here, and I want to give you an update about what is going on with HUD–VASH. Last December, this Congress appropriated funds to HUD that will create more than 10,000 units of dedicated vouchers for permanent housing under the Housing Voucher Choice Program for homeless veterans and family members with a requirement that VA provide dedicated case managers to those veterans.

We are currently working with our colleagues at HUD and expect that thousands of veterans will be able to move into that housing as early as this summer. We have already started the process to hire 290 case managers.

The Administration's proposed budget for the Department of Housing and Urban Development also includes 75 million which is estimated to create nearly an additional 10,000 next year. If that occurs, obviously VA will need to hire additional case managers.

You have mentioned Stand Downs and obviously you and I have both been to Stand Downs. Since San Diego started the Stand Down concept, VA has participated in over 2,000 of those events. Last year, we recorded participation in 143 events. More than 30,500 veterans and family members aided by over 18,000 volunteers participated.

VA has provided funding to more than 500 organizations to support the more than 9,000 operational beds in place today and ramping up to about 14,000 transitional housing beds. We have funded 23 service centers and more than 200 vans for transportation.

The Notice of Funding Availability (NOFA) that is out and closes today, we expect will add several thousand additional Grant Per Diem beds. We expect to award funding by late summer.

We have awarded technical assistance grants, homeless special needs funding. We have expanded our residential treatment programs, our domiciliary and other programs, and we have worked very diligently with the Multi-Family Housing Loan Guaranty Program.

As was mentioned earlier, we have been participating with the Department of Labor on the Incarcerated Veterans Transition Program. And although it was a pilot, we have testified previously that we wish the Congress would extend that program because we estimate that nearly 40 to 45 percent of all veterans we see in homeless programs have previously been incarcerated.

We appreciate the assistance of the Congress that you have given us and aiding us in this noble endeavor.

Mr. Chairman, that would conclude my statement as such and I would be more than happy to answer questions.

[The prepared statement of Mr. Dougherty appears on p. 95.]

The CHAIRMAN. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you.

Some of the previous witnesses this morning discussed the need for permanent supportive housing. Do you agree that we should have this particular type of housing, and are there any plans, ideas, or recommendations that the VA has about developing permanent supportive housing for homeless vets?

Mr. DOUGHERTY. This initiative really began at the end of the first President Bush Administration. It was an initiation by Secretary Kemp of HUD at the time and the Director of Mental Health Services for VA.

The idea was that many veterans, particularly those who have physical disabling conditions, long-term chronic mental illness, and other problems, the best thing we could do to them is to give them that safe environment in which to live without worrying about when they had to get out or where they were going next. They could address the physical and mental healthcare needs that they have.

Our colleagues at the Department of Housing and Urban Development tell us that their Government Performance and Results Act (GPRA) performance requirement for that type of program is that people in that housing stay at about 74 percent. The veterans that

we have had in that program, in that pilot that continues, about 1,500 units today stay at a rate of about 94 percent.

We have testified before and written reports on it before. We consider it one of the most successful programs that we have.

In the new initiative, that is most helpful is that we will have an ability to target who will get this housing because you all put it in the law. That really is going to allow us to take not only that chronically homeless veteran, but also to give options and to provide services for veterans and their family members who need that kind of housing. We find many veterans do not come in and seek services from us if they still have a family.

They are concerned about what is happening to my spouse or my child if I go into the VA healthcare system. This will give them a safe, stable place in which to stay. Many of the programs that we work with can work effectively as an outpatient program.

It also will give us an opportunity to work with those veterans who are coming back from Iraq and Afghanistan who need some assistance as has been outlined as well.

Ms. BROWN-WAITE. My last question relates to whether or not the VA participates in HUD's Homeless Management and Information System and, if not, why not, and have you taken any steps to become involved in this program?

Mr. DOUGHERTY. We do in some ways. Obviously, as you know, we have great restrictions as to providing information about veterans and their healthcare services. We are working with HUD all the time on trying to give aggregate information as opposed to specific information.

Most continuums work where if you and Mr. Filner had two different programs in the same city that you would have the ability to access the information about people in his program and he people in your program so that if you were providing some support services and he was providing some other support services, you would know whether people are coming and going.

In VA's case, we have a great deal of difficulty sharing that kind of level of information. One of the things we do appreciate is the Department of Housing and Urban Development has asked their continuums of care to collect data sources so we can help identify the number of veterans who are being seen.

And what that does for us is—New York City is a good example. New York says if you are coming into the New York City system, what you have to do is if you identify yourself as a veteran, they give that information to the VA. And what that does for our folks is if we have 40 veterans, for example, who are living in a place, in a shelter, if you will, that gives us the opportunity to reach out to them, to give benefits assistance to them, and to get better placement.

We are working with them, but, no, we are not fully engaged in the HMIS System.

Ms. BROWN-WAITE. Could there not be a waiver that the veteran signs?

Mr. DOUGHERTY. Those are the kinds of things that we are working on, but waivers as we understand it, are only as good as the day I wrote the waiver. So if I gave you a waiver today, it might not be applicable tomorrow. And I can restrict what I may give in

the waiver process as well. So I may want to share some information, but not others.

Ms. BROWN-WAITE. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Let me give you some frank reaction to your testimony. The problem looks to me to be quite immense.

I know what San Diego—I happened to be involved in the Veterans Village from the time I was on the City Council in San Diego. These guys have worked themselves, and in fact, the previous Director, almost to death year after year after year. They found money and they now have a few million dollars. They are serving 100, 200 veterans. I mean, they worked to the bone and they finally have millions of dollars. And, again, they are serving a few hundred.

So to serve whatever the number is, and, I am not sure we have a handle on it, but let us say a couple hundred thousand veterans, you need billions of dollars. So we are not solving the problem. We are not ending the issue.

And we know how much good you have done, but I wish one time somebody from the VA would come and testify and say here is what we need and here is what I would do with this much money. Let us help you do this job.

You know, everybody is doing such a wonderful job and, yet, I go out every couple of weeks to downtown San Diego, to the ballpark, to some of the shelters, and I can find dozens of veterans in a few minutes whose story rends your heart. We need to get these folks in for some help.

So I want to know what you need, what would you do, what can you not do? Is it just money? Is it local participation in a different way? Is it a commitment from all of your medical facilities? I mean, what do you need to do your job better?

Mr. DOUGHERTY. Well, I think one of the things, Mr. Chairman——

The CHAIRMAN. What would you do? What would you do with more money?

Mr. DOUGHERTY [continuing]. Is we have a Grant and Per Diem Program for homeless service. We have a figure of $130 million as the authorized level. The Appropriations Committee appropriated $130 million and we will spend $130 million on that program this year.

I think that was a ceiling to make us reach higher and has now been hit. So what we need if we are going to continue to move forward with that program is to break the ceiling that now exists for us.

We need to have either an increased level of authorization for appropriation or we need to simply have a floor to spend at least $130 million so we can spend as much as we need after that. That is one thing very specifically you could do to be helpful.

The other is that we do recognize both in the law, we referenced the fact about ending chronic homelessness. Now, we define chronic homelessness as a person who has been homeless for a year or more or who has had four or more times of homelessness over the past 3 years.

We are not as prepared and not as well versed in doing more for homeless prevention. I certainly think that having some specific authority to do more homeless prevention would help.

You mentioned the fact that if somebody comes in, we are trying to work very closely that we do not turn anybody who comes into us out on to the street, that we want to make sure they have a good place to go until they can get placement if they need placement or will accept placement.

But we are limited at this point in what we can do in that arena. Having more homeless prevention authority would be helpful to us as well.

I think beyond that, Mr. Chairman, the HUD–VASH Program, will help answer the need for permanent housing. I believe the last challenge report we had from community sources said we need 27,000 units of permanent housing in order to help meet the need as defined it for us.

If we get this year's amount and next year's proposed amount, we will obviously go very significantly toward that goal. The 11,000 number that was used was for transitional housing. With what we have added to that now, if you use that figure, we are probably still three or four thousand away from where we need to be.

We have thousands of units that we have approved that have not become operational. But obviously additional transitional housing in places is a significant need for us as well.

The CHAIRMAN. Okay. We are going to continue to discuss this issue. I appreciate all the witnesses here today. Some of the stories you have told help us and recommit us to this issue that is one that just breaks your heart, when you are talking to people.

And as a Nation, we can do a better job. I mean, the richest Nation in the history of the world does not need to have homeless people in our society.

I thank you all for what you are doing.

And all these people spoke to grants that they get from you. How much is the grant program that they are generally referring to?

Mr. DOUGHERTY. How much is the grant program under Grant Per Diem?

The CHAIRMAN. How much money are you giving out in these grants?

Mr. DOUGHERTY. Last year, I think our budget figure; we spent $107 million in payments under the Grant and Per Diem Program.

The CHAIRMAN. I mean, there are people all over the country who want to help, who have the ability to help, who have the creativity and the energy. And we have to let them do it. So I think we should significantly increase that amount of money.

Thank you all. This hearing is adjourned.

[Whereupon, at 12:25 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs

Good morning and welcome to the House Veterans' Affairs Committee hearing on the effectiveness of VA's homeless programs.

Last month, VA announced a 21 percent decrease in the homeless veteran population from more than 195,000 to about 154,000.

Research tells us that veterans are over represented in the homeless population. VA is the largest single provider of homeless services reaching about 25 percent of that population.

VA operates a wide variety of homeless veterans programs designed to provide outreach, supportive services, health care as well as counseling and treatment for mental health and substance use disorders. They rely heavily on their partnerships with the community and faith based organizations to provide these services.

According to *Health Care for Homeless Veterans Programs: The Nineteenth Annual Report,* March 31, 2006, VA's homeless population demographics are:

- 52 percent had a serious psychiatric problem defined as psychosis, mood disorder or PTSD.
- 68 percent, or two-thirds, were dependent on alcohol and/or drugs.
- 38 percent, or over one-third, were dually diagnosed with serious psychiatric and substance abuse problems.
- 57 percent, or over half, suffered from a serious medical problem.
- The number of homeless women veterans is rising.

Prior to becoming homeless, a large number of veterans at risk have struggled with PTSD or have addictions acquired during, or worsened by, their military service. These conditions can interrupt their ability to keep a job, establish savings, and in some cases, maintain family harmony.

Veterans' family, social, and professional networks may have been broken due to extensive mobility while in service or lengthy periods away from their hometowns and their civilian jobs. These problems are directly traceable to their experience in military service or to their return to civilian society without having had appropriate transitional supports.

VA reports that approximately 1,500 homeless veterans are from OEF/OIF. This is a growing population. It took roughly a decade for the lives of Vietnam veterans to unravel to the point that they started showing up among the homeless.

Concern has been expressed by many that such an early showing of OEF/OIF veterans in the homeless population does not bode well. It is also believed that the intense repeated deployments leave newer veterans particularly vulnerable.

We must do a better job of focusing on preventing homelessness, as well as ending it. This Committee must ensure that the current programs VA has implemented to end homelessness continue to be effective as well as adaptable to the newest generation's needs.

The time to act is now. We cannot afford to let history repeat itself.

Prepared Statement of Hon. Stephanie Herseth Sandlin, a Representative in Congress from the State of South Dakota

Chairman Filner and Ranking Member Buyer, thank you for holding this hearing to examine the effectiveness of the Department of Veterans Affairs homelessness programs.

Like all of my colleagues, I am troubled by the large number of veterans that are homeless. While I am thankful for the decline, during the past year, in the number

of veterans homeless on a typical night, more must be done. For example, I believe we must also focus on efforts to help prevent veterans from *becoming* homeless.

As you may know, I introduced the *Services To Prevent Veterans Homelessness Act* in May 2007 to authorize the Secretary of Veterans Affairs to provide financial assistance to nonprofit organizations and consumer cooperatives to provide and coordinate the provision of supportive services that addresses the needs of very low-income veterans occupying permanent housing.

I would like to thank Health Subcommittee Chairman Michaud and Ranking Member Miller for including the *Services to Prevent Veterans Homelessness Act in the Veterans' Health Care Improvement Act,* which passed the full House of Representatives in July 2007. I believe this legislation will go a long ways toward helping prevent more veterans from becoming homeless.

Thank you again to all of our witnesses for being here. I look forward to continuing to work with the Committee to examine the effectiveness of the Department of Veteran Affairs homeless programs and to support efforts to meet the housing assistance needs of our Nation's low-income veterans.

Prepared Statement of Hon. Henry E. Brown, Jr., a Representative in Congress from the State of South Carolina

Thank you to all the witnesses who are here today, I look forward to hearing your testimony and I would like to also thank the Chairman and Ranking Member for holding this hearing. One of my greatest passions is correcting the problem of homelessness among veterans and I appreciate this opportunity to discuss this important topic.

Though it is difficult to get an exact count, it is estimated that on any given night, over 150,000 veterans are homeless in this country. In my home State of South Carolina, we believe there are as many as 1400 homeless veterans. While that number has been going down in recent years, it is still far too high.

We don't always know why veterans become homeless, but we do know that veterans are overrepresented in the homeless population, studies suggest that 30–40% of all homeless are veterans. We also know that homeless veterans suffer from mental illness, substance abuse and other health problems at a higher rate than non-veterans. I am proud of the work we have been doing as a committee and as a Congress to combat this problem, but there is still a good deal of work to be done. We must continue to work with HUD to provide adequate housing and critical support services that address substance abuse problems many homeless veterans have. I hope that through discussions like this we can find the solutions to not only continue to reduce the number of current homeless veterans, but also prevent the soldiers serving in the current conflicts from becoming homeless.

I thank you again for being here, I look forward to your testimony and I yield back the balance of my time.

Prepared Statement of Hon. Joe Donnelly, a Representative in Congress from the State of Indiana

Mr. Chairman and fellow members of the House Veterans' Affairs Committee. The topic of homeless veterans is one that is truly a national tragedy and should be treated with the utmost urgency. While we have made great strides in recent years to reduce the number of homeless veterans, with a 21 percent drop just in the last year, we still have a long way to go. Having over 150,000 homeless veterans on any given night, and over 300,000 veterans experience homelessness at some point in 2007 is just not acceptable, and we should not rest until that number comes down to zero.

Additionally, it is clear that there is a systemic problem when military veterans comprise anywhere from 25 to 40 percent of the total homeless population. Therefore, in addition to programs for supporting veterans once they show up at our shelters, we must take steps to ensure that our brave men and women are not put in a situation where they have to show up at these shelters in the first place.

It is particularly disturbing that, according to VA statistics, there are already an estimated 1,500 OEF/OIF veterans showing up at homeless shelters. This is unprecedented and an alarming signal for future veteran homeless trends. It took about a decade for Vietnam veterans to start showing up among the homeless—we should not and cannot accept that, with all our 21st Century capabilities and resources, our returning veterans may be doing worse finding and staying in a home than return-

ing veterans in the 1970s. We must get to the root of the problem and address it before these numbers grow any further.

The VA has also identified veterans with PTSD as a large group of at-risk veterans. With this knowledge, we must work to ensure that we provide them with additional transitional resources and counseling to avoid their ending up among the homeless.

I look forward to working with Chairman Filner and members of this committee to continue to make strides toward ending homelessness of veterans of any era and offering a greater array of assistance programs in helping them find jobs and permanent housing. Our brave men and women are willing to make the ultimate sacrifice for their country, and as their hometown representatives, we owe them our greatest effort to help them get their lives back on track.

Prepared Statement of Hon. Timothy J. Walz, a Representative in Congress from the State of Minnesota

Mr. Chairman, Ranking Member Buyer, members of the committee, thank you for the opportunity to speak. And thank you to the witnesses who are here today.

As a 24-year veteran of the Army National Guard and the highest ranking enlisted man in Congress, I know that taking care of our active duty forces and our veterans is one of the most important issues facing this country and this Congress today. Making sure we can work toward eliminating homelessness among our veterans, and preventing a new generation of homeless veterans from emerging, is incredibly important. While we have made advances, I am concerned that we are not doing enough on either front.

It is unacceptable that in the United States today that there is a single homeless veteran. The number of veterans who are homeless appears to have dropped somewhat recently, and that would be a very good thing. VA reports that on any given day in 2007 there were about 154,000 homeless veterans, down from about 194,000 in 2006 and down even more from earlier years. But veterans are still over-represented among the Nation's homeless population. And there are troubling signs that veterans of our current conflicts may already be showing up homeless early. I am encouraged that some of the programs we have in place have been successful and efficient in serving homeless veterans and supporting providers of care to them. But at the same time I am concerned that some of those successful programs may not be getting the funding they deserve. The main question I have is how we can build on that success to reduce—ultimately to zero—the number of veterans who are homeless.

I look forward to hearing from the witnesses today and to working with the members of this committee, the Congress and the VA to ensure that we succeed at eliminating homelessness among our veterans.

Prepared Statement of John Driscoll, Vice President for Operations and Programs, National Coalition for Homeless Veterans

Chairman Filner, Ranking Member Mr. Buyer, and Distinguished Members of the Committee:

The National Coalition for Homeless Veterans (NCHV) is honored to participate in this hearing to discuss the programs in place to help America's homeless veterans, to consider how they may be improved, and to offer insights on what we believe is a historic opportunity to capitalize on our collective successes to focus on and develop strategies that will prevent homelessness among the next generation of America's veterans.

This Committee knows all too well that the cost of our freedom and prosperity necessarily includes tending to the wounds of the veterans who sacrifice some measure of their lives to preserve it. That we have been invited to offer testimony on these issues is, in itself, a testament to the leadership and devotion of this Committee to serve all veterans—including those who otherwise would have no hope of sharing in the peace and prosperity of the society they served to protect.

We therefore begin our testimony by expressing our sincere gratitude for the commendable legacy this Committee has forged in the campaign to end and prevent homelessness among this Nation's military veterans. For two decades you have engaged in a noble cause few others have even wanted to acknowledge. You have asked the tough questions, demanded accountability, and you have shouldered the

burden before Congress and delivered on your promise—and for all that you stand first among those who made possible the successes we celebrate today.

The homeless veteran assistance movement NCHV represents began in earnest in 1990, but like a locomotive it took time to build the momentum that has turned the battle in our favor. In partnership with the Departments of Veterans Affairs (VA), Labor, and Housing and Urban Development (HUD)—supported by the funding measures this Committee has championed—our community veteran service providers have helped reduce the number of homeless veterans on any given night in America by 38% in the last six years.

This assessment is not based on the biases of advocates and service providers, but by the Federal agencies charged with identifying and addressing the needs of the Nation's most vulnerable citizens.

To its credit, the VA has presented to Congress an annual estimate of the number of homeless veterans every year since 1994. It is called the CHALENG project, which stands for Community Homelessness Assessment, and Local Education Networking Groups. In 2003 the VA CHALENG report estimate of the number of homeless veterans on any given day stood at more than 314,000; in 2006 that number had dropped to about 194,000. We have been advised the estimate in the soon-to-be published 2007 CHALENG Report shows a continued decline, to about 154,000.

Part of that reduction can be attributed to better data collection and efforts to avoid multiple counts of homeless clients who receive assistance from more than one service provider in a given service area. But in testimony before the House Committee on Veterans' Affairs in the summer of 2005, VA officials affirmed that the number of homeless veterans was on the decline, and credited the agency's partnership with community-based and faith-based organizations for making that downturn possible.

Though estimates are not as reliable as comprehensive "point-in-time" counts, the positive trends noted in the CHALENG reports since 2003 are impressive. The number of contacts reporting data included in the assessments are increasing, while the number of identified and estimated homeless veterans is decreasing.

Other Federal assessments of veteran homelessness that support our testimony are found in HUD's 2007 "Annual Homelessness Assessment Report" (AHAR)—which reported that 18% of clients in HUD-funded homeless assistance programs are veterans—and the 2000 U.S. Census, which reported about 1.5 million veteran families are living below the Federal poverty level. Earlier this year, the National Alliance to End Homelessness (NAEH) published a report, based on information from these resources, that estimated approximately 46,000 veterans meet the criteria to be considered as "chronically homeless."

Homeless Veteran Assistance Programs

There are only two non-government veteran-specific homeless assistance programs serving the men and women who represent nearly a quarter of the Nation's homeless population. The over-representation of veterans among the homeless that is well documented and continues to this day is the result of several influences, most notably limited resources in communities with a heavy demand for assistance by single parents and families with dependent children, the elderly and the disabled.

The Department of Labor Homeless Veterans Reintegration program (HVRP) and the VA Homeless Providers Grant and Per Diem were created in the late 1980s to provide access to services for veterans who were unable to access local, federally funded, "mainstream" homeless assistance programs.

These programs are largely responsible for the downturn in veteran homelessness reported during the last six years, and must be advanced as essential components in any national strategy to prevent future veteran homelessness. We will touch on each separately, and briefly comment on how each may be enhanced.

Homeless Providers Grant and Per Diem Program (GPD)

Despite significant challenges and budgetary strains, the VA has quadrupled the capacity of community-based service providers to serve veterans in crisis since 2002, a noteworthy and commendable expansion that includes, at its very core, access to transitional housing, healthcare, mental health services and suicide prevention.

GPD is the foundation of the VA and community partnership, and currently funds nearly 10,000 service beds in non-VA facilities in every state. Under this program veterans receive a multitude of services that include housing, access to healthcare and dental services, substance abuse and mental health supports, personal and family counseling, education and employment assistance, and access to legal aid.

The purpose of the program is to provide the supportive services necessary to help homeless veterans achieve self sufficiency to the highest degree possible. Clients are eligible for this assistance for up to two years. Most veterans are able to move out

of the program before the two-year threshold; some will need supportive housing long after they complete the eligibility period. Client progress and participant outcomes must be reported to the VA GPD office quarterly, and all programs are required to conduct financial and performance audits annually.

In September 2007, despite the commendable growth and success of this program and its role in reducing the incidence of veteran homelessness, the GAO reported that the VA needs an additional 9,600 beds to adequately address the current need for assistance by the homeless veteran population. That finding was based on information provided by the VA, the GAO's in-depth review of the GPD program, and interviews with service providers. The VA concurred with the GAO findings.

Recommendations

1. Increase the annual appropriation of the GPD program to $200 million—The projected $137 million in the president's FY 2009 budget request will allow for expansion of the GPD program, but not nearly to the extent called for in the GAO report. While some VA officials may be concerned about the administrative capacity to handle such a large infusion of funds into the program, we believe the documented need to do so should drive the debate on this issue.

In 2006, the VA created the position of GPD Liaisons at each medical center to provide additional administrative support for the GPD office and grantees. The VA published a comprehensive program guide to better instruct grantees on funding and grant compliance issues, and expects to provide more intense training of GPD Liaisons. This represents a considerable and continual investment in the administrative oversight of the program that should translate into increased capacity to serve veterans in crisis.

Additional funding would increase the number of operational beds in the program, but under current law it could also enhance the level of other services that have been limited due to budget constraints. GPD funding for homeless veteran service centers—which has not been available in recent grant competitions—could be increased. These drop-in centers provide food, hygienic necessities, informal social supports and access to assistance that would otherwise be unavailable to men and women not yet ready to enter a residential program. They also could serve as the initial gateway for veterans in crisis who are threatened with homelessness or dealing with issues that may result in homelessness if not resolved. For OIF/OEF veterans in particular, this is a critical opportunity to prevent future veteran homelessness.

Additional funding could also be used under current law to increase the number of special needs grants awarded under the GPD program. The program awards these grants to reflect the changing demographics of the homeless veteran population. One grant targets women veterans, including those with dependent children—the fasted growing segment of the homeless veteran population. Women now account for more than 14% of the forces deployed to Iraq and Afghanistan, yet there are only eight GPD programs receiving special needs grants for women in the country.

Other focuses include the frail elderly, increasingly important to serve aging Vietnam-era veterans—still the largest subgroup of homeless veterans; veterans who are terminally ill; and veterans with chronic mental illness. These grants provide transitional housing and supports for veteran clients as organizations work to find longer term supportive housing options in their communities.

2. Change the mechanism for determining "per diem" allowances—Under the GPD program, service providers are reimbursed for the expenses they incur for serving homeless veterans on a formula based on the rate of reimbursement provided to state veterans homes, and those rates are then reduced based on the amount of funding received from other Federal sources. The current ceiling is about $33.00 per veteran per day.

This payment system is outdated for two reasons. The first is the difference in the cost of custodial care and the cost of comprehensive services that help individuals rebuild their lives. Whether provided on site or through contracts with partner agencies, the latter requires the intervention of highly trained professionals and intense case management. Revisions in the reimbursement formula should reflect the actual cost of services—based on each grantee's demonstrated capacity to provide those that are deemed critical to the success of the GPD program and veteran clients—rather than a flat rate based on custodial care.

The second reason is less obvious but equally important. Discounting the amount of an organization's "per diem" rate due to funding from other Federal agencies contradicts the fundamental intent of the GPD program and undermines the ability of organizations to provide the wide range of services these veterans need. In order to successfully compete for GPD funding, applicants must demonstrate they can pro-

vide a wide range of supportive services in addition to the transitional housing they offer. They should not be penalized for obtaining funds to enhance the services they are able to provide, regardless of the source of that funding.

Homeless Veterans Reintegration Program

HVRP is a grant program that awards funding to government agencies, private service agencies and community-based nonprofits that provide employment preparation and placement assistance to homeless veterans. It is the only Federal employment assistance program targeted to this special needs population. The grants are competitive, which means applicants must qualify for funding based on their proven record of success at helping clients with significant barriers to employment to enter the workforce and to remain employed. In September 2007 this program was judged by the Government Accountability Office (GAO) as one of the most successful and efficient programs in the Department of Labor portfolio.

HVRP is unique and so highly successful because it doesn't fund employment services per se, rather it rewards organizations that guarantee job placement. Administered by the Veterans Employment and Training Service (VETS), the program is responsible for placing a range of 14,000 to 16,000 veterans with considerable challenges into gainful employment each year at a cost of about $1,500 per client. Those numbers meet or exceed the results produced by most other Department of Labor programs.

Recommendation—The HVRP program is authorized at $50 million through FY 2009, yet the annual appropriation has been less than half that amount. For FY 2009, the proposed funding for the program is $25.6 million. We would ask this Committee to prevail upon appropriators—to the extent possible—to fully fund this program. We believe the proven success and efficiency of HVRP warrants this consideration, and that DoL–VETS has the administrative capacity, will and desire to expand the program. We also urge the Committee to ensure reauthorization of the program FY 2009. Employment is the key to transition from homelessness to self sufficiency—this program is critical to the campaign to end and prevent veteran homelessness.

Addressing Prevention of Veteran Homelessness

The reduction in the number of homeless veterans on the streets of America each night proves that the partnership of Federal agencies and community organizations—with the leadership and oversight of Congress—has succeeded in building an intervention network that is effective and efficient. That network must continue its work for the foreseeable future, but its impact is commendable and offers hope that we can, indeed, triumph in the campaign to end veteran homelessness.

However, the lessons we have learned and the knowledge we have gained during the last two decades must also guide our Nation's leaders and policy makers in their efforts to prevent future homelessness among veterans who are still at risk due to health and economic pressures, and the newest generation of combat veterans returning from Operations Iraqi Freedom and Enduring Freedom.

Again, NCHV bases its recommendations in this regard to the published findings of the Federal agencies already mentioned.

The lack of affordable permanent housing is cited as the No. 1 unmet need of America's veterans, according to the VA CHALENG report. We commend the work of HUD and VA to make up to 10,000 HUD–VA supportive housing (HUD–VASH) vouchers available to veterans with chronic health and disability challenges in FY 2008, and possibly another increase in equal measure in FY 2009. This is a historic and heroic achievement, and again we commend this committee for its leadership on this issue.

The affordable housing crisis, however, extends far beyond the realm of the VA system and its community partners. Once veterans successfully complete their GPD programs, many formerly homeless veterans still cannot afford fair market rents, nor will most of them qualify for mortgages even with the VA home loan guarantee. They are, essentially, still at risk of homelessness. With another 1.5 million veteran families living below the Federal poverty level (2000 U.S. Census), this is an issue that requires immediate attention and proactive engagement.

NCHV believes the issue of affordable permanent housing for veterans must be addressed on two levels—those veterans who need supportive services beyond the two-year eligibility for GPD; and those who are cost-burdened by fair market rents in their communities.

Veterans who graduate from GPD programs often need supportive services while they continue to build toward economic stability and social reintegration into mainstream society. Those who will need permanent supportive housing—the chronically mentally ill, those with functional disabilities, families impacted by poverty—may

be served by the HUD–VASH program. But the majority of GPD graduates need access to affordable housing with some level of follow-up services for up to two to three years to ensure their success.

Many community-based organizations are already providing that kind of "bridge housing," but resources for this purpose are scarce. NCHV supports two initiatives that would address this issue.

The first is a measure to provide grants to government and community agencies to provide services to low-income veterans in permanent housing. Funds would be used to provide continuing case management, counseling, job training, transportation and child care needs. This is the intent of House bill H.R. 2874, the **"Veterans Health Care Improvement Act."**

The second measure would make funds available to government agencies, community organizations and developers to increase the availability of affordable housing units for low-income veterans and their families. The **"Homes for Heroes Act"**—introduced in both the House (H.R. 3329) and Senate (S. 1084)—addresses this issue and NCHV has worked with staff in both houses in recognition and support of Congressional action on this historic veteran homelessness prevention initiative.

With respect to implementing a homelessness preventive strategy targeted to veterans returning from OIF/OEF, NCHV believes the first line of engagement is a strong **partnership between the VA and community health centers** in areas underserved by the Veterans Health Administration. While current practice allows a veteran to access services at non-VA facilities, the process is often frustrating and problematic, particularly for a veteran in crisis. Protocols should be developed to allow VA and community clinics to process a veteran's request for assistance directly and immediately without requiring the patient to first go to a VA medical facility.

Beyond that, we believe that VA Readjustment Counseling Centers, known as VA Centers, must serve as the clearinghouse for information that steers combat veterans in crisis to appropriate assistance in their communities, not just to VA services. Housing assistance referrals, financial counseling, access to legal aid, family counseling, identifying educational and employment opportunities—all of these are critical in any campaign to prevent homelessness. We know that is the goal of VA Centers, but some serve better than others. This is where the battle to prevent homelessness among OIF/OEF veterans will be won, and we encourage the VA and Congress to ensure adequate funding and training to guarantee their success.

In Summation:

The homeless veteran assistance movement is now 20 years old, but most of the historic achievements of the broad coalition now engaged in the campaign to end veteran homelessness have occurred in just the last six years. The partnership between the VA, Department of Labor, and the community-based organizations we represent has exceeded the most ambitious expectations of our founders, many of whom are still serving military veterans in crisis.

With the leadership of this Committee, we have developed a national network of programs and service providers that saves lives and offers hope to hundreds of thousands of veterans each year. We know what works, and you have provided us with the means to guide these deserving men and women to a future of promise and opportunity.

NCHV believes it is now time to take the next step in the campaign to end veteran homelessness. Developing a strategy that addresses the health and economic challenges of OIF/OEF veterans—before they are threatened with homelessness—should be a national priority. Never before in U.S. history has this Nation, during a time of war, concerned itself with preventing veteran homelessness. For all our collective accomplishments, this may yet be our finest moment.

COMMUNITY HOMELESSNESS ASSESSMENT, LOCAL EDUCATION AND NETWORKING GROUP (CHALENG) FOR VETERANS

THE FOURTEENTH ANNUAL PROGRESS REPORT ON PUBLIC LAW 105–114, SERVICES FOR HOMELESS VETERANS ASSESSMENT AND COORDINATION
February 28, 2008

John H. Kuhn, LCSW, MPH, National CHALENG Coordinator, VA New Jersey Health Care System, Lyons, NJ

John Nakashima, Ph.D., Program Analyst, Community Care, West Los Angeles Medical Center, Los Angeles, CA

ACKNOWLEDGEMENTS

The CHALENG for Veterans project continues to be successful because of the work done by each of the CHALENG points of contact (POCs) who are listed in Appendix 8. The dedication of VA staffs and their community counterparts are often the difference between life and death for the homeless veterans found on our city streets and country back roads. Their tireless efforts to improve the lives of our veterans often go unrecognized and unappreciated. To each of these marvelous, caring, gentle, and hardworking persons, we say THANK YOU!

We would like to thank Paul Smits, the Associate Chief Consultant, Homeless and Residential Rehabilitation and Treatment Services, for his assistance in the preparation of this report, and his leadership in addressing the health care needs of homeless veterans. We thank Peter Dougherty, Director of Homeless Programs Office for VA, for his endless dedication to the care of our Nation's homeless veterans. Paul and Pete's support, feedback and guidance to Project CHALENG are immeasurable.

We would like to also thank Dr. Robert Rosenheck, Director of the Northeast Program Evaluation Center (NEPEC) at the VA Connecticut Healthcare System, West Haven, Connecticut, who provides valuable consultation to the CHALENG process. Aiki Atkinson, Research Assistant, scanned in and proofed over 9,000 CHALENG Participant Surveys for this report. Janice Gibson, Homeless Veteran Analyst, located at the VA Medical Center, Perry Point, Maryland, provided final document preparation for printing. Chelsea Watson, Program Specialist from VA's Homeless Providers Grant and Per Diem Program, provided technical assistance in the creation and maintenance of the CHALENG Web site which posts the most recent CHALENG report. Rhonda Simmons, Administrative Assistant for Project CHALENG, provided immeasurable support to the coordinator and to the entire CHALENG process. Thanks to all these people who make this process work so well.

Finally, a special thanks to Dr. Jim McGuire who since 1997 was the lead CHALENG evaluator and researcher. Jim was instrumental in developing the current methodology and format for the annual CHALENG report. He set a high standard for us all.

John Kuhn
John Nakashima
February 28, 2008

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Appendices [will be retained in the Committee files.]

Appendix 1: 2007 CHALENG Needs Score by VA Facility—Provider (VA and Community) Assessment

Appendix 2: 2007 CHALENG Needs Score by VA Facility—Consumer (Homeless Veteran) Assessment

Appendix 3: 2007 CHALENG Needs Score by Network

Appendix 4: 2007 CHALENG Integration/Implementation Scores by VA Facility—Community Providers Assessment

Appendix 5: FY 2007 Estimated Number of Homeless Veterans and Information Sources by VISN and VA—POC Site Assessment

Appendix 6: VA Community Initiatives: Status of FY 2007 Action Plans Addressing Homeless Veterans Needs

Appendix 7: Agencies Recognized for Assisting in Implementing FY 2007 Action Plans

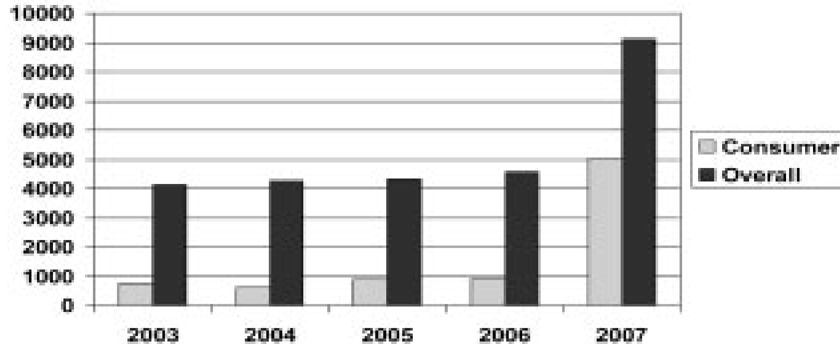
Appendix 8: Points of Contact by VISN

Fiscal Year (FY) 2007 Community Homelessness Assessment, Local Education and Networking Groups for Veterans (CHALENG) Report

Executive Summary

Since 1993, the Department of Veterans Affairs (VA) has collaborated with local communities across the United States in Project CHALENG for Veterans. The vision of CHALENG is to bring together consumers, providers, advocates, local officials and other concerned citizens to identify the needs of homeless veterans and then work to meet those needs through planning and cooperative action.

As in previous years, data collected during the FY 2007 CHALENG process are from questionnaires completed by VA staff, community providers, and homeless veterans. However, this year's CHALENG introduced a consumer specific survey. This effort is designed to empower consumers as active participants in the design and delivery of homeless services. Their involvement is consistent with the VA's recovery oriented approach to the delivery of mental health services. Judging by the level of participation in this year's CHALENG process, this change has been greeted enthusiastically. The following are highlights of the FY 2007 CHALENG report:



- *Participation was excellent.*
  - There were 9,132 respondents to the FY 2007 Participant Survey, a 99 percent increase from the previous year, which had a total of 4,578 participants.
  - Over half (55 percent) of the 2007 participants (n=5,046) were homeless or formerly homeless veterans. Consumer involvement went from 927 participants in 2006 to 5,046 participants in 2007, a fourfold increase.
- *Need remains high.*
  - It is estimated that on any given night there are approximately 154,000 homeless veterans. This is based on point-in-time estimates reported by the CHALENG points of contact (POCs). POCs are usually local VA homeless program coordinators from around the country.
  - The number of accessible beds increased between FY 2006 and FY 2007 from 72,196 to 73,430 emergency beds; 40,599 to 47,891 transitional beds; and 31,724 to 35,941 permanent beds (these beds are often not veteran specific and are also open to the general homeless population). The estimated number of additional beds required to meet existing needs decreased for emergency and transitional housing, but increased for permanent housing.
- *VA/Community partnerships continue to yield outcomes.*
  - 87 percent of POC sites that had a nearby Department of Housing and Urban Development (HUD) Continuum of Care planning group participated in it.
  - 543 new interagency collaborative agreements between VA and community agencies were developed in FY 2007. Veterans received dental care, eye care, and mental health/substance abuse treatment as a result of these agreements.
  - 377 new outreach sites were served in FY 2007.
  - 98 POC sites (71 percent of all sites) reported seeing a total of 1,038 homeless veteran families. This was a 5-percent increase over the previous year of 989 families served.
  - Preliminary data from the VA Northeast Program Evaluation Center from FY 2005 through FY 2007 suggests that the overall rate of homelessness among

Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans is 1.8 percent (unpublished data, NEPEC). Since OEF/OIF veterans represent about three percent of the overall veterans' population, they appear to be underrepresented in the homeless veteran population. However, as CHALENG POCs have prioritized services to this group, they indicate that more outreach, housing, and services are needed to help homeless veterans who recently served in Afghanistan and Iraq.

- POCs reported on their successes with their FY 2007 action plans. Several local housing projects are increasing capacity for homeless veterans.
- CHALENG POC action plans for FY 2008 addressed priority needs such as permanent, transitional, and emergency housing, job finding, transportation, job training, re-entry services for incarcerated veterans, VA disability/pension, psychiatric services, and dental care.
- Dental care, which was cited by homeless veterans as one of the top 3 unmet needs for the past 4 years, *dropped to 12th place.* It seems reasonable to conclude that the Homeless Veterans Dental Program (HVDP), begun in 2006, has had a major impact. In FY 2007, it is estimated that HVDP provided treatment to 7,666 eligible veterans at 129 CHALENG sites.

Introduction

In 1993, VA launched Project CHALENG for Veterans. CHALENG is a program designed to enhance the continuum of services for homeless veterans provided by the local VA medical center and regional office and their surrounding community service agencies. The guiding principle behind Project CHALENG is that no single agency can provide the full spectrum of services required to help homeless veterans reach their potential as productive, self-sufficient citizens. Project CHALENG fosters coordinated services by bringing VA together with community agencies and other Federal, state, and local government programs to raise awareness of homeless veterans' needs and to plan to meet those needs. This helps improve homeless veterans' access to all types of services and eliminate duplication of efforts.

The legislation guiding this initiative is contained in Public Laws 102–405, 103–446 and 105–114. The specific legislative requirements relating to Project CHALENG are that local VA medical center and regional office directors:

- assess the needs of homeless veterans living in the area,
- make assessments in coordiNation with representatives from state and local governments, appropriate Federal departments and agencies and non-governmental community organizations that serve the homeless population,
- identify the needs of homeless veterans with a focus on healthcare, education, training, employment, shelter, counseling, and outreach,
- assess the extent to which homeless veterans' needs are being met,
- develop a list of all homeless services in the local area,
- encourage the development of coordinated services,
- take action to meet the needs of homeless veterans,
- inform homeless veterans of non-VA resources that are available in the community to meet their needs.

At the local level, VA medical centers and regional offices designate CHALENG POCs who are responsible for the above requirements. These CHALENG POCs, usually local VA homeless program coordinators, work with local agencies throughout the year to coordinate services for homeless veterans.

CHALENG was designed to be an ongoing assessment process that described the needs of homeless veterans and identifies the barriers they face to successful community re-entry. In the current report, data was compiled from 9,132 respondents including, 5,046 survey responses that were completed by homeless or formerly homeless veterans. The CHALENG process is the only ongoing comprehensive national effort to poll VA staff, community providers and consumers about the needs of homeless veterans. The results have assisted VA to identify specific interventions needed to effectively assist homeless veterans. In recent years, there have been several new VA initiatives based in part on input from CHALENG, including:

- The Homeless Veterans Dental Program (HVDP) that has greatly expanded access to care and ending dental services as a top 10 unmet need among homeless veterans.
- The Healthcare for Re-Entry Veterans Program (HCRV), that is designed to help transition former veteran inmates back into the community.
- A demonstration project to help homeless veterans obtain eyeglasses.
- Continued expansion of the VA Grant and Per Diem transitional housing program.

- A major expansion of the HUD VA Supported Housing program (HUD–VASH), which will make thousands of new permanent housing vouchers and case management services available to homeless veterans.

The annual CHALENG report is an important source of information on homeless veterans for policymakers. Copies are routinely distributed to Members of the House and Senate Veterans' Affairs Committees and Appropriation Committees. The report is also used by VA Central Office to respond to media inquiries about homeless veterans. The report helps to keep homeless veteran issues present in the minds of Federal officials and the general public.

Finally, the CHALENG process has helped build thousands of relationships with community agencies, veterans groups, law enforcement agencies, and Federal, state, and local government. Local annual CHALENG meetings, where attendees complete the Participant Survey, represent important opportunities for VA, and public and private agency representatives to meet, network, and eventually develop meaningful partnerships to better serve homeless veterans.

Results from the Annual CHALENG Survey

This *Fourteenth Annual Progress Report on Public Law 105–114* (Project CHALENG) is based on data collected from two surveys:

1. The CHALENG POC Survey:

This survey, distributed to POCs only, is a self-administered questionnaire requesting information on the needs of homeless veterans in the local service area, development of new partnerships with local agencies, and progress in creating/securing new housing and treatment for homeless veterans.

2. The CHALENG Participant Survey:

This survey is distributed by each POC at his or her local CHALENG meeting to: various Federal, state, county, city, non-profit and for-profit agency representatives that serve the homeless in the POC's local service area; local VA medical center, Vet Center, VA regional office staffs; and to homeless and formerly homeless veterans. The self-administered survey requests information on the needs of homeless veterans in the local service area, and rates VA and community provider collaboration. There are two versions of the CHALENG Participant Survey: one for VA staff and community providers, officials, and volunteers, and a new homeless veteran version for 2007. The homeless veteran version is tailored for homeless veterans and includes only those questions pertinent to consumers and omits those questions appropriate only for providers.

CHALENG Survey Respondents

CHALENG Point of Contact Survey Respondents

Point of Contact survey questionnaires were mailed to all designated CHALENG POCs. Out of 138 POC sites, 138 (100 percent) were returned.

CHALENG Participant Survey Respondents

There were 9,132 respondents for the 2007 Participant Survey, nearly double (a 99 percent increase) the 4,578 respondents in 2006. Of the 9,132 respondents, 1,331 were VA providers (staff) and 3,409 were community providers/advocates (agency staff, local officials, interested individuals), and 4,392 respondents indicated no agency affiliation (many of these respondents were homeless veterans). Twenty-one percent of community providers who represented an agency said their agency was "faith-based."

There were 4,666 Participant Survey respondents who identified themselves as homeless veterans (51 percent of all participants) and 380 participants identified themselves as formerly homeless veterans (4 percent of the total sample). Collectively, consumers (homeless and formerly homeless veterans) represented 55 percent of all Participant Survey respondents. Consumer involvement went from 927 participants in 2006 to 5,046 participants in 2007, an increase of 447 percent.

Community provider respondents were asked to designate their organizational titles in the survey (see Table 1). As in prior years, survey respondents represented a range of service functions from top-level executives and policymakers to line-level service providers.

Table 1—CHALENG Community Provider Respondent Function, FY 2007

	Community Participants (n=3,409)
Local service agency top managers (Executive Directors, Chief Executive Officers)	17%
Mid-level managers, supervisors and advocates (program coordinators, veteran service officers)	34%
Clinicians and outreach workers (social workers, case managers, nurses)	30%
Elected government officials or their representatives	1%
Board Members	2%
Other (financial officers, attorneys, office staff, planning staff, etc.)	16%

VA representation in the Participant Survey was mainly through VA Medical Centers (see Table 2 below).

Table 2—VA Providers (staff), FY 2007

VA Agency	VA Staff (n=1,331)
VA Medical Center/Healthcare System staff	75%
VA Regional Office staff	4%
Vet Center staff	8%
VA Outpatient Clinic staff	12%
VA Other (National Cemetery Administration, Central Office and VISN staff)	1%

Community provider respondents were asked how long they had been personally involved in CHALENG (see Table 3). Over one-third (35 percent) of the participants had been involved with CHALENG for at least 2 years or more. This suggests the maintenance of long-time relationships between VA and community providers.

Table 3—Years of Community Provider Involvement in CHALENG, FY 2007

Involved in CHALENG . . .	Community Participants (n=3,409)
Since first local CHALENG meeting (12 years ago)	5%
Two to eleven years ago	30%
One year ago	10%
First time today	55%

Homeless veterans who participated in CHALENG came from many different stages in their recovery process (see Table 4 below). Over one-fifth (21 percent) were literally homeless (many of these veterans were contacted in initial outreach and Stand Down events). Nearly three-quarters (72 percent) were in a transitional housing program such as the VA Domiciliary or a VA Grant and Per Diem program. Seven percent were maintaining themselves in permanent housing (e.g., apartment, single room occupancy) in the community.

Table 4—Consumer (Homeless Veteran) Status

Where Homeless Veteran CHALENG Participant is Living	Homeless Veterans (n=4,666)*
Literally Homeless (on streets, in shelter, care)	21%
In VA Domiciliary	26%
In VA Grant and Per Diem or other Transitional housing program	46%
In Permanent Housing (including Section 8 Housing)	7%

*753 of the homeless veteran participants did not indicate a residence

Many homeless veteran CHALENG participants have been chronically homeless. Over half of the veterans (53 percent) had experienced homelessness at some time in their life for over a 1-year period. Over one-third (38 percent) had suffered four episodes of homelessness in the past 3 years.

Needs of Homeless Veterans

Rankings of Needs by All Participant Survey Respondents

Participant Survey respondents were asked to rate how well pre-identified homeless veteran service needs were met in their community, using a five-point scale ranging from "Not Met" (1) to "Met" (5). Table 5 shows the results for the entire sample of respondents for 2007 (n=9,132) as well as the previous year.

Table 5—Met and Unmet Needs of Homeless Veterans (All individuals who completed 2007, 2006 CHALENG Participant Surveys)

Need of homeless veterans	Average Score* 2007 (n=9,132)	Average Score* 2006 (n=4,578)	2006 Rank
1. TB testing *(highest "met" need score)*	3.97	3.68	3
2. Medical services	3.93	3.76	1
3. Food	3.89	3.73	2
4. Treatment for substance abuse	3.79	3.50	8
5. Hepatitis C testing	3.76	3.60	4
6. Help with medication	3.71	3.44	9
7. Personal hygiene (shower, haircut, etc.)	3.68	3.42	11
8. AIDS/HIV testing/counseling	3.67	3.50	7
9. Clothing	3.64	3.59	5
10. TB treatment	3.61	3.54	6
11. Detoxification from substances	3.60	3.32	14
12. Services for emotional or psychiatric problems	3.59	3.43	10
13. Spiritual	3.53	3.37	13
14. Emergency (immediate) shelter	3.48	3.25	16
15. Help getting needed documents or I.D.	3.43	3.28	15
16. Treatment for dual diagnosis	3.39	3.25	18
17. Transitional living facility or halfway house	3.31	3.02	25
18. Help with transportation	3.24	3.01	26
19. Help with finding a job or getting employment	3.22	3.20	19

Table 5—Met and Unmet Needs of Homeless Veterans (All individuals who completed 2007, 2006 CHALENG Participant Surveys)—Continued

Need of homeless veterans	Average Score* 2007 (n=9,132)	Average Score* 2006 (n=4,578)	2006 Rank
20. Eye care	3.18	2.93	30
21. VA disability/pension	3.16	3.38	12
22. Women's healthcare	3.14	3.25	17
23. Glasses	3.12	2.92	31
24. Education	3.10	3.05	24
25. Drop-in center or day program	3.06	2.98	29
26. Help managing money	3.03	2.86	32
27. Job training	3.03	3.09	20
28. Family counseling	3.01	2.98	28
29. Elder healthcare	2.99	3.07	21
30. Discharge upgrade	2.97	3.01	27
31. SSI/SSD process	2.93	3.07	22
32. Dental care	2.84	2.64	36
33. Welfare payments	2.81	3.05	23
34. Legal assistance	2.80	2.78	34
35. Guardianship (financial)	2.77	2.83	33
36. Re-entry services for incarcerated veterans	2.76	2.71	35
37. Long-term, permanent housing	2.57	2.46	38
38. Child care *(highest "unmet" need score)*	2.48	2.47	37

*Need is met = score of 5
*Need is unmet = score of 1

For FY 2007, Table 5 indicates that child care, long-term, permanent housing, re-entry services for incarcerated veterans, guardianship (financial), legal assistance, welfare payments, dental care, Supplemental Security Income/Social Security Disability (SSI/SSD) process, discharge upgrade, and elder healthcare were the ten highest unmet needs for homeless veterans as determined by all participants combined. It is important to note that there are significant differences between survey responses from homeless veterans and other participants. These differences are discussed on page 11, "Consumer versus Provider Views on Homeless Veteran Needs."

