

**HEARING ON VA'S PLAN FOR ENDING
HOMELESSNESS AMONG VETERANS**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ONE HUNDRED ELEVENTH CONGRESS
FIRST SESSION
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MARCH 24, 2010
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HEARING ON VA'S PLAN FOR ENDING HOMELESSNESS AMONG VETERANS

WEDNESDAY, MARCH 24, 2010

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Tester, and Burr.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. Aloha and good morning, everyone. The Senate Committee on Veterans' Affairs will come to order.

Today the Committee will hear testimony about the VA's 5-year plan and the collective efforts of the Federal Government to end homelessness among veterans. We will also hear from individuals who have worked to end homelessness among veterans for many years.

Earlier this month the VA announced approximately 107,000 veterans were homeless on any given night in 2009. In 2008 that number was 131,000. While the reduction is good news, there are still too many veterans without a place to call home. Homelessness for any American is a very difficult thing, but for an individual who has answered the call to duty, it is not unacceptable.

There are many challenges that veterans face which can lead to homelessness such as health concerns including mental health problems, economic issues, and a lack of access to safe housing. But these challenges are not new.

The central question is, what do we need to do now to try to address and resolve these issues so that we can keep from having to face this problem a decade from now.

Congress has been actively working on this issue for over 20 years. As Chairman of the Committee, I stand ready to do my part in supporting efforts to bring it to an end.

I am pleased that the Committee, with Senator Murray playing a leadership role, recently approved legislation to enhance the programs and services for homeless veterans and to expand services for homeless women veterans and veterans who have care for minor dependent children.

This legislation, which presents another important step in our collective efforts, will be brought before the Senate in future. In order to be successful in any plan to end homelessness among vet-

erans, we must recognize that a significant number of homeless veterans suffer from mental health issues.

VA estimates that more than half of all homeless veterans have a serious psychiatric diagnosis. Many others are addicted to drugs and alcohol. Providing these veterans with an alternative to living on the street is a challenge.

We must fully understand the needs of these veterans, the resources needed to assist them and be committed to meeting their needs.

I applaud Secretary Shinseki for the dedication to the task of ending homelessness among veterans. But as we will hear today, VA cannot do it alone. If we, as a Nation, are to achieve this goal, we must leave no stone unturned when trying to help veterans in need.

Today's hearing gives us a chance to better understand the current situation with an eye toward fixing what is not working and expanding what is working. I thank all of our witnesses for being here today to help us in this effort.

And now I would like to call on our Ranking Member, Senator Burr, for his opening statement.

Senator Burr.

**STATEMENT OF HON. RICHARD BURR, RANKING MEMBER,
U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Thank you, Mr. Chairman, and aloha.
Chairman AKAKA. Aloha.

Senator BURR. More importantly thank you for calling this hearing and I welcome our witnesses from the VA and from around the country.

There are few issues that we care more deeply about than making sure that we end homelessness among those who wore our Nation's uniform.

The present Secretary has set an ambitious goal to end homelessness in 5 years. It is going to be tough, but I am committed to work toward that goal.

According to the VA, 107,000 veterans were homeless on any given night last year including an estimated 15,089 in my State of North Carolina. Although those numbers represent an improvement over prior years, we still have much work to do.

Let there be no mistake, however. The goal is not just to end homelessness in 5 years. It is also to make sure that the solutions are sustainable beyond the 5-year period. I have said it many times before; the only way to end homelessness is to ensure that it never begins in the first place.

Prevention is the key. We must develop successful programs to target the estimated 27,000 veterans who are at risk of falling into that cycle every single year. We must also think smarter about where and how we invest in homelessness programs.

Too often in the past we have been happy to point at the dollars we have thrown at the problem, without any real accountability for results, or an understanding of how public and private resources could better coordinate services with each other.

I believe we have some models of success out there that provide us with a promising path forward. I am pleased that Mr. Dennis

Parnell, President of the Healing Place of Wake County, NC, accepted the invitation to testify today. I think you will find their data riveting.

Through its public/private partnerships, the Healing Place is able to boast of a sobriety recovery rate of over 68 percent 1 year after. That success rate is three times the national average. And this success leads directly to the Healing Place's stellar record in reducing homelessness in the county. Not too many counties can claim that statistic.

Today, I am anxious to hear about the Secretary's plan to move forward. No doubt his plan will require Congress' involvement.

Unfortunately, I have been disappointed about the Administration's collaboration with us thus far. Last October, the Committee held a hearing on Comprehensive Homeless Legislation, S. 1547, but received no official views from VA on the bill.

In the absence of any views, the Committee marked up the legislation in January with the expectation that VA would be providing us with a greater understanding of how it fits in with the Secretary's plan. Five months and multiple inquiries later, we received the views last night, giving my staff no opportunity to do a thorough analysis of the information. Of course, this is not the first time VA waits until the 11th hour to provide responses to inquiries they have had for months. This is also not the first time I have mentioned this problem, and I will continue to do so. I do not understand the delay. Why does it take VA 5 months to provide Congress with the crucial information we need to do the best job we can for our veterans?

If in fact I go through the Secretary's blueprint and I find that this is another round of us throwing more money to programs that we cannot justify the outcome of, then we will need to figure out what the appropriate legislative action is after that. But I had committed to the Secretary to work with him because he assured me that we have a fresh, new pathway to get there.

The bottom line is we need to get this right. There is too much at stake. We need to make sure all the information we need to allocate resources in the most effective way possible is in fact delivered.

Mr. Chairman, I will work aggressively with you and through the witnesses that we have today to try to find out the answers to these questions.

I once again welcome our witnesses and I thank the Chairman for his indulgence.

Chairman AKAKA. Thank you so much, Senator Burr. We will look forward to working together on this problem.

I want to welcome the witnesses on our first panel. Each has had an important role in ending homelessness among veterans.

Many agencies are required to work in partnerships if there is ever going to be homelessness among veterans. Too often in the past the collaboration between agencies who should have been working together just did not exist but I am hopeful this is no longer the case. It certainly does not appear to be today especially with the make up of our first panel.

First, we have Pete Dougherty, Director of the Office of Homeless Veterans Programs at the Department of Veterans Affairs. I would

like to note that Mr. Dougherty was a staff member of this Committee during the early 1990s.

Welcome back, Mr. Dougherty.

Mr. Dougherty is accompanied by Lisa Pape, Acting Director for Mental Health Homeless and Residential Rehabilitation Treatment Programs.

Second, we have Hon. Raymond Jefferson, Assistant Secretary of Veterans' Employment and Training Service at the Department of Labor.

Then we have Mark Johnston, Deputy Assistant Secretary for Special Needs at the Department of Housing and Urban Development.

I thank you all for being here this morning. Your full testimony will appear in the record.

Before I call on Mr. Dougherty to begin and proceed with his testimony, I am going to call on Senator Tester for any opening remarks he may have.

**STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA**

Senator TESTER. Thank you, Mr. Chairman and Ranking Member Burr. I appreciate your having this hearing. I think this is a very, very critically important issue.

I want to welcome Assistant Secretary Jefferson. Ray, we still need to get you out to Montana to show you the sights and the veterans that are out there and the challenges that they face; and the same goes for everybody else on the panel too. Come and we will put you to work and show you the challenges we face in rural America from a Montana perspective.

As you know, statistically in rural America veterans represent about 11 percent of the population. Montana is the fourth largest State. We have 104,000 veterans; 147,000 square miles. Senator Begich beats me on that, but we are not far behind.

I do applaud Secretary Shinseki's call to end homelessness among veteran populations. This is the right goal. It absolutely is the right time to do that. We have to get the economy moving again and we have to make sure these folks are getting the health services and job training skills they need.

If we focus just on the shelter portion or just on the mental health or substance abuse portion or just on the job training portion, we are going to come up short, and you guys know that.

It takes all of these services delivered together in an integrated way to get the veteran off the street and make sure he does not end up back on the street.

So I am pleased to see that HUD, VA, and the Labor Department are all here on the same panel. As we move along this morning, I want to remind folks that by some estimates 7 percent of homeless veterans on any given night are in rural or frontier areas of our country. Some studies have it at 5 percent. In either case, I do not think any of us want these folks to be forgotten about.

The reality is that folks in rural areas are going to be harder to reach and it's harder to get key services and resources to them. That is why homelessness in rural parts of this country—the homeless—are referred to as the hidden homeless.

With that, Mr. Chairman, I want to thank you very, very much for having this hearing. I look forward to each witness's presentation and we will have a good hearing.

Chairman AKAKA. Thank you very much, Senator Tester.

I will now call on Mr. Pete Dougherty for your statement. Please proceed.

STATEMENT OF PETE DOUGHERTY, DIRECTOR, HOMELESS PROGRAMS, OFFICE OF PUBLIC & INTERGOVERNMENTAL AFFAIRS, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LISA PAPE, ACTING DIRECTOR, MENTAL HEALTH HOMELESS AND RESIDENTIAL REHABILITATION TREATMENT PROGRAMS

Mr. DOUGHERTY. Thank you, Mr. Chairman.

On behalf of the Secretary Shinseki, let me thank you and the Committee for the opportunity to review our plans to end homelessness among our Nation's veterans. As you have indicated, I am here and pleased to be with Lisa Pape.

Now is the time to end homelessness among veterans. We owe every man and woman who has worn our Nation's military uniform no less.

As has been stated, the number of homeless veterans have gone down, but as you also indicated, and we agree, that any homeless veteran who is seeking services needs to have us and this government help them.

This is an ambitious project. It requires a significant amount of resources. Our health care budget for next year is proposed to have \$3.4 billion for core medical care and assistance and nearly \$800 million in targeted programs that assist homeless veterans.

We are taking a no-wrong-door approach as we do this. We are trying to make sure that every veteran seeking services has access regardless of the hour or their condition. We anticipate that we will provide direct care and prevention assistance to more than 500,000 veterans over the next 5 years.

We are very concerned and we are constantly monitoring what we are doing. Our approach has been to be much more collaborative, much more diverse in the way we approach this problem.

But we have looked at what we have done in the past and we have completed a study that said that when you look at contract residential care, when you look at our in-patient care programs for homeless veterans and you look at our transitional housing programs, that veterans who complete those programs that about 80 percent are appropriately housed a year after they complete programs. That is good success.

We have opened a national call and referral center for homeless veterans. We are working in partnership with the National Suicide Prevention Hot Line. That call center is really addressing the needs of that veteran whether they are in urban America or rural America, whether they are a service provider or a veteran themselves seeking services.

The idea is to have an immediate ability to contact us and to get us to respond to that veteran's need. We will continue to actively engage with communities in outreach events. Many of them called stand downs.

Last year over 48,000 homeless veterans and their family members came and sought services not just from VA and not just for my colleagues at this table but from community groups and organizations who could help across the country.

We have a number of staff, about 350 staff who work in our health care for homeless veterans' program. That staff is going out and reaching about 40,000 homeless veterans. They go into soup kitchens and places like that.

As we approach this, as Senator Burr reminded us, we have to be more collaborative in the way we do this. Part of what we are going to do is we are going to outstation 20 substance abuse treatment specialists in community programs to get the programs to the veteran as opposed to the veteran having to come to us.

We are expanding contract residential care and expect to have about 5000 veterans who will get contract residential care so that when you contact us we have an immediate place for you to go to.

Homelessness also has been a problem for veterans who have dental care problems. Under our plan we are doing things to address and expect about 20,000 veterans who will get dental care treatment. This is very important both for their physical health but it is also very important to get back into gainful employment which is what the hope of many of them are.

We are expanding our opportunities to work with prosecutors and judges to expand efforts to work with veterans who are engaged in the criminal justice system and those who are exiting prisons. We are adding 46 full-time veterans' justice outreach specialists to assist veterans in treatment courts and veterans who are in drug courts.

We are adding to the 39 health care for re-entry specialists who are working on prerelease outreach and post-release case management. We expect about 12,500 will be aided by this effort.

We are taking what are called our compensated work therapy program which is really a hospital-based program. And we are going to transfer it and put those staff into the community to help veterans get gainful employment in the community again. We expect about 2500 veterans will get assisted by that next year.

We are making significant efforts to go out and offer funding to community groups and organizations on prevention services. As you and others have noted, prevention is where we have to be as well. We have to get to a prevention effort that will stop homelessness from ever beginning and we are looking forward to doing that.

I will defer to Mark Johnston to talk a little bit more about HUD-VASH. We know that is very important and in the remaining time let me also just say that we understand that getting benefits and assistance is important.

It is not just about getting a check; for many it is about getting back into gainful employment. So it is using my vocation rehabilitation benefits. It is about getting education services, going back to school, for many of these veterans. There are opportunities. We look forward to the opportunity to continue with our partners at this table, plus the U.S. Interagency Council, but more importantly, at the local level with thousands of groups who have come and helped us.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Dougherty follows:]

PREPARED STATEMENT OF PETE DOUGHERTY, DIRECTOR, HOMELESS PROGRAMS, U.S.
DEPARTMENT OF VETERANS AFFAIRS

Chairman Akaka, Ranking Member Burr, Distinguished Members of the Senate Committee on Veterans' Affairs. Thank you for this opportunity to discuss the most ambitious plan ever undertaken to effectively end homelessness among our Nation's Veterans. Today I am accompanied by Lisa Pape, Acting Director Mental Health Homeless and Residential Rehabilitation Treatment Programs.

Homelessness among Veterans is a tragedy. While much has happened over the last several decades to address this problem, some Veterans still have no place to lay their head at night. Over the past 23 years the number and percentage of Veterans in the homeless population has gone down dramatically but our job is far from finished. We are making progress; data demonstrate that the number of homeless Veterans continues to decline because of the aggressive efforts by the Department of Veterans Affairs (VA) and its partners, including local and community organizations as well as state and Federal programs. Six years ago, 195,000 homeless Veterans lived on the streets of America; today, 107,000 do. VA has a strong track record in helping homeless Veterans. A study completed several years ago found approximately 80 percent of Veterans who complete a VA program are successfully housed in permanent housing 1 year after treatment. We have invested \$500 million on specific homeless housing programs this year. We are moving in the right direction to remove this blot on our consciences, but we have more work to do.

VA's major homeless-specific programs constitute the largest integrated network of homeless treatment and assistance services for Veterans in the country. These programs provide a continuum of care for homeless Veterans, providing treatment, rehabilitation, and supportive services that assist homeless Veterans in addressing health, mental health and psychosocial issues. VA also offers a full range of support necessary to end the cycle of homelessness by providing education, claims assistance, jobs, and health care, in addition to safe housing. Effectively addressing homelessness requires breaking the downward spiral that leads Veterans into homelessness.

Veteran homelessness, at its root, is primarily a health care issue, as many homeless Veterans are heavily burdened with depression and substance abuse. VA's budget includes \$4.2 billion in 2011 to prevent and reduce homelessness among Veterans—over \$3.4 billion for core medical services and \$799 million for specific homeless programs and expanded medical programs. This same budget includes an additional investment of \$294 million in programs and new initiatives to reduce the cycle of homelessness, which represents a 55 percent increase over program funding for 2010.

Our strategy for ending homelessness is to create a collaborative approach focusing on prevention and ensuring there is "no wrong door" for a Veteran seeking service. VA's philosophy of "no wrong door" means that all Veterans seeking to avoid or escape from homelessness must have easy access to programs and services regardless of the hour. Any door a Veteran visits—a medical center, a regional office, or a community organization—must offer them assistance.

VA is expanding its existing programs and developing new initiatives to prevent Veterans from becoming homeless and to aggressively help those who already are. We will do this by providing housing, offering health care and benefits, enhancing employment opportunities, and creating residential stability for more than 500,000 Veterans. This further expansion will begin in fiscal year (FY) 2011 and continue through FY 2014, subject to the availability of appropriations. Specifically, we will:

- Increase the number and variety of housing options including permanent, transitional, contracted, community-operated, and VA-operated;
- Provide more supportive services through partnerships to prevent homelessness, improve employability, and increase independent living for Veterans; and
- Improve access to VA and community based mental health, substance abuse, and support services.

Over the next 5 years, our focus on ending Veteran homelessness is built upon six strategic pillars. First, we must aggressively reach out to and educate Veterans—both those who are homeless and those who are at risk of becoming homeless—and others about our programs, finding those who are already homeless and those who are at risk for homelessness. Second, we must ensure treatment options are available, whether for primary, specialty or mental health care, including care for substance use disorders. Third, we will bolster our efforts to prevent homelessness. Without a prevention strategy, effectively closing the front door into homeless-

ness, we will only continue responding after Veterans become homeless and therefore continue to manage the problem. Fourth, we will increase housing opportunities and provide appropriate supportive services tailored to the needs of each Veteran. Fifth, we will provide greater financial and employment support to Veterans, and work to improve benefits delivery for this vulnerable population. And finally, we will continue expanding our community partnerships, because our success in this venture is impossible without them. My testimony will describe our efforts in each of these areas.

OUTREACH AND EDUCATION

Our outreach and education initiatives must be led by a national effort to offer Veterans and others a way to contact us at any time. Veterans, particularly those in crisis, will benefit from our new National Call Center for Homeless Veterans. The Center will work in partnership with the highly successful National Suicide Prevention Hotline (operated in cooperation with the Substance Abuse and Mental Health Services Administration, SAMHSA, available at 1-800-273-TALK). The Call Center is operational, and Veterans and others who call (1-877-4AID VET, or 1-877-424-3838) can receive specific referrals to VA and other community services to meet their immediate needs. We expect to nationally announce this program within the next couple of months, and we anticipate tens of thousands of Veterans, community organizations, family members and community providers will contact us for prompt and appropriate information. In cases where a Veteran is in crisis, this Call Center will ensure Veterans are placed in direct contact with a person who can speak to and provide them immediate assistance.

We will continue expanding our outreach by engaging our community partners and supporting their efforts, as well as our own. An excellent example of our collaboration with community organizations are the Stand Down events VA has held for years. In 2009, VA participated in almost 200 events in 46 states, including the District of Columbia and Puerto Rico, reaching more than 42,000 Veterans, more than 4,600 spouses, and almost 1,200 children of Veterans; the highest totals we have ever recorded. This performance represented a 40 percent increase in outreach to Veterans from the previous year.

These efforts will also complement one of the most tried and true methods for helping homeless Veterans: sending staff to the streets and shelters to find them. There may be no more effective approach than meeting face-to-face, looking someone in the eye, and telling them you are there to help. Many Veterans, particularly those who have battled chronic homelessness, need skillful and repeated attempts to bring them the care they need. Along with our community partners, VA has 348 staff members engaged in this outreach every day, looking under bridges and in bread lines and visiting parks and parishes to find Veterans in need. The commitment and compassion these people display to those who have served America should stand as a model for us all, and VA will continue to support their vital work.

TREATMENT

VA recognizes that a plan to end Veteran homelessness will not be effective without a comprehensive suite of services for those with chronic and persistent health and mental health problems. This includes primary, specialty, and mental health care programs responsive to the needs of homeless Veterans. In 2009, VA had approximately 2,000 residential rehabilitation treatment beds specifically identified for homeless Veterans. We will expand our residential treatment capacity for homeless Veterans by establishing five new domiciliary care programs for homeless Veterans in areas where there are large numbers of Veterans without proximate access to our current infrastructure. VA expects to establish approximately 200 new residential treatment beds next year alone.

Veterans who are homeless often struggle with substance abuse. More than 60 percent of homeless Veterans have a substance use disorder which, if untreated, can keep them from returning to or sustaining independent living and gainful employment. As part of our 2011 budget, VA will enhance opportunities for Veterans to access these needed services in the community and help those who have achieved sobriety to maintain it by deploying an additional 20 community-based dual diagnosis clinicians. We expect this will help thousands more Veterans receive needed treatment in their communities. We will also integrate substance use and dual diagnosis expertise into 75 of our homeless Veteran case management teams to provide substance use services to Veterans and prevent relapse. We know that too many Veterans, even after they have completed employment or educational assistance programs, struggle to maintain stable lives because of continuing problems with sobri-

ety. We would like to work with the Committee to try to develop a proposal that will help these Veterans finally overcome these challenges.

Homeless Veterans, particularly the chronically homeless, often face health problems associated with inadequate dental care. These Veterans are at significantly greater risk for tooth and gum diseases that can impact their physical health, in some cases with serious health consequences. Moreover, the ability to return to gainful employment can be severely impacted when Veterans are afraid to smile or open their mouths to speak. VA often provides dental care for homeless Veterans through contracted care with private dentists. VA expects that as many as 20,000 homeless Veterans will receive dental care services this year. VA is currently authorized to provide a one-time dental visit to homeless Veterans who have remained in a VA domiciliary care program or a community program under the grant and per diem program for at least 60 days. At this time, this benefit does not apply to Veterans benefiting from the Housing and Urban Development (HUD)-VA Supportive Housing (HUD-VASH) program. This is increasingly a point of concern for Veterans and VA community partners, and we look forward to working with you to determine an appropriate remedy.

We are rapidly increasing resources at each VA medical center to enhance our community partnerships and expand opportunities for comprehensive residential care for Veterans by offering an immediate admission when a homeless Veteran with health care needs seeks our assistance. Approximately \$23 million has been allocated in FY 2010 to expand our community-based contract housing program, and we expect that as many as 4,800 Veterans will be placed into contract residential care this fiscal year. Though beginning there, we know that many will transition into one of our other programs for homeless Veterans. No matter the setting, our first priority is to assist those Veterans seeking help to escape from the street and improve their lives.

VA's continuum of care for homeless Veterans includes services for special populations, such as women and families, who may be at greater risk for homelessness. Programs targeted for women Veterans range from temporary and transitional housing to permanent housing with supportive services. VA has made women Veterans a funding priority in our Homeless Providers Grant & Per Diem program since 2007, and we have funded more than 220 programs with specific capacity to serve women. Since 2004, VA has provided seven special needs grants focused on additional services for women Veterans. Six of these programs are capable of supporting women with dependent children. The HUD-VASH Program provides permanent housing for homeless Veterans and their families with VA supportive services. Currently, 11 percent of Veterans who have received HUD-VASH vouchers are women. VA estimates that approximately 1,530 children live with their Veteran parent in HUD-VASH housing.

PREVENTION

Preventing homelessness under our 5-year plan will require a wide variety of efforts. One of our best efforts is our work with prosecutors and judges, as well as Veterans exiting prisons. VA now has at least a part-time Veterans Justice Outreach Specialist identified at each VA medical center. Forty-six of these outreach specialists are in full-time positions. These Specialists provide direct linkage to Veterans in treatment courts, including Veterans Courts. The 46 Veteran Justice Outreach Specialists being hired this year will work directly with Veterans in the criminal justice system to provide them appropriate care and services. We expect to help more than 7,500 Veterans through this program in 2010. Additionally, the Health Care for Re-entry Veterans (HCRV) program was developed to provide pre-release outreach, assessment, and brief term post-release case management services for incarcerated Veterans released from state and Federal prisons. The goal of the program is to promote successful community integration of Veterans by engaging them upon release in appropriate treatment and rehabilitation programs that will help them prevent homelessness, readjust to community life, and desist from commission of new crimes or parole or probation violations. The 39 HCRV Specialists have met with nearly 5,000 Veterans to aid their transition from prisons.

VA's 2011 budget will support clinical environments through the Compensated Work Therapy Program, and VA will offer community-based staff that will target supportive therapeutic opportunities for Veterans with significant health problems. Providing these services in community settings will make these services available for Veterans in locations that will encourage participation and enhance community opportunities. While hospital-based support services will continue serving Veterans, VA estimates that as many as 48,000 additional Veterans will benefit from this new approach.

We also are creating comprehensive efforts involving grants to community partners to provide supportive services to low-income Veterans and their families, including those making 50 percent or less of the area's median income. VA aims to improve very low-income Veteran families' housing stability through grantees (private non-profit organizations and consumer cooperatives) providing eligible Veteran families with outreach, case management, and assistance in obtaining VA and other benefits, which may include: health care services, financial planning services, transportation services, housing counseling services, legal services, child care services, and others. In addition, grantees may also provide time-limited payments to third parties (such as landlords, utility companies, moving companies, and licensed child care providers) if these payments help Veterans' families stay in or acquire permanent housing on a sustainable basis. This is critical to our efforts to end homelessness among Veterans. VA has draft regulations under review and we hope to publish them for public comment in time to allow us to issue a notice of funding availability early next calendar year.

Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans currently represent almost five percent of the population receiving VA benefits in its specialized homeless programs. This group tends to be younger, and women represent a greater proportion as well. It is imperative we act now to prevent this group from becoming chronically homeless and to ensure others of this generation do not become homeless either. Congress has asked VA, HUD and the Department of Labor to collaborate on a multi-site demonstration project to explore ways the Federal Government can do more to offer early intervention and to prevent homelessness among those returning from OEF/OIF. This collaborative effort will provide comprehensive community services for Veterans and families and intensive case management so that Veterans receive needed health care and benefits. VA continues to work with HUD to help determine sites that will receive funds for community-based intervention services for Veterans and their families. We are hopeful that HUD will be ready to announce the locations that will be funded within 60 days.

We know from past experience that homelessness among Veterans peaks 7-10 years after military service, and we are conducting aggressive early intervention now to ensure OEF/OIF Veterans do not have that same experience. Our current efforts have reached nearly 3,800 OEF/OIF Veterans, more than 1,100 of whom have sought homeless specific housing or treatment services. Since 2003, VA has expended 28,000 claims for compensation and pension for Veterans who are homeless or at-risk of homelessness.

Another prevention strategy VA is pursuing is a national homeless registry. This database will help us better track and monitor prevention, homeless response and treatment outcomes. It will provide a real-time data system that will identify all Veterans who have requested assistance and the programs and services in which they are engaged. This will in turn help us determine the effectiveness of our efforts. Our plan is to build on existing database systems, like the Homeless Management Information System (HMIS) currently operated by HUD, and to extend the database for use with our Federal partners.

HOUSING OPPORTUNITIES

While VA has many options for providing Veterans with housing assistance, the sentinel piece of these efforts is the HUD-VASH program. I cannot say enough about the positive aspects of HUD-VASH; it is literally ending homelessness for Veterans. This program is the Nation's largest permanent housing initiative for Veterans. Under this initiative, HUD provides permanent housing through housing choice vouchers to hundreds of local public housing authorities. VA provides dedicated case management services to Veterans living in those units to promote and maintain recovery, housing stability and independent living. We began this effort about 20 months ago, and as of February 2010, more than 19,000 Veterans have been accepted into the HUD-VASH program; more than 16,000 have received a housing voucher, and 10,600 formerly homeless Veterans are now housed through these efforts. Our case managers are working with the other 5,000 to locate and secure housing. VA is working closely with HUD to see that the funding Congress provided for an additional 10,000 vouchers is available as soon as possible.

Seventeen years ago, VA first offered funding to community and faith-based service organizations, as well as state and local governments, to provide transitional housing for homeless Veterans. Since then, VA has continued expanding transitional housing opportunities, and it now operates one or more programs in all 50 states, the District of Columbia, Puerto Rico, and Guam. Since 2007, approximately 15.6 percent of the projects receiving VA funds and 14.5 percent of the total funding were designed to help rural Veterans. These initiatives have provided 397 beds for rural

homeless Veterans. All together, there are more than 600 transitional housing programs, and there are two pending “notices of funding availability” that we expect will add more than 2,200 new units. These notices include targets to increase opportunities to service women Veterans and Veterans residing on tribal lands. The application deadline is March 31, 2010. This program has served almost 100,000 Veterans since it began, and we expect as many as 20,000 Veterans will benefit from transitional housing in FY 2010. This program helps Veterans find temporary housing (i.e., less than 2 years) and assists many Veterans in returning to independent living and gainful employment.

FINANCIAL AND EMPLOYMENT SUPPORT

Veterans who are homeless and those at-risk of homelessness often need economic help. Many have service-connected disabilities, and many combat Veterans are eligible for pension, vocational rehabilitation, or foreclosure assistance, among other benefits. Veterans struggling with homelessness often face challenges with maintaining gainful employment. Many Veterans who have been homeless have gone years without a steady job, and many have physical and mental health issues that require participation in a therapeutic rehabilitative environment before seeking employment.

Homeless Veterans and those at risk of being homeless need economic assistance. Many have service-connected disabilities and many are war-era Veterans eligible for pension. In addition to compensation and pension benefits and services, many Veterans need education, vocational rehabilitation and employment and foreclosure assistance.

Getting earned benefits to all Veterans is important. For homeless Veterans and those at risk, these benefits can make the difference in avoiding homelessness or exiting from it.

The Veterans Benefits Administration (VBA) is actively pursuing the engagement of individuals upon entrance into military service and throughout their military career so that they are fully aware of their entitlement upon discharge. Additionally, VBA is coordinating with the Veterans Health Administration’s health efforts and collaborating with our community partnerships to timely identify and process homeless Veterans’ benefits claims. Each VA regional office has a homeless Veteran coordinator designated to control and expedite the processing of homeless Veteran claims. In FY 2009, VBA received 6,285 claims from homeless Veterans and completed 5,888 homeless Veteran claims.

PARTNERSHIPS

VA has long maintained close working relationships with Federal partners, such as HUD, the Department of Labor (DOL), the Department of Defense, the Department of Health and Human Services, the Small Business Administration, the U.S. Interagency Council on Homelessness, and others, as well as state, local and tribal governments in its efforts to combat Veteran homelessness. Veterans Service Organizations also fill a critical role, as do community- and faith-based organizations and the business community. One example of these efforts is our work to develop better connections with prosecutors and judges in the criminal justice system. Another is the Homeless Veterans Reintegration Program (HVRP), which involves collaboration with DOL. Through this initiative, DOL’s Veterans Employment and Training Service (VETS) offers funding to community groups to help Veterans return to gainful employment. VA contributes and works closely with DOL to provide needed health care and benefits. Veterans benefit because their health and benefits needs are addressed in complement with their employment opportunities. We are happy to continue partnering with DOL, and we look forward to working with them as they develop new proposals to fund programs benefiting women Veterans, Veterans with families, and formerly incarcerated Veterans.

