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Report to the Chairman, Committee on Veterans' Affairs, U.S. Senate

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HOMELESS VETERANS

VA Expands Partnerships, but Homeless Program Effectiveness Is Unclear



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The Honorable Arlen Specter
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

Homelessness in the United States is a complex and difficult problem. The exact number of homeless is unknown, but on any given night an estimated 500,000 to 600,000 homeless people live on the streets or in shelters.[1] The Department of Veterans Affairs (VA) reports that approximately one-third of the adult homeless population are veterans, and these homeless veterans suffer with about the same relatively high rates of psychiatric and substance abuse disorders as the general homeless population. Over the past decade or so, VA established programs to address the needs of homeless veterans and, in fiscal year 1997, obligated approximately $84 million on targeted homeless programs. Other federal departments and agencies have also developed programs aimed at assisting the homeless. In fiscal year 1997, the Departments of Education, Health and Human Services (HHS), Housing and Urban Development (HUD), Labor, and VA, and the Federal Emergency Management Agency obligated approximately $1.2 billion on targeted homeless assistance.

Despite these programs, homelessness remains a persistent problem, prompting questions about the effectiveness of efforts to assist the homeless. For this reason, you asked us to (1) describe VA's homeless programs, (2) determine what VA knows about the effectiveness of its homeless programs, and (3) examine promising approaches aimed at different groups of homeless veterans.

To develop this information, we conducted work at VA headquarters and VA's Northeast Program Evaluation Center (NEPEC) in West Haven, Conn. We also reviewed reports from federally funded research and visited VA and community-based homeless programs that illustrate approaches to dealing with different homeless populations in Little Rock, Ark.; Denver, Colo.; Washington, D.C.; West Los Angeles and San Diego, Calif.; and New York, N.Y. We performed our work between April 1998 and January 1999 in accordance with generally accepted government auditing standards. (App. I contains a more detailed discussion of our scope and methodology,

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

and app. VI contains detailed descriptions of programs we visited that were designed for different homeless groups.)

Results in Brief

VA's homeless assistance and treatment programs address diverse needs of homeless veterans by providing services such as case management, employment assistance, and transitional housing. VA also provides medical, mental health, substance abuse, and social services to homeless veterans through its hospitals, outpatient clinics, and other health care facilities. Because of resource constraints and legislative mandates, VA expanded its homeless veterans efforts by better aligning itself with other federal departments, state and local government agencies, and community-based organizations. For example, in 1994, VA implemented a strategy that encourages its homeless staff to work more closely with community-based homeless organizations. The goal of this effort is to develop a continuum of care for the homeless—that is, to identify or create options for addressing the full array of housing, health, and service needs of this population.

Despite the resources VA has devoted to homeless programs—over $640 million between fiscal years 1987 and 1997—VA has little information about the effectiveness of its homeless programs. VA has relied on NEPEC to gather and report information about its homeless programs. Each of VA's homeless program sites routinely submits extensive data, mostly related to client characteristics and operations at individual program sites. These data are used primarily to provide program managers with information about service delivery and are of limited use in assessing program effectiveness. To evaluate effectiveness, information must be gathered about intended program results. The outcome measures that NEPEC uses focus on housing, employment, and changes in substance abuse and mental health at the time veterans are discharged from VA's homeless programs. Little is known about whether veterans served by VA's homeless programs remain housed or employed, or whether they instead relapse into homelessness. For this reason, we are recommending that VA initiate program evaluation studies designed to clarify the effectiveness of their homeless programs.

Many questions about how to treat homelessness remain unanswered. Experts agree, however, that a comprehensive continuum of care for the homeless—such as that which VA is striving to achieve—should include a range of housing and service alternatives, with specific approaches at any one site reflecting local needs and local resources. Some promising

approaches address the needs of different groups of the homeless. For example, some homeless veterans have medical conditions that, while not serious enough to require hospitalization, are likely to worsen if the individuals are not in a stable environment; programs in Washington, D.C., and Los Angeles address this need for convalescent care. Seriously mentally ill homeless persons can be among the most difficult to help; programs in New York City and San Diego, however, are showing promise. Projects like these target the needs of specific components of the homeless population and vary to include services for medical, mental health, substance abuse, or other problems depending on the population's specific needs.

Background

In July 1987, the Congress responded to the problems of homelessness by enacting several laws addressing different aspects of the problem. The most comprehensive of these was the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77). Combined, the more than 20 McKinney Act grant programs funded activities that provided homeless men, women, and children with supportive services such as emergency food and shelter, surplus goods and property, transitional housing, primary health care services, and mental health care.[2] The remaining McKinney Act grant programs and authorities are administered by five different departments—Education, HHS, HUD, Labor, and VA—and one agency, the Federal Emergency Management Agency. Since fiscal year 1987, federal funding for targeted homeless assistance has increased dramatically, from $490 million to more than $1.2 billion in fiscal year 1997.[3]

Veterans constitute about one-third of the homeless adult population in the United States on any given day. They form a heterogeneous group and are likely to have multiple needs. For example, VA estimates that approximately one-half of homeless veterans have a substance abuse problem, approximately one-third have a serious mental illness (of those, about half also have a substance abuse problem), and many have other medical problems. Some homeless veterans need assistance in obtaining benefits, managing their finances, resolving legal matters, developing work skills, or obtaining employment. Many require some form of transitional housing before a more permanent housing arrangement can be achieved. For some homeless veterans, independent housing and economic

[2]While authority for most McKinney Act programs has expired, some programs were consolidated and continue to be funded by Congress.

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

self-support are reasonable goals. But for others, including many seriously mentally ill homeless persons, neither full-time work nor independent housing may be feasible. Instead, for these individuals, relative stability in a supportive environment such as a group home may be the most reasonable outcome. Thus, efforts to assist the homeless require a range of housing options (including emergency shelter as well as transitional and permanent housing); treatment for medical, mental health, and substance abuse problems; and supportive services such as transportation and case management. This spectrum of options is referred to as the continuum of care.

Homeless veterans are eligible for health care through the VA by virtue of their status as veterans, but in addition, VA has established programs specifically for homeless veterans. Two major VA homeless programs, Health Care for Homeless Veterans[4] (HCHV) and Domiciliary Care for Homeless Veterans (DCHV), were created as a result of legislative actions taken during 1987 to address the needs of homeless veterans. The goal of these programs is to outreach and identify homeless veterans, assess their needs, and link them with VA or community-based programs for services, as appropriate.

The HCHV and DCHV programs are both managed by the Veterans Health Administration (VHA) but under the auspices of different health care groups within VHA. HCHV programs are under the jurisdiction of VHA's Strategic Health Care Group for Mental Health Services; the DCHV program is directed by VHA's Geriatrics and Extended Care Strategic Health Care Group. VA's annual obligations for its targeted homeless programs increased from $10 million in fiscal year 1987 to approximately $84 million in fiscal year 1997. During this period, VA has obligated over $640 million for its targeted homeless programs. Since the inception of VA's homeless programs, VA has served over 250,000 veterans.

VA's NEPEC monitors and evaluates VA's homeless programs using data it collects and analyzes from program sites. NEPEC generally issues annual reports for VA's homeless programs that include some outcome measures such as whether a veteran is housed or employed upon leaving a program.

With the reorganization of VHA into networks in 1995, headquarters oversight has been decentralized, and control of oversight and funding of the homeless programs has shifted to the local level. Specifically, VA

[4]When established, this was called the Homeless Chronically Mentally Ill (HCMI) program. HCHV is an umbrella term VA uses to (1) describe the targeted homeless programs and (2) avoid use of the term "chronically mentally ill."

organized its health care system to give greater authority and control to 22 Veterans Integrated Service Networks (VISN) and medical center managers. Headquarters program officials have now assumed a largely consultative role. Currently, all 22 VISNs participate in a Council of Network Homeless Coordinators to advise VA headquarters and VISN directors on issues related to the delivery and evaluation of homeless services to veterans.

In its fiscal year 2000 budget request, VA revised its strategic planning and performance measurement processes under the Government Performance and Results Act of 1993 by adding performance measures related to outcomes for veterans served by its homeless programs. These outcome measures, which are already monitored by NEPEC, address the percentage of veterans who have independent living arrangements and employment upon their discharge from VA or from community-based contract residential care programs. Beyond these outcome measures, VA has three process goals: to increase (1) the number of community-based beds for homeless veterans, (2) VA facilities' efforts to coordinate with other providers of homeless services, and (3) the number of homeless veterans treated in VA's health care system.

VA Provides Key Services, Builds Capacity Through Partnerships

VA provides services to homeless veterans through targeted homeless programs across the United States. VA also provides medical, mental health, substance abuse, and social services to homeless veterans through its mainstream health care programs. VA's homeless efforts include services such as outreach activities to identify homeless veterans, residential treatment programs to address clinical disorders, and job counseling and placement assistance to veterans seeking work. However, realizing that it does not have the resources to address all the needs of homelessness alone, VA is working more closely with community-based providers and other organizations to create a continuum of care to improve services for homeless veterans.

VA Provides an Array of Homeless Services

Since establishing its first homeless programs in 1987, VA has expanded its efforts to provide an array of services to homeless veterans. VA initially funded 43 HCHV program sites to contract with community-based providers for residential treatment and rehabilitation of mentally ill (including substance abusing) veterans. VA currently operates 73 HCHV program sites, 62 of which offer residential treatment for the homeless chronically mentally ill (HCMI), generally for less than 6 months. HCHV staff conduct

outreach at community-based homeless service providers such as shelters, soup kitchens, and other places frequented by the homeless.

HCHV staff also serve as case managers for homeless veterans. Case management services are provided to maintain continuity of care and assist veterans in obtaining needed services by referring them to VA and non-VA sources that can address their needs for medical and psychiatric treatment, social and work rehabilitation, income support, housing, and other services. In addition, HCHV staff are responsible for monitoring the services provided each veteran participating in the residential treatment component of the program. During fiscal year 1997, the 73 HCHV program sites served 35,059 homeless veterans.

The HCMI program is the core homeless program under the HCHV umbrella. The service delivery arrangements and treatment received by veterans participating in the HCMI program vary across sites. VA headquarters allows each site some flexibility in operating its program. Arrangements for using community-based residential treatment facilities for care and rehabilitation vary, in part, as a function of the availability of VA and community resources. Accordingly, the HCMI per diem rates paid by VA vary across community-based providers, depending on the type of services and the geographic location. In fiscal year 1997, veterans received treatment for an average of 73 days; the HCMI per diems ranged from approximately $15 to over $70, and the average daily rate was $38.58.[5]

Unlike the HCMI program, which was designed to rely on community-based residential treatment facilities, the DCHV program is primarily housed on the grounds of VA medical centers. Most DCHV program sites are located in existing VA domiciliaries.[6] DCHV is a hospital-based program that uses interdisciplinary treatment to provide services to homeless veterans with varying medical, substance abuse, and mental health problems. The number of DCHV sites has increased from 20 to 35 in the 12 years since the program's inception in 1987.