Child care has been one of the highest unmet needs for several years. While large numbers of veterans do not need child care, when the need for child care is present, it is a particularly compelling and difficult-to-meet need and thus has consistently ranked high among unmet needs identified through CHALENG. Also, even though most homeless veterans are noncustodial parents, they remain deeply concerned about their children's care. In many cases, these veterans struggle with the knowledge that their absence has contributed to their children living in single-parent households, under the care of extended family, or being placed in foster care. As VA cannot directly serve a veteran's children, arranging family services is necessarily split between multiple agencies. Coordinating such care may prove difficult. However, with the recent expansion of the cooperative program between VA and HUD, thousands of Section 8 vouchers will soon be made available to veterans and their immediate families. CHALENG will track the impact of this program not only for its effect on permanent housing as an unmet need, but also for its potential impact on child care concerns.

The need for long-term, permanent housing still remains high. This is not surprising, since developing this type of housing is expensive and time consuming, although local communities have been successful in creating permanent beds for

homeless veterans. (Please see the 11th annual CHALENG report section "Special Focus: Addressing Long-term, Permanent Housing Need in 2004 Action Plan" for more discussion.)

Guardianship (Financial), SSI/SSD) process, discharge upgrade, and welfare payments represent a cluster of needs. Those needs, if addressed adequately, can make a homeless veteran more economically viable and able to transition out of homelessness. Recent literature supports the need for more and better management of financial resources. In 2006, the national average rent of studio/efficiency apartments of $633 (O'Hara et al., 2006) was beyond the means of a disabled person whose primary source of income was SSI or a VA pension. Income assistance either through entitlements, subsidized housing, or vocational training will continue to play an important part in keeping veterans out of homelessness.

Legal issues can often play a role in a veteran's finances. Credit problems and obligations stemming from debts, fines, and child support can prove especially burdensome, particularly for those recently released from prison. The typical incarcerated parent owes $20,000 in child support when released from prison, with payment schedules averaging $225 to $300 per month (Turetsky, 2007). Minimum wage workers have little hope of making these payments while supporting themselves in independent community living. Unresolved debts can result in liens against bank accounts, denial of credit, inability to secure a lease, failure in background checks commonly a part of job applications, forfeiture of driver's licenses, and ultimately re-arrest. In order to generate income without having funds garnished, these workers may enter the underground economy where income is often generated by involvement in illegal activities. Hence, legal assistance is one key to helping veterans meet their obligations to society, while still having the means to avoid relapsing to homelessness.

Re-entry services for incarcerated veterans was a needs category introduced in the FY 2005 report and has made it to the top ten unmet needs list the past 3 years. Providing pre-release planning and after-release services for incarcerated veterans is receiving increasing attention throughout the VA system. In FY 2007, VA launched its Healthcare for Re-entry Veterans (HCRV) Program. VA has designated a national HCRV Coordinator and has funded a Re-entry Specialist for each Veteran Integrated Services Network (VISN). The HCRV Coordinator and the Re-entry Specialists will establish working relationships with correctional institutions, to provide outreach services and follow-up linkages to VA and non-VA social, medical, and psychiatric services to veterans within 6 months of release to the community. In FY 2008, an additional 17 Re-entry Specialists have been funded to expand this effort.

Dental care was the seventh highest unmet need, as identified by **all** survey participants, for homeless veterans this year. This marks a continued decline as it had been ranked second in 2004 and third in the previous 2 years. (NOTE: Homeless veterans surveyed no longer rate dental care as a top ten unmet need). VA medical centers have reported that more dental care services have been provided for homeless veterans. The HVDP offers medically necessary treatment to homeless veterans who have been in a VA-approved transitional housing or residential program for at least 60 consecutive days, and has had a significant impact. For FY 2007, 93 percent of CHALENG sites (129) indicated the HVDP was operational at their local VA medical center (some sites do not have qualifying VA transitional housing or residential programs). These CHALENG sites reported a total of 10,507 veterans who needed dental care and were eligible for care because they had fulfilled residential treatment requirements. Of these 10,507 individuals, 7,666 received care (73 percent of total) either through VA Dental Services or a community provider.

For the first time, elder healthcare made the top ten list of highest unmet needs for homeless veterans. This may reflect the aging of the homeless veteran population. In FY 2007, 5 percent of all veterans accepted in VA homeless programs nationwide were 65 or older (U.S. Department of Veterans Affairs, 2007). Currently, the average age of homeless veterans who receive VA services is 51 and this mean age has increased slowly over the past few years.

Highest Met Needs

Turning to *highest met* needs as rated by the provider sample, many of the top ten categories were health services-related: Tuberculosis (TB) testing, medical services, substance abuse treatment, Hepatitis C testing, help with medication, HIV/AIDS testing/counseling and TB treatment. Most of these services are routinely offered by VA medical centers. Food, personal hygiene services, and clothing are basic needs addressed at virtually all homeless shelters and programs.

Consumer versus Provider Views on Homeless Veteran Needs

Past CHALENG reports routinely compared need rankings of VA staff and community partners (i.e., local agency staff, public officials, volunteers, and community leaders). Due to the unprecedented number of homeless veterans involved in this year's CHALENG survey, however, it was believed it would be more meaningful to focus on comparing the need rankings of consumers (current and former homeless veterans) and providers (i.e., VA and community participants).

In Tables 6 and 7, the ten highest unmet needs of homeless veterans as ranked by homeless and formerly homeless veterans are compared to the rankings by VA and community providers.

For 2007, there are differences between homeless and formerly homeless veterans identification of highest unmet needs compared to service provider participants. Providers rank dental care as the third highest unmet need, homeless veterans—who for years identified dental care as a top ten unmet need—now rank it at #12 (not shown in the table). This suggests that rankings by providers may sometimes be "trailing indicators," reflecting beliefs that are no longer experienced by consumers.

Unlike other respondents, homeless and formerly homeless veterans placed welfare payment, SSI/SSDI process, VA disability/pension and discharge upgrade in the top ten list of highest unmet needs. Thematically, this suggests the personal desire of veterans to secure financial resources in transitioning off the streets. Also, homeless and formerly homeless veterans placed elder healthcare in the list of top ten unmet needs, which may reflect a growing awareness of about the impact of the aging process.

Homeless and formerly homeless veterans agreed with the CHALENG community participants that the following were among the top unmet needs: permanent housing, re-entry services for incarcerated veterans, and financial guardianship.

A Multi-year Overview of Needs

Reviewing Tables 6 and 7, there is some concurrence between the views of homeless and formerly homeless veterans and other CHALENG participants across years. Long-term permanent housing, legal assistance, and child care rank among the top ten unmet needs for all participants from FY 2005–2007.

It is noteworthy that homeless and formerly homeless veterans differ from providers in naming financial and legal needs as a major concern. They rate these needs more highly than the providers surveyed during the 2007 CHALENG process. Further, many of these needs have risen in rank on the consumer's list of top ten unmet needs between FY 2006 and FY 2007. Consumers rank five financial and legal issues in the top ten: welfare payments (the number two unmet need), financial guardianship at four (up from five in 2006), SSI/SSDI at five (up from seven), legal assistance at seven (up from eight), and VA disability/pension at the eighth ranked need (not on the top ten unmet need list for FY 2005 or FY 2006).

Broadly, it suggests that consumers believe that having more personal resources is important in leaving homelessness. By contrast, providers are more likely to rank services such as eye care, glasses and help managing money among the top unmet needs. These results reflect an interesting difference in perspective between consumers and providers.

In terms of highest met needs, homeless and formerly homeless veterans and other participants placed medical services, TB testing, Hepatitis C testing, substance abuse treatment, and food in the top ten list in FY 2005, FY 2006, and FY 2007 (see Tables 8 and 9). As mentioned previously, such medical and basic need services are usually addressed by VA or community providers.

3-Year Comparison—Consumer and Provider (VA and Community) Assessment of Homeless Veteran *UNMET* Needs

Table 6—Top Ten Highest *Unmet* Needs Identified by Homeless Veterans, FY 2005–FY 2007

2005	2006	2007
1. Child care	1. Child care	1. Child care
2. Dental care	2. Welfare payments	2. Welfare payments
3. Welfare payments	3. Dental care	3. Long-term, permanent housing
4. Legal assistance	4. Long-term, permanent housing	4. Guardianship (financial)
5. Long-term, permanent housing	5. Guardianship (financial)	5. SSI/SSD process
6. Re-entry services for incarcerated veterans	6. Re-entry services for incarcerated veterans	6. Re-entry services for incarcerated veterans
7. Guardianship (financial)	7. SSI/SSD process	7. Legal assistance
8. Discharge upgrade	8. Legal assistance	8. VA Disability/Pension
9. SSI/SSD process	9. Discharge upgrade	9. Discharge upgrade
10. Job Training	10. Family counseling	10. Elder healthcare

Table 7—Top Ten Highest *Unmet* Needs Identified by VA and Community Providers, FY 2005–FY 2007

2005	2006	2007
1. Long-term, permanent housing	1. Long-term, permanent housing	1. Long-term, permanent housing
2. Child care	2. Child care	2. Child care
3. Dental care	3. Dental care	3. Dental care
4. Re-entry services for incarcerated veterans	4. Re-entry services for incarcerated veterans	4. Re-entry services for incarcerated veterans
5. Legal assistance	5. Legal assistance	5. Legal assistance
6. Help managing money	6. Help managing money	6. Help managing money
7. Glasses	7. Guardianship (financial)	7. Guardianship (financial)
8. Eye care	8. Glasses	8. Glasses
9. Guardianship (financial)	9. Eye care	9. Eye care
10. Transportation	10. Transitional living facility or halfway house	10. Transitional living facility or halfway house

3–Year Comparison—Consumer and Provider (VA and Community) Assessment of Homeless Veteran *MET* Needs

Table 8—Top Ten Highest *Met* Needs Identified by Homeless Veterans, FY 2005–FY 2007

2005	2006	2007
1. Medical services	1. Medical services	1. TB testing
2. Substance abuse treatment	2. TB testing	2. Substance abuse treatment
3. TB testing	3. Substance abuse treatment	3. Medical Services
4. Food	4. Food	4. Food
5. Help with medication	5. Help with medication	5. Help with medication
6. Hepatitis C testing	6. Hepatitis C testing	6. Personal hygiene
7. Detoxification	7. Personal hygiene	7. Hepatitis C testing
8. Personal hygiene	8. Detoxification	8. Detoxification
9. Services for emotional or psychiatric problems	9. Services for emotional or psychiatric problems	9. AIDS/HIV testing/ counseling
10. TB treatment	10. AIDS/HIV testing/ counseling	10. Services for emotional or psychiatric problems

Table 9—Top Ten Highest *Met* Needs Identified by VA and Community Providers, FY 2005–FY 2007

2005	2006	2007
1. Food	1. Medical services	1. Medical services
2. Medical services	2. Food	2. Food
3. TB testing	3. TB testing	3. TB testing
4. Clothing	4. Clothing	4. Clothing
5. Hepatitis C testing	5. Hepatitis C testing	5. Hepatitis C testing
6. TB treatment	6. TB treatment	6. TB treatment
7. VA disability/pension	7. AIDS/HIV testing/counseling	7. AIDS/HIV testing/counseling
8. AIDS/HIV testing/counseling	8. VA disability/pension	8. VA disability/pension
9. Substance abuse treatment	9. Substance abuse treatment	9. Substance abuse treatment
10. Services for emotional or psychiatric problems	10. Services for emotional or psychiatric problems	10. Help with medication

Homeless Veterans with Families

CHALENG sites continue to report increases in the number of homeless veterans with families (i.e., dependent children) being served at their programs. Ninety-eight POC sites (71 percent of all sites) reported a total of 1,038 homeless veteran families seen. This was a 5-percent increase over the previous year's 989 homeless veteran families.

Homeless veterans with dependents present a challenge to VA homeless programs. Many VA housing programs are veteran-specific. VA homeless workers must often find other community housing resources to place the entire family or the dependent children separately. Access to family housing through the distribution of the thousands of new Section 8 vouchers that will be made available through the HUD–VASH, will offer an important new resource allowing VA staff to assist the veteran and his family.

Homeless Veterans Returning from Afghanistan and Iraq

For the first time, CHALENG asked POCs about the coordiNation and provision of services to homeless veterans who have served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). Ninety-five percent (95%) of the POCs said they have coordinated the care of OEF/OIF homeless veterans with their local VA medical center Transition Patient Advocate. The Transition Patient Advocate is usually a social worker case manager assigned to work with recently returning veterans.

Eighty-five percent of sites said they could provide same-day housing (emergency or transitional) to homeless OEF/OIF veterans. The most common reasons for those sites not able to provide same-day housing included: insufficient emergency or transitional housing available, long wait lists (33 percent of sites that could not provide same-day housing), or no housing available on site (also 33 percent).

CHALENG POCs were asked how VA could improve services for OEF/OIF homeless veterans. The most mentioned themes included: outreach, housing, and services. The following lists specific suggestions:

Outreach: Greater use of the Internet to inform returning veterans about VA services; outreach to National Guard, reserve units, armories and Vet Centers; general community outreach (including American Indian reservations); more welcome home events; hiring of OEF/OIF veterans to serve as peer outreach workers; and use of outreach workers to follow-up with OEF/OIF veterans to help ensure they come to their initial VA appointments and get "plugged into" the system.

Housing: Specific housing programs targeting OEF/OIF veterans were frequently suggested. Such programs would be less restrictive, more short-term, and emphasize quicker reintegration into the community through mental health outpatient counseling, vocational rehabilitation and job-finding assistance. Some sites have noted that many OEF/OIF homeless veterans cannot relate to current housing programs targeting chronically homeless and mentally ill veterans in their fifties and sixties. It is expected that the influx of thousands of veteran specific permanent housing units made available through the HUD–VASH program will have an impact on this need.

Services: More case management, mental health, and employment services; more programs targeting women and veterans with families; more rapid eligibility determination; and greater coordiNation between homeless programs and the local VA medical center OEF/OIF specialist.

Site Estimates of Numbers of Homeless Veterans and Housing Capacity

Introduction: Challenges to Estimating the Number of Homeless Veterans in America

Counting the number of homeless people, specifically the number of homeless veterans is a difficult task. There have been few systematic, national efforts to count the homeless. Prior to 2005, the most highly regarded effort took place in 1996, the National Survey of Homeless Assistance Providers and Clients (NSHAPC). At that time, the NSHAPC estimated that 23 percent of the homeless population was composed of veterans (Burt, 1999).

In 2005, HUD began organizing comprehensive, national counts of homeless persons. This major endeavor requires local Continuums of Care, to conduct point-in-time counts of homeless persons. Continuums of Care are local bodies composed of agencies addressing homelessness. These point-in-time counts not only tally the number of homeless persons, but also seek to determine a homeless person's veteran status. HUD's point-in-time count now occurs every 2 years and is the only nationwide process to estimate homeless individuals in the U.S. This process began because HUD is required by the McKinney-Vento Act to produce "statistically reliable, unduplicated counts or estimates of homeless persons in sheltered and unsheltered locations at a 1-day point in time (HUD, 2008)."

In conducting the point-in-time, Continuums of Care must rely heavily on local organizations and volunteers. It has been observed that the precision of local counts varies. In 2005, over half of the point-in-time counts of unsheltered homeless individuals did not collect information on veteran status (HUD, 2007). Also, some CHALENG POCs reported that their local point-in-time count missed certain places or areas (e.g., transitional housing programs, encampments) that homeless veterans are known to reside.

Another challenge is the transience of homeless persons. Even over a short period of time, significant changes in the homeless population can occur due to seasonal variation and natural disasters. As the most recent Annual Homeless Assessment Report from HUD acknowledged: "There is no evidence that the size of the homeless population has changed dramatically over the past 10 years. However, given the limitations of the Annual Homeless Assessment Report as well as the limitations of earlier studies, it is not possible to make a definitive conclusion on the change of the homeless population" (U.S. Department of Housing and Urban Development, 2007).

CHALENG FY 2007 Homeless Veteran Estimate and Sources

Despite procedural problems in counting homeless people, it is believed that a good-faith effort is made through the CHALENG process to estimate homeless veterans annually. Such estimates are important to guide the allocation of existing resources and services for veterans. HUD's notable work in developing a more accurate count of the assessment of homeless veterans has allowed the VA to improve its CHALENG estimate.

For this CHALENG report, each POC was asked to estimate the number of homeless veterans in her or his service area. For the 2007 CHALENG survey, instructions emphasized that POCs were to provide a point-in-time estimate. A point-in-time estimate asks for how many homeless veterans are in the service area during a *given day* of the year. A point-in-time estimate is different from estimating how many homeless veterans are in a service area during the year. For example, a POC may say there are 200 homeless veterans in her service area on any given day (point-in-time), but there are 400 homeless veterans total who are in the service area sometime during the year.

This year, for the first time, CHALENG POCs were asked to provide a point-in-time estimate of the homeless veterans in their service area on any day during the last week of January 2007. This time period was selected so CHALENG estimates would coincide with the homeless point-in-time counts executed by HUD Continuums of Care nationwide. It is believed that CHALENG should make every effort to base their estimates on the local point-in-time count, as it is the only nationwide homeless count conducted on an ongoing basis. *For the first time, all CHALENG point-in-time estimates were compared to local HUD point-in-time estimates from 2005,* the most recent data readily available. If there was a major difference between the estimates, the CHALENG POC provided an explaNation of why there were differences, such as the local HUD point-in-time not canvassing areas with known concentrations of homeless veterans, or utilization of data from a local, non-HUD homeless count.

Findings

The 2007 CHALENG Report estimates that on any given night, approximately 154,000 veterans are homeless* (see NOTE below). This figure is a decrease of 21

percent from the estimate 195,827 given in the 2006 CHALENG report. Individual site estimates are presented in Appendix Table 5.

***NOTE: The CHALENG estimate includes approximately 8,000 veterans currently residing in VA supported transitional housing. VA, as does HUD, counts residents of transitional housing in the estimates of homelessness. In addition, approximately 2,000 homeless veterans included in the count are currently receiving treatment in VA residential care programs. The vast majority of all of these veterans are placed in housing when discharged from these VA residential services.**

The reduction in the reported numbers of homeless veterans may be a result of improved methodology. As described above, CHALENG homeless veteran estimates were compared to local HUD point-in-time estimates. As a result, many sites adjusted their homeless estimates to be more consistent with the local HUD point-in-time count. When adjusted upward to account for gaps in its unsheltered count, the 2005 HUD point-in-time still only indicates that on any given night approximately 15 percent of the homeless population or 112,000 people are veterans.

However, some VA sites were able to successfully document why their estimates were not the same as the HUD point-in-time count. For example, after consultation with community providers, some sites reported that their local HUD point-in-time count missed particular areas or transitional residences where homeless veterans are known to congregate. Some sites had data from local non-HUD homeless counts which they felt were more accurate. Homeless veteran estimates by CHALENG POCs included the following non-HUD sources: U.S. Census data (10 percent); VA low-income population estimates (7 percent); local homeless census studies (state, county, local university, etc.) (42 percent); VA client data (36 percent); estimates from local homeless community coalition/providers (59 percent); and VA staff impressions (52 percent). (Note: of the sites that used staff impressions in their estimate, 94 percent used at least one additional source.) Seventy-one percent of POCs used more than one source.

In summary, it is believed the HUD point-in-time data has resulted in a revised CHALENG count that is more aligned with the most extensive homeless estimate methodology currently available, while allowing for adjustments of local estimates based on VA staffs' first-hand knowledge of their service areas.

Other Possible Factors Related to a Drop in Veteran Homelessness

In addition to changing methods of estimation noted, two significant factors have likely contributed to a continuing decline in the estimate of homeless veterans:

1. VA Program Interventions

Reductions in veteran homelessness may be due in part to the effectiveness of VA's programs that serve homeless veterans. In the past decade, major VA homeless initiatives on outreach, treatment, residential services and vocational rehabilitation have served tens of thousands of veterans. For example, VA's Grant & Per Diem program, which had just begun in the mid-nineties when the NSHAPC estimated that veterans composed 23 percent of the homeless population, has over 8,500 operational beds today. In the past year alone, 15,000 veterans were provided Grant and Per Diem homeless residential services and an additional 5,000 plus veterans were treated in specialized VA homeless domiciliary residential care programs.

These programs have demonstrated remarkable success at placing and keeping veterans in community housing. A recent study of VA discharges determined that 79 percent of those leaving Grant and Per Diem and homeless domiciliary programs remained housed 1 year after discharge (McGuire, Kasprow, & Rosenheck, 2007).

2. Changing Demographics

The overall population of veterans continues to decline as World War II and Korean war-era veterans age. In 1990, there were 27.5 million veterans, a total that has decreased to 23.5 million today. Similarly, there has been a substantial reduction in the number of poor veterans, decreasing from 3 million in 1990 to 1.8 million in 2000. Since most homeless veterans are poor, it is believed there has been a corresponding drop in the number of homeless veterans as well.

Homeless Veteran Estimate Summary

It is not possible to determine the relative impact of these causes (VA program interventions, changing demographics, or methodological refinement) upon the reported number of homeless veterans. Despite recent changes in methodology, when comparing current HUD and VA surveys to the 1996 NSHAPC data, it does appear

that a significant, long term reduction in the numbers of homeless veterans has occurred.

Bed Accessibility and Need

To aid in determining the need for housing for homeless veterans, POCs were asked to include an estimate of the number of beds, emergency, transitional, and permanent beds that are *accessible* to homeless veterans in their local area. It did not ask whether the beds are veteran-specific. POCs were also asked to report the number of beds *needed* beyond the present capacity to meet the local needs of homeless veterans. (Asking only about bed *capacity*, how many beds that can be accessed, would provide an incomplete picture of bed *need* for homeless veterans. For example, there may be several homeless beds in a community, i.e., capacity, but if they are always full and there is a lengthy waiting list, extra beds would still be needed to meet homeless veteran demand.)

Table 10—Bed Capacity (these beds are often not veteran specific and are also open to the general homeless population) and Bed Need Assessment

Type of Bed	Available in FY 2007	*Available in FY 2006*	Needed Beyond Present Capacity (est.) FY 2007	*Needed Beyond Present Capacity (est.) FY 2006*
Emergency	73,430	72,196	8,712	14,753
Transitional	47,891	40,599	10,328	11,067
Permanent	35,941	31,724	25,662	24,364

Comparing the data from FY 2006 and FY 2007, it appears that existing bed capacity has increased for all three housing types. This increased capacity may impact on the drop in estimated need for emergency and transitional housing.

Estimated need for permanent housing, however, increased slightly. This may reflect the maturation of VA homeless programs nationwide. As more veterans transition out of emergency and transitional housing programs, which emphasize stabilization and rehabilitation, there is a growing need to place them into permanent housing. The need for permanent housing is being addressed through the Consolidated Appropriations Act of 2008 which provided funding for HUD to expand the HUD–VASH Program. Section 8 vouchers available through HUD–VASH will be utilized to provide housing and supportive services for homeless veterans. The Consolidated Appropriations Act also directed VA to provide sufficient funding for case managers to accommodate the increase in vouchers for this program. This initiative has the potential to reduce permanent housing demand in future CHALENG reports.

Assessment of VA and Community Partnering

As stated in the introduction, the CHALENG mandate is to bring VA and community service providers together in partnership to encourage the development of coordinated services for homeless veterans. For this year's report, we examined three indicators of VA and community partnership. These are: (1) partnership integration and implementation measures; (2) VA involvement in community homeless coalitions; and (3) interagency collaborative agreements.

Partnership Integration and Implementation Measures

Since FY 2000, CHALENG has used two sets of questions to ascertain the level of VA/community partnering as perceived by community (non-VA) providers: (A) *Integration* measures, and (B) *Implementation* measures. The questions were adapted from the nationwide Access to Community Care and Effective Services and Supports study of service system integration for homeless clients with severe mental illness (Randolph et al., 1997).

For this year's CHALENG report, the *Integration* measures consisted of two questions asking community providers from the Participant Survey to rate the following:

1. *VA Accessibility:* accessibility of VA services to homeless veterans.
2. *VA Coordination:* the ability of VA to coordinate clinical services for homeless veterans with the community provider respondent's agency.

A five-point scale was used for each item (1=not accessible, not committed, etc., to 5=highly accessible, highly committed, etc.).

Implementation measures consisted of 12 items pertaining to concrete activities associated with VA and community partnering. Community provider respondents

were asked to rate the level of implementation of the following strategies between their agency and VA:

1. *Regular Meetings:* Formal, regular meetings of VA and the community participant's agency to exchange information and plan.
2. *Service Co-location:* Provision of services by VA and the community participant's agency in one location.
3. *Cross-training:* Training of VA and the community participant agency's staff on each others' objectives, procedures, and services.
4. *Interagency Agreements:* Agreements between VA and the community participant's agency regarding collaboration, referrals, client information sharing, and/or coordinating services.
5. *Client Tracking:* Computer tracking system enabling VA and the community participant's agency to share client information.
6. *Joint Funding:* Combined/layering funding between VA and the community participant's agency to create new resources or services.
7. *Standard Forms:* Standardized forms that clients fill out once to apply for services at the local VA and the community participant's agency.
8. *Joint Service Teams:* Service teams comprised of staff from both VA and the community participant's agency to assist clients with multiple needs.
9. *Combined Programs:* Combined programs from VA and the community participant's agency under one administrative structure.
10. *Flexible Funding:* Flexible funding to promote service integration between VA and the community participant's agency: for example, funds to pay for emergency services not usually available to clients.
11. *Special Waivers:* Waiving requirements for funding, eligibility, or service delivery to reduce service barriers, promote access, and/or avoid service duplication.
12. *System Coordinator:* Creation of a specific staff position focusing on improving system integration between VA and the community participant's agency.

All implementation items used the same four-point scale: 1=none (no steps taken to initiate implementation of the strategy), 2=low (in planning and/or initial minor steps taken), 3=moderate (significant steps taken but full implementation not achieved), and 4=high (strategy fully implemented).

Table 11 shows the results of the integration ratings by community providers (mean scores of aggregated sites). We compared the aggregated integration scores of each VA facility for FY 2006 versus FY 2007. Using paired t-tests, we found no statistically significant difference in the integration scores between FY 2006 and FY 2007.

Table 11—Community Providers Respondent Ratings of Partnership Integration in CHALENG Participant Survey, FY 2006 and FY 2007

Integration Items	Community Respondents FY 2006 (134 sites)	Community Respondents FY 2007 (134 sites)
VA Accessibility (1=not accessible . . . 5=highly accessible)	3.64	3.57
VA Service CoordiNation (1=not able to coordinate . . . 5=highly able)	3.63	3.58

Implementation scores for FY 2006 and FY 2007 were also reviewed. Again, data were aggregated by site and paired t-tests were conducted (see Table 12). There was one significant difference ($p<.01$): the implementation score for cross-training *decreased* from 2006 to 2007.

Table 12—Community Provider Respondent Ratings of Partnership Implementation in the CHALENG Participant Survey, FY 2006 and FY 2007

Implementation Items [a]	Community Respondents FY 2006 (133 sites)	Community Respondents FY 2007 (133 sites)
Regular Meetings	2.57	2.56
Service Co-location	1.95	1.89

Table 12—Community Provider Respondent Ratings of Partnership Implementation in the CHALENG Participant Survey, FY 2006 and FY 2007—Continued

Implementation Items [a]	Community Respondents FY 2006 (133 sites)	Community Respondents FY 2007 (133 sites)
Cross-training	1.97	1.86**
Interagency Agreements	2.30	2.26
Client Tracking	1.65	1.59
Joint Funding	1.66	1.67
Standard Forms	1.79	1.75
Joint Service Teams	2.19	2.15
Combined Programs	1.97	1.94
Flexible Funding	1.64	1.61
Special Waivers	1.67	1.62
System Coordinator	1.88	1.83

[a] 1=none, 2=low, 3=moderate, 4=high ** p<.01

There was no change in the two integration items which measure community provider perception of VA's accessibility to homeless veterans and VA's ability to coordinate homeless services with community partners.

Overall, there has been no increase in community rating of the 12 partnership implementation activities. Generally, there has usually been an increase in one or more activity scores. This suggests that VA and community progress in implementing partnership activities may have leveled off. (Note: It was reported in last year's CHALENG report that there were no significant changes between 2005 and 2006. It will be interesting to see if this leveling off in partnering is seen in next year's CHALENG report as well.)

VA Involvement in Local Homeless Coalitions

Involvement in local homeless coalitions has been identified as a useful way for VA staff to network with local homeless service providers and develop partnerships. Ninety-six percent of the POC Surveys indicated participation in a local homeless coalition.

As noted previously, the HUD sponsors local planning groups called Continuums of Care to help address the needs of the homeless. VA homeless programs are encouraged to participate in their local Continuum of Care. In FY 2007, 88 percent of POC sites that had a nearby HUD Continuum of Care planning group (111 of 127) participated in the local Continuum of Care planning efforts.

Interagency Collaborative Agreements

Existing Interagency Collaborations Agreements: CHALENG POCs reported on VA efforts to serve homeless veterans through arrangements with local community agencies. CHALENG POCs were asked to identify whether they currently had interagency collaborative agreements with: correctional facilities; psychiatric and substance abuse inpatient programs; nursing homes and faith-based organizations. Table 13 shows the prevalence of current interagency collaborative agreements.

Table 13—Percentage of POCs (n=138) Indicating Interagency Collaborative Agreements With Select Program Types

	Formal 2007	Informal 2007	Formal or Informal* 2007
Correctional Facilities (jails, prisons, courts)	13%	59%	67%
Psychiatric/substance abuse inpatient (hospitals, wards)	17%	60%	75%

Table 13—Percentage of POCs (n=138) Indicating Interagency Collaborative Agreements With Select Program Types—Continued

	Formal 2007	Informal 2007	Formal or Informal* 2007
Nursing homes	28%	19%	45%
Faith-based organizations	62%	56%	88%

*Note: Some sites had both a formal and informal agreement with a program type.

Eighty-eight percent of POC respondents indicated their VA medical care facility had an interagency collaborative agreement with a faith-based organization. This is not surprising given the fact that many faith-based organizations have a long history of serving the poor and homeless. Seventy-five percent of sites reported ties with a psychiatric and/or substance abuse inpatient program, an indication of the link between mental illness and homelessness and the need to coordinate services between mental health and homeless agencies.

Two-thirds (67 percent) of POCs had relationships with a local correctional facility. Incarcerated veterans are at high-risk for homelessness upon leaving jail or prison. Several VA homeless programs provide information to homeless veterans in local jails and prisons to help them arrange transitional housing and substance abuse or mental health treatment after their release. With the recent implementation of the HCRV program, including the hiring of a national HCRV Coordinator and HCRV specialists for every VISN, the percentage of medical centers which have agreements with correctional facilities should increase in the coming years.

Forty-five percent of POCs had arrangements with a nursing home, usually through VA nursing home contracts. This reflects the aging of the homeless population and the need for facilities to address the multiple medical needs of older homeless veterans and chronically ill homeless veterans.

New Interagency Collaborative Agreements and Outreach Efforts: VA staff continue to establish new interagency collaborative agreements and to identify and serve new outreach sites. Table 14 displays figures for new agreements (formal and informal arrangements) and outreach sites, broken down by VISN. Compared to 2006, there were increases in the number of agreements and outreach sites in 2007.

Table 14—New Interagency Collaborative Agreements and Outreach Sites for FY 2007

VISN	Formal Agreements	Informal Agreements	Agreements (total)	Number of New Homeless Outreach Sites
1	11	31	42	8
2	5	13	18	8
3	6	24	30	28
4	7	19	26	33
5	4	10	14	24
6	3	21	24	19
7	1	14	15	27
8	2	26	28	16
9	1	18	19	16
10	5	14	19	15
11	5	6	11	2
12	1	10	11	9
15	5	10	15	12
16	10	17	27	18

Table 14—New Interagency Collaborative Agreements and Outreach Sites for FY 2007—Continued

VISN	Formal Agreements	Informal Agreements	Agreements (total)	Number of New Homeless Outreach Sites
17	4	12	16	14
18	2	20	22	17
19	4	9	13	6
20	54	58	112	21
21	3	15	18	15
22	6	17	23	42
23	8	32	40	27
Totals, All VISNs (FY 2007):	147	396	543	377
Totals, All VISNs (FY 2006):	*81*	*352*	*433*	*343*

Nature of New Interagency Collaborative Agreements: 113 out of 138 reporting POC sites (82 percent) had at least one new agreement with a community agency. The most frequent topic of the new agreements was transitional housing (see Table 15 below). Nearly half (49 percent) of the POC sites which reported a new agreement indicated that securing transitional housing for veterans was a focus. The other two of the top three topics of interagency collaborative agreements were emergency (immediate) shelter (27 percent) and re-entry services for incarcerated veterans (24 percent).

Table 15—Subject of New Interagency Collaborative Agreements Between VA and Community Providers, FY 2007

Need	Percentage of POCs With New Collaborative Agreement who Indicated Need Was Addressed in Agreement*
Transitional living facility or halfway house	49%
Emergency (immediate) shelter	27%
Re-entry services for incarcerated veterans	24%
Services for emotional or psychiatric problems	22%
Food	21%
Long-term, permanent housing	21%
Help with finding a job or getting employment	21%
Job training	20%
Help with transportation	20%
Clothing	19%
Dental care	18%
Help managing money	15%
Help getting needed documents or identification	13%
Treatment for substance abuse	11%
Glasses	11%

Table 15—Subject of New Interagency Collaborative Agreements Between VA and Community Providers, FY 2007—Continued

Need	Percentage of POCs With New Collaborative Agreement who Indicated Need Was Addressed in Agreement*
Personal hygiene (shower, haircut, etc.)	9%
Detoxification from substances	9%
Medical services	9%
Eye care	8%
VA disability or pension	8%
Treatment for dual diagnoses	7%
Help with medication	7%
SSI/SSD process	7%
Legal assistance	7%
Spiritual	7%
AIDS/HIV testing/counseling	6%
Family counseling	3%
Women's healthcare	3%
Welfare payments	3%
Drop-in center or day program	2%
TB testing	2%
Guardianship (financial)	2%
Education	2%
Discharge upgrade	2%
Child care	1%
Elder healthcare	1%
TB treatment	0%
Hepatitis C testing	0%

*Multiple needs addressed in the new interagency collaborative agreements may be identified by POCs

Veterans Served Due to New Collaborative Agreements: CHALENG POCs were asked to report how many veterans received key services (mental health and/or substance abuse treatment, dental care, and eye care) as a result of new collaborative agreements in FY 2007 (see Table 16).

Table 16—Number of Veterans Served Through New Interagency Collaborative Agreements, FY 2007

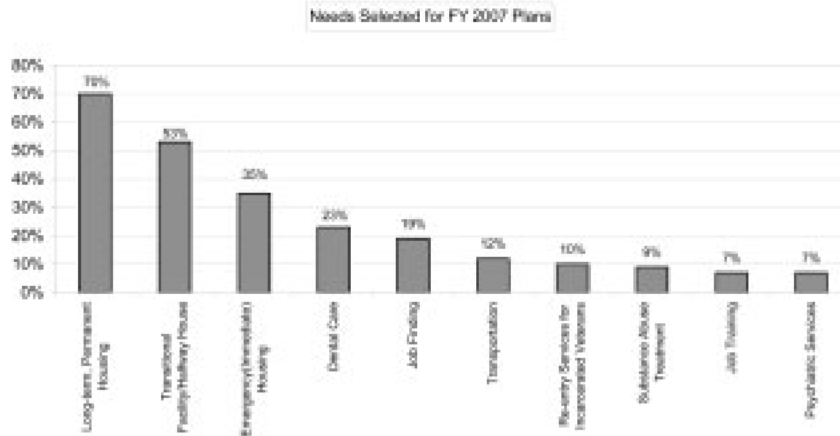
Service	Number of Veterans Served as result of New Interagency Collaborative Agreement
Mental Health/Substance Abuse Treatment	344
Dental Care	1,131
Eye Care	500

POC Action Plans

POC Success in Executing FY 2007 Action Plans

As part of the CHALENG survey in FY 2007, POCs were asked to select the three highest priority needs in their areas and to indicate how they would address these needs in FY 2007. The most frequently selected needs included: permanent, transitional, and emergency housing; dental care; job finding; transportation; re-entry services for incarcerated veterans; substance abuse treatment; job training and psychiatric services.

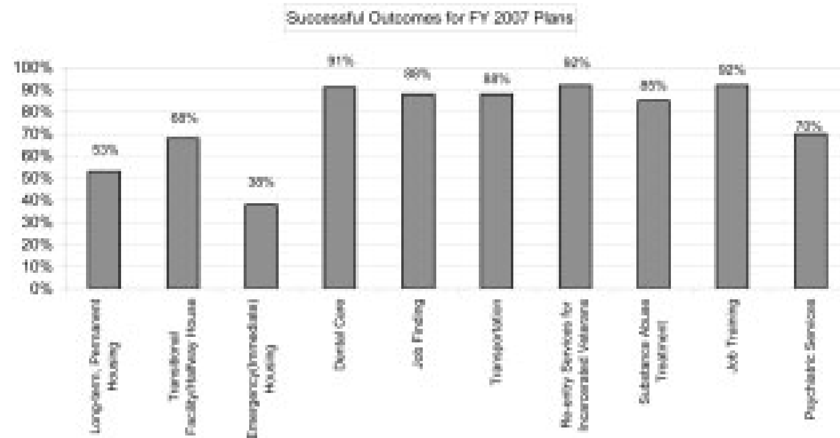
Figure 1—Top Needs Selected for Points of Contact to Address



For this CHALENG report, POCs were asked to indicate their success in implementing their plans to meet the top three needs that were identified. (See Appendix Table 6 for all POC progress reports.) For the purposes of this report, success was defined as achieving tangible outcomes such as securing additional transitional housing beds, negotiating a reduced or free bus fare for homeless veterans, or receiving grant funding for a project. Success did not include the beginning of processes such as starting initial planning or submitting a grant for funding.

Figure 2 shows the percentage of sites that were successful in obtaining an outcome for the ten most frequently selected needs to address in FY 2007.

Figure 2—Outcomes for Top Ten Action Plan Topics with Percentages of POC Sites that were Successful



Listed below are some examples of how POCs achieved success in addressing their priorities for FY 2007. This summary does not reflect the total level of CHALENG partnership activity in addressing these needs—only the activity from the sites that identified the need as one of its top three.

- Long-term, permanent housing: Community agencies opened new permanent housing (20 sites); VA used HUD Section 8/Shelter Plus Care vouchers (20 sites).
- Transitional housing: Community agencies opened VA Grant and Per Diem-funded beds or received VA Grant and Per Diem funding (39 sites); VA accessed non VA-funded transitional housing (two sites); new VA Domiciliary opened (one site).
- Emergency housing: Shelter opened/expanded (ten sites), new agreements made with existing shelters (six sites), local motel used as temporary shelter (one site), new shelter database or directory facilitated better placement (two sites).
- Dental care: VA provided services under VHA Directive 2002–080 (eight sites); local dental providers offered care (some being paid with special VA dental funding) (21 sites).
- Job finding: VA Compensated Work Therapy/Supported Employment programs started or expanded (11 sites); local Department of Labor Homeless Veterans Reintegration Program utilized (two sites); VA partnered with local private and public agencies for job finding (15 sites).
- Transportation: VA or local transit authority offered new lines and services to accommodate veterans (nine sites); bus passes and tokens distributed (four sites); local agency purchased a van or hired a driver (two sites); veterans re-assigned to a VA clinic closer to their residence (one site).
- Job training: New VA employment program begun or vocational rehabilitation staff hired (five sites); job training provided through local community agencies (five sites).
- Substance abuse treatment: Added VA substance abuse staff (six sites); new VA Grant and Per Diem program serving dually diagnosis patients (one site); community agencies offered substance abuse treatment (three sites).
- Re-entry services for incarcerated veterans: New outreach worker/discharge planner hired (nine sites); local task force of VA and community agencies coordinated services for formerly incarcerated veterans (five sites).
- Psychiatric services: New programs started and new staff hired (two sites); existing VA mental health services restructured to improve treatment access and care (three sites); veterans referred to local community mental health program (two sites).

Most commonly, POC sites that did not achieve success with their FY 2007 plans mentioned lack of funding (grant proposals denied, loss/reduction of existing program funding) as a factor.

The least successful action plan topic was emergency housing or immediate shelter. Only 36 percent of all sites reported success in addressing this FY 2007 action topic. Many sites indicated they were in the early planning and development stages of creating shelters. Also, unlike transitional and permanent housing development, there has been difficulty in locating funding sources for the development of additional emergency shelters. For example, the VA Grant and Per Diem program has funded and maintained several transitional housing programs throughout the country; similarly HUD, through its Section 8 and Shelter Plus Care programs, has created permanent housing resources in many local communities.

Similarly, some of the more successfully met needs were tied to specific funding and initiatives. Many sites mentioned the implementation of VHA Directive 2002–080 in addressing dental needs. VA Compensated Work Therapy and Supported Employment programs and Department of Labor Homeless Veteran Reintegration Programs addressed job training and job finding needs. New VISN HCRV program specialists provided a boost for local efforts to serve recently released incarcerated veterans.

Important CHALENG Partners

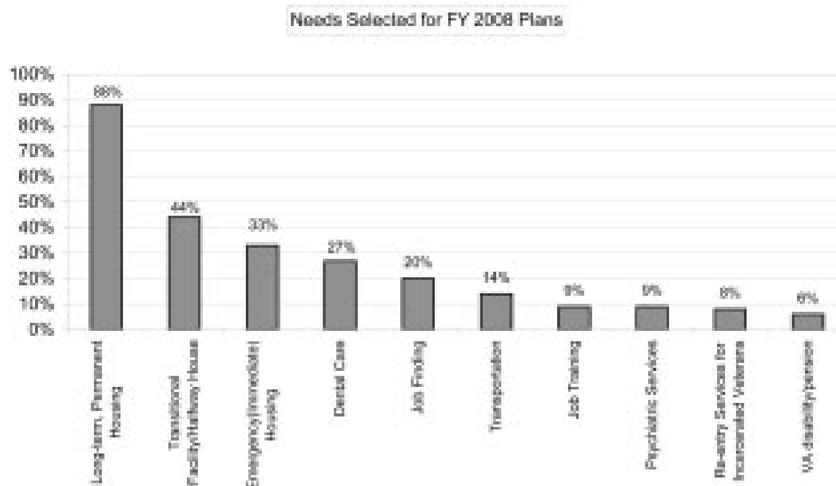
CHALENG POCs were asked to identify community partners who helped them address their past year's action plan. Appendix 7 highlights and acknowledges the accomplishments of these partners in FY 2007.

POC Action Plans for FY 2008

The 2007 POC survey requested that POCs outline their action plans for addressing top unmet needs of local homeless veterans in FY 2008. These unmet needs included: permanent, transitional, and emergency housing; dental care; job finding;

transportation; psychiatric services; job training; re-entry services for incarcerated veterans, and VA disability and pension.

Figure 3—Needs Selected For Plans



In the CHALENG Participant Survey, respondents were asked to name the top three greatest unmet needs in their communities that they would like to address in FY 2008. Importantly, nine of the ten needs they wished to work on the most were on the top ten list for VA POC action plans for FY 2008.

The CHALENG 2008 top ten list of needs to address is consistent with recent thought on addressing homelessness. A variety of reports have attempted to define the program elements necessary to end homelessness. Although these descriptions tend to be more general and may lack detailed input from consumers, they offer a framework for planning a comprehensive intervention. One important effort was made by The Federal Task Force on Homelessness and Severe Mental Illness (1992), which identified five critical service components essential to resolving homelessness: housing; employment; psychiatric and substance abuse treatment; medical care; and social support. Related, the 2008 CHALENG action plan top ten list includes housing, employment and psychiatric care. As noted earlier, CHALENG participants rate medical care as a high met need for homeless veterans. VA currently provides a broad range of medical services for these veterans.

While acknowledged as an important component of recovery, social support has never been officially listed by CHALENG as a specific, pre-identified need to be ranked. Related to the report from The Federal Task Force on Homelessness, a recent Canadian survey (Russell, Hubley, & Palepu, 2005) of homeless persons concluded that in addition to access to basic necessities, relationships, self-respect, the respect of others, and having choices all influenced the quality of life of homeless persons. It is not known whether such quality of life indicators impact directly upon homelessness, but they are certainly clinically relevant to those veterans we treat. Social support will be measured in the 2008 CHALENG survey.

Update on CHALENG Activities

Individualized CHALENG reports by POC site are now available on the Internet in draft form. Each report includes: an estimate of homeless veterans in the service area; an estimate of homeless veterans who are chronically homeless; bed counts; FY 2008 action plan, and need and integration/implementation rankings. The Web site address is: http://www.va.gov/homeless/page.cfm?pg=17.

Also on the site is the 14th Annual Progress Report on Public Law 105–114 in its entirety. The current report and site profiles are useful for sites that are undergoing Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation or have community partners that are applying for VA Grant and Per Diem funding. CARF requires programs to provide feedback from external stakeholders such as community partners and clients. As part of their VA Grant and Per Diem application, community agencies must document the local needs of homeless veterans in

their area. Much information from stakeholders and their perception of homeless veterans needs is available in the annual CHALENG report.

Summary

Trends In Veteran Homelessness

Over the short-term, the combiNation of demographic changes decreasing the overall veteran population and the increase of VA resources for the homeless should continue to reduce homelessness among veterans. At some point, changes already apparent in the active military force structure will likely be mirrored in the profile of homeless veterans. Although only 4 percent of all homeless veterans are women, this proportion will likely increase as currently 15 percent of all U.S. troops are women. The extensive use of the National Guards and Reserve units in Iraq and Afghanistan means that in addition to the typical influx of new, younger veterans expected from any conflict, a greater proportion of "new" veterans will be older and have families. VA will face significant challenges in addressing the needs of these veterans if they become homeless, unless it can meaningfully address their homelessness in the context of the family unit. The continued prominence of child care as an unmet need highlights the potential impact of this concern. Recognizing this need, the Consolidated Appropriations Act of 2008 provided funding for HUD to expand the HUD/VASH Program. Section 8 vouchers available through HUD/VASH will be utilized to provide housing and supportive services for homeless veterans *and their families.*

VA's success in reducing homelessness brings new demands. Although housing is obviously a critical step in ending homelessness, it is not a sufficient intervention to restore health and quality to life. Through CHALENG, VA continues to assess the needs of homeless veterans so that we may identify areas where the overall quality of life for these veterans may be improved. We believe this approach is not only the humane one, but the one most likely to result in long term solutions to homelessness. VA will continue to work to establish a continuum of care that meets the full spectrum of economic, vocational, legal, social, and spiritual needs identified by veterans and providers in this report.

Final Thoughts

The annual CHALENG Survey documents the needs of homeless veterans identified by veterans, community agencies and VA staff. CHALENG also records how VA and community agencies work together to plan and meet those needs.

Constructively, housing capacity increased between FY 2006 and FY 2007 with emergency and transitional bed need decreasing. POC actions plan updates have documented many success stories in developing housing, particularly through the use of VA Grant and Per Diem funding for transitional housing and HUD Section 8/Shelter Plus Care funding for permanent housing.

There is also evidence that non-housing initiatives have been successful. About 7,600 veterans received dental care through the HVDP in FY 2007. Ninety-two percent of sites that selected re-entry services for incarcerated veterans as a priority need in FY 2007 reported some success coordinating care with new VISN HCRV Program liaisons, prisons, and other community agencies.

The estimated need for affordable permanent housing continues to increase even as capacity increased. Although growth in partnership activities as indicated by the report's 12 implementation measures remained flat, that may mask increasing collaborative activities through the expansion of existing partnerships. This will be a focus for assessment in future CHALENG reports. Significant new national initiatives, particularly the major expansion of the HUD–VASH program, are expected to make a marked difference in the coming year.

In summary, there has been significant accomplishment in serving homeless veterans with our community partners, although the information obtained through CHALENG indicates that much work still remains. CHALENG will continue to examine the progress of VA and the community toward that goal.

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Prepared Statement of Libby Perl, Analyst in Housing, Congressional Research Service, Library of Congress

Chairman Filner, Ranking Member Buyer, and members of the Committee, my name is Libby Perl and I am an analyst at the Congressional Research Service (CRS). Thank you for the opportunity to testify today. As requested, in my testimony I will provide a summary of research regarding homeless veterans, a brief overview of Federal programs that assist homeless veterans, and funding levels for those programs.

Research Regarding Homeless Veterans

Research that has captured information about the entire national homeless population, including veteran status, is rare. While the Department of Housing and Urban Development (HUD) is engaged in ongoing efforts to collect information about homeless individuals, the most extensive information about homeless veterans specifically comes from earlier studies. Possibly the most comprehensive national data collection effort regarding persons experiencing homelessness took place in 1996 as part of the National Survey of Homeless Assistance Providers and Clients (NSHAPC), when researchers interviewed thousands of homeless assistance providers and homeless individuals across the country.[1] Prior to the NSHAPC, in 1987, researchers from the Urban Institute surveyed nearly 2,000 homeless individuals and clients in large cities nationwide as part of a national study.[2] The data from these two surveys serve as the basis for more in depth research regarding homeless veterans. No matter the data source, however, research has found that veterans make up a greater percentage of the homeless population than their percentage in the general population.

Research from the 1980s and 1990s. Two studies—one published in 1994 using data from the 1987 Urban Institute survey (as well as data from surveys in Los Angeles, Baltimore, and Chicago), and the other published in 2001 using data from the 1996 NSHAPC—found that male veterans were overrepresented in the homeless population. In addition, researchers in both studies determined that the likelihood of homelessness depended on the ages of veterans.[3] During both periods of time, the

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[1] Martha R. Burt, Laudan Y. Aron, et al., *Homelessness: Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients, Technical Report,* December 1999, available at [http://www.huduser.org/publications/homeless/homeless_tech.html].