VA is also partnering with several Federal agencies in an effort to improve the utilization of HUD-VASH vouchers and to reach Veterans who are chronically homeless. Under the leadership of the U.S. Interagency Council on Homelessness and the White House Office of Urban Affairs, VA along with HUD, HHS, the Department of Justice and the Department of Labor will develop an interagency initiative that will bring the full arsenal of their resources to bear on the problem of homelessness. This initiative will not only target and house the most vulnerable Veterans that are chronically homeless, but it will also link them to employment, benefits and services to address other needs, including child support payments.

CONCLUSION

The President’s FY 2011 budget and FY 2012 advanced appropriation request for the VA will provide us with the resources necessary to transform VA into a 21st

Century organization and to ensure we provide timely access to benefits and high quality care to our Veterans over their lifetimes. Our Nation's Veterans experience higher than average rates of homelessness, depression, substance abuse, and suicides; many also suffer from joblessness.

The time to end homelessness among Veterans is now. With your help, we will effectively end homelessness for all Veterans who will seek or accept services from us. We owe every man and woman who wore our Nation's military uniforms no less.

Mr. Chairman this concludes my testimony. I am happy to respond to any questions you or the Committee may wish to ask.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO PETE DOUGHERTY, DIRECTOR, OFFICE OF HOMELESS VETERANS PROGRAMS, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. There are some critics out there that do not believe VA is equipped to end homelessness for the seriously mentally ill Veterans. How would you respond to this claim and how does the 5 year plan specifically address this population?

Response. The Department of Veterans Affairs (VA) is committed to ending homelessness among all Veterans. The Five Year Plan to End Homelessness includes significant enhancements focused on improving the treatment services VA provides to homeless Veterans and specifically homeless Veterans with serious mental illness (SMI). In this fiscal year, the Department of Housing and Urban Development-VA Supported Housing (HUD-VASH) has enhanced funding for case management services. This enhancement has enabled VA to decrease VA caseloads from 35:1 to 25:1 which allows case managers to provide more frequent and more intense services to homeless Veterans with SMI and Veterans with families. VA has also enhanced services to ensure that the Veterans who have been chronically homeless, continuously homeless for one year or who have had four or more episodes of homeless in the prior three years, receive timely access to the program. Additionally, VA has added over 80 addiction specialists to the HUD-VASH case management teams to better meet the needs of Veterans with co-occurring mental health and substance use treatment needs. In fiscal year (FY) 2011, vocational specialists will be added to the homeless outreach and case management teams to provide supported employment services, an evidence-based vocational service for individuals suffering from SMI. The current plan is to enhance every HUD-VASH team with vocational specialist.

To further address the needs of homeless Veterans with SMI, VA has enhanced Healthcare for Homeless Veterans (HCHV) contract residential treatment beds with supportive services designed to help engage the hard-to-reach, hard-to-engage homeless, and at-risk Veterans by providing temporary housing as an alternative to shelter care. VA has also increased funding for transitional housing through the Grant and Per Diem (GPD) program, which provides transitional housing to meet the needs of homeless Veterans with SMI. Moreover, VA's FY 2011 budget funds five new Residential Rehabilitation and Treatment Programs (MH RRTP) in large metropolitan communities, so that Veterans with more intensive treatment needs can receive services in their local communities.

The VA National Center on Homelessness Among Veterans is supporting a demonstration project in 16 Veterans Integrated Service Networks (VISNs) that combines homeless services with rural health intensive case management teams to better address the needs of homeless Veterans in rural communities who also suffer from a SMI. If proven effective, VA plans to expand this demonstration project to additional sites in future years.

VA has significantly expanded mental health services in recent years to promote greater access to services and to ensure that Veterans receive evidence-based treatments that promote recovery. These efforts have enhanced VA's ability to meet the needs of Veterans with SMI, many of whom are homeless and/or at risk for becoming homeless. VA has funded Rural Mental Health Intensive Case Management (MHICM RURAL) teams and expanded existing Mental Health Intensive Case Management (MHICM) teams. VA has also implemented Psychosocial Rehabilitation and Recovery Centers (PRRC) to provide a therapeutic and supportive learning environment for Veterans with SMI. In its residential and mainstream mental health services, VA has sought to codify and implement best practices at mental health programs throughout the country, thereby strengthening efforts to successfully treat the chronically homeless who are more likely to struggle with SMI. National policies on suicide prevention and medication management have improved safety, while the new Uniform Mental Health Services Handbook has expanded access by mandating

that all Veterans, wherever they obtain care in the Veterans Health Administration (VHA), have access to needed mental health services.

Question 2. HUD and VA should be commended for the level of coordination and cooperation they've had in getting HUD-VASH vouchers distributed to housing authorities with quick guidance on program rules and regulations. Unfortunately that same level of cooperation isn't playing out in many communities where housing authorities (PHAs) and VAMCs are simply not leasing up vouchers as quickly as they should. What can we do to improve lease-up rates for these vouchers? Should PHAs and VAMCs be required to have a memorandum of understanding in order to be awarded vouchers? For communities that are using HUD-VASH very successfully, how can we better get their story shared with other communities?

Response. Both HUD and VA are committed to promoting timely access to permanent supportive housing through HUD-VASH. Both agencies are working closely together and enacting several key initiatives to improve access to HUD-VASH. VA has established performance monitors that promote timely hiring of case managers and timely lease-up rates of awarded vouchers by medical centers. Medical Centers that are deficient have been asked to provide performance improvement plans. Both HUD and VA have conducted consultative site visits with communities experiencing implementation delays. These visits have assisted in reducing barriers and promoting greater coordination between VA, Public Housing Authorities (PHA) and community partners. VA plans to continue this process through FY 2010. VA is also looking for ways to streamline the referral process as part of this improved coordination for all sites. VA and HUD have added a performance component to the voucher award allocation process for 2010 that incentivizes high performers and challenges low performers to increase their productivity as a pre-condition to receiving additional vouchers. VA and HUD are also encouraging targeted project-based developments in communities where there are difficulties securing safe, affordable housing and where there is capacity to rapidly establish a project-based program for Veterans. VA and HUD will continue to conduct training for both VA case managers and for PHA staff. Four Regional trainings are planned for this year, and VA and HUD will continue to conduct satellite broadcasts for staff. In response to extreme situations, VA and HUD have also reassigned PHAs and contracted out case management services in an effort to improve lease-up rates.

In FY 2010, VA is promoting the utilization of a Housing First Model in several large cities. Housing First promotes rapid and direct placement of homeless individuals and their families into housing emphasis, and offers treatment and supportive services with variable intensity and frequency as an integrated component of the service. The Housing First approach represents a change from linear models that seek to prepare individuals for permanent housing by requiring completion of treatment in residential rehabilitation or transitional housing, and often require demonstrated sobriety before moving into permanent independent housing.

The question of whether there should be a required memorandum of understanding between the VA medical center and PHA has been raised. Both agencies believe that this is not necessary, and may, in some cases, even impede timely access. What is most critical is an ongoing dialog between the VA case management team and the PHA to mutually define targets, identify areas for improvement and monitor progress.

In an effort to share successful programs and best practices with other PHAs, VA and HUD sponsored a workshop on this topic at the national HUD-VASH training held in June 2009. Similar workshops will be held at the upcoming regional training sessions. In addition, VA and HUD plan to conduct site visits at four of the top-performing HUD-VASH sites, for the specific purpose of identifying the policies and practices that have created the positive results we are hoping to achieve at all sites. The information learned from these sessions will be distributed to all HUD-VASH sites in the form of a "best practices" document.

Question 3. Please elaborate on the residential rehabilitation treatment and domiciliary care programs for homeless Veterans?

Response. Mental Health Residential Rehabilitative Treatment Services Programs (MH RRTP) provide residential rehabilitative and clinical care to eligible Veterans who have a wide range of medical, psychiatric, and substance use illnesses. MH RRTPs are designed to provide comprehensive treatment and rehabilitative services meant to decrease reliance upon more resource-intensive forms of treatment and improve the quality of the Veteran's functioning. The residential component promotes personal responsibility and self-care lifestyle changes in a milieu that provides opportunities to practice and master new skills. Many Veterans require treatment for illnesses that are severe enough to warrant residential rehabilitative care. These illnesses adversely impact the Veteran's vocational, educational, social functioning and

housing conditions. VA operates a wide range of mental health and substance use disorder residential programs under the Mental Health Residential Rehabilitation Treatment Program (MH RRTP) continuum. Currently there are 236 MH RRTP programs with over 8400 beds. FY 2009, the MH RRTPs served approximately 34,000 Veterans of which approximately 60 percent were homeless Veterans. FY 2009 outcome data on Veterans discharged from the DCHV and Compensated Work Therapy (CWT/TR) programs indicate that 55.6 percent and 73 percent, respectively, are housed, either in an apartment, a room or a house.

Domiciliary Care for Homeless Veterans (DCHVs) Programs are MH RRTPs that provide a residential level of care specifically for homeless Veterans in a structured and supportive rehabilitative treatment environment.

The Domiciliary Care for Homeless Veterans (DCHV) program provides homeless Veterans with 24 hour-per-day, 7 day-per-week (24/7), time-limited residential rehabilitation and treatment services to include care for medical health, psychiatric health, substance use disorders and sobriety maintenance support. These programs also provide medication management; social and vocational rehabilitation; and include work-for-pay programs.

The mission and goals of the DCHV Program are to: 1) address the co-occurring disorders and complex psychosocial barriers that contribute to homelessness among Veterans; 2) improve Veterans' health status, employment performance and access to basic social and material resources; 3) reduce overall reliance on costly VA inpatient services, and, most importantly; 4) reduce homelessness by preparing Veterans for, and facilitating their transition to, appropriate community housing. From the program's inception in 1987 to the end of FY 2009, more than 98,000 episodes of treatment have been provided. A three-month post-discharge outcome study of the DCHV program showed that program participation was found to be associated with improvement in all areas of mental health and community adjustment in particular; increases in social contact with friends and family and increases in income primarily from earnings from employment. Among Veterans discharged from DCHV treatment in FY 2009, 71 percent were noted to have improvements in financial status. In FY 2008, the average monthly earnings, among Veterans participating in CWT/TR working either part time or full-time, were approximately \$800/month.

Over six thousand episodes of DCHV care (n=6,311) were completed during FY 2009, nearly 400 more episodes than in FY 2008. The mean age of Veterans receiving treatment is 49.6 years and 4.9 percent were women (n=309 females). Half of Veterans in DCHV programs served during the Post-Vietnam Era, nearly one-third served during the Vietnam Era and 17.1 percent served during the Persian Gulf Era. Of particular note, 69 Veterans reported service in Afghanistan and 278 Veterans reported serving in Iraq, or 5.5 percent of the total Veterans admitted to DCHV. The proportion of White Veterans was 48.5 percent, with 43.6 percent African American Veterans and 5.0 percent Hispanic Veterans. Fourteen percent of Veterans entering the program were homeless for less than one month, 47.4 percent were homeless between one to eleven months; 27.3 percent were homeless for a year or more and 11.8 percent of Veterans were considered to be at risk of homelessness.

Monitoring data indicate that ninety percent of Veterans discharged from the DCHV Program in FY 2009 had a substance use disorder and over half had both alcohol and drug problems. In addition, over two-thirds (68 percent) of participant Veterans had a diagnosis of a serious mental illness, and 61 percent had both a serious mental illness and a substance use disorder. As the mean age of Veterans in the program has increased over the years, so has the proportion of Veterans with serious medical conditions. In FY 2009, Veterans were diagnosed with the following medical conditions: orthopedic problems (42 percent), hypertension (37.7 percent), liver disease (22.3 percent), gastrointestinal problems (17.9 percent) and diabetes (11.8 percent).

The average length of stay in FY 2009 was approximately three and a half months and nearly three-quarters of Veterans successfully completed the program. Over 80 percent of Veterans were discharged to an appropriate community environment after completing their DCHV treatment. Nearly one-third (30.5 percent) went to live in their own apartment, room or house and an additional 25.1 percent were discharged to a stable arrangement in an apartment, room or house of a family member or friend. While the majority of Veterans were housed at discharge, 26.7 percent continued to receive additional treatment either in a halfway house or transitional housing program, a hospital or nursing home, or another domiciliary program. Twenty-two percent of veterans were able to secure part-time or full-time employment at the time of their discharge. One quarter of Veterans were unemployed and 23.6 percent were retired or disabled. An additional 18.1 percent had arrangements to participate in a VA work therapy program such as Compensated Work Therapy (CWT) or Incentive Therapy (IT). Data is not currently available on the

number of Veterans that return to DCHV treatment; however, data are available on Veterans discharged from DCHV treatment who are re-admitted to an acute VA inpatient psychiatric bed section. During FY 2009 5.2 percent of Veterans were re-admitted to an acute VA inpatient psychiatric bed section 30 days following their DCHV discharge. Data from VA's administrative file, the Monthly Program Cost Report indicates that the average cost per episode of treatment in the DCHV program during FY 2009 was \$20,653. Approximately 6 percent of Veterans participating in VA's HUD—VASH program were referred by a MH RRTP including a DCHV program. Housing affordability will vary depending on the local housing market and availability of housing. Other factors to consider include the local economy and the availability of good paying full-time jobs. There are creative ways that VA assists Veterans in obtaining affordable housing including sharing apartments with other Veterans, placements in the Oxford House model, and referrals to VA's HUD-VASH program. VA continues to forge relationships with community non-profit organizations to build affordable and permanent housing specifically for Veterans.

Currently there are 42 DCHV sites with a total of 2,152 operational beds located in all 21 VISNs. VA is planning to develop five additional new 40-bed DCHV programs in large metropolitan locations.

Question 4. How does VA measure the success of its many homeless Veteran programs?

Response. VA will measure the success of its homeless Veteran programs by the consistent reduction of the number of homeless Veterans. The ultimate success for the VA homeless programs is when a formerly homeless Veteran is able to live as independently and self-sufficiently as possible in a community of his or her choosing. Veterans living in shelters or sleeping on a couch in others' housing are still homeless, and ending that homelessness requires placing those Veterans in permanent housing, with access to any treatment or other supportive services they require. There are other, more program-specific goals related to outreach, residential treatment, access and sustaining mental health and primary care, employment and accessing benefits both inside and outside of the VA. The ultimate goal is to eliminate Veteran homelessness by assisting homeless and at-risk Veterans in obtaining stable, safe, and affordable housing. Through stable, safe, and affordable housing, Veterans will reach their highest level of recovery, enjoying an improved quality of life and functioning at the Veteran's highest possible level.

The VA Homeless Program Office has a robust and comprehensive data collection system overseen by the Northeast Program Evaluation Center (NEPEC) located at New Haven VA Medical Center. This office has been providing homeless program evaluation for the past 20 years. A broad array of information about homeless Veterans and the care they receive from VHA homeless programs is collected, analyzed, and published in quarterly and annual reports. The categories of data collected include the following: Program Structure and Resources (e.g., number and type of treatment beds, occupancy rate, staffing information), Veteran Characteristics (e.g., demographics, psychosocial, psychiatric, vocational, legal history), Process Data (e.g., number of Veterans treated, type, frequency, and intensity of services provided), and Discharge and Post-Discharge Outcomes (e.g., length of stay, discharge to independent housing, sobriety at discharge and follow-up, readmission rates to inpatient psychiatry).

Information about homeless Veterans and the services they receive is collected at numerous time points, including at first contact through outreach, at admission to a homeless program, at variable intervals while receiving care within certain programs (e.g., Housing and Urban Development-VA Supported Housing (HUD-VASH)), at discharge from a homeless program, and at follow-up intervals for Veterans discharged from certain homeless programs (e.g., Grant & Per Diem (GPD) Program). This information is collected via multiple methods, including online data collection managed by NEPEC, manual completion of surveys and forms that are submitted to NEPEC, and information sharing between NEPEC and the VISN Support Services Center (VSSC).

In most cases, a VA employee completes a survey or online form related to the homeless Veteran and services he/she received. This information is Veteran-specific and is submitted to NEPEC where it is compiled into quarterly and annual reports at the national, VISN, and medical center levels. In cases where the Veteran is providing direct feedback about services received, the Veteran completes the form and submits it to a VA employee in a sealed envelope who submits it to NEPEC. This information is utilized at all levels to review, analyze and make adjustments in programming and services as needed.

Consistent with VA's goal of establishing a homeless registry and a data management system capable of generating real time reports, the office has been developing a web based data entry system that will be designed to be Veteran-centric. The new

data system will generate reports that describe both Veteran-specific episodes of care data and program-specific information. The data management system will also be used to help populate a more comprehensive Homeless Registry so VA will have the capacity to monitor on an ongoing basis treatment outcomes of Veterans who have fallen into homelessness or who were identified as at risk for homelessness and received supportive services from VA or other community partners. The first phase of the data management system will be available in May 2010.

One of the most exciting aspects of this new data management system is the real-time nature of the data. In the past, national program reports lagged after the end of the fiscal year. With this first phase of the registry and data management system, the Homeless Program Office can answer questions related to its programs with data up to the previous completed month. For example, in the first half of FY 2010, 53 percent of Veterans who discharged from GPD obtained stable, independent housing. VA has not historically collected actual income levels at admission and discharge, but future phases of the registry will include this data and enable specific evaluation of improvement in income over the course of treatment in a VA homeless program.

The first phase of the homeless registry and data management system focused on internal VA data. Future phases will include data sharing agreements with other national agencies in order to incorporate critical data on homeless services and resources that the Veteran receives outside of VA. Extended discussion has occurred with HUD regarding the compatibility between the Homeless Registry and HUD's Homeless Management Information System (HMIS), with plans to connect these two systems so that the HMIS data can be reflected in the VA Homeless Registry and vice versa. There are challenges still to overcome in this endeavor, primarily related to the fact that the HMIS does not include individual-specific data, whereas the ability to reflect Veteran-specific data is crucial to the functioning of the Homeless Registry.

Question 5. Unfortunately, not all stories about the HUD-VASH program are positive. Occasionally there are reports about an area being awarded an increase in vouchers, but within a year, less than half of them were used. With the significant increases recently in the number of vouchers awarded across the country, what obstacles do VA's case managers face when trying to locate and secure housing for Veterans?

Response. The most significant challenges to VA case managers include assisting Veterans with security deposits, utility deposits, down payments for first and last month rents, and obtaining the essentials to move into housing (bedding, tableware, furniture, etc.). Related concerns include assisting Veterans with credit restoration so they can be more attractive candidates for landlords. In addition, many veterans have accrued large amounts of child support arrearage incurred while the veteran was homeless, in a phase of active addiction, or otherwise untreated for a serious mental illness. For incarcerated veterans, growing arrears from unpaid child support can be particularly challenging to their ability to reintegrate in the community. In some large metropolitan communities, limited availability of safe, accessible housing stock has contributed to delays in lease up rates; however, this is not a large scale concern and HUD and VA are working with those communities to explore options to maximize HUD-VASH implementation.

Recently HUD has awarded funding for Homelessness Prevention and Rapid Re-Housing (HPRP) which does encourage the use of these funds to assist Veterans in HUD-VASH. Access to these funds has not been uniform, however, and the two agencies are developing strategies to maximize access to these resources. Enhancing access to these funds or similar funding will improve lease-up rates in the HUD-VASH program.

Question 6. A few of the witnesses on the second panel believe that VA has good programs, yet, they are not as successful as they could be due to poor implementation at the local level. What kind of oversight do you and your staff conduct regularly to ensure proper implementation of the programs

Response. VA agrees that its homeless programs are effective and that the level of cooperation and coordination between Federal and community partners is high, but notes there are outliers who are under performing. To address these issues, VA and HUD have been conducting joint satellite broadcast training and providing information to the field to promote more timely implementation and compliance with programmatic goals. The VA Homeless program office has established metrics to monitor medical center performance related to the Five Year Plan. Currently, the HUD-VASH monitor is reviewed with the VISN Directors in their quarterly meetings with the Deputy Under Secretary for Health for Operations and Management. VA and HUD have conducted site visits with underperforming communities, and

both agencies have monthly calls to assist with questions and concerns related to implementation. As HUD-VASH continues to grow, VA and HUD are planning to provide more focused technical assistance to the field to improve timely access and compliance with program goals, and both agencies plan to continue joint site visits to promote more timely and coordinated access to services. VA, HUD and US ICH are also working closely together to develop strategies for enhancing coordination of programs serving homeless Veterans.

For the past 20 years, VA has been conducting program evaluations for its homeless services. Within this reporting structure VA has been able to identify service utilization for homeless Veterans who have accessed VA funded programs such as Outreach, Residential Rehabilitation and Treatment, Grant and Per Diem, HUD-VASH and VA Contract housing. In addition, VA is developing a registry that will be designed to identify service utilization of Veterans both inside and outside of the VA. Once complete, the registry will promote VA's capacity to track service utilization and outcomes for our Veterans who have fallen into homelessness.

Question 7. What challenges do you face when trying to execute your department's homeless Veteran programs in conjunction with another agency's programs?

Response. The level of cooperation between the VA's homeless Veterans programs and other agencies programs has been remarkable. Our most significant partners are the United States Departments of Housing and Urban Development (HUD) and the Department of Labor (DOL). Some challenges are the result of the different cycles of times for notices of funding availability (NOFA), but these are modest in comparison to the added strength in collaboration between agencies that provides to all programs serving homeless Veterans. One specific challenge relates to the At-Risk Pilot for recently discharged Veterans, a significant percentage of whom are Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) Veterans, and their families. While VA and HUD have worked closely for months to determine the locations which should receive HUD funding for the pilot, the VA cannot recruit staff until HUD makes their announcement.

We are also developing a working relationship with the Department of Health and Human Services (HHS) to address findings from the most recent CHALENG survey (Please see response to question 3, Senator Burris), completed by service providers, advocates and Veterans themselves, who identified assistance with family related issues including assistance with child support, child care and family reunification as unmet needs. Currently HHS's Office of Child Support Enforcement, the American Bar Association, and the VA have formed a collaborative effort in nine major cities to address unresolved child support issues that may impact the Veteran's ability to obtain and retain employment.

Question 8. HUD's homeless programs have embraced the Housing First model, in which homeless individuals have access to housing first and then providing services as needed. A growing body of research has validated this model and the media is reporting on it more frequently. This model differs from a more linear approach Veterans housing programs take, in which individuals are expected to first demonstrate their "ready" for housing. Can you describe the differences and similarities in the two Department's approaches? Does the VA intend to encourage the homeless providers it supports to utilize a housing first approach?

Response. Until the enhancement of HUD-VASH in 2008 with 10,000 vouchers, VA was not fully engaged with permanent supportive housing models, but focused on residential treatment and transitional housing models. With the growth of HUD-VASH, VA has been meeting with HUD and the community to explore enhancing its current practices to be more supportive of permanent supportive housing models, including "Housing First". Housing First is a widely applied service approach encompassing a broad range of treatment and supportive services offered to individuals who are homeless. Housing First promotes rapid and direct placement of homeless individuals (in some cases with accompanying family members) into housing, and offers treatment and supportive services with variable intensity and frequency as an integrated component of the service. In some programs, for example, 24 hour Assertive Community Treatment coverage is offered, but only minimal (twice monthly) participation is required. The Housing First approach represents a change from linear models that seek to prepare individuals for permanent housing by requiring completion of treatment in residential rehabilitation or transitional housing, (e.g., VA's Homeless Providers Grant and Per Diem program), and often require, as well, achievement of sobriety, before moving into permanent independent housing. VA is aware that Housing First is a proven best practice for the chronic homeless population who present with serious mental illness and VA is working with HUD and select communities to evaluate how it can adapt this approach for Veterans seen in HUD-VASH.

Question 9. The Committee is concerned about outreach and identification of homeless Veterans who are eligible for HUD-VASH vouchers. We understand that many VAMCs are identifying potential VASH recipients from Grant and Per Diem programs, and that by doing so they are failing to serve the chronically homeless Veteran who is still out on the street and has been for a very long time. Is data available for how many VASH voucher holders came directly from a Grant and Per Diem program? How can the Department encourage VAMCs to better identify chronically homeless Veterans who may not be currently accessing VA services?

Response. VA understands the importance of targeting homeless Veterans who are currently on the streets and in shelters. In a memorandum to the field regarding HUD-VASH funding for FY 2010, VA has made it very clear that targeting chronically street homeless and Veterans who are in emergency shelters is critically important, and that each medical center must target our most vulnerable, chronically homeless Veterans who also have the most acute needs. Additionally, each VA medical center must make every effort to coordinate with our community partners, especially the local Continuum of Care, to identify this most vulnerable population with referrals to HUD-VASH. Referrals from the community into HUD-VASH are vital to meeting our goals, so every effort must be made to enhance these partnerships. VA is currently in the process of revising its HUD-VASH evaluation tool so that data regarding the sources of the referral will be gathered and monitored.

VA has a full continuum of treatment and supportive services where homeless Veterans with SMI can receive services including specialized Residential Rehabilitation and Treatment Programs and Grant and Per Diem (GPD) Programs. Many of the Veterans served in these programs were referred from the streets and shelters. Based on preliminary program evaluation data for HUD-VASH, approximately 30 percent were referred to HUD-VASH from VA transitional housing and treatment programs (Residential Rehabilitation and Grant and Per Diem).

Many specialized GPD programs focus on homeless Veterans with substance use issues, mental health disorders, chronically homeless Veterans, and chronically mentally ill Veterans. Services provided to these clients include substance use disorder education and treatment, relapse prevention, cognitive-behavioral therapy, other individual psychotherapy, Veteran-to-Veteran peer support groups, recreational activities, case management, vocational assessment and computer training. GPD providers who have successfully housed chronically homeless Veterans for many years understand the special needs of this population including a preference for living in Veteran-specific housing, among their peers. Providers work closely with VA medical centers to share their experiences in working with this population.

Question 10. In the 110th Congress this Committee passed legislation (S. 2162, The Veterans' Mental Health and Other Care Improvements Act), which became law in September 2008. Among other provisions, the bill authorizes the VA Secretary to provide grants to community organizations to provide supportive services to homeless Veterans. Can you please update us on the distribution of those funds?"

Response. The Supportive Services for Veteran Families (SSVF) program currently has published proposed rules in the *Federal Register*. The public comment period for these proposed rules closed on June 4, 2010. The VA is currently evaluating these comments. In order to disseminate information about this new program, VA has awarded a technical assistance contract to the Corporation for Supported Housing (CSH). CSH is currently working with the VA on a plan that will educate and assist potential grant applicants who may want to apply for the SSVF program funding. Before the end of the calendar year, VA expects to have final regulations approved and issue a notice of funding availability (NOFA).

Through the Supportive Services Grants VA will offer funding to non-profit organizations to work with Veterans and their families in order to maintain them in their current housing and to help them gain permanent housing. These community-based programs will offer eligible Veterans and their families' limited rental assistance, child care services, employment training, emergency supplies, case management and referral services, such as linkages to primary and specialty care services, as well as other community entitlement and supportive services.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. JIM WEBB TO PETE DOUGHERTY, DIRECTOR, OFFICE OF HOMELESS VETERANS PROGRAMS, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary Shinseki, according to VA's Director of Homelessness, as of February 10, 2010, more than 19,000 Veterans have been accepted into the HUD-VA Supported Housing (HUD-VASH) program; more than 16,000 have received a housing

voucher, and 10,600 formerly homeless Veterans are now housed through these efforts.

Question 1. How many of those 19,000 Veterans subsequently no longer need vouchers because they were able to raise their income to a level sufficient to lead an independent life?

Response. It is important to note that all of the 19,000 homeless Veterans accepted into HUD-VASH case management services were recently identified as homeless and have been admitted into the program within the past 24 months. As part of the admission process, VA assures that the Veteran meet eligibility requirements for homelessness while the Public Housing Authority (PHA) determines if they meet income eligibility requirements. Once it is determined that the Veterans meet income eligibility requirements, they are issued a housing voucher and the VA case manager works with them to place them into housing. Of the 19,000 Veterans admitted into HUD-VASH, only 10,600 were placed in housing as of the end of February. It is important to note that some Veterans admitted and housed through HUD-VASH no longer need the support of HUD-VASH and are able to move into more independent housing allowing the voucher to be re-issued to another Veteran.

HUD-VASH is in the early stages of implementation and there is insufficient data for a meaningful response on the average length of support through the voucher program or to identify how many vouchers have been returned. The evaluation plan is designed to answer this type of questions at a later date. In addition, as the following discussion covers, Veterans using the voucher program have serious challenges, and rapid progress toward no longer needing the voucher should not be a program goal. In general, sustained housing through HUD-VASH or other permanent housing is a primary goal.

HUD-VASH is a joint program between the Department of Veteran Affairs (VA) and the Department of Housing and Urban Development; its goal is to move Veterans and their families out of homelessness and into permanent housing with case management services as needed. VA provides case management services, and HUD provides permanent housing subsidies to homeless Veterans and their families, as defined by the McKinney Act, Title 42, United States Code, Section 11302. VA screens homeless Veterans for program eligibility. HUD allocates rental subsidies from its "Housing Choice" program, which is administered by the Office of Public and Indian Housing. VA case management services are a core component of the program, designed to improve the Veteran's physical and mental health, and to enhance the Veteran's ability to live in safe, affordable permanent housing in a community chosen by the Veteran.

The target population for HUD-VASH includes homeless Veterans with disabilities that require ongoing case management services to help them obtain and remain in permanent housing. The 19,000 Veterans accepted for case management services have been deemed clinically eligible for the program and work with VA to submit a formal application to the local Public Housing Authority, which determines financial eligibility for the program. All 19,000 accepted for case management are thought to need the voucher to achieve housing, and case management services to ensure ongoing connection to treatment and other supports. Veterans entering into HUD-VASH do have significant disabilities and are anticipated to require ongoing supports to live in the community. As a result, Veteran participants in HUD-VASH are not expected to begin functioning completely independently within a short time; Veterans with time-limited or less serious needs are referred for services in other VA programs without the long-term orientation of HUD-VASH.