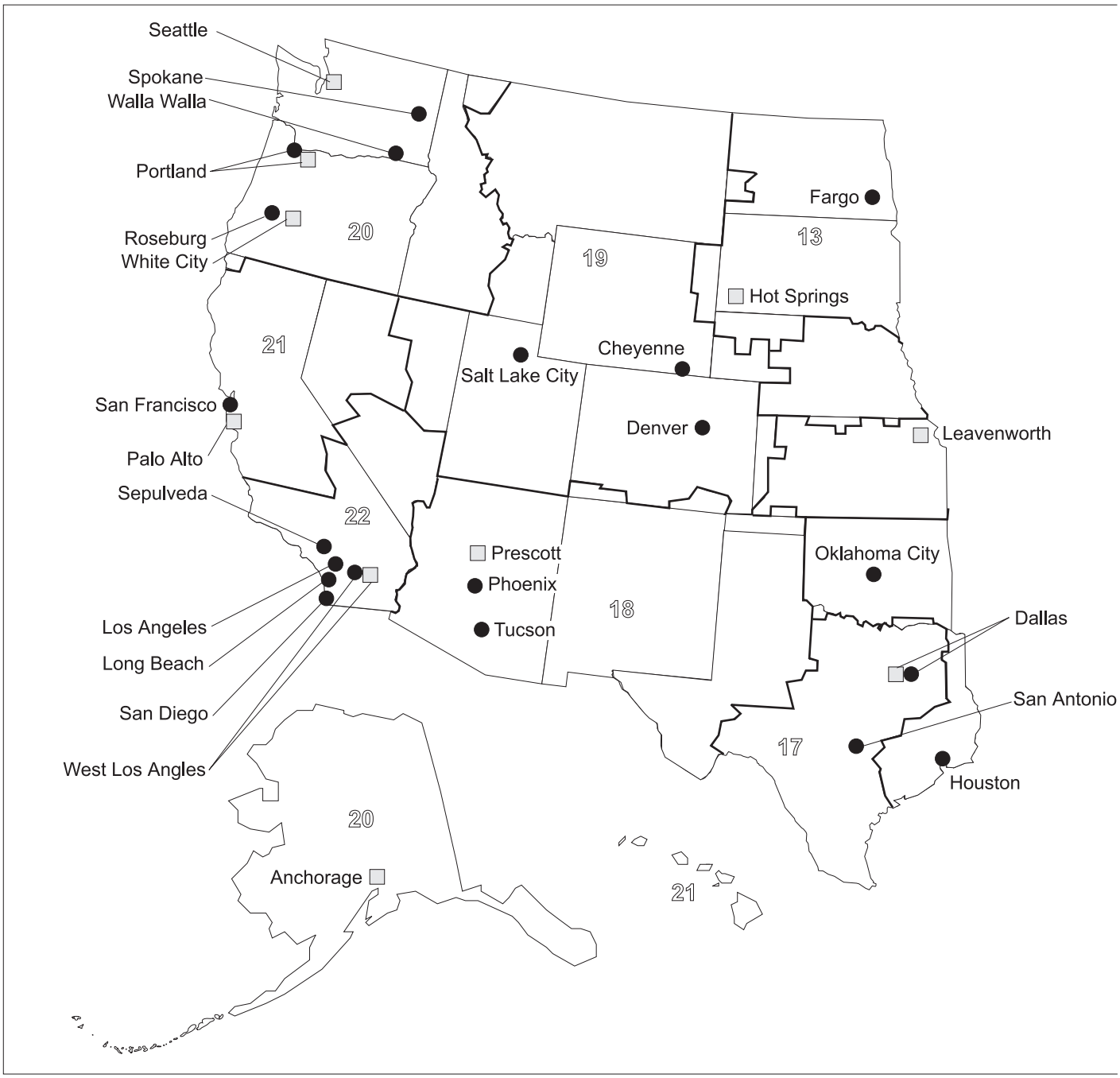
The DCHV program focuses on rehabilitation. Basic services provided by the DCHV program include (1) outreach at some sites to identify underserved homeless veterans, (2) time-limited residential treatment that offers medical and psychiatric services, and job counseling and placement

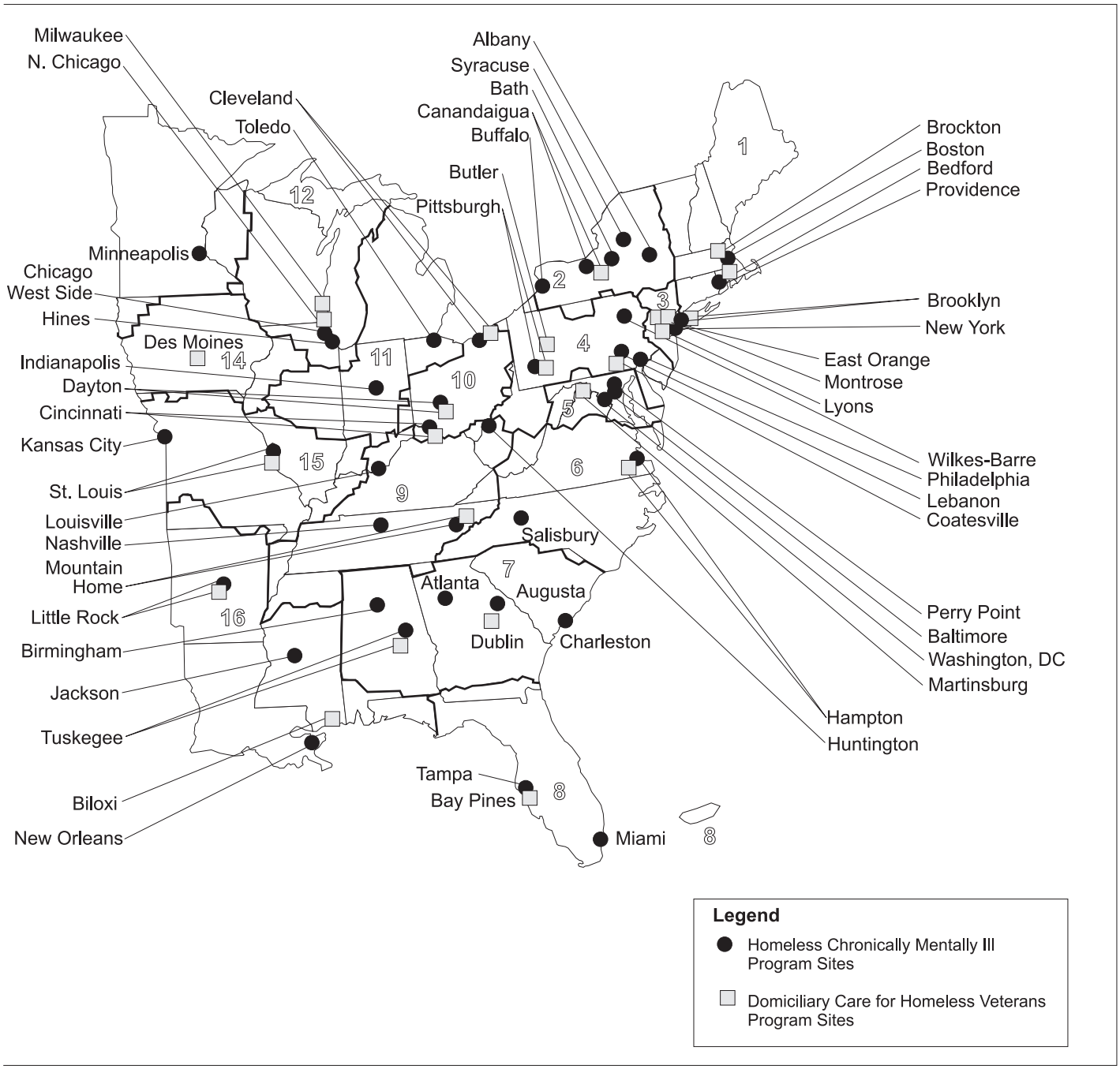
[5]These costs do not include other expenses borne by VA in treating the homeless such as medical, substance abuse, and mental health services provided to veterans participating in the HCMI program.

[6]Domiciliaries provide rehabilitative and long-term health maintenance care for veterans who require minimal medical care but do not need the skilled nursing services provided in nursing homes.

services, and (3) postdischarge community support and aftercare. In fiscal year 1997, the DCHV program discharged 4,619 homeless veterans from treatment in its 1,587 beds nationwide. Veterans received treatment for an average of about 116 days at a cost to VA of approximately $70 per day. The locations of the HCMI and DCHV sites are shown in figure 1. (See app. II for a summary of HCHV and DCHV program locations.)

Figure 1: VA's HCMI and DCHV Program Locations




Milwaukee
N. Chicago
Cleveland
Toledo
Albany
Syracuse
Bath
Canandaigua
Buffalo
Butler
Pittsburgh
Brockton
Boston
Bedford
Providence
Minneapolis
Chicago
West Side
Hines
Brooklyn
New York
Des Moines
Indianapolis
Dayton
Cincinnati
East Orange
Montrose
Lyons
Kansas City
St. Louis
Louisville
Nashville
Mountain
Home
Little Rock
Wilkes-Barre
Philadelphia
Lebanon
Coatesville
Salisbury
Atlanta
Augusta
Perry Point
Baltimore
Washington, DC
Martinsburg
Birmingham
Dublin
Charleston
Jackson
Tuskegee
Hampton
Huntington
Tampa
Bay Pines
Biloxi
New Orleans
Miami
1
2
3
4
5
6
7
8
9
10
11
12
14
15
16
Legend
Homeless Chronically Mentally Ill Program Sites
Domiciliary Care for Homeless Veterans Program Sites

Over time, VA has developed new programs and approaches to complement the HCMI and DCHV programs and provide services that are more integrated, longer term, and more intensive (see table 1). For example, homeless veterans participating in VA's Supported Housing program are provided on-going case management services by HCHV staff for an extended period. Moreover, these efforts involve partnerships with other federal agencies to assist homeless veterans in obtaining housing and other benefits. (See app. III for more information about these homeless assistance and treatment programs and the other approaches VA uses to assist homeless veterans.)