[2] Martha R. Burt and Barbara E. Cohen, *America's Homeless: Numbers, Characteristics, and Programs that Serve Them* (Washington, DC: The Urban Institute Press, July 1989).

[3] See Robert Rosenheck, Linda Frisman, and An-Me Chung, "The Proportion of Veterans Among Homeless Men," American Journal of Public Health 84, no. 3 (March 1994): 466; Gail Gamache, Robert Rosenheck, and Richard Tessler, "The Proportion of Veterans Among Homeless Men: A Decade Later," *Social Psychiatry and Psychiatric Epidemiology* 36, no. 10 (October 2001): 481.

odds of a veteran being homeless were highest for veterans who had enlisted after the military transitioned to an all-volunteer force (AVF) in 1973.

In the earlier study, researchers found that 41% of adult homeless men were veterans, compared to just under 34% of adult males in the general population. Overall, male veterans were 1.4 times as likely to be homeless as nonveterans.[4] Notably, though, those veterans who served after the Vietnam War were four times more likely to be homeless than nonveterans in the same age group.[5] Vietnam era veterans, who are often thought to be the most overrepresented group of homeless veterans, were barely more likely to be homeless than nonveterans (1.01 times).

In the second study, researchers found that nearly 33% of adult homeless men were veterans, compared to 28% of males in the general population. Once again, the likelihood of homelessness differed among age groups. Overall, male veterans were 1.25 times more likely to be homeless than nonveterans.[6] However, the same post-Vietnam birth cohort as that in the 1994 study was most at risk of homelessness; those in the cohort were over three times as likely to be homeless as nonveterans in their birth cohort. Younger veterans, those age 20–34 in 1996, were two times as likely to be homeless as nonveterans. And Vietnam era veterans were approximately 1.4 times as likely to be homeless as their nonveteran counterparts.

Like male veterans, women veterans are more likely to be homeless than women who are not veterans. A study published in 2003 examined two data sources, one a survey of mentally ill homeless women, and the other the NSHAPC, and found that 4.4% and 3.1% of those homeless persons surveyed were female veterans, respectively (compared to approximately 1.3% of the general population who are women veterans).[7] Although the likelihood of homelessness was different for each of the two surveyed populations, the study estimated that female veterans were between two and four times as likely to be homeless as their nonveteran counterparts.[8] Unlike male veterans, all birth cohorts were more likely to be homeless than nonveterans. However, with the exception of women veterans age 35–55 (representing the post-Vietnam era), who were between approximately 3.5 and 4.0 times as likely to be homeless as nonveterans, cohort data were not consistent between the two surveys.

HUD's Annual Homeless Assessment Reports. HUD is engaged in an ongoing effort to establish database systems at the local level to collect information about persons experiencing homelessness. Using these data, HUD has released two Annual Homeless Assessment Reports (AHARs), one in 2007 using data from 2005, and one in 2008, using data from 2006. While both AHARs provide information about homeless veteran status, there are limitations. Both report the number of sheltered homeless individuals, so persons living on the street are not captured, and in both reports, data regarding veteran status are incomplete. The first AHAR estimated that 18.7% of the adult homeless population was made up of veterans, compared to 12.6% of the general population.[9] Of the records used, however, 35% were missing information on veteran status. The second AHAR estimated that 14.3% of the homeless adult population were veterans compared to 11.2% of the general population.[10] In this case, 20% of records were missing information on veteran status.[11]

Federal Programs Targeted to Homeless Veterans

The majority of the Federal programs that target services specifically to homeless veterans are part of the Department of Veterans Affairs. One program, the Homeless Veterans Reintegration Program, is a Department of Labor (DoL) program. In addition, HUD collaborates with the VA to provide permanent supportive housing for homeless veterans through the HUD–VA Supported Housing, or HUD–VASH program. HUD also provides services to homeless veterans through its Homeless Assistance Grants, though these funds are not targeted to veterans.

[4] "The Proportion of Homeless Veterans Among Men," p. 467.
[5] Ibid
[6] "The Proportion of Homeless Veterans Among Men: A Decade Later," p. 483.
[7] Gail Gamache, Robert Rosenheck, and Richard Tessler, "Overrepresentation of Women Veterans Among Homeless Women," *American Journal of Public Health* 93, no. 7 (July 2003): 1133.
[8] Ibid, p. 1134.
[9] U.S. Department of Housing and Urban Development, *The Annual Homeless Assessment Report to Congress,* February 2007, p. 31, available at [http://www.huduser.org/Publications/pdf/ahar.pdf].
[10] U.S. Department of Housing and Urban Development, *The Second Annual Homeless Assessment Report to Congress,* March 2008, p. 23, available at [http://www.hudhre.info/documents/2ndHomelessAssessmentReport.pdf].
[11] For more information about HUD's efforts to collect information about homeless individuals, see CRS Report RL33956, *Counting Homeless Persons: Homeless Management Information Systems.*

HUD–VASH. Beginning in 1992, through a collaboration between HUD and the VA, funding for approximately 1,753 Section 8 vouchers was made available for use by homeless veterans with severe psychiatric or substance abuse disorders.[12] Section 8 vouchers are subsidies used by families to rent apartments in the private rental market. Through the program, called HUD–VA Supported Housing (HUD–VASH), local Public Housing Authorities (PHAs) administer the Section 8 vouchers while local VA medical centers provide case management and clinical services to participating veterans. HUD distributed the vouchers to PHAs through three competitions, in 1992, 1993, and 1994. Prior to issuing the vouchers, HUD and the VA had identified medical centers with Domiciliary Care and Healthcare for Homeless Veterans programs that were best suited to providing services. HUD does not separately track these vouchers. However, the VA keeps statistics on veterans with vouchers who receive treatment through the VA. In FY2006, 1,238 veterans with HUD–VASH vouchers received treatment during the year, with 1,028 veterans still receiving treatment at the end of that year.[13]

In 2001, Congress codified the HUD–VASH program (P.L. 107–95) and authorized the creation of an additional 500 vouchers for each year from FY2003 through FY2006.[14] A bill enacted at the end of the 109th Congress (P.L. 109–461) also provided the authorization for additional HUD–VASH vouchers. However, not until FY2008 did Congress provide funding for additional vouchers: the Consolidated Appropriations Act (P.L. 110–161) included $75 million for Section 8 vouchers for homeless veterans. HUD has estimated that this will fund between 9,800 additional vouchers.[15] The Administration has also requested an additional $75 million for HUD–VASH vouchers in FY2009.[16]

Research has found that permanent supportive housing, like that provided through the HUD–VASH program, improves outcomes for formerly homeless individuals. HUD–VASH specifically has been found to result in both improved housing and improved substance abuse outcomes among veterans who received the vouchers over those who did not.[17] Veterans who received vouchers experienced fewer days of homelessness and more days housed than veterans who received intensive case management assistance or standard care through VA homeless programs alone.[18] Analysis also found that veterans with HUD–VASH vouchers had fewer days of alcohol use, fewer days on which they drank to intoxication, and fewer days of drug use.[19] HUD–VASH veterans were also found to have spent fewer days in institutions.[20]

Health Care for Homeless Veterans. The first Federal program to specifically address the needs of homeless veterans, Health Care for Homeless Veterans (HCHV) was created as part of an emergency appropriations act for FY1987 (P.L. 100–6) in which Congress allocated $5 million to the VA to provide medical and psychiatric care in community-based facilities to homeless veterans suffering from mental illness.[21] Through the HCHV program, VA medical center staff conduct outreach to homeless veterans, provide care and treatment for medical, psychiatric, and sub-

[12] The first announcement of voucher availability was announced in the Federal Register. See U.S. Department of Housing and Urban Development, "Invitation for FY1992 Section 8 Rental Voucher Set-Aside for Homeless Veterans with Severe Psychiatric or Substance Abuse Disorders," *Federal Register* vol. 57, no. 55, p. 9955, March 20, 1992.

[13] Wesley J. Kasprow, Robert A. Rosenheck, Diane DiLello, Leslie Cavallaro, and Nicole Harelik, *Healthcare for Homeless Veterans Programs: Twentieth Annual Report,* U.S. Department of Veterans Affairs Northeast Program Evaluation Center, March 31, 2007, pp. 272–273.

[14] 42 U.S.C. § 1437f(o)(19).

[15] Testimony of Alphonso Jackson, Secretary of Housing and Urban Development, House Appropriations Committee, Subcommittee on Transportation and Housing and Urban Development, *FY2009 Appropriations,* 110th Cong., 2nd sess., February 13, 2008.

[16] See Budget of the U.S. Government FY2009—Appendix, Department of Housing and Urban Development, p. 541, available at [http://www.whitehouse.gov/omb/budget/fy2009/pdf/appendix/hud.pdf].

[17] Robert Rosenheck, Wesley Kasprow, Linda Frisman, and Wen Liu-Mares, "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness," *Archives of General Psychiatry* 60 (September 2003): 940. An-Lin Cheng, Haiqun Lin, Wesley Kasprow, and Robert Rosenheck, "Impact of Supported Housing on Clinical Outcomes," *Journal of Nervous and Mental Disease* 195, no. 1 (January 2007): 83.

[18] "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness," p. 945.

[19] "Impact of Supported Housing on Clinical Outcomes," p. 85.

[20] Ibid

[21] Shortly after the HCHV program was enacted in P.L. 100–6, Congress passed another law (P.L. 100–322) that repealed the authority in P.L. 100–6 and established the HCHV program as a pilot program. The program was then made permanent in the Veterans Benefits Act 1997 (P.L. 105–114). The HCHV program is now codified at 38 U.S.C. §§ 2031–2034.

stance abuse disorders, and refer veterans to other needed supportive services.[22] In some cases, veterans may stay in residential treatment facilities while receiving treatment. According to the most recent data available from the VA, in FY2006, the HCHV program treated approximately 60,857 veterans.[23] Of those, 82% had either a serious psychiatric or substance abuse problem.

Domiciliary Care for Homeless Veterans. The Domiciliary Care Program for homeless veterans was implemented to reduce the use of more expensive inpatient treatment, improve health status, and reduce the likelihood of homelessness through employment and other assistance. The DCHV program operates at 38 VA medical centers and has 1,991 beds available.[24] In FY2006, the number of veterans completing treatment was 5,282.[25] Of those admitted to DCHV programs, 92.7% were diagnosed with a substance abuse disorder, more than half (56.7%) were diagnosed with serious mental illness, and 52.5% had both diagnoses.[26] The average length of stay for veterans in FY2006 was 104.4 days, in which they received medical, psychiatric and substance abuse treatment, as well as vocational rehabilitation.

Compensated Work Therapy/Therapeutic Residence Program. Through the Compensated Work Therapy Program, the VA enters into contracts with private companies or nonprofit organizations which then provide disabled veterans with work opportunities.[27] Veterans must be paid wages commensurate with those wages in the community for similar work, and through the experience the goal is that participants improve their chances of living independently and reaching self sufficiency. The CWT program also provides work skills training, employment support services, and job development and placement services. The VA estimates that approximately 14,000 veterans participate in the CWT program each year.[28] In addition, a transitional housing component provides housing to participants in the CWT program who have mental illnesses or chronic substance abuse disorders and who are homeless or at risk of homelessness.[29] As of September 2006, the VA operated 66 transitional housing facilities with 520 beds.[30]

Grant and Per Diem Program. Initially called the Comprehensive Service Programs, the Grant and Per Diem program was introduced as a pilot program in 1992 through the Homeless Veterans Comprehensive Services Act (P.L. 102–590). The law establishing the Grant and Per Diem program, which was made permanent in the Homeless Veterans Comprehensive Services Act of 2001 (P.L. 107–95), authorizes the VA to make grants to public entities or private nonprofit organizations to provide services and transitional housing to homeless veterans. According to the most recent data available from the VA, in FY2006 the Grant and Per Diem program funded more than 300 service providers. These providers had a total of 8,200 beds available and served more than 15,000 homeless veterans.[31] The Grant and Per Diem program is permanently authorized at $130 million (P.L. 109–461).

The program has two parts: grant and per diem. Eligible grant recipients may apply for funding for one or both parts. The grants portion provides capital grants to purchase, rehabilitate, or convert facilities so that they are suitable for use as either service centers or transitional housing facilities. The capital grants will fund up to 65% of the costs of acquisition, expansion or remodeling of facilities.[32] Grants may also be used to procure vans for outreach and transportation of homeless veterans. The per diem portion of the program reimburses grant recipients for the costs of providing housing and supportive services to homeless veterans using the domiciliary care per diem rate. The per diem rate increases periodically; the FY2007 rate

[22] 38 U.S.C. § 2031, § 2034.
[23] *Healthcare for Homeless Veterans Programs: Twentieth Annual Report,* p. 25.
[24] Sandra G. Resnick, Robert Rosenheck, Sharon Medak, and Linda Corwel, *Eighteenth Progress Report on the Domiciliary Care for Homeless Veterans Program, FY2006,* U.S. Department of Veterans Affairs Northeast Program Evaluation Center, March 2007, p. 1.
[25] Ibid, p. 9.
[26] Ibid, p. 10.
[27] The Compensated Work Therapy program was authorized in P.L. 87–574 as "Therapeutic and Rehabilitative Activities." It was substantially amended in P.L. 94–581, and is codified at 38 U.S.C. § 1718.
[28] VA Fact Sheet, "VA Programs for Homeless Veterans," September 2006, available at [http://www1.va.gov/opa/fact/docs/hmlssfs.doc] (hereafter "VA Programs for Homeless Veterans").
[29] The VA's authority to operate therapeutic housing is codified at 38 U.S.C. § 2032.
[30] "VA Programs for Homeless Veterans."
[31] *Healthcare for Homeless Veterans Programs: Twentieth Annual Report,* p. 154.
[32] 38 U.S.C. § 2011(c).

was $31.30 per day.[33] The supportive services that grantees may provide include outreach activities, food and nutrition services, healthcare, mental health services, substance abuse counseling, case management, child care, assistance in obtaining housing, employment counseling, job training and placement services, and transportation assistance.[34]

Grant and Per Diem for Homeless Veterans with Special Needs. In 2001, Congress created a demonstration program to target grant and per diem funds to specific groups of veterans (P.L. 107–95). These groups include women, women with children, frail elderly individuals, those veterans with terminal illnesses, and those with chronic mental illnesses. The program was initially authorized at $5 million per year for FY2003 through FY2005. P.L. 109–461, enacted on December 22, 2006, reauthorized the program for FY2007 through FY2011 at $7 million per year.

Loan Guarantee for Multifamily Transitional Housing Program. The Veterans Programs Enhancement Act 1998 (P.L. 105–368) created a program in which the VA guarantees loans to eligible organizations so that they may construct, rehabilitate or acquire property to provide multifamily transitional housing for homeless veterans.[35] Eligible project sponsors may be any legal entity that has experience in providing multifamily housing.[36] The law requires sponsors to provide supportive services, ensure that residents seek to obtain and maintain employment, enact guidelines to require sobriety as a condition of residency, and charge veterans a reasonable fee.[37] Supportive services that project sponsors provide include outreach; food and nutritional counseling; healthcare, mental health services, and substance abuse counseling; child care; assistance in obtaining permanent housing; education, job training, and employment assistance; assistance in obtaining various types of benefits; and transportation.[38] Not more than 15 loans with an aggregate total of up to $100 million may be guaranteed under this program.

Acquired Property Sales for Homeless Veterans. The Acquired Property Sales for Homeless Veterans program is operated through the Veterans Benefits Administration (VBA). The program was originally enacted as part of the Veterans Home Loan Guarantee and Property Rehabilitation Act 1987 (P.L. 100–198); it is authorized through December 31, 2008.[39] Through the program, the VA is able to dispose of properties that it has acquired through foreclosures on its loans so that they can be used for the benefit of homeless veterans. Specifically, the VA can sell, lease, lease with the option to buy, or donate, properties to nonprofit organizations and state government agencies that will use the property only as homeless shelters primarily for veterans and their families. The VA estimates that over 200 properties have been sold through the program.[40]

Homeless Veterans Reintegration Program. Established in 1987 as part of the McKinney-Vento Homeless Assistance Act (P.L. 100–77), the HVRP is authorized through FY2011 as part of the Veterans Benefits, Healthcare, and Information Technology Act of 2006 (P.L. 109–461) and is administered through the Department of Labor (DoL). The program has two goals. The first is to assist veterans in achieving meaningful employment, and the second is to assist in the development of a service delivery system to address the problems facing homeless veterans. Eligible grantee organizations are state and local Workforce Investment Boards, local public agencies, and both for- and non-profit organizations.[41] Grantees receive funding for one year, with the possibility for two additional years of funding contingent on performance and fund availability.[42]

HVRP grantee organizations provide services that include outreach, assistance in drafting a resume and preparing for interviews, job search assistance, subsidized

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[33] U.S. Department of Veterans Affairs, Department of Geriatrics and Extended Care, Description of the State Veterans Home Program, available at [http://www1.va.gov/geriatricsshg/docs/FY07STATEVETHOMEPROGRAMHistory.doc].

[34] 38 CFR § 61.1.

[35] 38 U.S.C. §§ 2051–2054.

[36] U.S. Department of Veterans Affairs, *Multifamily Transitional Housing Loan Guarantee Program: Program Manual,* April 6, 2007, p. 9, available at [http://www1.va.gov/homeless/docs/Loan_Guarantee_Program_Manual_4–6-07.pdf].

[37] 38 U.S.C. § 2052(b).

[38] *Multifamily Transitional Housing Loan Guarantee Program: Program Manual,* p. 10.

[39] The program was most recently authorized in the Veterans Healthcare, Capital Asset, and Business Improvement Act of 2003 (P.L. 108–170). The program is codified at 38 U.S.C. § 2041.

[40] "VA Programs for Homeless Veterans."

[41] Veterans Employment and Training Service Program Year 2007 Solicitation for Grant Applications, *Federal Register* vol. 72, no. 71, April 13, 2007, p. 18682.

[42] Ibid, p. 18679.

trial employment, job training, and follow-up assistance after placement. Recipients of HVRP grants also provide supportive services not directly related to employment such as transportation, provision of or assistance in finding housing, and referral for mental health treatment or substance abuse counseling. In program year (PY) 2006, HVRP grantees served a total of 13,346 homeless veterans, of whom 8,713, or 65%, were placed in employment.[43]

Incarcerated Veterans Transition Program Demonstration Grants. The Homeless Veterans Comprehensive Assistance Act of 2001 (P.L. 107–95) instituted a demonstration program to provide job training and placement services to veterans leaving prison.[44] Authorization for the incarcerated veterans transition program expired on January 24, 2006 and no additional funding has been provided. The DoL reported that grant recipients enrolled 2,191 veterans in the program from FY2004 to FY2006 and that of these enrollees, 1,104 (54%) entered employment.[45]

Funding for Targeted Federal Programs

In FY2008, total funding for targeted Federal programs for homeless veterans is estimated to be about $317 million. In FY2007, approximately $282 million was obligated or appropriated for these programs. (See **Table 1.**) This total does not include the HUD funds used for HUD–VASH vouchers. The costs of Section 8 vouchers vary based on the size of a unit rented and fair market rents across the country. The average cost of a Section 8 voucher in 2007 was between $6,000 and $7,000, however, the amount needed for a HUD–VASH voucher could be different. In addition, the estimate does not include VA funds for treatment of homeless veterans, including inpatient medical, surgical, psychiatric, and long term care.

HUD Homeless Assistance Grants

Though the HUD Homeless Assistance Grants do not specifically target homeless veterans, homeless veterans benefit from the grants. The Homeless Assistance Grants account was established in 1987 as part of the Stewart B. McKinney Homeless Assistance Act (P.L. 100–77). The grants, administered by HUD, fund housing and services for homeless persons. There are four Homeless Assistance Grants: the Emergency Shelter Grants (ESG) program, Supportive Housing Program (SHP), the Shelter Plus Care (S+C) program, and the Section 8 Moderate Rehabilitation Assistance for Single-Room Occupancy Dwellings (SRO) program.

In FY2007, approximately $1.3 billion was awarded to homeless services providers through the Homeless Assistance Grants. A total of 5,911 projects received funding.[46] Of the grantees, HUD estimates that 149 were veteran specific projects, meaning that 70% or more of those served are veterans. These veteran specific organizations received approximately $135 million. Veterans may also be served by projects where veterans make up less than 70% of clients.

In addition, since 2003, HUD has participated with the VA and the Department of Health and Human Services (HHS) in the Collaborative Initiative to Help End Chronic Homelessness, coordinated through the Interagency Council on Homelessness. Through the initiative, HUD funds permanent supportive housing for chronically homeless individuals while the VA and HHS fund supportive services. The initiative has provided housing for 1,242 individuals; according to an evaluation of the initiative, 30% of program participants who took part in the evaluation surveys were veterans.[47]

For more information about the programs described in this report, please see CRS Report. RL34024, *Veterans and Homelessness.* Thank you again for the opportunity to speak here today, and I look forward to your questions.

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[43] Presentation of Charles S. Ciccolella, Assistant Secretary for Veterans' Employment and Training, U.S. Department of Labor, to the VA Advisory Committee on Homeless Veterans, January 31, 2008.

[44] 38 U.S.C. § 2023.

[45] Presentation of Charles S. Ciccolella.

[46] U.S. Department of Housing and Urban Development, FY2007, Summary of Competition Awards Report, available at [http://www.hudhre.info/documents/2007_NationalHomeless AwardsSummary.pdf].

[47] Alvin S. Mares and Robert A. Rosenheck, *Evaluation of the Collaborative Initiative to Help End Chronic Homelessness,* Northeast Program Evaluation Center, February 26, 2007, Table 4, available at [http://www.hudhre.info/documents/CICH_ClientOutcomesReport.pdf].

Table 1—Funding for Selected Homeless Veterans Programs FY1988–FY2008 (dollars in thousands)

Fiscal Year	Obligations (VA Programs)						Budget Authority (DoL Program)	Total Funding for Selected Programs
	Healthcare for Homeless Veterans[a]	Domiciliary Care for Homeless Veterans	Compensated Work Therapy/ Therapeutic Residence	Grant and Per Diem Program	HUD–VA Supported Housing	Loan Guarantee for Multifamily Transitional Housing	Homeless Veterans Reintegration Program	
1988	$12,932	$15,000[b]	NA	NA	NA	NA	$1,915	$29,847
1989	13,252	10,367	NA	NA	NA	NA	1,877	25,496
1990	15,000	15,000	NA	NA	NA	NA	1,920	31,920
1991	15,461[c]	15,750	—[c]	NA	NA	NA	2,018	33,229
1992	16,500[c]	16,500	—[c]	NA	2,300	NA	1,366	36,666
1993	22,150	22,300	400	NA	2,000	NA	5,055	51,905
1994	24,513	27,140	3,051	8,000	3,235	NA	5,055	70,994
1995	38,585[d]	38,948	3,387	—[d]	4,270	NA	107[e]	85,297
1996	38,433[d]	41,117	3,886	—[d]	4,829	NA	0	88,265
1997	38,063[d]	37,214	3,628	—[d]	4,958	NA	0	83,863
1998	36,407	38,489	8,612	5,886	5,084	NA	3,000	97,478
1999	32,421	39,955	4,092	20,000	5,223	NA	3,000	104,691
2000	38,381	34,434	8,068	19,640	5,137	661	9,636	115,957
2001	58,602	34,576	8,144	31,100	5,219	366	17,500	155,507
2002	54,135	45,443	8,028	22,431	4,729	528	18,250	153,544
2003	45,188	49,213	8,371	43,388	4,603	594	18,131	169,488
2004	42,905	51,829	10,240	62,965	3,375	605	18,888	190,807
2005	40,357	57,555	10,004	62,180	3,243	574	20,832	194,745

2006	56,998	63,592	19,529	63,621	5,297	507	21,780	231,324
2007	71,925	77,633	21,514	81,187	7,487	613	21,809	282,168
2008[f]	74,802	80,738	22,375	107,180	7,786	660	23,620	317,161

Sources: Department of Veterans Affairs Budget Justifications, FY1989–FY2009, VA Office of Homeless Veterans Programs, Department of Labor Budget Justifications FY1989–FY2009, and the FY2008 Consolidated Appropriations Act P.L. 110–161.

[a] Healthcare for Homeless Veterans was originally called the Homeless Chronically Mentally Ill veterans program. In 1992, the VA began to use the title "Healthcare for Homeless Veterans."

[b] Congress appropriated funds for the DCHV program for both FY1987 and FY1988 (P.L. 100–71), however, the VA obligated the entire amount in FY1988. See VA Budget Summary for FY1989, Volume 2, Medical Benefits, p. 6–10.

[c] For FY1991 and FY1992, funds from the Homeless Chronically Mentally Ill veterans program as well as substance abuse enhancement funds were used for the Compensated Work Therapy/Therapeutic Residence program.

[d] For FY1995 through FY1997, Grant and Per Diem funds were obligated with funds for the Healthcare for Homeless Veterans program. VA budget documents do not provide a separate breakdown of Grant and Per Diem Obligations.

[e] Congress appropriated $5.011 million for HVRP in P.L. 103–333. However, a subsequent rescission in P.L. 104–19 reduced the amount.

[f] The obligation amounts for FY2008 are estimates.

Prepared Statement of Michelle Saunders, Arlington, VA (Veteran)

Mr. Chairman and members of the committee, I want to thank you for allowing me the opportunity to testify on behalf of myself and my fellow veterans both current and future. My name is Michelle Saunders and I am a wounded veteran from Operation Iraqi Freedom. I went through my transition from the military to the civilian sector in May of 2006. Prior to my getting injured on May 1st, 2004, I was motivated, proud, extremely physically fit and ready to wear the uniform for at least another 20 years of my life, I was a career soldier. After hearing the words "your military career has come to a halt" I went through some serious hardships that I never imagined going through, as most veterans do today.

The military had taught me some of the most valuable tools and how to apply them in order to be a successful leader; I thought for sure I was going to be ok in my transition because of all the "promises" that had been made by veteran service providers and folk who already transitioned and had jobs. The day I left the gates of Walter Reed, I never imagined in a million years that I would ever look back. The reality was and still is, it's by far the worst relationship I had to walk away from. Aside from being angry, broken and in complete emotional turmoil, I fell into serious financial hardship and a serious state of depression to the point where I held a loaded gun to my head on many lonely nights. The only thing that stopped me was my lack of selfishness and what it would do to my family. I have always been a person of pride and strength, I felt like I was completely stripped of every shred down to the core. I had literally lost my own self worth.

After many months of trying so desperately to find a job and barely escaping homelessness, by the grace of god I was fortunate enough to be at the right place at the right time. I was offered a job at the military severely injured center as an employment coordinator for the Department of Labor, it seemed a bit ironic since I had just gone through the trials and tribulations of finding a job. I was interviewed on a Tuesday afternoon, that night I was asked to attend a wounded summit conference that following Thursday in Alabama. I was so excited just to know I had a job that I forgotten about the fact I had no money to make travel arrangements. I thought to myself how incredibly embarrassing it would be to ask for a cash advance just to cover my travel expenses on my first day of work. I had literally exhausted all of my resources and had no time. I hung my head and called my new boss at ten pm and explained my situation, he soon became my angel as he told me to breathe and took care of everything.

Finally, I arrived in Alabama at 3 am and I was able to sleep for three hrs before having to get up for the conference, the conference I knew nothing about. Little did I know that I was going to be asked to speak in front of many of our senior military and government leadership. I was asked to speak about my experiences of being wounded and the struggles I faced in the after math. I remember having severe anxiety about speaking and exposing my living hell, let alone in front of such a large crowd however; the scariest part was having to speak next to, two other wounded veterans—veterans with visible disabilities, veterans with amputations.

That feeling of losing self worth had started to surface again because for so long, I didn't feel worthy or injured enough to be standing next to them. Sure I had been in a combat zone accompanied by multiple mortar attacks, serious fire fights, loss of good friends and sustained serious back injuries, but I had all my limbs and some sense of sanity. At that moment I realized that if I were to run out of that room, I would never have an opportunity to release all of what I was harboring. This was clearly a major pivotal point in my life.

I decided to speak last, so I was clear in my thoughts, as I had no idea what to expect. After listening to the two amputees ahead of me I realized at that moment, that I was different, I was in a totally different category—the category that clearly over shadows our visible wounded heroes. People fail to realize that a visible wounded hero has someone by their bedside twenty-four hrs a day seven days a week. Where as the "invisible" wounded heroes are overlooked on a daily basis. These thoughts were circling my head over and over but in a good way, good because I was in a position to finally embrace the hard "stuff" and help those who can't voice the pain that is eating them alive, so I thought anyway . . .

I felt liberated after I walked off that stage, I felt as though my voice finally penetrated the core of the systemic issues that so many of us veterans share day to day. I had Viet Nam and other era veterans coming up to me in tears, just to say "thank you, you have said all the things that we could not say, or find the words to say"

When I left the conference, I was so eager to get in the trenches and start figuring the best strategic approach on how to stop the bleeding, but little did I know it was

like trying to put a band-aid on a sucking chest wound. I soon started to see the blackness of bureaucracy from the inside as opposed to being the victim on the outside. I started to see how a "success" was measured by a number, how a problem would disappear when it was time to report to the higher chain of command, how the "collaborating" agencies would point fingers at each other of all the pitfalls and the hiccups, but would leverage each other for the "successes". After reading that, one may ask or presume I am bitter. The answer is, I am not bitter, I am disappointed and I am embarrassed. I am disappointed because I stand next to people every day who are in the positions to make effective change, who make six plus figure salaries a year and are able to go home at night and provide for their families just to start over the next day. I am embarrassed because I can't financially afford to bite the hand that feeds me. For me, it's a little different, I go home at night and I am in pain because I know that my brothers and sisters who once stood by my side at arms and always covered me, are gasping for air because they're worried about where the next pocket of money is coming from, their VA appeal claims, their lack of credentials, because of what their families may think of their, once proud American soldier. These are the parts of the transition that holds the needed healing of the broken soul, how do you heal when you can't stop firing squad?

We are still repeating history in a sense that during the 1970s and 1980s, our streets were crawling with Vietnam War veterans with the same issues. The only difference today is our veterans are not being ignored by society and the government is being held accountable. For the first time Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) are being recognized as issues and they are abnormal conditions caused by combat trauma and combat stress. We live in a society that does not accept murder as something "normal". We live in a society that is spiritual and compassionate by nature regardless of religious beliefs. When these horrific acts are witnessed or are performed by an American soldier in a time of war, it breaks the spirit in a way that can't be defined. However, we are expected to act "normal" when we arrive back to our home soil. In addition our peers are forced to look at us different and weak because of the mentality of our senior military leadership, we are "STRONG" warriors that aren't supposed to feel, yet we must follow the rules of the Geneva Convention because our morals and beliefs as a Nation dictate. Yes there are services in place for those who "need it" but there is a silent voice that is extremely loud that puts those who "need it" in a corner. Fortunately, the American population as a whole is finally pushing back because they understand what our eyes see across the water is not "normal" however; there is still an uncomfortable stigma that is associated with this. Society as a whole wants to help, but that help must happen away from their children and their neighborhoods. We are making a difference however, the flood gates have been opened and an enormous amount of water has fractured the backbone of our infrastructure. It is up to those who can speak for the ones who can not. WE MUST INFORM, EDUCATE AND PROMOTE AWARENESS. The blind eye approach is NOT working; it is MUCH bigger than us, so we must take a different approach.

The million dollar question is "how do we fix it?" First, we must understand our veterans are fighting two wars, one across the water and one here on the home front. The concept and words "Support our Troops" seems to be everywhere you look today, from yellow ribbons to American flags to the "support the troops" bumper stickers, but do we really know what the reality of "support" means. We will never know how to properly support the veteran population as long as the "right" questions are not being asked and we will continue to have those veterans who will "fall" through the cracks and become a statistic in the homeless veteran population.

I will attempt to illustrate where the flood gates are broken, the following line items are currently staring us in the eye of the systemic core:

Inability for the services to admit that "PTSD" is an issue: Until the senior leadership of the military comes forward and recognizes that combat trauma is **not** normal then we as a society will continue to see it as a stigma and continue to work in a vacuum.

- How do we heal if we can't sleep?
- How do we heal if we are hyper vigilant in every facet of our days?
- How do we heal if we have social withdrawal because we feel so disconnected?
- How do we heal when our own leaders keep us at an arms distance and call this disorder a "personality disorder"—in turn ending in an even bigger stigma?

Lack of accountability and collaboration of agencies: We are finding that more and more agencies and service components are wanting to "take care of their own" however, what the services/service providers are missing is that there must be case management across all lines, that is the only approach when dealing with

physical and psychological wounds. No matter what a person's situation, there is a history and it must be captured. In the case of the VA, the military must make that "warm" hand off. In the case of the Department of Labor, the VA must determine someone employment ready, there are many steps that must take place before a subject matter expert can consider someone "employment ready" We also must stop counting numbers as a measurement of success. Just because a veteran request services doesn't mean they're a success because they were entered into a data base. There is way too much anecdotal information that is being reported as successes in order to continue the fluff that is delivered to congress in the exchange of funding. This is clear reason why congress and our administration are being bastardized on a daily basis not only here in our own country but across the world, this is why we as a Nation are so divided and we're repeating history yet again.

Program Qualifications: All programs must have a certain criteria in place in order to provide and deliver services, of course for their continuity. However, when the criteria's are different across the board even though the mission is the same, it can seriously complicate matters. Examples:

- Who is the authorizing authority to determine someone "seriously injured"
- If someone is not able to work because of serious PTSD why should he or she have to prove time and time again their condition, if it is clearly stated in their VA disability record?
- Why do almost all current providers only work with OIF/OEF, when we have other veterans from other eras that desperately need services?
- Why do veterans have to be homeless before they receive a grant? We should not be taking the re-active approach; we should be taking the pro-active approach. That is why we as a government spend so much money on R&D to better the future; we are a much smarter society to allow these pitfalls.
- We MUST understand that the entire family is fractured when a service member is injured physically and or psychologically and we MUST treat and provide services to the whole family

Identification Issues: When a service member is injured down range and medically evacuated, the service member still carries their original unit identification code (UIC). This particular issue is creating long-term identification issues. Because of this standard operating procedure it creates problems for the following reasons:

- Once the service member has arrived at the medical treatment facility there is a determiNation made whether or not that service member will be attached to a wounded transition brigade (WTB) or they will be assigned.
- Attached and assigned are two different categories. This means that if a wounded service member is attached, then he or she will then carry two UIC codes until he or she has been assigned due to long-term care needs or identified for separation.
- Those who have been augmented from other Active, Reserve and National Guard units fall between the cracks almost automatically because these individuals were never considered permanent party in the first place and once they are considered "broken" they're no longer wanted on the roster, so the unit in combat can fill that billet immediately.
- Service members who are put into a temporary retired disabled category (TRDL) are sent to a civilian based health care organization (CBCHO). Once in this category a lot of service members are being put out of the service and not followed up through the VA or the military therefore resulting in "falling through the cracks." This particular population often times are forgotten and are unaware of their benefits and services available to them.

> Recommendation: Once a service member is injured, he or she should automatically be assigned a second identifier that will allow the outgoing unit and the potential incoming unit to keep one hundred percent accountability. Recovery coordinators must be assigned immediately to maintain continuity. **(On a personal note it took Walter Reed six months to realize I was even there. In addition my unit informed me that if I wanted to go back to Hawaii I could and they would arrange with or without the facilitation of Walter Reed, *not a bad deal if you just want to run away because you just can't deal mentally.)***

Veterans struggle to find employment: Currently the average age of our veterans today are between the ages 19–25. It is the reality that of being in such a young age group which often masks the very accomplishments and career progression that also reflects the approximate time and grade of a service member anywhere between the ranks of private through sergeant. In the eyes of the military

a sergeant has the ability to lead, manage and supervise approximately 6–8 people under multitudes of stress however, in the corporate world this is something foreign. There are many challenges in the way of disabled veterans finding gainful employment, to include the competition of young college graduates chomping at the bit for sinking their teeth into the best corporate positions possible. With today's competitive society, power is knowledge and often equates to increased earning potential. Realistically without these tools/credentials our veterans are automatically at a disadvantage the minute they leave the gates of the military installations. Being a Nation at war, with back to back deployments our military do not have the option to go to school. After being discharged, many are relegated to lower paying jobs simply to make ends meet and will not have the time to utilize and maximize their educational benefits due to the stress of keeping food on the table and a roof over their families' heads. Coupled with a disability and a competitive labor market many of our heroes are falling into homelessness. We as a Nation need not only protect our veteran population but we need to equip them with the proper tools and an environment to ensure they're ready for the 21st century workforce.

Traumatic Service member's Group Life Insurance (TSGLI): This one time payout of $25k up to $100k is causing SERIOUS debt for our wounded coming back. Regardless of the financial counseling, a person who has never received this kind of money is going to spend it the way they want to, in addition the financial decisions being made while under heavy narcotics and other medications are creating serious financial hardships. A large number of our younger service members are over 30k in debt due to the misuse of funds.

Recommendation: If the payment is made through the VA insurance provider, then perhaps have the money added to the veterans already disability pay. In the event that a wounded service member while still on active duty falls under financial hardship, then they should be able to file for a cash advance to cover the vital expenses at that current time. This should also apply to veterans that are already receiving disability compensation. Keep in mind most of our newly discharged veterans are between the ages 19–25 years of age.

We as a country are protected by the gate keepers who wear the uniform for the purpose of keeping peace of such a great nation. We as a country can not and must not fail those who didn't fail us. We can do no less, we owe them that, we owe them a future.

Prepared Statement of John F. Downing, President and Chief Executive Officer, Soldier On (United Veterans of America)

Chairman Filner, Representative Buyer, and Members of the Committee: on behalf of the hundreds of homeless veterans served every year by United Veterans of America, I am honored by your invitation to be here today testifying on the subject of homelessness among veterans of U.S. military service.

I have the privilege of serving as President and CEO of United Veterans of America, Inc., doing business as Soldier On. Based in Leeds, Massachusetts, with facilities serving homeless veterans in Pittsfield and Leeds, Soldier On serves upward of 250 veterans every day. Our program is based on a continuum of care, ranging from the treatment of trauma and mental health issues to substance abuse counseling, shelter, food and other necessities, job training, and permanent housing. Our partners include the U.S. Department of Veterans Affairs, the U.S. Department of Labor, HUD, and many state and local agencies. Shelter, treatment, and hope are our cornerstones.

Soldier On hosts one hundred and forty-five men and women in transitional living on site at the VA Medical Center campus in the Leeds section of Northampton, Massachusetts. Soldier On rents from the VA a few of the old staff "cottages" where we have created appropriate housing for women veterans and for frail, elderly male veterans. We pay HUD's fair market rent to the VA for the privilege of housing these men and women. Sixty more vets live in transitional housing at our Berkshire Veterans Residence in Pittsfield, Massachusetts, which opened in September, 2004. Ten new studio apartments, funded through the U.S. Department of Housing and Urban Development, provide permanent housing for homeless veterans with a disability at the Pittsfield site.

Soldier On serves veterans primarily from the northeast United States. A few are referred to us from across the country. The average age of our population is 54, but the mean age is trending younger as we see more veterans of Operation Enduring

Freedom and Operation Iraqi Freedom. Approximately eighty-eight percent of our vets suffer mental health and/or substance abuse issues. Some ten percent are elderly, at age 65 or older. Five percent of our vets are women. More than twenty-five percent of our vets have been diagnosed with post traumatic stress disorder (PTSD); twenty-eight percent are on parole or probation; forty-two percent of Soldier On's vets are minority.

I could go on, but I would invite you to take a look at our Web site at www.wesoldieron.org to learn more about our program. I am supported by a dedicated staff and a committed board of directors, and I enjoy a strong, collaborative relationship with our VA Medical Center and with VA Headquarters here in Washington.

Currently we are in the pre-development stage of a 39 unit limited equity cooperative, to be built on our site in Pittsfield, Massachusetts. The development will be *owned* cooperatively and *managed* by formerly homeless veterans. These apartments will meet the highest standards of "green" building, incorporating energy efficiency, renewable energy, and alternative fuels. This housing will be sustainable in perpetuity for low income veterans. Additionally, with reasonable support from the Federal government, we can dedicate a portion of each veteran's rent to an Individual Development Account (IDA), thus enabling formerly homeless veterans to realize the American dream of homeownership and building wealth through equity. This changes the end of the story for homeless veterans of U.S. military service.

I mentioned changing the end of the story for homeless veterans, and I'd like to go back to that. Typically, the veterans in our care, both men and women, cycle from the streets to shelter, back to the old neighborhood and, ultimately, back to shelter. Along the way, these men and women lose everything. It's hard to imagine but, typically, every contact with family and community has been lost. Jobs, houses, family ties, self-respect, sobriety, mental health, personal hygiene—all gone. Dignity—gone. At Soldier On our vets come to see each other as their community. Only by creating permanent, affordable housing for veterans can we change that pattern. By creating permanent, affordable housing opportunities, whether it's rental, cooperative, or homeownership, and by bringing comprehensive support services to the veterans in this housing, we can change the end of that story once and for all. In the long run, permanent supportive housing is less expensive than shelter. And, finally, our veterans deserve better than what we're doing today.

Why is all this necessary? How is it that nearly one hundred fifty thousand veterans of U.S. military service are homeless on any given night? How is it that so many men and women who have worn the uniform can end up on the streets of America's cities and towns? Lately, we have seen somewhat of a downturn in those numbers, which leads us to believe that our efforts have been successful to some degree. But, sometime soon, we hope, the GIs serving bravely today in Iraq and Afghanistan will return home, and we know that the rate of homelessness among veterans will increase. What are we doing to get ready for our returning GIs? Soldier On's 39 units in Pittsfield, Massachusetts will be occupied fully the day we cut the ribbon. What is our plan?

Last fall the National Alliance to End Homelessness released a comprehensive report on the status of homeless veterans. I know you've all received that report, and I commend it to you. You will read about poverty and unemployment among veterans. You will read about veterans with disabilities who are further burdened by severe housing costs, especially among veterans who are renters. And, sadly, you will read about veterans who fall into more than one of these high risk categories. Factor in such variables as substance abuse, mental illness, and arrest or incarceration history, and the picture is bleak, indeed. But the situation is not hopeless. Just as we, as a country, have been able to marshal resources to take the battle to terrorists abroad, so can we mobilize to meet the needs of those who, in the words of Lincoln, "shall have born the battle." Last week The Boston Globe reported the story of a disabled OIF veteran whose wife has had to quit her job a number of times as they have moved around to be near a VA Medical Center. She is saving the system a lot of money by taking care of her husband at home, but the family is suffering. The child has been moved from school to school, the wife—a flight attendant—has devoted herself to her husband, whose brain injury makes him difficult to live with, and the family now is impoverished. What kind of future do they have? Don't that veteran and his family deserve our help? What's wrong with us? Must they become homeless before we help them?

The answer to the homelessness issue is not complicated. This congress, in this year's budget, funded the HUD VASH rental assistance program. In your wisdom, you eliminated much of HUD's red tape, thus providing developers of housing for veterans with more project-based rental subsidies. In the coming years we will need more HUD VASH subsidies, and many of them will be used as project-based sub-

sidies as we develop new units. HUD VASH should be allowed to be used as Homeownership Section 8 subsidies, as well as for limited equity cooperative developments, such as the project we are developing in Pittsfield. The beauty of HUD VASH is, of course, that VA case managers accompany the subsidy, improving the veteran's chances of a successful tenancy.

But we'll need more help. In general, to the best of my knowledge, the Federal government has no program that supports exclusively the creation of permanent, affordable housing for veterans. I realize that this is a policy decision for the consideration of the entire Congress and the Administration. If we truly are to be successful, we must embark on a production program to create new units of safe, decent, affordable housing for veterans—not only for individual veterans, but for veterans with families as well. Recently, Soldier On has developed a partnership with the AFL–CIO Housing Investment Trust, which is based here in Washington, D.C. The Housing Investment Trust is eager to work with us to develop housing for veterans; beginning in Massachusetts, and working with MassHousing, our state's housing finance agency, we will create homeownership opportunities for veterans, as well as more limited equity cooperative apartments. And, although the Housing Investment Trust has considerable human and financial resources to invest, we will need an equity partner in that enterprise. The most appropriate equity partner is the very Nation that our veterans have served. Fortunately, a precedent exists that provides a model for that equity partnership. Now, Federal earmarks get a bad rap, and some of that might be deserved. But our representative in this body, Congressman John Olver of the First Massachusetts Congressional District, has secured for us two direct Federal appropriations, without which our project in Pittsfield would not be feasible. We would ask that Congress create programs that provide long-term, soft deferred loans, along the lines of the Federal HOME program that would work as equity and reduce the debt load of these projects—a HUD-VA-HOME program, if you will. The simple fact is that, by providing homeownership opportunities, case management, and affordable rental housing, we could eliminate most of the VA's shelter programs. And we know that an investment in permanent housing, whether homeownership or rental, is a better investment than spending money year after year on shelter programs. We need housing first.

Back home, the Commonwealth of Massachusetts, under both Governor Romney and Governor Patrick, is stepping up to the plate with state money and a willingness to support the project with Federal resources, such as project-based Section 8 subsidies, VASH subsidies, and HOME funds. At this point, however, Federal participation has been limited to a relatively small direct appropriation from HUD, procured through the good offices of Congressmen John Olver and Richard Neal. For Soldier On to complete this project with a reasonable, minimal debt load, the Federal government must be more of a partner with us.

The beauty of the project we're building in Pittsfield is that it is replicable. With a little help from the banks and state and Federal government, this type of housing can be adapted for any part of the country. We are working now with the VA Medical Center in Leeds, Massachusetts to create another limited equity cooperative on the grounds of the Medical Center. Across the country, VA Medical Center campuses typically enjoy lots of unused green space. A project like ours could be built on the grounds of any VA Medical Center. Working with the VA, non-profit developers could lease the land at a nominal rate, while taking the entire responsibility for building and operating the permanent housing on that land. No additional expense would accrue to the VA, and the VA Medical Center would have a new out-patient population on its doorstep. But the best reason for doing this is that it serves veterans. And that's what we're talking about today—serving veterans.

I would add, parenthetically, that, although not the purview of this committee, I would ask Congress to amend the Fair Housing Act to include veterans of U.S. military service as a protected class. I mention this because, if we are successful in creating permanent housing for veterans, we run the real risk of violating Fair Housing laws by giving veterans priority—again, a Catch-22 situation which I'm sure is unintentional, and which I'm sure can be fixed. Other technical fixes are within our grasp as well. For instance, the VA's payment system is a nightmare. Good people in this Congress, working with good people at the VA, passed legislation to change the payment system last year, but that legislation never made it to a final bill. If I go out and raise money to improve service to homeless veterans, the VA is forced to reduce as result of OMB Circulars its payments to us. We would like to see the Secretary of the Department of Veterans Affairs be allowed to create a system of payments for approved providers of services that allows reasonable funding to insure appropriate care and services are provided. The Secretary should be allowed to consider the higher costs of doing business in certain geographical areas. If I can get donations to cover the high cost of heating our buildings in west-

ern Massachusetts, the Secretary of the VA should not be forced to penalize me for that initiative. Services for homeless veterans within a community are most effective when a recipient can augment payments from the VA with funds from any source, including Federal, state, local, and private sources.

Soon, we hope, we will be welcoming home the veterans of Operation Enduring Freedom and Operation Iraqi Freedom. Each Veteran deserves a system of care that is anchored in safe, affordable permanent housing that he or she can own.

Prepared Statement of Colonel Charles Williams, USA (Ret.), Executive Director, Maryland Center for Veterans Education and Training, Inc.

Mr. Chairman, members of the subcommittee, my name is Charles Williams and I am the Executive Director of the Maryland Center for Veterans Education and Training, Inc., commonly referred to as MCVET.

MCVET was established approximately 15 years ago with a mission to provide 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 where veterans are reintroduced to the military type of discipline that they were accustomed to through their service. The services offered during a veteran's stay in our facility are designed to remove barriers to recovery. These barriers include but are not limited to, debts, courts, child support, discharge upgrades and physical/mental health issues.

The reawakening of the routine military discipline enhances MCVET's ability to stabilize and reorder the lives of these veterans. Each student attends substance abuse classes and alcoholics/narcotics anonymous meetings, and works 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.

Services include:

- Outreach
- Day drop-in, emergency, transitional and permanent housing
- Substance abuse counseling
- Assistance with physical and mental health issues, including post traumatic stress disorder (PTSD) and traumatic brain injury (TBI)
- Education
- Job training and placement
- Aftercare

MCVET owes its very existence to the Federal Grants to community based 501(c)(3) organizations. We have uniquely married the housing services available from HUD, the medical and social service support available from Veterans Affairs, and the job training/education services available from the Department of Labor in order to move homeless veterans into the societal mainstream as self-supporting and contributing members to their families and their communities.

Veterans returning from Afghanistan and Iraq face problems that can be overcome through the Veterans Affairs system. Many problems occur from an ineffective readjustment period after transitioning from war zones. If the veteran is not connected to comprehensive services, then other problems, e.g., drugs, crime and homelessness, will surface.

A unified service delivery system should be developed with HUD, VA and DOL participating in an effort to create a one stop application process. This process would be designed to eliminate the barriers which have been put in place that severely limit and discourage the veterans' efforts at accessing services in a timely manner.

In discharging soldiers from active duty, there should be a "handoff" system whereby their final physical, specifically their psychosocial and mental health issues, are documented and forwarded to their nearest VA medical center in their home areas. This should eliminate duplication of efforts and accelerate the time that treatment can begin.