Question 2. What is the average length of time a voucher is needed by a HUD-VASH recipient?

Response. HUD-VASH is in the early stages of implementation and there is insufficient data for a meaningful response on the average length of utilization of vouchers. The evaluation plan is designed to answer this question at a later date. Veterans entering into HUD-VASH do have significant disabilities and are anticipated to require ongoing supports to live in the community.

Question 3. What is the average per capita cost of a homeless Veteran in the HUD-VASH program?

Response. The average per capita cost of VA case management services is approximately \$4,500. The cost of VA health care services for Veterans in HUD-VASH is likely to vary significantly and is not tracked by the HUD-VASH program, as Veteran participants are eligible for this care regardless of their participation in HUD-VASH. Annual costs associated with the vouchers themselves are borne by HUD.

Question 4. Please describe the additional supportive services the VA intends to use to transition Veterans off HUD-VASH.

Response. VA will provide additional supportive services to assist Veterans moving from HUD-VASH to independent living in the community, including vocational rehabilitation services with case management, traditional mental health and primary care services, and the facilitation of access to VA benefits. Some Veterans may also qualify for VA and/or community based prevention services designed to assist individuals rapidly return to independent housing in the community. These time-limited supportive services can include case management, financial assistance, child care, vocational training and transportation.

Question 5. What are the average costs, by state, of providing support to homeless Veterans through established group housing shelter programs as, for instance, the New England Center for the Homeless?"

Response. We cannot answer this question as phrased, since VA does not have direct access to cost data from non-VA programs. We can provide costs for VA programs that provide housing as well as a broad array of other VA services to help the Veteran end homelessness.

VA funds community-based transitional housing programs through its Grant and Per Diem program. Grant and Per Diem support can help defray operational costs for community-based programs that have been awarded grants. Capital grants can help enable providers to acquire or renovate physical facilities for use as transitional housing. The per diem component pays for operational costs (services, utilities, etc) based on the provider's cost per Veteran per day. In accordance with current regulations, VA can pay up to \$34.40 per day in per diem funds. Costs are calculated based on budgets submitted by the grantee. Currently, the average rate paid nationally is approximately \$31.00. This equates to an estimated \$1,000 per month, per Veteran. Data for average costs by state for VA's Grant and Per Diem Programs could be obtained by June 1, 2010.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. ROLAND W. BURRIS TO PETE DOUGHERTY, DIRECTOR, OFFICE OF HOMELESS VETERANS PROGRAMS, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Mr. Dougherty I am following Senator Tester's questions. I would also be very interested in seeing your plan to address Veteran homelessness in rural areas, as it is developed.

Response. VA remains concerned about the needs of all homeless Veterans in both urban and rural settings. The Grant and Per Diem Program has funded more than 600 projects across the country of which approximately 16 percent of the projects funded and 15 percent of the funds awarded have gone to programs that serve Veterans in rural areas. Additionally, VA targeted funding to states that did not have an operational Grant and Per Diem Program, of which the majority were rural states. VA awarded funds to create one or more operational programs in each state.

VA's most recent Grant and Per Diem funding round is targeted to programs that would operate on tribal lands. HUD-VASH is another program that addresses Veteran homelessness. Both HUD and VA have increased resources for permanent housing with case management into our rural communities. Additionally, VA's homeless programs work collaboratively with VA's Office of Rural Health by conducting demonstration projects to enhance homeless and mental health services. Re-adjustment Counseling Services are also being expanded in rural sites. New centers are being established and mobile teams are being deployed to assist with outreach and engagement of our homeless and at-risk for homelessness population.

Question 2. Mr. Dougherty, I am sure many of the homeless Veterans that you are working to identify do not even have basic identifying documentation. Could you elaborate on how you verify Veteran status? Does this process impede speedy access to services?

Response. While documentation of Veteran status is an issue for benefits and services, VA's approach has been to engage all persons who identify themselves as Veterans and seek documentation as soon as possible. The vast majority of Veterans who seek our services have utilized VA services in the past. VA does all it can to expedite verification for those who have not been seen previously. If a Veteran has not been seen within the Veterans Health Administration within the past three years, a request is made to the Veterans Benefits Administration to determine Veteran eligibility.

Question 3. Mr. Dougherty, I understand that some significant steps have been taken federally in terms of interagency communication, but I was hoping you could elaborate on how this cooperation filters down to the local VISNs? What type of co-

ordination of services is occurring on the local level? Is there any way that you track the services that homeless Veterans are receiving from multiple providers?

Response. VA at the highest levels has been an active part of that national effort. VA collaborates at all levels; Federal, regional and local. VA is an active participant of the US Interagency Council on Homelessness (USICH). USICH is the Federal coordinating body that works tirelessly to coordinate efforts across departmental lines to improve the delivery of meaningful services to all homeless people.

All of VA's 21 Veterans Integrated Service Networks (VISNs) has a Network Homeless Coordinator who is responsible for coordinating homeless services at the regional levels. Part of their responsibilities include building partnerships with community organizations, coordination of services within the VISNs and ensuring continuity of information regarding homeless Veterans both within the VA and with community partners. Additionally, each medical center has a Health Care for Homeless Veteran coordinator who is responsible for coordination of care for homeless Veterans which includes connections to community agencies. At the local level VA works closely with local government, community agencies, philanthropic organizations and Vet Centers and regional offices that assist Veterans.

In 1993, VA launched Project Community Homeless Assessment Local Education Networking Groups (CHALENG) for Veterans. CHALENG is a program designed to enhance the continuum of services for homeless Veterans provided by local VA healthcare facilities and their surrounding community service agencies. The guiding principle behind Project CHALENG is that the VA must work closely with the local community to identify needed services and then deliver the full spectrum of services required to help homeless Veterans reach their potential. Project CHALENG fosters collaborative planning by bringing VA together with community agencies and other Federal, state, and local government programs. This cooperation raises awareness of homeless Veterans' needs, and spurs planning to meet those needs. Meeting the goals of Project CHALENG requires each VA medical center to:

- Assess the needs of homeless Veterans living in the area;
- Assess community needs in coordination with representatives from state and local governments, appropriate Federal departments and agencies and non-governmental community organizations that serve the homeless population;
- Identify the needs of homeless Veterans with a focus on healthcare, education, training, employment, shelter, counseling, and outreach;
- Assess the extent to which homeless Veterans' needs are being met;
- Develop a list of all homeless services in the local area;
- Encourage the development of coordinated services;
- Take action to meet the needs of homeless Veterans;
- Educate homeless Veterans about non-VA resources that are available in the community to meet their needs.

For the past 20 years, VA has been conducting program evaluations for its homeless services. Within this reporting structure VA has been able to identify service utilization for homeless Veterans who have accessed VA funded programs such as Outreach, Residential Rehabilitation and Treatment, Grant and Per Diem, HUD-VASH, and VA Contract housing. In addition, VA is developing a registry that will be designed to identify service utilization of Veterans both inside and outside of the VA. Once complete, the registry will promote VA's capacity to track service utilization and outcomes for our Veterans who have fallen into homelessness.

Question 4. Mr. Dougherty, I understand that the St. Leo's Residence, run by Catholic Charities, is the only operational project under the Loan Guarantee for Multifamily Transitional Housing Program. They are providing outstanding service to Homeless Veterans in Chicago. However, as you may be aware, the design of this particular pilot program presents challenges in securing operational funding. I understand that you have been in talks with the facility about options going forward; could you give me an update on the full range of options being considered?

Response. VA worked to create transitional housing opportunities for homeless Veterans under the Multi-family Housing Loan Guarantee Program for a decade. VA tested the pilot as Congress directed and found it to be an ineffective method to create housing options for Veterans. VA wrote the Senate Veteran Affairs Committee in January 2009 stating that the effort was ineffective and VA would no longer pursue this project. As you noted, the only loan guarantee made was to Catholic Charities in Chicago. That program has worked hard to meet its obligations under the terms of the agreement, and there have been a number of discussions to see if their existing agreement can be modified to allow changes that will positively affect Veterans in that housing program.

VA would be happy to meet with you to review the possible options and will keep you apprised of any change that may need to be made to the existing agreement.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. MIKE JOHANNIS TO
 PETE DOUGHERTY, DIRECTOR, OFFICE OF HOMELESS VETERANS PROGRAMS, U.S.
 DEPARTMENT OF VETERANS AFFAIRS

Question 1. Let me say that I appreciate the aggressive approach both agencies are cooperatively taking to tackle the national problem of Veteran homelessness. In particular, the HUD-Veterans Affairs supportive Housing (HUD-VASH) program [manages housing vouchers for Veterans] will play an important role in ending homelessness among Veterans that Secretary Shinseki is striving for. But ending homelessness among Veterans will require that the programs described in your testimonies reach all sectors of our societies.

Response. VA fully concurs that if we are to end Veteran homelessness, VA must have services that reach all sectors of our society to promote access to VA services in both rural and urban settings. As the plan continues to be implemented, VA will be monitoring its impact and making adjustments to ensure that all Veterans who are homeless or at-risk for homelessness have access to VA services.

Chairman AKAKA. Thank you very much.

Mr. Jefferson, please proceed with your testimony.

STATEMENT OF RAYMOND M. JEFFERSON, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR

Mr. JEFFERSON. Yes. Chairman Akaka, Ranking Member Burr, Senator Murray, Senator Tester. Aloha.

Chairman AKAKA. Aloha.

Mr. JEFFERSON. Two weeks ago I had the privilege of welcoming the Honor Flight at National Airport, welcoming several of our World War II veterans to the Nation's Capital, and to shake the hand of a Pearl Harbor survivor. It was an inspiring reminder of the honor and privilege we have as vets to serve this community and the importance of providing them with the very best programs and services.

I am grateful today to show what we are doing at the Department of Labor's VETS and in collaboration with our partners to help end veterans' homelessness.

Veterans are a priority of Secretary Solis and a priority of the Department of Labor. We are fully integrated into the Secretary's goal of good jobs for everyone and keeping veterans and their families in the middle class.

VETS. We provide expertise and assistance to assist and prepare veterans to obtain meaningful careers, to maximize their employment opportunities, and to protect their employment rights. We do that in close partnership with stakeholders and other government agencies like those represented here at the table, HUD, VA, HHS, and DOD.

Three words symbolize the approach we are taking at VETS to help end veterans' homelessness: excellence, innovation, and transformation. I would like to share four examples of those.

The first example is prevention. Our transition assistance program (TAP) currently has a module on preventing homelessness where for those 142,000 members who go through it, we do a diagnostic to help assess their risk factor for being homeless and then connecting them with resources if they are at risk to prevent them from becoming homeless.

I am currently doing a review of that module to see how it can be strengthened and improved as part of our TAP modernization process.

Number 2, let us talk about action. We have our Homeless Veterans' Reintegration Program. The only Federal nationwide program that focuses on the employment of homeless veterans.

Right now, with our budget for fiscal year 2010 of \$36 million, we are serving around 21,000 homeless veterans through that program. What we do is we provide them with the training and services to prepare them to obtain meaningful careers.

A significant new undertaking is identifying the best practices to serve homeless women veterans and homeless veterans with families. The old models and ways of doing that are not effective. We have learned that from the 60 listening sessions that the Women's Bureau has held with homeless women veterans.

So, we are taking \$5 million to fund about 25 grantees this year to determine which best practices serve homeless women veterans and to get those women into meaningful careers. Next year, we will continue funding those same 25 grantees.

Additionally we have a program for incarcerated veterans. This is a population that is at tremendous risk of becoming homeless when they transition from incarceration back into the workforce.

We are taking \$4 million to serve 1500 incarcerated veterans through 12 sites this year to prepare them to make a successful transition back into the labor force and we will continue funding those grantees next year as well.

The final thing which I would like to talk about is the importance of connecting the supply with the demand; connecting our formerly homeless veterans, veterans who are transitioning through these programs with employers.

We are developing relationships with the largest private sector organizations in the country to have access to those CEOs and senior executives who make the hiring decisions so that they are aware of the reasons to hire a veteran and how to hire a veteran so that our VETS team members, the local veterans' employment representative in the field, have access to more opportunities for homeless veterans and can help expedite and accelerate their return to meaningful employment.

We feel that this recent cover on *Fortune* magazine, the "New Face of Business Leadership in America"—a veteran—is indicative of where we are going and how we are going to get there. It is effectively communicating the message of what veterans offer to companies and employers in America.

We are grateful to be here as a part of this hearing and look forward to your questions.

[The prepared statement of Mr. Jefferson follows:]

PREPARED STATEMENT OF HON. RAYMOND M. JEFFERSON, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR

Chairman Akaka, Ranking Member Burr, and Members of the Committee: I am pleased to appear before you today to discuss how the Department of Labor's Veterans' Employment and Training Service (VETS) fulfills its mission of supporting the Department of Veterans' Affairs (VA) goal of ending Veteran homelessness in five years.

Every day, we are reminded of the tremendous sacrifices made by our Servicemembers and their families. As this latest generation of Veterans returns home, we want to make sure that they can have a home . . . when they come home. One way that we can honor their sacrifices is by providing them with the best services and programs our Nation has to offer and making sure they have a home. Ending home-

lessness means both obtaining a home and obtaining a job—which is why we are committed to providing a path to employment with family-sustaining wages.

The Department of Labor has made helping Veterans a priority. VETS' programs support Secretary Solis's vision of "*Good Jobs for Everyone*" by helping homeless Veterans get into middle class and maintain stability. VETS works closely with the Department of Defense (DOD), the VA, and the Department of Housing and Urban Development (HUD) to help Veterans reach this goal through seamless employment assistance. Seamless employment assistance will, in turn, require close collaboration, enhanced communication, and sustained, purposeful action. It's going to take all of us working together, sharing best practices, and developing innovative solutions to challenging problems.

VETS MISSIONS

We accomplish our mission through three distinct functions: employment and training programs; transition assistance services; and enforcement of relevant Federal laws. I have testified before this Committee on my five aspirations. One of those is helping Servicemembers transition seamlessly into meaningful employment and careers while emphasizing success in high-growth and emerging industries such as clean energy and health care. While we normally think of assistance for Servicemembers as they leave the military and transition to civilian employment, we must also look at homeless Veterans as they transition back into employment.

HOMELESS VETERANS VISION

Secretary Solis shares Secretary Shinseki's vision of ultimately eliminating homelessness among our Nation's Veterans. We have strengthened our interagency collaboration at all levels to mobilize for this important and necessary goal.

We are drawing upon the expertise and resources of the highest levels of the executive branch. For example, the deputy secretaries of DOL, VA, Health and Human Services (HHS), and HUD are pulling together and meeting regularly to increase the collaborative efforts of their departments toward the goal of ending Veteran homelessness. Among other initiatives, the departments have agreed to:

- Share data on how their programs serve the Veteran homeless population.
- Consider how best to provide outreach to Tribal communities, through ideas generated by a DOL-led working group.
- Provide information to each department's grantees regarding how Veterans served by those grants can determine if they are eligible for VA services and how they can access those services.
- Share draft Solicitations for Grant Applications (SGA) and Notices of Funding Availability between the departments to ensure alignment of efforts.
 - For example, DOL has shared its draft SGA with VA for the Incarcerated Veterans Transition Program (IVTP), which provides employment services to veterans who have recently been incarcerated, including those who are at risk of becoming homeless. DOL will also provide VA with an early view of its initial IVTP applicant rankings in order to incorporate VA input.
- Identify ways to link VA Supportive Services grants to the VA/HUD homeless prevention pilot program and ways to involve HHS in that effort.

HOMELESS VETERAN REINTEGRATION PROGRAM (HVRP)

VETS' major program to tackle the problem of Veteran homelessness is the Homeless Veterans Reintegration Program (HVRP). This is the only Federal nationwide program focusing exclusively on employment of Veterans who are homeless. HVRP provides employment and training services to help homeless Veterans with the skills and opportunities they need to gain meaningful employment and turn around their lives.

HVRP grants are awarded competitively to state and local workforce investment boards, state agencies, local public agencies, and private non-profit organizations, including faith-based organizations and neighborhood partnerships. HVRP grantees provide an array of services utilizing a holistic case management approach that directly assists homeless Veterans and provides training services to help them to successfully transition into the labor force. Homeless Veterans receive occupational, classroom, and on-the-job training as well as job search and placement assistance, including follow-up services.

Grantees provide additional services by networking with Federal, State, and local resources for Veteran support programs. This includes working with Federal, State, and local agencies such as the VA, HUD, the Social Security Administration, the

local Continuum of Care agencies and organizations, State Workforce Agencies, and local One-Stop Career Centers.

VETS requested a total of \$41,330,000 in Fiscal Year (FY) 2011 for HVRP, an increase of \$5 million (14 percent) over the FY 2010 funding level. In Program Year (PY) 2010, which will begin in July 2010, HVRP expects to serve 21,000 homeless Veterans. VETS plans to serve 25,000 homeless Veterans in PY 2011.

For PY 2009, \$26,330,000 was appropriated for HVRP, a 13 percent increase over PY 2008. HVRP grantees will serve 15,500 homeless Veterans in PY 2009. During PY 2008, HVRP grantees served 13,700 homeless Veterans. The employment placement rate was 67.4 percent. The cost for serving this hard-to-serve population was \$1,500 per participant and \$2,600 per placement. In PY 2009, VETS awarded a total of 98 HVRP grants, including third-year funding for two cooperative agreements to assist in developing the HVRP National Technical Assistance Center. The Center provides technical assistance to current grantees, potential grant applicants, and the public; gathers grantee best practices; conducts employment-related research on homeless Veterans; carries out regional grantee training sessions and self-employment boot camps; and performs outreach to the employer community in order to increase job opportunities for Veterans.

HOMELESS WOMEN VETERANS

A major new undertaking in HVRP is a separate grant initiative to serve the needs of homeless women Veterans and homeless Veterans with families, a population that is on the rise and in need of specialized services. In PY 2010, we will use up to \$5 million of the \$10 million increase appropriated to HVRP in FY 2010 for this program to provide customized employment services. We expect to fund about 25 grantees in PY 2010. We requested an additional \$5 million in the FY 2011 budget to provide continued funding for the homeless women Veterans initiative.

VETS is collaborating with DOL's Women's Bureau, which has already conducted 28 moderated listening sessions nationwide with formerly and currently homeless women Veterans to identify the causes and the solutions for homelessness among women Veterans. The findings from these sessions are available on the Women's Bureau Web site at: <http://www.dol.gov/wb/programs/listeningsessions.htm>.

We also conducted a national listening session with service providers, VA, HUD, and other government agencies to begin identifying the best practices for serving homeless women Veterans and homeless Veterans with families. We will continue to identify such practices and disseminate them to service providers throughout the Nation.

INCARCERATED VETERANS

The Incarcerated Veterans Transition Program (IVTP) provides employment services to assist in reintegrating incarcerated and/or transitioning incarcerated veterans, who are at risk of becoming homeless, into meaningful employment within the labor force.

Through the program, VETS will continue its efforts to help incarcerated Veterans and will coordinate these efforts with the VA. Of the \$36 million for HVRP in FY 2010, VETS plans to use \$4 million for IVTP, which will serve approximately 1,500 Veterans through 12 grants. We plan to continue this program at that level in FY 2011.

ADDITIONAL ACTIVITIES

Of note to this hearing, the DOL Transition Assistance Program Employment Workshop addresses homelessness prevention. This module includes a presentation on general risk factors for homelessness, a self-assessment to help determine individual risk, and contact information for preventative assistance associated with homelessness.

VETS also utilizes a portion of HVRP funds to support stand down activities. A stand down is an event held in a local community where a variety of social services are provided to homeless Veterans. Stand down organizers partner with local business and social service providers to provide critical services such as: showers and haircuts; meals; legal advice; medical and dental examinations and treatment; and information on Veterans' benefits and opportunities for employment and training.

Stand down events are a gateway for many homeless Veterans into a structured housing and reintegration program. VETS funds HVRP eligible entities (that do not have a competitive HVRP grant) to support a stand down event. During FY 2009, VETS awarded over \$540,000 in non-competitive grants for 66 stand down events that provided direct assistance to 9,600 homeless Veterans.

Finally, there is also tremendous potential and opportunity for increasing engagement with employers to increase the hiring of Veterans. This involves communicating the value proposition for hiring Veterans more effectively, making the hiring process more convenient and efficient, and developing hiring partnerships. VETS is also developing new relationships with major private sector organizations to enlist their advice and support to increase Veterans' hiring.

CLOSING

In closing, I'd like to recount my experience from earlier this month, when I had the privilege of meeting the Honor Flight at Reagan National Airport and welcoming many of our country's WWII Veterans to our Nation's Capitol. When I shook the hand of a Pearl Harbor survivor, I was reminded of the honor and privilege we have at VETS to serve America's Veterans.

Thank you again for your unwavering commitment to Veterans and for the support that you've been providing to us.

I appreciate the opportunity to testify before you today and look forward to answering your questions.

Chairman AKAKA. Thank you very much, Mr. Jefferson.
Now we will hear from Mr. Johnston.

STATEMENT OF MARK JOHNSTON, DEPUTY ASSISTANT SECRETARY FOR SPECIAL NEEDS, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Mr. JOHNSTON. Chairman Akaka, Ranking Member Burr, Senator Murray, I am pleased to be here on behalf of Secretary Donovan and the U.S. Department of Housing and Urban Development. I oversee the Department's efforts to confront the housing and service needs of homeless persons and of veterans.

As President Obama has said, "Too many who once wore our Nation's uniform now sleep in our Nation's streets."

As we know, Secretary Shinseki has announced the Department of Veterans Affairs' plans for ending homelessness among veterans. HUD fully supports these efforts. In fact, in HUD's 2011 budget HUD has just four priority performance goals. One is veterans' homelessness. This performance goal is shared with the Department of Veterans Affairs—to end homelessness among veterans.

To help achieve this goal, HUD will provide housing and needed supports to homeless veterans through the following initiatives which I will briefly summarize.

First, targeted homeless grants. In December 2009, we awarded nearly \$1.4 billion to well over 6400 projects locally to serve homeless persons including veterans.

It is important to note that veterans are eligible for all of HUD's homeless assistance programs, and HUD emphasizes the importance of serving veterans in our grant application. As a result, one in ten persons served by HUD targeted homeless programs is a veteran.

HUD-VASH. The Congress has provided \$75 million in 2008, in 2009, and in 2010 for this program: the HUD-Veterans Affairs Supported Housing Program.

Through this partnership, HUD and VA will be providing permanent housing and services for approximately 30,000 homeless veterans and their families, including veterans who have been returning from Iraq and Afghanistan.

HUD and VA want to focus this year on making the 30,000 vouchers already appropriated to be used very effectively and very efficiently. The stimulus's Homelessness Prevention and Rapid Re-

housing program which we refer to as HPRP is a great resource that can be used to prevent homelessness including veterans.

It is a \$1.5 billion program that can do two things. It can prevent homelessness for persons, including veterans, by providing resources such as rental assistance, security deposits, and case management and can also assist people who have fallen into homelessness to rapidly re-house them into conventional housing.

The HPRP program can and does serve homeless veterans. Funds can be used for these various resources, and one thing that we have been touting is to connect this with HUD-VASH so that when a veteran is having a tough time saving the funds for a security deposit, for instance, or utility assistance, they can use the HPRP program and we have been actively touting that with our various grantees around the country.

The recently enacted Homeless Emergency Assistance and Rapid Transition to Housing Act, or HEARTH Act, provides unprecedented flexibility to confronting homelessness.

This Act consolidates HUD's various competitive programs into a single, streamlined, flexible program which we will be implementing in 2011. The program requires that all stakeholders, including veterans' organizations, determine how the funds should be used.

HUD's 2009 Appropriations Act provides the department with \$10 million for a demonstration program to prevent homelessness among veterans. HUD is working with the VA and the Department of Labor on this initiative. We will be conducting evaluation on this demonstration, and the three agencies will be sharing the results widely with organizations that serve veterans.

HUD's Secretary Donovan, in addition to being the Secretary of our department, is also currently the Chairman of the U.S. Inter-agency Council on Homelessness. He has met with Secretary Shinseki, the former Chair of the Council, to discuss the needs of homeless veterans and how our agencies can work collaboratively to solve this problem.

The Council is developing the Federal plan to end homelessness which is due to Congress on May 20. The Council has been reaching out to a variety of stakeholders of which there have been many participants, including those who are homeless veterans. This effort will further ensure a Federal-wide focus on ending homelessness among veterans.

Finally, each year HUD collects information from communities nationwide on homelessness, develops a detailed report and submits this to Congress as the Annual Homeless Assessment Report.

Similarly, HUD is working closely with the VA this year on collecting data and developing a special report on veteran homelessness which will be issued later this year.

In closing, I want to reiterate my and the Department's desire to truly end homelessness among veterans.

Thank you very much.

[The prepared statement of Mr. Johnston follows:]

PREPARED STATEMENT OF MARK JOHNSTON, ASSISTANT SECRETARY FOR COMMUNITY
PLANNING AND DEVELOPMENT, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

INTRODUCTION

Chairman Akaka, Ranking member Burr, Members of the Committee, I am pleased to be here today to represent the Department of Housing and Urban Development. My name is Mark Johnston, the Deputy Assistant Secretary for Special Needs. I oversee the Department's efforts to confront the housing and service needs of homeless persons and of veterans.

This responsibility includes confronting the specific needs of our country's homeless veterans and their families. As President Obama has said, "Too many who once wore our Nation's uniform now sleep in our Nation's streets." Secretary Shinseki has announced the Department of Veterans Affairs' plans for ending homelessness among veterans. HUD fully supports these efforts. In fact, in HUD's 2011 Budget, HUD has four priority performance goals. One is Veterans Homelessness. This performance goal is shared with the Department of Veterans Affairs (VA) to end homelessness among veterans. The joint efforts will reduce the number of homeless veterans from the estimated 131,000 in fiscal year 2009 to 59,000 in fiscal year 2012. To help achieve this goal, HUD will provide housing and needed supports to homeless veterans through the Department's targeted homeless assistance programs, as well as through mainstream HUD resources.

The Department administers a variety of programs that can house veterans. These include the Housing Choice Voucher Program, Public Housing, HOME Investment Partnerships, and the Community Development Block Grant (CDBG) program. These programs, by statute, provide great flexibility so that communities can use these Federal resources to meet their local needs, including the needs of their veterans. In addition to these programs, Congress has authorized a variety of targeted programs for special needs populations, including for persons who are homeless.

Unfortunately, veterans are well represented in the homeless population. HUD is committed to serving homeless veterans and recognizes that Congress charges HUD to serve all homeless groups. HUD's homeless assistance programs serve single individuals as well as families with children. Our programs serve persons who are disabled, including those who are impaired by substance abuse, severe mental illness and physical disabilities as well as persons who are not disabled. HUD provides an array of housing and supportive services to all homeless groups, including homeless veterans.

TARGETED HUD HOMELESS ASSISTANCE GRANTS

In December 2009, HUD competitively awarded approximately \$1.4 billion in targeted homeless assistance renewal grants. A record 6,445 renewal projects received awards. It is important to note that veterans are eligible for all of our homeless assistance programs and HUD emphasizes the importance of serving veterans in its grant application. Communities may submit veteran-specific projects or projects that support a general homeless population that includes veterans. In this competition, HUD awarded 1,372 projects that serve veterans, either as a veteran-specific project or more typically as a project that serves veterans among other persons. Overall, 1 in 10 persons served by HUD's targeted homeless programs is a veteran.

To underscore our continued commitment to serve homeless veterans, we have highlighted veterans in our annual planning and application process. In the annual grant application we encourage organizations that represent homeless veterans to be at the planning table. Because of HUD's emphasis, communities have active homeless veteran representation. We also require that communities identify the number of homeless persons who are veterans so that each community can more effectively address their needs.

HUD-VASH

The Congress provided \$75 million in 2008, 2009 and 2010 for the HUD-Veterans Affairs Supportive Housing Program, called HUD-VASH. The program combines HUD Housing Choice Voucher rental assistance (administered through HUD's Office of Public and Indian Housing) for homeless veterans with case management and clinical services provided by the Department of Veterans Affairs (VA) at its medical centers in the community. Through this partnership, HUD and VA will provide permanent housing and services for approximately 30,000 homeless veterans and their family members, including veterans who have become homeless after serving in Iraq and Afghanistan. HUD and VA are working to get the vouchers out on the street and leased up. We're making good progress on this between our agencies and with

housing authorities and VA medical centers, and want to focus this next year on making sure that the 30,000 HUD-VASH vouchers already appropriated are being efficiently and effectively used.

RECOVERY REINVESTMENT ACT (ARRA) FUNDING

ARRA provides unprecedented funding to HUD and other Federal agencies to directly confront the very difficult economic times in which we live. Overall HUD is responsible for \$13.6 billion in ARRA funds for housing and community development. The ARRA Homelessness Prevention and Rapid Re-Housing Program (HPRP) is specifically targeted to confront homelessness. HPRP provides \$1.5 billion to communities nationwide. These funds were awarded to States, metropolitan cities, urban counties and territories.

The funds are now being used by grantees and sub-grantees, including non-profit organizations, to provide an array of prevention assistance to persons, including veterans, who but for this assistance would need to go to a homeless shelter. The program is also being used to rapidly re-house persons who have become homeless. Program funds can be used to provide financial assistance (e.g., rental assistance and security deposits) and housing stabilization services (e.g., case management, legal services, and housing search). The HPRP funding notice expressly references that the program can serve homeless veterans and that program funds can be used to provide to homeless veterans with security deposits and HUD-VASH can be used for long-term rental assistance. To date, well over 150,000 persons have been assisted through HPRP.