Table 1: Additional HCHV Homeless Programs

HCHV Outreach	The HCHV outreach program is similar to the HCMI program except it does not include the residential treatment component. VA staff identify homeless veterans and help them obtain services that address their needs.
Homeless Compensated Work Therapy (CWT)	CWT provides veterans with therapeutic work opportunities to develop or improve work habits and job skills, and earn income.
Homeless Compensated Work Therapy/Transitional Residence	In a few locations, VA has purchased houses or arranged housing for homeless veterans participating in CWT.
Homeless Providers Grant and per Diem (GPD)	The GPD program awards funds to local organizations to develop transitional housing or other supportive services to homeless veterans.
Housing and Urban Development–VA Supported Housing (HUD-VASH)	The HUD-VASH initiative combines agency resources to provide independent housing for veterans. Qualified veterans are issued HUD section 8 housing vouchers; they must agree to VA case manager involvement while they are adjusting to living independently.
Supported Housing (SH)	This multifaceted program varies in how it is implemented at HCHV program sites. In general, HCHV staff help homeless veterans reintegrate into local communities.
Social Security Administration-VA Joint Outreach Initiative (SSA-VA)	SSA-VA is another example of two federal agencies working collaboratively to assist homeless veterans. The primary goal of this program is to assist eligible veterans in filing and expediting benefit claims.
Veterans Benefits Administration Outreach (VBA)	The VBA outreach initiative is an example of two divisions within VA working together to identify and assist homeless veterans who may be eligible for VA pension and other benefits.

VA's Role in Providing Health Services

While VA has expanded its homeless programs and community partnerships, it continues to be a provider of medical, mental health, and

substance abuse services to homeless veterans through its general health care programs. Although VA does not know the extent to which its annual health care appropriations are spent on medical care and other treatment services for homeless veterans, recent estimates suggest that the amount spent on these health care services far exceeds the approximately $84 million VA used for its targeted homeless programs. NEPEC estimated that in fiscal year 1995 VA spent $404 million on inpatient general psychiatry and substance abuse services for homeless veterans, representing approximately 26 percent of all inpatient VA mental health expenditures. Cost estimates are unavailable for other health care expenditures, but NEPEC estimated that homeless veterans occupied 5 percent of the inpatient medical and surgical beds during fiscal year 1996. Moreover, these estimates do not account for primary care and other outpatient medical services rendered to homeless veterans at VA's 173 hospitals and over 400 outpatient clinics nationwide.

VA Homeless Programs Exist at Selected Locations With Limited Capacity

Although VA has developed a number of programs to assist homeless veterans, VA acknowledges that it alone cannot meet all their needs. These programs are not available in all locations and, where available, capacity for residential treatment is limited.

VA's homeless programs are available at selected locations. HCMI and DCHV homeless program sites were established on a voluntary basis; interested medical centers submitted proposals and those ranked highest by VA headquarters were initially funded. VA's homeless programs vary dramatically in terms of the number of sites available to treat homeless veterans. For example, VISN 3 is the only network to have at least one site for each of VA's homeless programs. As shown in table 2, the number of sites provided by each of VA's programs ranges from 4 to 62.[7]

[7]Homeless Providers Grant and per Diem recipients are not included in this analysis.

Table 2: VA's Homeless Program Sites by VISN

VISN	HCMI[a]	DCHV[b]	HUD-VASH[c]	SH[d]	CWT[e]	VBA[f]	HCHV (O/R)[g]	CWT-TR[h]	SSA-VA[i]	Total program sites
1	1	2	2	3	2	1	2	1	0	**14**
2	5	1	3	2	1	0	0	1	0	**13**
3	3	3	2	3	1	2	1	1	2	**18**
4	4	3	0	3	1	1	0	1	0	**13**
5	3	2	1	0	1	1	0	1	0	**9**
6	2	1	1	0	0	0	0	0	0	**4**
7	5	2	1	0	2	0	0	1	0	**11**
8	2	1	3	1	1	0	0	0	0	**8**
9	4	1	1	0	0	0	0	0	0	**6**
10	3	3	2	0	0	1	1	0	0	**10**
11	2	0	1	2	0	1	2	0	0	**8**
12	2	2	1	4	2	2	2	0	0	**15**
13	2	1	0	0	1	1	0	0	0	**5**
14	0	1	0	0	0	0	0	0	0	**1**
15	2	2	0	1	0	0	0	0	0	**5**
16	5	2	3	2	1	0	0	1	0	**14**
17	2	1	2	0	1	1	0	1	1	**9**
18	2	1	1	1	0	0	0	0	0	**5**
19	3	0	2	0	0	0	0	0	0	**5**
20	4	4	4	3	3	1	2	0	0	**21**
21	1	1	1	0	1	1	0	1	0	**6**
22	5	1	4	1	1	2	1	0	1	**16**
Total	**62**	**35**	**35**	**26**	**19**	**15**	**11**	**9**	**4**	**216**

[a]Homeless Chronically Mentally Ill.

[b]Domiciliary Care for Homeless Veterans.

[c]Housing and Urban Development–VA Supported Housing.

[d]Supported Housing.

[e]Homeless Compensated Work Therapy.

[f]Veterans Benefits Administration Outreach.

[g]Health Care for Homeless Veterans–Outreach.

[h]Homeless Compensated Work Therapy–Transitional Residence.

[i]Social Security Administration–VA Joint Outreach Initiative.

In those locations that have an HCMI or DCHV program, residential capacity is limited. For example, the HCHV site in Washington, D.C.—a city with a homeless veteran population ranging from an estimated 3,300 to 6,700—served 963 homeless veterans during fiscal year 1997, of whom 31 were treated in the HCMI residential component. Of the 30,857 homeless veterans contacted nationwide at the 62 HCHV sites with an HCMI residential treatment program, only 4,317 were placed in VA contracted residential treatment during fiscal year 1997—an average of 70 homeless veterans per site.

Similarly, the DCHV program has limited inpatient capacity. For example, VISN 14, which covers parts of five states, including most of Iowa and Nebraska, has one homeless program: a homeless domiciliary at the Des Moines VA hospital with 20 beds that served 56 veterans during fiscal year 1997. In another instance, VISN 11, which includes urban cities such as Detroit, Mich., and Indianapolis, Ind., has no DCHV beds. In sum, the 35 DCHV program sites operated 1,587 beds and discharged 4,619 veterans from treatment in fiscal year 1997. On average, each DCHV site provided residential care to approximately 132 homeless veterans.

VA Expands Community Partnerships to Serve Homeless Veterans

Over the past 5 years, VA has expanded its commitment to partnering with community-based organizations. This commitment to community-based providers is reflected in VA's long-range strategic planning. One such goal under the Results Act is to maximize participation in Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) by increasing VA medical facility participation to 100 percent by fiscal year 2001. In response to the requirement to encourage coordination in Veterans' Medical Programs Amendments of 1992 (P.L. 102-405), VA homeless staff began holding annual CHALENG meetings to better coordinate with other homeless providers and organizations. For example, in 1997, nearly 2,000 service providers attended CHALENG meetings nationwide and completed surveys about the extent to which specific needs were being met. Once local needs are prioritized, VA collaborates with community providers to resolve any community resource problems. This collaborative effort provides a forum for VA to work with its non-VA partners to assess, plan for, and address the needs of homeless veterans. Since the inception of the CHALENG initiative in fiscal year 1994, most medical centers have participated in the process. In fiscal year 1998, VA reported that 88 percent of its medical facilities conducted their annual CHALENG meetings.

Also, the Congress authorized VA to establish alternative housing programs for homeless veterans through partnerships with nonprofit or local government agencies.[8] As a result, VA created the Homeless Providers Grant and per Diem (GPD) program to award grants and per diem payments to public and nonprofit organizations that establish and operate new supportive housing and services for homeless veterans. Between fiscal years 1994 and 1998, 127 grants were awarded to 103 nonprofit and state or local government agencies, providing in excess of $26 million. Grant moneys have been awarded to recipients in 39 states and the District of Columbia; all 22 VISNs have at least one GPD recipient in their jurisdiction. Once grants awarded during the first 5 years become fully operational, VA estimates that over 2,700 new community-based transitional housing beds will be available for homeless veterans.

Finally, in the Veterans Programs Enhancement Act of 1998, VA received authority to make $100 million in guaranteed loans over a 3-year period to qualified organizations. Most loans will be awarded to construct, rehabilitate, or acquire land for the purpose of providing multifamily transitional housing projects for homeless veterans.

Effectiveness of VA Homeless Programs Is Unclear

Although NEPEC collects extensive data, VA has little information about the effectiveness of its homeless programs. Homeless program sites submit primarily descriptive data about veterans and program characteristics. In addition, some outcome data are collected on program participants at discharge. (Outcome data are measures of a veteran's status upon discharge from a homeless program, including housing, employment, and changes in substance abuse and mental health.) These data are of limited use in assessing program effectiveness, however, because no follow-up information is obtained after a veteran is discharged from a residential or DCHV treatment program. As a result, VA does not know whether veterans served by its homeless programs remain employed or stably housed.

Program Data Focuses on Descriptive Characteristics, Status at Discharge

NEPEC collects and analyzes extensive descriptive information regarding program structure, veteran characteristics, program processes, and status at discharge for specific sites. Program managers use this information to monitor and compare program sites. For all measures except those involving status at discharge, the HCHV and DCHV programs use the average performance for all of their respective sites as the norm for evaluating each site. To account for homeless veterans who are particularly difficult

[8]The Homeless Veterans Comprehensive Service Programs Act of 1992 (P.L. 102-590).

to treat, data regarding status at discharge are adjusted for patient characteristics that influence treatment results, such as age or number of medical problems. Our analyses focused on the DCHV and HCHV programs because they are the two main components of VA's homeless programs.

NEPEC monitors the 62 HCMI sites that contract with community-based programs to provide residential treatment to homeless veterans. NEPEC collects data obtained upon initial contact with homeless veterans and at the conclusion of a veteran's participation in the HCMI program. From these data, 32 indicators have been selected as "critical monitors" of site performance. These measures reflect four different categories of information about sites: (1) program structure (for example, the average number of days veterans spend in residential treatment and the average number of unique veterans served by each clinical staff member); (2) patient characteristics (for example, the percentage of veterans served who were not literally homeless[9] at the time of intake and the percentage of veterans served who were diagnosed with a serious mental illness or substance abuse disorder[10]); (3) program process measures which indicate how the program operates (for example, percentage of veterans served who were contacted by outreach and the percentage of veterans inappropriately placed in residential treatment[11]); and (4) status at discharge (for example, percentages of veterans who report being housed and employed at discharge). Appendix IV contains a complete list of the 32 HCHV critical monitors.