MCVET is uniquely positioned because of the presence of Veterans Affairs' staff who are stationed at the agency. The staff includes but is not limited to psychologists and psychiatrists at the doctoral level and social workers. Additionally, a liaison from the Grant and Per Diem program is in the office during the week.

These VA personnel assist in the admissions process for veterans who are in immediate need of mental health services and are key in determining the level of care needed. Our students are able to access mental health services within one week of entering our program. Also, psychosocial assessments are conducted at the agency

within the first week in an effort to identify for MCVET staff the level of mental health services that should be given to each student. Without the assistance of VA mental health professionals, the admissions process becomes time consuming with a distinct possibility of losing the veteran to the streets. Veterans Affairs has adequate resources to treat mental health issues once the veteran is admitted. We can recommend that Veterans Affairs develop the ability to use its resources and expand the utilization of the Vet Centers. Vet Centers can be found in most major population centers.

MCVET's job placement office has placed veterans in high profile jobs such as drafting, certified computer systems administrator, and maintenance technician for a municipal transportation system, master fitness trainer, web designer, and schoolteacher. MCVET strives to place veterans in situations where they can succeed rather than fail.

- For FY 2007, the retention rate after 90 days for veterans placed in employment was 96 percent.
- After 180 days, the retention rate for FY 2007 was 90 percent.
- For FY 2006, it was 79 percent.

We have placed 97 percent of the veterans seeking employment for FY 2007. (See chart below) We are committed to developing careers for our veterans rather than dead-end jobs that tend to perpetuate the cycle of poverty and homelessness.

Veterans who are educated, gainfully employed and independent are assets to their communities. They are reunifying with families, purchasing their own homes, starting their own businesses and participating in the economy. Because of our work with veterans, HUD declared the program a national model on 7 May 1997. This occurred after we had been serving veterans a little less than 3 years.

In closing, I would like to thank you for this opportunity to appear before you and to share MCVET's story. Homeless veterans are likely to face greater challenges in the years ahead as scarce resources strain a service delivery system that is already overburdened. I urge you, in your deliberations, to consider the plight of those young men and women who have been sent to defend the ideals of this country. Many of them are returning home broken of body, mind and soul and this country needs to provide them with resources to enable them to share in the American dream.

Department of Labor Performance Measures

Category	Year	MCVET Goal	Accomplishment	Percentage of Goal	Department of Labor Goal
	FY 06–07				
Assessments		300	313	104%	85%
Enrollments		200	208	104%	85%
Placements		160	154	97%	85%
90-Day Retention		112	107	96%	85%
Average Hrly. Wage		$9.00	$13.12	146%	85%
	FY 05–06				
Assessments		300	321	107%	85%
Enrollments		200	202	101%	85%
Placements		160	155	97%	85%
90-Day Retention		112	109	97%	85%
Average Hrly. Wage		$9.00	$12.03	134%	85%
	FY 04–05				
Assessments		300	309	103%	85%
Enrollments		200	204	102%	85%
Placements		160	159	99%	85%

Department of Labor Performance Measures—Continued

Category	Year	MCVET Goal	Accomp-lishment	Percentage of Goal	Department of Labor Goal
90-Day Retention		112	118	105%	85%
Average Hrly. Wage		$9.00	$12.17	135%	85%

Prepared Statement of Phil Landis, Chief Executive Officer, Veterans Village of San Diego, CA

Chairman Filner, Congressman Buyer, Committee Members, My name is Phil Landis and I am the Chief Executive Officer of the finest homeless, veteran-only, drug and alcohol treatment facility in the United States. Prior to assuming duties as CEO, for the previous 11 years I was blessed to be a member of the Board of Directors and ultimately chair of Veterans Village of San Diego (VVSD), formerly known as Vietnam Veterans of San Diego. In addition to the Veteran Recovery Center, VVSD is the founder of the National Stand Down which annually, for three days in July, hosts over 700 homeless veterans and their families in a tent city where they can access medical and dental services, employment services, VA, Social Security, and have available to them the services of other providers in the San Diego area. While at Stand Down, veterans also have the opportunity to have legal issues examined and potentially have misdemeanors and their records cleared at "Homeless Court", also founded by VVSD in partnership with the San Diego Public Defenders Office. As you can readily see, I have been involved with/in the homeless veteran issue for many years.

First, let me say that homelessness in the United States of America is a fact of life that we as the richest Nation in the world should be ashamed of. Further, the fact that in San Diego County alone there are over 2000 homeless veterans each and every night is a national travesty. Our veterans should not be relegated to a life on the streets with no hope for a return to a healthy, sober and productive life.

Homelessness and drug/alcohol addiction go hand in hand and they are not limited to any one socio economic level. At Veterans Village of San Diego, we count among our successful alumni a Medal of Honor recipient, navy fighter pilots, army helicopter pilots, officers and enlisted, senior and junior, infantry to administration.

Until the last couple of years, most of our clients have been Vietnam Veterans, Cold War Era Veterans, Gulf War Veterans, most with a time lag before they seek help of up to several years. Recently, we are seeing a startling trend with our young OIF/OEF/GWOT veterans, the time between separation from the service and becoming homeless and addicted is diminishing from years to, in some cases, months. The issues are remarkably similar to those carried by their predecessors, drug/alcohol abuse and addiction, mixed with post traumatic stress disorder or some other treatable mental illness. We cannot let this happen again, the lessons we learned from our Vietnam Veterans should be applied to our OIF/OEF veterans through early identification of mental health issues, specifically PTSD and Traumatic Brain Injury (TBI). If this early treatment is available for not only veterans but active duty as well, and they are encouraged to participate in the treatment, then perhaps we can stop the cycle before it has a chance to become an embarrassment to our great country.

For the last 20 years, VVSD has sponsored the National Stand Down. Each year the number of veterans participating has continued to grow to over 700 this past year, with at least that number anticipated this July. If the number continues to grow, we as a Nation are not addressing the needs of our veterans and this generation of combat heroes will relive what their comrades in arms from past conflicts have lived, more homelessness and addiction.

For the last 8 years the city of San Diego has funded an emergency shelter program, two shelters, one for the general population and one for veterans only. VVSD has operated the Veteran Only Winter Shelter for the city each year of operation. This year's shelter program ended on April 2, 2008 and over 400, non-duplicated Social Security numbers of veterans were recorded. What does this mean, the issue of homeless veterans is not going away and may in fact be growing.

What can we do?

VVSD is just a small part of the answer, currently we operate 224 early treatment beds where homeless addicted veterans receive residential recovery services, mental health therapy and a safe environment to learn how to stay clean and sober. Once clean and sober, our employment services department enters the game, skills and aptitude assessment, training if required, assistance with writing a resume, and finally placement in a job with a life sustaining wage. After employment, VVSD provides 64 beds in three sober living facilities where the veteran can stay for up to 24 months. All of this, and more, information is available on our Web site, www.vvsd.net.

What do we need?

After becoming clean and sober, gaining life sustaining employment, and getting physically healthy, our veterans need affordable ***supportive*** housing, both transitional and permanent. Studies have demonstrated that the longer a person stays in a supportive environment, the greater the likelihood of long term success is. We need additional funding to build or purchase additional transitional/permanent housing beds, not just in San Diego or California, but throughout the United States, in any city where there resides a veteran who for what ever reason must spend the night on the street, under a bridge or in a doorway. We also need additional funding to expand the supportive services that are provided, specifically weekly case management and therapy.

The Department of Veteran Affairs is meeting the challenge of providing services and treatment of our newest veterans head on. However, resources seem to be limited and the need continues to escalate. Though the VA budget for healthcare has steadily increased, more needs to be done. I am sure that Secretary Peak would happily provide the committee with the budget needed to meet the growing requirements. Again, this is step one, treat the veteran before he falls into the cycle of drug/alcohol addiction and ultimately homelessness. Our veterans deserve no less.

New to the homeless veteran issue is **prevention**. Armed with the lessons learned from treating Vietnam Era veterans, many with post traumatic stress disorder (PTSD), now is the time to act to prevent the veterans of the Iraqi and Afghanistan Theatres of war from entering the cycle that leads to homelessness and addiction. To that end VVSD has embarked on a new program, privately funded by a grant, called the Warrior Tradition Program. This program will be targeted to our most recent veterans and **active duty** service members, to provide them with a safe place to voice their concerns, receive peer support and guidance from experienced facilitators who have experienced the rigors of combat and PTSD and referral to other services as the needs are identified.

On a slightly different note, I would like to address a VA policy that impacts service providers to veterans such as VVSD.

The VA Grant and Per Diem program is the largest government funder of homeless veteran programs in America. This important and successful program provides transitional housing and services to thousands of homeless veterans through over 300 programs across America.

Approximately one year ago, the VA Grant and Per Diem Program informed grantee that to open any new beds or to receive a per diem rate increase, agencies are now required to provide a valid, Indirect Cost Rate to determine the cost of administrative overhead. This requirement is difficult for homeless veteran providers like VVSD to meet for three reasons:

1. The amount of work to determine this rate is overwhelming. It took our Chief Financial Officer, who has both a Bachelors and Masters in Accounting, four months to put the required information together.
2. The Indirect Cost Rate places a huge financial burden on the resources of homeless veteran agencies. Some agencies such as HUD have a maximum Administrative Rate of 5%. Others, like some city grants, pay no administrative overhead. Some government funders provide up to a 20% rate. Under the Indirect Cost Rate, a small nonprofit like VVSD must use its precious and limited non-governmental funds to subsidize a grant that pays less than the agency's average Indirect Cost Rate.
3. Because of this requirement, VVSD was near walking away from a foundation grant of almost $1 Million., that helps Iraqi and Afghanistan veterans and active duty members cope with PTSD. Only after the Foundation unhappily agreed to include an Indirect Cost Rate and budget realignments was the grant saved. Currently, VVSD is in danger of discontinuing our contract with the City of San Diego for the 4 month long, 150 bed Emergency Winter Shelter for

Veterans for the same reason: being required to operate the program at a deficit. This would be tragic.

Most nonprofits receive funding from multiple government agencies: Federal, state and local, and they each have different rules and allowances for administration. The Indirect Cost Rate places the burden of covering administrative overhead on the usually small nonprofit that is juggling these grants to provide the best possible services to veterans. **The Indirect Cost Rate requirement reduces services for homeless veterans and should be discontinued.**

This concludes my remarks.

Prepared Statement of William G. D'Arcy, Chief Operating Officer, Catholic Charities Housing Development Corporation, Chicago, IL

Hello, Mr. Chairman, honorable committee members and guests.

My name is William D'Arcy. I am honored to be invited to offer testimony on the status of the St. Leo Residence for Veterans that was developed as a pilot project under Public Law 107–95, the Homeless Veterans Comprehensive Assistance Act of 2001.

I am employed at Catholic Charities of the Archdiocese of Chicago and serve as the Chief Operating Officer of the Catholic Charities Housing Development Corporation in Chicago, IL. I will give testimony about the pilot project at the St. Leo Residence for Veterans and Auburn Gresham Community Based Outpatient Clinic (Clinic) that Catholic Charities developed in Chicago, IL by working with the U.S. Department of Veterans Affairs (VA).

We at Catholic Charities of Chicago are committed to work toward the national goal to end chronic homelessness among veterans. I am happy to report that we had a successful first year of operations at the St. Leo Residence and Auburn Gresham Clinic in Chicago, IL. I will summarize my comments in three sections: Project Planning & Construction, First Year of Operations, and Lessons Learned.

Section One—Project Planning & Construction

In November 2002, representatives of the Department of Veterans Affairs requested Catholic Charities of the Archdiocese of Chicago to join in a national pilot program aimed at developing affordable housing for homeless veterans. Specifically, the pilot project included building a residence of 141 studio apartments for homeless veterans and an outpatient clinic for veterans partially funded through the Veterans Affairs Loan Guarantee program (P.L. 107–95).

The Catholic Charities Housing Development Corporation (CCHDC) is the project sponsor. CCHDC has developed and managed affordable housing in Cook County, IL since 1985. Presently Catholic Charities manages 24 affordable and federally assisted housing properties that serve more than 1,700 seniors, adults and families on a daily basis. Veterans live in many of our buildings and three properties serve veterans by design.

Mission and Vision

The *mission* of the St. Leo Residence is to furnish housing for homeless veterans, and the Auburn Gresham Clinic provides medical services, mental health counseling, job search assistance and case management supportive services.

The *vision* is to attract homeless veterans to live at St. Leo Residence in a safe and sober environment while they obtain employment, improve their ability to live independently and attain financial stability. It is also expected that thousands of veterans from the south side of Chicago will travel to the nearby Auburn Gresham Clinic to receive primary care, mental health, benefits assistance, employment assistance and related services.

The Unmet Need

The Department of Veterans Affairs estimates there are as many as 154,000 homeless veterans in the United States and approximately 800 homeless veterans in the Chicago area.

In addition, the Veterans Integrated Service Network 12 reported that a zip code analysis of Chicago veteran patients found over 70,000 veterans residing on the south and southeast sides of Chicago. This group is served by the Auburn Gresham Clinic.

Building Sites and Construction

The St. Leo Residence is located at 7750 S. Emerald Avenue, Chicago, IL and was built on the site of a closed Catholic church procured from the Archdiocese of Chicago. The Auburn Gresham Clinic is one block away at 7731 S. Halsted Street, Chicago, IL.

These sites were chosen because public transportation is available at the intersection of 79th Street and Halsted Street on the south side of Chicago. Catholic Charities purchased the land and buildings of the former St. Leo Church complex. The Church tower was saved but the old church, convent and school were demolished to make way for the apartment building. Catholic Charities purchased land on Halsted Street for the Clinic and its parking lot.

Construction at the St. Leo Residence began in June 2005. Homeless veterans began moving in January 18, 2007 and the building was fully occupied in two weeks. The Auburn Gresham Clinic was completed in late April 2007 and the Jesse Brown VA Medical Center began offering services at the Clinic on May 15, 2007.

Project Description

At St. Leo Residence, the formerly homeless veterans live in 141 studio units, each containing its own kitchen and full bathroom. The 65,632 square foot apartment building has four floors and provides common recreational, exercise and meeting areas. The front door is monitored at the main desk on a 24 hour per day, 7 days per week schedule. Off-street parking is provided.

The Auburn Gresham Clinic is a two-story 15,800 square foot building. The primary care and mental health services are located on the first floor. Offices and meeting rooms on the second floor provide spaces for the Illinois Department of Employment Security, Veterans Benefits Administration, Veterans Resource Center, a computer training room, and an Illinois AMVETS service officer. Off street parking is provided.

Purposes of the Housing

St. Leo Residence houses 141 formerly homeless veterans. It provides supportive services and counseling with the goal of making them self-sufficient. Each veteran is required to seek/obtain/maintain employment. Veterans are charged a reasonable fee for rent and must maintain strict guidelines about sobriety as a condition of occupancy.

Financing

Catholic Charities structured its financing plan with 10 layers of funding. The cost for the St. Leo Residence and the nearby Auburn Gresham Clinic was approximately $20 million.

Source	**Amount**
U.S. Department of Veterans Affairs loan	$4,900,000
Illinois Low Income Housing Tax Credits	$9,821,498
Park National Bank purchase of doNation tax credits	$1,855,287
Illinois Housing Development Authority Trust Fund loan	$750,000
Federal Home Loan Bank loan	$750,000
McKinney Supportive Housing Program grant	$400,000
Chicago Community Trust grant	$250,000
Illinois Dept. Commerce & Economic Opportunity energy grant	$129,882
Hilton Chicago Hotel donation	$19,250
Catholic Charities contribution	$1,030,463
Total budget cost	$19,906,380

Subsidized Rental Income

Operating revenue is greatly enhanced through project based Housing Choice Vouchers from the Chicago Housing Authority for 50 units. Recently, an additional 10 vouchers were received from the Rental Subsidy Program of the Chicago Low Income Housing Trust Fund.

Partners

This pilot project became a reality because it grew out of a public and private partnership. Collaborators included: U.S. Department of Veterans Affairs, Archdiocese of Chicago, Catholic Charities Housing Development Corporation, Illinois Housing Development Authority, National Equity Fund, Park National Bank, Federal Home Loan Bank of Chicago, Chicago Community Trust, Illinois Department of Commerce & Economic Opportunity, City of Chicago Department of Housing, U.S. Department of Housing & Urban Development, U.S. Department of Labor and Hilton Chicago Hotel.

Section Two—First Year of Operations

The St. Leo Residence and Auburn Gresham Clinic project are viewed as quite successful in the first year of operations. The project has been recognized by three groups already: the Chicago Neighborhood Development Awards gave "Special Recognition;" the Institute of Real Estate Management presented its "Affordable Housing" award; and the 2007 Charles L. Edson Tax Credit Excellence Awards gave "Honorable Mention" to St. Leo campus.

Property Management

Catholic Charities Housing Development Corporation is the property manager for St. Leo Residence and the Auburn Gresham Clinic. Catholic Charities provides five full-time staff plus two part-time staff, three of whom are veterans living at the residence.

Occupancy

St. Leo Residence averaged 98% occupancy in its first 12 months of operation. One measure of success is that 23 veterans (14%) moved out into permanent housing. Only seven veterans (4%) left the program because they broke the lease requirements. Another success is that St. Leo Residence operated at breakeven financially after funding the escrow and reserve accounts.

Social Services

Catholic Charities provides four case managers, a job developer, a community liaison and supervisory staff that serve a tenant population comprised of chronically homeless and mentally ill veterans who are highly eligible and highly connected to veteran's services. In the first year, Catholic Charities found a need to expand its social service staff in response to the personal needs presented by the veterans. Case managers maintained frequent contact with the veterans.

Clinic Services

Jesse Brown VA Medical Center reports that Auburn Gresham Clinic served 1,185 veterans in the first nine months of operation. These same veterans had 4,951 encounters of service at the Clinic, including: medical health care, mental health counseling, Vet Center counseling and a computer training program.

The Illinois Department of Employment Security reports that it assisted 312 veterans in job searches and that 45 (14%) obtained employment in the first nine months of operation.

Section Three—Lessons Learned

Several components of the project contribute to its overall success, namely:

Public & Private Partnership

Part of the success of the St. Leo Residence and Auburn Gresham Clinic stems from the public and private partnership that developed to support the project. It must be noted that the VA's commitment to this project was vital in assisting Catholic Charities to recruit others to join. The project engaged 4 Federal agencies, 2 State of Illinois agencies and the City of Chicago to participate. In addition, private participants were 2 faith based groups, a foundation, a bank, the tax credit syndicator and a hotel. Public and private partnerships are necessary but they can be quite complicated and require a considerable time commitment.

Financing

Part of the success relates to the 10 layers of funding that were assembled. The VA's ability to commit the first funding for the project was the key that opened the door to other sources of funding. In addition, the commercial component of the Auburn Gresham Clinic is a stabilizing factor. The State of Illinois provided $10 million in Federal low income housing tax credits to this project—one of its largest allocations ever. Catholic Charities procured more than $4 million in donations to fill

funding gaps. If other pilot projects are to be built, a simpler financing approach must be found.

Housing Vouchers

Part of the success comes from having project-based housing vouchers to ensure operational funding. While the first year had a breakeven financial outcome, housing vouchers provided only 35% of the rental income. Low rents collected from veterans provided 65% of funding. Such a small revenue budget cannot pay for both property management and social services. More housing vouchers and/or grants are needed or it is likely this project will fail.

Social Services

Part of the success comes from the large Catholic Charities social service team. In the first year, 79 residents (48.5%) of St. Leo Residence obtained some employment—seasonal, part-time or full-time. Nearly all the veterans are receiving benefits. This is a great achievement. However, the cost of social services was in excess of $500,000. These funds came from grants and donors—not from collecting rents from the veterans. It is doubtful that Catholic Charities can sustain the first year level of social services for subsequent years because most grants and donations were one-time events. Without social services, positive outcomes for the veterans are unlikely, thus, funding for social services is vital to future success.

Community Response

Part of the success comes from community acceptance of St. Leo Residence and the Auburn Gresham Clinic. Being located in a neighborhood and near transportation is very important. Benefactors of St. Leo Residence come from various areas: local businesses, church groups, and veterans groups are frequently generous with donations of food, clothing and financial support of social activities. Ongoing support from these groups is critical to helping the veterans.

Conclusion

We at Catholic Charities believe that our country needs more housing to address the problem of homelessness among veterans. The St. Leo Residence and Auburn Gresham Clinic have made a real contribution to the national plan to end homelessness. The formerly homeless veterans are becoming viable contributors to our society. We are willing to work with anyone you designate to review this pilot project in order to make the next project even more successful. I urge the Committee to promote this program, find a way to simplify its implementation and provide financial support for social services. Thank you.

Prepared Statement of Peter H. Dougherty, Director, Homeless Veterans Programs, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and members of the committee, I am pleased to be here today to discuss the Department of Veterans Affairs' programs and services that help homeless veterans achieve self-sufficiency. Thank you for inviting us to testify today.

Mr. Chairman, as you and this Committee know, homelessness for any person is unacceptable; however, for those who have honorably served our Nation in the military, homelessness should be inconceivable. VA's commitment to end chronic homelessness among veterans gains strength every day. To meet that goal, VA is making unprecedented strides to create opportunities to bring together veterans in need of assistance with the wide range of services and treatment VA provides directly as well as those services we offer in partnership with others.

As the largest integrated health care system in the United States and, as such, the largest provider of homeless treatment and assistance services to homeless veterans in the Nation, VA provides health care and services to more than 100,000 homeless veterans each year. We do this by aggressively reaching out and engaging veterans in shelters and in soup kitchens, on the streets and under bridges. By not waiting for veterans to contact us and by proactively offering services, VA helps some 70,000 of these veterans each year who would not otherwise know of their eligibility for assistance. We connect homeless veterans to a full complement of VA health care and benefits, including compensation and pension, vocational rehabilitation, loan guaranty and education services.

We continuously work to reach and identify homeless veterans and encourage their utilization of VA's health care system. Once they are enrolled, we furnish time-

ly access to quality primary health care, as well as psychiatric evaluations and treatment and engagement in treatment programs for substance abuse disorders. In addition, it is extremely important that these veterans are seen by mental health specialists and a case manager. Our objective is to help these veterans receive coordinated needed care and other VA benefits, which, in turn, furthers their chances of obtaining and maintaining independent housing and gainful employment. The provision of such VA assistance should enable most veterans to live as independently as possible given their individual circumstances.

We work very closely with our Federal partners at the Departments of Housing and Urban Development (HUD), Health and Human Services (HHS) and Labor (DOL) specifically DOL's Veterans' Employment and Training Service, to ensure those homeless veterans who want and need housing, alternative access to health care and supportive services and employment have an opportunity to become productive, tax-paying members of society. Housing and employment are very important because we understand from many formerly homeless veterans that having opportunities for gainful employment were vital to their being able to overcome psychological barriers that contributed to their homelessness.

With the support of Congress, VA continues to make a significant investment in the provision of services for homeless veterans. We expect to spend nearly $300 million this year. VA expects to spend nearly $1.6 billion to cover homeless veteran treatments and programs to assist homeless veterans supported through the Veterans Health Administration (VHA).

Services and treatment for mental health and substance use disorders are essential both to the already homeless veteran and to those at risk for homelessness. VA's overall mental health funding increased by nearly $200 million this year, and we use those funds to enhance access to mental health services and substance use treatment programs. Increasing access and availability to mental health and substance use treatment services are critical to ensure that those veterans who live far away from VA healthcare facilities are able to live successfully in their communities.

Equally important is the work of the Veterans Benefits Administration (VBA). VBA's Loan Guaranty Service program allows non-profit entities to purchase VA foreclosed properties. More than 200 homes have been sold to non-profit and faith-based organizations that are helping to provide thousands of nights of shelter to homeless veterans and other homeless individuals. I also want to note that VBA's Compensation and Pension Service strives to provide timely processing and payment of benefits claims to homeless veterans. As a result of VBA's efforts, 21,000 veterans' claims were expedited to allow these veterans to receive the benefits to which they are entitled.

As part of VA's efforts to eradicate homelessness among veterans, we work in a variety of venues with multiple partners at the Federal, state, territorial, tribal and local government levels. We have hundreds of community non-profit and faith-based service providers working in tandem with our healthcare and benefits staff to improve the lives of tens of thousands of homeless veterans each night. We have about 2,000 beds for homeless veterans specifically available under our domiciliary care and other VA operated residential rehabilitation programs.

A year-long follow-up study of 1,350 veterans discharged from VA's residential care programs indicates that we are achieving long-term success for the well-being of these veterans. Four out of five veterans who completed these programs remain appropriately housed one year after discharge. Through such effective, innovative and extensive collaboration, VA is able to maximize opportunities for success.

We firmly believe that the best strategy to prevent homelessness is early intervention. As the Subcommittee knows, combat-theater veterans returning from the present conflicts in Iraq and Afghanistan have, depending on their date of discharge, enhanced enrollment priority for up to five years in VA's health care system and extended eligibility for VA health care at no cost for conditions possibly related to their combat service. We believe that this eligibility allows our clinical staff to identify additional health problems that may, if otherwise left untreated, contribute to future homelessness among those veterans. During the past two years, 556 returning veterans have needed VA residential services either in VA-operated programs or in the community transitional housing programs under our Homeless Grant and Per Diem Program. The best option is to reach out and to treat those in need who are willing to seek services today to prevent more acute problems later.

Interagency Council on Homelessness (ICH), Intergovernmental and Local Relationships

VA has always been an active partner with nearly all Federal departments and agencies that provide services to homeless veterans. Last month, Secretary Peake was passed the chair of the Interagency Council on Homelessness (ICH), dem-

onstrating his and VA's commitment to working collaboratively. We participate in a variety of interagency efforts to assist homeless veterans. During Secretary Peake's tenure as ICH Chair, VA will continue hosting regular meetings of the ICH Senior Policy Group. These efforts have brought VA to an unprecedented involvement in State and local plans to end chronic homelessness.

In the past, VA has worked closely with HUD and HHS to assist the chronically homeless with housing, healthcare and benefits coordination. Under this initiative, funding was provided to 11 communities that developed quality plans to house and provide wraparound services. As a result of our collaboration, nearly 1200 individuals were enrolled in the program during the first year of the project, and nearly 600 were housed. Thirty percent of those receiving services under this initiative are veterans. This effort is based on the premise that housing and treating those who are chronically homeless will decrease total costs for healthcare, emergency housing, related social services and the court system. VA is pleased to be a partner in this effort. We are also pleased to lead the effort to evaluate this project, in partnership with HUD and HHS, and look forward to sharing with you our findings regarding the subsequent year of the project when they become available.

VA has a long tradition of engaging and working with local providers in their communities. VA collaborates annually with communities across the United States in Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for veterans. At regularly scheduled CHALENG meetings, VA works with faith-based and community homeless service providers, representatives of Federal, state, territorial, tribal and local governments, and homeless veterans, themselves. Our meetings and annual reports are designed to identify met and unmet needs for homeless veterans, aid in the community effort to aid homeless veterans, and develop local action plans to address those identified needs.

Last year our CHALENG meetings had over 9,000 participants, including nearly 5,000 current or formerly homeless veterans at meetings sponsored by VA medical centers and supported by regional offices to strengthen their partnerships with community service providers. This leads to better coordiNation of VA services as well as the development of innovative, cost-effective strategies to address the needs of homeless veterans at the local level. It shows us what is being done effectively and what pressing unmet needs remain.

This process also helps us to establish, as part of local needs, the number of veterans who are homeless on any given night. You should be pleased to know that the number of homeless veterans is going down. Two years ago we estimated there were approximately 195,000 homeless veterans on any given night. Last year we believe that number dropped to 154,000, a 21-percent reduction. While there are still far too many veterans among the homeless, we are making progress, and their numbers are coming down. This progress demonstrates to us that this scourge is not unmanageable and that our collective efforts are realizing success. We are confident that our continued efforts will achieve our goal of ending chronic homelessness among veterans.

VA Involvement in Stand Downs

VA's involvement in stand downs began more than 20 years ago when the first stand down for homeless veterans was held in San Diego. We have participated in over 2,000 events since then. Participating in stand downs for homeless veterans is another avenue by which VA continues its collaborative outreach at the local level through coordiNation of our programs with other departments, agencies, and private sector programs. In calendar year 2007, VA, along with hundreds of veteran service organization representatives, community homeless service providers, state and local government offices, faith-based organizations, and health and social service providers, provided assistance to more than 27,000 veterans. The latest information shows that more than 3,500 spouses and children attended these events. Nearly 18,000 volunteers and VA employees participated in last year's stand downs.

Homeless Providers Grant and Per Diem Program

VA's largest program involving local communities remains our Homeless Providers Grant and Per Diem Program. As you are aware, this highly successful program allows VA to provide grants to state and local governments as well as faith-based and other non-profit organizations to develop supportive transitional housing programs and supportive service centers for homeless veterans. The current Notices of Funding Availability (NOFA) has $37 million available: $12 million for per diem only programs and $25 million for new grant programs. Organizations may also use VA grants to purchase vans to conduct outreach and provide transportation for homeless veterans to health care and employment services.

Since the Grant and Per Diem Program was authorized in 1992, VA has fostered the development of nearly 500 programs with more than 9,000 operational beds today and with plans already approved or in process to develop more than 14,000 transitional housing beds. We already have 23 independent service centers and provided funding for 200 vans to provide transportation for outreach and connections with services.

We are currently accepting applications to create 2,200 new transitional housing beds. Applications will be accepted until April 11, 2008 and will be promptly reviewed, with awards expected by this summer.

Technical Assistance Grants

With the enactment of Public Law 107–95, VA was authorized to provide grants to entities with expertise in preparing grant applications. We have awarded funding to two entities that are providing technical assistance to non-profit community and faith-based groups that are interested in seeking VA and other grants relating to serving homeless veterans. Grants were awarded to National Coalition for Homeless Veterans (NCHV), Public Resources, Inc., and the North Carolina Governor's Institute on Alcohol and Substance Abuse, Inc. to aid us in this effort. VA will continue to expand and improve services to connect veteran-specific service providers to other governmental and non-government resources.

Grants for Homeless Veterans with Special Needs

VA also provides grants to its health care facilities and existing grant and per diem recipients to assist them to serve homeless veterans with special needs, including women, women who care for dependent children, the chronically mentally ill, frail elderly, and, the terminally ill. We initiated this program in FY 2004 and have provided special needs funding totaling $15.7 million to 29 organizations. We issued two notices of funding availability on February 22, 2007. That call resulted in $8.8 million to continue to fund both existing special needs grants and new awards.

Residential Rehabilitation and Treatment Programs (RRTPs)

VA's Domiciliary Care for Homeless Veterans (DCHV) Program, which was recently renamed the "Residential Rehabilitation and Treatment Program," provides a full range of treatment and rehabilitation services to many homeless veterans. Over the past 17 years, VA has established 34 DCHV programs providing 1,873 beds. There have been over 71,000 episodes of treatment in the DCHV program since 1987. VA continues to improve access to the services offered through these programs. In FY 2007, DCHV programs treated 5,905 Homeless veterans, while VA funded the development of nine new DCHV programs offering a total of 400 new beds. In FY 2006, VA funded the development of two additional DCHV programs totaling 100 beds. In addition to the DCHV program, homeless veterans receive treatment and rehabilitation services in the Psychosocial Residential Rehabilitation Treatment Program (PRRTP). Currently there are 72 PRRTP programs with a total of 2,020 beds.

Staffing at VBA Regional Offices

Homeless Veterans Outreach Coordinators (HVOCs) at all VBA regional offices work in their communities to identify eligible homeless veterans, advise them of VA benefits and services, and assist them with claims. The coordinators also network with other VA entities, veteran service organizations, local governments, social service agencies and other service providers to inform homeless veterans about other benefits and services available to them. In FY 2007, VBA staff assisted homeless veterans in 28,962 instances. They contacted 4,434 shelters, made 5,053 referrals to community agencies, and made 4,006 referrals to VHA and DoL's Homeless Veterans Reintegration Programs (HVRP).

Since the beginning of FY 2003, regional offices have maintained an active record of all compensation and pension claims received from homeless veterans. Procedures for the special handling and processing of these claims are in place. From FY 2003 through FY 2007, VBA received 21,366 claims for compensation and pension from homeless veterans. Of those claims, 59 percent were for compensation and 41 percent were for pension. Of the compensation claims processed, 42.04 percent were granted, with an average disability rating of 44.85 percent, and 15.24 percent of claimants were rated at 100 percent disabled. Of the total claims denied, 42.66 percent were due to the veteran's disability not being service connected. The average processing time for all compensation claims of homeless veterans was 155 days. Of the pension claims processed, 76.60 percent were granted. Nine percent of the claims denied were due to the veteran's disability not being permanent and total. The average processing time for all pension claims of homeless veterans was 123 days.

Multifamily Transitional Housing Loan Guaranty Program

Public Law 105–368 authorized VA to establish a pilot program to guarantee up to 15 loans, up to an aggregate loan amount of $100 million, for multifamily transitional housing. Many complex issues, often varying from jurisdiction to jurisdiction, surround implementation, and VA has worked closely with veteran service organizations, veteran-specific housing providers, faith-based organizations, clinical support service programs, VA medical care staff, state, city and county agencies, homeless service providers, and finance and housing experts. We are also using consultants to assist us with our evaluation of potential sites and providers of housing services.

VA has issued a final commitment under this program for a project to provide 144 new beds for homeless veterans through the Catholic Charities of Chicago. The Catholic Charities' project opened in January 2007 and was full within a week. At present we do not have any additional loans that appear to be approved

CoordiNation of Outreach Services for Veterans At Risk of Homelessness

VA, together with DoL and with additional assistance from the Department of Justice (DOJ), has helped develop demonstration projects providing referral and counseling services for veterans who are at risk of homelessness and are currently incarcerated. Through FY 2007, VA and DOL had seven sites that provided referral and counseling services to eligible veterans at risk of homelessness upon their release from correctional institutions. Local staffs from VHA and VBA provided veterans at each demonstration site with information about available VA benefits and services.

DOL provided funding for these seven sites under its Homeless Veterans Reintegration Programs (HVRP) for the Incarcerated Veterans' Transition Program (IVTP). VA and DOL are reviewing this program carefully and will provide a report on its effectiveness.

HUD-Veterans Affairs Supported Housing (HUD–VASH)

VA recognizes HUD's longstanding support of the HUD–VASH program. This very successful partnership links the provision of VA case management services with permanent housing in order to assist the homeless veterans. HUD and VA hope to continue this valuable program, subject to the availability of resources. Last December, Congress appropriated funds to create about 10,000 units of permanent housing under the Housing Voucher Choice program. We are working closely with our colleagues at HUD and expect that thousands of veterans will be able to use these vouchers to move into housing by summer. We are starting to hire nearly 300 case managers who will provide case management services to those veterans who are eligible for VA health care to ensure that they have access to all needed health care and services.

The Administration has proposed in HUD's budget adding an additional 9,800 units of permanent housing next year. If that occurs, we will make sure these additional veterans receive the appropriate case management services.

Recently Discharged Veterans (Operation Enduring Freedom/Operation Iraqi Freedom, OEF/OIF, Veterans)

During the past three fiscal years, 556 veterans who served in Iraq and Afghanistan have been treated in one of VA's homeless-specific residential treatment programs. Currently, there are approximately 90 OEF/OIF veterans in homeless-specific residential treatment programs. It is clear to us that there is a strong need for VA to be extremely diligent in insuring that these veterans get immediate attention. VA, with a host of external partners, seeks out these veterans. I want to be abundantly clear that our mission is to serve all eligible veterans who need our services.

I should note that these veterans, like all veterans who enter VA's homeless specific services, get access to primary care, but also as needed, to appropriate mental health and substance abuse services. Our efforts to reach out, find, and appropriately serve these veterans will do nothing but increase in the months and years ahead.

Summary

VA continues to make progress to prevent homelessness and treat our homeless veterans. Each year, we provide an annual report to Congress that outlines our activities for homeless veterans. VA collaborates closely with other Federal agencies, state and local governments and community and faith-based organizations to ensure that homeless veterans have access to a full range of health care, benefits and support services. We still have much to do to end chronic homelessness among veterans in America, and we are eager to work with you to meet that challenge. Developing appropriate links to health care, housing, benefits assistance, employment and transportation are all components that help bring these veterans out of despair and

homelessness. We appreciate all of the assistance the Congress gives us to aid in this noble effort.

Mr. Chairman that concludes my statement. I am pleased to respond to any questions you or the subcommittee members may have.

Statement of Ronald F. Chamrin, Assistant Director, Economic Commission, American Legion

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to submit The American Legion's views on the issue of homelessness among America's veterans. The American Legion commends the Committee for addressing this important issue.

The Fiscal Year (FY) 2007 Veterans Affairs (VA) Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) report estimates that there are nearly 154,000 veterans who are homeless at any point in time, down from 195,000 in FY 2006. We must be wary of the VA's claim of a decrease of a 21 percent (41,000) of homeless veterans over the past year. According to the February 2007 Homeless Assessment Report to Congress from the U.S. Department of Housing and Urban Development 2007, veterans account for 19 percent of all homeless people in America. The National Alliance to End Homelessness (NAEH) reports that there are 195,827 homeless veterans on the street each night. This accounts for 26 percent of all homeless people. The Alliance also estimates that 336,627 veterans were homeless in 2006.

According to a report on homelessness released by the Urban Institute in 2000, "Homelessness: Programs and the People They Serve, Findings of the National Survey of Homeless Assistance Providers and Clients" the spike in homelessness among veterans during the eighties was attributed to: "the recession 1981–1982, and would go away when the economy recovered, while others argued that the problem stemmed from a lack of affordable housing and that homeless clients were simply a cross section of poor Americans." This 2000 study stated that of current homeless veterans: "21 percent served before the Vietnam era (before August 1964); 47 percent served during the Vietnam era (between August 1964 and April 1975); and 57 percent served since the Vietnam era (after April 1975). Many have served in more than one time period."

In order to prevent a national epidemic of homeless veterans in the upcoming years, measures must be taken to assist those veterans who are homeless. Steps must also be taken to prevent the future veterans and their families from facing homelessness.

THE AMERICAN LEGION HOMELESS VETERANS TASK FORCE

The American Legion coordinates a Homeless Veterans Task Force (HVTF) amongst its 55 departments. Our goal is to augment existing homeless veteran providers, the VA Network Homeless Coordinators, and the Department of Labor's (DoL) Homeless Veterans Reintegration Program (HVRP), Veterans Workforce Investment Program (VWIP), Disabled Veterans' Outreach Personnel (DVOPs) and Local Veterans' Employment Representative (LVERs). In addition to augmentation, the Task Force attempts to fill in the gaps where there is no coverage. Many of The American Legion's Departments contain an HVTF chairman and an employment chairman. These two individuals coordinate activities with The American Legion's local posts within their state. The three-tiered coordiNation of these two chairmen and numerous local posts attempts to address the needs of homeless veterans in the local community, while identifying those at risk and preventing homelessness.

The American Legion has conducted training with the assistance of the National Coalition for Homeless Veterans (NCHV), DoL–Veterans Employment and Training Service (VETS), Project Homeless Connect, and VA on how to apply for Federal grants in various assistance programs, most notably the "Stand Down" and Grant and Per Diem programs. It is our goal to assist the Grant and Per Diem program by enabling individual posts and homeless providers to use The American Legion as a force multiplier.

The American Legion augments homeless veteran providers with transportation, food, clothing, cash and in-kind donations, technical assistance, employment placement, employment referral, claims assistance, veterans' benefits assistance, and in some cases housing for homeless veterans. The American Legion department service officers are accredited representatives that assist homeless veterans with their VA compensation and pension claims.

A separate program administered by The American Legion that assists veterans in need is our "Heroes to Hometowns" program. "Heroes to Hometowns" is a transi-

tion program for severely injured service members returning home from Operation Enduring Freedom and Operation Iraqi Freedom. The "Heroes to Hometowns" establishes a support network and coordinates resources for severely injured service members returning home.

"Heroes To Hometowns" can provide a welcome home celebration, temporary financial assistance, pro-bono financial planning, housing assistance, home and vehicle adaptation, government claims assistance, transportation to hospital visits, entertainment options, childcare, counseling, family support, and other benefits.

The "Heroes To Hometowns" program has proven successful in preventing many veterans and their families from losing their homes by providing financial assistance.

POTENTIAL HOMELESS VETERANS OF OPERATION ENDURING FREEDOM (OEF) AND OPERATION IRAQI FREEDOM (OIF)

Returning OEF/OIF combat veterans are at risk of becoming homeless. Combat veterans of OEF/OIF and the Global War on Terrorism (GWOT) in need of assistance are beginning to trickle into the nation's community-based veterans' service organizations' homeless programs. Already stressed by an increasing need for assistance by post-Vietnam Era veterans and strained budgets, homeless services providers are deeply concerned about the inevitable rising tide of combat veterans who will soon be requesting their support.

VA's Health Care for Homeless Veterans (HCHV) operates at 133 sites and reports assisting 1,819 OIF/OEF era homeless veterans over the past three years with an average age of 33. Nearly half of them, 859, were seen in the past year alone. The HCHV conducted physical and psychiatric health exams, treatment, referrals and ongoing case management to these homeless veterans with mental health problems, including substance abuse. Now treating combat veterans from Iraq and Afghanistan daily, VA is reporting that a high percentage of those casualties need treatment for mental health issues. That is consistent with studies conducted by VA and other agencies that conclude anywhere from 15 percent to more than 35 percent of combat veterans will experience some clinical degree of post traumatic stress disorder (PTSD), depression or other psychosocial problems.

Unemployment, underemployment, difficulty translating military skills to the civilian sector and the state of our economy all contribute to conditions that could lead to homelessness. Younger veterans of OIF/OEF are experiencing employment obstacles at an alarming rate. A report by the DOL–VETS finds that 11.3 percent of veterans ages 20 to 24 were unemployed in 2007, compared to only 8.1 percent of nonveterans in the same age group. Moreover, a separate report by VA (Employment Histories Report Final Compilation Report, Associates Inc. September 28, 2007) shows a rise in the figure for those who stopped looking for work because they couldn't find jobs or returned to school from just 10 percent of young veterans in 2000 to 23 percent in 2005. The VA even reports a higher percentage of unemployed veterans, 18 percent of veterans aged 20–24 who sought jobs within one to three years of discharge were unemployed.

According to the Department of Defense's (DOD's) Manpower Data Center, since 9/11, over 1.7 million U.S. service men and women have deployed in support of OIF/OEF. Rotations of troops returning home from Iraq and Afghanistan are a common occurrence. Military analysts and government sources say the military deployments, then the reintegration of combat veterans into the civilian society, is unlike anything the Nation has experienced since the end of the Vietnam War.

The DoD has reported that in the support of OIF/OEF from FY 2002 to February 29, 2008:

- 2.6 million deployment events;
- 1.7 million service members have been deployed;
- Currently there are 258,000 service members deployed;
- 600,000 service members have more than one deployment;
- 468,591 National Guard and Reservists have been deployed to Iraq or Afghanistan since 2001
- Out of 600,000 service members with more than one deployment, 115,000 are members of the Reserve components

DEPARTMENT OF VETERANS AFFAIRS HOMELESS SERVICES

The signs of an impending crisis are clearly seen in VA's own numbers. Under considerable pressure to stretch dollars, VA estimates it can provide assistance to about 100,000 homeless veterans each year, 70,000 are currently receiving services in specialized VA homeless programs. Yet, this accounts for less than 20 percent of the more than 400,000 who will need supportive services during the course of a

year. Hundreds of community-based organizations nationwide struggle to provide assistance to the other 80 percent, but the need far exceeds available resources.

Opponents of additional funding of homeless veteran programs frequently state that homeless veterans are all rated a Total Disability based upon Individual Unemployability (TDIU) and receive 100 percent compensation payments. They further argue that because these veterans are already receiving enough money to put them on their feet, more funding is not needed. In stark contrast to this absurd claim, VA reports that only 41 percent of homeless veterans are receiving compensation and pension benefits and even then it cannot be assumed that all of those 41 percent are receiving the full 100 percent Total Disability they often need.

In addition to this low number of homeless veterans receiving monthly benefit payments, many of their claims remain in the enormous backlog of all veteran claims. Identification and expedition of claims by homeless veterans has the potential to allow for a quicker adjudication process and ultimately, money to veterans and in turn assisting their transition to a more stable housing situation. VA has expedited 21,800 claims for homeless veterans since 2003 and approximately 44 percent of compensation claims and 77 percent of pension claims of homeless veterans have been approved annually.

VA HOMELESS PROVIDERS GRANT AND PER DIEM PROGRAM REAUTHORIZATION AND APPROPRIATIONS

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem (GPD) Program under the Homeless Veterans Comprehensive Service Programs Act 1992, Public Law 102–590. The GPD Program is offered annually, as funding permits, by VA to fund community agencies providing service to homeless veterans. VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans. VA's Central Office staff needs additional full-time employees to expand the program to reach even more participants.

Funds are available for assistance in the form of grants to provide transitional housing (for up to 24 months) with supportive services. Funds can also be used for supportive services in a service center facility for homeless veterans not in conjunction with supportive housing, or to purchase vans. VA can provide up to $33.10 for each day of care a veteran receives in a transitional housing program approved under VA's Homeless Providers GPD Program. This token amount is far too little to fully assist a single veteran. Finally, all providers must justify that their costs are attributed to veterans.

The American Legion is concerned with the ebb and flow of the homeless veteran population and asserts that measures should be enacted that allow a provider to always maintain a space for a homeless veteran. Due to the transient and drifting nature of chronically homeless veterans, seasonal weather changes that allow more homeless veterans to venture outside, and other factors, there are periods when GPD providers may have an empty bed. If a provider has an empty space dedicated for a homeless veteran under the program and, due to factors out of their control, a bed remains empty for a period of time, they have occasional difficulty justifying the grant and therefore may be penalized.

The application process for grants must be streamlined. The accounting process currently required for reimbursement is in constant flux during the year and the strain of accurately reporting is placed on small community-based providers. Additionally, there are other Federal programs that can provide monetary assistance to homeless veterans, yet the GPD does not allow these funds to be used as a match for VA programs. This often discourages participation. However, other Federal programs do allow VA funds to be used as a match. VA's GPD program requires unique flexibility due to the nature of the funding, homeless veteran providers, and homeless veterans.

VA reports success in their performance measures to increase access and availability to both primary health care and specialty care within 30 and 60 days. Short-term assistance, between 30 to 60 days, is imperative in order to prevent chronic homelessness. Many times, a veteran may be in transition due to loss of a job, a medical problem, poor finances, or some other factor and only requires a short-term transitional shelter that can be provided by the GPD program. In FY 2006, VA reported that they provided transitional housing services to nearly 15,500 homeless veterans. It is imperative that the number of veterans served by transitional housing services continues to increase and be adjusted to meet the demand. The consequences of inaction will be a stagnant, steady number of homeless veterans rather than a decrease of the number of homeless veterans.

The American Legion strongly supports funding the Grant and Per Diem Program for a 5-year period (instead of annually) and supports increasing the funding level to $200 million annually.

DEPARTMENTS OF HOUSING AND URBAN DEVELOPMENT—VETERANS AFFAIRS SUPPORTIVE HOUSING (HUD–VASH) HOMELESS PROGRAM

The American Legion supports mandatory funding for the Departments of Housing and Urban Development (HUD)-Veterans Affairs Supportive Housing (HUD–VASH) Homeless Program.

The Homeless Veterans Comprehensive Assistance Act of 2001 (P.L. 107–95) codified the HUD–VASH Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders. Under the HUD–VASH Program, VA screens homeless veterans for program eligibility and provides case management services to enrollees. HUD allocates rental subsidies from its Housing Choice Voucher program to VA, which then distributes them to the enrollees. A decade ago, there were approximately 2,000 vouchers earmarked for veterans in need of permanent housing.

The American Legion is pleased to see $75 million appropriated for the HUD–VASH program which will create 10,000 units of Section 8 housing dedicated for veterans and their families. An influx of 300 VA staff will assist the residents of these units by providing case management.

CHANGING DEMOGRAPHICS OF TRADITIONAL HOMELESS VETERANS

The Federal definition of a homeless person is: "An individual who (1) lacks a fixed, regular, and adequate nighttime residence and (2) has a primary nighttime residence that is (a) a supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill), (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings." McKinney Act (P.L. 100–77, sec 103(2) (1), 101 stat. 485 (1987).

No longer can a homeless veteran be easily identified as the McKinney Act defines. The American Legion is not advocating for an expanded definition of a homeless individual, but rather indicating that this country needs to help those normally financially secure veterans who continue to lose their homes.

The stereotypes and faces of veterans on the road to homelessness are drastically changing. Professionals, the middle-class, blue collar and white collar veterans, students, and more middle-aged veterans are all affected by the current housing and economic crisis. Each day, external factors are affecting a more vulnerable population and thus creating different tiers and descriptions of those who are homeless veterans. Living with neighbors and relatives, staying short-term in hotel rooms, and in vehicles are the realities of those who are unemployed and homeless. To quote a veteran who wishes to remain anonymous: "I've been crashing on my buddy's couch for 6 months while trying to find a job." It is important to note that this veteran is not accounted for in the classic definition of homeless.

HOUSING COST BURDEN AMONGST VETERANS

The American Legion is very concerned with the ever-growing gap of housing expenses versus veterans' income. The National Alliance to End Homelessness (NAEH) report, "Vital Mission, Ending Homelessness Among Veterans" reports that currently, over 930,000 veterans pay more than 50 percent of their income toward housing, be it renting or owning a home. (476,877 rent/ 453,354 own).