HPRP represents a unique opportunity for communities. This significant level of funding—which equals the approximate level of funding historically appropriated by Congress for all of HUD’s other homeless programs combined—will enable communities to re-shape their local homeless systems. For the first time, communities now have targeted funding to prevent homelessness. In the past, virtually all of HUD’s homeless-related programs could only assist persons after they became homeless. These funds have the potential to assist persons at risk, including veterans, stay in their homes rather than be relegated to moving themselves and their families to emergency shelters, or worse, the streets. HPRP also will allow communities to significantly reduce the time that veterans and others must stay in emergency shelters, as HPRP can be used to immediately re-house persons in conventional housing and also provide temporary supports such as case management to help ensure housing stability. These two components—homelessness prevention and rapid re-housing—have been the missing links in each communities’ Continuum of Care system. Communities now have the tools they need to effectively confront homelessness. Importantly, the new approaches that communities implement with HPRP will have the potential to be carried on, thanks to legislation passed by the Congress and enacted by the President on May 20, 2009.

NEW HUD HOMELESS PROGRAMS

The recently enacted Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH) provides unprecedented flexibility to confronting homelessness. The Act consolidates HUD’s existing competitive homeless programs into a single, streamlined program, the Continuum of Care Program. The program requires that all stakeholders—including veterans organizations—determine how the funds should be used. The law also reforms the Emergency Shelter Grants program into the Emergency Solutions Grant (ESG) program. The new ESG will provide for flexible prevention and rapid re-housing responses to homelessness—similar to the Stimulus HPRP program—so that veterans and others who are either at risk or who literally become homeless may receive assistance. Finally, the legislation provides for the Rural Housing Stability Assistance Program to provide targeted assistance to rural areas. HEARTH includes as a selection criterion for grant award, which is the extent to which the applicant addresses the needs of all subpopulations, which includes veterans.

VETERAN HOMELESS PREVENTION DEMONSTRATION

The 2009 Appropriations Act provides HUD with \$10 million for a demonstration program to prevent homelessness among veterans as part of the appropriation for HUD’s homelessness programs. HUD is working with the VA and the Department of Labor to design and implement this initiative. Urban and rural sites will be selected. The demonstration funds may be used to provide both housing and services to prevent veterans and their families from becoming homeless or to reduce the length of time veterans and their families are homeless. HUD intends to conduct an evaluation of this demonstration, with funds provided for by the Congress, and

then share the results widely through HUD's technical assistance resources to organizations serving veterans. The findings from this effort will help inform future initiatives to prevent homelessness among veterans, as we agree with the Congress that homeless prevention needs to be a key element to solve this problem.

INTERAGENCY COLLABORATION ON HOMELESS VETERANS ISSUES

Secretary Shaun Donovan is the current Chair of the U.S. Interagency Council on Homelessness (USICH). He has met with VA Secretary Shinseki to discuss the needs of homeless veterans and how our agencies can work collaboratively to solve this problem.

The Interagency Council on Homelessness is developing the Federal Plan to End Homelessness, which is due to Congress on May 20, 2010. The Council has been reaching out to a variety of stakeholders, including those who serve homeless veterans. This effort will further ensure a Federal-wide focus on ending homelessness among veterans.

Historically HUD and VA have been involved in several collaborations related to homelessness among veterans. The agencies are currently working together in implementing and operating HUD-VASH. Another joint initiative involved reducing chronic homelessness, in which HUD provided the housing assistance and the VA and the Department of Health and Human Services provided support services to chronically homeless persons. Finally, I serve as an ex-officio member of the Secretary of VA's Advisory Committee on Homeless Veterans, which is focused on ending homelessness among veterans.

TECHNICAL ASSISTANCE

To coordinate veterans' efforts within HUD, to reach out to veterans organizations, and to help individual veterans, HUD established the HUD Veterans Resource Center. The Center, headed by a veteran, has a 1-800 number to take calls from veterans and to help address their individual needs. The Resource Center works with each veteran to connect them to resources in their own community.

HUD's Homelessness Resource Exchange (located at www.HUDHRE.info) is HUD's one-stop shop for information and resources for people and organizations who want to help persons who are homeless or at risk of becoming homeless. It provides an overview of HUD homeless and housing programs, our national homeless assistance competition, technical assistance information, and more.

The HUDHRE has a number of materials that address homeless veterans issues. For example, HUD dedicated approximately \$350,000 to enhance the capacity of organizations that do or want to specifically focus on serving homeless veterans, update existing technical assistance materials, and coordinate with VA's homeless planning networks. As a result, we developed two technical assistance guidebooks, available on the Web site. The first guidebook, *Coordinating Resources and Developing Strategies to Address the Needs of Homeless Veterans*, describes programs serving veterans that are effectively coordinating HUD homeless funding with other resources. The second guidebook, *A Place at the Table: Homeless Veterans and Local Homeless Assistance Planning Networks*, describes the successful participation of ten veterans' organizations in their local Continuums of Care. Additionally, we have held national conference calls and workshops to provide training and assistance to organizations that are serving, or planning to serve, homeless veterans.

Finally, each year HUD collects information from communities nationwide on homelessness and develops a detailed report on of homelessness and submits that to the Congress. This report helps inform the Congress, the Administration, and communities nationwide on the nature and extent of homelessness in America so that we collectively can more effectively confront the problem. Similarly, HUD is working closely with the VA on collecting data and developing a special report on veteran homelessness, which will be issued later this year.

CONCLUSION

In closing, I want to reiterate my and HUD's desire and commitment to help end homelessness among our veterans by working effectively with our Federal, state, tribal and local partners.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO
MARK JOHNSTON, DEPUTY ASSISTANT SECRETARY FOR SPECIAL NEEDS, U.S. DE-
PARTMENT OF HOUSING AND URBAN DEVELOPMENT

Question 1. Once a veteran is successfully placed in permanent housing using a HUD-VASH voucher, what assistance is available so he or she can become independent of the voucher?

Response. Assistance is provided through the VA's case management services, which involve regular meetings with mental health and primary care providers that assist Veterans in improving their well-being, as well as accessing needed treatment services. VA case managers work with Veterans on adjustment to community living addressing issues and provide supports for money management, time management and maximizing quality of life issues. The VA case managers also work with Veterans Benefits Office, Department of Labor and other Federal partners to address access to benefits and employment opportunities for veterans in HUD-VASH. VA case managers also help the Veteran address family reunification so they can fully reintegrate back into the community.

Question 2. On average, how long does it take to place a veteran in permanent housing once the veteran is determined to be eligible for a HUD-VASH voucher?

Response. It takes an average of three months to place an eligible veteran in permanent housing. Placing a veteran in housing continues to be challenging for several reasons. Poor credit histories, lack of funding for security and utility deposits, delayed or multiple inspections, and in some areas, the availability of suitable affordable housing can cause the leasing process to be lengthy. HUD and the VA continue to work with case managers and Public Housing Authority (PHA) staff to identify solutions for speeding up the leasing process.

Question 3. What challenges do you each face when trying to execute your department's homeless veteran programs in conjunction with another agency's programs?

Response. To date, the VA and HUD have prevented potential challenges arising through regular planning and administrative meetings, ongoing email and phone conversations, as well as joint efforts to coordinate activities in the field. Within HUD, staff from the Housing Choice Voucher Programs (HCVP) and Special Needs Assistance Programs (SNAPs) have contributed their expertise to the development and implementation of the program. Both HCVP and SNAPs staff have worked with VA staff to establish shared goals, as well as common metrics and milestones to ensure our goals are achieved.

A few sites have struggled with the coordination of program activities at a local level. Communication between the local VA case managers and the PHA staff is crucial to successful administration of this program. To ensure that strong partnerships exist among PHAs and VA medical centers (VAMCs) at all sites, VA and HUD will continue conducting site visits, satellite broadcasts and joint training sessions for both PHAs and VA case managers. Meetings to address problems at low-performing sites will be held with staff attending from HUD and VA headquarters, agency field offices, PHAs, VAMCs, and Continuums of Care.

The VA and HUD are also working toward establishing a data sharing agreement to allow the agencies to share data on homeless veterans and the veterans served. Improved data-sharing mechanisms will enable agencies to more effectively monitor the program's implementation.

Question 4. HUD and VA should be commended for the level of coordination and cooperation they've had in getting HUD-VASH vouchers distributed to housing authorities with quick guidance on program rules and regulations. Unfortunately that same level of cooperation isn't playing out in many communities where housing authorities (PHAs) and VAMCs are simply not leasing up vouchers as quickly as they should. What can we do to improve lease-up rates for these vouchers? Should PHAs and VAMCs be required to have a memorandum of understanding in order to be awarded vouchers? For communities that are using HUD-VASH very successfully, how can we better get their story shared with other communities?

Response. Due to the ongoing monitoring of site performance, HUD and VA are acutely aware of low-performing sites and the communities in which improved coordination is needed among PHAs and VAMCs. The agencies have developed joint and agency-specific strategies to improve lease-up rates and strengthen cooperation among community partners.

From the outset of HUD-VASH implementation, HUD and VA have shared information on a monthly basis in order to monitor outcomes and identify areas for improvement. The agencies together have recognized sites in which problems exist with coordination and lease-up rates. Field visits to low-performing sites will help identify and resolve implementation issues, and the agencies will facilitate meetings

among community partners to address issues and establish corrective action plans or performance improvement plans.

Other measures to improve lease-up rates include taking into consideration the past performance of VAMCs and PHAs when allocating 2010 awards. Capacity-building efforts will continue for new and existing sites through satellite broadcasts and regional trainings for PHAs and VA case managers. In addition, approximately 300 vouchers will be set aside as project-based vouchers (PBV) for communities in which safe, affordable housing for veterans is more difficult to secure. The criteria for determining the distribution of the PBV set-aside vouchers will include sites' ability to make units available for occupancy in the least amount of time. HUD and VA also will continue to consider transferring vouchers from low-performing PHAs to other PHAs nearby, as well as the contracting out of case management services.

For HUD, field offices will continue to play a critical role in monitoring the program's implementation at a local level by issuing monthly status reports, reviewing with headquarters the information received from HUD-VASH reports, and contacting low-performing PHAs on a monthly basis. In addition, HUD will enable HUD-VASH participants to have access to financial assistance for security deposits available through the Homelessness Prevention and Rapid Re-Housing Program (HPRP). HUD will also aim to increase the number of referrals from Continuum of Care service providers, which receive funds through HUD's homeless assistance programs.

A requirement for PHAs and VAMCs to sign memorandums of understanding has been considered; however, both agencies believe that this is not necessary and in some cases may impede the program's timely implementation. It is critical, however, that the VAMCs and PHAs of low-performing sites work together to strengthen collaboration, define shared targets, monitor progress, and identify areas for improvement.

In recognition of the well-performing sites, HUD and VA sponsored a workshop on successes and best practices at the national HUD-VASH training in June 2009. Similar workshops will be held at the regional training sessions, and site visits will be conducted at four of the top-performing sites to gather more information on best practices. A best-practices document subsequently will be developed and distributed that highlights recommended procedures and the positive outcomes that all sites should aim to achieve. Success stories will also be published on the HUD and VA Web sites.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. JIM WEBB TO MARK JOHNSTON, DEPUTY ASSISTANT SECRETARY FOR SPECIAL NEEDS, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Secretary Donovan, according to the VA's Director of Homelessness, as of February 10, 2010, more than 19,000 veterans have been accepted into the HUD-VA Supported Housing (HUD-VASH) program; more than 16,000 have received a housing voucher, and 10,600 formerly homeless veterans are now housed through these efforts.

Question 1. How many of those 19,000 veterans subsequently no longer need vouchers because they were able to raise their income to a level sufficient to lead an independent life?

Response. HUD ran a point-in-time query on all HUD-VASH veterans housed in February 2010 and found that approximately 0.8 percent were able to pay the full amount of rent at that time. The query did not take into consideration how long veterans had been enrolled in HUD-VASH. The primary sources of income for the majority of veterans are pensions and social security, and approximately 60 percent of those we have served to date are elderly or disabled. Therefore we expect that a significant number of veterans will need housing assistance for many years.

The HUD-VASH program has been designed for those veterans and their families that are homeless due to mental and physical disabilities. Participating veterans receive ongoing case management through the VA in order to secure access to mental and physical health services, as well as safe, affordable housing. VA case managers have determined that the 19,000 veterans accepted for the HUD-VASH program are clinically eligible for the program and that vouchers are needed by the veterans in order to secure permanent housing. Therefore, it is a hope, but not an expectation, for such veterans to achieve self-sufficiency and be able to live independently without housing assistance in the short term.

Particularly with the funding allocated in FY 2010, the veterans that participate are likely to be those that HUD considers to be chronically homeless. As defined in the 2009 Continuum of Care NOFA, a chronically homeless person is an accom-

panied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years. The term "homeless" refers to a person sleeping in a place not meant for human habitation (e.g., living on the streets), in an emergency homeless shelter, or in a Safe Haven as defined by HUD. A disabling condition is defined as: (1) a disability as defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration, substantially impedes an individual's ability to live independently, and of such a nature that the disability could be improved by more suitable conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; or (5) a diagnosable substance abuse disorder.

Question 2. What is the average length of time a voucher is needed by a HUD-VASH recipient?

Response. HUD-VASH is in the beginning stages of implementation, and only preliminary data exists on the average length of stay of participating veterans. However, HUD ran a query on homeless families that have participated in the broader Section 8 Housing Choice Voucher program, which targets all low-income families and not just veterans. HUD found that the average length of assistance for a family that was homeless at the time of admission is 861 days. However, we do not have data that identifies the reason families leave the program. Potential reasons could include the family achieving self-sufficiency, as well as termination of assistance due to the violation of lease requirements or other family obligations, which could result in the family returning to homelessness.

Question 3. What is the average per capita cost of a homeless veteran in the HUD-VASH program?

Response. The average cost of a VASH voucher on a yearly basis is \$6,444, and the average cost of case management services per veteran is approximately \$4,500. The total direct cost per year is approximately \$11,000 per veteran.

Question 4. Please describe the additional supportive services the VA intends to use to transition veterans off HUD-VASH.

Response. The VA intends to provide vocational rehabilitation services with case management, as well as traditional mental health and primary care services and access to VA benefits. Some veterans may also qualify for VA and/or community-based prevention services designed to assist individuals to rapidly return to independent living. These time-limited services include case management, financial assistance, child care, vocational training, and transportation assistance.

Question 5. What are the average costs, by state, of providing support to homeless veterans through established group housing shelter programs as, for instance, the New England Center for the Homeless?"

Response. There is no readily available cost information on group housing shelter costs for veterans. However, the VA funds transitional housing programs through its Grant and Per Diem program for community agencies providing services to homeless Veterans. The Per Diem portion pays for operational costs, such as services and utilities, based on cost per veteran per day. VA pays up to \$34.40 per day per veteran housed, in accordance with current regulations. Costs are calculated based on budgets submitted by the grantee. Currently, the average rate paid nationally is approximately \$31, which equates to an estimated \$1,000 per month per veteran.

Chairman AKAKA. Thank you very much, Mr. Johnston.

When we started talking ending homelessness among veterans, it is important to know the size of the problem. However, VA and HUD have two very different figures for how many of our Nation's veterans are homeless at any given night in a year.

Would you, Mr. Dougherty and Mr. Johnston, please explain your departments' numbers and why there is such a large difference?

Mr. Dougherty, we will start with you.

Mr. DOUGHERTY. Mr. Chairman, I do not think the numbers are really as far apart as they may appear. Sometimes it is the reporting cycle that we are reporting in.

One of the things—I think Mark will back me up—as we are moving forward, our Secretaries have talked about having one single reporting system.

The Department of Housing and Urban Development has a requirement to go out and identify homelessness in America and to identify veterans among that population. So we have been working collaboratively with HUD so that as we do this in the future we are going to use simply one number.

The number that we use is really largely based upon what HUD reports through its continuance of care along with some additional information that we have. What we want to do, as Mark mentioned a moment ago, is we want to make sure that we have all the “Ts” crossed and all the “Is” dotted in the right places to make sure we have a good count.

But I think our numbers are within a very small percentage as we report year to year in the last few years.

Chairman AKAKA. Mr. Johnston.

Mr. JOHNSTON. Just to briefly elaborate on that, the figure that HUD has for homeless veterans is 135,000. That is based on January 2008 data. The data that is provided by Pete Dougherty and the VA is a little bit more recent.

Our numbers for 2009 will be submitted in the annual report to Congress in June. So that will be an update. Then later in the year, in other words, later this summer, we will have the 2010 figures. I certainly agree with Pete that the difference is relatively minor and it really is a reporting period difference I think.

Chairman AKAKA. Thank you.

This question is for all of the panelists. What is your department’s perception of the Housing First approach to assisting the chronically mentally ill, homeless veteran population?

Mr. JOHNSTON. I will begin.

Chairman AKAKA. Mr. Johnston.

Mr. JOHNSTON. HUD absolutely supports the concept. We have been using it across the country for a number of years. In fact, one of our first permanent housing programs, Shelter Plus Care, which was created in 1992, was based on housing first.

That is the model that we see being implemented across the country for most of our projects. The notion, of course, being you take a homeless client where they are, wherever that is, and help move them into housing and address the various issues that they have got.

We did a study about 2 years ago on this and found about 84 percent of persons who were chronically homeless, who moved into permanent housing were there a year later.

It is not to say there is not an effort to make sure that happens by having good, strong supportive services in place but it certainly can and should happen.

Mr. DOUGHERTY. Mr. Chairman, both our secretaries, the Secretary of HUD and the Secretary of Veterans’ Affairs, have met. We have talked about this.

It is certainly a significant change for our department from where we were years ago. When we first had some vouchers with HUD, it was really predicated on a veteran who had already been in a long course of treatment and probably would be what we

might refer to as patient compliant before they would be able to get in.

We do not have that kind of restriction today. We are looking more and more on how we can get that placement faster because we do agree there is an effective way to provide this service to veterans but it is a corporate shift change for us to get to that point.

Mr. JEFFERSON. Chairman Akaka, I would just say one of the Labor Department's commitments, sir, is just to make sure that these service providers have easy access and frequent access to our employment representatives and our disabled veteran outreach program specialists.

So whether these homeless veterans in Housing First need case management or access to the employment opportunities in their area our DVOPs, LVERs, and employment representatives are there to provide the employment piece of that transformation.

Chairman AKAKA. Thank you very much, Mr. Jefferson.

Let me call on our Ranking Member, Senator Burr, for his questions.

Senator BURR. Thank you, Mr. Chairman.

Mr. Dougherty, will we be here 5 years from today only talking about prevention programs?

Mr. DOUGHERTY. Mr. Burr, I do not think we will be only talking about prevention programs because just as we would face in any other health problem, there will be veterans who, because of mental illness, substance abuse problems, and other things including not having enough support, will show up and become homeless.

Senator BURR. Do you believe that the Secretary's blueprint provides the flexibility as time goes on for us to change the programs to reflect any changes in population?

Mr. DOUGHERTY. Mr. Burr, you are asking an excellent question. Lisa Pape and I talk regularly and one of the things we talk about is that there is not a 5-year plan at this point. There is a fourth-year and 6-month plan that requires that every month we look at what we are doing, how effective we are at getting the services out there and what we can do to make shifts if we are not meeting that.

Senator BURR. Let me encourage both of you. Where you can share that thought process, that matrix with Congress, it would be extremely helpful because, as I said in my opening statement, we have been starved for information on this plan.

We would like to be a full-fledged partner. I know Senator Murray invested a tremendous amount of time and passion into the issue. I think you leave us out and then suggest, well, just trust us.

Mark, you made a statement that one of the programs was to take the money, consolidate it, and let everybody decide how to use it, meaning the stakeholders. Well, I am not sure that is necessarily the right way; and I take for granted that I only heard you at face value for what you said. But I think everything we say, we have got to understand it here in a different fashion. And the goal here is not about process, it is about outcome. It is about reaching the goal which, as I said, is going to be very difficult for us to do.

Let me ask you, Mr. Dougherty. From a standpoint of your numbers or HUD numbers, is there any outside validation of those numbers?

Mr. JOHNSTON. I will start. These numbers are not from HUD. These numbers are from the communities. So we aggregate them from every city and county in America.

Senator BURR. OK.

Mr. DOUGHERTY. We rely a lot on that. Also as we report through each of our sites, we also look at if there are good local studies. Sometimes universities and others do some studies like that.

The other is that the process that we use is called the CHALENG meeting process. This past year we had about 15,000 people who came, including more than 10,000 currently and formerly homeless veterans. So we think we are getting good information as to what is needed and what kinds of services. That really is helping to drive us as to where we need to go. We are listening to the consumer who needs our help.

Senator BURR. Let me ask about the plan in a slightly different say. How many programs, if any, are not going to be funded that have been funded in the past?

Mr. DOUGHERTY. The only program that we had before that we are no longer actively pursuing is the Multi-Family Housing Loan Guarantee Program. We simply tried it. It was passed by Congress. We tried that for a number of years. We found that it just did not meet the need. It did not serve the veterans that needed to be served. We wrote Congress last year saying we were no longer going to pursue that program.

Senator BURR. So incorporated in the blueprint are how many new programs that did not exist last year?

Mr. DOUGHERTY. There are several new programs. I do not know if I can tell you off the top of my head all of them. But obviously we have a call and referral center we think is very important.

Obviously our continued efforts with HUD are a very important way to address this issue because we have to address that veteran, as I said in the opening statement, where they are. Some of them need an emergency sort of assistance.

We are increasing contract care. We are increasing contract care in places that we did not have it before because, as Senator Tester pointed out as well, if you are in rural America, you may not have a big homeless program somewhere. But that does not mean that a veteran who needs to get off the street; VA should be able to provide some service to get that veteran off the street.

Senator BURR. That is extremely helpful. The question is what then supports that effort to make sure that this becomes a permanent experience versus only a temporary triumph.

I guess I am looking for specific measures that you have identified that are incorporated in these programs that would lead me to believe we are going to have a different outcome versus just a deep commitment which is typically a financial commitment to the problem.

Mr. DOUGHERTY. Right. I think the answer to that in large part is that you have to be responsive to the veteran when they first need our care services. Otherwise, they are never going to come to

us until they are so sick and so disabled that the cost to treat them is much more significant, much more intense.

That is why the effort at prevention and going for supportive services before that veteran ever becomes homeless is where we really need to be more focused on.

We are going to do the things we have done in the past and do them effectively but we are also going to do a better job of trying to stop that from ever happening in partnership with the folks at this table.

Senator BURR. I appreciate that answer and my time has expired. But let me say this that I think it even starts earlier than when you get it and it is a debate that we have in this Committee with VA overall, and that is when you look at our veterans that have medical needs, not all of them physical, their willingness to participate at the earliest possible point is not always there, and we accept the fact that we offer it; and if they do not utilize it, then that is their responsibility, until they end up as a focus of you.

I think that we collectively have to begin to look at how we provide those early programs on the health care side in a different way that attracts participation, does not allow us to have individuals that a year later, 2 years later end up with you trying to deal with all the manifestations that they are dealing with; and the lack of a roof over their head is one of the major contributors then.

I thank the chair.

Chairman AKAKA. Thank you very much, Senator Burr.
Senator Murray.

**STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Thank you very much, Mr. Chairman. I appreciate your having this hearing today.

Mr. Dougherty, in your testimony, you noted that homelessness is primarily a health care issue. Given that the VA is planning to expand access to more non-service-connected disabled veterans with moderate incomes and to actually increase the number of presumptive diseases like Agent Orange, can you tell us whether or not the VA actually has the capacity now to address the needs of all those veterans or do we need to be looking at additional resources?

Mr. DOUGHERTY. I am not sure I know the total answer to your question. I do believe that when it comes to veterans who are homeless that we think we are well positioned to take care of those veterans as they come to us.

One of the things, as we look toward going to prevention, we are looking more and more to align the Benefits Administration with this because I think, as Senator Burr just noted a moment ago, one of the things that we think is very important is we need to be more in the wellness business and less in the serious health care problem business.

The wellness issue is going to be addressed by catching it at the earliest stage.

Senator MURRAY. Right. I know that we are going to be increasing the number of veterans, which I applaud you in doing. I just want to make sure you are staying in touch with us to make sure

that we have got the resources to be able to deal with that issue and see that happen.

Mr. DOUGHERTY. The 2011 budget I think addresses that adequately; yes, ma'am.

Senator MURRAY. Does the VA have an estimate of how many of their veterans tried to or accessed the VA for care before they return to homelessness?

Mr. DOUGHERTY. No, we do not have a very good estimate of how many of them tried and did not. That is one of the things that the Call Center and this registry we are working on is going to be able to do for us. It is going to tell us when veterans are doing that, and one of the things that we are doing with HUD in trying to align more of the information that they have is trying to get a better handle on who is out there and who has not been served.

Senator MURRAY. When will we be able to see information back on that?

Mr. DOUGHERTY. I think this summer we are going to work on this report.

Ms. PAPE. We hope the registry starts phasing in during the summer, and hopefully will be fully operational sometime before the beginning of the fiscal year 2011.

Senator MURRAY. OK. I also wanted to ask you, Mr. Dougherty, how the VA validates a program out in the community before allowing them to provide service to veterans?

Mr. DOUGHERTY. In our traditional housing program, what we do is we not only run you through a grant application process but then before you actually provide services to veterans we come on-site. We meet with you. We look at your financial ability to provide services. We look at the physical facilities that you have. We look at the service plan that you have for veterans.

Then and only then do we approve you for payment. Then we come back on an annual basis in a formal way, yet we are informally in those programs year around.

Senator MURRAY. OK. Secretary Jefferson, in the next panel a veteran is going to testify about how he fell into a life of drug dealing and later using while he was trying to get a job as a mechanic. We have a lot of veterans transitioning home to a tough economy and falling into the same kind of traps.

How are we going to work better with our communities to help create partnerships or apprenticeships or other ways for our veterans to get back into the workforce?

Mr. JEFFERSON. One of the things that we are doing is engaging with our DVOPs and LVERs. So, making sure our employment representatives around America, as they are working with veterans, when they identify that there is a need for mental health support and services, that they can effectively refer them to the VA or to other health providers. That is one.

Number 2, we think, is just making sure that we increase the opportunities that this community has available to it.

So we are developing some employer engagement and outreach partnerships now that will increase substantially the opportunities that we can provide for veterans and that is an area which I am placing a very high priority on during my tenure.

By increasing the demand for veterans, we can accelerate them finding meaningful careers, not just jobs.

Senator MURRAY. Because that is a really important part of this. Mr. JEFFERSON. Absolutely, Senator Murray.

We can have all of the best HVRP grantees, the best preparatory programs, but if when these veterans step out to find meaningful employment, there are no jobs for them, then they are going to become demoralized, and they will move into that downward spiral.

Senator MURRAY. Mr. Johnston, I am almost out of time. But I do want to submit some questions to you about the HUD-VASH program. As we put that out there, communities are using it really well, others are not, and as a result, veterans are not getting access to it.

I want to ask you about that and especially how it is being implemented here in DC with some of the private contractors, making sure that HUD stays in touch with them and confirming that veterans are continuing to get that despite it being contracted out.

So I will submit those questions to you because I have run out of time.

Mr. Chairman, before I yield I did just want to say to the world in general that I am a little frustrated with the bureaucracy and the delay surrounding the release of the suicide rates for female veterans by the VA.

My office has been in touch with the VA. We are trying to get a better understanding of the depth of this really serious issue facing female veterans today and the lack of transparency that we are experiencing is really frustrating me.

We have the suicide rate for male veterans and are getting hopefully accurate information on that. But we also need to know what is happening to women and how they are being affected. I have asked for this information and I have not been able to get it, so I am going to be pursuing that.

[The information requested during the hearing follows:]

RESPONSE TO SENATOR MURRAY'S REQUEST FOR DATA ON
SUICIDE IN WOMEN VETERANS

HIGHLIGHTS

- The Department of Veterans Affairs (VA) is fully committed to preventing suicide among all Veterans. The Secretary and the Under Secretary for Health have ensured that this is a top priority for the Veterans Health Administration (VHA).
- Accordingly, VHA has established an extensive national program, including collection and analysis of one of the richest collections of data available on suicide rates among Veterans in the context of the best available national and state data.
- Specifically, VA utilizes three data sources: 1) Data from all states collected by the Centers for Disease Control and Prevention National Death Index; data are available currently through FY 2007; 2) Data from 16 states with more detail on Veteran status—the Centers for Disease Control and Prevention National Death Index, National Violent Death Reporting System, VetPop; 3) Data collected by VA's network of Suicide Prevention Coordinators on known suicide attempts and deaths among those using VHA health care services.
- Using these data, VA calculates indices of suicide risk that are also used by all suicide researchers nationally and internationally—Suicide Rates and Standardized Mortality Ratios. These are explained in more detail in the following discussion.
- VA's health system uses this data not just for research but focuses keenly on using the data to create and continuously improve suicide prevention programs that are spelled out in the "VHA Strategic Plan for Suicide Prevention FY 2009–2010," which was developed in response to the recommendations of the Secretary's Blue Ribbon Panel on Suicide Prevention to "prepare a single document that details the

comprehensive suicide prevention strategic plan . . . in order to facilitate more efficient review of suicide prevention progress.” Data demonstrate initial success in VA’s efforts to prevent suicide, although more work needs to be done.

- Suicide rates among women are far lower than among men. Although data show no evidence of a rise in suicide rates women Veterans who use VHA services, VA is exerting every effort to intervene before problems worsen. Since suicide among women (including Veterans) is a rare event, shifts in annual suicide rates (Rate/100,000/Year) reflect only small numbers of incidents.