In fiscal year 1997, 35,059 veterans were served through HCHV programs. Of the 3,883 veterans discharged from residential treatment facilities in fiscal year 1997, 52 percent were considered to have successfully completed the program (that is, the veteran and clinician agreed that program goals had been met); 39 percent reported having their own apartment, room, or house at discharge; 43 percent reported having full- or part-time employment at discharge; 73 percent were rated as showing improvement in drug problems; and 74 percent were rated as showing improvement in mental health problems. Under most circumstances, NEPEC data regarding status at discharge are obtained from veterans who have completed

[9]VA's homeless programs occasionally serve veterans who are not literally homeless, but are instead at risk of homelessness or are without secure housing, for example, living temporarily with friends.

[10]NEPEC classifies psychoses, mood disorders, and post-traumatic stress disorder (PTSD) as a serious psychiatric problem and dependency on alcohol or drugs as a substance abuse problem.

[11]NEPEC classifies veterans with an income of $1,000 or more per month; who have their own apartment, room, or house; or who are without serious psychiatric or substance abuse problems as inappropriate for HCMI placement.

residential treatment. In some cases, however, HCMI pays for only part of a veteran's residential treatment program, and the veteran remains in treatment after discharge from the HCMI program. In these instances, the veteran's status upon completion of residential treatment (which may occur some time later) is not captured in the NEPEC data.

NEPEC also monitors the performance of the 35 DCHV sites using data gathered when veterans are admitted to the program and their status at the time of discharge. These measures reflect four different categories of information about the DCHV sites: (1) program structure (assessed solely by the annual turnover rate); (2) veteran characteristics (for example, the percentage of veterans who entered the program from the community and the percentage of veterans who were living outdoors or in a shelter prior to admission); (3) program participation (for example, the average length of stay and the percentage of veterans who completed the program); and (4) status at discharge (for example, percentages of veterans who are housed and employed at discharge). The 20 DCHV critical monitors are contained in appendix V.

In fiscal year 1997, the DCHV program discharged 4,619 veterans after an average length of stay of about 116 days. NEPEC reported that 62 percent successfully completed the program, 57 percent were housed at discharge, 52 percent had full- or part-time employment at discharge, 79 percent were rated as improved in alcohol problems, 79 percent were rated as improved in drug problems, and 75 percent were rated as improved in mental health problems.

Limited Information Available About Program Effectiveness

Because information is not obtained after veterans leave treatment, VA cannot determine whether its homeless programs are effective over the long term. Moreover, NEPEC has only limited information about what aspects of its programs are most beneficial for certain veterans. Finally, NEPEC has little information about whether its programs are more beneficial than other strategies for helping the homeless. Evaluation research (including follow-up) is difficult and expensive to conduct on this hard-to-serve population. However, VA's fiscal year 2000 budget request contains an additional $50 million to expand VA's homeless programs and monitoring and evaluation efforts.

VA has acknowledged the need for program evaluation and now includes a plan for program evaluation in its strategic plan. However, NEPEC officials told us that their primary emphasis is to monitor the performance of

program sites, rather than to evaluate the effectiveness of treatments or programs. These monitoring activities provide information about program operations. As a result, NEPEC does not typically examine outcomes in a way that clarifies what aspects of treatment are associated with positive results for different clinical groups (for example, those with serious mental illnesses or those with a substance abuse disorder). NEPEC officials periodically supplement their data files with additional information (for example, about treatment approaches) and then conduct analyses that distinguish clinical subgroups. These findings are often published in academic journals. For example, one study looked at outcomes for dually diagnosed veterans (that is, those with both a serious psychiatric disorder and a substance abuse problem), comparing those in programs that specialize in substance abuse treatment with those treated in integrated programs that simultaneously address both psychiatric and substance abuse problems. Although differences between the two types of programs were modest, results suggested that those in integrated treatment programs were more likely than those in the substance abuse programs to be discharged to housing in the community rather than to an institutional setting.

Currently, NEPEC does not conduct follow-up of veterans who have left the DCHV or HCMI programs. Follow-up is needed to determine whether veterans are still employed, housed, or successfully dealing with substance abuse or mental health problems after program completion and thereby to estimate the duration of any positive effects. Other research efforts involving the homeless that have included follow-up data suggest that positive outcomes observed at discharge are not necessarily sustained.

Between 1987 and 1990, in order to evaluate the benefits associated with program participation, NEPEC conducted pilot follow-up projects at nine HCMI and three DCHV sites. NEPEC reported that veterans were substantially better off 3 months after discharge from DCHV treatment than when they were admitted to the program. Improvements were noted in housing, income, employment, substance abuse, and psychiatric functioning. Similarly, veterans who participated in the HCMI study exhibited improvements on follow-up (assessed from 1 month to 2 years after intake, with an average of 8.3 months) compared with intake in housing, employment, psychiatric problems, and substance abuse. For example, 73 percent of the veterans reported that they had spent no days homeless during the 90 days prior to their interview. The HCMI study stated that veterans derived substantial benefit from their participation in this program.

While these follow-up studies were a major undertaking, NEPEC reports on these studies cite two major shortcomings. First, interview data were not collected from a fully representative sample. Of veterans who agreed to participate in these studies, follow-up interviews were conducted with 67 percent in the DCHV study and 72 percent in the HCMI study. Although the status of those veterans who were not reinterviewed is not known, it cannot be ruled out that the veterans who were doing the poorest were also the least likely to be reinterviewed. As a result, the data from those who were reinterviewed could suggest more positive outcomes than is true for the program as a whole. Second, no control or comparison groups were studied. Data from such groups would allow an estimate of the degree of improvement attributable to the DCHV or HCMI programs. In other words, it is possible that some of the improvements noted among those veterans who were reinterviewed would have occurred in the absence of DCHV or HCMI treatment. Research suggests that some improvement over time is likely among the homeless even in the absence of intensive treatment. Without data from an appropriate comparison group of veterans who were not served through VA's homeless programs, VA cannot determine how much additional benefit the veterans derived from those programs.

NEPEC officials stated that they have not conducted additional follow-up studies on the HCMI and DCHV programs because such information is difficult and expensive to obtain on this hard-to-serve population.[12] A NEPEC official estimated that if they were to conduct another follow-up study for the HCMI program, the cost would be about $60,000 per site with an approximate annual total cost of $600,000.

Limited Data but Some Approaches for Different Groups Appear Promising

Approaches to homelessness vary with the needs (for example, medical, mental health, substance abuse, or other problems) of the subgroup being served. Although many questions about how to help the homeless remain unanswered, a series of research initiatives launched in 1982 and funded primarily by HHS have begun to shed light on the issues; and initial findings from a few projects are promising.[13] These efforts suggest that effective

[12]Veterans who have participated in the Compensated Work Therapy/Transitional Residence, HUD-VASH, and VA Supported Housing programs, which are smaller VA homeless programs, are reinterviewed periodically, and the HUD-VASH program is being compared to case management and HCMI residential treatment.

[13]All programs we visited except the homeless program in New York, N.Y., involved services provided by VA or VA in collaboration with community-based homeless service providers. The research literature reviewed regarding the effectiveness of homeless programs was largely funded through grants from HHS or Labor.

interventions for the homeless involve comprehensive, integrated treatments. These initiatives also suggest that a range of housing, treatment, and supportive-service options need to be included within a continuum of care for the homeless.

As early as 1982, but particularly in response to the McKinney Act in 1987, HHS funded several major research initiatives to learn more about homelessness in general and about treatments for the mentally ill or substance abusing homeless in particular. These efforts involved epidemiological studies to identify the homeless and their needs, demonstration projects to explore promising strategies for helping the homeless, and outcome evaluations to assess the effectiveness of selected programs. Cross-site analyses addressed overarching questions; and procedures for sharing information, such as conferences and an information clearinghouse, were established. Many questions remain unanswered, but several broad themes have emerged from these efforts. In addition, these research programs indicate that although it can be difficult to study homeless populations, such research can be done and can include follow-ups.

This body of research indicates that effective treatment for the homeless requires comprehensive, integrated services. Although meeting the most basic needs of a homeless person for food, clothing, and shelter is a first step, it is rarely sufficient to enable a person to exit homelessness. Instead, progress in achieving housing stability requires comprehensive attention to the full range of a homeless person's needs, addressing basic needs (such as shelter, food, and clothing), medical and mental health needs (including dental and eye care), and supportive services (such as transportation, assistance in obtaining benefits, and child care if necessary). Thus, as examples, untreated mental illness may interfere with a person's ability to retain housing, and lack of transportation may limit access to medical appointments or job interviews.

Moreover, research suggests that positive outcomes are promoted by integration of services. Attempts to address the needs of a homeless person one by one, or in parallel but without coordination, seem less effective than strategies that involve integrated efforts to address multiple needs. For example, homeless persons who have both a mental illness and a substance abuse problem seem to benefit more from integrated treatment programs than from programs that approach these problems separately. Similarly, the effectiveness of employment and training programs for the homeless is enhanced by linkage to housing assistance

and supportive services. The importance of integration is attributable in part to fragmentation of the homeless service-delivery system, so that addressing a homeless person's needs often requires multiple organizations. Case managers may facilitate integration by helping the homeless obtain services in ways that complement rather than conflict with one another. In addition, organizations that serve the homeless may collaborate to promote integrated, comprehensive service provision.

At least one-third of homeless veterans have a serious mental illness. These disorders are more common among the homeless, and particularly among the episodically and chronically homeless, than among those who are domiciled. Disorders such as schizophrenia or severe depression can have markedly disabling effects on multiple aspects of a person's life, including employment, housing stability, interpersonal relationships, and physical health. Specific psychiatric symptoms vary across disorders, but these illnesses often involve impairments in judgment, motivation, and cognitive and social skills, difficulties that not only contribute to housing instability but also limit the person's ability to obtain treatment. Because of their impairments, the seriously mentally ill homeless may find it particularly difficult to negotiate the complexities of a fragmented service delivery system. Several researchers have focused on outreach and case management strategies for this homeless subgroup, finding that the seriously mentally ill homeless can be helped through such strategies.

Some seriously mentally ill persons are able to function well, typically with the aid of psychiatric medication, but others face recurrent or persisting difficulties even with medication. Neither independent housing nor full-time work may be reasonable goals for some of these persons. Instead, a successful outcome might involve increased housing stability (perhaps in a group home), fewer and shorter psychiatric hospitalizations, and improved daily living skills. Thus, homeless services are often targeted to helping the homeless maximize self-sufficiency, which may or may not mean achieving economic or housing independence.