> "There is a subset of veterans who rent housing and have severe housing cost burden (paying more than 50 percent of their income toward housing costs). Of all veterans who rent housing (476,877), approximately 10 percent pay more than 50 percent of their income for rent. Of those with severe housing cost burden, 20 percent are *very* low income (have incomes at or below 50 percent of area median income) and 67 percent are *extremely* low income (have incomes at or below 30 percent of area median income). More than half of veterans with severe housing cost burden (55 percent) fall below the poverty level and 43 percent are receiving foods stamps. Using bivariate analysis, the National Alliance to End Homelessness found a number of statistically significant differences among veterans with severe housing cost burden and those paying less than 50 percent of their income for housing."

The 2006 American Community Survey (ACS) conducted by the U.S. Census Bureau reports that the median monthly housing costs for mortgaged owners was $1,402, non-mortgaged owners $399, and renters $763. Approximately 37 percent of owners with mortgages, 16 percent of owners without mortgages, and 50 percent of renters in the United States spent 30 percent or more of household income on housing. The 2006 ACS further states that the median income for veterans in the past 12 months of their survey was $34,437.

Numerous mortgage consultants and financial advisors recommend adhering to the 28 percent/36 percent debt to income qualifying ratio. That is, in order to safely own a home or rent, an individual should be within the 28/36 range in order to withstand emergency financial situations without becoming delinquent in payments. Using his ratio, the median monthly cost of $1,402 for housing expenses is approximately $400 greater than what the average veteran can afford.

Debt to Income Example *(28/36 qualifying ratio model)*

Yearly Gross Income = $34,437 / Divided by 12 = $2,870 per month income
$2,870 Monthly Income × .28 = *$803* allowed for housing expense
$2,870 Monthly Income × .36 = *$1,033* allowed for housing expense plus recurring debt

The VA Loan Guarantee service has a very strong program, but even they report that the median income of all of their veteran loan holders is $60,276, or an average of $5,023 a month. However, they have reported a drop in loan initiations every month since 2003 (50,000 in August 2003 to 10,000 at the end of FY 2007). This could indicate that recently discharged and younger veterans may not be able to afford a home even using the VA Loan Guarantee program. Research should be conducted to ascertain the average age of a veteran homeowner and the correlation between the median income, affordability of homes, and the impact of the VA Loan Guarantee Program.

CONCLUSION

The Homeless Grant and Per Diem program is effective, but should be augmented with additional HUD–VASH Program vouchers. With 300,000 service members becoming veterans each year the availability of transitional housing must be increased. Our observations have shown that when the GPD program is allocated money, they are successful in distributing grants and administering their program and are only limited by the total dollar amount of funds available.

Affordable housing, transition assistance, education, and employment are each a pillar of financial stability. They will prevent homelessness, afford veterans to compete in the private sector, and allow this nation's veterans to contribute their transferable military occupational skills and education to the civilian sector. Homeless veterans have answered the call of duty for this country and are not asking for a handout, but rather a hand up.

The American Legion looks forward to continue working with the Committee to assist the nation's homeless veterans and to prevent future homelessness. Mr. Chairman and Members of the Committee, this concludes my statement.

Statement of Hon. Jeff Miller, a Representative in Congress from the State of Florida

Thank you Mr. Chairman.

Homelessness among our nation's veterans is a concern that Congress has been diligently working to address. Understanding the needs of this special population—including food, clothing, shelter, medical services, job training, and transportation—is critical to ending homelessness among veterans.

The Department of Veterans Affairs (VA) is the largest Federal provider of direct assistance to the homeless, and has been providing specialized services to homeless veterans for over 20 years. And, it is encouraging to note that VA reports a 21 percent drop in the number of homeless veterans from 2006 to 2007. Yet, we still are a long way from meeting our goal to end chronic homelessness in this decade.

Sadly, my home state of Florida has the third highest population of homeless veterans in the country. That is why ensuring that programs available through VA are effective and monitoring programs to help veterans reach and maintain their independence is so important to me.

I want to note that VA is planning at least 10 "Stand Downs" in Florida this year. Stand Downs are collaborative events, coordinated between local VA's, other government agencies, and community agencies who serve the homeless. These events are

important to reaching out to homeless veterans. They provide food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment.

The veteran population is becoming more diverse and we have a special obligation to ensure that VA adapts their programs to meet the needs of all of our veterans. While a majority of homeless veterans are male, we are seeing an increase in the number of women serving in our military, and women veterans are also overrepresented among the homeless population. Additionally, over 400 veterans from Operation Iraqi Freedom and Operation Enduring Freedom have sought VA services for homeless veterans. These men and women have served us honorably, and it is now our turn to serve them, and give them the tools they need to reintegrate into civilian life.

I look forward to hearing from our witnesses today and their view of what we must do to combat the vicious cycle of homelessness and prevent those veterans at risk of homelessness from becoming homeless.

Statement of Hon. John T. Salazar,
a Representative in Congress from the State of Colorado

Good morning Chairman Filner, Ranking Member Buyer and distinguished members of this Committee.

I thank the witnesses joining us here today and look forward to hearing their expert testimony and their personal experiences with homelessness across our nation.

Our servicemen and women willingly serve our Nation to ensure that our rights and freedoms are preserved.

At times, their service places them in harm's way.

It is a tragedy when a veteran loses his or her life in the service of our nation.

It is also tragic when these brave individuals return from the battlefield without the ability or the tools to reintegrate into civilian life.

This has resulted in dedicated and talented individuals falling victim to poverty and homelessness.

According to the Veterans' Administration, nearly one-quarter of all homeless adults are veterans.

In addition, many of our veterans who live in poverty are at risk of becoming homeless.

I know that homelessness is a major issue for Veterans in the Third District of Colorado.

The issue of homelessness among veterans is particularly moving.

It is unbelievable to think that in our Nation, individuals who gave so much of themselves can end up without such a basic human need.

We are fortunate to have such a courageous group of people serving in our armed forces.

They deserve to know that after serving our Nation, there are programs in place to help them enter into civilian life.

I look forward to working with the committee, the VA, community groups and others to address the issue of homelessness among our Veteran population.

Mr. Chairman, I thank you and the members of this committee for giving us the opportunity to discuss these issues that are so important to the well-being of our veterans.

Statement of Sandra A. Miller, Chair,
Homeless Veterans Committee, Vietnam Veterans of America

Mr. Chairman, and members of the House Veterans' Affairs Committee, my name is Sandra A. Miller. I served as a senior enlisted woman in the U.S. Navy from 1975 until 1981 and I currently chair Vietnam Veterans of America's (VVA) Homeless Veterans Committee. Perhaps more importantly, I work with homeless veterans as the daily Program Coordinator of a transitional residence, one of the many programs provided by The Philadelphia Veterans Multi-Service & Education Center. Our transitional residence receives funding from the Department of Veterans Affairs Homeless Grant and Per Diem Program (HGPD) and operates under a shared lease agreement on the grounds of the Coatesville VA Medical Center.

On behalf of VVA, I thank you and your colleagues for this opportunity to submit testimony sharing our views on the status of homeless assistance programs for veterans conducted by the VA.

Homelessness continues to be a significant problem for veterans. The VA estimates about one-third of the adult homeless population have served their country in the Armed Services. Current population estimates suggest that about 154,000 veterans (male and female) are homeless on any given night and perhaps twice as many experience homelessness at some point during the course of a year.

Federal efforts regarding homeless veterans must be particularly vigorous for women veterans with minor children in their care. And those Federal agencies that have responsibilities in addressing this situation, particularly the Departments of Veterans Affairs, Labor, and Housing and Urban Development, must work in concert and should be held accountable for achieving clearly defined results.

VA HOMELESS GRANT & PER DIEM PROGRAM

The VA's Homeless Grant & Per Diem Program has been in existence since 1994. Since then, thousands of homeless veterans have availed themselves of the programs provided by community-based service providers. In some areas of this country, the VA and community-based service providers work successfully in a collaborative effort to actively address homelessness among veterans. The community-based service providers are able to supply much needed services in a cost-effective and efficient manner. The VA recognizes this and encourages residential and service center programs in areas where homeless veterans would most benefit. The VA HGPD program offers funding in a highly competitive grant round. Because financial resources available to HGPD are limited, the number of grants awarded and the dollars granted are restrictive and hence many geographic areas in need suffer a loss that HGPD could address.

It has been VVA's position that VA Homeless Grant and Per Diem funding must be considered a payment rather than a reimbursement for expenses, an important distinction that will enable the community-based organizations that deliver the majority of these services to operate more effectively. Per diem dollars received by services centers are not capable of obtaining or retaining appropriate staffing to provide services supporting the special needs of the veterans seeking assistance. Per diem for service centers is provided on an hourly rate, currently only $3.91 per hour. The reality is that most city and municipality social services do not have the knowledge or capacity to provide appropriate supportive services that directly involve the treatment, care, and entitlements of veterans.

Veterans are disproportionately represented among the homeless population, accounting, according to most estimates, for one in three homeless persons on any given night—and roughly 400,000 veterans over the course of a year. VA's Grant and Per Diem program is effective in creating and aiding local shelters by providing transitional housing, vocational rehabilitation, and referrals for clinical services.

VVA is recommending that Congress go above the authorizing level for the Homeless Grant and Per Diem program and fund the program at $200 million and not the $138 million authorized. Additionally, VVA supports and seeks legislation to establish Supportive Services Assistance Grants for VA Homeless Grant and Per Diem Service Center Grant awardees.

VA HOMELESS DOMICILIARY PROGRAMS

Domiciliary programs located within various medical centers throughout the VA system have proven costly. As stand-alone programs, many do not display a high rate of long-term success. Additionally, not all VISNs even have Homeless Domiciliary programs.

Programs assisting homeless veterans need to show a cost/benefit ratio in order to survive. Due to the Federal pay scales and other indirect cost factors, VA Homeless Domiciliary programs generally cost twice as much per homeless veteran participant (often over $100 per day per veteran) as programs of community-based organizations. If the operational cost of the VA Homeless Domiciliary program is to be justified, then an assurance of success, including a diminished rate of recidivism, should be expected. This is not always the case and is especially true if the veteran has no linked transitional residential placement at time of discharge. A linkage with non-profit community programs will enhance outcomes in a cost-effective manner and openly speak to the belief in the "continuum of care" concept embraced by the VA. HGPD has increased transitional placement possibilities in a number of areas, but more are desperately needed.

Where no VA Homeless Veteran Domiciliary exists, VVA urges the VA to form an active linkage with community-based organizations for extended homeless veteran transitional services at the conclusion of VA Homeless Domiciliary care.

HOMELESS VETERANS SPECIAL NEEDS

VVA urges the Presidential Interagency Council on Homeless to recognize homeless veterans as a Special Needs Population. Further, we urge Congress to require all entities/agencies, including non-profit and governmental, that receive Federal program funding dollars, to report statistics on the number of veterans they serve, their residential status, and the services needed and provided. Additionally, VVA supports legislation that would incorporate a "fair share" dollar approach for the Federal funding of all homeless programs and services to specifically target homeless veterans.

HOMELESS WOMEN VETERANS

Women comprise a growing segment of the Armed Forces, and thousands have been deployed to Iraq and Afghanistan. Of the 154,000 homeless veterans estimated by the VA, women make up 3 percent of that population. The VA must be prepared to provide services to these former servicemembers in appropriate settings.

One of the confounding factors with homeless women veterans is the sexual trauma many if not most of them suffered during their service to our Nation. Few of us can know the dark places in which those who have suffered as the result of rape and physical abuse must live every day. It is a very long road to find the path that leads them to some semblance of "normalcy" and helps them escape from the secluded, lonely, fearful, angry corner in which they have been hiding. Not all residential programs are designed to treat mental health problems of this very vulnerable population. In light of the high incidence of past sexual trauma, rape, and domestic violence, many of these women find it difficult, if not impossible, to share residential programs with their male counterparts. They openly discuss their concern for a safe treatment setting, especially where the treatment unit layout does not provide them with a physically segregated, secured area. In light of the nature of some of their personal and trauma issues, they also discuss the need for gender-specific group sessions. The VA requests that all residential treatment areas be evaluated for the ability to provide and facilitate these services, and that medical centers develop plans to ensure this accommodation.

While some facilities have found innovative solutions to meet the unique needs of women veterans, others are still lagging behind. VVA believes that to adequately serve this growing special population of veterans, additional funding is required. We recommend an additional $10 million over FY08.

HUD–VASH

In 1992, the VA joined with HUD to launch the HUD–VASH program. HUD funded almost 600 vouchers for this program. Through the end of FY'02, 4,300 veterans had been served by the program, and had participated for an average of 4.1 years. Of veterans enrolled in the program, 90 percent successfully obtained vouchers and 87 percent moved into an apartment of their own. This partnership highlights the success of linking ongoing clinical care to permanent housing to assist homeless chronically mentally ill veterans. This program was given additional HUD–VASH vouchers with the passage of P.L. 107–95, which authorized 500 HUD/VASH vouchers in FY'03, 1,000 in FY'04, 1,500 in FY'05, and 2,000 in FY'06. The program was reauthorized under section 710, Rental Assistance Vouchers for Veterans Affairs Supported Housing Program, with the passage of PL 109–461, which authorized 500 vouchers for FY'07, 1,000 vouchers for FY'08, 1,500 vouchers for FY'09, 2,000 vouchers for FY'10 and 2,500 vouchers for FY'11.

VVA applauds the Senate Appropriations Committee for having funded $75,000,000 for the HUD–VASH Program in Public Law 110–161. The vouchers created by this funding will prove paramount in addressing the permanent housing needs of our less fortunate veterans. By allocating this funding, Congress has given providers the greatest tool possible in our fight to end homelessness among our veterans. VVA supports the FY'09 appropriations request from the Department of Housing and Urban Development for $75,000,000, which will provide an additional 10,000 vouchers. If enacted into law, some 20,000 vouchers will now be available to assist homeless veterans. VVA urges this Committee to reach out to your colleagues and request their support of these vouchers.

"SUPPORTIVE SERVICES ONLY" PROGRAMS

VVA realizes that, to a certain extent, the budget drives the ability of the VA to fund HGPD programs. Consider these few items: the VA's limited funding ability; the decreasing desire of HUD to fund Supportive Services programs; the disincentives placed by HUD on cities to renew the McKinney-Vento supportive services program; the impact that lost supportive service programs will have on the local social service system. Drop-in centers are one type of program that utilize homeless grants

for what is known as "Supportive Services Only" (SSO) funding. HUD funds these SSO programs via the local agency's inclusion on their city's priority list for its annual HUD McKinney-Vento submission. When originally funded, an agency was required to commit to a 20-year operational program. SSO programs targeting homeless veterans are included in this evolving funding atmosphere. Our question is: To what extent are the cities responsible for the continued renewals of programs that were previously vital to the local continuum?

We ask this in light of the 20-year financial burden of commitment required by small non-profit agencies when they are originally awarded grants and led to believe they are a crucial component and partner to the comprehensive approach to the elimiNation of homelessness. To suggest the non-profits find alternate funding in order to continue and satisfy a commitment of over 20 years seems unrealistic in light of the very limited grant funding available for these programs. In some instances, this could ultimately lead to the death of some non-profit agencies—the life line of not only the agencies' homeless clients, but also some of the city social service agencies that depend on the agency to assist with clients in an already over-burdened local service system.

At a time when the big push is on permanent housing for the homeless, with wraparound supportive services, is it logical to eliminate these programs on the community level? In light of this situation, and as a logical fit, VVA believes it is time for the Department of Health and Human Services (HHS) to enter this arena. We urge this Committee to encourage HHS to work with the VA in establishing a unique partnership, creating a joint program in an effort to provide enhanced opportunities to homeless veterans. VVA urges a continuing dialog between these two agencies to reach a viable option to the situation that is facing the non-profits gravely concerned about their own potential demise. What a terrible loss this would be to the structure of community involvement that has been so encouraged.

PERMANENT HOUSING NEEDS FOR LOW-INCOME VETERANS

Although the Federal government makes a sizeable investment in home ownership opportunities for veterans, there is no parallel national rental housing assistance program targeted to low-income veterans. Veterans are not well served through existing housing assistance programs due to their program designs. Low-income veterans in and of themselves are not a priority population for subsidized housing assistance. And HUD devotes minimal attention to the housing needs of low-income veterans. This has been made abundantly clear by the longstanding vacancy for special assistant for veterans programs within the Office of Community Planning and Development. It is imperative that Congress elevate national attention to the housing assistance needs of our Nation's low-income veterans.

P.L. 105–276, The Quality Housing and Work Responsibility Act of 1998 under Title III, permanently repealed Federal preferences for public housing and allowed the Public Housing Authority to establish preference for low-income veterans applying for public housing. In accordance with the GAO report, "Rental Housing Information on Low-Income Veterans Housing Condition and Participation in HUD's Programs," only a few of the PHAs surveyed were using veterans' preference criteria to assist low income veterans with housing. VVA has found no mention of these guidelines in any of the 5-year plans issued by the PHAs since the law was passed in 1998, which means HUD is once again creating homeless veterans by not abiding by and instead overlooking laws mandated by Congress.

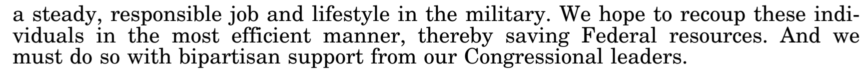
VVA is requesting that this committee support H.R. 3329, the Homes for Heroes Act of 2007 introduced by Representative Al Green, which would repeal the 1998 decision and provide additional benefits and services to homeless veterans. VVA also encourages this committee to begin open dialog with your colleagues on the House Appropriations Subcommittee on Transportation, Housing and Urban Development and Related Agencies, for they are a willing partner in ending homelessness among veterans.

Lastly, VVA urges full funding to the authorized level of $50 million for the Homeless Veterans Reintegration Program (HVRP) administered by the Department of Labor. This training/employment program has long suffered the consequences of limited funding. How can the DOL extol a commitment to the training of homeless veterans and deny them the full funding that has been requested under P.L. 107–95 and P.L. 109–233?

Former Congressman Lane Evans, in a 1994 statement before the full House of Representatives, explained, "Veterans are veterans no matter what else has transpired in their lives. These men and women served our nation. Providing them with their rightful benefits can only remind them of their prior commitment to society, promote their sense of self, and further their rehabilitation."

VVA strongly believes that homeless veterans have perhaps the best possibility for achieving rehabilitation because at an earlier point in their lives they did have

a steady, responsible job and lifestyle in the military. We hope to recoup these individuals in the most efficient manner, thereby saving Federal resources. And we must do so with bipartisan support from our Congressional leaders.



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Veterans and Homelessness
Updated April 4, 2008

Libby Perl, Analyst in Housing, Domestic Social Policy Division

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Summary

The current conflicts in Iraq and Afghanistan have brought renewed attention to the needs of veterans, including the needs of homeless veterans. The Department of Veterans Affairs (VA) estimates that it has served approximately 400 returning veterans in its homeless programs and has identified over 1,500 more as being at risk of homelessness. Both male and female veterans are overrepresented in the homeless population, and as the number of veterans increases due to the current wars, there is concern that the number of homeless veterans could rise commensurately.

Congress has created numerous programs that serve homeless veterans specifically, almost all of which are funded through the Veterans Health Administration. These programs provide health care and rehabilitation services for homeless veterans (the Health Care for Homeless Veterans and Domiciliary Care for Homeless Veterans programs), employment assistance (Homeless Veterans Reintegration Program and Compensated Work Therapy program), transitional housing (Grant and Per Diem and Loan Guarantee programs) as well as other supportive services. Through an arrangement with the Department of Housing and Urban Development (HUD), approximately 1,000 veterans currently use dedicated Section 8 vouchers for permanent housing, with supportive services provided through the VA. These are referred to as HUD–VASH vouchers. In FY2007, it is estimated that approximately $282 million was used to fund programs targeted to homeless veterans.

Several issues regarding veterans and homelessness have become prominent, in part because of the current conflicts. One issue is the need for permanent supportive housing for low-income and homeless veterans. With the exception of HUD–VASH vouchers, there is no source of permanent housing specifically for veterans. In FY2007, the Veterans Benefits, Health Care, and Information Technology Act (P.L. 109–461) authorized funding for additional HUD–VASH vouchers. Although these vouchers were not initially funded, the FY2008 Consolidated Appropriations Act (P.L. 110–161) included $75 million for Section 8 vouchers for homeless veterans. In addition, proposed legislation in the 110th Congress would both fund additional vouchers and provide resources for the acquisition, rehabilitation, and construction of permanent supportive housing for very low-income veterans and their families.

A second emerging issue is the concern that veterans returning from Iraq and Afghanistan who are at risk of homelessness may not receive the services they need. Efforts are being made to coordinate services between the VA and Department of Defense to ensure that those leaving military service transition to VA programs. Another emerging issue is the needs of female veterans, whose numbers are increasing. Women veterans face challenges that could contribute to their risks of homelessness. They are more likely to have experienced sexual abuse than women in the general population and are more likely than male veterans to be single parents. Few homeless programs for veterans have the facilities to provide separate accommodations for women and women with children.

Introduction

The wars in Iraq and Afghanistan have brought renewed attention to the needs of veterans, including the needs of homeless veterans. Homeless veterans initially came to the country's attention in the seventies and eighties, when homelessness generally was becoming a more prevalent and noticeable phenomenon. The first section of this report defines the term "homeless veteran," discusses attempts to count homeless veterans, and presents the results of studies regarding the characteristics of homeless veterans.

At the same time that the number of homeless persons began to grow, it became clear through various analyses of homeless individuals that homeless veterans are overrepresented in the homeless population. The second section of this report summarizes the available research regarding the overrepresentation of both male and female veterans, who are present in greater percentages in the homeless population than their percentages in the general population. This section also reviews research regarding possible explanations for why homeless veterans are overrepresented.

In response to the issue of homelessness among veterans, the Federal government has created numerous programs to fund services and transitional housing specifically for homeless veterans. The third section of this report discusses eight of these programs. The majority of programs are funded through the Department of Veterans Affairs (VA). Within the VA, the Veterans Health Administration (VHA), which is responsible for the health care of veterans, operates all but one of the programs for homeless veterans. The Veterans Benefits Administration (VBA), which is responsible for compensation, pensions, educational assistance, home loan guarantees, and insurance, operates the other. In addition, the Department of Labor oper-

ates one program for homeless veterans. In FY2007, approximately $282 million funded the majority of programs targeted to homeless veterans.

Several issues regarding homelessness among veterans have become prominent since the beginning of the conflicts in Iraq and Afghanistan. The fourth section of this report discusses three of these emerging issues. The first is the need for permanent supportive housing for homeless and low-income veterans. A second issue is ensuring that an adequate transition process exists for returning veterans to assist them with issues that might put them at risk of homelessness. Third is the concern that adequate services might not exist to serve the needs of women veterans. This report will be updated when new statistical information becomes available and to reflect programmatic changes.

Overview of Veterans and Homelessness

Homelessness has always existed in the United States, but only in recent decades has the issue come to prominence. In the 1970s and 1980s, the number of homeless persons increased, as did their visibility. Experts cite various causes for the increase in homelessness. These include the demolition of single room occupancy dwellings in so-called "skid rows" where transient single men lived, the decreased availability of affordable housing generally, the reduced need for seasonal unskilled labor, the reduced likelihood that relatives will accommodate homeless family members, the decreased value of public benefits, and changed admissions standards at mental hospitals.[1] The increased visibility of homeless persons was due, in part, to the decriminalization of actions such as public drunkenness, loitering, and vagrancy.[2]

Homelessness occurs among families with children and single individuals, in rural communities as well as large urban cities, and for varying periods of time. Depending on circumstances, periods of homelessness may vary from days to years. Researchers have created three categories of homelessness based on the amount of time that individuals are homeless.[3] First, the transitionally homeless are those who have one short stay in a homeless shelter before returning to permanent housing. In the second category, those who are episodically homeless frequently move in and out of homelessness but do not remain homeless for long periods of time. Third, the chronically homeless are those who are homeless continuously for a period of one year or have at least four episodes of homelessness in three years. Chronically homeless individuals often suffer from mental illness and/or substance abuse disorders. Although veterans experience all types of homelessness, they are thought to be chronically homeless in higher numbers than nonveterans.[4]

Homeless veterans began to come to the attention of the public at the same time that homelessness generally was becoming more common. News accounts chronicled the plight of veterans who had served their country but were living (and dying) on the street.[5] The commonly held notion that the military experience provides young people with job training, educational and other benefits, as well as the maturity needed for a productive life, conflicted with the presence of veterans among the homeless population.[6]

Definition of "Homeless Veteran"

Although the term "homeless veteran" might appear straightforward, it contains two layers of definition.[7] First, the definition of "veteran" for purposes of Title 38 benefits (the Title of the United States Code that governs veterans benefits) is a person who "served in the active military, naval, or air service" and was not dishonorably discharged.[8] In order to be a "veteran" who is eligible for benefits according

[1] Peter H. Rossi, *Down and Out in America: The Origins of Homelessness* (Chicago: The University of Chicago Press, 1989), 181–194, 41. See, also, Martha Burt, *Over the Edge: The Growth of Homelessness in the 1980s* (New York: Russell Sage Foundation, 1992), 31–126.

[2] *Down and Out in America,* p. 34; *Over the Edge,* p. 123.

[3] See Randall Kuhn and Dennis P. Culhane, "Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data," *American Journal of Community Psychology* 26, no. 2 (April 1998): 210–212.

[4] Martha R. Burt, Laudan Y. Aron et al., *Homelessness: Programs and the People They Serve, Technical Report,* Urban Institute, December 1999, p. 11–1, available at http://www.huduser.org/Publications/pdf/home_tech/tchap-11.pdf. Of homeless male veterans surveyed, 32% reported being homeless for 13 or more months, versus 17% of nonveteran homeless men.

[5] Marjorie J. Robertson, "Homeless Veterans, An Emerging Problem?" in *The Homeless in Contemporary Society,* ed. Richard J. Bingham, Roy E. Green, and Sammis B. White (Newbury Park, CA: Sage Publications, 1987), 66.

[6] Ibid, pp. 64–65.

[7] The United States Code defines the term as "a veteran who is homeless" as defined by the McKinney-Vento Homeless Assistance Act. 38 U.S.C. § 2002(1).

[8] 12 U.S.C. § 101(2).

to this definition, at least four criteria must be met. (For a detailed discussion of these criteria see CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Program,* by Douglas Reid Weimer.)

Second, veterans are considered homeless if they meet the definition of "homeless individual" established by the McKinney-Vento Homeless Assistance Act (P.L. 100–77).[9] According to McKinney-Vento, a homeless individual is (1) an individual who lacks a fixed, regular, and adequate nighttime residence, and (2) a person who has a nighttime residence that is:

- a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
- an institution that provides a temporary residence for individuals intended to be institutionalized; or
- a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Counts of Homeless Veterans

The Department of Veterans Affairs. The exact number of homeless veterans is unknown, although attempts have been made to estimate their numbers. In every year since 1998, the VA has included estimates of the number of homeless veterans receiving services in its "Community Homelessness Assessment, Local Education and Networking Groups" (CHALENG) report to Congress.[10] The estimates are made as part of the CHALENG process, through which representatives from each local VA medical center called "points of contact" (POCs) coordinate with service providers from state and local governments and nonprofit organizations as well as homeless or formerly homeless veterans themselves to determine the needs of homeless veterans and plan for how to best deliver services.

CHALENG Estimates FY1998–FY2006. In the first six years of CHALENG estimates (FY1998 through FY2003), the VA asked POCs to estimate the number of veterans homeless *at any time during the year.* Starting in FY2004 and continuing through FY2006, the VA changed its methodology, and asked POCs from each medical center to provide estimates of the highest number of veterans who are homeless on *any given day during the year.* The new methodology used in the FY2004–FY2006 CHALENG estimates is a point-in-time count and is not meant to reflect the total number of veterans who might experience homelessness at some time during the year. The VA considers the estimates from FY2004 to FY2006 to be more reliable than earlier estimates.[11]

CHALENG Estimate FY2007. During the FY2007 CHALENG process, the VA again asked POCs to provide a point-in-time estimate, just as they had in FY2004–FY2006. However, for the first time, the VA asked that POC estimates of homeless veterans coincide with the Department of Housing and Urban Development (HUD) counts of homeless individuals. Every other year HUD directs local jurisdictions called "Continuums of Care" (CoCs)[12] to conduct a count of sheltered and unsheltered homeless persons on one night during the last week of January (though some CoCs conduct counts every year). The most recent HUD count in which all CoCs participated took place in January 2007.

To arrive at the FY2007 CHALENG estimate, POCs estimated the number of veterans experiencing homelessness on one night during the same 1-week period used by HUD. In order to bring the VA count in line with HUD estimates, POCs compared their 2007 estimates to the 2005 HUD estimates (the most recent data available at that time); if there were "major differences" between the two estimates, the

[9] The McKinney-Vento definition of homeless individual is codified at 42 U.S.C. 11302(a).

[10] For the most recent CHALENG report, see John H. Kuhn and John Nakashima, *The Fourteenth Annual Progress Report on Public Law 105–114: Services for Homeless Veterans Assessment and CoordiNation,* U.S. Department of Veterans Affairs, February 28, 2008 (hereafter *Fourteenth Annual CHALENG Report).* Congress required the VA to issue the report as part of the Veterans Benefits Improvement Act 1994, P.L. 103–446 (38 U.S.C. § 2065).

[11] Government Accountability Office, *Homeless Veterans Programs: Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program,* GAO–06–859, September 2006, p. 13, available at http://www.gao.gov/new.items/d06859.pdf.

[12] Continuums of Care are typically formed by cities, counties, or combinations of both. Representatives from local government agencies and service provider organizations serve on CoC boards, which conduct the business of the CoC. HUD first required these Continuums of Care to conduct counts of sheltered and unsheltered homeless persons in 2005.

POCs provided an explaNation of why this might be the case.[13] In some jurisdictions, POC estimates were adjusted to be more consistent with HUD's estimates. In addition to consulting HUD estimates, some POCs (71%) used more than one source to arrive at their estimates of homeless veterans. These included U.S. Census data (10%), VA low-income population estimates (7%), local homeless census studies (42%), VA client data (36%), estimates from local homeless assistance providers (59%), and VA staff impressions (52%).[14]

The most recent CHALENG report estimated that 154,000 veterans were homeless on one day during the last week of January 2007.[15] This estimate is down from 2006 and 2005 estimates of 195,827 and 194,254 respectively. The VA hypothesizes that improved methodology, VA program interventions for homeless veterans, and the changing demographics of the veteran population could account for the reduction in the CHALENG estimate.[16]

The Department of Housing and Urban Development. In addition to the CoC point-in-time counts, described above, HUD is engaged in an ongoing process to count homeless persons, including homeless veterans, through its Homeless Management Information Systems (HMIS). Continuums of Care collect and store information about homeless individuals they serve, and the information is aggregated in computer systems at the CoC level. Eventually the HMIS initiative is expected to produce an unduplicated count of homeless individuals as well as a summary of demographic information. HUD has released two Annual Homeless Assessment Reports (AHARs), in which it used HMIS data to estimate the number of individuals nationwide who were homeless during particular periods of time. The most recent AHAR was released in March 2008 and estimated the number of individuals who experienced homelessness at some point during a six-month period, from January 1 to June 30, 2006.[17] These estimates did not include homeless persons who were not residing in emergency shelters or transitional housing during the relevant time periods.

The first and second AHARs did not provide estimates of the *number* of homeless veterans, though they did provide estimates of the *percentage* of the adult homeless population who are veterans. There are limitations to these data, however. The second AHAR estimated that 14.3% of adults who were homeless during the 6-month period from January 1 to June 30, 2006, were veterans (while 11.2% of the general population were veterans).[18] These data do not include persons living on the street or other location not meant for human habitation. In addition, 20% of records were missing data on veteran status. The first AHAR estimated that 18.7% of the homeless population were veterans (compared to 12.6% of the general population) in the three-month period between February 1 and April 30, 2005. Of the records submitted, 35% were missing information on veteran status.[19] (For more information about efforts to count homeless persons, see CRS Report RL33956, *Counting Homeless Persons: Homeless Management Information Systems,* by Libby Perl.)

Characteristics of Homeless Veterans

Homeless male veterans differ from homeless men who are nonveterans in a variety of ways. According to data from several studies during the 1980s, homeless male veterans were more likely to be older and better educated than the general population of homeless men.[20] However, they were found to have more health problems than nonveteran homeless men, including AIDS, cancer, and hypertension.[21] They also suffered from mental illness and alcohol abuse at higher rates than nonveterans. A study published in 2002 found similar results regarding age and education. Homeless male veterans tended to be older, on average, than nonveteran homeless men.[22] Homeless veterans were also different in that they had reached

[13] *Fourteenth Annual CHALENG Report,* p. 16.
[14] Ibid, pp. 16–17.
[15] Ibid, p. 16.
[16] Ibid, pp. 16–17.
[17] U.S. Department of Housing and Urban Development, *The Second Annual Homeless Assessment Report to Congress,* March 2008, available at http://www.hudhre.info/documents/2ndHomelessAssessmentReport.pdf.
[18] Ibid, p. 23.
[19] U.S. Department of Housing and Urban Development, *The Annual Homeless Assessment Report to Congress,* February 2007, p. 31, available at http://www.huduser.org/Publications/pdf/ahar.pdf.
[20] "Homeless Veterans," pp. 104–105.
[21] Ibid, p. 105.
[22] Richard Tessler, Robert Rosenheck, and Gail Gamache, "Comparison of Homeless Veterans with Other Homeless Men in a Large Clinical Outreach Program," *Psychiatric Quarterly* 73, no. 2 (Summer 2002): 113–114.

higher levels of education than their nonveteran counterparts[23] and were more likely to be working for pay. They were also more likely to have been homeless for more than one year, and more likely to be dependent on or abuse alcohol. Family backgrounds among homeless veterans tended to be more stable, with veterans experiencing less family instability[24] and fewer incidents of conduct disorder,[25] while also being less likely to have never married than nonveteran homeless men.

Homeless women veterans have also been found to have different characteristics than nonveteran homeless women. Based on data collected during the late 1990s, female veterans, like male veterans, were found to have reached higher levels of education than nonveteran homeless women, and also more likely to have been employed in the 30 days prior to being surveyed.[26] They also had more stable family backgrounds, and lower rates of conduct disorder as children.

Overrepresentation of Veterans in the Homeless Population

Research that has captured information about the entire national homeless population, including veteran status, is rare. Although HUD is engaged in ongoing efforts to collect information about homeless individuals, the most extensive information about homeless veterans specifically comes from earlier studies. Possibly the most comprehensive national data collection effort regarding persons experiencing homelessness took place in 1996 as part of the National Survey of Homeless Assistance Providers and Clients (NSHAPC), when researchers interviewed thousands of homeless assistance providers and homeless individuals across the country.[27] Prior to the NSHAPC, in 1987, researchers from the Urban Institute surveyed nearly 2,000 homeless individuals and clients in large cities nationwide as part of a national study.[28] The data from these two surveys serve as the basis for more in depth research regarding homeless veterans, described below. No matter the data source, however, research has found that veterans make up a greater percentage of the homeless population than their percentage in the general population.

Both male and female veterans are more likely to be homeless than their nonveteran counterparts.[29] This has not always been the case, however. Although veterans have always been present among the homeless population, the birth cohorts that served in the military more recently, from the Vietnam[30] and post-Vietnam eras, have been found to be overrepresented. Veterans of World War II and Korea are less likely to be homeless than their nonveteran counterparts.[31] (The same cohort effect is not as evident for women veterans.) Four studies of homeless veterans, two of male veterans and two of female veterans, provide evidence of this overrepresentation and increased likelihood of experiencing homelessness.

Overrepresentation of Male Veterans

Two national studies—one published in 1994 using data from the 1987 Urban Institute survey (as well as data from surveys in Los Angeles, Baltimore, and Chicago), and the other published in 2001 using data from the 1996 NSHAPC—found that male veterans were overrepresented in the homeless population. In addition, researchers in both studies determined that the likelihood of homelessness de-

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[23] Veterans averaged 12.43 years of education completed, versus 11.21 for nonveterans.

[24] Family instability is measured by factors that include parental separation or divorce and time spent in foster care.

[25] Conduct disorder is measured by factors such as school suspensions, expulsions, drinking, using drugs, stealing, and fighting.

[26] Gail Gamache, Robert Rosenheck, and Richard Tessler, "Overrepresentation of Women Veterans Among Homeless Women," *American Journal of Public Health* 93, no. 7 (July 2003): 1133–1134 (hereafter "Overrepresentation of Women Veterans Among Homeless Women").

[27] Martha R. Burt, Laudan Y. Aron, et al., Homelessness: *Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients, Technical Report,* December 1999, available at http://www.huduser.org/publications/homeless/homeless_tech.html.

[28] Martha R. Burt and Barbara E. Cohen, *America's Homeless: Numbers, Characteristics, and Programs that Serve Them* (Washington, DC: The Urban Institute Press, July 1989).

[29] See Gail Gamache, Robert Rosenheck, and Richard Tessler, "The Proportion of Veterans Among Homeless Men: A Decade Later," *Social Psychiatry and Psychiatric Epidemiology* 36, no. 10 (October 2001): 481 (hereafter "The Proportion of Homeless Veterans Among Men: A Decade Later"). "Overrepresentation of Women Veterans Among Homeless Women," p. 1134.

[30] Generally, the Vietnam era is defined as the period from 1964 to 1975. 38 U.S.C. § 101(29)(B).

[31] Alvin S. Mares and Robert A. Rosenheck, "Perceived Relationship Between Military Service and Homelessness Among Homeless Veterans with Mental Illness," *The Journal of Nervous and Mental Disease* 192, no. 10 (October 2004): 715.

pended on the ages of veterans.[32] During both periods of time, the odds of a veteran being homeless was highest for veterans who had enlisted after the military transitioned to an all-volunteer force (AVF) in 1973. These veterans were age 20–34 at the time of the first study, and age 35–44 at the time of the second study.

In the first study, researchers found that 41% of adult homeless men were veterans, compared to just under 34% of adult males in the general population. Overall, male veterans were 1.4 times as likely to be homeless as nonveterans.[33] Notably, though, those veterans who served after the Vietnam War were four times more likely to be homeless than nonveterans in the same age group.[34] Vietnam era veterans, who are often thought to be the most overrepresented group of homeless veterans, were barely more likely to be homeless than nonveterans (1.01 times). (See **Table 1** for a breakdown of the likelihood of homelessness based on age.)

In the second study, researchers found that nearly 33% of adult homeless men were veterans, compared to 28% of males in the general population. Once again, the likelihood of homelessness differed among age groups. Overall, male veterans were 1.25 times more likely to be homeless than nonveterans.[35] However, the same post-Vietnam birth cohort as that in the 1994 study was most at risk of homelessness; those veterans in the cohort were over three times as likely to be homeless as nonveterans in the same cohort. Younger veterans, those age 20–34 in 1996, were two times as likely to be homeless as nonveterans. And Vietnam era veterans were approximately 1.4 times as likely to be homeless as their nonveteran counterparts. (See **Table 1**.)

Overrepresentation of Female Veterans

Like male veterans, women veterans are more likely to be homeless than women who are not veterans. A study published in 2003 examined two data sources, one a survey of mentally ill homeless women, and the other the NSHAPC, and found that 4.4% and 3.1% of those homeless persons surveyed were female veterans, respectively (compared to approximately 1.3% of the general population).[36] Although the likelihood of homelessness was different for each of the two surveyed populations, the study estimated that female veterans were between two and four times as likely to be homeless as their nonveteran counterparts.[37] Unlike male veterans, all birth cohorts were more likely to be homeless than nonveterans. However, with the exception of women veterans age 35–55 (representing the post-Vietnam era), who were between approximately 3.5 and 4.0 times as likely to be homeless as nonveterans, cohort data were not consistent between the two surveys. (See **Table 1** for a breakdown of likelihood of homelessness by cohort.)

Table 1—Results from Four Studies: Veterans as a Percentage of the Homeless Population and Likelihood of Experiencing Homelessness

Veteran Group	Veterans as a Percentage of the General Population[a]	Veterans as a Percentage of the Homeless Population	Odds Ratio (Likelihood of Homelessness among Veterans vs. Nonveterans)
Men (data 1986–87)[b]	33.6	41.2	1.38
Age 20–34	10.0	30.6	3.95
Age 35–44	36.9	37.2	1.01
Age 45–54	44.8	58.7	1.75
Age 55–64	69.9	61.7	0.69
> Age 64	46.3	37.4	0.71
Men (data 1996)[c]	28.0	32.7	1.25

[32] See Robert Rosenheck, Linda Frisman, and An-Me Chung, "The Proportion of Veterans Among Homeless Men," *American Journal of Public Health* 84, no. 3 (March 1994): 466 (hereafter "The Proportion of Homeless Veterans Among Men"); "The Proportion of Veterans Among Homeless Men: A Decade Later," p. 481.
[33] "The Proportion of Homeless Veterans Among Men," p. 467.
[34] Ibid
[35] "The Proportion of Homeless Veterans Among Men: A Decade Later," p. 483.
[36] "Overrepresentation of Women Veterans Among Homeless Women," p. 1133.
[37] Ibid, p. 1134.

Table 1—Results from Four Studies: Veterans as a Percentage of the Homeless Population and Likelihood of Experiencing Homelessness—Continued

Veteran Group	Veterans as a Percentage of the General Population[a]	Veterans as a Percentage of the Homeless Population	Odds Ratio (Likelihood of Homelessness among Veterans vs. Nonveterans)
Age 20–34	7.7	14.5	2.04
Age 35–44	13.8	33.7	3.17
Age 45–54	38.4	46.5	1.39
Age 55–64	48.7	45.8	0.89[f]
> Age 64	62.6	59.5	0.88[f]
Women (data 1994–98)[d]	1.3	4.4	3.58
Age 20–34	—	—	3.61
Age 35–44	—	—	3.48
Age 45–54	—	—	4.42
Age 55 and Older	—	—	1.54[f]
Women (data 1996)[e]	1.2	3.1	2.71
Age 20–34	—	—	1.60[f]
Age 35–44	—	—	3.98
Age 45–54	—	—	2.00[f]
Age 55 and Older	—	—	4.40

Sources: Robert Rosenheck, Linda Frisman, and An-Me Chung, "The Proportion of Veterans Among Homeless Men," *American Journal of Public Health* 84, no. 3 (March 1994): 466–469; Gail Gamache, Robert Rosenheck, and Richard Tessler, "The Proportion of Veterans Among Homeless Men: A Decade Later," *Social Psychiatry and Psychiatric Epidemiology* 36, no. 10 (October 2001): 481–485; Gail Gamache, Robert Rosenheck, and Richard Tessler, "Overrepresentation of Women Veterans Among Homeless Women," *American Journal of Public Health* 93, no. 7 (July 2003): 1132–1136.

[a] Data are from the Current Population Survey.
[b] Data are from the Urban Institute Study and three community surveys conducted between 1985 and 1987.
[c] Data are from the National Survey of Homeless Assistance Providers and Clients (NSHAPC).
[d] Data are from the Access to Community Care and Effective Services and Supports sample of women with mental illness.
[e] Data are from the NSHAPC.
[f] Not statistically significant.

Why Are Veterans Overrepresented in the Homeless Population?

As the number of homeless veterans has grown, researchers have attempted to explain why veterans are homeless in higher proportions than their numbers in the general population. Factors present both prior to military service, and those that developed during or after service, have been found to be associated with veterans' homelessness.

Most of the evidence about factors associated with homelessness among veterans comes from The National Vietnam Veterans Readjustment Study (NVVRS) conducted from 1984 to 1988.[38] Researchers for the NVVRS surveyed 1,600 Vietnam theater veterans (those serving in Vietnam, Cambodia, or Laos) and 730 Vietnam era veterans (who did not serve in the theater) to determine their mental health status and their ability to readjust to civilian life. The NVVRS did not specifically analyze homelessness. However, a later study, published in 1994, used data from the NVVRS to examine homelessness specifically.[39] Findings from both studies are discussed below.

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[38] The NVVRS was undertaken at the direction of Congress as part of P.L. 98–160, the Veterans Health Care Amendments of 1983.

[39] Robert Rosenheck and Alan Fontana, "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," *The American Journal of Psychiatry* 151, no. 3 (March 1994):

Continued

Factors Present During and After Military Service. Although researchers have not found that military service alone is associated with homelessness,[40] it may be associated with other factors that contribute to homelessness. The NVVRS found an indirect connection between the stress that occurs as a result of deployment and exposure to combat, or "war-zone stress," and homelessness. Vietnam theater and era veterans who experienced war-zone stress were found to have difficulty readjusting to civilian life, resulting in higher levels of problems that included social isolation, violent behavior, and, for white male veterans, homelessness.[41]

The 1994 study of Vietnam era veterans (hereafter referred to as the Rosenheck/Fontana study) evaluated 18 variables that could be associated with homelessness. The study categorized each variable in one of four groups, according to when they occurred in the veteran's life: pre-military, military, the 1-year readjustment period, and the post-military period subsequent to readjustment.[42] Variables from each time period were found to be associated with homelessness, although their effects varied. The two military factors—combat exposure and participation in atrocities—did not have a direct relationship to homelessness. However, those two factors did contribute to (1) low levels of social support upon returning home, (2) psychiatric disorders (not including post traumatic stress disorder (PTSD)), (3) substance abuse disorders, and (4) being unmarried (including separation and divorce). Each of these four post-military variables, in turn, contributed directly to homelessness.[43] In fact, social isolation, measured by low levels of support in the first year after discharge from military service, together with the status of being unmarried, had the strongest association with homelessness of the 18 factors examined in the study.[44]

Post Traumatic Stress Disorder (PTSD). Researchers have not found a direct relationship between PTSD and homelessness. The Rosenheck/Fontana study "found no unique association between combat-related PTSD and homelessness."[45] Unrelated research has determined that homeless combat veterans were no more likely to be diagnosed with PTSD than combat veterans who were not homeless.[46] However, the NVVRS found that PTSD was significantly related to other psychiatric disorders, substance abuse, problems in interpersonal relationships, and unemployment.[47] These conditions can lead to readjustment difficulties and are considered risk factors for homelessness.[48]

Factors that Pre-Date Military Service. According to research, factors that predate military service also play a role in homelessness among veterans. The Rosenheck/Fontana study found that three variables present in the lives of veterans before they joined the military had a significant direct relationship to homelessness. These were exposure to physical or sexual abuse prior to age 18; exposure to other traumatic experiences, such as experiencing a serious accident or natural disaster, or seeing someone killed; and placement in foster care prior to age 16.[49] The researchers also found that a history of conduct disorder had a substantial indirect

421–427 (hereafter "A Model of Homelessness Among Male Veterans of the Vietnam War Generation").

[40] See, for example, Alvin S. Mares and Robert Rosenheck, "Perceived Relationship Between Military Service and Homelessness Among Homeless Veterans With Mental Illness," *Journal of Nervous and Mental Disease* 192, no. 10 (October 2004): 715.

[41] Richard A. Kulka, John A. Fairbank, B. Kathleen Jordan, and Daniel S. Weiss, *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* (Levittown, PA: Brunner/Mazel, 1990), 142.

[42] The first category consisted of nine factors: year of birth, belonging to a racial or ethnic minority, childhood poverty, parental mental illness, experience of physical or sexual abuse prior to age 18, other trauma, treatment for mental illness before age 18, placement in foster care before age 16, and history of conduct disorder. The military category contained three factors: exposure to combat, participation in atrocities, and non-military trauma. The readjustment period consisted of two variables: accessibility to someone with whom to discuss personal matters and the availability of material and social support (together these two variables were termed low levels of social support). The final category contained four factors: post traumatic stress disorder (PTSD), psychiatric disorders not including PTSD, substance abuse, and unmarried status.

[43] "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," p. 424.

[44] Ibid, p. 425.

[45] "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," p. 425.

[46] Robert Rosenheck, Catherine A. Leda, Linda K. Frisman, Julie Lam, and An-Me Chung, "Homeless Veterans" in *Homelessness in America,* ed. Jim Baumohl (Phoenix, AZ: Oryx Press, 1996), 99 (hereafter "Homeless Veterans").

[47] Robert Rosenheck, Catherine Leda, and Peggy Gallup, "Combat Stress, Psychosocial Adjustment, and Service Use Among Homeless Vietnam Veterans," *Hospital and Community Psychiatry* 42, no. 2 (February 1992): 148.

[48] "Homeless Veterans," p. 98.

[49] "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," p. 426.

effect on homelessness.[50] Conduct disorder includes behaviors such as being suspended or expelled from school, involvement with law enforcement, or having poor academic performance. Another pre-military variable that might contribute to homelessness among veterans is a lack of family support prior to enlistment.[51]

The conditions present in the lives of veterans prior to military service, and the growth of homelessness among veterans, have been tied to the institution of the all volunteer force (AVF) in 1973. As discussed earlier in this report, the overrepresentation of veterans in the homeless population is most prevalent in the birth cohort that joined the military after the Vietnam War. It is possible that higher rates of homelessness among these veterans are due to "lowered recruitment standards during periods where military service was not held in high regard."[52] Individuals who joined the military during the time after the implementation of the AVF might have been more likely to have characteristics that are risk factors for homelessness.[53]

Federal Programs that Serve Homeless Veterans

The Federal response to the needs of homeless veterans, like the Federal response to homelessness generally, began in the late eighties. Congress, aware of the data showing that veterans were disproportionately represented among homeless persons,[54] began to hold hearings and enact legislation in the late eighties. Among the programs enacted were Health Care for Homeless Veterans, Domiciliary Care for Homeless Veterans, and the Homeless Veterans Reintegration Projects. Also around this time, the first (and only) national group dedicated to the cause of homeless veterans, the National Coalition for Homeless Veterans, was founded by service providers that were concerned about the growing number of homeless veterans.

