United States General Accounting Office

GAO

Testimony

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

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

HOMELESS VETERANS

VA Expands Partnerships, but Effectiveness of Homeless Programs Is Unclear

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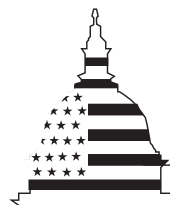

GAO/T-HEHS-99-150

Homeless Veterans: VA Expands Partnerships, but Effectiveness of Homeless Programs Is Unclear

Mr. Chairman and Members of the Subcommittee:

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

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

[1]Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness Is Unclear (GAO/HEHS-99-53, Apr. 1, 1999).

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

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

programs in Little Rock, Ark.; Denver, Colo.; Washington, D.C.; Los Angeles and San Diego, Calif.; and New York, N.Y.

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

Background

Veterans constitute about one-third of the adult homeless population in the United States on any given day. They form a heterogeneous group and are likely to have multiple needs. Many homeless veterans need treatment for medical or psychiatric conditions in addition to housing and other supportive services. Although many questions remain about how to treat homelessness, a series of research initiatives launched in 1982 and funded primarily by HHS suggests that effective interventions for the homeless involve comprehensive, integrated services. These initiatives also suggest that a range of housing, treatment, and supportive-service options needs to be available to the homeless, and that flexibility is needed to appropriately match services to the individual needs of homeless people.

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

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

Experts suggest that in terms of housing, the goal of homeless assistance programs should be stable residence in a setting that allows the highest level of independence each person can achieve. For some homeless veterans, independent housing and economic self-support are reasonable goals. But for others, including many seriously mentally ill homeless people, neither full-time work nor independent housing may be feasible. Instead, for these individuals, residence in a supportive environment, such as a group home, may be the most reasonable outcome. In addition, transitional housing may be necessary before a more permanent housing

arrangement can be achieved. Thus, efforts to assist the homeless require a range of housing options (including emergency shelter as well as transitional and permanent housing); treatment for medical, mental health, and substance abuse problems; and supportive services such as transportation and case management. This spectrum of options is referred to as the continuum of care. Because the homeless have diverse needs and local resources vary, flexibility in arranging partnerships among organizations optimizes the development of a continuum of care at the local level.

VA Provides Key Services, Builds Capacity Through Partnerships

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

Many homeless veterans receive medical, mental health, and substance abuse services through VA's mainstream health care programs. Although VA does not know the extent to which its annual health care appropriations are spent on medical care and other treatment services for homeless veterans, recent estimates suggest the amount is substantially greater than the level of funding for VA's targeted homeless programs. VA's targeted homeless efforts include additional services, such as outreach to identify homeless veterans, case management to assess the needs of homeless veterans and link them with appropriate VA or community-based service providers, job counseling and placement assistance, and referral to residential treatment programs to address clinical disorders.

Since establishing its targeted homeless programs, VA has worked with other service providers and expanded its relationships with community-based organizations. This commitment to partnering is reflected in annual meetings among VA homeless program staff and other homeless service providers and organizations. These meetings are intended to promote a collaborative effort to assess, plan for, and address the needs of homeless veterans. VA has acknowledged that it alone cannot

meet all the needs of homeless veterans. Not only are its resources insufficient, but VA's homeless programs are not available in all locations. By partnering with other providers, VA increases its potential for stretching its resources to provide needed services to homeless veterans and ensure better coordination of services.

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

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

assistance in obtaining and maintaining employment through a GPD program. In a few instances, VA has awarded GPD funds to programs with more unique missions. For example, the Veterans Hospice Homestead in Leominster, Massachusetts, provides housing and support for terminally ill homeless veterans.

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

Effectiveness of VA Homeless Programs Is Unclear

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

Program Data Focus on Descriptive Characteristics, Status at Discharge

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

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

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

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

have completed a program successfully were rated as improved in these domains. It is difficult to interpret a rating of "improved" with regard to drug or alcohol use when that assessment is made at the end of a program that requires participants to avoid alcohol and drugs (as VA residential treatment programs do), especially when the only alternative ratings are "unchanged" or "worse."