DISCUSSION

We received two requests with regard to data on suicide in women Veterans. The first two responses address each of these requests. In addition, we want to place these data in context: VA is totally committed to preventing suicide among all Veterans. The VHA Strategic Plan for Suicide Prevention is a living document of initiatives to be implemented by October 1, 2010 based on the US National Strategy for Suicide Prevention and recommendations or requirements from the National Strategy, the Institute of Medicine (IOM) Report, “Reducing Suicide: A National Imperative”, the VHA Comprehensive Mental Health Strategy Strategic Plan, the Joshua Omvig Veterans Suicide Prevention Act, and the report of the Secretary’s Blue Ribbon Work Group on Suicide Prevention.

Although the data presented show no evidence of a rise in suicide rates for women Veterans who use Veterans Health Administration services, the time to begin prevention efforts is now, not after waiting until rates could rise at some future time. VA has an extensive program of suicide prevention efforts, guided by a VA Strategic Plan for Suicide Prevention. Those efforts will be discussed further after providing the information that directly addresses Senator Murray’s requests:

Request 1. The first request was for overall data on suicide rates among women Veterans. The following table shows information through FY 2007, which is the most recent year for which data have been released by the Centers for Disease Control (CDC).

Response. To track suicide mortality over time, we use suicide rates—rather than the absolute number of suicide deaths per year—because they account for differences in the size of the at-risk population; for example, 10 deaths in a group of 100 would have much different meaning than 10 deaths in a group of 100,000. This approach is the standard for work nationally and internationally that explores suicidality; VA uses this approach because it is the standard and because it does provide a clearer picture of how much risk there is of suicide in a designated population. The suicide rate is the number of suicide deaths per 100,000. It is calculated as (# of suicide deaths/total time at risk of having an observed suicide)*100,000. Total risk time is not necessarily the number of individuals who received VHA services, as some patients may have died from other causes in the year or may not have had their first VHA use until halfway through the year.

Table 1 below presents suicide rates for women Veterans who have used VHA health care, and breaks down the data by age group, after showing the overall rate for each year from FY 2001 to FY 2007, the most recent year for which data are available from the Centers for Disease Control, the national governmental site that collects information on deaths and causes of death. Overall suicide rates among women receiving VHA health services ranged from 9.8/100,000 in FY 2003 to 13.7/100,000 in FY 2005. The rate observed in the most recent year for which data are available (FY 2007) was that same as in the initial year (FY 2001), being 10.6/100,000. It is also important to note that these rates of suicide are dramatically lower than rates for male Veterans, as is true for the US population as a whole.

Table 1.—Suicide Rates Among VHA Health Care Utilizers: FY 2001–2007
Rate/100,000/Year

Sex and Age Group	Suicide Rates							Standardized Mortality Ratios						
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY01	FY02	FY03	FY04	FY05	FY06	FY07
Females	10.6	12.6	9.8	12.4	13.7	11.0	10.6	1.90	2.17	1.67	1.98	2.24	1.73	
18-29	1.8	15.1	5.7	8.9	8.2	3.2	11.8	0.53	4.12	1.60	2.26	2.10	0.80	
30-39	9.2	9.5	21.1	12.7	9.7	12.3	14.6	1.71	1.76	3.85	2.19	1.71	2.16	
40-49	15.6	12.5	14.0	18.9	22.3	14.7	12.2	2.18	1.59	1.84	2.26	2.84	1.86	
50-59	16.1	12.4	2.3	12.4	8.5	13.2	8.2	2.41	1.91	0.32	1.64	1.19	1.67	
60-69	7.1	11.9	7.1	6.9	9.3	6.9	11.0	1.50	2.54	1.57	1.47	1.90	1.26	
70-79	8.4	17.8	3.3	7.7	23.8	5.2	0.0	2.13	4.48	0.88	1.89	6.53	1.37	
80+	0.0	12.0	5.0	4.2	19.2	11.4	7.9	0.00	2.93	1.39	1.20	4.43	3.14	

Data sources: VHA National Patient Care Database, Centers for Disease Control and Prevention National Death Index Revised 11/19/09

The Standardized Mortality Ratio (SMR), also shown in Table 1, is another standard tool used in epidemiologic analyses for comparing mortality rates among populations, in terms of their relationship to a standard population. VA also uses this index because it is commonly accepted as the best analysis to consider differential risk of death by suicide across different populations. The SMR is related to two rates: that of the population of interest and that of individuals with similar characteristics (here, sex and age) in the standard population (here, the general US population). SMRs are calculated as follows. We assess the number of suicide deaths observed among women Veterans (overall and by age group) relative to the number of suicide deaths that would be expected in this group if their rates of suicide mortality were identical to those among women in the general US population. The ratio of the number of observed to the number of expected suicide deaths is the SMR.

In these analyses, we present SMRs among women receiving VHA health services, from fiscal years 2001–2006, both overall and for specific age categories. CDC does not yet have FY 2007 data available for the US population, and so Standardized Mortality Ratios are not calculated for FY 2007. The SMRs can be interpreted as follows: for FY 2001, among women Veterans receiving care in the VHA, suicide risks were 90% greater than for women in the general population. For FY 2006, among women Veterans receiving care in the VHA, suicide risks were 73% greater than for women in the general population.

We note that suicide is a rare event compared to other causes of mortality and that there may be substantial instability in calculated rates over time without extremely large denominators. Small differences in the number of suicides may result in large differences in the calculated rate per 100,000 person years of risk time. We note that, as compared to analyses specific to men receiving VHA services, rates among women patients have greater variability across years, although they are always markedly lower than male rates. For this reason, calculated SMRs may vary substantially over time, particularly where the population for that age group is smaller in size.

Request 2. The second request asked that data from the National Violent Death Reporting System (NVDRS) be broken out for women Veterans alone, such that suicide rates for women Veterans who are users vs. non-users of Veterans Health Administration health care can be compared.

Response. Comparable data for all Veterans, without gender broken out, have recently been reported by VA. The following information addresses this second request.

Table 2.—Estimated Suicide Rates per 100,000 among Female VHA Users and VHA Non-Users in the National Violent Death Reporting System (NVDRS) States,* 2004–2007

	Suicide Rates			
	2004	2005	2006	2007
VHA Users	11.30	11.57	8.12	13.96
VHA Non-Users	10.63	10.90	9.85	11.61

Data sources: VHA National Patient Care Data base, Centers for Disease Control and Prevention National Death Index, National Violent Death Reporting System, VetPop 2008

* For 2005–2007, data were available for 16 NVDRS states. These included Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin. However, for 2004, data were available for only 13 states (the above states, excluding Kentucky, New Mexico, and Utah.)

Table 2 presents suicide rates. In 2004 through 2007, in data reported by the 16 NVDRS states, suicide rates among female VHA patients ranged from 8.12 (in 2006) to 13.96 per 100,000 (in 2007). Among women Veterans who did not receive VHA services, estimated rates ranged from 9.85 (in 2006) to 11.61 per 100,000 (in 2007). In three of the four years, suicide rates among female VA patients were somewhat higher than among women Veterans who did not receive VHA services, though in all years, rates were fairly close. It should be noted that female Veterans who use VHA care have higher rates of mental and physical illness, which can be risk factors for suicide, than women Veterans who do not use VHA care.

The reader is again cautioned that these rates are based on small numbers of rare events. Although there is a fair degree of variability in the reported rates from one year to the next, this is based on a small sample with a very low number of suicides (e.g., 9 deaths by suicide of women Veterans who used VHA services in 2006). Second the rates reported in this second table reflect only those states included in the NVDRS reporting database, so the rates for the VHA Users are slightly different from those reports in Table 1A, which includes data from all 50 states.

Request 3. VHA Suicide Prevention Program and Strategic Plan Highlights

Response. Every Veteran suicide is a tragic outcome and, regardless of the numbers or rates, one Veteran suicide is too many. We feel the responsibility to continue to spread the word throughout VA that “Suicide Prevention is Everyone’s Business”. Even though we understand why some may be at increased risk, we are continuing to investigate and are proactively taking action based on what we already know, with the goal of eliminating suicides among Veterans. VA has a national Strategic Plan for Suicide Prevention. This lays out the philosophical framework for our prevention efforts and also defines specific programs and actions that have potential to reduce the risk of death suicide among Veterans.

The VHA Strategic Plan for Suicide Prevention FY 2009–2010 was developed in response to the recommendations of the Secretary’s Blue Ribbon Panel on Suicide Prevention to “prepare a single document that details the comprehensive suicide prevention strategic plan . . . in order to facilitate more efficient review of suicide prevention progress.” The VHA Strategic Plan for Suicide Prevention is a living document of initiatives to be implemented by October 1, 2010 based on the US National Strategy for Suicide Prevention and recommendations or requirements from the National Strategy, the Institute of Medicine (IOM) Report, “Reducing Suicide: A National Imperative”, the VHA Comprehensive Mental Health Strategy Strategic Plan, the Joshua Omvig Veterans Suicide Prevention Act, and the report of the Secretary’s Blue Ribbon Work Group on Suicide Prevention. The Strategic Plan includes 67 elements. Of these, 33 have been implemented, 27 are in the process of being implemented, and 7 are new elements being developed.

Current Initiatives

The VA’s basic strategy for suicide prevention can be conceptualized as a pyramid. At the base is early prevention of any Veteran with a mental health disorder from becoming so distressed that suicide is considered as an option. This requires ready access to high quality mental health (and other health care) services made available to anyone with a need. Ideally needs will be identified at the earliest possible time and treatment will be provided at that early point. At the next level of intervention, those with identifiably higher risk of suicide need additional intensity of services, for example through programs designed to help individuals and families engage in care and to address suicide prevention in those higher risk patients. Finally, those who are at imminent risk of suicide need urgent care available immediately, care that can rescue the Veteran from a suicidal crisis and get them into intensive services addressing their specific needs. Some of the initiatives that have proven to be very effective in our efforts include:

Enhancement of overall VA mental health services:

- Over the last five years, and with renewed commitment by the current Administration, VA has implemented a comprehensive Mental Health Strategic Plan and is now actively implementing the VHA Handbook Uniform Mental Health Services In VA medical centers And Clinics.
- As part of these transformative efforts, VA has added almost 6,000 mental health providers, for a total of just over 20,000 providers as of March, 2009.

- Also as part of these efforts, access to care has met a standard unmatched in the rest of US health care; those who are newly seeking mental health care are seen for full evaluation and the start of treatment implementation within 15 days of referral, at a level of 96% across the VA system.
- VA has integrated mental health services into its primary care system, so that mental health providers are part of the primary care team and mental health care can very often be delivered in that setting, where patients have been shown to be most likely to bring mental health concerns. Referral to mental health specialty care is still fully available when that level of care is identified as the appropriate setting of care.
- Screening and assessment processes have been set up in primary care to assist in the early identification of patients with mental health problems. When patients screen positive, further evaluation can occur immediately in the primary care setting. If a patient screens positive for depression or PTSD, a full evaluation of possible suicidal risk also is mandated and provided.
- To help staff understand how excellent mental health services are also good suicide prevention strategies, VA has taken numerous educational efforts:
 - Sponsored three Suicide Prevention Days to increase awareness of the problem and co-sponsored 2 conferences on suicide prevention with the Department of Defense for clinicians in both systems.
 - Sponsors public service announcements, web sites and display ads designed to inform Veterans and their family members of the VA Suicide Prevention Hotline (1-800-273-TALK/8255).
 - Distributes brochures, wallet cards, bumper magnets, key chains and stress balls to Veterans, their families and VA employees to promote awareness of the Hotline number and educate its employees, the community and Veterans about how to identify and help those who may be at risk.
 - VHA Suicide Prevention Coordinators are required to do outreach activities in all of their local communities and are able to provide a Community version of Operation S.A.V.E. to returning Veterans and family groups, Veterans Service Organizations or other community groups as desired.
 - Family psycho-educational materials have been developed including information sheets intended to serve as guides for adults to use when talking with children about a suicide attempt in the family and family ACE (Ask, Care, Escort) card.

Services for Veterans Identified as at Increased Risk for Suicide:

- Employee education programs such as Operation S.A.V.E. (a VA specific suicide awareness program) and a web-based clinical training module have been mandated for VA employees. S.A.V.E. refers to: know the **S**igns of Suicidal thinking, **A**sk the questions, **V**erify the experience with the Veteran, and **E**xpedite or **E**scort to help. This is designed to increase awareness among all staff who may come in contact with Veterans—not just mental health service providers—of factors indicating possible suicidal risk. As the S.A.V.E. acronym lays out, the training also guides staffing actions to take when a Veteran is identified as potential suicidal.
- Each VA Medical Center has a suicide prevention coordinator or team. The coordinators and their teams ensure that the Veteran receives the appropriate services. Calls from VA's Suicide Prevention Hotline (discussed in detail below) are referred to the coordinators, who follow up with Veterans and coordinate care.
- Patients who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, weekly follow-up visits, and care plans that directly address their suicidality. A chart “flagging” system for those at risk has been developed to assure continuity of care and provide awareness among care-givers.
- Reporting and tracking systems have been established in order to learn more about Veterans who may be at risk and help determine areas of concentration for intervention. Continual analysis of reports and VA data has led to 3 recent information letters to the field:
 - Each of the mental health conditions increases the risk of suicide, but the effect of PTSD may be related separately from its co-occurrence with other conditions
 - Chart diagnoses associated with Traumatic Brain Injury are associated with increased risks of suicide, even after controlling for co-occurring mental health conditions
 - Some, but not all, chart diagnoses associated with chronic pain are associated with increased risks of suicide, even after controlling for co-occurring mental health conditions

Services for Veterans in Suicidal Crisis:

- A 24/7 Suicide Prevention Hotline. Veterans call the national suicide prevention hotline number 1-800-273-TALK and then “push 1” to reach a trained VA professional who can deal with any immediate crisis. More than 245,000 callers have called the hotline and over 144,000 of these callers have identified themselves as Veterans or family members or friends of Veterans. There have been over 7,000 rescues of actively suicidal Veterans to date.

- An on-line Chat Service was initiated in July 2009 and to date there have been almost 4,000 chatters that have utilized the Service. Several of them have been referred to the Hotline for immediate care.

Despite all of the above efforts, VA recognizes that ongoing research is needed to expand our knowledge and inform our continuous efforts to improve suicide prevention services. We are proud of what we do now, but can never be satisfied as long as there are Veterans who commit suicide; the more we can learn, the more we will be able to do:

- The development of two centers devoted to research, education and clinical practice in the area of suicide prevention. The VA VISN 2 Center of Excellence in Canandaigua, NY develops and tests clinical and public health intervention strategies for suicide prevention. The VA VISN 19 MIRECC in Denver, CO focuses on: 1) clinical conditions and neurobiological underpinnings that can lead to increased suicide risk; 2) the implementation of interventions aimed at decreasing negative outcomes; and 3) training future leaders in the area of VA suicide prevention.

- Suicide prevention research is challenging for many reasons, however scientists are attacking the problem through epidemiology studies to identify risk and protective factors; prevention interventions, and biological research examining

- VA researchers are also engaged in efforts to assure safety plans are in place for participants in research, including coordination with the VA National Suicide Hotline and standardized assessments for suicidality

- A recent comprehensive review concluded that intensive education of physicians and restricting access to lethal means had substantial evidence for preventing suicide.

- In order to explore the impact of Safety Planning in VA emergency department settings, a clinical demonstration program has been initiated. This project has included the use of Acute Service Coordinators who help veterans negotiate the transition from urgent to sub-acute care.

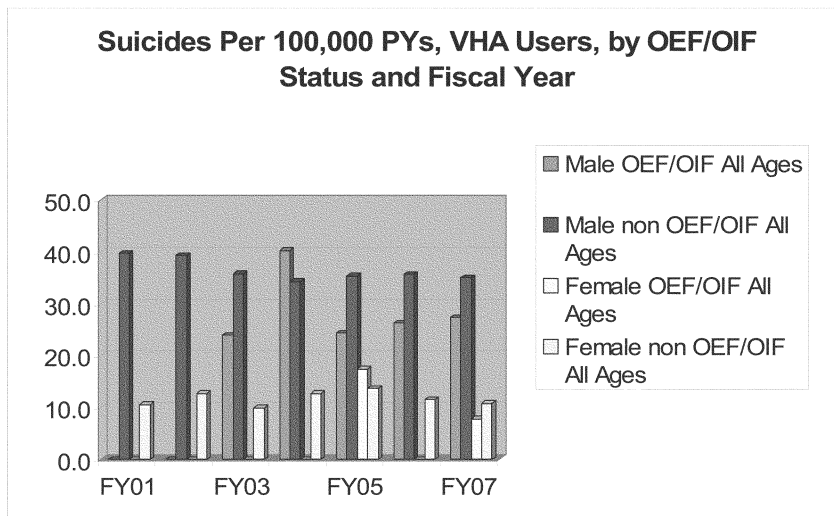
- Other approaches needing further research include: screening programs, media education, and public education. Structured cognitive therapy (CBT) approaches for those who are suicidal, or suicide attempters, and education of what are often called community “gatekeepers”, and means restriction initiatives (e.g., gun locks, blister packaging medications) show promise.

Finally, VA seeks to be a leader in contributing to a public health approach to suicide prevention in America.

- VA’s Hotline Call Center gets more than 20% of all calls to the National Lifeline and provides the only national suicide chat service.

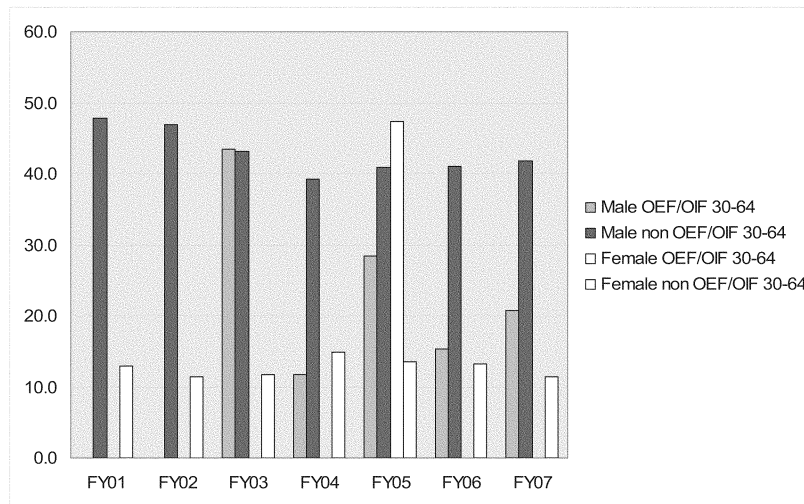
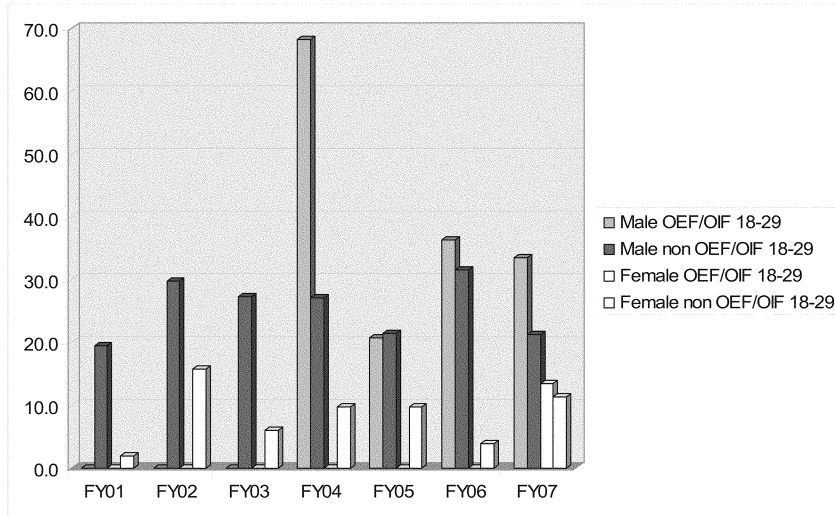
- VA’s Media Campaign has provided access to the National Suicide Crisis Line number to innumerable Americans.

- Suicide Prevention Coordinator Outreach work has touched innumerable community members and VA employees and employee families.

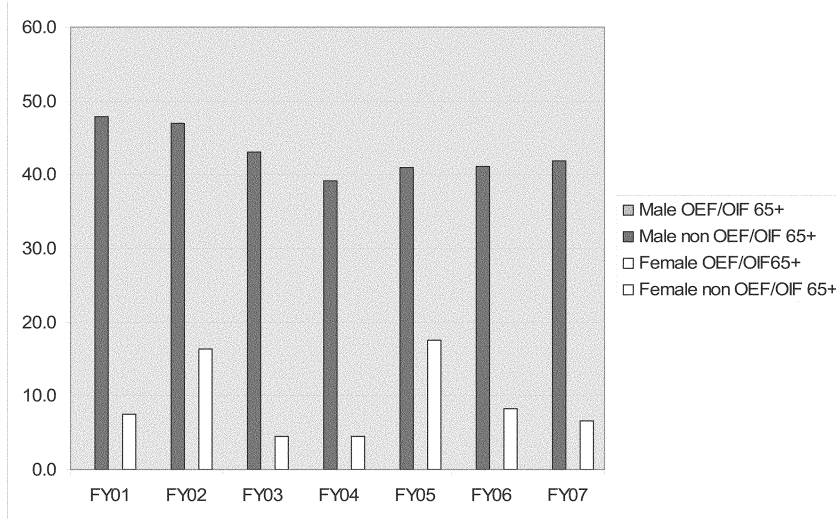


Notes:

1. To track suicide mortality over time, we use suicide rates - rather than the absolute number of suicide deaths per year - because they account for differences in the size of the at-risk population; this statistic is used by all suicide researchers because they account for differences in the size of the at-risk population; this statistic is used by all suicide researchers
2. The suicide rate is the number of suicide deaths per 100,000. It is calculated as: $(\# \text{ of suicide deaths} / \text{total time at risk of having an observed suicide}) * 100,000$. We use suicide rates - rather than the absolute number of suicide deaths per year - because they account for differences in the size of the at-risk population; for example, 10 deaths in a group of 100 would have much different meaning than 10 deaths in a group of 100,000.
3. The highest rate for male Veterans from OEF/OIF was in FY04. This was the year when VA, for a variety of reasons, focused on deficits in its mental health care and developed a VA Comprehensive Mental Health Strategic Plan (MHSP) to address those problems.
4. Implementation of the MHSP has resulted in significant expansions of overall mental health services and culminated in FY09 in the Uniform Mental Health Services handbook, which continues to be implemented in VA.
5. Focused suicide prevention efforts such as the Suicide Hotline and hiring of Suicide Prevention Coordinators began in FY07, with full implementation in FY08.
6. Data in this graph particularly illustrate the much higher rate of suicide for men than for women; this is true for the US population (and in much of the world) as well as for Veterans.



Note:
 The high suicide rate for women OEF/OIF Veterans aged 30-64 in FY05 is based on 2 deaths by suicide. The rate is high because there was a very small number of women in the population at risk in that year. There may be substantial instability in calculated rates over time without extremely large denominators; i.e., small differences in the number of suicides may result in large differences in the calculated rate per 100,000 person years of risk time.





Department of
Veterans Affairs

Office of Patient Care Services
Office of Mental Health Services

Fact Sheet

April 2010

VA Suicide Prevention Program Facts about Veteran Suicide

***The VA Suicide Prevention Hotline number is:
1-800-272-8255. Push "1" for Veteran services***

Overview

Every Veteran suicide is a tragic outcome and regardless of the numbers or rates one Veteran suicide is too many. We feel the responsibility to continue to spread the word throughout VA that "Suicide Prevention is Everyone's Business". Even though we understand why some may be at increased risk, we are continuing to investigate and taking proactive steps based on information we already know, with the ultimate goal of eliminating suicides among Veterans.

VA relies on multiple sources of information to identify deaths that are potentially due to suicide. This includes VA's own Beneficiary Identification and Records Locator Subsystem, called BIRLS; records from the Social Security Administration; and data compiled by the National Center for Health Statistics in its National Death Index.

These sources give us specific indications about Veteran vulnerability to suicide:

- 30,000-32,000 US deaths from suicide per year among the population overall.
 - *Centers for Disease Control and Prevention*
- About 20% are Veterans.
 - *National Violent Death Reporting System*
- About 18 deaths from suicide per day are Veterans.
 - *National Violent Death Reporting System*
- About 5 deaths from suicide per day among Veterans receiving care in VHA.
 - *VA Serious Mental Illness Treatment, Research and Evaluation Center*

- About 950 attempts per month among Veterans receiving care in VHA as reported by suicide prevention coordinators (Oct 1 2008 – Dec 31st, 2010)
- About 11% (1051/10228) of those who attempted suicide in FY2009 (and did not die as a result of this attempt) made a repeat suicide attempt with an average of 9 months of follow-up
- About 7% (724/10228) of suicide attempts resulted in death. Among those who survived their first suicide attempt and reattempted suicide within 9 months of their first FY09 event, ~ 6% (60/1051) died from suicide.
- About 33% of recent suicides have a history of previous attempts.
 - *VA National Suicide Prevention Coordinator reports*
- There is evidence of a 21% excess of suicides through 2007 among OEF/OIF Veterans when their mortality was compared to that of the US general population, with adjustment for age, sex, race, and calendar year.
 - *VA Office of Environmental Epidemiology*
- There is preliminary evidence which suggests that there are decreased suicide rates in Veterans (men and women) aged 18-29 who use VA health care services relative to Veterans in the same age group who do not since 2006. This decrease in rates translates to approximately 250 lives per year.
 - *National Violent Death Reporting System and VA Serious Mental Illness Treatment Resource and Evaluation Center*
- More than 60% of suicides among utilizers of VHA services are among patients with a known diagnosis of a mental health condition.
 - *Serious Mental Illness Treatment Research and Education Center*
- Veterans are more likely to use firearms as a means for suicide.
 - *National Violent Death Reporting System*

In terms of specific numbers, the incidence of Veteran suicide by gender is indicated by data from the VA's Suicide Prevention Coordinator reports. While this under-represents the total number of events, these are only the reports that have reached our Suicide Prevention Coordinators (incidents can occur not under VA care and not become readily known to VA staff) and where the cause of death was identified as suicide – it does provide information about male/female ratios.

<u>FY09</u>	<u>Male</u>	<u>Female</u>
Attempts (non-fatal):	9323	1342
Completions	676	31

NOTE: OF THIS TOTAL ABOVE, THE FOLLOWING ARE A SUBSET SHOWING DATA FOR RECENT OEF/OIF VETERANS:

<u>FY 09 OEF/OIF</u>	<u>Male</u>	<u>Female</u>
Attempts (non-fatal)	1621	247
Completions	94	4

Longitudinal data derived from national sources are shown in the attached graphs showing suicide rates among male and female Veterans of particular age cohorts.

1. The suicide rate is much higher for men than for women; this is true for the US population (and in much of the world) as well as for Veterans.
2. The highest rate for male Veterans from OEF/OIF was in FY04. This was the year when VA, for a variety of reasons, focused on deficits in its mental health care and developed a VA Comprehensive Mental Health Strategic Plan (MHSP) to address those problems. Data in subsequent years, when overall mental health care was greatly enhanced, show reduced rates.
3. Focused suicide prevention efforts, such as the Suicide Hotline and hiring of Suicide Prevention Coordinators, began in FY07 with full implementation in FY08, so we do not yet have data to see the full impact of VA's intensive efforts focused specifically on suicide prevention. Those initiatives are described in detail in the following section.

Current Initiatives

The VA's basic strategy for suicide prevention requires ready access to high quality mental health (and other health care) services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high risk patients. Some of the initiatives that have proven to be very effective in our efforts include:

- A 24/7 Suicide Prevention Hotline. Veterans call the national suicide prevention hotline number 1-800-273-TALK and then "push 1" to reach a

trained VA professional who can deal with any immediate crisis. More than 245,000 callers have called the hotline and over 144,000 of these callers have identified themselves as Veterans or family members or friends of Veterans. There have been over 7,000 rescues of actively suicidal Veterans to date. An on-line Chat Service was initiated in July 2009 and to date there have been almost 4,000 chatters that have utilized the Service. Several of them have been referred to the Hotline for immediate care.

- Each VA Medical Center has a suicide prevention coordinator or team. The coordinators and their teams ensure that the Veteran receives the appropriate services. Calls from the Hotline are referred to the coordinators, who follow up with Veterans and coordinate care.
- Screening and assessment processes have been set up throughout the system to assist in the identification of patients at risk for suicide. A chart “flagging” system has been developed to assure continuity of care and provide awareness among care-givers.
- Patients who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, weekly follow-up visits and care plans that directly address their suicidality.
- Reporting and tracking systems have been established in order to learn more about Veterans who may be at risk and help determine areas of concentration for intervention. Continual analysis of reports and VA data has led to 3 recent information letters to the field:
 - Each of the mental health conditions increases the risk of suicide, but the effect of PTSD may be related separately from its co-occurrence with other conditions
 - Chart diagnoses associated with Traumatic Brain Injury are associated with increased risks of suicide, even after controlling for co-occurring mental health conditions
 - Some, but not all, chart diagnoses associated with chronic pain are associated with increased risks of suicide, even after controlling for co-occurring mental health conditions
- Employee education programs such as Operation S.A.V.E. (a VA specific suicide awareness program) and a web-based clinical training module have been mandated for VA employees. (S.A.V.E. refers to: know the Signs of Suicidal thinking, Ask the questions, Verify the experience with the Veteran, and Expedite or Escort to help.)

- The development of two centers devoted to research, education and clinical practice in the area of suicide prevention. The VA VISN 2 Center of Excellence in Canandaigua, NY develops and tests clinical and public health intervention strategies for suicide prevention. The VA VISN 19 MIRECC in Denver, CO focuses on: 1) clinical conditions and neurobiological underpinnings that can lead to increased suicide risk; 2) the implementation of interventions aimed at decreasing negative outcomes; and 3) training future leaders in the area of VA suicide prevention.