While homeless veterans are eligible for and receive services through programs that are not designed specifically for homeless veterans, the VA funds multiple programs to serve homeless veterans. The majority of homeless programs are run through the Veterans Health Administration (VHA), which administers health care programs for veterans.[55] The Veterans Benefits Administration (VBA), which is responsible for compensation and pensions,[56] education assistance,[57] home loan guarantees,[58] and insurance, operates one program for homeless veterans. In addition, the Department of Labor (DoL) is responsible for one program that provides employment services for homeless veterans. In FY2007, funding of approximately $282 million was provided for homeless veterans programs,[59] eight of which are summarized in this section. **Table 2**, below, shows historical funding levels for seven of these eight programs.

[50] Ibid

[51] Richard Tessler, Robert Rosenheck, and Gail Gamache, "Homeless Veterans of the All-Volunteer Force: A Social Selection Perspective," *Armed Forces & Society* 29, no. 4 (Summer 2003): 511 (hereafter "Homeless Veterans of the All-Volunteer Force: A Social Selection Perspective").

[52] Testimony of Robert Rosenheck, M.D., Director of Northeast Program Evaluation Center, Department of Veterans Affairs, Senate Committee on Veterans' Affairs, 103rd Cong., 2nd sess., February 23, 1994.

[53] "Homeless Veterans of the All-Volunteer Force: A Social Selection Perspective," p. 510.

[54] Senate Committee on Veterans' Affairs, *Veterans' Administration FY1988 Budget, the Vet Center Program, and Homeless Veterans Issues,* 100th Cong., 1st sess., S.Hrg. 100–350, February 18 & 19, 1987, p. 2–6.

[55] For more information about the VHA, see CRS Report RL33993, *Veterans' Health Care Issues,* by Sidath Viranga Panangala.

[56] For more information about veterans benefits, see CRS Report RL33985, *Veterans Benefits: Issues in the 110th Congress,* coordinated by Carol Davis.

[57] For more information about educational assistance, see CRS Report RL33281, *Montgomery GI Bill Education Benefits: Analysis of College Prices and Federal Student Aid Under the Higher Education Act,* by Charmaine Mercer.

[58] For more information about VA home loan guarantees, see CRS Report RS20533, *VA–Home Loan Guaranty Program: An Overview,* by Bruce E. Foote and Meredith Peterson.

[59] The amount of funding is based on FY2007 VA obligations for its homeless programs and the amount appropriated for the Department of Labor's Homeless Veterans Reintegration Program.

Table 2—Funding for Selected Homeless Veterans Programs FY1988–FY2008 (dollars in thousands)

Fiscal Year	Obligations (VA Programs)						Budget Authority (DoL Program)	Total Funding for Selected Programs
	Health Care for Homeless Veterans[a]	Domiciliary Care for Homeless Veterans	Compensated Work Therapy/ Therapeutic Residence	Grant and Per Diem Program	HUD–VA Supported Housing	Loan Guarantee for Multifamily Transitional Housing	Homeless Veterans Reintegration Program	
1988	$12,932	$15,000[b]	NA	NA	NA	NA	$1,915	$29,847
1989	13,252	10,367	NA	NA	NA	NA	1,877	25,496
1990	15,000	15,000	NA	NA	NA	NA	1,920	31,920
1991	15,461[c]	15,750	—[c]	NA	NA	NA	2,018	33,229
1992	16,500[c]	16,500	—[c]	NA	2,300	NA	1,366	36,666
1993	22,150	22,300	400	NA	2,000	NA	5,055	51,905
1994	24,513	27,140	3,051	8,000	3,235	NA	5,055	70,994
1995	38,585[d]	38,948	3,387	—[d]	4,270	NA	107[e]	85,297
1996	38,433[d]	41,117	3,886	—[d]	4,829	NA	0	88,265
1997	38,063[d]	37,214	3,628	—[d]	4,958	NA	0	83,863
1998	36,407	38,489	8,612	5,886	5,084	NA	3,000	97,478
1999	32,421	39,955	4,092	20,000	5,223	NA	3,000	104,691
2000	38,381	34,434	8,068	19,640	5,137	661	9,636	115,957
2001	58,602	34,576	8,144	31,100	5,219	366	17,500	155,507
2002	54,135	45,443	8,028	22,431	4,729	528	18,250	153,544
2003	45,188	49,213	8,371	43,388	4,603	594	18,131	169,488
2004	42,905	51,829	10,240	62,965	3,375	605	18,888	190,807
2005	40,357	57,555	10,004	62,180	3,243	574	20,832	194,745

2006	56,998	63,592	19,529	63,621	5,297	507	21,780	231,324
2007	71,925	77,633	21,514	81,187	7,487	613	21,809	282,168
2008[f]	74,802	80,738	22,375	107,180	7,786	660	23,620	317,161

Sources: Department of Veterans Affairs Budget Justifications, FY1989–FY2009, VA Office of Homeless Veterans Programs, Department of Labor Budget Justifications FY1989–FY2009, and the FY2008 Consolidated Appropriations Act P.L. 110–161.

[a] Health Care for Homeless Veterans was originally called the Homeless Chronically Mentally Ill veterans program. In 1992, the VA began to use the title "Health Care for Homeless Veterans."

[b] Congress appropriated funds for the DCHV program for both FY1987 and FY1988 (P.L. 100–71), however, the VA obligated the entire amount in FY1988. See VA Budget Summary for FY1989, Volume 2, Medical Benefits, p. 6–10.

[c] For FY1991 and FY1992, funds from the Homeless Chronically Mentally Ill veterans program as well as substance abuse enhancement funds were used for the Compensated Work Therapy/Therapeutic Residence program.

[d] For FY1995 through FY1997, Grant and Per Diem funds were obligated with funds for the Health Care for Homeless Veterans program. VA budget documents do not provide a separate breakdown of Grant and Per Diem Obligations.

[e] Congress appropriated $5.011 million for HVRP in P.L. 103–333. However, a subsequent rescission in P.L. 104–19 reduced the amount.

[f] The obligation amounts for FY2008 are estimates.

The Department of Veterans Affairs

The majority of programs that serve homeless veterans are part of the Veterans Health Administration (VHA), one of the three major organizations within the VA (the other two are the Veterans Benefits Administration (VBA) and the National Cemetery Administration).[60] The VHA operates hospitals and outpatient clinics across the country through 21 Veterans Integrated Services Networks (VISNs). Each VISN oversees between five and eleven VA hospitals as well as outpatient clinics, nursing homes, and domiciliary care facilities. In all, there are 157 VA hospitals, 750 outpatient clinics, 134 nursing homes, and 42 domiciliary care facilities across the country. Many services for homeless veterans are provided in these facilities. In addition, the VBA has made efforts to coordinate with the VHA regarding homeless veterans by placing Homeless Veteran Outreach Coordinators (HVOCs) in its offices in order to assist homeless veterans in their applications for benefits.

Health Care for Homeless Veterans. The first Federal program to specifically address the needs of homeless veterans, Health Care for Homeless Veterans (HCHV), was initially called the Homeless Chronically Mentally Ill veterans program.[61] The program was created as part of an emergency appropriations act for FY1987 (P.L. 100–6) in which Congress allocated $5 million to the VA to provide medical and psychiatric care in community-based facilities to homeless veterans suffering from mental illness.[62] Through the HCHV program, VA medical center staff conduct outreach to homeless veterans, provide care and treatment for medical, psychiatric, and substance abuse disorders, and refer veterans to other needed supportive services.[63] Although P.L. 100–6 provided priority for veterans whose illnesses were service-connected, veterans with non-service-connected disabilities were also made eligible for the program. Within two months of the program's enactment, 43 VA Medical Centers had initiated programs to find and assist mentally ill homeless veterans.[64] The HCHV program is currently authorized through December 31, 2011.[65]

Program Data. The HCHV program itself does not provide housing for veterans who receive services. However, the VA was initially authorized to enter into contracts with non-VA service providers to place veterans in residential treatment facilities so that they would have a place to stay while receiving treatment. In FY2003, the VA shifted funding from contracts with residential treatment facilities to the VA Grant and Per Diem program (described later in this report).[66] Local funding for residential treatment facilities continues to be provided by some VA medical center locations, however. According to the most recent data available from the VA, 1,131 veterans stayed in residential treatment facilities in FY2006, with an average stay of about 58 days.[67] The HCHV program treated approximately 60,857 veterans in that same year.[68]

Domiciliary Care for Homeless Veterans. Domiciliary care consists of rehabilitative services for physically and mentally ill or aged veterans who need assistance, but are not in need of the level of care offered by hospitals and nursing homes. Congress first provided funds for the Domiciliary Care program for *homeless* veterans in 1987 through a supplemental appropriations act (P.L. 100–71). Prior to enactment of P.L. 100–71, domiciliary care for veterans generally (now often referred to as Residential Rehabilitation and Treatment programs) had existed since the 1860s. The program for homeless veterans was implemented to reduce the use of

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[60] For more information about the organization of the VA, see U.S. Department of Veterans Affairs, *Organizational Briefing Book,* May 2007, available at http://www.va.gov/ofcadmin/ViewPDF.asp?fType=1.

[61] In 1992, the VA began to refer to the program by its new name. VA FY1994 Budget Summary, Volume 2, Medical Benefits, p. 2–63.

[62] Shortly after the HCHV program was enacted in P.L. 100–6, Congress passed another law (P.L. 100–322) that repealed the authority in P.L. 100–6 and established the HCHV program as a pilot program. The program was then made permanent in the Veterans Benefits Act of 1997 (P.L. 105–114). The HCHV program is now codified at 38 U.S.C. §§ 2031–2034.

[63] 38 U.S.C. § 2031, § 2034.

[64] Veterans Administration, Report to Congress of member agencies of the Interagency Council on Homelessness pursuant to section 203(c)(1) of P.L. 100–77, October 15, 1987.

[65] The program was most recently authorized in the Veterans Benefits, Health Care, and Information Technology Act of 2006 (P.L. 109–461).

[66] FY2004 VA Budget Justifications, p. 2–163.

[67] Wesley J. Kasprow, Robert A. Rosenheck, Diane DiLello, Leslie Cavallaro, and Nicole Harelik, *Health Care for Homeless Veterans Programs: Twentieth Annual Report,* U.S. Department of Veterans Affairs Northeast Program Evaluation Center, March 31, 2007, pp. 117–118 (hereafter *Health Care for Homeless Veterans Programs: Twentieth Annual Report).*

[68] Ibid, p. 25.

more expensive inpatient treatment, improve health status, and reduce the likelihood of homelessness through employment and other assistance. Congress has appropriated funds for the DCHV program since its inception.

Program Data. The DCHV program operates at 38 VA medical centers and has 1,991 beds available.[69] In FY2006, the number of veterans completing treatment was 5,282.[70] Of those admitted to DCHV programs, 92.7% were diagnosed with a substance abuse disorder, more than half (56.7%) were diagnosed with serious mental illness, and 52.5% had both diagnoses.[71] The average length of stay for veterans in FY2006 was 104.4 days, in which they received medical, psychiatric and substance abuse treatment, as well as vocational rehabilitation.

Compensated Work Therapy/Therapeutic Residence Program. The Compensated Work Therapy (CWT) Program has existed at the VA in some form since the thirties.[72] In the most current version of the program, the VA enters into contracts with private companies or nonprofit organizations that then provide disabled veterans with work opportunities.[73] Veterans must be paid wages commensurate with those wages in the community for similar work, and through the experience the goal is that participants will improve their chances of living independently and reaching self sufficiency. Most CWT positions are semiskilled or unskilled, and include work in clerical, retail, warehouse, manufacturing, and food service positions.[74] In 2003, the Veterans Health Care, Capital Asset, and Business Improvement Act (P.L. 108–170) added work skills training, employment support services, and job development and placement services to the activities authorized by the CWT program. The VA estimates that approximately 14,000 veterans participate in the CWT program each year.[75] The CWT program is permanently authorized through the VA's Special Therapeutic and Rehabilitation Activities Fund.[76]

In 1991, as part of P.L. 102–54, the Veterans Housing, Memorial Affairs, and Technical Amendments Act, Congress added the Therapeutic Transitional Housing component to the CWT program. The purpose of the program is to provide housing to participants in the CWT program who have mental illnesses or chronic substance abuse disorders and who are homeless or at risk of homelessness.[77] Although the law initially provided that both the VA itself or private nonprofit organizations, through contracts with the VA, could operate housing, the law was subsequently changed so that only the VA now owns and operates housing.[78] The housing is transitional—up to 12 months—and veterans who reside there receive supportive services. As of September 2006, the VA operated 66 transitional housing facilities with 520 beds.[79]

Grant and Per Diem Program. Initially called the Comprehensive Service Programs, the Grant and Per Diem program was introduced as a pilot program in 1992 through the Homeless Veterans Comprehensive Services Act (P.L. 102–590). The law establishing the Grant and Per Diem program, which was made permanent in the Homeless Veterans Comprehensive Services Act of 2001 (P.L. 107–95), authorizes the VA to make grants to public entities or private nonprofit organizations to provide services and transitional housing to homeless veterans.[80] For the last four fiscal years (FY2004–FY2007) the Grant and Per Diem program has received more funding than any of the other eight VA programs that are targeted to homeless veterans (see **Table 2**). The Grant and Per Diem program is permanently authorized at $130 million (P.L. 109–461).

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[69] Sandra G. Resnick, Robert Rosenheck, Sharon Medak, and Linda Corwel, *Eighteenth Progress Report on the Domiciliary Care for Homeless Veterans Program, FY2006,* U.S. Department of Veterans Affairs Northeast Program Evaluation Center, March 2007, p. 1.

[70] Ibid, p. 9.

[71] Ibid, p. 10.

[72] Senate Veterans Affairs Committee, report to accompany S. 2908, 94th Cong., 2nd sess., S.Rept. 94–1206, September 9, 1976.

[73] The Compensated Work Therapy program was authorized in P.L. 87–574 as "Therapeutic and Rehabilitative Activities." It was substantially amended in P.L. 94–581, and is codified at 38 U.S.C. § 1718.

[74] VA Veterans Industry/Compensated Work Therapy web pages, available at http://www1.va.gov/vetind/.

[75] VA Fact Sheet, "VA Programs for Homeless Veterans," September 2006 (hereafter "VA Programs for Homeless Veterans").

[76] 38 U.S.C. § 1718(c).

[77] The VA's authority to operate therapeutic housing is codified at 38 U.S.C. § 2032.

[78] The provision for nonprofits was in P.L. 102–54, but was repealed by P.L. 105–114, section 1720A(c)(1).

[79] "VA Programs for Homeless Veterans."

[80] The Grant and Per Diem program is codified at 38 U.S.C. §§ 2011–2013.

The program has two parts: grant and per diem. Eligible grant recipients may apply for funding for one or both parts. The grants portion provides capital grants to purchase, rehabilitate, or convert facilities so that they are suitable for use as either service centers or transitional housing facilities. The capital grants will fund up to 65% of the costs of acquisition, expansion or remodeling of facilities.[81] Grants may also be used to procure vans for outreach and transportation of homeless veterans. The per diem portion of the program reimburses grant recipients for the costs of providing housing and supportive services to homeless veterans. The supportive services that grantees may provide include outreach activities, food and nutrition services, health care, mental health services, substance abuse counseling, case management, child care, assistance in obtaining housing, employment counseling, job training and placement services, and transportation assistance.[82] Organizations may apply for per diem funds alone (without capital grant funds), as long as they would be eligible to apply for and receive capital grants.

Program Rules and Data. The per diem portion of the Grant and Per Diem program pays organizations for the housing that they provide to veterans at a fixed dollar rate for each bed that is occupied.[83] Organizations apply to be reimbursed for the cost of care provided, not to exceed the current per diem rate for domiciliary care. The per diem rate increases periodically; the FY2007 rate is $31.30 per day.[84] The per diem portion of the program also compensates grant recipients for the services they provide to veterans at service centers. Grantee organizations are paid at an hourly rate of one eighth of either the cost of services or the domiciliary care per diem rate, however organizations cannot be reimbursed for both housing and services provided to the same individual. Organizations are paid by the hour for each veteran served for up to eight hours per day. Any per diem payments are offset by other funds that the grant recipient receives. The Advisory Committee on Homeless Veterans has recommended that the per diem reimbursement system be revised to take account of actual service costs instead of using a capped rate.[85] Legislation has been introduced in the 110th Congress that would make changes to the way in which grant recipients are reimbursed. For more information about proposed legislation, see CRS Report RL30442, *Homelessness: Targeted Federal Programs and Recent Legislation,* by Libby Perl et al.

According to the most recent data available from the VA, in FY2006 the Grant and Per Diem program funded more than 300 service providers. These providers had a total of 8,200 beds available and served more than 15,000 homeless veterans.[86] According to a 2006 Government Accountability Office report, an additional 9,600 Grant and Per Diem transitional beds are needed to meet the demand.[87] The VA has stated that an additional 3,000 beds are expected to become available once construction and renovation of various facilities is completed.[88]

Grant and Per Diem for Homeless Veterans with Special Needs. In 2001, Congress created a demonstration program to target grant and per diem funds to specific groups of veterans (P.L. 107–95). These groups include women, women with children, the frail elderly, those veterans with terminal illnesses, and those with chronic mental illnesses. The program was initially authorized at $5 million per year for FY2003 through FY2005. P.L. 109–461, enacted on December 22, 2006, reauthorized the program for FY2007 through FY2011 at $7 million per year.

HUD–VASH. Beginning in 1992, through a collaboration between HUD and the VA, funding for approximately 1,753 Section 8 vouchers was made available for use by homeless veterans with severe psychiatric or substance abuse disorders.[89] Sec-

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[81] 38 U.S.C. § 2011(c).
[82] 38 CFR § 61.1.
[83] 38 CFR § 61.33.
[84] U.S. Department of Veterans Affairs, Department of Geriatrics and Extended Care, Description of the State Veterans Home Program, available at http://www1.va.gov/geriatricsshg/docs/FY07STATEVETHOMEPROGRAMHistory.doc.
[85] *Advisory Committee on Homeless Veterans Fifth Annual Report,* p. 11.
[86] *Health Care for Homeless Veterans Programs: Twentieth Annual Report,* p. 154.
[87] Government Accountability Office, *Homeless Veterans Programs: Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program,* September 2006, p. 12, available at http://www.gao.gov/new.items/d06859.pdf.
[88] Statement of Pete Dougherty, Director, Homeless Veterans Programs, Department of Veterans Affairs, House Committee on Veterans' Affairs, Subcommittee on Health, *U.S. Department of Veterans Affairs Grant and Per Diem Program,* 110th Cong., 1st sess., September 27, 2007.
[89] The first announcement of voucher availability was announced in the Federal Register. See U.S. Department of Housing and Urban Development, "Invitation for FY1992 Section 8 Rental Voucher Set-Aside for Homeless Veterans with Severe Psychiatric or Substance Abuse Disorders," *Federal Register* vol. 57, no. 55, p. 9955, March 20, 1992.

tion 8 vouchers are subsidies used by families to rent apartments in the private rental market.[90] Through the program, called HUD–VA Supported Housing (HUD–VASH), local Public Housing Authorities (PHAs) administer the Section 8 vouchers while local VA medical centers provide case management and clinical services to participating veterans. HUD distributed the vouchers to PHAs through three competitions, in 1992, 1993, and 1994. Prior to issuing the vouchers, HUD and the VA had identified medical centers with Domiciliary Care and Health Care for Homeless Veterans programs that were best suited to providing services. PHAs within the geographic areas of the VA medical centers were invited to apply for vouchers. In the first year that HUD issued vouchers, 19 PHAs were eligible to apply, and by the third year the list of eligible VA medical centers and PHAs had expanded to 87.[91] HUD does not separately track these vouchers. However, the VA keeps statistics on veterans with vouchers who receive treatment through the VA. In FY2006, 1,238 veterans with HUD–VASH vouchers received treatment during the course of the year, with 1,028 veterans still receiving treatment at the end of that year.[92]

In 2001, Congress codified the HUD–VASH program (P.L. 107–95) and authorized the creation of an additional 500 vouchers for each year from FY2003 through FY2006.[93] A bill enacted at the end of the 109th Congress (P.L. 109–461) also provided the authorization for additional HUD–VASH vouchers. However, not until FY2008 did Congress provide funding for additional vouchers: the Consolidated Appropriations Act (P.L. 110–161) included $75 million for Section 8 vouchers for homeless veterans. HUD has estimated that this will fund between 9,000 and 10,000 additional vouchers.[94] The Administration has also requested an additional $75 million for HUD–VASH vouchers in FY2009.[95]

Program Evaluations. Long-term evaluations of the HUD–VASH program have shown both improved housing and improved substance abuse outcomes among veterans who received the vouchers over those who did not.[96] Veterans who received vouchers experienced fewer days of homelessness and more days housed than veterans who received intensive case management assistance or standard care through VA homeless programs alone.[97] Analysis also found that veterans with HUD–VASH vouchers had fewer days of alcohol use, fewer days on which they drank to intoxication, and fewer days of drug use.[98] HUD–VASH veterans were also found to have spent fewer days in institutions.[99]

Loan Guarantee for Multifamily Transitional Housing Program. The Veterans Programs Enhancement Act 1998 (P.L. 105–368) created a program in which the VA guarantees loans to eligible organizations so that they may construct, rehabilitate or acquire property to provide multifamily transitional housing for homeless veterans.[100] Eligible project sponsors may be any legal entity that has experience in providing multifamily housing.[101] The law requires sponsors to provide sup-

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[90] For more information about Section 8 in general, see CRS Report RL32284, *An Overview of the Section 8 Housing Programs,* by Maggie McCarty.

[91] U.S. Department of Housing and Urban Development, "Funding Availability (NOFA) for the Section 8 Set-Aside for Homeless Veterans with Severe Psychiatric or Substance Abuse Disorders," *Federal Register* vol. 59, no. 134, p. 36015, July 14, 1994.

[92] Wesley J. Kasprow, Robert A. Rosenheck, Diane DiLello, Leslie Cavallaro, and Nicole Harelik, *Health Care for Homeless Veterans Programs: Twentieth Annual Report,* U.S. Department of Veterans Affairs Northeast Program Evaluation Center, March 31, 2007, pp. 272–273.

[93] 42 U.S.C. § 1437f(o)(19).

[94] Testimony of Alphonso Jackson, Secretary of Housing and Urban Development, House Appropriations Committee, Subcommittee on Transportation and Housing and Urban Development, *FY2009 Appropriations,* 110th Cong., 2nd sess., February 13, 2008.

[95] See Budget of the U.S. Government FY2009—Appendix, Department of Housing and Urban Development, p. 541, available at http://www.whitehouse.gov/omb/budget/fy2009/pdf/appendix/hud.pdf.

[96] Robert Rosenheck, Wesley Kasprow, Linda Frisman, and Wen Liu-Mares, "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness," *Archives of General Psychiatry* 60 (September 2003): 940 (hereafter "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness"). An-Lin Cheng, Haiqun Lin, Wesley Kasprow, and Robert Rosenheck, "Impact of Supported Housing on Clinical Outcomes," *Journal of Nervous and Mental Disease* 195, no. 1 (January 2007): 83 (hereafter "Impact of Supported Housing on Clinical Outcomes").

[97] "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness," p. 945.

[98] "Impact of Supported Housing on Clinical Outcomes," p. 85.

[99] Ibid

[100] 38 U.S.C. §§ 2051–2054.

[101] U.S. Department of Veterans Affairs, *Multifamily Transitional Housing Loan Guarantee Program: Program Manual,* April 6, 2007, p. 9, available at http://www1.va.gov/homeless/docs/Loan_Guarantee_Program_Manual_4-6-07.pdf.

portive services, ensure that residents seek to obtain and maintain employment, enact guidelines to require sobriety as a condition of residency, and charge veterans a reasonable fee.[102] Veterans who are not homeless, and homeless individuals who are not veterans, may be occupants of the transitional housing if all of the transitional housing needs of homeless veterans in the project area have been met.[103]

Supportive services that project sponsors are to provide include outreach; food and nutritional counseling; health care, mental health services, and substance abuse counseling; child care; assistance in obtaining permanent housing; education, job training, and employment assistance; assistance in obtaining various types of benefits; and transportation.[104] Not more than 15 loans with an aggregate total of up to $100 million may be guaranteed under this program. The VA has committed loans to two projects and released a notice of funding availability for additional applications.[105] One project, sponsored by Catholic Charities of Chicago, opened in January 2007 with 141 transitional units for homeless veterans.[106] A second project in San Diego is also expected to provide 144 transitional housing units.[107] According to the VA, the agency has been slow to implement the program due to service providers' concerns that they may not be able to operate housing for such a needy population and still repay the guaranteed loans.[108] The VA has stated that it plans to review the program to determine whether it should be modified, discontinued, or replaced by another program.[109]

Acquired Property Sales for Homeless Veterans. The Acquired Property Sales for Homeless Veterans program is operated through the Veterans Benefits Administration (VBA). The program was enacted as part of the Veterans Home Loan Guarantee and Property Rehabilitation Act of 1987 (P.L. 100–198). The current version of the program was authorized in P.L. 102–54 (a bill to amend Title 38 of the U.S. Code), and is authorized through December 31, 2008.[110]

Through the program, the VA is able to dispose of properties that it has acquired through foreclosures on its loans so that they can be used for the benefit of homeless veterans. Specifically, the VA can sell, lease, lease with the option to buy, or donate, properties to nonprofit organizations and state government agencies that will use the property only as homeless shelters primarily for veterans and their families. The VA estimates that over 200 properties have been sold through the program.[111]

The Department of Labor

The Department of Labor (DoL) contains an office specifically dedicated to the employment needs of veterans, the office of Veterans' Employment and Training Service (VETS). In addition to its program for homeless veterans—the Homeless Veterans Reintegration Program (HVRP)—VETS funds employment training programs for all veterans. These include the Veterans Workforce Investment Program and the Transition Assistance Program.

Homeless Veterans Reintegration Program. Established in 1987 as part of the McKinney-Vento Homeless Assistance Act (P.L. 100–77), the HVRP was authorized through FY2011 as part of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (P.L. 109–461). The program has two goals. The first is to assist veterans in achieving meaningful employment, and the second is to assist in the development of a service delivery system to address the problems facing homeless veterans. Eligible grantee organizations are state and local Workforce Invest-

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[102] 38 U.S.C. § 2052(b).

[103] Ibid

[104] *Multifamily Transitional Housing Loan Guarantee Program: Program Manual,* p. 10.

[105] The Notice of Funding Availability is available at *Federal Register* 71, no. 10, April 12, 2006, p. 18813.

[106] See U.S. Department of Veterans Affairs, "Multifamily Transitional Housing Loan Guarantee Program: Program Overview," Presentation by Claude B. Hutchinson, Jr., July 2007, available at http://www1.va.gov/homeless/docs/Loan_Guarantee_Informational_Video_Slides.ppt.

[107] Statement of Pete Dougherty, Director, Homeless Veterans Programs, Senate Veterans Affairs Committee, *Looking At Our Homeless Veterans Programs: How Effective Are They?,* 109th Cong., 2nd sess., March 16, 2006.

[108] Testimony of Pete Dougherty, Director, Homeless Veterans Programs, Department of Veterans Affairs, House Appropriations Committee, Subcommittee on Military Construction and Veterans Affairs, *FY2008 Appropriations,* 110th Cong., 1st sess., March 8, 2007.

[109] *Advisory Committee on Homeless Veterans Fifth Annual Report,* p. 14.

[110] The program was most recently authorized in the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (P.L. 108–170). The program is codified at 38 U.S.C. § 2041.

[111] "VA Programs for Homeless Veterans."

ment Boards, local public agencies, and both for- and non-profit organizations.[112] Grantees receive funding for one year, with the possibility for two additional years of funding contingent on performance and fund availability.[113]

HVRP grantee organizations provide services that include outreach, assistance in drafting a resume and preparing for interviews, job search assistance, subsidized trial employment, job training, and follow-up assistance after placement. Recipients of HVRP grants also provide supportive services not directly related to employment such as transportation, provision of or assistance in finding housing, and referral for mental health treatment or substance abuse counseling. HVRP grantees often employ formerly homeless veterans to provide outreach to homeless veterans and to counsel them as they search for employment and stability. In fact, from the inception of the HVRP, it has been required that at least one employee of grantee organizations be a veteran who has experienced homelessness.[114]

Program Data. In program year (PY) 2006, HVRP grantees served a total of 13,346 homeless veterans, of whom 8,713, or 65%, were placed in employment.[115] The percentage of participants placed in employment has grown nearly every year since PY2000, when 52.8% of veterans participating in HVRP entered employment.[116] In PY2004, the most recent year for which more extensive data are available, of those who became employed, an estimated 64% were still employed after 90 days, and 58% after 180 days.[117] The average wage for participants has grown steadily from $8.73 per hour in PY2000 to $9.55 per hour in PY2004.

Stand Downs for Homeless Veterans. A battlefield stand down is the process in which troops are removed from danger and taken to a safe area to rest, eat, clean up, receive medical care, and generally recover from the stress and chaos of battle. Stand Downs for Homeless Veterans are modeled on the battlefield stand down and are local events, staged annually in many cities across the country, in which local Veterans Service Organizations, businesses, government entities, and other social service organizations come together for up to three days to provide similar services for homeless veterans. Items and services provided at stand downs include food, clothing, showers, haircuts, medical exams, dental care, immunizations, and, in some locations where stand downs take place for more than one day, shelter. Another important facet of stand downs, according to the National Coalition for Homeless Veterans, is the camaraderie that occurs when veterans spend time among other veterans.

Although stand downs are largely supported through donations of funds, goods, and volunteer time, the DoL VETS office allows HVRP grant recipient organizations to use up to $8,000 of their grants to fund stand downs. The VETS program also awards up to $8,000 to HVRP eligible organizations that have not received an HVRP grant. According to the most recent data available, $364,460 was used to serve 10,155 veterans at stand downs in FY2005.[118]

Incarcerated Veterans Transition Program Demonstration Grants. The Homeless Veterans Comprehensive Assistance Act of 2001 (P.L. 107–95) instituted a demonstration program to provide job training and placement services to veterans leaving prison.[119] By 2005, the program awarded $1.45 million in initial grants to seven recipients, and extended these seven grants through March 2006 with funding of $1.6 million.[120] The Department of Labor reported that these grant recipients enrolled 2,191 veterans in the transition program in fiscal years 2004 through 2006 and that of these enrollees, 1,104, or 54%, entered employment.[121] The average wage for those veterans entering employment was $10.00 per hour.

Authorization for the incarcerated veterans transition program expired on January 24, 2006 and no additional funding has been provided. However, service pro-

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[112] Veterans Employment and Training Service Program Year 2007 Solicitation for Grant Applications, *Federal Register* vol. 72, no. 71, April 13, 2007, p. 18682.

[113] Ibid, p. 18679.

[114] "Procedures for Preapplication for Funds; Stewart B. McKinney Homeless Assistance Act, FY1988" *Federal Register* vol. 53, no. 70, April 12, 1988, p. 12089.

[115] Presentation of Charles S. Ciccolella, Assistant Secretary for Veterans' Employment and Training, U.S. Department of Labor, to the VA Advisory Committee on Homeless Veterans, January 31, 2008.

[116] U.S. Department of Labor, Office of the Assistant Secretary for Veterans' Employment and Training, *FY2005 Annual Report to Congress,* March 23, 2007, p. 9, available at http://www.dol.gov/vets/media/FY2005_Annual_Report_To_Congress.pdf.

[117] Ibid, p. 9.

[118] Ibid, p. 12.

[119] 38 U.S.C. § 2023.

[120] DoL VETS *FY2005 Annual Report to Congress,* p. 13.

[121] Presentation of Charles S. Ciccolella.

viders encourage continued involvement in making arrangements for veterans leaving correctional facilities.[122] And in its report for 2007, the Advisory Committee on Homeless Veterans recommended that the program be continued.[123] Legislation that would remove the program's demonstration status and authorize it has been introduced in the 110th Congress. For more information about pending legislation, see CRS Report RL30442, *Homelessness: Targeted Federal Programs and Recent Legislation,* by Libby Perl et al.

Emerging Issues

Permanent Supportive Housing

With the exception of Section 8 vouchers provided through the HUD–VASH program, the Federal programs for homeless veterans offer funding only for transitional housing developments; they do not fund permanent supportive housing. The permanent supportive housing model promotes stability by ensuring that residents receive services tailored to their particular needs, including health care, counseling, employment assistance, help with financial matters, and assistance with other daily activities that might present challenges to a formerly homeless individual.

Although veterans are eligible for permanent supportive housing through HUD programs for homeless persons, they are not prioritized above nonveteran homeless individuals. Some members of Congress, service providers, and the VA Advisory Committee on Homeless Veterans support the creation of permanent supportive housing dedicated to veterans. According to local government and community participants in the last five VA CHALENG surveys, permanent supportive housing is the number one unmet need of homeless veterans.[124]

In a report released in August 2007, the Government Accountability Office (GAO) found that low-income veteran renter households were less likely to receive HUD rental assistance than other low-income households.[125] GAO estimated that 11% of low-income veteran renter households received HUD rental assistance compared to 19% of low-income nonveteran renter households.[126] Limited resources are available to house low-income families, and veterans must compete with other needy groups including elderly residents, persons with disabilities, and families with young children. Due to a lack of permanent housing options, when veterans complete programs that have transitional housing components, there is not always a place for them to go. Another concern is that, as Vietnam-era veterans age, there is a reduced chance that they will be able to find employment and support themselves. Permanent supportive housing would serve that population.[127]

As discussed previously, Congress appropriated $75 million for up to 10,000 additional Section 8 vouchers for homeless veterans in the FY2008 Consolidated Appropriations Act (P.L. 110–161). The President's FY2009 budget request also proposed $75 million to fund additional vouchers. Legislation has been introduced in the 110th Congress that would provide funds for additional HUD–VASH vouchers, as well as funds for permanent supportive housing for very low-income veterans and their families. For more information about proposed legislation, see CRS Report RL30442, *Homelessness: Targeted Federal Programs and Recent Legislation,* by Libby Perl et al.

Veterans of the Wars in Iraq and Afghanistan

As veterans return from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), just as veterans before them, they face risks that could lead to homelessness. To date, approximately 400 OEF/OIF veterans have used VA services for homeless veterans, and the VA has classified 1,500 as being at risk of homelessness. The National Coalition for Homeless Veterans, in an informal survey of service providers, estimated that 1,260 veterans of the Iraq War sought assistance from

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[122] See National Coalition for Homeless Veterans, "FY2007 Public Policy Priorities," January 24, 2007, available at http://www.nchv.org/content.cfm?id=24.

[123] U.S. Department of Veterans Affairs, *Advisory Committee on Homeless Veterans, Advisory Committee on Homeless Veterans Fifth Annual Report,* 2007, p. 16 (hereafter *Advisory Committee on Homeless Veterans Fifth Annual Report).*

[124] *The Fourteenth Annual CHALENG Report,* p. 12.

[125] Government Accountability Office, *Information on Low-Income Veterans' Housing Needs Conditions and Participation in HUD's Programs,* GAO–07–1012, August 17, 2007, p. 29, available at http://www.gao.gov/new.items/d071012.pdf.

[126] Ibid

[127] Testimony of Cheryl Beversdorf, Director, National Coalition for Homeless Veterans, before the House Appropriations Committee, Subcommittee on Military Construction and Veterans Affairs, *FY2008 Appropriations,* 110th Cong., 1st sess., March 8, 2007.

Grant and Per Diem programs in 2006.[128] Approximately 751,273 OEF/OIF troops have been separated from active duty since 2002.[129] If the experiences of the Vietnam War are any indication, the risk of becoming homeless continues for many years after service. After the Vietnam War, 76% of Vietnam era combat troops and 50% of non-combat troops who eventually became homeless reported that at least 10 years passed between the time they left military service and when they became homeless.[130]

Among troops returning from Iraq, between 15% and 17% have screened positive for depression, generalized anxiety, and PTSD.[131] Veterans returning from Iraq also appear to be seeking out mental health services at higher rates than veterans returning from other conflicts.[132] Research has also found that the length and number of deployments of troops in Iraq result in greater risk of mental health problems.[133] Access to VA health services could be a critical component of reintegration into the community for some veterans, and there is concern that returning veterans might not be aware of available VA health programs and services.[134] The VA has multiple means of reaching out to injured veterans and veterans currently receiving treatment through the Department of Defense (DoD) to ensure that they know about VA health services and to help them make the transition from DoD to VA services. (For more information about these efforts see CRS Report RL33993, *Veterans' Health Care Issues,* by Sidath Viranga Panangala.) However, for some veterans, health issues, particularly mental health issues, may arise later. A study of Iraq soldiers returning from deployment found that a higher percentage of soldiers reported mental health concerns six months after returning than immediately after returning.[135] Legislation has been introduced in the 110th Congress that would attempt to identify returning members of the armed services who are at risk of homelessness. For more information on this legislation and its status, see CRS Report RL30442, *Homelessness: Targeted Federal Programs and Recent Legislation,* by Libby Perl et al.

Female Veterans

The number and percentage of women enlisted in the military have increased since previous wars. In FY2005, approximately 14.4% of enlisted troops in the active components of the military (Army, Navy, Air Force, and Marines) were female, up from approximately 3.3% in FY1974 and 10.9% in FY1990.[136] The number of women deployed to war is also on the rise. To date, over 165,000 female troops have been deployed to Iraq and Afghanistan,[137] compared to 7,500 in the Vietnam War, and 41,000 in the Gulf War.[138] The number of women veterans can be expected to grow commensurately. According to the VA, there were approximately 1.2 million female

[128] Conversation with Cheryl Beversdorf, Director, National Coalition for Homeless Veterans, April 10, 2007 (hereafter "Conversation with Cheryl Beversdorf").

[129] Since October 2003, DoD's Defense Manpower Data Center (DMDC) has periodically (every 60 days) sent VA an updated personnel roster of troops who participated in OEF and OIF, and who have separated from active duty and become eligible for VA benefits. The roster was originally prepared based on pay records of individuals. However, in more recent months it has been based on a combiNation of pay records and operational records provided by each service branch. The current separation data are from FY2002 through May 2007.

[130] See "Homeless Veterans," p. 105.

[131] Charles W. Hoge, Carl A. Castro, Stephen C. Messer, and Dennis McGurk, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine* 351, no. 1 (July 1, 2004): Table 3.

[132] Charles W. Hoge, Jennifer L. Auchterlonie, and Charles S. Milliken, "Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan," *JAMA* 295, no. 9 (March 1, 2006): 1026, 1029.

[133] Office of the Surgeon Multi-National Force—Iraq and Office of the Surgeon General United States Army Command, *Mental Health Advisory Team V,* February 14, 2008, pp. 42–43, 46–47, available at http://www.armymedicine.army.mil/news/mhat/mhat_v/Redacted1-MHATV-OIF-4-FEB-2008Report.pdf.

[134] See, for example, Amy Fairweather, *Risk and Protective Factors for Homelessness Among OIF/OEF Veterans,* Swords to Plowshares' Iraq Veteran Project, December 7, 2006, p. 6.

[135] Charles S. Milliken, Jennifer L. Auchterlonie, and Charles W. Hoge, "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War," JAMA 298, no. 18 (November 14, 2007): 2141, 2144.

[136] U.S. Department of Defense, Office of the Under Secretary of Defense, Personnel and Readiness, *Population Representation in the Military Services, FY2005,* Appendix D, Table D–13, available at http://www.defenselink.mil/prhome/poprep2005/contents/contents.html.

[137] The Joint Economic Committee, *Helping Military Moms Balance Family and Longer Deployment,* May 11, 2007, p. 2, available at http://www.jec.senate.gov/Documents/Reports/MilitaryMoms05.11.07Final.pdf.

[138] U.S. Department of Veterans Affairs.

veterans in 1990 (4% of the veteran population) and 1.6 million in 2000 (6%).[139] The VA anticipates that there will be 1.8 million female veterans in 2010 (8% of the veteran population) and 1.9 million (10%) in 2020. At the same time, the number of male veterans is expected to decline.[140]

Women veterans face challenges that could contribute to their risks of homelessness. Experts have found that female veterans report incidents of sexual assault that exceed rates reported in the general population.[141] The percentage of female veterans seeking medical care through the VA who have reported that they have experienced sexual assault ranges between 23% and 29%.[142] Female active duty soldiers have been found to suffer from PTSD at higher rates than male soldiers.[143] Experience with sexual assault has been linked to PTSD, depression, alcohol and drug abuse, disrupted social networks, and employment difficulties.[144] These factors can increase the difficulty with which women veterans readjust to civilian life, and could be risk factors for homelessness (see earlier discussion in this report).

Women veterans are estimated to make up a relatively small proportion of the homeless veteran population. Among veterans who use VA's services for homeless veterans, women are estimated to make up just under 4% of the total.[145] As a result, programs serving homeless veterans may not have adequate facilities for female veterans at risk of homelessness, particularly transitional housing for women and women with children. As of 2007, eight Grant and Per Diem programs provide transitional housing for female veterans and their children.[146] The VA Advisory Committee on Homeless Veterans noted in its 2007 report that "the needs and complexity of issues involving women veterans are increasing" and recommended continued support through the Grant and Per Diem Special Needs grants.[147]

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[139] Robert A. Klein, *Women Veterans: Past, Present, and Future,* U.S. Department of Veterans Affairs, Office of the Actuary, updated September 2007, pp. 8–9, available at http://www1.va.gov/vetdata/docs/Womenveterans_past_present_future_9-30-07a.pdf.

[140] Ibid

[141] Jessica Wolfe et al., "Changing Demographic Characteristics of Women Veterans: Results from a National Sample," *Military Medicine* 165, no. 10 (October 2000): 800.

[142] Anne G. Sandler, Brenda M. Booth, Michelle A. Mengeling, and Bradley N. Doebbeling, "Life Span and Repeated Violence Against Women During Military Service: Effects on Health Status and Outpatient Utilization," *Journal of Women's Health* 13, no. 7 (2004): 800.

[143] Laurel L. Hourani and Huixing Yuan, "The Mental Health Status of Women in the Navy and Marine Corps: Preliminary Findings from the Perceptions of Wellness and Readiness Assessment," *Military Medicine* 164, no. 3 (March 1999): 176.

[144] Maureen Murdoch et al., "Women and War: What Physicians Should Know," *Journal of General Internal Medicine* 21, no. s3 (March 2006): S7.

[145] *Health Care for Homeless Veterans 20th Annual Report,* p. 26.

[146] Conversation with Cheryl Beversdorf.

[147] *Advisory Committee on Homeless Veterans Fifth Annual Report,* p. 13.

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Counting Homeless Persons: Homeless Management Information Systems
Updated April 3, 2008

Libby Perl, Analyst in Housing, Domestic Social Policy Division

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Summary

In 1998, Congress directed the Department of Housing and Urban Development (HUD) to develop a process for collecting data about homeless persons. Together with local communities, HUD began in 2001 to implement a series of Homeless Management Information Systems (HMIS). Two categories of Federal fund recipients are required to participate in HMIS: organizations that receive grants through the Housing Opportunities for Persons with AIDS (HOPWA) program and organizations that receive HUD Homeless Assistance Grants. The HOPWA program provides housing and supportive services for persons living with AIDS, while the Homeless Assistance Grants fund transitional and permanent housing, as well as services, for homeless individuals.

Local jurisdictions called "Continuums of Care" (CoCs)—typically cities, counties, or combinations of both—are the entities that implement HMIS. Homeless service providers in these CoCs collect and store information about homeless individuals they serve, and the information is aggregated in computer systems at the CoC level. HUD anticipates that information about homeless individuals from CoCs across the country eventually will help it to better serve their needs.

HUD released its second analysis of data from a sample of participating HMIS jurisdictions—the second Annual Homeless Assessment Report (AHAR)—in March 2008. The second AHAR used HMIS data from a sample of 74 communities to derive national-level estimates of the number of homeless persons for three points in time during the six-month period from January 1 to June 30, 2006, as well as an estimate of the total number of people who experienced homelessness at least once during this same period. It is expected that data from HMIS eventually will provide an unduplicated count of the number of persons experiencing homelessness from communities across the country.

Congress initially allocated funds for data collection regarding homeless persons in the FY2001 HUD Appropriations Act (P.L. 106–377), and has continued to allocate funds in all HUD spending bills from FY2002 to FY2008. Local communities can then apply to HUD for available funds that they may use to implement HMIS. Community implementation of HMIS increased from 2005 to 2006. According to the most recent HUD progress report to Congress regarding HMIS, 91% of local CoCs were implementing HMIS in 2006, meaning that they had established systems into which data are entered (compared to 72% in 2005). Approximately 9% of CoCs had decided to implement an HMIS, and were in the process of planning the system (compared to 20% in 2005), and 1% of CoCs were not yet planning an HMIS (compared to 7% in 2005).

This report describes the development of HMIS, reports on the continuing progress of HMIS, summarizes information released in the first and second AHARs, and describes previous attempts to count homeless persons. It will be updated as events warrant.

Introduction

It is difficult to ascertain the number and characteristics of persons experiencing homelessness due to the transient nature of the population, although attempts to count and describe homeless individuals have been made in recent decades.[1] Beginning in the mid-1990s, for example, the Department of Housing and Urban Development (HUD) required its grant recipients to provide information about the homeless clients they served. In addition, comprehensive attempts to count homeless individuals were made in both the 1980s and 1990s, first via Census data and then through a national collaborative survey called the National Survey of Homeless Assistance Providers and Clients. However, no systematic method for tracking homeless persons has existed until now. In response to a directive from Congress in 1998, HUD began in 2001 to develop a system to track homeless individuals; the processes of data collection, organization, and storage systems, which take place at the local level, have been termed Homeless Management Information Systems (HMIS). In March 2008, HUD released results of its second analysis of HMIS data—the second Annual Homeless Assessment Report (AHAR). This CRS report describes the devel-

[1] As defined by the McKinney-Vento Homeless Assistance Act (P.L. 100–77), a homeless person is "(1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is—(A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

opment of HMIS, the results of the first and second AHARs, and previous attempts to count homeless individuals.

What Are Homeless Management Information Systems?

Homeless Management Information Systems (HMIS) are databases established at the local level through which homeless service providers collect, organize, and store information about homeless clients who receive services. HUD is implementing the HMIS initiative through local "Continuums of Care" (CoCs), which acquire and process data from all participating local service providers. CoCs are local boards formed by communities—typically cities, counties, or combinations of both—made up of representatives from nonprofit service providers, advocacy groups, local government, and other interested organizations.[2] Local boards identify the needs of homeless persons in their communities and try to ensure that they receive the appropriate mix of preventative assistance, emergency services, transitional housing, supportive services, and permanent housing. Local homeless services providers submit requests for funding to their local CoC boards, which each in turn submit single consolidated applications to HUD. As of FY2007, there were approximately 467 CoCs, including those in the Territories.[3]

Two types of organizations are required to participate in HMIS: those that receive funding through the Housing Opportunities for Persons with AIDS (HOPWA) program and those that receive Homeless Assistance Grants. The HOPWA program, enacted in 1990 (P.L. 101–625) provides housing and supportive services for persons living with HIV/AIDS.[4] The Homeless Assistance Grants, enacted as part of the McKinney-Vento Homeless Assistance Act (P.L. 100–77),[5] consist of both formula grants, which are distributed through the Emergency Shelter Grants program, and competitive grants, which are available through the Shelter Plus Care program, Supportive Housing Program, and Section 8 Moderate Rehabilitation Assistance for Single Room Occupancy Dwellings program.[6] Other service providers that serve homeless individuals and families but do not receive Federal funds from these sources are also encouraged to participate in HMIS.

HUD's Continuing Role in Collecting Information About Homeless Persons

Even prior to the congressional directive to implement HMIS (described in the next section of this report, "Development of the HMIS Network"), HUD began efforts to collect information about homeless clients served in the communities that receive HUD Homeless Assistance Grants. Beginning in the mid-nineties, about the time that the Continuum of Care system developed, HUD required applicants for Homeless Assistance Grants to include in their applications information about the number of persons receiving assistance and the type of assistance they received. Initially this was done in narrative form. However, by 2003, the grant application required CoC applicants to complete a housing activity chart that included a point-in-time count of homeless individuals and families receiving services, though HUD did not specify when this count should take place.[7] The 2003 application also asked applicants to categorize subpopulations served, including the number of chronically homeless individuals, veterans, those with severe mental illnesses, those with HIV/AIDS, and victims of domestic violence. Some CoCs used database systems similar to HMIS to keep track of homeless individuals who were served; these predecessor systems are sometimes referred to as "legacy systems."[8]

The 2005 HUD point-in-time count of homeless persons marked the first time that HUD required all CoCs to conduct a count of both sheltered and unsheltered homeless individuals, and to do it at a particular time of year. HUD directed CoCs to conduct a one-night count during the last week of January of both clients who used

[2] States may also constitute CoCs to coordinate funding in sparsely populated areas.

[3] "HUD-Defined CoC Names and Numbers Listed by State," Revised March 15, 2007, available at http://www.hud.gov/library/bookshelf12/supernofa/nofa07/coclist.pdf.

[4] For more information on the HOPWA program, see CRS Report RS20704, *Housing Opportunities for Persons with AIDS (HOPWA),* by Libby Perl.

[5] P.L. 100–77 is codified at 42 U.S.C. §§ 11301–11435.

[6] For more information about the Homeless Assistance Grants, see CRS Report RL33764, *The HUD Homeless Assistance Grants: Distribution of Funds,* by Libby Perl.

[7] The FY2003 application is available on HUD's website, http://www.hud.gov/library/bookshelf12/supernofa/nofa03/cocapp.doc.

[8] See U.S. Department of Housing and Urban Development, *The Annual Homeless Assessment Report to Congress,* February 2007, p. 2, available at http://www.huduser.org/Publications/pdf/ahar.pdf (hereafter *First AHAR)*.

homeless services and those who were on the street.[9] HUD continues to require CoCs to conduct point-in-time counts every two years, though some CoCs choose to conduct counts every year. In 2006, 61% of CoCs voluntarily conducted counts.[10] The most recent point-in-time count in which all CoCs participated occurred in January 2007. The results of these counts are described later in this report, in the section "CoC Estimates of Homeless Individuals."