About half of homeless veterans have a substance abuse problem, whether a cause or consequence of homelessness, which makes intervention more complicated. Several studies have suggested that housing and employment stability are impeded by ongoing substance use, and many housing options for the homeless require abstinence. On the other hand, many homeless substance abusers are initially unwilling to accept the goal of sobriety, although they may be willing to accept substance abuse treatment once some of their other needs are met. Thus, low-demand alternatives to the

street (such as safe havens) have been advocated as a necessary part of a full continuum of care for the homeless.

Although research has not yet determined what specific strategies are most effective with homeless substance abusers, initial findings suggest that drop-out rates are often high and the gains made by those who complete treatment programs are not necessarily maintained. Thus, ongoing contact may be necessary for long-term improvement. Too new to have been clearly evaluated, New Directions, associated with the West Los Angeles VA Medical Center, offers substance abuse treatment and job training/job placement services to medically stable substance abusers who do not have serious mental illnesses.

Among the most difficult to treat homeless are those with both a serious mental illness and a substance abuse problem. About one-half of veterans with serious mental illness also have a substance abuse problem. Compared with other homeless persons, these dually diagnosed persons tend to have longer and more frequent episodes of homelessness, are harder to engage and retain in treatment, and require more services.

Nonetheless, early research has indicated some promising approaches for the dually diagnosed homeless. For example, results of a randomized clinical trial of one case management strategy, Critical Time Intervention (CTI), suggested that homelessness was reduced among a group of seriously mentally ill men, many of whom were substance abusers.[14] Compared with a control group of similar homeless men who received services as usual (for example, referrals), CTI was associated with a greater reduction in homelessness throughout a period that included a 9-month intervention phase and a 9-month follow-up phase. As another example, empirical evaluation of a program established by Vietnam Veterans of San Diego for substance abusing veterans, many of whom also suffered from PTSD or depression, yielded positive housing, employment, and substance abuse outcomes at a 6-month follow-up. Some veterans are referred to this program through the San Diego VA Medical Center. Long-term follow-up research with the dually diagnosed homeless suggests that set-backs are not uncommon, but that increases in residential and psychological stability are possible.

[14]Assertive Community Treatment (ACT) is another case management strategy that has yielded promising results for the seriously mentally ill homeless. Neither case management strategy is formally used within the VA system, but VA recently indicated its intention to develop a pilot implementation of CTI.

Medical problems are also common among the homeless, with rates of illness and injury estimated at two to six times higher than among those who are housed. Typical conditions of homelessness—poor nutrition and hygiene; fatigue; and exposure to the elements, violence, and communicable diseases—contribute to poor health and make recovery from illnesses more difficult. Physical illnesses commonly reported among the homeless include respiratory infections, trauma (for example, lacerations, fractures, and burns), hypertension, skin disorders, gastrointestinal diseases, peripheral vascular disease, musculoskeletal problems, and dental and visual problems. Rates of tuberculosis and human immunodeficiency virus (HIV) are higher among the homeless than among the housed. It has been reported that the homeless end up using expensive health care alternatives, including emergency and inpatient services, and mortality rates among the homeless have been estimated to be three to four times higher than in the general population.

Lack of adequate housing can exacerbate illnesses among the homeless. To illustrate this issue, persons with homes can typically deal with acute respiratory infections or chronic disorders such as hypertension or diabetes through a combination of medications, diet, and rest. Those living on the street or in shelters, however, may lack access to appropriate meals, safe storage facilities for medications and medical supplies, or the opportunity for adequate rest. As a result, health may deteriorate, and resultant long-term medical complications may further interfere with the person's ability to exit homelessness. Convalescent care facilities, such as Christ House, a residential treatment facility with which the Washington, D.C., VA Medical Center contracts for services, provide medical care for homeless persons who do not warrant (and are not being considered for) inpatient medical treatment, but whose medical conditions are likely to worsen without proper attention in a stable environment. Haven II, affiliated with the West Los Angeles VA Medical Center, provides short-term housing for veterans who have been discharged from an inpatient medical unit but are still recuperating. Once medically stabilized, homeless persons served by these facilities can be referred to other housing options.

For those homeless individuals who are able to work, research on job training suggests some promising strategies. Services have been provided through the Department of Labor's Job Training for the Homeless Demonstration Program to over 45,000 homeless persons since 1988. More than a third obtained jobs, and half of those were employed 13 weeks later. Results suggest that ongoing case management, work readiness

training, assistance in locating work, and postplacement support are among the elements that contribute to obtaining and maintaining employment. The Welfare-to-Work program at L.A. Vets, associated with the West Los Angeles VA Medical Center, incorporates many of these components.

Experts agree that the continuum of care for the homeless must include a range of housing and treatment options, and that flexibility is needed to match homeless persons to appropriate services. Housing options should include emergency shelter, transitional housing, and permanent housing, all linked to supportive services. Housing and residential treatment programs should include options suitable for mentally ill, substance abusing, dually diagnosed, and convalescent persons. Although relatively few programs for the homeless have been empirically evaluated, the available research includes some promising approaches. Experts also note that attention to the individual's preferences is important, and that failure to acknowledge those choices may reduce the effectiveness of intervention. Because the homeless have diverse needs and local resources vary, flexibility is needed in serving individuals and in arranging partnerships among organizations.

Conclusions

As VA facilities attempt to develop a continuum of care for homeless veterans, variations in local needs and resources will result in different patterns of involvement for VA and its partners. Because homeless veterans differ from one another in their needs, no single treatment program can serve all veterans with equal effectiveness. Recent federally funded research projects suggest there are beneficial long-term effects attributable to certain strategies for serving mentally ill and substance abusing homeless persons, which VA could replicate. Local programs designed to serve these groups are likely to be important components of any continuum of care for the homeless.

To maximize the effectiveness of its homeless dollars, VA should direct its resources to those programs and partnerships that show the greatest potential for increasing housing stability and reducing the risk of reentry into homelessness. Research on program effectiveness can provide the information needed to make decisions about how to direct these resources. To better understand the effects of VA's homeless programs and ways to improve or enhance its programs, a series of program evaluation studies should be conducted to address long-term effects, processes associated with positive outcomes, and program impact. Thus, VA could

design follow-up studies to examine the stability of housing and employment in the year or 2 after program discharge. VA could also undertake outcome evaluations designed to assess program processes to better understand how desirable outcomes are produced. Such studies could identify aspects of treatment that are associated with positive outcomes for veterans with different conditions. Finally, VA could estimate how program outcomes differ from outcomes that would be likely in the absence of the program. For example, results observed for a sample of homeless veterans who received a particular kind of treatment could be compared to a comparable group who did not receive that treatment.

In its fiscal year 2000 budget, VA requested an additional $50 million for its homeless programs and indicated its desire to invest some of those funds in evaluating its homeless programs. Even though evaluation research can be difficult and expensive to conduct, such studies are necessary to ensure that VA directs its resources to those efforts with the greatest potential for beneficial effects.

Recommendation

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health and the Assistant Secretary for Planning and Analysis to collaborate on conducting a series of program evaluation studies to clarify the effectiveness of VA's core homeless programs and provide information about how to improve those programs. Where appropriate, VA should make decisions about these studies (including the type of data needed and the methods to be used) in coordination with other federal agencies with homeless programs, including HHS, HUD, and Labor.

Agency Comments

In commenting on a draft of this report, VA generally agreed with our findings and the thrust of our recommendation. VA suggested, however, that our recommendation be modified to recognize the role of the Assistant Secretary for Planning and Analysis in coordinating the Department's program evaluations under the Results Act. We made this change. VA also identified several recent initiatives and planned actions to evaluate VA's homeless program efforts, which we incorporated into the report. Finally, VA provided other comments regarding technical aspects of the report, which we incorporated as appropriate. (See app. VII for VA's comments.)

Copies of this report are being sent to the Honorable Togo West, the Secretary of Veterans Affairs; Senator John D. Rockefeller IV, Ranking Minority Member, Senate Veterans' Affairs Committee; other interested congressional committees; and interested parties. Copies will be made available to others upon request.

Please contact me on (202) 512-7111 if you have any questions about this report. Other GAO contacts and staff acknowledgments are listed in appendix VIII.

Sincerely yours,



Stephen P. Backhus
Director, Veterans' Affairs
and Military Health Care Issues

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Abbreviations

ACT	Assertive Community Treatment
CHALENG	Community Homeless Assessment, Local Education and Networking Groups
CHC	Comprehensive Homeless Centers
CTI	Critical Time Intervention
CWT	Homeless Compensated Work Therapy
CWT/TR	Homeless Compensated Work Therapy/Transitional Residence
DCHV	Domiciliary Care for Homeless Veterans
GPD	Homeless Providers Grant and per Diem
HCHV	Health Care for Homeless Veterans
HCMI	Homeless Chronically Mentally Ill
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HUD	Department of Housing and Urban Development
HUD-VASH	Housing and Urban Development-VA Supported Housing
NEPEC	Northeast Program Evaluation Center
PTSD	post-traumatic stress disorder
SH	Supported Housing
SSA	Social Security Administration
SSA-VA	Social Security Administration-VA Joint Outreach Initiative
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Networks
VVSD	Vietnam Veterans of San Diego

Scope and Methodology

In conducting our review, we interviewed officials at VA headquarters, Veterans Integrated Service Networks, VA's Northeast Program Evaluation Center, researchers who study homeless issues, and representatives of veterans service organizations. We visited homeless programs at VA medical centers and community-based providers with whom they have partnerships; these sites were in Little Rock, Ark.; Denver, Colo.; Washington, D.C.; Los Angeles, Calif.; and San Diego, Calif. We also visited a community-based program in New York, N.Y., that is not affiliated with VA, and we attended a VA Community Homeless Assessment, Local Education and Networking Groups meeting. We analyzed annual NEPEC reports and other reports and documents relating to VA's homeless programs.

To describe the programs and approaches used by VA to assist homeless veterans, we obtained documents from VA headquarters and NEPEC that identified and provided detailed information about VA's homeless efforts.

To determine what VA knows about the effectiveness of its homeless programs, we reviewed NEPEC reports issued since the inception of VA's homeless programs. NEPEC generally issues annual reports on its two major homeless programs, the Homeless Chronically Mentally Ill (HCMI) and Domiciliary Care for Homeless Veterans (DCHV). We discussed these reports and program effectiveness issues including performance indicators and outcome data with NEPEC staff and VA headquarters officials to better understand how the information is used to monitor and evaluate VA's homeless programs. In addition, as part of our review of NEPEC's reporting system, we evaluated the reliability of NEPEC's data by testing a random sample of 5 percent of 1,059 intake and discharge forms collected during our site visits. We found, based on our limited reliability testing of the data, an error rate of less than one percent.