Outreach

- The VA has sponsored three Suicide Prevention Days to increase awareness of the problem and co-sponsored 2 conferences on suicide prevention with the Department of Defense for clinicians in both systems.
- The VA is sponsoring public service announcements, web sites and display ads designed to inform Veterans and their family members of the VA Suicide Prevention Hotline (1-800-273-TALK/8255).
- The VA has been distributing brochures, wallet cards, bumper magnets, key chains and stress balls to Veterans, their families and VA employees to promote awareness of the Hotline number and educate its employees, the community and Veterans about how to identify and help those who may be at risk.
- Suicide Prevention Coordinators are required to do outreach activities in all of their local communities and are able to provide a Community version of Operation S.A.V.E. to returning Veterans and family groups, Veterans Service Organizations or other community groups as desired.
- Family psycho-educational materials have been developed including information sheets intended to serve as guides for adults to use when talking with children about a suicide attempt in the family and family ACE (Ask, Care, Escort) card.

Research

- Suicide prevention research is challenging for many reasons; however, scientists are attacking the problem through epidemiology studies to identify risk and protective factors, prevention interventions, and biological research examining brain related changes in suicidal patients.
- A recent comprehensive review concluded that intensive education of physicians and restricting access to lethal means had substantial evidence for preventing suicide.

- VA researchers are also engaged in efforts to assure safety plans are in place for participants in research including coordination with the VA National Suicide Hotline and standardized assessments for suicidality.
- A recent comprehensive review concluded that intensive education of physicians and restricting access to lethal means had substantial evidence for preventing suicide.
- In order to explore the impact of Safety Planning in VA emergency department settings, a clinical demonstration program has been initiated. This project includes the use of Acute Service Coordinators who help Veterans negotiate the transition from urgent to sub-acute care.
- Other approaches needing further research include screening programs, media education, and public education. Structured cognitive therapy (CBT) approaches for those who are suicidal (or suicide attempters) education of what are often called community “gatekeepers”, and means of access restriction initiatives (e.g., gun locks, blister packaging medications) show promise.

Public Health Contribution to Suicide Prevention in America

- VA’s Hotline Call Center gets more than 20% of all calls to the National Lifeline and provides the only national suicide chat service.
- VA’s Media Campaign has provided access to the National Suicide Crisis Line number to innumerable Americans.
- Suicide Prevention Coordinator Outreach work has touched innumerable community members and VA employees and employee families.

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Chairman AKAKA. Thank you very much. We will pursue that with you.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

Secretary Jefferson, I appreciate what you said about making sure that veterans at risk of homelessness have access to the offices of DVOP and the local veterans’ reps. I want to give you an example of how hard it is in a place like Montana.

We have six DVOP and LVR staff in Montana to serve a State with 147,000 miles. That means less than one full-time staffer for each of the eight biggest cities, and there is a whole lot more to Montana than just the eight biggest cities where veterans reside. And no full-time staff for any of the seven Indian reservations in the State.

Would you want to address that issue from your perspective and its adequacy?

Mr. JEFFERSON. Yes, sir. After the November 18 hearing, one of the things we talked about was getting out into rural America to learn more about the issues firsthand. We reached out to your office and to Senator Begich to go ahead and set that up. We had a trip to Alaska, which was very informative.

Sir, at the last hearing I talked about a concept that we had to provide boots on the ground in rural America and to provide better services. Although we are not ready to announce anything publicly, we have made some significant progress on a way to get more ca-

capacity to actually provide greater services to rural America—a rural outreach initiative.

So, in the next few months I am optimistic that we will be able to share something more about that. We have identified the gap and are working to finalize a demonstration project to deal exactly with the issues that you have raised, sir.

Senator TESTER. So you would agree that there are now gaps and we are not serving to the level even close to what needs to be served in rural America?

Mr. JEFFERSON. Sir, I feel that there is a significant gap between the services which are needed to provide coverage to rural America and what we have now.

Senator TESTER. We look forward to the proposals in the next few months.

You know, when we talk about homeless vets, I had a hearing in Montana with Secretary Peake a couple of years ago, and we had a veteran come to the hearing who said he just came out of the woods. He had been there for 20 years.

After further questioning, we found out that he literally just came out of the woods after being there for 20 years.

We have a lot of folks out there in rural America living in abandoned farm buildings, in the woods. The question is—Mr. Dougherty, you have said you have standouts; you have the DVOP folks and the LVR folks.

How do you find them? I mean there are a lot of homeless folks who are not veterans. How do you find them? How do you get to the folks who need help?

Mr. JEFFERSON. Sir, one element of this demonstration project that we are working on is engaging with individuals, groups and communities in that local area who would know where the veterans are, what parts of the town, what parts of the environment where folks aggregate even if they are individuals. So that is an element.

This demonstration project is to actually get into the heart of rural America to access those veterans.

Senator TESTER. That is exactly right. That question reverts back to your other answer. I mean I think we have got a big issue. Rural America has a high percentage of folks who sign up for the military. A lot of those folks go right back to rural America when they get done with the military.

The same thing with Indian reservations. A high percentage of those folks sign up, and they go back. Many of them were in leadership positions. There has got to be some way for all three of the folks here to address the issue that is not being addressed. I really do look forward to the pilot project.

I want to talk a little bit about the numbers that were put forth. 135,000, and then if my memory serves me correctly, one of you three had written and said that the number of homeless is going down.

Is that correct?

Mr. DOUGHERTY. Correct.

Senator TESTER. By how much?

Mr. DOUGHERTY. Our estimate for last year was 107,000 on any given night. The year before the estimate was a 131,000.

Senator TESTER. Do you anticipate that number continuing at that rate?

Mr. DOUGHERTY. Yes, sir. It will have to.

Senator TESTER. Mr. Johnston, you talked about the numbers from communities and counties. Who gives you the numbers?

Mr. JOHNSTON. We have an approach called continuum of care where all of the stakeholders within any community, and for Montana, it is the entire State working together. It includes city agencies that relate to homelessness such as health agencies, employment agencies, housing agencies. It includes nonprofits, foundations, any organization or person that touches the issue of homelessness. They get together on a regular basis to identify where homeless people are and what their needs are.

Senator TESTER. My time has expired but I am just going to ask one question. Do you feel comfortable that you are getting the numbers? A lot of these agencies do not do much work in rural America. We are talking about places where there are far more cows than there are people.

Do you feel comfortable you are getting the numbers you need out of those areas?

Mr. JOHNSTON. It is not a science, clearly. I have been working on this issue for several decades.

Senator TESTER. Because a lot of those agencies do not do much in rural America.

Mr. JOHNSTON. Right. The nonprofits are really the backbone of HUD's programs. About 90 percent of our funds go to local nonprofit organizations.

Part of the consolidated program I referred to, there is a new rural housing stability program we are also launching because of the frustration that you are citing that in rural communities they feel like HUD's homeless dollars do not always get to where they need to go.

So, in 2011 communities will have a choice about using the consolidated program or a rural housing stability program to focus on rural America.

Senator TESTER. OK. I think the key is finding them and getting them help.

Thank you all for your testimony.

Thank you, Mr. Chairman.

Chairman AKAKA. We will have a second round of questions here.

Mr. Johnston, in your testimony you stated that the HUD-VASH program combines HUD housing choice voucher rental assistance for homeless veterans with case management and clinical services provided by VA at its medical centers in the community.

I am building on what Senator Tester said on this. My question is what happens if there is not a VA medical center in the veteran community?

Mr. JOHNSTON. To be honest, I think the best answer is going to come from Pete on this. We allocate the Section 8 vouchers and the VA provides the case management, but it is not just through the VA medical hospital.

Do you mind if I defer part of that answer to Mr. Dougherty?

Chairman AKAKA. Mr. Dougherty.

Mr. DOUGHERTY. Mr. Chairman, although it is connected to the VA medical center it is not that it has got to be connected to a VA hospital. Many of these staff work out of community-based clinics and other locations. It is to have a person who is part of the medical care system who is providing the case management.

So I think what you will find from year one to year two is the vouchers are getting into a lot of more smaller communities, and I think what you will find when HUD comes out with round three is that we are getting into more communities as well.

It is not just that the vouchers are concentrated in or near VA medical centers; many of them are far distances away.

Chairman AKAKA. Secretary Jefferson, are there any obstacles to working with homeless veterans once they have been accepted into the HUD-VASH program? If so, how do you believe the obstacles can be removed?

Mr. JEFFERSON. Senator, I think one of the things that we have learned from the listening sessions with homeless women veterans is recognizing that the best practices for serving the women veterans are different from the male veterans, and we need to incorporate those best practices.

Some specific examples are: counselors who are female, trained in military sexual trauma, trained in domestic violence and physical abuse, trained in substance abuse, and are, again, female; the need to incorporate child care; and also access to educational opportunities once those children are of age to go to school.

So, as we look at the services need for the homeless women veterans, we need to incorporate those best practices into what the larger veteran service providers are offering.

Chairman AKAKA. Mr. Dougherty, your testimony states that we know from past experience that homelessness among veterans peaks 7 to 10 years after military service. Can you elaborate on VA's plans to prevent homelessness of current servicemembers 7 to 10 years from now?

Mr. DOUGHERTY. Yes. Mr. Chairman, that is, in fact, historically what we have seen. Of course, that is before we got into the present conflict and before we began working on an active intervention.

As I remind myself all the time regarding Vietnam veterans, VA probably saw one in ten in the first few years after the veteran came for any kind of services on the health care side. Now we are seeing about 40 percent of veterans who served in Iraq and Afghanistan.

We are making a deliberate attempt to—as you know because you have done this—to help us provide medical services and services for them, and we are actively reaching out to do that.

The collaborative effort that we are working on with the Department of Housing and Urban Development for those at risk of recently discharged veterans, we think is going to do a much better job because our care coordination staff and our Vet Center staff are going to be, before that veteran becomes homeless, able to hook that veteran into services that we can provide and housing and support assistance that HUD will be able to provide for them.

So, although historically that has been the case, I am looking for that trend to change radically moving forward.

Chairman AKAKA. Secretary Jefferson, how does DOL evaluate and measure the effectiveness of HVRP grantees and how are the results used in determining subsequent grants?

Mr. JEFFERSON. Thank you, Senator. We look at the entered employment rate as well as the retention rate; and choosing 2009 as an example, we served about 15,500 homeless veterans and had an entered employment rate of about 67 percent. So roughly two-thirds of those veterans going through the program were able to find meaningful careers, meaningful employment.

We also monitor all of our grantees, and when grantees are not performing at the level of which they could, they are first put on a performance plan. We try to work with them to get them back up to a high level of performance. And there is a monitoring component.

We currently have about a 67 percent success rate of entered employment for the community we serve.

Chairman AKAKA. Do you believe there is any value in using HVRP grants in conjunction with efforts to prevent homelessness among veterans or in assisting veterans who just recently are no longer homeless?

Mr. JEFFERSON. Yes, Senator. We are collaborating already with Housing and Urban Development and Department of Veterans Affairs in working on the initiative to prevent veterans' homelessness.

One of the ways we will provide that is by making sure employment representatives are involved with the sites where we are doing these demonstration projects.

Chairman AKAKA. Thank you.

Senator Burr.

Senator BURR. One question, Mr. Chairman and Mr. Dougherty. What key legislative provisions will need to be enacted to incorporate the Secretary's 5-year plan?

Mr. DOUGHERTY. Senator, most of the legislative authority we think we already have. There is one thing that we are looking to try to do, and that is around sober living housing.

One of the things we have found is that many veterans who have been homeless have substance abuse problems. Many of them are returning to gainful employment but they are limited in their income and their ability to live independently in communities.

There was some legislative authority back in Public Law 102-54. We think that what we need to do is also try to figure out how we can get more of that kind of housing out there because for many of those veterans, sobriety is something that if maintained, gets them stronger and then gives them the ability to live independently within their income.

Many of these veterans when they first go back to work have very limited income, and over time their income level rises. So, one of the things that we are looking to work with you and the Committee on is how do we get more of that kind of housing availability, which has very low start-up cost and does not have an ongoing cost to VA.

Senator BURR. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

Assistant Secretary Jefferson, in the last round of questioning, you intimated that there would be in the next few months a rural outreach program announced. Do you anticipate that to be before the Fourth of July?

Mr. JEFFERSON. Sir, I cannot make that commitment. I will just tell you that we are working very hard to bring the relevant partners in that together. We are looking at everything from metrics, operationalizing, and execution. It is one of my top priorities.

Senator TESTER. If it is one of your top priorities, I anticipate, I mean—I think it is something that is critically important and would go a step further to say, when you make that announcement, I would love to have you do it in Montana where you would have a willing audience.

Mr. JEFFERSON. Sir, we are always excited to work closely with your office.

Senator TESTER. I want to talk about competitive grants just for a second. Each of you is responsible for running large competitive grant programs to service homeless vets. This is for each one of you: how do you compare grant proposals with regard to rural States versus urban areas?

Who wants to start? Pete?

Mr. DOUGHERTY. Yes. Senator, what we do is we look at what the need is. When our transitional housing grants first came about, it was deliberately designed to give rural communities an advantage, or at least not to have a disadvantage in applying.

There is what I like to refer to as an intensity of need. You are from a very rural State. If you have 20 homeless veterans in New York City probably no one would care. If you have 20 homeless veterans in Missoula, people are really concerned and want us to do something about it.

So we fund many small grants; many of our programs are small. You do not have to have a 50-bed program in order to get funding from us.

In rural areas, with our current Notice of Funding Availability, it allows us, as was mentioned before, to serve tribal programs. One of the things that we have done is we have targeted tribal lands, programs on tribal lands to help meet that need.

So, in that case, you need to have a passing grade, and you will not be at a competitive disadvantage by having to hire a high cost grant writer.

Senator TESTER. Secretary Jefferson, would you want to respond to that question?

Mr. JEFFERSON. Sir, just a few quick thoughts. One is very candidly, with the resources we had we did not have the ability to create a grant program that would target just rural communities, which is how this demonstration program came out; and through partnerships I believe we are going to have the capacity to provide services there.

Based upon the awareness we have of the needs in rural America, which I want to thank you for sharing a lot of those over the past few months, we will be looking at that when we make grant decisions for the current grants that we have.

Senator TESTER. Mr. Johnston.

Mr. JOHNSTON. In our competitive programs, by law need is one of the selection factors. We have performance as another key element. We have found and we have compared this over years that rural communities do just as well in the competition as all areas do in the country.

Nonetheless, given the perception and concern that rural areas are not getting enough, this new rural housing stability competitive program will provide more resources in rural areas.

Senator TESTER. I appreciate your answers. I would also say that the numbers in rural areas are not there because it is rural. So when these grants go out—and I have just as much empathy for the veteran that is living in an urban center as I do out in the woods in Montana. They both have their issues. They both have their problems. I just want to make sure that we do not forget about them.

Mr. Johnston.

Mr. JOHNSTON. Just one quick observation. We have another program that is not competitive. It is a formula program and it can be used flexibly for homeless prevention so that in rural communities where you may not be living on the streets because it just would not happen there or there is not a shelter, you can use homeless prevention funds to serve that person.

Senator TESTER. Do the folks in rural America know about it?

Mr. JOHNSTON. They do. The problem in the past was it had been limited. It had been a very, very small program. Our request this year significantly increases the size of that program.

Senator TESTER. Thank you, Mr. Chairman.

I want to thank the work each and every one of you do. I appreciate it.

Chairman AKAKA. Thank you very much, Senator Tester.

I want to thank this first panel. I urge that you continue this discussion on the homeless amongst yourselves and to be in touch with us as we look into it and discuss the details of the VA's 5-year plan.

We also want to join together with you to bring this about. As Senator Burr has mentioned, we are looking at outcomes and that is very, very important to all of us.

So thank you. This has been a valuable hearing for us. Thank you for your contributions.

Now I would like to welcome the witnesses on our second panel.

Arnold Shipman, U.S. Air Force Veteran. Dennis H. Parnell, President/CEO, The Healing Place of Wake County. Sandra A. Miller, Program Director, Homeless Veteran Residential Services, Philadelphia Veterans Multi-Service & Education Center. Patrick Ryan, Vice Chair, Board of Directors, National Coalition for Homeless Veterans. Sam Tsemberis, Ph.D., Founder and CEO, Pathways to Housing, Inc.

Mr. Shipman, would you please begin with your testimony.

STATEMENT OF ARNOLD SHIPMAN, U.S. AIR FORCE VETERAN

Mr. SHIPMAN. Good morning, Senator Akaka, Ranking Member Burr.

My name is Arnold Shipman and I am a 49 year-old Air Force veteran and homeless from Baltimore, MD. I joined the Air Force

in June 1978 right after high school. My specific job assignment in the Air Force was as a Security Police Customs Inspector. I went from Eglin Air Force Base in Florida to Okinawa, Japan and finally to Dover Air Force Base in Delaware.

It was at Dover Air Force Base where the realities of life took a heavy toll on a then twenty-one year old young man. Part of my job was inspecting the body bags of women, children and babies who died under the hand of Reverend Jim Jones in Jonestown. There were women, children and babies who died in this horrible and tragic chapter of our history. Their lives had not even begun. This had a powerful and profound effect upon me.

After my military career was over, I returned to my home in Baltimore. Thus began a series of menial jobs while waiting to pursue a career as a diesel mechanic. It was during this time that my life began to seriously spiral out of control.

Cocaine was becoming very popular. Several of my friends were selling cocaine. Because there was nothing else happening for me, I began to sell this. The money was rolling in and I thought this could make me forget my experiences at Dover AFB. I thought this could make me happy. It was a momentary respite.

Outwardly, I portrayed someone who was happy, someone who had his life together and was functioning as a normal person. Inwardly, I was a mess. Nothing fulfilled me no matter what I did.

It was at this point that I began to use drugs. Not the cocaine I had been selling, but heroin. This is a more deadly drug and its most devastating effects soon became very apparent to me.

Now began the endless incarcerations and the increased drug use. It seemed each time someone close to me died, my mother, my father, my two sisters and my brother; it only whetted my appetite for more drugs. As I reflect upon that period in my life, any excuse would have done. It was as if I was on a runaway train taking me to the darkest places of life.

It was during this time in a damp jail cell, alone, at night, by myself I remembered a place I had heard of earlier. A place called MCVET-Maryland Center for Veteran's Education and Training. A place where help could be had if one wanted it.

I thought about how life had not gone very well for me so far and anything might be better than what I had been used to. Thinking I had nothing to lose and maybe everything to gain, I decided to enter the program and was accepted.

That was one of the best decisions I have ever made in my life. The structure which was sorely missing immediately was found. The support I needed I accepted. The guidance I sought was provided.

Since being in the program, I have begun to clean up the wreckage of my past, piece by piece and inch by inch. I am also working on my degree in radiology. I am also a part of the "Back On My Feet" running program and recently completed my first marathon in October 2009 which was 26.2 miles. I am in training for the annual 5k/10k race in May and was featured in the national magazine which focused on my training for the marathon and the recovery that I am going through. And now I have the opportunity of a lifetime to address a U.S. Senate committee. I could not have imagined the changes my life would take.

I feel truly blessed. None of these accomplishments would have been possible for me without the MCVET program. They have provided me structure along with a positive support system which has allowed me to excel. They have helped me to address the issues which fed my addiction which I am overcoming. They have inspired me to be the best.

So, I thank the Committee. Thank you, Chairman Akaka. Thank you Ranking Member Burr.

In conclusion, I would also like to thank Colonel Charles Williams and the staff at MCVET. The opportunities they provided for me and other homeless veterans and other veterans in need have been unsurpassed. Thank you.

[The prepared statement of Mr. Shipman follows:]

PREPARED STATEMENT OF ARNOLD SHIPMAN, AIR FORCE VETERAN

My name is Arnold Shipman and I am a 49 year-old African-American male, Air Force veteran and homeless. I live in Baltimore, Maryland.

I joined the Air Force in June 1978 immediately after completing high school. My specific job assignment was as a Security Police Custom's Inspector. I went from Eglin Air Force Base in Florida to Okinawa, Japan and finally to Dover Air Force Base in Delaware.

It was at Dover Air Force Base where the realities of life took a heavy toll on a then, twenty-one year old young man. Part of my job was inspecting the body bags of those who the Rev. Jim Jones murdered in Jonestown. There were women, children and babies who died in this horrible and tragic chapter of our history. Their lives had not even begun. This had a profound affect upon me.

After my military career was over, I returned to my home in Baltimore, MD. Thus began a series of menial jobs while waiting to pursue a career as a diesel mechanic. It was during this time that my life began to seriously spiral out of control.

Cocaine was becoming very popular. Several of my friends were selling cocaine. Because there was nothing else happening for me, I began selling cocaine. The money was rolling in and I thought this could make me forget my experiences at Dover AFB. I thought this could make me happy. It was a momentary respite.

Outwardly, I portrayed someone who was happy, someone who had his life together and was functioning as a normal person. Inwardly, I was a mess. Nothing fulfilled me no matter what I did.

It was at this point that I began to use drugs. Not the cocaine I had been selling, but heroin. This is a more deadly drug and it's most devastating effects soon became very apparent to me.

Now began the endless incarcerations and the increased drug use. It seems each time someone close to me died, my mother, my father, my two sisters and my brother, it only whetted my appetite for more drugs. As I reflect upon that period in my life, any excuse would have done. It was as if I was on a runaway train taking me to the darkest places of life.

It was during this time in a damp jail cell, alone, at night, by my self I remembered a place I had heard of earlier. A place called MCVET-Maryland Center for Veteran's Education and Training. A place where help could be had if one wanted it.

I thought about how life had not gone very well for me so far and anything might be better than what I was doing. Thinking I had nothing to lose and maybe, everything to gain, I decided to enter the program there and was accepted.

That was one of the best decisions I have ever made in my life. The structure which was sorely missing immediately was found. The support I needed I accepted. The guidance I sought was provided.

Since being in the program, I have begun to clean up the wreckage of my past, piece by piece and inch by inch. I am working on my Associate Degree in Radiology. I am also a part of the "Back On My Feet" running team and recently completed my first marathon which was 26.2 miles. I am in training for the annual 5k/10k MCVET race in May. In December 2009, I was featured in the national magazine "Urbanite", which focused on my training for the marathon. And now I have the opportunity of a lifetime, to address a U.S. Senate Committee. I could not have imagined the changes my life would take.

I feel truly blessed. None of these accomplishments would have been possible for me without the MCVET program. They have provided me structure along with a

positive support system which has allowed me to excel. They have helped me to address the issues which fed my addiction which I am overcoming. They have inspired me to be the best.

Many thanks go to Col. Williams and the staff at MCVET. The opportunities they provided for me, homeless veterans and other veterans in need has been unsurpassed.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO
ARNOLD SHIPMAN, U.S. AIR FORCE VETERAN

Question 1. Other than the briefing you received from MCVET while you were incarcerated, do you remember any other outreach efforts regarding programs and benefits for veterans after you left the military?

Response. There were detox clinics at the VA hospitals in Philadelphia and Baltimore. Their primary purpose was removing drugs from your system. The programs lasted for approximately five (5) which included two (2) counseling sessions.

There was also a twenty-eight (28) day civilian program. It did not provide any structure or attempt to address the problems which led to my addiction. No counseling was provided.

From my experience, addicts just do not want to open up and talk about what's really troubling them in front of other people. As a result, they become frustrated and return to a life of active addiction.

I feel that structure is the key, just like what we received while we were in basic training. This is why I am so adamant about the MCVET program. The structure that I had lost was found at MCVET's. It has enabled me to remain clean and sober longer than I ever have, including my incarcerations. Because I used while I was locked up.

Question 2. How do you think your situation might have been different if you were placed in an apartment first, with no requirement for you to be clean and sober?

Response. My situation might be different given the fact that if I was not required to be clean and sober, I might be dead. It seems like without that requirement, it would be a haven for me and other addicts to use drugs. I was not homeless when I started using drugs. I became homeless because I was using drugs. Using drugs caused my life to become unmanageable. I was no longer a productive member of society. No program, apartment, room, car or anything else would have worked if there was no requirement for staying clean. As the literature in Narcotics Anonymous states, "staying clean must come first."

Question 3. Based on your experiences, do you believe there are any simple changes that can be done immediately to improve the services and programs available to assist our homeless veteran population and what are they?

Response. I think more money should be allocated to assist homeless veteran and other veterans in need. This would have an immediate effect and could be life saving.

Chairman AKAKA. Thank you very much, Mr. Shipman.
Ms. Miller.

**STATEMENT OF SANDRA A. MILLER, PROGRAM DIRECTOR,
HOMELESS VETERAN RESIDENTIAL SERVICES, PHILADELPHIA
VETERANS MULTI-SERVICE & EDUCATION CENTER**

Ms. MILLER. Good morning, Mr. Chairman, Ranking Member Burr. I am Sandy Miller, and I am the Program Director of Residential Services for The Philadelphia Veterans Multi-Service & Education Center. On behalf of our Executive Director, Marsha Four, our Board of Directors and our entire staff, I would like to thank you for the opportunity to provide comment here today.

Our executive director and I were present at the summit when Secretary Shinseki unveiled the VA's Five-Year Plan to End Homelessness. We respect the attention and energy that both he and President Obama have committed to this cause.

We at our agency, however, do have some serious concerns, and it may be cynical on our part, but we see a very real obstacle. Re-

member, we were here 10 years ago when the 10-year plan was introduced and we are still today.

The obstacle I mentioned is a large bureaucracy of the Department of Veterans Affairs. On one hand we have the Central Office, the VISNs, and the medical centers; on the other hand we have directors, managers, supervisors, a myriad of chiefs, program staff, triads, quadrads, and on and on.

If every person at the Department of Veterans Affairs at every level is not held accountable to these tasks, we will never accomplish it. There must be program measures in place at every level from the lowest person working in the kitchen of the VA medical center all the way up to the highest-ranking members at central office. Every level of the VA must be held accountable.

Resources must find their way to those of us who are in the trenches, boots on the ground. Receiving our first VA homeless grant per diem awards in 1996, we established the foundation for our comprehensive homeless veteran programs.

These programs include The Perimeter, a day service center; LZ2, a 95-bed transitional facility for male veterans; the Mary E. Walker House, a 30-bed facility for female veterans; in addition to HUD and DOL grants which have resulted in 40 housing units under HUD and a number of HVRP grants.

We are here to restate our concerns so they are not lost in the shuffle.

Day service centers reach deep into homeless veteran population still on the streets and in the shelters of our cities and towns. They are the portal from the streets and shelters to substance abuse treatment, job training and placement, VA benefits, VA mental and medical health, placement in jobs and transitional facilities. These day drop-in centers are the first step to ending veteran homelessness.

At the multi-service center for our day service center we receive—are you ready for this?—\$4.30 per hour to provide services for these homeless veterans and that is only for the period of time that that veteran is physically on site.

The services and assistance that we have to provide to these veterans go on long after that veteran leaves us. It is for this reason alone that many service centers have either closed or never opened after receiving their funding through grant and per diem.

We would like to suggest the creation of service center staffing and operational grants much like those special needs grants at the VA. Senators, we have been holding onto this mission for far too long by our fingertips. We need help.

Nonprofits have long struggled with the process used to justify the receipt of per diem payments through the VA. Although the amount of per diem has increased over the years, the documentation requirements have created a significant burden on these small nonprofits.

We argue that without the upkeep and solvency of the parent agency, the per diem programs could not function because they are inexplicably part of the parent agency.

Grantees are paid based on past accounted and audited expenses, not on anticipated expenses for the operating year in which the per diem will be paid. We suggest that the VA consider payment in

much the same way, for example, that HUD does, whereas funds are allocated and drawn down throughout the year with a reconciliation done at the end of the year.

We cannot enhance services or hire additional staff if we are unable to access the dollars of the increased per diem to pay for them. The current process leaves the agency in a situation where we do not have the money to do any advanced or real-time enhancements to our programs.

In the past some very successful programs identified a need for increased bed capacity. These existing programs requested additional beds under the per diem only grant process and were able to increase their bed capacity.

The original grant and the PDO were issued under separate times so therefore they have separate project numbers. These two project numbers are attached to the same program with the same expenses, utilizing the same staff. The only difference is the increase in bed capacity.

We believe that these programs must be treated as one and the two project numbers merged.

As with any change, we understand oversight is key. With the requirement for intensive annual inspections by the VA on all grant and per diem programs, we do not see any diminished ability if the VA was to provide this oversight and we feel that oversight of these programs should have no effect on how we are funded.

HUD-VASH and MHICM. HUD-VASH truly is a perfect marriage. We at the local level have seen one very large gap and that is that some of our veterans are not able to access VASH. They are too sick for one program yet not sick enough for another.

With not being eligible for the MHICM program, the Mental Health Intensive Case Management—again this is something we are seeing locally—these veterans who are not qualified for one or too sick for one and not sick enough for the other will slip through the cracks.

We believe that a coordination of MHICM and HUD-VASH for these special veterans could benefit them in providing them with a fighting chance at obtaining independent housing and happiness too.

In closing, can we end veterans living on the streets or in boxes, cars, shelters, vacant buildings? We do not know the answer but we know that we are going to keep on trying to do our best to be part of any solution. Eventually this does make a difference. It certainly does to the veteran who finds her way home.

Thank you.

[The prepared statement of Ms. Miller follows:]

PREPARED STATEMENT OF SANDRA A. MILLER, PROGRAM DIRECTOR, HOMELESS VETERAN RESIDENTIAL SERVICES, THE PHILADELPHIA VETERANS MULTI-SERVICE & EDUCATION CENTER, INC.

Good morning Mr. Chairman, Ranking Member Burr, and Distinguished Members of this Committee. As introduced, I am Sandy Miller, and although I am Chair of the Homeless Veterans Committee of Vietnam Veterans of America, I am here today as the Program Director of Residential Services for The Philadelphia Veterans Multi-Service & Education Center. On behalf of our Executive Director, Marsha Four, our Board of Directors and our entire staff, I would like to thank you for giving our agency the opportunity to offer comments on the VA Plan to End Homelessness in Five Years.