Development of the HMIS Network

Congressional Direction

HUD's ongoing attempts to count homeless individuals were given greater direction beginning in 1998, when Congress instructed HUD to count homeless persons and gather data about both their characteristics and use of homeless assistance services. The FY1999 HUD spending bill (P.L. 105–276) set aside up to 1% of the total appropriation for Homeless Assistance Grants for systems to track those persons experiencing homelessness. Specifically, Congress directed HUD to produce an unduplicated count of homeless persons and to collect information about homeless individuals surveyed such as age, race, sex, disability status, health status, and income; the types of services that homeless clients received; and client outcomes such as length of stay in transitional housing, success in acquiring permanent housing, and employment status.[11] Congress concluded that this information would allow HUD to better assess the quality of service programs supported with Federal funds.[12]

Congress provided further direction to HUD in the HUD Appropriations Act for FY2001 (P.L. 106–377). The law made Supportive Housing Program funds available for local CoCs to implement management information systems.[13] Congress directed HUD to work with local jurisdictions to develop a system to collect data, and to be ready to analyze the data within three years of passage of the appropriations bill.[14] Congress also requested that HUD provide Congress with a report on its findings containing an unduplicated count of homeless persons and a descriptive profile of the population.[15] The FY2001 Appropriations Act once again allocated funds to pay for data collection, this time setting aside 1.5% of the total appropriation for Homeless Assistance Grants of $1.02 billion. Congress has continued to allocate funds for homeless data collection in spending bills from FY2002 to FY2008.

HUD Actions

In the time since Congress directed HUD to implement a system to count homeless persons and collect information on their characteristics, HUD has issued six annual reports to Congress updating its progress. In an initial report, dated August 2001, HUD stated that it would help CoCs collect homelessness data through four means: [16]

- flexibly implementing the new Homeless Management Information System (HMIS) eligible activity under the Supportive Housing Program in the 2001 McKinney-Vento competition;
- initiating a comprehensive technical assistance program to help local jurisdictions collect unduplicated client-level data by 2004;

[9] Ibid, p. 16.

[10] U.S. Department of Housing and Urban Development, *The Second Annual Homeless Assessment Report to Congress,* March 2008, p. 12, available at http://www.hudhre.info/documents/2ndHomelessAssessmentReport.pdf (hereafter *Second AHAR).*

[11] See House Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act 1999,* report to accompany H.R. 4194, H.Rept. 105–610, 105th Cong., 2nd sess., July 8, 1998. The FY1999 HUD Appropriations Act referred to the House Committee Report language for specific requirements.

[12] Ibid

[13] The provision allowing HMIS funding from the Supportive Housing Program (SHP) is codified at 42 U.S.C. § 11383(a)(7). HUD enumerated the ways in which CoCs may use SHP funds for management information systems in *Federal Register,* volume 69, no. 146, July 30, 2005, p. 45890.

[14] See Conference Committee, *Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act 2001,* conference report to accompany H.R. 4635, H.Rept. 106–988, 106th Cong., 2nd sess., October 18, 2000.

[15] See Senate Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act 2001,* report to accompany H.R. 4635, S.Rept. 106–410, 106th Cong., 2nd sess., September 13, 2000.

[16] U.S. Department of Housing and Urban Development, *Report to Congress: HUD's Strategy for Homeless Data Collection, Analysis and Reporting,* August 2001, p. 1, available at http://www.hud.gov/offices/cpd/homeless/hmis/strategy/congressreport.pdf.

- developing an approach to obtaining meaningful data for an Annual Homeless Assessment Report from a nationally representative sample of jurisdictions; and
- analyzing the most viable approaches to obtaining homeless client-level reporting.

Since issuing this 2001 report, HUD has initiated a number of activities to follow through on its pledge to assist CoCs. It specified that CoCs may use Supportive Housing Program funds for computer hardware, software, and personnel to manage and operate information systems, analyze HMIS data, and produce reports. HUD technical assistance teams hold training sessions for CoCs across the country. In each year from 2004 to 2007, HUD sponsored national conferences in which it provided sessions on a wide range of topics, including data entry, strategies for including data on domestic violence clients and chronically homeless individuals, and how to use HMIS to evaluate program performance and improve services to persons experiencing homelessness. HUD established a website—HMIS.Info—where information about HMIS implementation across the country can be disseminated.[17] Since October 2004, the HMIS.Info site has published a newsletter, managed a listserv, and hosted conference calls. In addition, a number of publications on implementing management information systems are available on the HMIS.Info website.

HMIS Data and Technical Standards. On July 30, 2004, HUD released its final notice on HMIS data and technical standards that local CoCs are expected to follow when they collect information about their homeless clients.[18] The standards describe two levels of data collection—universal data, which homeless service providers must collect from all clients, and program-specific data, which programs that receive certain types of funding must collect, but that other programs are encouraged to collect as well.

All participants must report on universal data elements, which include name, date of birth, race, ethnicity, gender, veteran status, Social Security Number, prior residence, and disabling conditions.[19] In general, all programs that receive funds under the McKinney-Vento Homeless Assistance Act and HOPWA are required to provide program-specific data; this requirement is not new, as HUD already requires grantee organizations to provide this information in their Annual Progress Reports.[20] Included in program-specific data elements are amount and sources of income, receipt of non-cash benefits, physical and developmental disabilities, HIV status, mental illness, substance abuse status, and domestic violence status.[21]

Confidentiality of Domestic Violence Victims. Due to the sensitive nature of much of the information that homeless service providers must collect, some groups that provide services to domestic violence victims raised privacy concerns to HUD after its release of proposed data and technical standards but prior to release of final standards in 2004. These organizations requested that information about domestic violence victims not be included in HMIS.[22] At the time, HUD acknowledged the sensitivity of certain information, but concluded that CoCs could collect the information in such a way that would protect the identity of those in the system. To this end, HUD included privacy and security standards in the data and technical standards that all organizations must follow.

However, on January 5, 2006, President Bush signed the Violence Against Women and Department of Justice Reauthorization Act (P.L. 109–162), which included provisions to (1) amend the McKinney-Vento Homeless Assistance Act to prevent victim service providers from disclosing personally identifying information through HMIS, and (2) permit disclosure of non-personally identifying information only after a public notice and comment period. On March 16, 2007, HUD released a notice regarding HMIS and the amendments to McKinney-Vento made by P.L. 109–162.[23] In the notice, HUD confirmed that it would require disclosure of non-personally identifying information only after going through a notice and comment period. Until HUD does so, it has instructed organizations that provide services to domestic violence victims not to input information about their clients into HMIS.

[17] The website is http://www.hmis.info.
[18] *Federal Register* vol. 69, no. 146, July 30, 2004, pp. 45888–45934.
[19] Ibid, p. 45905.
[20] Ibid, pp. 45913–45914.
[21] Ibid, p. 45914.
[22] Ibid, p. 45891–45892.
[23] U.S. Department of Housing and Urban Development, "The Violence Against Women and Department of Justice Reauthorization Act of 2005: Applicability to HUD Programs," 72 *Federal Register* 12695–12700, March 16, 2007.

Status of the HMIS Network

Two aspects of HMIS implementation contribute to a CoC's ability to capture data regarding homeless persons. The first aspect is whether a data collection system has been established at the CoC level, and the second is the degree to which homeless service providers within a CoC are participating in the system. Although almost all CoCs have established an HMIS system into which data may be entered, the extent to which data are actually entered into these systems remains incomplete, on average. Once established, a comprehensive HMIS network is meant to improve the ability of communities to provide services to homeless persons as well as to help HUD determine how best to allocate resources.[24]

HMIS Implementation. HUD's initial goal was that every CoC implement an HMIS by October 2004—meaning establish a system into which communities are entering data. Although this goal was not accomplished by 2004, the number of CoCs participating in HMIS has increased in every year since 2001.[25] Between 2005 and 2006, the percentage of CoCs that had implemented an HMIS (meaning they were actually inputting data) increased from 72% to 91%.[26] From 2005 to 2006, the percentage of CoCs that had decided to implement an HMIS but were still in the planning stages decreased from 20% to 9%, and the percentage that were not yet planning an HMIS dropped from 7% to 1%.[27]

At the local level, CoCs have several options for implementing and maintaining their HMIS databases. Not all CoCs are implementing their own HMIS. Some are collaborating to create a multi-jurisdictional HMIS with two or more CoCs. Others are planning to make individual CoC data accessible at the state level, while 19 states have decided to implement a state-level HMIS.[28] Local initiatives also differ in their methods of incorporating service providers into HMIS. Local CoCs may use one central HMIS, into which all service providers input client information. Another option is to allow service providers to use different database systems, but to have technical specialists available at the CoC level to merge all data into one unified system. A third option is to use side-by-side systems where individual service providers enter data into their own systems, and also enter data into a CoC-wide HMIS.

Participation of Service Providers in HMIS. Even where CoCs have successfully implemented HMIS, coverage of homeless service providers may be incomplete. HUD uses the term "bed coverage" to describe the rate at which local service providers within a CoC participate in HMIS. The term refers to the percentage of available beds in a CoC that are actually accounted for in HMIS. If not all service providers within a CoC participate in HMIS, then bed coverage may be low. Issues with bed coverage may arise in cases of domestic violence shelters that are reluctant to report data due to confidentiality concerns, or where service providers do not receive HUD funds and are not required to participate in HMIS. In addition, even when service providers report data to HMIS, they might not include all clients served, which could result in another limitation on the usefulness of the data.[29]

HUD keeps track of bed coverage rates both by the type of shelter provided, such as emergency shelter, transitional housing, and permanent housing, and by household type, such as homeless individuals and homeless families. From 2005 to 2006, the average number of beds across CoCs that were included in HMIS increased in all categories.[30] HUD reports bed coverage as an average rate—the average of all CoCs' bed coverage rates.

- Emergency Shelter: The average bed coverage rate for shelters serving individuals went from 43% in 2005 to 55% in 2006. For shelters serving homeless families, the average bed coverage rate went from 45% in 2005 to 51% in 2006.
- Transitional Housing: The average bed coverage rate for transitional housing serving homeless individuals increased from 41% in 2005 to 50% in 2006. Average bed coverage rates for homeless families increased from 51% to 62%.

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[24] *First AHAR,* p. 1.

[25] U.S. Department of Housing and Urban Development, *Report to Congress: Sixth Progress Report on HUD's Strategy for Homeless Data Collection, Reporting and Analysis,* May 2007, p. 4, available at http://www.hud.gov/offices/cpd/homeless/library/improvingDataCollection.pdf (hereafter *Sixth Progress Report to Congress).*

[26] Ibid

[27] Ibid

[28] Ibid, p. 5.

[29] *First AHAR,* p. 13.

[30] *Sixth Progress Report to Congress,* p. 5.

- Permanent Housing: Average bed coverage rates for permanent supportive housing for individuals went from 46% in 2005 to 58% in 2006. Average bed coverage rates for homeless families went from 54% in 2005 to 58% in 2006.

Counts of Homeless Persons

Since the eighties, a number of attempts have been made to estimate the total number of homeless persons in the country as well as to describe their characteristics. Although the specific methods used in the studies have varied, in most, researchers surveyed a sample of the homeless population and used the sample to estimate the total number of homeless persons in the country. The time periods covered by these counts vary. Some are "point-in-time" counts that estimate the number of homeless people on a single night during the year. Others estimate the number of persons who are homeless during longer periods—a week or span of months. Researchers have also used samples to estimate the total number of persons who are homeless at some point during the year.[31]

The HMIS initiative differs from these previous efforts to count homeless people and gather information. Instead of sampling only certain communities or counting homeless individuals on only a single night, CoCs gather information from all homeless assistance providers regarding all homeless individuals who use their services each day of the year. Eventually, once communities have fully implemented HMIS, the network of systems is expected to provide an annual unduplicated count of homeless persons from each jurisdiction. Counting homeless populations on the street might continue to be important, however, as their use of services is unknown.[32] HUD released its first report to Congress using HMIS data, the Annual Homeless Assessment Report (AHAR), in February 2007. In March 2008, HUD released the second AHAR. Because HMIS is not fully implemented in all jurisdictions around the country, the two AHARs, like previous efforts to count homeless persons, rely on a sample of jurisdictions.

This section describes several efforts to estimate the number of homeless individuals over the years. These include CoC point-in-time counts that take place every two years, estimates in the two AHARs using HMIS data, and previous estimates from the eighties and nineties. This section also includes resources that describe homeless demographic data.

CoC Counts of Homeless Individuals

As mentioned earlier in this report, in 2005 and 2007, HUD required all CoCs to conduct point-in-time counts of both the sheltered and unsheltered homeless individuals in their jurisdictions. In 2006, 61% of CoCs voluntarily conducted point-in-time counts. Although currently most CoCs conduct counts without using HMIS,[33] eventually HUD expects the HMIS initiative to be part of this point-in-time collection of information about homeless individuals. As HMIS programs develop, CoCs will be able to use the systems as part of the data collection process in estimating the number of sheltered homeless people.[34]

The reliability of CoC point-in-time data vary by Continuum, particularly in the case of estimates of unsheltered homeless individuals. Unsheltered individuals are those living in places not meant for human habitation, such as cars, abandoned buildings, highway underpasses, and public parks. Although HUD has published guidance on how to conduct street counts[35] and provides technical assistance to CoCs, the task is complicated, and not all CoCs are able to conduct statistically reliable surveys of those individuals who are not sheltered.[36]

During the point-in-time counts, HUD also asks participating CoCs to collect information about homeless individuals, which is referred to as "subpopulation information." CoCs are to ask homeless individuals whether they are chronically homeless; have severe mental illnesses, substance abuse disorders, or HIV/AIDS; are vet-

[31] For an explaNation of how annual counts are estimated using data from point-in-time counts, see Martha R. Burt and Carol Wilkens, *Estimating the Need: Projecting from Point-in-Time to Annual Estimates of the Number of Homeless People in a Community and Using this Information to Plan for Permanent Supportive Housing,* Corporation for Supportive Housing, March 2005, available at http://documents.csh.org/documents/pubs/csh_estimatingneed.pdf.

[32] U.S. Department of Housing and Urban Development, *HUD's Homeless Assistance Programs: A Guide to Counting Unsheltered Homeless People,* Second Revision, January 15, 2008, p. 14, available at http://www.hudhre.info/documents/counting_unsheltered.pdf (hereinafter *A Guide to Counting Unsheltered Homeless People).*

[33] *First AHAR,* p. 17.

[34] Ibid

[35] *A Guide to Counting Unsheltered Homeless People.*

[36] *First AHAR,* p. 18.

erans; have experienced domestic violence; or are unaccompanied youth. CoCs are not always able to gather this information, and even when they do, according to HUD, the subpopulation information is less reliable than the estimates of the number of homeless individuals.[37] Further, in the required 2005 CoC count, it was optional for CoCs to provide information regarding unsheltered homeless subpopulations. Information about homeless subpopulations is available on HUD's website.[38]

2005 CoC Counts. In both 2005 and 2007, HUD directed all CoCs to conduct counts on one night during the last week of January.[39] As of the date of this report, the results of the 2007 count are not available. The HUD website provides a breakdown of these point-in-time estimates for each CoC from 2005.[40] The 2005 results for the states and territories are as follows:[41]

- the sheltered homeless population consisted of 418,165 persons on a single day during the last week of January 2005;
- the unsheltered homeless population numbered 344,845;
- the total number of homeless individuals counted on one day during the last week of January 2005 was 763,010.[42]

2006 CoC Counts. In 2006, 277 out of 448 CoCs, or just under 62%, voluntarily conducted point-in-time counts. HUD added the 2006 results from these 277 CoCs to the 2005 results of the CoCs that did not conduct counts to arrive at a total number of homeless individuals. HUD refers to this number as the 2006 estimate although some of the results come from 2005 point-in-time counts. The 2006 results for the states and territories are as follows:[43]

- the sheltered homeless population consisted of 427,971 persons on a single day during the last week of either January 2005 or January 2006;
- the unsheltered population numbered 331,130; and
- the total number of homeless individuals counted on 1 day during the last week of either January 2005 or January 2006 was 759,101.[44]

The Annual Homeless Assessment Report (AHAR)

On February 28, 2007, HUD released the first Annual Homeless Assessment Report, in which HMIS data were analyzed for the first time.[45] A year later, in March 2008, the second AHAR was released.[46] For both the first and second AHARs, researchers relied on HMIS data collected from a sample of communities during a period of time and used these data to derive national-level estimates of the number of homeless persons. The two reports provide point-in-time estimates of the number of homeless individuals, estimates of the number of homeless persons during a longer period (three months during the first AHAR and six months during the second AHAR), and a description of characteristics of those persons experiencing homelessness.

The HMIS data in the two AHARs provide estimates only of the *sheltered* homeless population—individuals living in emergency shelter and transitional housing—and do not include estimates of individuals living on the street or other places not meant for human habitation. As a result, both AHARs also reported data collected from CoCs during their one-night counts of homeless persons in January 2005 and

[37] Ibid

[38] For 2005, see http://www.hud.gov/offices/cpd/homeless/05local/05StatesHomelessData.pdf. For 2006, see http://www.hud.gov/offices/cpd/homeless/local/reports/06StatesHomelessData.pdf.

[39] Because HUD directed CoCs to conduct a point-in-time count of homeless individuals during the last week of January 2005, not all CoC point-in-time counts took place on the same day in January.

[40] The counts are available at http://www.hud.gov/offices/cpd/homeless/local/index.cfm.

[41] For these results, see http://www.hud.gov/offices/cpd/homeless/05local/05CoCHomelessData.pdf.

[42] The AHAR estimates using HMIS data, described in the next section of this report, do not include data from the territories. For comparability purposes, the CoC point-in-time counts in the states only were 415,366 sheltered homeless individuals, 338,781 unsheltered individuals, and 754,147 total individuals. See http://www.hud.gov/offices/cpd/homeless/05local/05StatesHomelessData.pdf.

[43] The CoC point-in-time counts of homeless individuals in the states only were 424,932 sheltered individuals, 323,899 unsheltered individuals, and 748,831 total individuals. See http://www.hud.gov/offices/cpd/homeless/local/reports/06StatesHomelessData.pdf.

[44] For these results, see http://www.hud.gov/offices/cpd/homeless/local/reports/06CoCHomelessData.pdf.

[45] The first AHAR is available at http://www.huduser.org/Publications/pdf/ahar.pdf.

[46] The second AHAR is available at http://www.hudhre.info/documents/2ndHomelessAssessmentReport.pdf.

January 2006, which included individuals and families who were on the street or similar location.

In the coming years, the AHAR is expected to include data from a larger number of service providers, cover nonresidential populations, examine longitudinal data over a time period greater than three months, and include more information about the clients served.[47]

Estimates from the First AHAR Using HMIS Data. Initially, data from a nationally representative sample of 80 CoCs were expected to be used in the first AHAR. However, minimum HMIS requirements meant that some sample communities were excluded from the analysis. In order to participate, each jurisdiction was required to have a minimum level of bed coverage—only CoCs in which at least 50% of beds in at least one of four categories (emergency shelter for individuals, emergency shelter for families, transitional housing for individuals, and transitional housing for families) could participate in the AHAR.[48] As a result, data from 64 rather than 80 sample communities were used to arrive at estimates in the first AHAR.

Using HMIS data, the first AHAR reported two point-in-time estimates of the number of *sheltered* homeless persons, as well as an estimate of the number of persons who were homeless in the three-month period from February 1 to April 30, 2005. (See **Table 1**.) These estimates do not include homeless people who were not residing in emergency shelters or transitional housing during the relevant time periods. Nor do the estimates include the territories. Data from the HMIS sample communities provided that

- an estimated 313,722 persons in the country were homeless on April 30, 2005;[49]
- an estimated 334,744 persons were homeless on an average day between February 1 and April 30, 2005;[50] and
- an estimated 704,146 persons were homeless on at least one day between February 1 and April 30, 2005.[51]

The first AHAR did not attempt to use these numbers to estimate the total number of persons who were homeless at some point during the year.

The HMIS data collected over the three-month period in 2005 also provided information about the characteristics of the homeless persons surveyed. Information from the sampled jurisdictions was used to estimate that 65.7% of homeless persons were individuals or households without children, while 34.4% consisted of households with children. Unaccompanied adult males made up the largest percentage of the population (47.4%). Children made up 21.2% of the population. The majority of homeless individuals in the three-month count were members of minority groups, 58.9%. Of the adult homeless population counted during the three-month period, 18.7% were veterans and 25.0% were disabled. However, 35% of the HMIS records were missing information on veteran status and 55% of records were missing information on disability status.[52]

Estimates from the Second AHAR Using HMIS Data. The second AHAR relied on data from a total of 74 communities that were collected from January through June 2006. As in the first AHAR, communities were required to meet bed coverage requirements of 50% in at least one of four categories in order to participate.[53] Also, like the first AHAR, the second AHAR estimated the number of *sheltered* homeless individuals—those living in transitional housing or emergency shelters—and did not include those living in places not meant for human habitation. Unlike the first AHAR, the sample communities did not include any data from domestic violence shelters.[54]

The second AHAR reported three point-in-time estimates and an estimate of the total number of persons who were homeless during the six-month period from Janu-

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[47] *First AHAR,* p. 53.

[48] Ibid, p. 13.

[49] The 95% confidence interval for this estimate is 218,890 to 408,554, meaning that researchers are 95% sure that the actual number of homeless individuals on this date was somewhere in this range. See *First AHAR,* p. 22.

[50] The 95% confidence interval for this estimate is 235,315 to 434,233. *First AHAR,* p. 22.

[51] The 95% confidence interval for this estimate is 399,244 to 1,009,048. *First AHAR,* p. 28.

[52] *First AHAR,* p. 31.

[53] *Second AHAR,* p. 61.

[54] *Second AHAR,* pp. 4–5. As explained earlier in this report, the Violence Against Women and Department of Justice Reauthorization Act (P.L. 109–162) prevented domestic violence service providers from participating in HMIS. The first AHAR data collection period occurred prior to enactment of P.L. 109–162, and some of these providers were still participating in HMIS at that time.

ary 2006 through June 2006. The estimates include only the states and do not include the territories:[55]

- an estimated 338,000 persons were homeless on January 25, 2006;[56]
- an estimated 339,000 persons were homeless on April 26, 2006;[57]
- an estimated 337,000 persons were homeless on an average day between January 1, 2006, and June 30, 2006;[58] and
- an estimated 1,150,866 persons were homeless at some time during the period January 1, 2006, and June 30, 2006.[59]

The second AHAR did not attempt to estimate the total number of people who were homeless in 2006.

The HMIS data for the second AHAR collected over the six-month period in 2006 also provided information about the characteristics of the homeless persons surveyed. Information from the sampled jurisdictions was used to estimate that 72.8% of homeless persons were individuals or households without children, while 27.2% were households with children.[60] Unaccompanied adult males made up the largest percentage of the population (53%).[61] Children made up 17% of the population, and unaccompanied youth were 3%.[62] The majority of homeless individuals in the six-month period were members of minority groups, 66.3%.[63] Of the adult homeless population counted during the six-month period, 14.3% were veterans and 38.4% were disabled. However, 20% of the HMIS records were missing information on veteran status and 43% of records were missing information on disability status.[64]

AHAR Estimates Using CoC Point-in-Time Counts. Because the HMIS data used for the two AHARs did not include information about individuals and families who were unsheltered, both reports included estimates of sheltered and unsheltered homeless persons collected as part of CoCs point-in-time counts. The estimates summarized in the previous section of this report "CoC Estimates of Homeless Individuals" were reported in the first and second AHARs.[65]

Previous Attempts to Count Homeless Persons

Previous attempts have been made both to arrive at an accurate count of the number of homeless persons in the United States and to describe their characteristics. The first national count occurred in 1983, when HUD reported an estimate of homeless individuals by asking service providers to estimate the number of homeless individuals in their area.[66] Through this process, HUD estimated that between 250,000 and 350,000 individuals were homeless at a given point in time. Two more recent, comprehensive estimates are described below.

The Urban Institute (1987). In March 1987, the Urban Institute conducted interviews of a sample of homeless individuals living in 34 different cities with a population of 100,000 or more and who used soup kitchens and shelters.[67] The researchers estimated that the number of homeless persons during an average seven-day period in March 1987 ranged from 496,000 to 600,000.[68] They used this seven-day estimate to project that approximately one million individuals were homeless at some time during 1987.[69]

The National Survey of Homeless Assistance Providers and Clients (1996). The Urban Institute released a second estimate in 2000 using data collected in 1996 by the Census Bureau as part of the National Survey of Homeless Assistance Providers and Clients (NSHAPC). The NSHAPC surveyed both homeless individuals and service providers. Surveys were conducted in 76 communities of varying size and included clients and staff of numerous organizations such as emergency shel-

[55] *Second AHAR,* p. 18.
[56] The 95% confidence interval for this estimate is 248,900 to 426,400. *Second AHAR,* p. 12.
[57] The 95% confidence interval for this estimate is 249,100 to 428,500. *Second AHAR,* p. 12.
[58] The 95% confidence interval for this estimate is 249,200 to 424,900. *Second AHAR,* p. 12.
[59] The 95% confidence interval for this estimate is 691,129 to 1,610,603. Second AHAR, p. 20.
[60] *Second AHAR,* p. 20.
[61] Ibid, p. 22.
[62] Ibid
[63] Ibid, p. 23.
[64] Ibid
[65] See *First AHAR,* pp. 23–24 and *Second AHAR,* pp. 11–12.
[66] For a short description of HUD's 1983 count, see *First AHAR,* p. 3.
[67] Martha R. Burt and Barbara E. Cohen, *America's Homeless: Numbers, Characteristics, and Programs that Serve Them* (Washington, DC: The Urban Institute Press, July 1989).
[68] Ibid, p. 29. The range varies based on estimates of homeless individuals who did not use homeless services, and therefore were not counted.
[69] Ibid, p. 32.

ters, transitional and permanent housing facilities, soup kitchens, food pantries, and drop-in centers.[70] Although the purpose of the NSHAPC was not to arrive at a count of homeless individuals,[71] researchers used the data to arrive at an estimate of the number of homeless individuals who relied on homeless services during two different seven-day periods in 1996.[72] During a seven-day period in the fall 1996, an estimated 444,000 clients used homeless assistance services,[73] and during a seven-day period in the winter of that year, the number was estimated to be 842,000.[74] The researchers used these numbers to estimate that during all of 1996, between 2.3 million and 3.5 million individuals were homeless at some time.[75]

Table 1—National Estimates of the Number of Homeless Individuals

Time Period	Source	Population Sampled	Estimate
Data from Second Annual Homeless Assessment Report			
One Day, January 2006	CoC Counts [a]	Sheltered Persons Only	424,932
One Day, January 2006	CoC Counts	Sheltered and Unsheltered Persons	748,831
January 24, 2006	HMIS	Sheltered Persons Only	338,000
April 26, 2006	HMIS	Sheltered Persons Only	339,000
Average Day, January—June 2006	HMIS	Sheltered Persons Only	337,000
Six Months, January—June 2006	HMIS	Sheltered Persons Only	1,150,866
Data from Previous Estimates			
Average Week, March 1987	Urban Institute	Persons Using Shelters and Soup Kitchens	496,000–600,000
Average Week, October 1996	NSHAPC	Persons Using Various Services	444,000
Average Week, February 1996	NSHAPC	Persons Using Various Services	842,000
Full Year, 1996	NSHAPC	Persons Using Various Services	2.3–3.5 million

Sources: U.S. Department of Housing and Urban Development, *The Second Annual Homeless Assessment Report to Congress,* March 2008, available at http://www.hudhre.info/documents/2ndHomelessAssessment Report.pdf; Martha R. Burt and Barbara E. Cohen, *America's Homeless: Numbers, Characteristics, and Programs that Serve Them* (Washington, DC: The Urban Institute Press, July 1989), 32; and Martha Burt and Laudan Y. Aron, *America's Homeless II: Population and Services,* The Urban Institute: February 1, 2000, at http://www.urban.org/UploadedPDF/900344_AmericasHomelessII.pdf.

[a] Although the second AHAR reported the results of CoC point-in-time counts that included counts from the territories, for comparability purposes (because HMIS estimates did not include the territories), the numbers in this table are for the states only. For these numbers, see HUD's website http://www.hud.gov/offices/cpd/homeless/local/index.cfm.

Sources of Demographic Information About Homeless Persons

A number of surveys have been conducted to collect information to describe the characteristics of the national homeless population. The NSHAPC data resulted in demographic, income, and other information about homeless individuals in 1996.[76] Among the findings were that homeless clients were predominantly male (68%) and

[70] Martha R. Burt, Laudan Y. Aron, et al., *Homelessness: Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients, Technical Report,* December 1999, Chapter 2, p. 2–1, available at http://www.huduser.org/publications/homeless/homeless_tech.html.

[71] Ibid, p. 1–7.

[72] Martha Burt and Laudan Y. Aron, *America's Homeless II: Population and Services,* The Urban Institute, February 1, 2000, available at http://www.urban.org/UploadedPDF/900344_AmericasHomelessII.pdf.

[73] The estimate for one week during the fall of 1996 was based on service usage by homeless individuals.

[74] The estimate for one week during winter of 1996 was based on service provider estimates.

[75] *America's Homeless II: Population and Services.*

[76] *Homelessness: Programs and the People They Serve.*

nonwhite (53%); 23% of homeless clients were veterans.[77] Large proportions of homeless adults had never married (48%) and had not received a high school diploma (38%).[78] The NSHAPC also found that although 48% of homeless adults had minor children, only 31% of those with children lived with them.[79] Thirty-eight percent of homeless clients reported alcohol problems during the past month, and 39% reported mental health problems during that period.[80] Over one-quarter (27%) of homeless clients had lived in foster care, a group home, or other institutional setting for part of their childhood.[81] Twenty-five percent reported childhood physical or sexual abuse.[82]

The U.S. Conference of Mayors has issued an annual report since 1984, in which between 20 and 30 large cities survey their social service providers' efforts to combat hunger and homelessness and provide housing.[83] In 2007, the U.S. Conference of Mayors appointed 25 Mayors to serve on its Task Force on Hunger and Homelessness. The cities where those 25 Mayors serve were surveyed for the organization's annual report on hunger and homelessness between November 1, 2006, and October 31, 2007; 23 cities responded.[84] Regarding the demographics of the homeless population, the surveyed cities estimated that 76% of homeless persons were single individuals, 23% were members of a family with children, and 1% were unaccompanied youth. Among single individuals and unaccompanied youth, an estimated 67.5% were men, 22.4% had mental health issues, 37.1% had substance abuse issues, and 16.9% were veterans.[85] The single homeless population was estimated to be 50.0% white, 45.7% African American, 12.8% Hispanic, 2.5% American Indian, and 1.6% Asian. Among homeless families with children, 60.6% of all members were estimated to be under age 18, 65% of adults were female, and 12.0% of adults were victims of domestic violence. Members of homeless families with children were estimated to be 47.0% white, 47.0% African American, 24.0% Hispanic, 4.0% American Indian, and 2.0% Asian.

The Census Bureau released a report using data collected during the 2000 Census of individuals living in emergency and transitional housing. The information was collected on one day in March 2000 and captured information from nearly 171,000 respondents. The report described some basic demographic characteristics of those who were included in the survey.[86] Of those persons who were interviewed, 74% were adults (age 18 and older), and of the entire population (adults and children), 61% were male and 39% were female.[87] The most respondents were white (41%), slightly fewer were African American (40%), and 20% reported that they were Hispanic.[88]

In the area of veterans who experience homelessness, the Department of Veterans Affairs (VA) annually estimates the number of veterans who are homeless through the "Community Homelessness Assessment, Local Education and Networking Groups" (CHALENG) process. The estimates are based on a variety of sources, although the VA is attempting to make its process consistent with HUD's CoC counts of homeless individuals. In its most recent report, the VA estimated that in 2007 approximately 154,000 veterans were homeless on one day during the last week of January.[89] For more information about the CHALENG process and estimates, see CRS Report RL34024, *Veterans and Homelessness*, by Libby Perl.

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[77] Ibid, p. 3–4.
[78] Ibid, pp. 3–5 to 3–7.
[79] Ibid, p. 3–3.
[80] Ibid, pp. 8–3 to 8–8.
[81] Ibid, p. 10–2.
[82] Ibid, p. 10–10.
[83] For the most recent U.S. Conference of Mayors report, see U.S. Conference of Mayors, *Hunger and Homelessness Survey: A Status Report on Hunger and Homelessness in America's Cities,* December 2007, available at http://www.usmayors.org/HHSurvey2007/hhsurvey07.pdf.
[84] The cities surveyed were Boston, Charleston, Charlotte, Chicago, Cleveland, Denver, Des Moines, Detroit, Kansas City, Los Angeles, Louisville, Miami, Nashville, Philadelphia, Phoenix, Portland (OR), Providence, Salt Lake City, San Francisco, Santa Monica, Seattle, St. Paul, and Trenton.
[85] Ibid, p. 15.
[86] Annetta C. Smith and Denise I. Smith, *Emergency and Transitional Shelter Population: 2000,* U.S. Census Bureau, October 2001. The report is available from the Census Bureau website, at http://www.census.gov/prod/2001pubs/censr01–2.pdf.
[87] Ibid, p. 6.
[88] Ibid, p. 8.
[89] John H. Kuhn and John Nakashima, *The Fourteenth Annual Progress Report on Public Law 105–114: Services for Homeless Veterans Assessment and CoordiNation,* U.S. Department of Veterans Affairs, February 28, 2008.

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

John Driscoll
Vice President for Operations and Programs
National Coalition for Homeless Veterans
333½ Pennsylvania Ave., SE
Washington, DC 20003–1148

Dear John:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

John Driscoll, Vice President for Operations and Programs
National Coalition for Homeless Veterans

"Ending Homelessness for Our Nation's Veterans"
April 9, 2008

Questions from House Committee on Veterans' Affairs

Question 1: In your testimony you devote quite a bit of time talking about the Grant and Per Diem Program and the fact that the payment system is outdated. You state that the reimbursement formula should reflect the actual cost of services—based on each grantee's demonstrated capacity to provide those that are deemed critical to the success of the GPD program and veteran clients—rather than a flat rate on custodial care.

Question 1(a): Please explain to the Committee how that would work and how that is different than what is now being done.

Response: Grant and Per Diem Payment Restructuring

Currently the reimbursement an organization receives under the Grant and Per Diem Program (GPD) is based on the state veterans' home rate—which is generally custodial care—and limited to about $31 per day. That rate is then discounted based on additional Federal funding an organization receives. The original intent of the GPD program was to provide beds in a safe, substance-free environment for veterans transitioning out of homelessness. Experience has shown this transition also requires intense case management; counseling for substance abuse and behavioral problems; treatment for physical and mental illnesses; employment preparation, placement and follow-up services; lifeskills training; legal assistance; family reunification services, child care assistance. Access to these services is vital to successful transition out of homelessness; and these all represent additional costs to the service provider.

Many organizations receive grants from the Departments of Housing and Urban Development, Labor, Justice, Health and Human Services, and Education to provide specialized services for their homeless clients, but the amount of reimbursement under the GPD program is reduced if homeless veteran programs receive other Federal funding. The guidelines of the GPD program make it clear that successfully competing for funds requires links to other community-based and local government agencies, yet penalize organizations that receive Federal funds to do so.

A payment system based on the scope of services available at a facility rather than simply a daily amount for a veteran in a bed would allow VA to better coordinate and regulate the GPD program. VA would, as it does now, continue to monitor activities at GPD providers and audit their annual reports. However, organizations

that provide on-site case management, 24-hour emergency psychiatric assistance, on-site employment preparation and placement services, on-site kitchen and meals, transportation assistance, child care facilities for dependent children and other supportive services would be able to incorporate those necessary costs in their grant applications as "allowable" costs chargeable to the VA under the Grant and Per Diem Program.

The list of supportive services allowable under the grant would have to be revised, but not the application process. Organizations would have to clearly indicate the number of veterans their programs would serve, acceptable housing and employment "placement targets," as they do now, but also an estimation of the cost and reach of their supportive services offerings. Annual audits would validate reported expenses and certify program outcomes. The audits are currently required, and GPD liaisons at all VA Medical Centers are responsible for completing these oversight functions, so there would be no significant increase in administrative burden for the program. Applicants would be evaluated on the number of veterans they help, the breadth of services they provide, and success reaching or exceeding their goals.

While the prime objective of this recommendation is to help organizations provide the best level of care and continuity of services possible, it would also provide more financial stability to organizations—mostly nonprofits—focusing on service gaps that the government needs help to fill. That is the fundamental purpose of the Grant and Per Diem Program, and we now have an appreciable body of evidence that supports revising the payment system.

Question 1(b): What are the barriers to updating the Grant and Per Diem payment system?

Response: Barriers to updating the Grant and Per Diem Payment System

Our greatest concern with respect to revising the GPD payment system is the equitable distribution of limited funds between larger organizations and smaller, less sophisticated homeless service providers. The larger GPD organizations that have social workers, psychiatric specialists, counselors, and employment specialists on staff will demonstrate a much larger services portfolio and much higher costs than the small organization that must refer clients to partner agencies for most of those services. The great majority of current GPD funding goes to renewal applications and special needs grants. Any move to increase funding for large organizations without increasing the annual appropriation will strain funding available for smaller programs—the vast majority of GDP programs nationwide. One possible solution is to introduce a new competitive level under the GPD program—Comprehensive Service Centers—that would apply for funding under a "services-focused" approach rather than a simple "client census" basis, with additional funding infused into the program for that purpose.

We believe modifying the repayment system is a more pressing issue. Currently, service providers spell out in their applications what they are going to do, and submit a detailed program budget that must be approved by the VA. Then they provide services according to that agreement, and apply for reimbursement after the services are rendered. Payments are received as a "reimbursement" only, which means smaller organizations cannot draw on their approved funds to provide approved and critical support. They must sometimes go into debt while waiting for VA reimbursement payments. We have also heard of organizations not receiving their full funding, or having to pay back money they spent on previously approved activities that subsequent auditors ruled were unallowable.

Grantees should be allowed to draw down the funds they need to provide services they are contractually obligated to provide while they are providing those services—not one to three months later. And once an agreement between the VA and a community-based service provider is executed, the VA should be responsible for monitoring the provider's activities closely enough to safeguard against major disagreements on allowable expenses at a later date that could threaten the survival of the service provider.

Question 2: In your testimony you state that the lack of affordable permanent housing is cited as the number one unmet need of America's veterans, according to the CHALENG report.

Question 2(a): What is your agency's view on how to best address this shortfall?

Response: Addressing the Lack of Affordable Housing

Congress, with the help of several members of this committee, has already taken the first monumental step in this regard with the passing of the 10,000 HUD–VASH vouchers for veterans with chronic mental illness, disabilities and extreme poverty

in FY 2008; and HUD's inclusion of another 10,000 vouchers in FY 2009. This will go a long way in providing housing for nearly half of the 46,000 chronically homeless veterans (*National Alliance to End Homelessness*) in the Nation today.

We worked closely with both House and Senate staffs to address this issue in the Homes for Heroes Act (H.R. 3329, S. 1084). More than 1.5 million veteran families live below the Federal poverty level, and most of them are one catastrophic economic or health event away from homelessness. This act would direct the HUD Secretary to provide assistance to private nonprofit organizations and consumer cooperatives to expand the supply of supportive housing for very low-income veteran families (that is, families with incomes not exceeding 50% of the area median income). The bill would also provide emergency funding and services for families in crisis. Administered through the VA, services could include rental assistance, child care, employment services, personal and financial counseling, case management, etc. The bills would increase housing stability by addressing health and economic problems of veterans before they result in an increased risk of homelessness.

We also believe there needs to be greater participation by state and local governments to ensure the development of more affordable housing stock for special needs clients—the disabled, the elderly, the chronically ill, and low-income families. Much of the individual and family supportive work is being done by nonprofits, but developing housing options within a community is government's work. We are currently working with the development and finance communities to study public-private partnerships to help local authorities understand the social and economic incentives of building these supported housing developments.

A strategy to produce more affordable housing stock for low-income and homeless veterans must include a renewed focus on the VA Enhanced Use Lease Program. The program allows government and community-based service providers to enter into a lease agreement with the VA to use surplus or "underutilized" facilities for purposes that benefit veterans. It is our understanding the VA is already doing this with the hope of entering into agreements with homeless service providers in several locations this year. We will be following these developments closely.

ReexamiNation of the purpose of the VA Multifamily Transitional Housing Loan Guarantee Program is another option. This initiative authorizes VA to guarantee 15 loans with an aggregate value of $100 million for construction, renovation of existing property, and refinancing of existing loans to develop transitional housing projects for homeless veterans and their families. First authorized in 1998, only two projects have survived beyond the initial planning stages—in Chicago and San Diego—and only St. Leo's in Chicago has been developed.

While we believe this program seemed promising in its original design and intent, the real-life difficulties in long-term coalition building, planning and economic hardships developers have encountered to date strongly suggest a much more practical and streamlined program should be developed to address the critical supportive housing needs of homeless veterans and those at serious risk of homelessness due to chronic health problems and poverty.

The need for increased service capacity is immediate, and many community-based providers have successfully developed additional transitional and longer term residential opportunities for their clients. We believe the resources earmarked for the Multifamily Transitional Housing Loan Guarantee Program might be better allocated to support projects that can be developed and brought online more swiftly.

Question 2(b): What are the other unmet needs of America's veterans?

Response: The "Other" Unmet Needs of Homeless Veterans

Each year since 1994, the VA publishes the CHALENG Report, which gives an estimate of the number of homeless veterans across the Nation, as well as a list ranking how well the needs of homeless veterans are being met. This listing of "met" and "unmet" needs of veterans has been surprisingly consistent over the years, with the lack of affordable long-term housing firmly established in the top two or three "unmet" needs for the last five years. From the 2006 CHALENG Report, the most recent posted on the VA website:

Top unmet needs of homeless veterans nationwide (5 = need is met):

1. Long-term, permanent housing (2.46)
2. Child care (2.47)
3. Access to dental care (2.64)
4. Re-entry services for incarcerated veterans (2.71)
5. Legal assistance (2.78)
6. Guardianship (financial) (2.83)
7. Helping manage money (2.86)
8. Eyeglasses (2.92)

9. Eye care (2.93)
10. Drop-in day centers (2.98)

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

Libby Perl
Analyst in Housing
Domestic Social Policy Division
Congressional Research Service
101 Independence Avenue, SE
Washington, DC 20540–7500

Dear Libby:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Questions from Hon. Bob Filner
For Libby Perl, Analyst in Housing
Congressional Research Service
June 5, 2008

Question 1: The counting of the veteran homeless population has been a challenge for many years. The fact is we just don't know how many veterans there are that are homeless.

- How can we better design a program or instrument that would help us to more accurately capture the veteran homeless population?

Response: Homeless Management Information Systems. Currently the most comprehensive attempt to count homeless persons occurs through the Department of Housing and Urban Development (HUD). HUD has developed a system through which local communities collect data on homeless persons served by recipients of HUD Homeless Assistance Grants and through the Housing Opportunities for Persons with AIDS (HOPWA) program. This effort has been termed "Homeless Management Information Systems" (HMIS) and its purpose is to develop an unduplicated count of homeless people, which, in turn, is expected to improve the effectiveness of homeless assistance services.[1] Although HMIS currently has some limitations in its ability to count all homeless persons, including homeless veterans, it could at some point serve as a source for accurately capturing the homeless veteran population.

Once HMIS is fully implemented, veterans who are served by participating homeless service providers should be identified because veteran status is one of the required data elements that service providers are to collect. (Other information includes name, date of birth, race, ethnicity, gender, and presence of a disabling condition). However, currently there are several reasons that some veterans might not be counted as part of the HMIS initiative:

[1] See House Committee on Appropriations, Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act 1999, report to accompany H.R. 4194, H.Rept. 105–610, 105th Cong., 2nd sess., July 8, 1998. The FY1999 HUD Appropriations Act referred to the House Committee Report language for specific requirements.

- HMIS implementation is incomplete. As of 2006, approximately 91% of communities, called “Continuums of Care” that receive homeless assistance funds through HUD were implementing HMIS—meaning they had established a system into which service providers are entering data.[2]
- Participation of service providers, even among those communities in which HMIS is being implemented, is incomplete. Even when service providers report data to HMIS, they might not include all clients served, which could result in another limitation on the usefulness of the data. HUD keeps track of the percentage of persons included in HMIS through what it terms “bed coverage rates.” These bed coverage rates are categorized both by the type of shelter provided, such as emergency shelter, transitional housing, and permanent housing, and by household type, such as homeless individuals and homeless families. In 2006, the average level of bed coverage for service providers ranged from 50% to 62%, depending on the type of shelter and household type served.[3]
- If service providers do not receive HUD funds, they might not participate in HMIS. This could preclude the identification of veterans who are being served by service providers that do not receive HUD funds. However, many communities are attempting to integrate all homeless service providers in their communities into HMIS, no matter the sources of their funding.

Limitations on the usefulness of these data regarding homeless veterans can be seen in HUD’s Annual Homeless Assessment Report (AHAR) to Congress. HUD has released two AHARs since the implementation of HMIS; these reports use HMIS data to arrive at estimates of the number of individuals who are homeless during several different time periods. In the first AHAR, released in 2007 and using data from 2005, HUD estimated that 18.7% of homeless individuals were veterans. However, 35% of the HMIS records were missing information on veteran status.[4] In the second AHAR, 20% of HMIS records were missing information on veteran status.[5] Once service providers are able to collect better information about clients served, including whether they are veterans, HMIS could serve as a good measure of the number of homeless veterans. In addition, the ability of communities to include non-HUD funded service providers that assist homeless veterans in the HMIS initiative could improve the ability to capture the homeless veteran population.

Street Counts of Homeless Individuals. Even when HMIS is fully implemented, street counts of homeless individuals would still be necessary to identify those individuals who are not seeking out homeless services, including veterans. Every other year, HUD requires Continuums of Care to conduct point-in-time counts of both the sheltered and unsheltered homeless individuals in their jurisdictions on one night during the last week of January. HUD issues guidance on how to do this in a statistically reliable way.[6] In its most recent CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) report, the Department of Veterans Affairs (VA) coordinated its estimate of the number of homeless veterans with these HUD-directed point-in-time counts. Greater collaboration between service providers and the VA at the local level should help in making counts of homeless individuals, including veterans, more accurate.

Question 2. According to your testimony, HUD is engaged in an ongoing effort to establish database systems at the local level to collect information about persons experiencing homelessness. There seem to be many issues surrounding this effort to include only sheltered individuals and not those on the street, as well as a large portion of the records were missing information on veteran status.

Question 2(a): Is VA engaged in an attempt to accurately count ALL homeless veterans?

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[2] U.S. Department of Housing and Urban Development, Report to Congress: Sixth Progress Report on HUD’s Strategy for Homeless Data Collection, Reporting and Analysis, May 2007, p. 4, available at [http://www.hud.gov/offices/cpd/homeless/library/improvingDataCollection.pdf].

[3] Ibid, p. 5.

[4] See U.S. Department of Housing and Urban Development, The Annual Homeless Assessment Report to Congress, February 2007, p. 31, available at [http://www.huduser.org/Publications/pdf/ahar.pdf].

[5] U.S. Department of Housing and Urban Development, The Second Annual Homeless Assessment Report to Congress, March 2008, p. 23, available at [http://www.hudhre.info/documents/2ndHomelessAssessmentReport.pdf].

[6] See U.S. Department of Housing and Urban Development, *A Guide to Counting Unsheltered Homeless People,* revised January 2008, available at [http://www.hudhre.info/documents/counting_unsheltered.pdf].

Response: VA CHALENG. In response to the first question, VA attempts to estimate the number of homeless veterans each year through the annual CHALENG process. However, the CHALENG estimate is not a physical count of homeless veterans in the same way that communities count homeless individuals during HUD point-in-time counts. In FY2007, the VA asked "points of contact" (POCs) at local VA medical centers to *estimate* the number of veterans who were homeless on one night during the last week of January. POCs arrive at estimates in a variety of ways, one of which includes consulting with local HUD Continuums of Care about their counts of homeless individuals. In fact, FY2007 was the first year in which the VA asked POCs to compare their estimates to the results of the 2005 HUD point-in-time counts conducted by Continuums (the most current data available at the time). In addition, some POCs (71%) used more than one source to arrive at their estimates of homeless veterans.[7] These included U.S. Census data (10%), VA low-income population estimates (7%), local homeless census studies (42%), VA client data (36%), estimates from local homeless assistance providers (59%), and VA staff impressions (52%).

Question 2(b): Do VA and HUD work together to ensure the most accurate information is captured?

Response: In answer to the second question, this most recent CHALENG estimate is an effort to bring CHALENG estimates in line with HUD counts of homeless individuals. According to the VA, they chose the last week in January for their estimate so that "CHALENG estimates would coincide with the homeless point-in-time counts executed by HUD Continuums of Care nationwide. It is believed that CHALENG should make every effort to base their estimates on the local point-in-time count, as it is the only nationwide homeless count conducted on an ongoing basis."[8] The VA goes on to say that "In summary, it is believed the HUD point-in-time data has resulted in a revised CHALENG count that is more aligned with the most extensive homeless estimate methodology currently available, while allowing for adjustments of local estimates based on VA staffs first-hand knowledge of their service areas."[9]

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

Michelle Saunders
Veterans Moving Forward
5008 South 12th Street
Arlington, VA 22204

Dear Michelle:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

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[7] John H. Kuhn and John Nakashima, The Fourteenth Annual Progress Report on Public Law 105–114: Services for Homeless Veterans Assessment and CoordiNation, U.S. Department of Veterans Affairs, pp. 16–17, February 28, 2008.
[8] Ibid, p. 16.
[9] Ibid, p. 17.