To identify options or approaches for addressing the needs of specific groups of homeless veterans that VA might replicate we conducted a literature review to clarify issues involving homelessness and identify strategies associated with effective treatment. The data bases scanned included PsycINFO and several bibliographies regarding homelessness (Federally-Sponsored Research Findings on Homelessness and Mental Illness prepared by the National Resource Center on Homelessness and Mental Illness, HHS Publications Related to Homelessness from the Department of Health and Human Services, the National Institute on Alcohol Abuse and Alcoholism's ETOH data base, and relevant bibliographies available through Policy Research Associates, Inc.). The

focus of this literature review was on federally-funded research into interventions for homelessness. We also spoke with experts and visited community-based programs in New York, Los Angeles, San Diego, and Washington, D.C., that serve different subgroups of the homeless.

We reviewed VA's strategic plan for fiscal years 1998 through 2003 and its homeless performance measures in the FY 1997 Performance Measures for VA Homeless Veterans Treatment & Assistance Programs and VHA Directive 96-051, Veterans Health Administration Special Emphasis Programs.

Summary of Domiciliary Care for Homeless Veterans and Health Care for Homeless Veterans Program Locations as of January 1999

Location	1	2	3	4	5	6	7	8	9
VISN 1									
Bedford	✓			✓				✓	✓
Boston		✓			✓				
Brockton	✓								
Providence			✓		✓			✓	
West Haven			✓	✓	✓		✓		
VISN 2									
Albany		✓		✓	✓			✓	✓
Bath		✓							
Buffalo		✓		✓	✓				
Canandaigua	✓	✓							
Syracuse		✓		✓					
VISN 3									
Bronx			✓		✓				
Brooklyn	✓	✓		✓		✓	✓		
East Orange		✓			✓		✓		
Lyons	✓				✓			✓	✓
Montrose	✓								
New York		✓		✓		✓			
VISN 4									
Butler	✓								
Coatesville	✓				✓				
Lebanon		✓						✓	✓
Philadelphia		✓							
Pittsburgh	✓	✓			✓		✓		
Wilkes-Barre		✓			✓				
VISN 5									
Baltimore		✓					✓		
Martinsburg	✓								
Perry Point	✓	✓							
Washington, DC		✓		✓				✓	✓

Location	1	2	3	4	5	6	7	8	9
VISN 6									
Hampton	✓	✓		✓					
Salisbury		✓							
VISN 7									
Atlanta		✓		✓				✓	✓
Augusta		✓							
Birmingham		✓							
Charleston		✓						✓	
Dublin	✓								
Tuskegee	✓	✓							
VISN 8									
Bay Pines	✓			✓					
Miami		✓		✓					
Tampa		✓		✓	✓			✓	
VISN 9									
Huntington		✓							
Louisville		✓							
Mountain Home	✓	✓							
Nashville		✓		✓					
VISN 10									
Cincinnati	✓	✓		✓					
Cleveland	✓	✓		✓			✓		
Columbus			✓						
Dayton	✓	✓							
VISN 11									
Detroit			✓				✓		
Battle Creek			✓		✓				
Indianapolis		✓		✓	✓				
Toledo		✓							

Appendix II
Summary of Domiciliary Care for Homeless Veterans and Health Care for Homeless Veterans Program Locations as of January 1999

Location	1	2	3	4	5	6	7	8	9
VISN 12									
Chicago West Side		✓			✓				
Hines		✓		✓	✓				
Milwaukee	✓		✓		✓		✓	✓	
North Chicago	✓								
Tomah			✓		✓		✓	✓	
VISN 13									
Fargo		✓							
Hot Springs	✓							✓	
Minneapolis		✓					✓		
VISN 14									
Des Moines	✓								
VISN 15									
Kansas City		✓			✓				
Leavenworth	✓								
Saint Louis	✓	✓							
VISN 16									
Biloxi	✓								
Houston		✓		✓	✓				
Jackson		✓							
Little Rock	✓	✓		✓	✓				
New Orleans		✓		✓					
Oklahoma City		✓						✓	✓
VISN 17									
Dallas	✓	✓		✓		✓	✓	✓	✓
San Antonio		✓		✓					
VISN 18									
Phoenix		✓							
Prescott	✓								
Tucson		✓		✓	✓				

Location	1	2	3	4	5	6	7	8	9
VISN 19									
Cheyenne		✓							
Denver		✓		✓					
Salt Lake City		✓		✓					
VISN 20									
American Lake				✓				✓	
Anchorage	✓		✓	✓	✓		✓	✓	
Portland	✓	✓		✓	✓			✓	
Roseburg		✓		✓					
Seattle	✓		✓		✓				
Spokane		✓							
Walla Walla		✓							
White City	✓								
VISN 21									
Palo Alto	✓								
San Francisco		✓		✓			✓	✓	✓
VISN 22									
Loma Linda			✓	✓					
Long Beach		✓							
Los Angeles		✓		✓					
San Diego		✓		✓			✓		
Sepulveda		✓							
West Los Angeles	✓	✓		✓	✓	✓	✓	✓	

Legend

1 = Domiciliary Care for Homeless Veterans
2 = Homeless Chronically Mentally Ill
3 = Health Care for Homeless Veterans–Outreach
4 = Housing and Urban Development–VA Supported Housing
5 = Supported Housing
6 = Social Security Administration–VA
7 = Veterans Benefits Administration Outreach
8 = Homeless Compensated Work Therapy
9 = Homeless Compensated Work Therapy–Transitional Residence

VA Homeless Assistance and Treatment Programs and Other Homeless Approaches

VA Homeless Assistance and Treatment Programs

HCHV Outreach. This initiative is similar to the HCMI program, except that the 11 sites included in this program do not offer the residential treatment component. Moreover, these HCHV outreach sites generally do not provide the array of VA homeless programs typically found at HCHV locations with the HCMI program. Under this initiative, HCHV staff perform outreach activities at locations where the homeless congregate, conduct initial intake assessments, and link clients with appropriate and available VA and non-VA homeless service providers. In fiscal year 1997, the number of veterans served by each outreach site varied between 129 and 680.[1]

Homeless Compensated Work Therapy (CWT). CWT, also known as Veterans Industries, is a work program that provides veterans with job skills development and a source of income. Work is used as a therapeutic tool to help homeless veterans improve their work habits and mental health. While participating in this program, veterans may receive individual or group therapy and follow-up medical care on an outpatient basis. Currently, 19 homeless CWT program locations exist nationwide supported by VA medical centers.[2] In fiscal year 1997, 1,371 homeless veterans were discharged from these programs.

Homeless Compensated Work Therapy/Transitional Residence (CWT/TR). At selected locations, homeless veterans reside in transitional residences while participating in the CWT work program. The transitional residences are community-based group homes; and veterans are required to use a portion of their income from the CWT work program to pay rent, utilities, and food costs. VA owns 15 houses at 9 HCHV program sites which have 142 beds available for homeless veterans while they participate in the CWT/TR program. In addition, VA has contracted with one facility in Washington, D.C., to house 10 veterans. In fiscal year 1997, 132 homeless veterans were admitted to the program, and VA obligated about $3.6 million.

Homeless Providers Grant and per Diem (GPD). This program offers grant moneys, through a competitive process, to homeless providers who construct or renovate facilities for transitional housing or other supportive services to homeless veterans. Over a 5-year period, 127 grants have been awarded, and total VA funding for these projects exceeds $26 million. Upon completion of these projects, over 2,700 new community-based transitional housing beds will be available for homeless veterans.

[1]The costs of operating the HCHV Outreach program are included in the HCHV program allocation.

[2]CWT programs serve homeless and non-homeless veterans alike. Some staff costs are funded by the HCHV program allocation, but total program costs for serving homeless veterans are unavailable.

Housing and Urban Development-VA Supported Housing (HUD-VASH). This interagency housing program combines the resources of HUD and VA to provide homeless veterans with permanent, subsidized housing. Through local housing authorities nationwide, HUD allocates section 8 vouchers for use by homeless veterans. Veterans are required to pay a portion of their income for rent; those without income receive fully subsidized housing. In general, veterans who do not exceed the maximum allowable income can remain in their section 8 housing. Prior to accepting section 8 housing, veterans agree to intensive case management services from VA staff and long-term commitment to treatment and rehabilitation. HUD allocated 1,805 vouchers to local housing authorities; as of September 1998, 1,383 were being used to house former homeless veterans. In fiscal year 1997, VA's cost to support this program was approximately $5 million.

Social Security Administration-VA Joint Outreach Initiative (SSA-VA). This outreach initiative involves the Social Security Administration and VA: staff from both agencies work collaboratively to identify homeless veterans who are eligible for social security benefits but not receiving them. Once veterans are identified, SSA and VA staff take action to expeditiously prepare and process claims so qualified veterans can obtain their benefits as quickly as possible. The SSA-VA initiative currently operates at four HCHV program locations. In fiscal year 1997, 372 applications were filed on behalf of homeless veterans, and 56 awards were received.

Supported Housing. This multifaceted program offers a variety of services that vary among sites. In general, staff provide case management services and assist homeless veterans in locating either affordable permanent or transitional housing. In addition, staff offer practical services to homeless veterans to help them relearn daily living skills such as budgeting, shopping, and cleaning. They also assist veterans with job hunting and developing and maintaining good relationships with family members, neighbors, or others. These staff also serve as a link between homeless veterans and VA. As such, they facilitate care by ensuring that veterans obtain whatever services they need to reintegrate into community living. By the end of fiscal year 1997, 26 supported housing sites existed, situated at 23 HCHV and 3 DCHV program locations. During fiscal year 1997, these 26 sites served 1,688 homeless veterans.[3]

Veterans Benefits Administration Outreach (VBA). VBA staff work with HCHV and DCHV staff to conduct joint outreach, provide counseling, and offer other activities to homeless veterans, for example, helping them apply for

[3]The costs of operating the Supported Housing program are included in the HCHV program allocation.

veterans benefits. One of the goals of this program is to expedite the process for benefit claims of homeless veterans. In fiscal year 1997, 2,893 contacts with homeless veterans were made, and as a result of these contacts, 734 were awarded new benefits.

Other Homeless Approaches

Acquired Property Sales for Homeless Providers. VA properties that are obtained through foreclosures on VA-insured mortgages are available for sale to homeless provider organizations at below fair market value. Some of these properties are also available for lease. Since the inception of this program, 120 properties have been sold or leased.

Comprehensive Homeless Centers (CHC). This initiative is not a program that provides direct services but is rather an effort to develop an integrated and coordinated system of treatment services for homeless veterans. Generally, CHC staff seek to (1) organize and enhance communications and cooperation among the VA homeless programs; (2) cultivate relationships with community-based homeless service providers and organizations; and (3) work with other government entities, including local, state, and federal agencies in the area. These actions help VA and non-VA homeless providers work collaboratively to prevent or eliminate overlap and duplication of efforts, and to streamline the delivery of services to homeless veterans.