After all these years of effort, energy, and attention to this issue on the part of Congress, the VA, veteran advocates, veteran service organizations, and non-profit organizations the disturbing situation of life for homeless veterans endures. Can we bring an end to veterans living on the streets or in boxes, cars, shelters, vacant buildings? None of us can answer that question but we can try. There will always be those who choose this way of life . . . there always have been . . . from the beginning of time. We can, however, offer and assist those who seek a different way of existing in the short time we have all been granted, but they can't make it on their own. They just can't make it out of the darkness alone. And we can continue to try to find an effective and efficient way to help those who are helping these veterans.

The Philadelphia Veterans Multi-Service & Education Center is one of the non-profit organizations that has been working toward this end for over thirty years. We received our first two of many VA Homeless Grant and Per Diem (HGPD) awards in 1996. Though always providing for the homeless veterans who found their way to our agency, in 1996, we established the foundation of our comprehensive homeless veteran programs that also made use of HUD and DOL grants. Today these programs include: The Perimeter, a day long comprehensive, day service program; LZ II, a ninety-five (95) bed transitional residential program for male veterans; The Mary E. Walker House, a thirty (30) bed transitional residential program for female veterans; a thirty (30) unit Veteran only Shelter Plus Care Program; a ten (10) unit Veteran only HUD McKinney Supported Housing Program; ARRA 2009 funding from the city of Philadelphia for Rapid Re-Housing for veterans; and a number of DOL grant to include Homeless Veteran Reintegration Program grants (HVRP).

While our comments today may well be seen as a rehash of previously mentioned concerns, we are here to re-state them so they are not lost in the current massive movement to bring additional services and help to homeless veterans. PVMSEC has worked in this field and inside the grant programs of VA, HUD and Labor for so long, that we have identified over time the gaps, shortfalls, and enhancements that can only be known by those who utilize the system on the ground.

There are a number of Congressional bills to assist homeless veterans, improve or enhance programs for them, or initiate new opportunities in both this Committee and the House Veterans' Affairs Committee. We are all anxious for these to move as quickly as possible, but we also understanding, however, the need to allow enough input to make the provisions of each as comprehensive and responsive to the need as possible. And so we are here.

NUMBERS

With the increasing number of new veterans joining the ranks of the homeless veterans, it is puzzling that two years ago the VA estimated that 154,000 were homeless, last fall the number was 131,000, and most recently it was stated that the number has dropped to 107,000 homeless veterans on any given night. Those of us working in this arena are a bit confused because we have not seen a decrease in the number of homeless veterans we are seeing and assisting in our programs.

DAY SERVICE CENTERS: THE DOOR TO THE INSIDE

One of the most effective front line outreach operations funded by VA HGPD is the Day Service Center, sometimes referred to as a Drop-In-Center. As mentioned earlier, The Philadelphia Veterans Multi-Service & Education Center operates a Day Service Center in center city Philadelphia. We are committed to this program but our agency stretches itself and its staff almost beyond its limit in order to keep the program afloat. Few even remain in the HGPD system due to the limited per diem funding support.

These service centers are unique and indispensable as a resource for VA contact with homeless veterans. These Service Centers reach deep into the homeless veteran population that are still on the streets and in the shelters of our cities and towns. They are the portal from the streets and shelters to substance abuse treatment, job placement, job training, VA benefits, VA medical and mental health care and treatment, homeless domiciliary placement, and transitional housing. They are the first step to independent living. They can be the first step to ending homelessness. But this can only happen if they are able to operate in an effective environment.

Under the VA HGPD program non-profits receive per diem at rates based on an hourly calculation per diem (\$4.30) for the actual time that the homeless veteran is actually on site in the center. This amount may cover the cost of the coffee and food that the veterans receive but it does not come close to paying for the professional staff that must provide the assistance and comprehensive services that must

be continued on his/her behalf, long after they leave the facility. An example, our homeless veteran daily case load is fifty-seventy (50–70) and our annual unique veteran count is approximately 900. As one can well imagine the needs of these veterans are great and demands an enormous amount of time, energy, and manpower in order to be effective and successful. Their problems are complicated by years of abuse on many levels of life experience.

It is for this reason, the lack of sufficient operational funding, that many service centers for homeless veterans have either closed or never opened after being funded by VA HGPS. The VA acknowledges and understands that this problem exists. This is a tremendous loss to the outreach efforts so important in connecting the homeless veterans with the VA.

The reality is that most city and municipality social services do not have the knowledge or capacity to provide appropriate supportive services that directly involve the treatment, care, and entitlements of veterans. It is for this reason that these homeless veteran service centers are so vital. These service centers desperately need help and attention. They are an integral part of the outreach and first line contact with homeless veterans that is, in fact, so essential as part of the Secretary's 5 Year Plan. Service Center programs are challenging and staff intensive. But they are one of the raw conduits out of homelessness in many cases.

We believe that it is possible to create "Service Center Staffing/Operational" grants, much like the VA "Special Needs" grants. Passing the legislation to establish this funding stream/resource shouldn't take a year to figure out. "Special Needs" grants have been doing it for years. And we can't wait too much longer. We have been holding on to this mission by our fingernails for a long time. Without serious and speedy activation of staffing grants the result may well be the demise of these critically needed services centers.

We cannot lose these valuable front line, "on the streets", service center outreach programs. They are the heartthrob of VA homeless veteran programs; the first hand offered too many of the homeless veterans who are on the streets and in the shelter system of our cities.

A UNITED FRONT: MHICM AND HUD-VASH

HUD-VASH: the vision of a perfect marriage. Like all unions, however, nothing is perfect and for those who work inside the program, it is evolving. But The Center would like to bring forward a situation that identifies a very real gap in services for a group of our homeless veterans that don't seem to fit anywhere else in the system. These are the homeless veterans who are diagnosed with significant mental health problems (i.e. schizophrenia) but do not meet the criteria for placement in the VA Mental Health Intensive Case Management (MHICM) program. (MHICM eligibility criteria requires >30 days or >=3 episodes of psychiatric hospitalization, a diagnosis of schizophrenia or bipolar disorder, and living within 60 miles of a VA hospital.)

Though HUD-VASH and its case management are a significant improvement and source of continuous support for many of the homeless veterans, it is not intensive enough for those homeless veterans with a level of significant mental health illness. So therein lies the dilemma. Not "sick enough" . . . "too sick." They fit nowhere. They have not been ruled incompetent. They are left to find apartments in the community with no case management or organized support. These homeless veterans are now the forgotten. They are left with little chance for success and they will continuously recycle into and out of homelessness for the rest of their lives. The Center believes the VA could establish a coordination of MHICM and HUD-VASH for this "special needs" population of homeless veteran. They need to have a fighting chance at independent happiness too.

SERVICE SUPPORT FOR OTHER VETERAN PROGRAMS

There are agencies in this country that bring support, services, and housing to homeless veterans. They often times do this with little financial assistance from the outside. There are even some HUD programs that are developed for homeless veterans (i.e. Shelter Plus Care) that do not provide operational dollars. We are hoping that some consideration will be made to provide grant dollars through the HGPS program to these veteran specific programs. This will enable them to hire appropriate staff for case management. Without this possible assistance and resource, the full opportunity of these homeless veteran programs will be lost.

VA PER DIEM PROGRAMS

Non-profits have long struggled with the process used to justify the receipt of the per diem payments from VA Homeless Grant and Per Diem (HGPS) program. Al-

though the amount of the per diem money received per veteran per day provided has increased over time, the requirement documentation to meet a 100% cost expense has created a significant burden on non-profits.

UNALLOWABLE EXPENSES

The collateral expenses of a HGPD program often can be incurred by a non-profit agency and even require discretionary dollars to pay for them. This occurs because of certain restrictions on allowable expenses. This is especially true if the HGPD program is not located on the site of the home agency. We argue, though, that without the up keep and solvency of the parent agency the per diem program could not function because, in truth, the program is linked inexplicably to the parent agency. The HGPD program could not exist without the home agency and therefore some of the expenses of the agency must be directly allowable as expenses to the program. We believe it should be at the discretion of the non-profit agency as to how much administrative expenses are incurred to cover the cost of the program.

"FEE FOR SERVICE"

In actuality, HGPD is "fee for service." One difference is that it is not set up as a contract agreement as utilized in the past by the VA where agencies were paid as contractors. Today's methodology works on the approach that grantees are paid based on past accounted and audited expenses, not anticipated expenses.

Though not a popular resolve some non-profit agencies as asking, "Why aren't our programs seen as "fee for service" operations instead of a reimbursement?" This option would, it seems, place the existing and future grant awardees in a per diem program much like that of the past programs which were paid as contractors. But this option is one that is discussed due to the frustration in obtaining the correct amount of per diem based on actual program expenses.

DETERMINATION OF PER DIEM RATES

Currently, the per diem amount that non-profits receive is based on the previous year expenses as defined in its annual audit. It is not based on anticipated expenses for the operating year in which the per diem will be paid. This causes the program to fall short in meeting its expenses for the agency's operating year. For this reason, we believe it is a reasonable suggestion that VA consider the distribution of per diem payments in much the same way that other Federal agencies operate. One solution to consider would be to set up HGPD disbursements in a "draw down" account similar to the system utilized by the U.S. Department of Housing and Urban Development, whereby agencies submit their projected budgets, are allocated the funds, and draw down on the allocated funds throughout the year. At the end of year reconciliations and adjustments as made.

Payments need to be based on actual anticipated budgetary expenses, not based on past year expenses. We cannot enhance services or hire additional necessary staff before we are able to access the dollars of increased per diem to pay for them. It sets in place a vicious cycle of need. (The agencies have a set per diem; they need more staff; they haven't shown it as an expense on the approved per diem they are receiving, so they can't afford to hire new staff because they don't have the money to do so.) This process leaves the program and the agency at a clear disadvantage because they do not have the money to do any advanced or "real time" enhancements to the program. To do so would place them at high risk and this action could be suicidal for a small non-profit. It places them at risk with creditors or, the agency has to reach into its line of credit at the bank. This action could result in paying in pay interest on the use of its line of credit until they can be approved for higher per diem. This interest is then an added expense to the program . . . a cost they cannot recoup.

S. 1547, The Zero Tolerance for Veterans Homelessness Act of 2009, introduced by Mr. Reed, provides for a much needed and greatly anticipated study on per diem payments. This study will include all aspects relating to the methodology used in making per diem payments. The bill also calls for the development of an improved method for adequately reimbursing grantees for services provided to homeless veterans. Non profits across the country anxiously await the results of this study and long overdue improved "reimbursement for services" method of allocating per diem dollars.

As with any change, oversight is the key to the success or failure of the programs. There is already a process for defined oversight in regard to annual inspections, services offered, and goals attained in place. With the requirement for intensive annual inspections by the VA on all GPD programs, we do not see any potential dimin-

ished ability by the VA in the oversight of the programs. The method by which funds are paid should have no effect on the VA's ability to provide oversight.

CONSOLIDATION OF VA HGPS PROJECT NUMBERS

In the past, some very successful VA HGPS residential programs identified a need for increased bed capacity due to a clear identification of increased need for program admission. These existing programs requested additional beds under a VA HGPS "Per Diem Only" (PDO) grant process and were awarded the ability to increase the overall number of program beds.

The original HGPS grant and the PDO grant were awarded at different times; hence, they have separate and different VA "project numbers." These two project numbers are attached to the same program with the same expenses and the same staff. The only difference it has brought to the program is an increase in bed capacity. Here's where it gets convoluted and tricky.

VA policy states that everything related to the one program must be divided out by a percentage based on the number of beds attached to the two project numbers. This includes the request for per diem amounts and the entire budgeted expenses of the entire program. Every bed in the one program has been assigned to one of the two project numbers. For the purpose of billing the VA at the end of each month, each veteran must be tracked on a daily basis, indicating the bed he/she was assigned on that particular day. And this must be done because when the audit was done for the one program to determine the level of per diem the agency can receive, it was identified that the per diem per day for the two project numbers was different. Not only is this a very time consuming process on the reporting side, all expenses for the one program on the bookkeeping side of the agency have to be calculated by percentage. This also makes it extremely difficult to request increased per diem.

We believe that if a single program has two different project numbers based solely on an approved expansion without change to the program, that program should be treated as a whole and the two projects numbers should be merged. This is the only fair way to work with the non-profit. To do so would allow an agency to function in a more efficient manner, have access to an appropriate and true per diem structure, and reduce the paper work for the VA HGPS offices.

THE FIVE YEAR PLAN TO END HOMELESSNESS AMONG VETERANS

I have spent some time highlighting a number of areas that PVMSEC feels need attention or change. In actuality we have struggled with them for years. Because you have asked us here to testify, we are trusting in your serious consideration of our thoughts. We would certainly discuss these ideas further if you would like.

Our agency had several staff who were present at the summit when Secretary Shinseki revealed the VA's Five Year Plan to End Homelessness. We respect the attention and energy that both he and President Obama have committed to eliminating homelessness among veterans.

It is a plan of wide scope. And if it's deliverable it will make a tremendous impact on the lives of thousands of homeless veterans. The Secretary had a team of extremely experienced and knowledgeable staff that worked on the development of this comprehensive document. They embraced the Secretary's priority of this issue and the immediacy of the need.

Needless to say, we have serious doubts and concerns if the plan will meet the expectations of Secretary Shinseki. It may be cynical on our part but not only do we see a very real obstacle stretching across the road to this plan . . . we were also around about ten years ago when there was another edict to end homelessness in ten years. And here we are today . . . still working on the issue.

The obstacle I mentioned was the large bureaucracy of the VA. On one hand we have the stratus of the Central Office, the VISNs, and the medical centers. On the other we have the agency's layer upon layer of directors, managers, supervisors, chiefs of staff, chiefs of social work, chief of patient services, chiefs of psychiatry, chiefs of psychology, program staff, triads, quadrads, and on and on.

If everyone at all these various levels doesn't buy-in to the plan or doesn't seriously create a place for it in their own priority list it will just linger until five years have past us by. If the urgency of this address isn't made tangible, it may lose its kick. Perhaps it should be on the list of annual performance measures and position evaluations from top to bottom. We don't know the answer but we know we are going to try . . . and keep on trying to do our best to be a part of any solution that will help. Eventually, this does make a difference. It certainly does to the veteran who finds her way home.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HONORABLE DANIEL K. AKAKA TO SANDRA A. MILLER, PROGRAM DIRECTOR, HOMELESS RESIDENTIAL SERVICES, PHILADELPHIA VETERANS MULTI-SERVICE AND EDUCATION CENTER

Question 1. If VA used a “draw down” method similar to HUD’s, as your testimony suggests, what is the difference between—what your center receives annually from the grant and per diem programs—and what your center would be allocated if it submitted a projected budget?

Response. The major difference between what and how we receive payment from the VA and how we recommend being paid through a “draw down” method is that our monies would be immediately available to us. Currently, it can take weeks or even months to receive our payments, which causes us, and we are sure other non-profits, to have to tap into our “line of credit” with our banking institution. The fees associated with this practice are not able to be charged back as an expense to the program. In some instances, by not receiving our funding in a timely manner, we find it difficult to meet payroll or pay other bills necessary to the overall operation of the program and agency. By having our funds allocated and available “up front,” we will be able to access the funds necessary to keep the agency operating. It is our opinion that, if in fact our budget has been reviewed and approved, then we should be able to access those funds without delay. This would allow for the hiring of staff to provide enhancements to the program. With the current method of basing our budget on past year expenses and not on projected year expenses puts agencies in a very dangerous position. We are unable to hire new staff to enhance our programs because we can’t include projected expenses, only those expenses incurred in the previous year.

Question 2. In your testimony you mention that about 10 years ago there was a plea to end homelessness, yet we are still talking about it today. What do you believe can be done to overcome the obstacle, which you refer to as the large bureaucracy of the VA, in order to finally achieve our goal?

Response. Every level of the VA must be held accountable if the 5 Year Plan is to succeed. It is our suggestion that Performance Measures be included that would provide qualitative measurable goals. The success of the 5 Year Plan lies in hands of the local medical centers and their staff, not in the hands of Central Office. Mandates can be handed down, directing VA employees on what the plan is, but if the local medical centers and their directors do not totally buy in to it, it will not happen. There needs to be accountability, not only from top to bottom, but bottom to top and every level in between.

Question 3. You stated in your written testimony that you believe that it is possible to create “Service Center Staffing/Operational” grants to cover the staffing costs at the veterans homeless centers. Have you had discussions with members of VA with regard to implementing these types of grants, and if so, what has been the outcome of those conversations?

Response. Our agency has had conversation with Mr. Dougherty at Central Office regarding the creation of Service Center Staffing/Operational Grants. In conversation with both Mr. Dougherty and Mr. Casey, it is our understanding that there needs to be legislative action in order to permit these grants through OMB.

Question 4. Based on your experiences, do you believe there are any simple changes that can be done immediately to improve the services and programs available to assist our homeless veteran population and what are they?

Response. We believe one of the quickest and easiest “fixes,” aside from the “draw down” method and creating Service Center Grants, would be to take per diem only projects awarded as expansions of existing capital grants and grandfather them in with the original capital grants. This would eliminate the cumbersome and labor intensive process whereby each PDO associated with a capital grant must be presented as separate line items in the agency budget. These are the same programs utilizing the same staff and services, yet all expenses must be reported out by percentage. An example would be our transitional residence, which started out with 50 beds, increased its’ bed capacity to 95 beds through per diem only, and then increased it again to 125 through another per diem only grant. Each resident must be tracked by bed every day because, depending on where their room is the per diem received could be either \$28.27 or \$27.85 or \$34.40 per day. All three has separate Project Numbers, when in fact, they should be grandfathered into the capital grant and operate under one single project number.

Chairman AKAKA. Thank you very much.
Now we will hear from Dr. Tsemberis.

**STATEMENT OF SAM TSEMBERIS, Ph.D., FOUNDER AND CEO,
PATHWAYS TO HOUSING, INC.**

Mr. TSEMBERIS. Thank you very much, Mr. Chairman and Senator. It is an honor to be here and I hope my testimony is helpful to informing this conversation.

I am the founder and CEO of a nonprofit called Pathways to Housing, started in New York City. We currently operate programs in Washington, DC, Philadelphia, PA, and Burlington, VT. We are providing technical assistance to about 20 cities across the country now.

One of the reasons our program has expanded so quickly is that we initially pioneered the Housing First approach. It has received a lot of attention and there is a lot of evidence supporting the usefulness of this approach both in studies by HUD and the Veterans Administration, formally studies published in 17 cities.

In my testimony I hope to provide some information about how Housing First, as a program, practice, and philosophy could maybe address some of the components of the proposed 5-year plan of the Veterans Administration.

I have to say that it is commendable that the VA has come up with a 5-year plan as opposed to a 10-year plan—shows a kind of urgency and also signals that it is actually doable, that this conversation about the multiple needs of veterans with psychiatric disabilities, addiction disorders, employment, and, of course, homelessness in some ways has been an elusive and very complex challenge.

The manner which we have found our way through it was not through our own resources but when we engaged with the people we were surveying in order to come up with a solution.

Housing First is essentially a ground-up solution where the homeless person drives the program. When you study the myriad of problems that we are looking at, the sequencing of these problems, the timeframe in which they are handled is hugely important.

For example, when you are looking at homelessness, mental illness, addiction, just those three, the solution for homeless is quite different than the solution for mental illness and addiction. They are not on the same timeframe.

Homelessness can be ended immediately. Addiction and mental illness require a much longer timeframe. People who are homeless know this. People who suffer with these conditions know this. The system that has served these complex needs for years has not really completely adopted this approach yet.

There is still an enormous investment in transition—getting people cured of their addiction or mental illness prior to receiving housing—that has kept people in a homeless service system; expensive, multiple uses of acute-care services with no solution to their homelessness.

So, the timeframe is important and the sequence in which you provide services and housing is key.

We, of course, have taken the direction from our clients and said what is it that you want? Every client we deal with says I want a place to live, a place of my own first. And that is the direction that we take. Housing First is really that person's first choice in service.

The next sequence of services, whether it is mental health or family re-connection or employment, is also driven by that person.

What we provide is the case management support so that once the person is housed they are continuously able to direct their own program to recovery.

Here is what we have learned in doing it this way. People are much more capable than we ever imagined possible.

Seeing someone on the street who is vulnerable and disheveled, poor, desperate, and afraid, that person looks completely different the day after they are put into housing. That person surviving on the street requires the resourcefulness to know where they can get a meal, where services are available, who they can trust on the street, all of those skills invisible to the passer-by are actually there and intact and serve the person well once they move into housing.

One of the fears I think in adopting a Housing First approach is how can this person possibly manage in housing? The answer is over and over again they manage extremely well. They need the support.

Let me emphasize that Housing First is not about housing. It is about the relationship with the homeless person in a way that engages them with the services that they want first. Housing first. Then all of the other services follow.

One of the challenges I think in the Veterans Administration is that it is a hierarchical organization. While running a military requires a hierarchical approach and following orders, excellence in mental health services and most of the evidence-based practice suggest that the best way to do a mental health service is to have the client drive the service.

This is an enormous culture change challenge to the VA in terms of allowing veterans to dictate the sequence and intensity of the services they seek. But to offer them in any other way would mostly generate refusals on behalf of the veterans.

Someone who has served as a veteran is not going to accept services that are an insult to their dignity, their honor, or their capabilities which they have proven already and demonstrated for their country, to then have to come and accept social services at a level that is demeaning and in a way an insult to their capability.

So, the philosophy and culture is important in terms of how successful you are in engaging these services.

The investment has been another part of the surprise. Investment in transitional preparatory services is expensive and does not lead to permanent housing very often. In studies that we have done in randomized controlled trial studies published in the *American Journal of Public Health*—all of this is in my testimony and on our Web site—people who are going through the treatment first approach end up being permanently housed about 40 percent of the time.

When you house someone directly from the street and offer services to support their staying in housing, that percentage jumps up to 80 percent of the time.

In the HUD studies, sponsored by HUD, and the VA study as part of the chronic homelessness initiative in 2003, that 85 percent

housing stability number is the same number that the researchers who conducted those studies found.

[The prepared statement of Mr. Tsemberis follows:]

PREPARED STATEMENT OF SAM TSEMBERIS, PH.D., FOUNDER AND CEO,
PATHWAYS TO HOUSING, INC.

www.pathwaystohousing.org

PATHWAYS HOUSING FIRST: PROGRAM DESCRIPTION

Pathways Housing First is a humane, highly effective and cost efficient consumer driven, evidence-based program that ends homelessness for people diagnosed with psychiatric disabilities and/or addiction disorders. In 2007, this program successfully completed peer review and is listed on HHS/SAMHSA's National Registry of Evidence-Based Programs and Practices.

The Pathways' Housing First program is based on a philosophy that emphasizes consumer choice, rehabilitation, and recovery. Housing First is designed to address the needs of homeless individuals from the consumers' perspective, encouraging program participants to define their own needs and goals. The program provides what most consumers identify as their primary need—immediate access to housing (a place of their own, a place to call home).

Independent, affordable apartments rented from community landlords is by far the most preferred housing option of all people who are homeless. Units are rented very quickly from the available housing rental market in normal integrated community settings by using rent subsidies such as Section 8 vouchers, shelter plus care funds or other permanent housing rent stipend. The program uses a 'scatter site' approach never renting more than 20% of the total number of units in a building. Program participants pay 30% of their income (usually SSI) toward their share of the rent. Thus supported housing program has a remarkably quick startup: it takes about 3 months from the time a program is funded to hire the support staff and begin moving people into apartments.

The program successfully removes the traditional barriers to housing for people who have disabilities. Notably, it does not place conditions such as achieving a period of sobriety or mandatory participation in psychiatric treatment as a precondition to housing. The program is especially effective with people who are chronically homeless and cycling through expensive acute care services such as emergency rooms, shelters, hospitals, police and jails.

It is important to note that cycling through these acute care services is very costly and yet completely ineffectively for ending homelessness. By addressing the homelessness problem first and providing the person with a place to live and then the support services need to succeed in that housing we have been able to achieve enormous success in both ending homelessness and helping people with their recovery. And the cost of this permanent supported housing program—a section 8 voucher (or its' equivalent) and the support services component is significantly less than the cost of keeping the person in a hospital bed, jail cell, or even city shelter.

The clinical and support services of this program ensure that housing is found quickly and that it can be successfully maintained. The services include both clinical or case management staff and housing staff. We have found that housing is itself a stabilizing factor for program participants and allows them to move in the direction of treatment. The program fosters a sense of home (not simply providing housing) and belonging; being part of a building, neighborhood and community as well as a member of a treatment and support team. The way that the housing is integrated into the community promotes community integration, and empowers participants to define their own paths to recovery.

The Pathways Housing First program addresses housing and clinical issues as separate but coordinated domains. By providing housing first, the program effectively addresses a person's homelessness. By providing program participants with an apartment of their own and then, once safe and secure, they work with the support services team to address their other problems such as addiction, mental health, employment and so on. The program requires that all program participants agree to a home visit by a member of the support services team at a minimum of once a week. This visit assures the health and safety of the program participant and is the setting for developing the treatment and rehabilitation service plan.

Treatment and support services are provided by an Assertive Community Treatment (ACT) team [comprised of social workers, nurses, psychiatrists, employment specialists, substance abuse counselors, peer counselors, and other professionals] or an Intensive Case Management (ICM) team that provides support services but may

broker other services including mental health, health, substance abuse treatment, supported employment, education, health and wellness to community based providers. ACT is the preferred support for persons with severe mental illness and ICM teams can be used for tenants with moderate mental health needs. ICM support can also be used when programs have a smaller census (less than 40 clients) and are not well suited to sustaining the staffing pattern of an ACT team. The housing component is always a community based apartment or equivalent depending on the housing stock available in the community and whether the participant is single, couple or family. The type and intensity of support services being provided to the participants is adjusted to meet their needs.

Over time, as individuals recover they can be referred to community-based providers that deliver needed services. Upon graduation, consumers do not have to transition into another housing program. They are already living in their own apartment with the subsidy still available if they need it. The only thing that changes at graduation is that the support services are reduced or eliminated altogether and the person continues to live in the building and community to which they are accustomed.

The most remarkable and exciting discovery of this Housing First program concerns what we have learned about the capabilities of people who are homeless and have multiple disabling conditions. We have found that when given the right housing and support services people who we had previously considered 'hard to reach,' 'hard to house,' and 'not housing ready' are in fact capable of making and managing a home, successfully participating in treatment, reuniting with families, and getting a job. This remarkable success of the program's participants is the main reason that in a relatively short 10 year span, the Pathways Housing First program has grown from a small local program operating in one city to an internationally replicated model in hundreds of cities.

RESEARCH STUDIES AND DEMONSTRATED EFFECTIVENESS

There is an ever-growing body of research evidence for the effectiveness of the Pathways' Housing First program for ending homelessness, promoting housing stability, improving quality of life, reducing acute care service use and reducing costs. Results from some of the larger studies are summarized below.

I. Greater Housing Retention

Studies have shown that Housing First participants achieve stable housing faster & spend more time in stable housing.

1) A randomized controlled trial of persons who were literally homeless showed that after one year, participants in Housing First (experimental) spent 85% of their time stably housed, compared with less than 25% for participants in the services-as-usual group (control) (Tsemberis, Gulcur, & Nakae, 2004). After two years, Housing First participants still spent approximately 80% of their time stably housed, compared with only 30% for the control group (see Figure 1). Housing First tenants also reduced the proportion of time they spent homeless from approximately 55% at baseline to 12% at one year, and less than 5% after two years (see Figure 2). Reductions in homelessness were significantly slower and less drastic for the control group, who were homeless approximately 50% of the time at baseline, 27% at one year, and 25% after two years (Tsemberis, Gulcur, & Nakae, 2004).

Figure 1. Proportion of Time Spent in Stable Housing

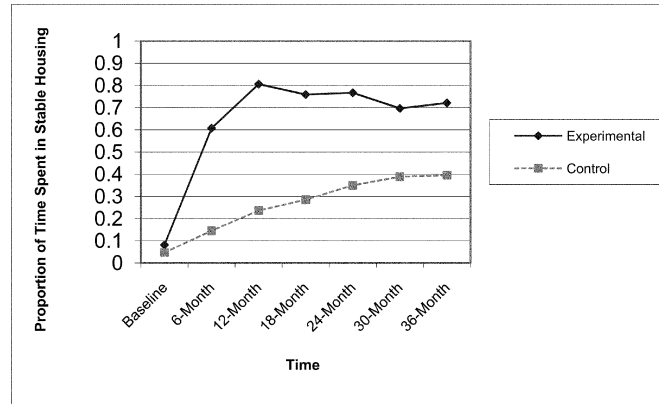
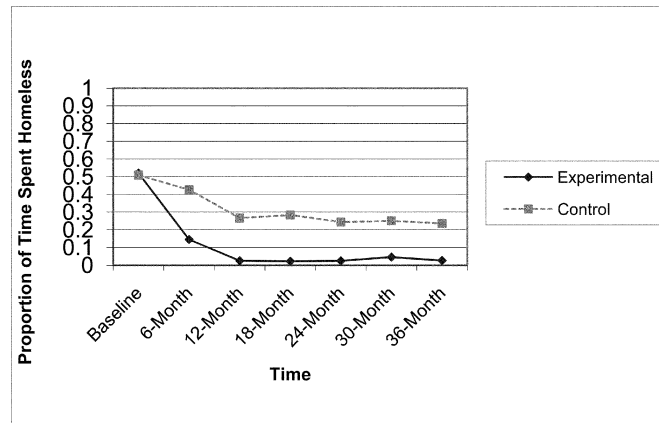


Figure 2. Proportion of Time Spent Homeless



2) A randomized controlled trial of long-term shelter stayers found that participants assigned to Housing First obtained permanent, independent housing at higher rates than a services-as-usual control group. The majority of consumers housed by both Housing First agencies retained their housing over the course of four years with 78% of participants in the Pathways Housing First program remaining housed over that period (Stefancic & Tsemberis, 2007).