Questions from Hon. Bob Filner
For Michelle Saunders

Before the Committee on Veterans' Affairs Hearing
"Ending Homelessness for Our Nation's Veterans"
April 9, 2008

Question 1: During my transition did anyone sit me down and ask me if I had a job lined up and a place to live? Do I believe this would have helped my transition?

Response: No, no one asked me as a formality during any part of my out processing period. If someone had, I do believe it would've helped my transition, if in fact there was a simple answer/answers for me to help myself e.g. a place where I could go to get assistance for financial, employment, education and emotional counseling. During the transition phase there are a series of out processing blocks that need to be checked prior to a service member being discharged. Just because the blocks are "checked" doesn't justify services actually being provided. Keep in mind the service member also plays the game in order "to JUST go home" Our service members do NOT experience the struggles and hurdles of the transition until already transitioned out of the military for numerous reasons already stated in my testimony.

Question 2: In my estimation, how do I think DOD and VA can best work together in order to prevent other veterans falling through the crack and or even becoming homeless?

Response: First, DOD and VA must collaborate prior to our service members being discharged from the military. Although they work together after and during the transition process they are failing in the aftermath. The aftermath is where the MOST assistance is needed. The process of a transitioning service member is parallel to a victim of trauma that acts out when he or she has time to actually get passed the initial trauma and the adrenaline calms down. This is when everything seems to surface and bleed through, by this time things have already manifested themselves into a fragile and tragic state. If there such a place where veterans could go after the transition or even start their transition process while still on active duty (a week is NOT enough) through the continuum of care that is currently lacking but also the rehabilitation and education needed to provide the skills in order to make them successful for the 21st century workforce.

Question 3: What would have made my transition easier?

Response: Having a place to go and receive the counseling without having to worry about just jumping into the workforce/paying bills and having to put all of my therapy on the backburner along with all other realities. This happens to a lot of our returning combat veterans. We are forced to "adapt and overcome" by finding "meaningful" employment without the proper education and training. There are benefits out there to help assist with education, however, how does one go to school and provide for his or her family at the same time, while trying to figure out why they are SO angry and disconnected from the rest of society? This is a very complex process and it is complex because we as a government are working in a vacuum instead of paving the road from the beginning. I have mentioned my idea to build transitional housing facilities on college campuses in order to provide the continuum of care and the education and training needed to be productive. I am more than willing to share these ideas if asked.

I am also attaching my business plan/idea on how I think we could better prepare ourselves in the future and also address the present.

Thank you,

Michelle Saunders

Veterans Moving Forward

The Reality and the Challenge

There are approximately 32,000 wounded in the Global war on terror, not including service members with Post Traumatic Stress Disorder (PSTD) or traumatic brain injuries which may not manifest for months or years after a soldier returns from combat. Our Military services are faced with processing more wounded than existing facilities have room to accommodate; troops are being rushed through their rehabilitation process, thus exacerbating the long-term effects of their injuries.

Given this large number of wounded, it is also an expected reality that the number of single and multiple amputees will be much higher than in other conflicts. The need for an intensive care, in-house, rehabilitation facility is now more vital and immediate than ever before. Our goal is to be able to facilitate as many projects as we can across the country, by laying the foundation and footprint of the *Northeast Veteran Training and Rehabilitation Center* (NVTRC).

The "Hope for the Future"

The Veterans Moving Forward Foundation addresses this new reality and associated challenge through the creation of the *Northeast Veteran Training and Rehabilitation Center (NVTRC).* All veterans at the *NVTRC* will have serious injuries, including, but certainly not limited to, the loss of limbs, disfiguring burns, traumatic brain injuries and deep personal psychological wounds. The center will provide these wounded veterans with both the time and the resources needed to first cope and then to successfully transition into a new career and way of life, essentially making the veteran population more marketable. The NVTRC is the first such facility to simultaneously offer education, counseling, therapy and vocational skill building which are so vital for the successful futures of our wounded service members. Providing "Hope for the future" is what the *NVTRC* is all about. More specifically, the NVTRC will provide:

- Rehabilitation services to restore the "whole person" to a life in which he or she can live and interact with friends and family while addressing the psychological baggage that so often accompanies our disabled Veterans;
- Physical, occupational and psychological therapies with an emphasis on family counseling and the life and recreational skills that are so often taken for granted;
- Support for Veterans suffering from PTSD, providing them and their families the information and therapy necessary to cope with this debilitating condition.

The Facility

The facility will have room for up to twenty (20) veterans and their families at one time. Located on 10+ acres of the Wachusett Community College campus in Gardner, MA, the *NVTRC* will offer extensive state-of-the-art physical and occupational therapy facilities, including a golf simulator, an indoor swimming pool, a jogging track, a weight/exercise room, a gymnasium, a trout pond and a variety of other amenities designed to prepare residents for a life in which their disability will be more of a mere annoyance than a burden. Veterans and their families will be housed in 1000 sq. ft. town homes near the college campus. These housing units will have two bedrooms, one bath, a kitchen and living area. This concept allows disabled veterans to practice their living skills and provides privacy and on-going support during the rehabilitation process.

Intake, Assessment, and Planning

Upon arrival, an *individual treatment plan,* sculpted to each veteran's needs, will be developed by state certified counselors. All therapy, counseling, educational/vocational pursuits, and estimated length of stay will be determined and outlined within the plan. Veterans who choose to pursue a degree while obtaining new life skills will be permitted to stay in the program for up to two years. The *NVTRC, along with Veterans Moving Forward* will collaborate with the Veterans Administration and other appropriate veteran service organizations to coordinate benefit and entitlement programs.

All *individual treatment plans* will contain milestones and measures of success. All caseworkers will work with their assigned Veteran resident to measure progress and ensure success by addressing any unforeseen difficulties along the way. Upon completion of the treatment plan, there will be a number of follow up contacts in order to increase the effectiveness of the program.

Providing "Hope for the future, is what "Veterans Moving Forward" is all about. Michelle Saunders, founder and co-chairman Msaunders@veterans movingforward.org

Approximate Total Cost of Each Project
$5,000,000

Executive Summary

Military veterans are returning from the battlefields of Iraq and Afghanistan with severe, debilitating physical and mental injuries. Eighty percent of the wounded face a lifetime of recovery, two-thirds will have post-traumatic stress disorder, and 59

percent of blast victims (if diagnosed) will have traumatic brain injuries. At 15.8 percent, the unemployment rate for this population has tripled the national average. In addition the homeless rate of our veterans is currently increasing at a staggering 1 in every 4 in the United States.

To address this crisis, Veterans Moving Forward has partnered with the Veterans Homestead in Massachusetts and has developed an exemplary model that will be used as the template for the service portion of this Program. The model is based on the work of the organization's founder, Leslie Lightfoot, and Michelle Saunders, a wounded veteran of the Iraq conflict. This holistic approach has addressed two major challenges faced by wounded veterans assimilating back into their community and family environments (often where the family becomes the caretaker); and acquiring the job skills needed in today's 21st century workforce.

Education, job- and life-skills training are central to the model: a lack of a higher education or job training coupled with their wounds places many veterans at a disadvantage when seeking employment.

The Program's mission statement reflects both the support services and housing required to help America's veterans.

The Problem

Military veterans are returning from the battlefields of Iraq and Afghanistan with severe, debilitating physical and mental injuries. According to industry research, 80 percent of wounded veterans face a lifetime of recovery, two-thirds of them will have post-traumatic stress disorder (PTSD), and 59 percent of blast victims (if diagnosed) will have traumatic brain injuries (TBIs). Returning wounded veterans, many of whom are 19 to 25 years old, face a 15.8-percent unemployment rate, which is triple the national average. In addition the homeless rate of our veterans is currently increasing at a staggering 1 in every 4 in the United States.

The Solution

Given these staggering figures, there is a societal need to help these wounded veterans. In partnership with the Veterans Homestead (a service provider), Veterans Moving Forward will first build a facility in Massachusetts and use the footprint to replicate facilities across the U.S. that will provide supportive services to help these heroes attain self-sufficiency, and move forward with dignity and pride.

A key component to the services aspect of this program is education and job- and life-skills training. Many wounded veterans entered the Armed Services at an early age, frequently straight from high school. A lack of a higher education or specific job training coupled with their wounds places many veterans at a distinct disadvantage when attempting to secure gainful, skills-appropriate employment.

The Mission

To create an environment that allows our wounded heroes and their families the opportunity to utilize and maximize their educational benefits without financial burden. This environment will also have the nurturing support and job skills training needed to properly transition our veterans back to a productive life.

The Outcome

As a result of participating in this Program, each veteran will be more confident, more marketable, and more professionally prepared to enter the 21st century workforce and transition back into their families and communities with success and sustainability.

Each Veteran will be able to achieve his or her full intellectual, physical, and professional capacity unhindered by a lack of education, by insufficient skill levels required for the career field of their choice, or by fears relating to their own capabilities.

This Program will differ for each veteran, just as their injuries differ. Some may have physical wounds: these veterans will learn how to live with the condition emotionally and physically—both internally and in a family and community setting. Some may have emotional wounds: they will receive support and coaching that enable them to live to their full capacity. Some may need job skills training in order to succeed in today's workforce: they will receive job-skill assessments, learn new professional skills, and receive job placement help. Referrals will be made for those who need extended care and supportive services.

Program's Design

Short-term Goal: to create the model footprint in Massachusetts, as we have already acquired 10.5 acres of land on Mount Wachusett Community College, courtesy

of the college. In addition to researching the most capable veterans' service providers in the surrounding area to help facilitate the needs and resources needed.

Long-term Goal: the Program will build multi-unit transitional housing across the country and donate it to the best Service Providers (charities/social service agencies) who will house veterans returning from Iraq and Afghanistan. The Service Providers will offer on-site services that include emotional support, physical rehabilitation, and education/job skills training. The facilities will be built as individual town homes or apartments with enough space for single veterans or veterans with their families. Engaging veterans in rehabilitation while they are in a family setting not only strengthens the veteran but the family unit as well.

Where possible, housing will be built near community colleges or universities; and where space allows, housing will be constructed directly on the campus. Education is a central, integral part of the Program's design in order to address a vital need of returning veterans: employability. Current statistics show today's veterans have three to four times the national unemployment rate! Therefore, to avoid long-term dissolution of the family structure for these veterans—and to avoid future homelessness for this population—education is a critical component of this Program.

Service Providers and the Support Services Function

Service Providers will operate the housing facilities after the Program donates the facilities to them. They are responsible for providing (directly or through subcontracts) the emotional and intellectual services, the physical rehabilitation services, and the professional skills training that enable veterans to live to their full capacity.

A "Support Services" function has been established to define the criteria for evaluating which Service Providers will be eligible to receive the Program's housing donations. Support Services will use a "gap analysis" approach to establishing the criteria.

Management and Operations

This program was co-developed by Michelle Saunders (wounded OIF veteran and Dept. of Labor employment specialist) and Leslie Lightfoot (Vietnam Veteran and Director of Veterans Homestead Inc.). Operationally the program will be guided and directed by both Michelle and Leslie. Through the partnership and collaboration of Veterans Moving Forward and Veterans Homestead we have developed a holistic approach for veteran care that will be discussed throughout this plan. Through the guidance and coaching of this partnership it is anticipated that this model will be replicated across the country, so that multiple services providers will be able to replicate this model. The ultimate goal will be to serve as many veterans as possible.

Direct Project Costs vs. Administrative Costs

In-Kind Donations

Veterans Moving Forward and Veterans Homestead will engage local construction companies in the surrounding communities and solicit in-kind donations of labor and materials for the housing they build. For conducting this effort the Project will be paid 5% of the in-kind donations obtained in order to cover operational costs. For example, if the project receives $500,000 in donations, the project will receive $25,000—*a savings of $475,000 for the Project's future Projects!*

Tax Deductions for Donations

For donors to receive tax credit for their contributions, Veterans Moving Forward-501(c)(3) will provide a Federal tax exempt form including the foundation Federal tax identification. The Veterans Homestead has successfully implemented this procedure for over fifteen years and will be pleased to utilize its experience (and documentation) on behalf of Veterans Moving Forward.

In-kind donations of time and materials that are contributed during construction require a very specific method of tracking in order to:

- Reflect accurate IRS reporting
- Provide accurate records/receipts to the donors so that they receive recognition from the Program, the veterans, and the general public; and that they receive IRS credit
- Reflect accurate contribution levels for the Project to use in marketing, communication, and fund development.

The Veterans Homestead has over fifteen years' experience perfecting this system and will use it on behalf of the Project.

- Veterans Homestead audits are conducted annually by Boisselle, Morton and Assoc., LLP, of Hadley, MA.

- Additional audits are welcomed if VMF's Steering and Finance Committees require.

Funds

All funding received for the Project must be used for either direct project costs or administrative costs directly related to the building and operational costs of the project.

Two Project Bank Accounts

A checking account has been established specifically for the Veterans Moving Forward organization with Bank of America. This account will be restricted to Project funding and can only be drawn upon with signatures from representatives that are authorized by the Project's Finance Committee.

This account will be linked to a separate Program account that will be opened: a treasury money market (sweep account). Funds in excess of $100,000 will be automatically transferred on a daily basis (each night) into the interest bearing treasury account and will transfer back into the checking account each morning. Interest is calculated by Bank of America on a daily basis and is reported to VMF at the end of each month. Interest earned is automatically deposited into the account on the 1st of each month. Interest earned may be used for general VMF operations and is not considered restricted funds, unless otherwise specified by the Veterans Project's donors. The unopened monthly bank statement shall be given to VMF and VH Executive Directors and the Project's Finance Committee for review before being forwarded to the Finance Department for processing.

Donations Received

Checks received in the mail will be logged on a daily basis by the Office Manager. Copies and original documents are sent to the Finance Manager for deposit into checking account (all deposits are made within 24 hours of receipt). Deposits are entered into both QuickBooks (accounting package) and Donor Perfect (donor database) by the Finance Manager and Office Manager respectively and are posted to a general ledger account number that will be specific to the Project.

Expenses

All costs related to the Project will be tracked in accounting system using a specified set of general ledger account numbers. These account numbers will be classified under the "Strategic Initiatives Department" and will have an "a.1" extension after the main account number. All invoices will be coded by the Finance manager and approved by both VMF and VH Executive Directors. All checks over $10,000 will require two signatures (Executive Director and the Project's Finance Committees).

Note: Any Veterans Project expenses paid via the VMF operations general checking account shall be reimbursed to the operations checking account monthly once revenue streams are established.

VMF Credit Cards Used

All credit card holders are authorized to charge all travel-related expenses. This includes airfare, meals, ground transportation, lodging, and unanticipated meeting supplies or copying expenses. In addition to the above, credit card holders are authorized to charge up to $100 (per purchase) for non-travel related expenses without prior approval. If the expenditure is over $100, credit card holders must submit an approved Request for Purchase Form to the Finance Department before charging the expense to their credit card.

Milestones and Timelines

Phase 1 Pre-Planning

- Create vision and mission—**Completed** (Apr 2007)
- Define tangible and non tangible outcomes—**Completed** (Jun 2007)
- Identify essential participants and their roles—**Completed** (Nov 2007)

Phase II Planning

- Develop business plan—**Completed** (Nov 2007)
- Distribute circulation of business plan to proper participants—**In process**
- Obtain celebrity and/or Corporate endorsement—**In process**
- Begin short-term fund development (marketing costs)—**In process**

Phase III Implementation

- Launch program—**Completed (work in progress)**
- Hire and orient staff; develop project plans—**In progress**
- Begin long-term fund development and associated marketing—**In progress**

Phase IV Success and Assurance

- TBD during Phase III

Overall Marketing Goals

The overall marketing goals for VMF are to elevate the Project's brand and to increase market awareness and development opportunities through the following:

- Generate brand awareness for the Project between four development segments: builders, building industry suppliers and manufacturers, non-building industry partners, and possible government entities
- Position the Project and its **spokespeople** as authorities on the topic of rehabilitation for wounded veterans from Iraq and Afghanistan; and
- Produce/Initiate positive national trade and local press coverage for the Project's work

Target Markets and Audiences

The Project will achieve its goals through the following target markets and audiences:

- **Builders and their trade partners**—To secure in-kind donations of time, expertise, resources, and cash donations to perform building projects and service providers' resources
- **Building industry suppliers and manufacturers**—To secure in-kind and cash donations to perform building projects and service providers' resources
- **Non-building industry partners, such as corporations, sports leagues, consumer product companies, etc.**—To secure in-kind and cash donations to perform building projects and service providers resources
- **Federal Government entities, including the Department of Veterans Affairs, the Department of Labor, the Department of Housing and Human Services and Congress**—To secure cooperative assistance in providing funds, intelligence, land, partnerships, etc. at the national level
- **State government entities**—To secure cooperative assistance in providing funds, intelligence, land, partnerships, etc. at the state level
- **City and county (local) government entities**—To secure cooperative assistance in providing funds, intelligence, land, partnerships, permits, etc. at the community level
- **Veterans service providers**—To secure organizations to operate facilities that are constructed for wounded veterans and their families
- **Other veterans nonprofit organizations**—To secure cash or in-kind support for building projects and necessary resources
- **National, trade, and local media**—To raise national, trade, and local awareness of the work performed by the Project and its partners at all levels
- **General public**—To raise mainstream awareness of the work performed by the Project and its partners, and to obtain cash donations.

Strategic Messaging

A common tool to encapsulate and focus all of the high-level messaging for a communications initiative is a positioning framework. The following positioning framework has been created for the Veterans Project.

Positioning Statement: The project creates an environment with dignified housing and educational services, nurturing support and job skills training to enable today's wounded veterans to return to and maintain a full productive life.

Tagline: Building hope for today's wounded heroes and their families

Target Audiences: Builders and their trade partners; building industry suppliers and manufacturers; non-building industry partners, such as corporations, professional sports organizations, consumer product companies etc.; national, state, and local government entities, including the Veterans Administration; veterans service providers; other veteran non-profit organizations; national, trade, and local media; and the general public.

Key Benefits:

- Dignified housing and quality living environments
- Camaraderie shared environment for veterans and their families
- Continuum of care that is currently lacking
- Family unit support (whole family)
- Non-Government solution to a dire societal need
- Opportunity for widespread involvement

Marketing Messaging

From within the positioning framework, high-level marketing messages can be derived through the following sample messages:

- With 80 percent of U.S. wounded veterans facing a lifetime of recovery, we as American citizens owe it to them to do as much as possible in helping their recovery and it starts with providing a basic roof over their head.
- Led by a celebrity and or corporate champion (e.g. Tiger Woods), Veterans Moving Forward and its partners will build multi-unit housing facilities across the country that offer education as well as job and life-skills training as part of the rehabilitation process.
- With 3 out of every 5 veterans responsible for their family, family counseling is a critical component of the rehabilitation process and the Projects unique model for housing accommodates a family environment as part of the healing process.

Fund Development Messaging

The development process will leverage the above-stated marketing message. In addition, there are primary ROI messages that can appeal to prospective partners/donors; they are as follows:

- Increase corporate social responsibility profile through association with a highly visible cause
- Leverage Project involvement through marketing and sales efforts with the following industries: Government; Military/defense; Academia/college institutions/trade schools; building industry
- Leverage association in the Project to "give back" to wounded veterans: Conduct corporate fundraising efforts; create scholarship programs to promote education among wounded veterans and or their caretakers; offer internships to wounded veterans and/or caretakers; employee voluntarism etc.
- Gain network access to the nation's leading builders through the organizations' leadership and partners

Core Value Prerequisites

It is critical for all potential partners/affiliates and donors to understand the value they will receive from their association with this Project. These benefits are described in the following sections: WHAT Partners/Affiliates and Donors can leverage and HOW Partners/Affiliates and Donors can leverage.

However, before proceeding to these sections, it is crucial to define an underlying philosophical approach that all Partners/Affiliates and Donors will require in order to maximize their alliance with the Veterans Moving Forward Project. This approach includes:

Sincerity: Partners/Affiliates and Donors must have a true desire to help wounded veterans and their families get back on their feet and attain self-sufficiency. A lack of this desire will be evident in their marketing-related activities, especially with the media.

Co-Branding Vision: They must have the vision to see that they are not contributing to the Project, but rather the wounded veteran population in which is being served. This vision enables Partners/Affiliates and Donors to more effectively utilize their association with the cause for their own marketing and communications purposes. In other words, they are serving a "long overdue" vital societal need, and co-branding with the project is a form of publicizing their giving back to not only the communities in which they live and work.

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

John F. Downing
President/Chief Executive Officer
Soldier On
421 North Main Street, Bldg. 6
Leeds, MA 01053

Dear John:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

June 5, 2008
Submitted by: John F. Downing, President/CEO
Ending Homelessness for Our Nation's Veterans
April 9, 2008

Questions from House Committee on Veterans' Affairs

Question 1: Over the past 20 years there has been an intense focus on helping the homeless become productive citizens again. It seems that through the programs offered primarily through VA, that we have been somewhat successful in that area. My immediate concern, however, is that we do not repeat the last 20 years and stand by as the newest returning veterans fall into the same cycle. It is past time to make a concerted shift to the prevention of homelessness.

Question 1(a): What has been done out in the field to tackle this issue?

Response: The VA Program has increased its focus on outreach by assigning personnel to visit community based shelters, correctional institutions, and detox facilities with a primary focus of identifying veterans in need of services.

Question 1(b): Rather than playing catch-up, what can we do to be proactive in identifying the "at risk" veterans?

Response: Individuals who were raised in one parent families, at or below the poverty level are 4 or 5 times more likely to be a homeless veteran than an individual raised in a two parent family above the poverty level. The exposure to combat, periods of intense vigilance, and living in areas where enemy combatants cannot be identified from the indigenous population escalate the adjustment disorders, mental illness; addiction which lead to homelessness.

Question 2: What type of new programs do you believe VA should be looking at implementing to address the needs of the OEF/OIF veteran returning from combat?

Response: Every member of the armed forces should receive his/her VA enrollment card ninety (90) days before discharge. It should be received at the point of duty to heighten the importance of this opportunity.

The Department of Defense should award each returning member of the Armed Forces a $1,000 a month bonus for the first three months post discharge if he/she has a 15 minute conversation with a Veterans Affairs Intake or Case Manager. This would increase by seven fold the likelihood of an individual contacting the VA personnel at the time of crisis.

Question 3: What do you believe is the biggest challenge facing the Department today regarding the homeless programs?

Response: Department of Veterans Affairs must be able to take complete control of the service delivery system to veterans. The inability to stay cost effective and remain competitive with cost/quality of community based health care is essential. The implementation of a "Smart Card" system that would have an individual's benefits loaded in and give the veteran the ability to choose the VA or a community based provider is the only way all returning veterans will be able to be served.

Question 4: The Grant and Per Diem Program is the VA's biggest program that helps veterans. However, the program is somewhat outdated. The Committee has heard from many community-based providers about some improvements that, in their estimation, need to be made. Many of you addressed this issue in your testimony.

Question 4(a): What is the number one issue for each of your organizations regarding the Grant and Per Diem Program?

Response: The Grant and per Diem Program needs to be able to support with services individuals in safe-affordable housing. The need to be able to convert transitional housing funds into permanent housing opportunities must be developed. The increasing acceptance and viability of the "Housing First" model will continue to increase the need for GPD to be able to sweep unused transitional funds into permanent housing opportunities. If we want to decrease the dependence on "institutional care" as a long term expensive option we must find a way to fund safe affordable housing with services.

Question 4(b): If you could change the Grant and Per Diem program what would it look like?

Response: Continue to appear as a multi-disciplined service system to disenfranchised and un-served veterans and continue to shelter and support the current intervention. The need to embrace the "10 Year Program to End Homelessness" will require the ability to develop, support and create new affordable housing with services for veterans.

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

Colonel Charles Williams, USA (Ret.)
Executive Director
Maryland Center for Veterans Education and Training, Inc.
301 North High Street
Baltimore, MD 21202

Dear Charles:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

The Maryland Center for Veterans Education and Training response to questions from Honorable Bob Filner, Chairman, Committee on Veterans' Affairs

Before the Committee on Veterans' Affairs Hearing "Ending Homelessness for Our Nation's Veterans" April 9, 2008

Question 1: Over the past 20 years there has been an intense focus on helping the homeless become productive citizens again. It seems that through the programs offered primarily through the VA, that we have been somewhat successful in that area. My immediate concern, however, is that we do not repeat the last 20 years and stand by as the newest returning veterans fall into the same cycle. It is past time to make a concerted shift to the prevention of homelessness.

Question 1(a): What has been done out in the field to tackle this issue?

Response: Traditionally, a period of time has elapsed before veterans returning from conflicts show up on the "radar screen" in need of assistance. Currently, agencies dealing with veterans have been servicing Vietnam veterans, in the main. OIF/OEF returning veterans, with the exception of those who are gravely injured and housed at Walter Reed Hospital, are not presenting themselves in great numbers for assistance. PTSD and TBI cases are trickling in. By the time they present themselves for treatment, many or all of them have fallen into cycles of addiction and homelessness. **The VA, once the veterans have presented themselves, provides the care needed to address substance abuse, housing and mental health treatment programs.**

Question 1(b): Rather than playing catch-up, what can we do to be proactive in identifying the "at risk" veterans?

Response: Veterans returning from Afghanistan and Iraq face problems that can be overcome through the Veterans Affairs system. Many problems occur from an ineffective readjustment period after transitioning from war zones. If the veteran is not connected to comprehensive services, then other problems, e.g., drugs, crime and homelessness, will surface.

A unified service delivery system should be developed with HUD, VA and DOL participating in an effort to create a one stop application process. This process would be designed to eliminate the barriers which have been put in place that severely limit and discourage the veterans' efforts at accessing services in a timely manner.

In discharging soldiers from active duty, there should be a "handoff" system whereby their final physical, specifically their psychosocial and mental health issues, are documented and forwarded to their nearest VA medical center in their home areas. This should eliminate duplication of efforts and accelerate the time that treatment can begin. The unified service delivery system should be automatic which both the active duty health service system and the VA health service system can access. A system of this kind would also be of use for those applying for benefits.

Psychosocial assessments should be done before the soldier leaves active duty service, especially if the soldier has served in a combat zone. Factors such as PTSD and TBI are not readily identifiable because physical trauma, i.e. loss of limbs and other visible wounds are not present. If factors that could adversely affect the individual leaving active duty are determined to be present prior to separation from the military, treatment and counseling should be provided to that individual.

Question 2: What type of new programs do you believe the VA should be looking at implementing to address the needs of the OEF/OIF veteran returning from combat?

Response: VA has developed a thrust to treat veterans returning from combat that is designed to ameliorate the effects of significant psychological trauma. **It is recommended that they partner with community providers who service veterans as a priority group.** The Maryland Center for Veterans Education & Training, Inc. is in the process of partnering with the Veterans Affair Medical Center in Baltimore, MD and the Veterans Affair Medical Center in Perry Point, MD in identifying participants in the MCVET program who are OEF/OIF veterans so that comprehensive services can be brought to bear. MCVET is partnering with the medical centers in an effort to stabilize those veterans who are in need of an inpatient stay in the hospital and those who can function on an outpatient basis while receiving stabilizing treatment. Meetings have been held and more are being planned.

Additionally, it is recommended that local police departments be briefed on OEF/OIF veterans returning to their respective cities and many have not had transitioning services that will prepare them for civilian life. Incidents have been recorded where returning veterans have been shot by local police during an altercation. MCVET has met with the Police Commissioner, at the time, to discuss the problems that could occur on Baltimore streets between returning veterans and the police. **It is recommended that local police departments began a dialog with service providers and the local Veterans Affairs Medical Centers in efforts to develop programs designed to sensitize police and other first responders to the needs of our returning veterans.**

Question 3: What do you believe is the biggest challenge facing the Department today regarding the homeless programs?

Response: Veterans Affairs (VA), Housing and Urban Development (HUD), and the Department of Labor (DOL) should develop a process that provides a seamless track for a veteran in need of services. That is, there should be a "pass through" referral system for the veteran that would expedite his access to services and the need to complete a number of applications. Since the aforementioned departments are crucial in the fight against homelessness, funding schemes would have to be developed that would involve satisfying the fiscal responsibility of each department.

Question 4: The Grant and Per Diem Program is the VA's biggest program that helps veterans. However, the program is somewhat outdated. The Committee has heard from many community-based providers about some improvements that in their estimation need to be made. Many of you addressed this issue in your testimony.

Question 4(a): What is the number one issue for each of your organizations regarding the Grant and Per Diem Program?

Response: No problem.

Question 4(b): If you could change the Grant and Per Diem program what would it look like?

Response: No changes.

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

Phil Landis
Chief Executive Officer
Veterans Village of San Diego
4141 Pacific Highway
San Diego, CA 92110

Dear Phil:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Responses from Veterans Village of San Diego
Questions from Hon. Bob Filner
Chairman, Committee on Veterans' Affairs

Question 1: Over the past 20 years there has been an intense focus on helping the homeless become productive citizens again. It seem that through the programs offered primarily through the VA, that we have been somewhat successful in that area. My immediate concern, however, is that we do not repeat the last 20 years and stand by as the newest returning veterans fall into the same cycle. It is past time to make a concerted shift to the prevention of homelessness.

Question 1(a): What has been done out in the field to tackle this issue?

Response: Organizations such as Veterans Village of San Diego (VVSD) have initiated programs, funded by private funds, to help meet the needs of the returning combat veteran, both those still on active duty and those who have left the service. This program, Warrior Tradition, provides a safe environment for OIF/OEF combat veterans to meet, share their issues, frustrations and problems and receive referral services for counseling, both individual and family if required.

Question 1(b): Rather than playing catch-up, what can we do to be proactive in identifying the "at risk" veterans?

Response: All combat veterans and support personnel who have experienced the rigors of war should be interviewed and counseled regarding their experiences, how to recognize the symptoms of PTSD, and the resources available both to active duty and those who have left the military. Should a veteran require treatment/therapy he should receive it prior to separation, and once separated, referred to the VA Hospital nearest his home of record or the area he/she intends on living in.

Question 2: What type of new programs do you believe VA should be looking at implementing to address the needs of the OEF/OIF veteran returning from combat?

Response: Programs that focus on identification and treatment of those veterans whose combat experiences are likely to result in PTSD or other treatable mental illness. This will require making sure that all veterans receive out briefings from the combat theaters while still on active duty, and for those leaving the military, separation briefings that insure they have an accurate list of resources for the veteran and his family.

Question 3: What do you believe is the biggest challenge facing the Department today regarding the homeless programs?

Response: Public awareness and continued funding by Congress when paired are the biggest issues I see today. If we as a Nation continue to ignore the plight of our veterans who are homeless today, we will continue to experience as we do today, the inclusion of the OIF/OEF combat veterans, not 5–10 years later, but 1–2 years after service.

Question 4: The Grant and Per Diem Program is the VA's biggest program that helps veterans. However, the program is somewhat outdated. The Committee has heard from many community-based providers about some improvements that, in their estimation, need to be made. Many of you addressed this issue in your testimony.

Question 4(a): What is the number one issue for each of your organizations regarding the Grant and Per Diem Program?

Response: VVSD spends approximately $50.00 per day per client. Per diem is presently only $30.00 per day. An increase in the daily rate of reimbursement would help reduce the need for matching funds and potential operating deficits.

Question 4(b): If you could change the Grant and Per Diem program what would it look like?

Response: The Grant would be separate from the Per Diem, not tied together as they are now. Also, as an organization grows, there should be a mechanism in place to retain the same contract number and just modify the existing contracted bed numbers. For example, VVSD has four different Grant and Per Diem or Per Diem only contracts, each with its own rate.

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

William G. D'Arcy
Chief Operating Officer
Catholic Charities Housing Development Corp.
721 N. LaSalle, 5th Floor
Chicago, IL 60610–3574

Dear William:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Responses from Catholic Charities
Questions from the Honorable Bob Filner
Chairman, Committee on Veterans' Affairs

Before the Committee on Veterans' Affairs Hearing
"Ending Homelessness for Our Nation's Veterans"
April 9, 2008

Question 1: Over the past 20 years there has been an intense focus on helping the homeless become productive citizens again. It seems that through the programs offered primarily through VA, that we have been somewhat successful in that area. My immediate concern, however, is that we do not repeat the last 20 years and stand by as the newest returning veterans fall into the same cycle. It is past time to make a concerted shift to the prevention of homelessness.

Question 1(a): What has been done out in the field to tackle this issue?

Response: Counseling, case management, and housing with the Grant and Per-Diem Program.

Question 1(b): Rather than playing catch-up what can we do to be proactive in identifying the "at risk" veterans?

Response:

1. At enlistment in the military, there is often a battery of exams that the recruits go through. At military discharge use that battery to capture some of the effects of their military experience. Use that info to offer service to the discharged personnel. Do follow up after 1 year, 2 years, 3 years post duty to see if any symptoms of PTSD or substance abuse problems develop rather than waiting for homelessness to occur.
2. Do incremental follow ups with vets who served in military action zones. Perhaps create a system of 6 mo. follow up for 2–3 years. The follow-up questions would include info re: family and marital satisfaction; employment and employment satisfaction; financial stability; social/community satisfaction (vs isolation) as noted by involvement in church, community, circle of friends, and other social activities outside of the family circle.
3. Good medical workups post military service and for a period of time afterward to diagnose appropriately any organic effects from their service.

Question 2: What type of new programs do you believe VA should be looking at implementing to address the needs of the OEF/OIF veterans returning from combat?

Response: The VA should increase their HUD VASH program, and emergency financial assistance to keep families and individuals out of homelessness.

Question 3: What do you believe is the biggest challenge facing the Department today regarding the homeless program?

- Develop community based Permanent Supportive Housing in partnership with private entities.
- Affordable housing with rental subsidy.
- Trained staff to operate the housing programs
- Employment reintegration—marketable skills—following military service to provide income to stay housed.
- Employment maintenance following military service to provide income to stay housed.

Question 4: The Grant and Per Diem Program is the VA's biggest program that helps veterans. However, the program is somewhat outdated. The Committee has heard from many community-based providers about some improvements that, in their estimation, need to be made. Many of you addressed this issue in your testimony.

Question 4(a): What is the number one issue for each of your organizations regarding the Grant and Per Diem Program?

Response: The 24 months lifetime limit presents a barrier for same veterans.

Question 4(b): If you could change the Grant Per Diem program what would it look like?

Response: Extend the length of stay with criteria.

Committee on Veterans' Affairs
Washington, DC.
April 10, 2008

Hon. James B. Peake, M.D.
Secretary
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on "Ending Homelessness for Our Nation's Veterans" on April 9, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Questions for the Record
From the Honorable Bob Filner
Chairman, Committee on Veterans' Affairs

April 9, 2008
Ending Homelessness for Our Nation's Veterans

Questions 1(a): For five years we have had veterans returning from combat, both men and women, who have to reintegrate into society. I know the agency has held round tables and/or focus groups with this cohort. Realizing that they represent a smaller contingent than Vietnam: What has the Department learned about the needs of these veterans?

Response: The Department of Veterans Affairs (VA) has learned a great deal about the needs of homeless veterans during the past 20 years, having seen more than 400,000 homeless veterans during that time. We have learned that the needs are complex and to be effective we need to have a wide array of services. We have learned that all homeless veterans need shelter (emergency, drop-in centers, transitional and permanent), food, clothing, personal hygiene, employment, transportation, education, job training and assistance in finding a job, assistance in getting documentation, financial assistance (welfare payments, VA or Social Security disability/pension benefits, and money management), legal assistance, child care, and medical/mental health services. The medical/mental health services required include testing and treatment for contagious diseases (tuberculosis, hepatitis C, and AIDS/HIV), medication, dental and eye care, substance abuse treatment, detoxification, counseling for emotional and psychiatric problems both individual and family.

We have identified specific differences in the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans that contributed to differing needs. These differences are OEF/OIF veterans are far more likely to be women, thus a need for shelters for women and a need for child care. OEF/OIF veterans are far more likely to have had combat participation; less likely to have alcohol abuse/dependency; less likely to have drug abuse/dependency, and far more likely to have combat post traumatic stress disorder (PTSD). So there need for substance abuse treatment, detoxification is diminished but there need for mental health services to treat PTSD is greater, as is there need for assistance in applying for disability benefits for service connected PTSD. These veterans are younger and are far more technologically savvy, so we have other opportunities to reach out to these veterans (beyond classic outreach—walking the streets, etc.).

Questions 1(b): What types of proactive activities have you implemented to ensure that a repeat of the past 20 years does not happen?

Response: In 1994, VA launched Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans, a program designed to enhance the continuum of care for homeless veterans provided by VA and its surrounding community service agencies. VA medical centers and regional offices designate CHALENG Points of Contact (POCs) who are responsible for

- assess the needs of homeless veterans living in the area,
- identify the needs of homeless veterans with a focus on health care, education and training, employment, shelter, counseling, and outreach,
- assess the extent to which homeless veterans' needs are being met,
- develop a list of all homeless services in the local area, and
- inform homeless veterans of non-VA resources that are available in the community to meet their needs. Project CHALENG brings VA together with community agencies and other Federal, State, and local governments who provide services to the homeless to raise awareness of homeless veterans' needs and to develop plan to meet those needs.

Other proactive activities VA has undertaken include:

Homeless Providers Grant and Per Diem Program. Provides funds to community-based agencies providing transitional housing or service centers for homeless veterans.

Loan Guarantee Program for Multifamily Transitional Housing. Provides loan guarantees for large-scale self-sustaining transitional multifamily housing. Eligible transitional project are those that: 1) provide supportive services including job counseling; 2) require veteran to seek and maintain employment; 3) require veteran to pay reasonable rent; and 4) require sobriety as a condition of occupancy.

Stand Downs. VA staff participated in the Stand Downs for Homeless Veterans run by local coalitions in various cities each year. Stand Downs give homeless veterans 1–3 days of safety and security where they can obtain food, shelter, clothing, and a range of other types of assistance, including VA provided health care, benefits certification, and links to other programs.

Veterans Industries. Disadvantaged, at-risk, and homeless veterans live in community-based supervised group homes while working for pay in VA's Compensated Work Therapy Program (also known as Veterans Industries). Veterans in VA's Compensated Work Therapy/Transitional Residence program work about 33 hours per week, earning approximately $732 per month, and paying an average of $186 per month toward maintenance and up-keep of the residence. The average length of stay is about 174 days. VA contracts with private industry and the public sector for work

done by these veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth.

Domiciliary Care for Homeless Veterans. Provides residential bio-psychosocial treatment to homeless veterans with health problems, average length of stay in the program is 4 months. The domiciliaries conduct outreach and referral; vocational counseling and rehabilitation; and post-discharge community support.

Department of Housing and Urban Development—VA Supported Housing Program (HUD–VASH). Provides permanent housing and ongoing treatment services to the harder-to-serve homeless mentally ill veterans and those suffering from substance abuse disorders. VA staff provide outreach, clinical care and ongoing case management services. Rigorous evaluation of this program indicates that this approach significantly reduces days of homelessness for veterans plagued by serious mental illness and substance abuse disorders.

Supported Housing. VA staff help veterans find permanent housing and providing clinical support needed to keep veterans in permanent housing. Staff in these programs operate without benefit of the specially dedicated Section 8 housing vouchers available in the HUD–VASH program but are often successful in locating transitional or permanent housing through local means, especially by collaborating with veterans service organizations.

Drop-In-Centers. Provide a daytime sanctuary where homeless veterans can clean up, wash their clothes, and participate in a variety of therapeutic and rehabilitative activities.

Special Outreach and Benefits Assistance. Specially funded staff provide dedicated outreach, benefits counseling, referral, and additional assistance to eligible veterans applying for VA benefits. These homeless veterans coordinators make over 4,700 visits to homeless facilities and over 9,000 contacts with non-VA agencies working with the homeless and provide over 24,000 homeless veterans with benefits counseling and referrals to other VA programs on an annual basis.

Acquired Property Sales for Homeless Providers. Makes properties VA obtains through foreclosures on VA-insured mortgages available for sale to homeless providers at a discount of 20 to 50 percent, depending on time of the market.

VA Excess Property for Homeless Veterans Initiative. Distributes Federal excess personal property, such as hats, parkas, footwear, socks, sleeping bags, and other items to homeless veterans and homeless veteran programs.

Program Monitoring and Evaluation. VA has built program monitoring and evaluation into all of its homeless veterans' treatment initiatives and it serves as an integral component of each program. These evaluations provide important information about the veterans served and the therapeutic value and cost effectiveness of the specialized programs. Information from these evaluations also helps program managers determine new directions to pursue in order to expand and improve services to homeless veterans.

Questions 1(c): Are you working with the Department of Defense on this issue?

Response: The Department of Defense (DoD) serves as a member of VA's Advisory Committee for Homeless Veterans. VA and DoD participate in and encourage service members leaving military service to participate in transition assistance programs. We believe the more departing members know about VA benefits and services the less likely they are to becoming homeless.

Question 2(a): Many of the community based providers are advocating for a change in the Grant and Per Diem Program. There is concern out there that the program is "pushing" providers out due to the low per diem rate and the onerous administrative duties to name a few. Does the VA believe this program needs to be "updated"?

Response: The Homeless Grant and Per Diem Program was authorized in 1992 and while much has changed over the past 16 years the basic approach and objective of that program is as relevant today as it was when authorized. The need for transitional housing for veterans that largely uses a veteran helping veteran approach in large and small program across the Nation still exists.

We know that the initial concept of payments to providers was patterned after the State home program and its provider base and the needs of the veterans each program serves are different.

Question 2(b): How many of the community based providers have you lost because of these issues?

Response: We have found that most of the "lost" providers were programs that we initially awarded funding that did not ever begin operating. We have found most did not anticipate the time and obstacles they would encounter when obtaining an appropriate location; site control and additional costs needed to complete their project. These are regrettable loses but are issues largely beyond our control.

Question 3: Effective outreach is a very important part of the homeless program. Please explain your outreach program to the homeless veteran population.

Response: VA has hundreds of staff based in our health care and benefits administrations who reach out to veterans who are homeless and at-risk. That effort is enhanced by thousands of community service providers, state and local veteran service officers and members of veteran service organizations. All have a common goal to help that veteran obtain needed health care and benefits assistance. Our staff goes to shelter, soup kitchens, food pantries, transitional housing program, under bridges, into parks; into the woods and other places where veterans are likely to seek shelter or daily living assistance. Each year between our outreach and health care services we engage more than 100,000 of these veterans.

VA staff participated in the Stand Downs for Homeless Veterans run by local coalitions in various cities each year. Stand Downs give homeless veterans 1–3 days of safety and security where they can obtain food, shelter, clothing, and a range of other types of assistance, including VA provided health care, benefits certification, and links to other programs.

Homeless veterans coordinators provide dedicated outreach, benefits counseling, referral, and additional assistance to eligible veterans applying for VA benefits. These homeless veterans coordinators make over 4,700 visits to homeless facilities and over 9,000 contacts with non-VA agencies working with the homeless and provide over 24,000 homeless veterans with benefits counseling and referrals to other VA programs on an annual basis.

Question 4: What do you believe is the single biggest challenge facing the Department in addressing the homeless veteran issue?

Response: Engaging that veteran who want and needs our assistance to participate is a major challenge. While that may sound simple many veteran are reluctant due to bad information and mental illness to engage in active treatment. That also creates pressure on us to continue to provide a comprehensive array of needed services: outreach; residential care; robust access to mental health and substance abuse and benefit assistance. That is why we constantly strive to improve our services at all levels at all locations.

Question 5: Can you name three things that we have learned over the last 20 years of running homeless programs that may help us to prevent an epidemic of homeless OEF/OIF veterans?

Response: Early intervention; comprehensive health care and benefits; transitional and long term housing with services is a key to getting veterans healthy and preventing homelessness.

Question 6: It is my understanding that many of the community-based providers do not have accommodations for women with children. Yet, many of our newest veterans are women who have served in combat or combat like conditions. Many of our women veterans have children. What positive steps is the agency taking to address the growing homeless women veteran population?

Response: For the past 5 years VA has targeted funding under our notices of funding availability (NOFA) for programs that provide transitional housing for women veterans. The NOFA that is being reviewed has that same targeting mechanism. We recognize that many women veterans are uncomfortable in male dominated programs. Based upon feedback from veterans we believe women only programs are effective. We have enhanced physical security and privacy for women in our residential treatment programs. The new HUD–VASH program that will offer permanent housing to more than 10,000 homeless veterans. That housing has a target to find women veterans including women veterans with children. We believe HUD–VASH will allow us to serve women who are more likely to have children. Our experience shows these veterans are reluctant to seek services from VA until the needs of their children are addressed.

Question 7(a): VA recently reported that there has been a decline in the homeless veteran population of 21 percent. You are to be commended on that. I know

many people work very hard for this cause. VA attributed some of the decline to the effectiveness of current programs and some of it was attributed to other factors such as counting methods. What definition does VA use to determine if a veteran is considered homeless?

Response: VA defines homeless veterans as a category of people who meet the criteria as a veteran under title 38 and who lack housing and food, usually because they cannot afford a regular, safe, and adequate shelter. This may also include veterans whose primary nighttime residence is a homeless shelter.

Question 7(b): Please explain to the Committee how the methodology with this count differed from the last one.

Response: The previous counts lacked a consistent nationwide methodology which was one of the problems that result in reliability issues with these counts. Our efforts each year are to develop consistent methodologies and to develop as precise a count as possible. For example our earlier reports did not have a point in time estimate and lacked the comprehensive data now collected by HUD. The methods used to arrive at the number of homeless veterans in the Nation, employ the following elements:

1. Each VA local point of contact (POC) for Project CHALENG are tasked to develop the best estimate of homeless veterans locally in their service areas based on a variety of data available.
2. Each POC was directed to use as a standardized reference the local HUD Continuum of Care count, with specific reference to the percentage of homeless veterans.
3. For the CHALENG estimates, POCs adjusted the HUD numbers, if needed, by taking into account input from community sources, local surveys, community leaders, and their own knowledge of veterans not covered within their service area by the HUD count.

Question 7(c): Is the decline indicative of the percent of formerly homeless veterans who now have jobs and are productive citizens?

Response: The 2007 CHALENG Report estimates that on any given night, approximately 154,000 veterans were homeless. This figure is a decrease of 21 percent from the estimate 195,827 given in the 2006 CHALENG report. This decline is in part a result of more precise estimates. VA homeless program interventions and changing demographics also contributed to this decline.

Reductions in veteran homelessness are also due in part to the effectiveness of VA's and other community programs that serve homeless veterans reaching more veterans than ever before. VA's Grant & Per Diem (GPD) program, which had just begun in the mid-nineties, has over 8500 operational beds today; 15,000 veterans were provided homeless residential services and an additional 5000 plus veterans were treated in specialized VA homeless domiciliary residential care programs in FY 2007. These programs have demonstrated remarkable success at placing and keeping veterans in community housing. Some of which have employment and others are receiving government financial assistance.

The overall population of veterans continues to decline as the World War II; Korean and Vietnam veterans' age. In 1990, there were 27.5 million veterans, a total that has decreased to 24 million today. Similarly, there has been a substantial reduction in the number of poor veterans, decreasing from 3 million in 1990 to 1.8 million in 2000.

Questions for the Record
From the Honorable Ciro D. Rodriguez

Question 1: Why did the Department of Veterans Affairs recently change its methodology for counting homeless veterans?

Response: Counting the number of homeless people, specifically the number of homeless veterans, is a difficult task. There have been few systematic, national efforts to count the homeless. Prior to 2005, the most highly regarded effort took place in 1996, the National Survey of Homeless Assistance Providers and Clients (NSHAPC). In 2005, Housing and Urban Development (HUD) began organizing comprehensive, national counts of homeless persons. This year, for the first time, Community Homeless Assessment, Local Education and Networking Groups for Veterans (CHALENG) points of contact (POCs) were asked to provide a point-in-time estimate of the homeless veterans in their service area on any day during the last week of January 2007. This time period was selected so CHALENG estimates would

coincide with the homeless point-in-time counts executed by HUD Continuums of Care nationwide. It is believed that CHALENG should make every effort to base their estimates on the local point-intime count, as it is the only nationwide homeless count conducted on an ongoing basis. In response to your inquiry about the methods used to arrive at the number of homeless veterans in the Nation, the following are the elements employed. Each VA local POC for Project CHALENG each year is tasked to develop the best estimate of homeless veterans locally in their service areas based on a variety of data available.

1. Each POC was directed to use as an important reference the estimated local HUD Continuum of Care count, with specific reference to the percentage of homeless veterans.
2. For the CHALENG estimates, POCs adjusted the HUD numbers, if needed, by taking into account input from community sources, local surveys, community leaders, and their own knowledge of veterans not covered within their service area by the HUD count.

Comprehensively using the HUD Continuum of Care counts as a standardized reference has helped to improve our CHALENG estimates. We do not believe that our methodology has really changed just incrementally improved.

Question 2: Is there a possibility that the marked decrease in homeless veterans from last year to this year had anything to do with the change in methodology?

Response: The 2007 CHALENG Report estimates that on any given night, approximately 154,000 veterans were homeless. This figure is a decrease of 21 percent from the estimate 195,827 given in the 2006 CHALENG report. We believe that improvements in methodology may a have contributed to the reduction in numbers, but we also believe the validity of the numbers has increased.

VA homeless program interventions and changing demographics also contributed. Reductions in veteran homelessness are due in part to the effectiveness of VA's and other community programs that serve homeless veterans reaching more veterans than ever before. VA's Grant & Per Diem (GPD) program, which had just begun in the mid-nineties, has over 8500 operational beds today; 15,000 veterans were provided homeless residential services and an additional 5000 plus veterans were treated in specialized VA homeless domiciliary residential care programs in FY 2007. These programs have demonstrated remarkable success at placing and keeping veterans in community housing.

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