Direct Leases With Service Providers on Medical Center Grounds. Where underutilized space exists, VA headquarters has encouraged medical centers to lease property on medical center grounds to homeless service providers.

Drop-In Centers. These daytime centers offer various services in a safe environment. Veterans can generally receive food and have access to showers and washer/dryer facilities. In addition, veterans can participate in therapeutic and rehabilitative activities and receive information about topics such as HIV prevention and good nutrition. The drop-in centers also function as a point of entry for veterans into other VA homeless programs, including those that provide more intensive services.

Psychiatric Residential Rehabilitation and Treatment Program. This program is a 24-hour-a-day therapeutic setting that provides professional support and treatment to chronically mentally ill homeless veterans in need of extended rehabilitation and treatment. There is one funded site in Anchorage, Alaska.

VA Assistance to Stand Downs. Over the past 3 years, VA staff have participated in more than 200 community "stand downs" that serve the homeless. Stand downs are 1- to 3-day events that provide the homeless a safe and secure place to obtain a variety of services such as food, clothing, shelter, and other assistance—including VA provided health care, benefits certification, and linkages with other programs.

VA Surplus/Excess Property for Homeless Veterans Initiative. With support from the General Services Administration and Department of Defense, VA searches for and obtains federal property such as hats, gloves, socks, boots, sleeping bags, furniture, and other items. These items are distributed to homeless veterans and programs that serve the homeless. Over the past 5 years, this initiative has distributed $42.6 million worth of surplus goods.

HCHV Critical Monitors

Structural (quantity or intensity of services provided)	**Length of stay in residential treatment** 1. Mean days in residential treatment. **Trend in veterans treated** 2. Unique veterans served per clinician. 3. Visits per clinician. **Trend in veterans contacted** 4. Difference from previous year of intakes. **Residence at intake** 5. Literally homeless intakes per clinician. **Supported housing workload** 6. Veterans treated per full-time equivalent employee in supported housing.
Patient characteristics (key characteristics of target population)	**Residence at intake** 7. Not strictly homeless. **Length of homelessness** 8. No time spent as homeless. **Trend in length of homelessness** 9. Difference from previous year of not strictly homeless. 10. Difference from previous year of homeless less than 1 month. **Medical and psychiatric indicators** 11. Percentage with serious psychiatric or substance abuse diagnosis. **Trend in psychiatric indicators** 12. Difference from previous year of serious psychiatric or substance abuse diagnosis. **Supported housing: Homelessness at intake** 13. Literally homeless veterans.

(continued)

Process (how the program operates)	**How contact was initiated** 14. Contact through VA or special program outreach. **Trend in outreach indicators** 15. Difference from previous year in contact through outreach. **Selection of veterans for residential treatment** 16. Ratio of veterans with no residence placed in residential treatment versus those not placed. 17. Ratio of veterans with serious psychiatric or substance abuse problems placed in residential treatment versus those not placed. 18. Inappropriate residential treatment. 19. Veterans in hospital day before intake assessment to residential treatment. **Supported housing: Percentage contacted by outreach** 20. VA outreach. **Supported housing: Status of discharges** 21. Mean total days in program.
Outcome (status at discharge from residential treatment)	**Deviation from median performance** 22. Successful completion of residential treatment. 23. Domiciled at discharge. 24. Housed at discharge. 25. Employed at discharge. 26. Improved psychiatric symptoms. 27. Improved alcohol symptoms. 28. Follow-up planned at discharge. **Supported housing: Change in problems at discharge** 29. Improved alcohol problems at discharge. 30. Improved psychiatric problems at discharge. **Supported housing: Status of discharges** 31. Mutually agreed-on termination. **Supported housing outcomes** 32. Discharge to homeless or unknown housing.

DCHV Critical Monitors

Structural	**Turnover rate** 1. Annual turnover rate.
Veteran characteristics	**Method of program contact** 2. Community entry (includes outreach initiated by VA staff and referrals by shelter staff or other non-VA staff). 3. VA inpatient and outpatient referrals (includes referrals from the HCHV program). **Usual residence in month prior to admission to program** 4. Outdoors/shelter. 5. Institution (includes health care facilities and prisons). 6. Own house, room, or apartment. **Length of time homeless** 7. At risk for homelessness (HCHV uses the term “no time homeless”). **Appropriateness for admission** 8. No medical/psychiatric diagnosis.
Program participation	**Length of stay** 9. Mean length of stay. **Method of discharge** 10. Completed program. 11. Asked to leave. 12. Left by choice.
Outcome	**Deviation from median performance** 13. Alcohol problems improved. 14. Drug problems improved. 15. Mental health problems improved. 16. Medical problems improved. 17. Housed at discharge. 18. Homeless at discharge. 19. Competitively employed or in VA’s CWT/TR at discharge. 20. Unemployed at discharge.

Approaches Targeted to Specific Subgroups of the Homeless

Specific approaches within the continuum of care for homelessness vary with the needs of the subgroup being served. These needs may involve medical, mental health, substance abuse, or other problems; and different needs may predominate at different times during an episode of homelessness. We visited collaborative programs that target a range of different groups of the homeless (for example, homeless with substance abuse problems, homeless with serious mental illnesses), thus representing different possible elements in a continuum of care for homeless veterans. Each of the programs we reviewed has the potential to be replicated, and we included two projects that have been empirically evaluated.

Convalescent Medical Care. Christ House (Washington, D.C.) and Haven II (Los Angeles, Calif.) address the need for convalescent medical care among homeless persons who do not warrant (and are not being considered for) inpatient medical treatment, but whose medical conditions are likely to worsen without continued attention in a stable environment.

Christ House in Washington, D.C., is a 34-bed medical recovery facility with a staff that includes nurses, a nurse practitioner, and doctors. Care is provided to homeless persons with a variety of medical problems, such as postsurgical recovery, temporary instability associated with HIV or diabetes, or sickness from chemotherapy. Homeless veterans placed at Christ House through an HCMI contract may stay for several months, receiving medical attention, sobriety support, and social service support as necessary.

Haven II, located on the West Los Angeles VA Medical Center grounds, is a 35-bed step-down care unit run by the Salvation Army. The Medical Center pays a per diem for up to 14 days for ambulatory veterans who have been discharged from an inpatient medical unit, but who are still recuperating and have not yet obtained other suitable housing. Veterans at Haven II receive their medical and mental health treatment through the VA Medical Center.

L.A. Vets' Westside Residence Hall. Targeting formerly homeless veterans who have achieved 90 days of sobriety and who appear ready to obtain and maintain employment, Westside Residence Hall provides housing and supportive services to veterans who are judged to be approaching the transition to permanent housing. A renovated dormitory, Westside Residence Hall is divided into suites, each with several single or double rooms. Meals are served through a food reprocessing and redistribution

business that also employs and trains some of the residents, and the facility has an Economic Development Center, where residents can pursue employment opportunities.

L.A. Vets is a joint venture between a for-profit corporation and a nonprofit one. Westside Residence Hall, Inc., the for-profit corporation, owns and manages the building, and is geared to generating enough cash to be self-sustaining and cover the core administrative costs of the nonprofit corporation, Los Angeles Veterans Initiative, Inc.

To be eligible for Westside Residence Hall, veterans must have been homeless or precariously housed, be medically and psychiatrically stable, have achieved 90 days of sobriety, be willing to submit to random toxicology screening, be actively involved in ongoing sobriety support (if a history of substance abuse was involved), be judged able to function independently and to seek employment, and be able to pay rent. Current rents range from $255 through $400.

Westside Residence Hall has two separate programs, a supported housing program and a welfare-to-work program. About 250 veterans are at Westside Residence Hall as part of the West Los Angeles VA Medical Center's Supported Housing Program. They receive case management services through VA staff, who work part time at Westside Residence Hall. A VA psychologist also spends time at this facility, and veterans go to the Medical Center for other needed services.

Preliminary analyses by the West Los Angeles VA Medical Center staff suggest that veterans stay at Westside for an average of 6 months and that placement at Westside Residence Hall may be associated with a reduced risk of inpatient hospitalization. This analysis also suggests that upon leaving, 54 percent report employment and 36 percent report having obtained both housing and employment; about 45 percent have relapsed at the time of exit.

Westside Residence Hall's welfare-to-work program provides up to 90 days of assistance in obtaining and maintaining employment. Begun in 1997 and funded in part by VA GPD funds, the program supports 100 beds. Sober veterans who appear able and motivated to reenter the job force must actively pursue work while in this program. They receive sobriety support, assistance in searching for employment, and services to help them maintain work once it is found. Although the Westside Residence Hall welfare-to-work program is too new to allow clear evaluation, research

suggests that job assistance programs for the homeless are enhanced by provision of supportive services and postplacement assistance.

Westside Residence Hall is thus designed to address needs that may arise toward the end of an episode of homelessness. According to L.A. Vets, projects such as Westside Residence Hall can be expected to serve at least 30 percent of homeless or precariously housed veterans. They suggest that replication of Westside Residence Hall is likely to require six conditions: (1) a large population of homeless veterans; (2) real estate suitable for adaptive reuse at an affordable cost; (3) geographic proximity to a VA medical center with expert staff committed to serving the homeless and the infrastructure to allow that involvement; (4) ready access to entry-level jobs; (5) willing for-profit and nonprofit partners, including a nonprofit service provider capable of planning and coordinating the project and an entrepreneur to spearhead efforts; and (6) long-term affordable financing. L.A. Vets is currently developing additional similar projects.

New Directions. New Directions offers substance abuse treatment and job training/job placement services to medically stable substance abusers who do not have serious mental illnesses and who are not receiving medications for psychiatric conditions. In a renovated building it leases on the grounds of the West Los Angeles VA Medical Center, New Directions operates a long-term residential treatment program. Beginning, if necessary, with medication-free detoxification, residents enter a highly structured substance-abuse treatment program, which can take from 3 to 9 months, and then a vocational program, which can take up to 2 more years.

Homeless program staff at the West Los Angeles VA Medical Center reported that as many as a third of their homeless veterans could be considered for placement at New Directions. New Directions receives a per diem rate through an HCMI contract for the first 30 days and through GPD funds for an additional 60 days. The facility has 24 detoxification beds, 64 long-term substance abuse treatment beds, and 40 beds for those in the vocational phase. It also has 24 shelter-plus-care beds, partially funded by HUD, for veterans who have completed the recovery phase of their treatment but have multiple disabilities. Residents with income are expected to pay a maximum of 25 percent of their income toward rent.