During fiscal year 1997, over 1,000 veterans were discharged from VA's GPD program. Reported outcomes were less favorable for these veterans; in particular, the proportion of unsuccessful discharges from GPD programs was high. As VA noted, however, the GPD program is relatively new, and early data may not provide a clear basis for evaluation. For example, veterans who were benefiting from their placements might not have been discharged from the GPD program yet, so no information about them would have been included in the data.

Limited Information Available About Program Effectiveness

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

To identify the benefits associated with program participation, NEPEC conducted pilot follow-up projects at a sample of its homeless program sites between 1987 and 1990, using more detailed outcome measures than VA typically collects from program participants. Follow-up is needed to determine whether veterans are still employed, housed, or successfully dealing with substance abuse or mental health problems after program completion. NEPEC concluded that, compared with their status at admission, veterans showed improvements in housing, employment, mental health, and substance abuse problems 6 months after discharge from DCHV treatment and that, with the exception of alcohol use, these improvements remained evident 1 year after discharge. Similarly, veterans who participated in the HCMI program were assessed from 1 month to 2

years after their initial contact with VA homeless staff. On average, these veterans were last interviewed 8.3 months after their first contact. About two-thirds were admitted to residential treatment; of these, some were still in residential treatment when last interviewed. NEPEC concluded that veterans who participated in VA's HCMI program (including both those who were and those who were not provided with contract residential treatment) showed improvements in terms of housing, employment, psychiatric problems, and substance abuse upon follow-up relative to initial contact.

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

In addition, NEPEC analyzed data from small subsamples of participants in the HCMI follow-up study to examine relationships between measures of program participation and improvement. These analyses suggested that certain aspects of participation in the program, such as longer stays in residential treatment, were associated with greater improvement. Again, these findings are promising, but NEPEC acknowledged that strong

conclusions could not be reached because of methodological limitations. Research designed to clarify the processes that make interventions effective, or what aspects of treatment are associated with positive results for different clinical groups (for example, those with serious mental illnesses or those with a substance abuse disorder), can yield information relevant to efforts to improve programs or to optimize program outcomes. NEPEC officials have occasionally conducted such analyses, which require them to supplement their data files with additional information (for example, about treatment approaches). Clear conclusions about what treatment strategies are most strongly associated with achieving housing stability, and about which strategies work best for which veterans, require more rigorous and costly research methods than NEPEC has typically employed.

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

NEPEC is not currently conducting evaluation research on its largest residential treatment and transitional housing programs (the DCHV, HCMI, and GPD programs). It is, however, studying some of VA's other programs. Follow-up data are being collected from participants in one of VA's smaller programs called the Housing and Urban Development-VA Supported Housing program. In this program, intensive case management and vouchers for permanent, subsidized housing are made available to homeless veterans through a cooperative arrangement between VA and HUD. To evaluate this program, NEPEC has collected follow-up information from a sample of program participants, as well as from a comparison group of veterans who were considered appropriate candidates for permanent housing but who were randomly assigned to receive either intensive case management without a housing voucher or more traditional case management through VA's HCMI program, again without a housing voucher. In addition, veterans who have participated in the Compensated Work Therapy/Transitional Residence and VA Supported Housing programs are also reinterviewed periodically.[5] VA has recently indicated its intention

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

to initiate three new homeless programs and to evaluate each of those programs using follow-up procedures similar to those it has used in the past. These new initiatives involve using a promising case management strategy called Critical Time Intervention, developing programs for homeless women veterans, and implementing a vocational service called Therapeutic Employment, Placement and Support. A NEPEC official acknowledged that to minimize the cost of these evaluative efforts, the methods used to evaluate Critical Time Intervention and the homeless women programs are likely to be less rigorous than would be ideal.

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

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

In summary, VA provides medical, mental health, and substance abuse treatment to homeless veterans through its mainstream health care

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

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

GAO Contact and Acknowledgments

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

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