In operation for just over 1 year, New Directions is too new to permit clear evaluation of its effectiveness. New Directions staff reported that about one-third of their residents are considered to have successfully completed

the program, and about one-third drop out of treatment within the first 60 days. Long-term residential treatment for substance abuse has not been clearly shown by other research to be any more or less effective than other treatment approaches, and questions remain about what treatments are most effective for homeless substance abusers.[1] Among the homeless, highly structured programs tend to have somewhat higher drop-out rates than other strategies.

Veterans Rehabilitation Center, Vietnam Veterans of San Diego (VVSD). Empirical evaluation of VVSD's Veterans Rehabilitation Center, which serves primarily substance abusing veterans with post-traumatic stress disorder (PTSD) or serious depression, suggested that it was associated with positive housing, employment, and substance abuse outcomes on 6-month follow-up. An 80-bed facility, the Veterans Rehabilitation Center provides treatment for substance abuse, PTSD, and other psychological disorders while also addressing preparation for employment. Some mental health needs are addressed in coordination with the VA or local Vet Center.

If a dually diagnosed veteran is referred to the Veterans Rehabilitation Center through the San Diego VA Medical Center HCMI program, a per diem is paid for up to 90 days. Other veterans are partially supported by a contract with that medical center's substance abuse treatment program. Residents are asked to pay rent of up to 30 percent of the income they receive during their stay, not to exceed $250 per month. The treatment program includes three phases, each of which typically requires at least 2 months. During the first phase, sobriety is emphasized. During the second phase, residents prepare for work by developing relevant skills. In the third phase, residents actively seek employment and prepare for the transition back into the community. The average length of stay is about 7 months, with a maximum of 1 year. The treatment program is described in a manual that could be used to replicate it.

VVSD's Veterans Rehabilitation Center was one of six promising treatment programs for homeless persons with co-occurring substance abuse or mental health problems that was selected for evaluation through a grant cosponsored by the Center for Substance Abuse Treatment and the Center for Mental Health Services. Data collected 3 and 6 months after veterans left the program suggested that program graduates spent fewer nights homeless and were more likely to be housed stably and independently, more likely to be employed, and less likely to be using alcohol or other

[1]Drug Abuse: Research Shows Treatment Is Effective, but Benefits May Be Overstated (GAO/HEHS-98-72, Mar. 27, 1998).

substances than participants who left the program prior to completion. Moreover, data from the California Employment Development Department suggested that program participants were not only more likely to be employed, but were earning better wages than a comparison group of homeless veterans who did not participate in VVSD's Veterans Rehabilitation Center. These results must be interpreted with some caution, as they reflect a single evaluation of the program with follow-up for only 6 months; also, participants were not randomly assigned to the VVSD program or control group. Nonetheless, this evaluation suggests that the VVSD Veterans Rehabilitation Center program offers a promising approach to the treatment of substance abusing veterans with PTSD or depression.

NEPEC reports that about 10 percent of the homeless veterans served by the HCHV program have combat-related PTSD (the overall rate of PTSD among homeless veterans is likely to be higher because traumatization and victimization are more common among homeless people than in the general population), about 29 percent have a mood disorder, and about 72 percent have a substance abuse diagnosis. Thus, a substantial proportion of homeless veterans might benefit from this kind of program.

Critical Time Intervention (CTI). Results of a randomized clinical trial that compared CTI (a case management strategy) to usual services only for seriously, chronically mentally ill (for example, schizophrenic) homeless persons indicated that CTI was associated with a greater reduction in homelessness throughout a period that included a 9-month intervention phase and a 9-month follow-up phase. ("Usual services" were those that the person would have received under normal circumstances, such as referrals to community agencies.) CTI differs from the other specific programs we visited, in that it is an approach to case management rather than a transitional housing or residential treatment program.[2]

CTI provides continuity of care during a homeless person's transition from an institution or the street to a more permanent suitable housing arrangement. Designed to span 9 months, it aims to ease this transition and minimize the risk of relapse to homelessness. Specific goals include performing an ongoing assessment, forming an appropriate long-term plan, establishing linkages to community resources, fostering independent living skills, and ensuring efficient use of services. For those with a substance abuse history, abstinence is a goal rather than a prerequisite. (Although

[2]Assertive Community Treatment (ACT) is another case management strategy that has yielded promising results for the seriously mentally ill homeless.

ongoing substance abuse makes intervention more difficult, it allows movement toward a goal of sobriety while other needs are being addressed.)

In a study funded by the Center for Mental Health Services,[3] 96 men with severe mental illness who had been placed in community housing were recruited for participation. Half were randomly assigned to receive CTI for 9 months, to be followed by 9 months of only usual services; half were randomly assigned to 18 months of usual services. Data were obtained from 94 of the 96 participants at the 18-month point. Results indicated that those provided with only usual services spent more nights homeless (91 on average) throughout the 18-month assessment interval than did those provided with CTI (30 on average). Moreover, the difference between these groups in the likelihood of spending a night homeless tended to become greater over time. (Research on homeless veterans has more typically indicated that treatment and comparison groups begin to converge rather than diverge after a program ends.) Similarly, fewer of those who had received CTI experienced prolonged periods of homelessness during the 18 months than those who received only usual services.

These results are based on a single study, but suggest promising outcomes for seriously mentally ill homeless persons, a particularly hard-to-serve subgroup. To date, CTI has been used most extensively with some of the hardest-to-serve homeless in the New York City shelter system: seriously mentally ill (for example, schizophrenic) persons, many of whom have multiple psychiatric diagnoses, chronic and heavy substance abuse problems, serious medical problems, and long histories of homelessness. NEPEC estimates that about 45 percent of the homeless veterans served by the HCHV program have serious psychiatric problems. Moreover, CTI clinicians believe that their procedures should be appropriate for use with homeless persons with less severe disorders as well. VA is not currently using CTI, although VA officials have indicated their intention to begin a pilot CTI project. Materials are available for training in CTI.

[3]E. Susser and others, "Preventing Recurrent Homelessness Among Mentally Ill Men: A 'Critical Time' Intervention After Discharge From a Shelter," American Journal of Public Health, Vol. 87, No. 2 (1997), pp. 256-62.

Comments From the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

MAR 12 1999

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military
Health Care Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

We have reviewed your draft report, ***HOMELESS VETERANS: VA Expands Community Partnerships, But Homeless Program Effectiveness Is Unclear*** (GAO/HEHS-99-53) and offer these comments. We concur with GAO's single recommendation that VA initiate a series of program evaluations to clarify the effectiveness of VA's core homeless programs and provide information about how to improve those programs. However, we believe that the recommendation should be modified to read as follows: "...the Secretary of Veterans Affairs directs the Under Secretary for Health and the Assistant Secretary for Planning and Analysis to collaborate on conducting a series of program evaluation studies...." This change reflects the role of the Office of Planning and Analysis to coordinate the Department's program evaluations under the Government Performance and Results Act (GPRA).

We are pleased the reviewers acknowledge the significant progress VA has made in addressing the special needs of homeless veterans. We have also long recognized the importance of establishing a methodology to evaluate objectively the effectiveness of the various homeless program approaches. In fact, the Veterans Health Administration (VHA) has already activated a variety of important evaluative efforts that we anticipate will have national implications. In many ways, VA is at the forefront when compared with activities of other Federal and private sector homeless programs.

VHA's Northeast Program Evaluation Center (NEPEC) coordinates and directs all national program evaluation efforts for VA's homeless veterans programs and will take the lead in developing initial evaluations that might prove to have national implications. For example, NEPEC is directing a three-year outcome evaluation of four VA medical centers (San Francisco, San Diego,

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Cleveland and New Orleans) to determine the effectiveness of: 1) the HUD-VASH Program (permanent housing plus long-term case management; 2) case management only; and, 3) the traditional contract community-based residential treatment with case management provided by the Health Care for Homeless Veterans (HCHV) Program. A total of 550 homeless veterans have been randomly assigned to one of these three treatment models. NEPEC has collected data from the first full year of the study and is now analyzing it.

In addition to the activities described above, the Mental Health Strategic Healthcare Group and four VISNs have been approved to develop a pilot initiative to provide Critical Time Intervention case management for homeless veterans in inpatient treatment. NEPEC will then direct the program evaluation to determine the effectiveness of this treatment strategy. The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (within the Department of Health and Human Services) has agreed to provide training to VA staff in the use of this treatment model and will be consulted on program evaluation.

Within the $50 million identified in VA's FY 2000 budget for homeless veterans programs, $2.3 million will be used to provide specialized services for homeless women veterans. Long-term program evaluation will be built into this service delivery model. Sufficient resources are available within the FY 2000 budget to support these and other program evaluation efforts. VHA's newly appointed Council of Network Homeless Coordinators will serve in an advisory capacity to the NEPEC and the Mental Health Strategic Healthcare Group to assist with the development of the referenced evaluation studies as well as others that may be needed.

One further development is a demonstration project which will be called the Therapeutic Employment, Placement and Support program. Over the past decade, research studies conducted outside of VA have demonstrated the effectiveness of a novel type of vocational service, the Individual Placement and Support model. In this integrated model, employment placement and support services are provided by specialists working within a case management team, rather than in a distinct employment program. In this model, direct employment assistance is provided to veterans from the beginning of their involvement with VA. VA plans to have NEPEC evaluate this model by comparing its effectiveness with both standard homeless services and with the current Compensated Work Therapy program, as suggested by GAO.

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As you are also aware, VHA recently designated the program for homeless veterans as a priority for program evaluations under GPRA. We have targeted FY 2001 in our most recent Performance Plan for this review. We anticipate this assessment will be conducted under contract in order to comprehensively evaluate the internal operation of homeless programs, program impacts, and long-term outcomes. In addition, we will be in a better position to evaluate the effectiveness of recent funding increases for VA's homeless veterans programs. The study will also examine cross-cutting issues involving other Federal programs designed to assist homeless veterans.

Thank you for the opportunity to comment on your draft report.

Sincerely,

Dennis Duffy
Assistant Secretary for
Planning and Analysis

GAO Contacts and Staff Acknowledgments

GAO Contacts

George Poindexter, Assistant Director, (202) 512-7213
Timothy Hall, Evaluator-in-Charge, (202) 512-7192

Staff Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Jean Harker reviewed NEPEC's reporting, monitoring, and evaluation systems for VA's homeless programs; Kristen Anderson assisted with the NEPEC review and conducted a literature review of homeless issues focused on interventions for the homeless; Deborah Edwards assisted with designing the job and methodological approaches used to perform the work and acted as an adviser throughout the assignment; Ann McDermott provided technical support; and Robert DeRoy assisted with the reliability testing of NEPEC's data.

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