3) A randomized controlled trial in Chicago found that 60% of persons in Housing First were stably housed at 18 months, compared with only 15% of persons assigned to usual care (Sadowski, 2008; Bendixen, 2008).

4) Archival data was used to compare rates of housing retention for Housing First tenants to those of tenants in New York supportive housing programs that required treatment and sobriety as a precondition to housing. After five years, 88% of participants in the Housing First program remained housed, compared to 47% of participants in more traditional housing programs (Tsemberis & Eisenberg, 2000).

5) A cross-site study of programs funded by HUD, SAMHSA, VA and HHS and coordinated by the US Interagency Council on the Homeless (called the Collaborative Initiative to End Chronic Homeless) demonstrated that high housing retention rates could be achieved across the diverse contexts of the 11 cities funded by this initiative. At least seven of the eleven programs funded used the Pathways' Housing First model and approximately 80% of clients were stably housed after 1 year (Rosenheck, 2007).

6) A HUD cross-site study of six Housing First programs found that 84% of Housing First participants were in permanent housing at baseline and 1 year later (HUD, 2007).

II. Reductions in Service Use

Studies have demonstrated that Housing First is associated with decreased use of emergency room visits, hospitalizations, incarcerations, and shelter stays, making Housing First a lower cost, more effective approach than traditional programs.

1) A randomized controlled trial found that persons assigned to Housing First spent significantly less time in psychiatric hospitals compared to participants assigned to services-as-usual (Gulcur et al., 2003).

2) A randomized controlled trial in Chicago found that persons in Housing First “used half as many nursing home days and were nearly two times less likely to be hospitalized or use emergency rooms” as compared to a usual care group over 18 months (Sadowski, 2008; Bendixen, 2008.).

3) A pre-post study in Denver documented reductions in institutional acute care subsequent to enrollment in Housing First. Housing First clients decreased emergency room use by 73%, inpatient stays by 66%, detox use by 82%, and incarceration by 76% (Perlman & Parvensky, 2006).

4) A pre-post study in Rhode Island documented decreases in hospital and jail stays, as well as emergency room visits, subsequent to clients’ enrollment in Housing First. “In the year prior to entering supported housing, the formerly chronically homeless individuals spent a combined total of 534 nights in hospitals, 919 nights in jail, and had 177 emergency room visits. In contrast, the newly housed individuals had a combined total of only 149 nights in hospitals, 149 jail nights, and 75 emergency room visits in the first year of housing” (Hirsch & Glasser, 2007).

5) A pre-post study in Seattle, documented reductions in various services subsequent to enrollment in one of two Housing First programs. Compared to 1 year prior to admission, Housing First participants in one program decreased jail bookings by 52%, jail days by 45%, admissions to a sobering center by 96%, EMS paramedic interventions by 20% and visits to a medical center by 33% (DESC, 2007). Participants in the other Housing First program reduced medical respite days by 100%, inpatient visits to a medical center by 83%, emergency room visits by 74%, jail days by 18%, and admissions to a sobering center by 97% (Srebnik, 2007).

6) A pre-post study of Housing First in Massachusetts demonstrated that, compared to the year prior to enrollment, in the year after enrollment in Housing First, inpatient hospitalizations were reduced by 77% and emergency room visits by 83% (Meschede, 2007).

III. Decreased Costs

Studies have shown that Housing First is associated with decreased costs.

1) A randomized controlled trial of persons who were literally homeless showed that, from baseline to 2-year follow-up, participants in Housing First accrued significantly lower supportive housing and services costs than participants in services-as-usual (Gulcur et al., 2003).

2) A pre-post study in Denver estimated that enrollment in Housing First was associated with a net cost savings of \$4,745 per person per year (Perlman & Parvensky, 2006).

3) A pre-post study in Rhode Island estimated that enrollment in Housing First was associated with a net cost savings of \$8,839 per person per year (Hirsch & Glasser, 2008).

4) A pre-post study in Seattle estimated that enrollment in two of their Housing First programs was associated with an aggregate reduction in cost of services used by \$1.7 million and \$1.5 million, respectively (DESC, 2007; Srebnik, 2007).

5) A randomized controlled trial in Chicago concluded that “health care savings far exceed the costs of the Housing [First] intervention” (The National AIDS Housing Coalition, 2008).

In all there are more than 35 cost studies on this model, all showing similar results.

IV. Improvements in Quality of Life & Other Outcomes

Studies find that Housing First is associated with greater consumer choice, greater satisfaction, improved quality of life, and improvements in other clinical and personal domains.

1) A randomized controlled trial found that participants assigned to Housing First reported higher ratings of perceived choice compared to those in services-as-usual

(Greenwood et al., 2005). Although program assignment did not have a direct effect on psychiatric symptoms, perceived choice significantly accounted for a decrease in psychiatric symptoms and this relationship was partially mediated by mastery (perceptions of personal control).

2) A qualitative study found that participants living in their own apartments through Housing First reported experiencing conditions that are indicative of a stable home that fosters a sense of control, allows for the enactment of daily routines, imparts a sense of privacy, and provides a foundation from which consumers can engage in identity construction (Padgett, 2007).

3) A Rhode Island study found that 93% of clients reported being "Very Dissatisfied" with their housing situation the year before entering their apartment. By contrast, 78% of clients reported being "Very Satisfied" and 12% "Somewhat Satisfied" with their housing situation at the time of first interviews . . . While homeless, nearly half of participants rated their health as "Poor" or "Very Poor" and two-thirds of participants said that physical or mental health disabilities had limited their ability to interact with those they felt close to. Once in the program nearly half rated their health as "Good" or "Very Good" and only one third felt that their disabilities limited their social interaction (Hirsch & Glasser, YEAR).

4) A Housing First program in Massachusetts found that "overall quality of life improved dramatically for all Housing First residents after leaving the shelter, including increased sense of independence, control of their lives, and satisfaction with their housing" (Meschede, 2007).

5) Compared to participants in community residences, those in supported housing (Housing First and another supported housing program) reported greater satisfaction in terms of autonomy and economic viability over 18 months (Siegel, Samuels, Tang, Berg, Jones, & Hopper, 2006).

6) A qualitative study of participants in a randomized controlled trial found that, for most Housing First clients, entering housing after a long period of homelessness was associated with improvements in several psychological aspects of integration (e.g., a sense of fitting in and belonging) as well as feelings of being "normal" or part of the mainstream human experience (Yanos et al., 2004).

7) An evaluation in Philadelphia compared participants in Housing First to a group of persons receiving services but no housing. Of the participants in Housing First, 79% showed improvement in mental health (comparison group 20%), 57% showed improvement on substance use (comparison group 15%) and 84% showed improvement on overall life status (comparison group 50%) (Dunbeck, 2006).

CONCLUSIONS

The Housing First model has been replicated in over 40 cities throughout the U.S. and it is included as a program component in most city and county plan to end chronic homelessness.

- Housing First is a consumer-centered approach that ends homelessness for individuals who have remained homeless for years. From the point of engagement, it empowers consumers to make choices, develop self-determination, and begin their individual journeys toward recovery and community integration.

- Housing First has a 18-year track record of success. It results in better outcomes at significantly lower costs, creating a significant return on investment relative to other programs.

- Practically speaking, the program has a very quick startup time since housing is rented from the existing rental market. Additionally, the program is extremely efficient in housing tenants, moving a person from homelessness into housing in two weeks, on average.

- Housing First eliminates costly transitional housing and treatment services that are aimed at preparing consumers to become "housing ready". The average cost of running a Housing First program is between \$15,000 to \$22,000 per person per year, depending on the intensity of services offered and local housing market rents. This cost compares very favorably with the cost of emergency room visits, jail stays, hospital stays, emergency shelter stays, and even the service and societal costs associated with street homelessness.

- Housing First promotes consumer choice, while encouraging use of mental health and other services. The provision of housing provides the environmental stability for consumers to participate in other services.

- Most importantly, the transformation of moving from homelessness into a home of one's own inspires physical and mental well-being and ignites hope in persons who had felt hopeless for years.

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POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO SAM TSEMBERIS, PH.D., FOUNDER AND CEO, PATHWAYS TO HOUSING, INC.

Question 1. How soon after a person is placed in permanent housing under the Housing First Model, does a member of the support services team make a home visit?

FOLLOW UP: What happens if a person does not honor the agreement to accept these home visits?

Question 2. Once a person is placed in permanent housing, where can that person go for supportive services in the time between the weekly home visits by a member of the supportive services team?

Question 3. Based on your experiences, do you believe there are any simple changes that can be done immediately to improve the services and programs available to assist our homeless veteran population and what are they?

[Responses were not received within the Committee's timeframe for publication.]

Chairman AKAKA. Thank you.

Ladies and gentlemen, I am very sorry but I must interrupt this hearing now. Committees are allowed to meet while the Senate is in session based on the unanimous consent of the Members.

This is a standard procedural agreement that is always permitted. However, there has been an objection on the floor to allow most committees, including our Committee, to meet.

I am very disappointed that we are forced to so abruptly close, missing the opportunity to voice your concerns and priorities. I hope that we can soon return to work we all support, and that is helping veterans.

But I want to thank you very much for appearing today for sharing your insights with us. We will have post-hearing questions.

Senator BURR. Mr. Chairman, could I be recognized for a unanimous consent request that the two witnesses who have not had an opportunity to speak that their full testimony be included in the record and that upon adjournment of this hearing we go into a roundtable discussion with the remainder of our panelists so that we can offer in an unofficial capacity questions. The roundtable is not in breach of I think the meetings of any of the Committees. The Committee can hold a roundtable at any point and I would make a unanimous consent request that we do that.

Chairman AKAKA. Senator Burr, I feel like you do but I do not think we should move to a roundtable discussion. I am sorry to say. There is no unanimous consent to continue the hearing so we will adjourn. The testimony of the witnesses unable to appear will be in the Appendix.

This hearing is adjourned.

[Whereupon, at 11:05 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF DENNIS H. PARNELL, PRESIDENT/CEO,
THE HEALING PLACE OF WAKE COUNTY

“THE HEALING PLACE MODEL—ENDING VETERAN HOMELESSNESS THROUGH
A COMMUNITY BASED PUBLIC/PRIVATE PARTNERSHIP”

Mr. Chairman and Members of the Committee, Thank you for the opportunity to speak to you this morning about the treatment needs of homeless veterans suffering from the ravages of alcohol and other drug disorders (AOD) and specifically about the provision of successful, community based, cost effective recovery services across the United States.

BACKGROUND STATISTICS ON THE NATURE & SEVERITY OF THE PROBLEM

National Coalition for Homeless Veterans

a. The VA estimates that 107,000 veterans are homeless on any given night. Approximately twice that many experience homelessness over the course of a year. Only eight percent of the general population can claim veteran status, but nearly one-fifth of the homeless population are veterans.

b. In addition to the complex set of factors influencing all homelessness—extreme shortage of affordable housing, livable income and access to health care—a large number of displaced and at-risk veterans live with lingering effects of Post Traumatic Stress Disorder (PTSD) and alcohol and other drug disorders (AOD), which are compounded by a lack of family and social support networks.

c. Veterans need a coordinated effort that provides secure housing, nutritional meals, basic physical health care, treatment and continuing care for alcohol and other drug disorders, mental health counseling, personal development and empowerment. Additionally, veterans need job assessment, training and placement assistance. NCHV strongly believes that all programs to assist homeless veterans must focus on helping them obtain and sustain employment.

Providing a Proven Solution

The Healing Place model has a 20+ year history of providing innovative rehabilitative services to homeless individuals with severe alcohol and other drug disorders including veterans of many distant and recent conflicts. The truly remarkable aspect of this model is the extraordinary program success—over 68% recovery rate a year after completing the program. The fully loaded costs for everyone in the program are less than \$30/day.

Early History

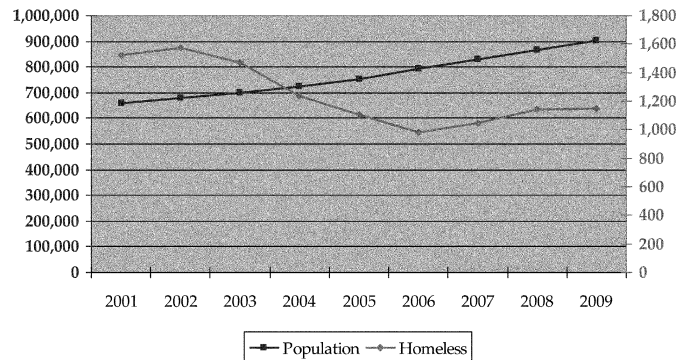
It all began in Jefferson County, Kentucky in 1989 when the Jefferson County Medical Society took over the operation of a shelter in Louisville and hired a Vietnam Veteran with a Masters Degree in Social Work as the fledgling program's first Executive Director. Together they began to craft a unique social model that targeted the specific population of homeless individuals with severe alcohol and other drug disorders. By utilizing and combining the knowledge base, resources and talents of the medical, social work and alcohol and other drug treatment fields they were able to establish a truly unique and holistic approach to a difficult and solution resistant social problem. In 1998 the success of the program was recognized on a national level and was honored by the public/private partnership between the Health Resource and Services Administration and the U.S. Department of Health & Human Services as a “Model That Works.” This opened the door for a concerted effort to begin to replicate the success of the original model.

Replication of the Model

Around this same time in Raleigh, NC an effort was undertaken by individuals from the public and private sectors to find answers to similar problems in Wake County, North Carolina. When the efforts and success of the Louisville Healing Place Model was discovered, stakeholders and organizers of this community launched a successful campaign to bring an exact replication to North Carolina. The original lure of the model was the fact that Louisville was able to demonstrate a 66% success rate (66% of program graduates were sober a year after completion) and that the facility was able to be operated at a fully loaded cost of \$25 per person per day.

In 2001 a 165 bed facility for men was opened in Wake County. A 100 bed women's facility followed in 2006. The impressive success and outcomes of the original model was carefully tracked and equally matched by "The Healing Place of Wake County" (THPWC). Current statistics show that more than 68% of clients who complete the program are sober one year later (three times the national average). The combined fully loaded cost of operating both the Men's and Women's facilities is less than \$30 per person per day. This is compared to a rate of over \$70 a day just to be housed in the Wake County jail. In addition to sobriety outcomes, the overall success of the program is also measured by its contribution to the reduction of homelessness in Wake County. While these numbers continue to grow in surrounding areas and indeed for the most part around the country, in Wake County the numbers tell a compelling story of success:

Wake County Population Growth and Homelessness
2001 - 2009



A Reason for Success—The Social Model Program

The Healing Place uses what is known as a "social model" recovery program that originated in California in the 1940s. These programs are regaining popularity due to unusually high success rates and extraordinarily low operating costs. The Healing Place model is an advanced and modern example of this type of programming.

This peer led program places a high value on an individual's own experience and places responsibility for recovery on the infusion of hope through shared experience, mutual respect, responsibility for the welfare of each other and program advancement directly tied to individual effort. Advancement through the multi-tiered program is carefully designed in progressive stages which match the natural intrinsic rewards of success with an individual's increasing efforts to help themselves and each other. People who were previously estranged from society and each other find themselves forming a community of "sober survivors." Optimism replaces cynicism, empowerment replaces entitlement and hope replaces hopelessness.

A full continuum of services starts with a non-medical Detox unit that is open 24/7 and a "wet shelter" that accepts individuals that are intoxicated or high. This low threshold of engagement is a key component of the overall success of the program and insures that services are provided "on demand"—no waiting list! These entry points provide an opportunity to mix people who have not yet made a decision to stop drinking or using with a larger number of people who have begun the process of change or are even further along in their shared commitment to remain clean and sober. This powerful influence is the force that perpetuates hope and begins movement into and throughout the entire program and process. It takes about eight

months to complete our program at which time the man or woman has a place to live, a job and is on the journey in recovery.

Complete Continuum & Coordination of Services

As an individual progresses and moves through the program a wide range of services are continually added, matching the individual's readiness, willingness and ability to effectively utilize these services.



Specialized Services

- | | |
|---|---|
| <ul style="list-style-type: none"> ■ Health Services Coordinator ■ Child and Family Specialist ■ Transitional Case Manager | <ul style="list-style-type: none"> ■ Assistance with: <ul style="list-style-type: none"> □ Medical □ Employment □ Housing □ Legal assistance □ Family reunification □ Education □ Advocacy |
|---|---|

"Helping People Find Their Way Back"

A vast array of local community partnerships fill in any perceived gaps in services and round out the complete continuum. An example of these types of partnerships include; local VA services, Vocational Rehabilitation, Hospitals, County & City Agencies, Housing Partners, Community and State Colleges, Employers, Drug Courts & Legal Services, Arts & Entertainment Organizations, Sports Complexes, Civic Groups and many others. In essence, it comprises the power and resources of the entire local community.

The Possibilities for the Future

We believe that homelessness among veterans and other citizens can be conquered both effectively and efficiently through best practice methods, community organization and maximizing readily available resources. Our immediate objective is to assist communities across North Carolina, and Virginia to develop and build a statewide network of this model. We have already assisted in the development of a working replication in Richmond, Virginia and we are working on startups in Fayetteville, NC, Norfolk VA and Lynchburg, VA. We will continue to evaluate and improve them, and then in partnership with The Healing Place in Louisville, Kentucky help other communities and states replicate this continuing success. We will continue to work with stakeholders such as the VA and other providers, especially those in underserved communities, to improve and expand AOD services to veterans and their families.

I invite you to visit The Healing Place of Wake County. You will be amazed before you are half way through the visit!

POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO DENNIS PARNELL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE HEALING PLACE OF WAKE COUNTY

Question 1. Based on your experiences, do you believe there are any simple changes that can be done immediately to improve the services and programs available to assist our homeless veteran population and what are they?

[Responses were not received within the Committee's timeframe for publication.]

PREPARED STATEMENT OF PATRICK RYAN, VICE CHAIR, BOARD OF DIRECTORS,
NATIONAL COALITION FOR HOMELESS VETERANS

Chairman Senator Akaka, Ranking Member Senator Burr, and Distinguished Members of the Committee: The National Coalition for Homeless Veterans (NCHV) is honored to appear before this Committee today to comment on ending veterans' homelessness.

For 20 years, NCHV has worked diligently to serve as the Nation's primary liaison between the community- and faith-based organizations that help homeless veterans, the Congress, and the Federal agencies that are invested in the campaign to end veteran homelessness in the United States. Department of Veterans Affairs (VA) officials have testified before the Congress that this partnership, despite considerable financial pressures due to war and economic uncertainty, is largely responsible for the phenomenal reduction in the number of homeless veterans on the streets of America each night—from about 250,000 in FY 2004 to 107,000 today, according to the annual VA Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) Reports.

Through the efforts of VA and the U.S. Department of Labor, some of the most innovative and successful grant programs in the Federal arsenal have jointly nourished a nationwide, community-based homeless veteran assistance network that provides transitional housing and services support for more than 100,000 veterans each year. The U.S. Department of Housing and Urban Development has become the third critical partner in this campaign through the HUD-VA Supportive Housing Program (HUD-VASH) for veterans with serious mental illness and other disabilities, and by incentivizing the inclusion of homeless and extreme low-income veterans in local Continuum of Care funding applications.

The success of these Federal agencies and the community- and faith-based service partners NCHV represents over the last five years offers proof that the campaign to end veteran homelessness can be won. The President has established this as a priority of his Administration; and VA Secretary Eric Shinseki is mobilizing his Department to strengthen its intervention programs and expand its support of local prevention strategies through his Five-Year Plan to End Homelessness Among Veterans. This plan will strengthen the services offered to veterans and their families in an unprecedented fashion by effectively engaging community partners and supports for all those who are in need of assistance.

On November 3–5, 2009, the Department of Veterans Affairs hosted a three-day summit focused on ending veterans' homelessness. During this historic event, Secretary Eric Shinseki boldly stated that "My name is Shinseki, and I am here to end veteran homelessness." This declaration shows the level of commitment and dedication to the serious problem of veteran homelessness.

The most noticeable recurring theme throughout the three-day program was the need to strengthen VA's partnership with other Federal agencies and the community- and faith-based service providers that have helped reduce veteran homelessness by more than 50 percent in the last five years. With more than 3,500 points of access to assistance available to veterans today that did not exist 35 years ago, VA can continue to serve those veterans who are homeless.

Our understanding of the VA's plan to end homelessness in five years is based on a presentation of the "basic framework" of the plan made by Mr. Peter Dougherty, Director of the VA Homeless Programs Office, and Mr. Paul Smits, Associate Chief Consultant for Homeless and Residential Rehabilitation and Treatment Services for the Veterans Health Administration, on the final day of the summit.

The plan will have six "strategic pillars." Included among those are four that have been in development for more than two decades—outreach, treatment, employment and benefits, and community partnerships—and two that represent new areas of engagement—prevention, and housing and supportive services for low-income veterans.

NCHV feels that these pillars are good starting points, but it is vital that VA knows the key to successfully ending homelessness among veterans in five years is through the relationships and connections of each community. Before offering our suggestions on what else VA and the Federal Government should be doing, we believe it's important to reflect for a moment on the history of the homeless veteran assistance movement NCHV represents, because it speaks volumes about why we are assembled in this room . . . and the reasonableness of VA Secretary Shinseki's ambitious vision of ending veteran homelessness in five years.

In the past nine years VA has quadrupled its investment in the Homeless Providers Grant and Per Diem Program from slightly more than 120 programs to nearly 500 across the country.

The Homeless Veterans' Reintegration Program has more than tripled in capacity to serve homeless veterans and has become one of the most successful employment assistance programs in the Department of Labor portfolio.

Under technical assistance grants and cooperative agreements with both those agencies, NCHV has provided program guidance, access to resources, and vital communications to more than 2,100 community- and faith-based service providers from Seattle to Puerto Rico, from Maine to the island of Guam.

Health Care for Homeless Veterans coordinators, women veteran coordinators, and OEF/OIF specialists have been placed at virtually every VA medical center and most VA Regional Benefits Offices.

HUD and VA have allocated 20,000 HUD-VASH vouchers to veterans with serious mental and physical disabilities, with another 10,000 expected to become available next year.

Five years ago, the VA CHALENG report estimated as many as 250,000 veterans slept on the streets of America each night. Today, that number stands at 107,000—more than a 50% reduction despite the fact the number of contact points in the CHALENG process has more than tripled during that time.

We offer the following additional thoughts on what NCHV sees as necessary steps to enable the Federal Government to end homelessness among veterans in five years:

1. VA needs to clearly identify gaps in the availability of transitional and permanent housing in communities with homeless veterans and make it a priority to build capacity in those communities using existing authorities. New York, Boston, Chicago, and Los Angeles have large gaps between the demand for transitional housing and the number of facilities available. Although the numbers are smaller, there are equally compelling gaps in many small and medium-sized communities and on Indian tribal lands. VA and its community-based partners cannot address these gaps without an immediate legislative change to the Grant and Per Diem Program.

2. VA needs to examine outreach, referral and admission policies at every VA medical center to ensure that these policies are collaborative and consistent with the goal of ending homelessness. This means a significant increase in the Office of VA Homeless Programs oversight capability.

3. VA needs to revise its program rules so that veterans who are seeking admission to a domiciliary or grant and per diem program are immediately admitted even if eligibility has not yet been determined. If a veteran is seeking to enter a program on a Friday evening, VA rules should authorize admission and reimbursement, even if it later turns out the veteran is ineligible for VA support.

4. VA should convene an open meeting with community-based organizations serving homeless veterans no later than the end of May 2010 to discuss ideas about how VA could immediately alter program rules and policies to permit greater flexibility in the use of grant funds.

5. The Federal Government needs to take immediate steps to stimulate the creation of additional permanent housing for homeless veterans, including project basing for Section 8 rental housing vouchers.

6. VA and HUD should adopt a plan so that eligible veterans who qualify for Section 8 rental housing vouchers are housed in 30 days or less. More vouchers without an assurance that they can be used is not going to solve the housing problem.

7. Congress and VA, working with the Office of Management and Budget, should agree on an immediate action plan to eliminate internal and external roadblocks and procedural delays in the award of enhanced-use leases to groups seeking to house homeless veterans. The current process takes too long and national objectives such as ending homelessness are often met with resistance by local opposition.

8. The Federal Government needs to work intensively to eliminate seams and build bridges between the various programs that provide funds to serve homeless veterans. This will require the active collaboration of a number of Department Secretaries who share Secretary Shinseki's and the President's desire to address this issue in an urgent manner.

9. VA needs to refocus its homeless program performance measures on increasing the overall number of veterans who are served by these programs, not just how many vouchers have been distributed this year. Congress can assist this change by demanding more timely and comprehensive program performance information.

10. It is clear from published research that early intervention can dramatically reduce the effects of traumatic stress and subsequent PTSD. As noted earlier in our testimony, mental illness is a significant contributor to veteran homelessness. This Committee should regularly monitor the Department of Defense's ability to provide mental health services by military health personnel to servicemembers who have experienced traumatic stress. Although Admiral Mullen and others have acknowledged the need to heal soldiers and Marines who have experienced such stress, it

would be very useful to compare the Defense Department's capacity to respond to servicemembers in a timely fashion with that of the Department of Veterans Affairs,

NCHV has on several occasions acknowledged the leadership role of the Committee in this noble campaign. We know it is your leadership that brings us to this moment in history—Never before have we, as a nation at war, been better prepared to ensure that those who sacrifice some measure of their lives to serve in the military have the support they need to enjoy the peace and prosperity they have helped protect and preserve. The Homeless Veterans and Other Health Care Authorities Act of 2010 lays the foundation on which we as a nation can wage a successful assault on veteran homelessness and fulfill the Secretary's Five-Year Plan.

HOMELESS VETERANS AND OTHER HEALTH CARE AUTHORITIES ACT OF 2010

For several years the homeless veteran assistance movement NCHV represents has realized there can be no end to veteran homelessness until we, as a Nation, develop a strategy to address the needs of our former guardians before they become homeless—victims of health and economic misfortunes they cannot overcome without assistance.

The causes of all homelessness can be grouped into three primary categories: health issues; economic issues; and lack of access to safe, affordable housing for low and extreme-low income families in most American communities. This has been a chronic problem since the birth of the Great Society during the Johnson administration.

The additional stressors veterans experience are prolonged separation from family and social support networks while engaging in extremely stressful training and occupational assignments; war-related illnesses and disabilities—both mental and physical; and the difficulty of many to transfer military occupational skills into the civilian workforce.

NCHV believes the Homeless Veterans and Other Health Care Authorities Act of 2010, introduced by Senator Patty Murray—and unanimously supported by this Committee—has the potential to set this Nation on course to finally achieve victory in the campaign to end veteran homelessness in the United States.

Victory in this campaign requires success on two fronts: effective, economical intervention strategies that help men and women rise above adversity to regain control of their lives; and prevention strategies that empower communities to support our wounded warriors and their families before they lose their ability to cope with stressors beyond their control.

We believe the Homeless Veterans and Other Health Care Authorities Act addresses needs on both fronts.

- As written, the Act calls for the Secretary of Veterans Affairs to study the method of reimbursing GPD community providers for their program expenses and report to Congress, within one year, his recommendations for revising the payment system. VA estimated that the current per diem payment of \$34.40 covers no more than 20–30% of the cost of services provided by grant recipients. Because the current formula provides such a low level of financial support, there is inadequate VA presence in many large cities where tens of thousands of homeless veterans live. Rural homelessness is more difficult to track, but it's easy to see that few VA-supported programs exist in rural locations. The best way to address this gap would be to authorize the Secretary to provide grant assistance to all eligible organizations on a program cost basis rather than a per diem basis, and authorize the Secretary to provide differing levels of support to programs in high cost areas and in areas where there are significant gaps in services for veterans.

This new authority could be time-limited if the Congress wanted to more closely examine the effect of such a change. To tell VA it needs to take a year to prepare a report, which would then be considered for up to two years by the next Congress, is to guarantee little progress in many parts of the country where VA-supported programs are sorely lacking. NCHV has been advocating this change since 2006. The Act calls for an increase in the annual GPD authorization to \$200 million, beginning in FY 2010, which could provide additional funds for outreach through community-based veteran service centers and mobile service vans for rural areas, while continuing to increase the bed capacity of VA's community-based partners. These outreach initiatives will likely play a pivotal role as the VA's veteran homelessness prevention strategy moves forward.

- Instructs the Secretary to establish a program to prevent veteran homelessness. The Act provides authorization for up to \$50 million annually to provide supportive services for low-income veterans to reduce their risks of becoming homeless, and to help those who are homeless find housing. Provisions include short- to medium-term rental assistance, poor credit history repair, housing search and relocation assist-

ance, and help with security and utilities deposits. For many of the Nation's 630,000 veterans living in extreme poverty (at or below 50% of the Federal poverty level), this aid could mean the difference between achieving stability and continuing on the downward spiral into homelessness.

- Develops the Homeless Veterans Management Information System. This system would collect the essential information needed to determine how many veterans requested and received housing assistance and for what length of time the assistance was given. This information will play a vital role in developing housing and services in future years.

- Provides for the expansion of HUD-VASH to a total of 60,000 housing vouchers for veterans with serious mental and emotional illnesses, other disabilities, and extreme low-income veteran families that will need additional services to remain housed. According to an analysis of data by the National Alliance to End Homelessness, about 63,000 veterans can be classified as chronically homeless. This Act would, therefore, effectively end chronic veteran homelessness within the next five years.

- Establishes within HUD a Special Assistant for Veterans Affairs to ensure veterans have access to housing and homeless assistance programs funded by the Department.

- Modernizes the extremely important and successful VA Grant and Per Diem Program (GPD) to allow for the utilization of innovative project funding strategies—including the use of matching funds from other private or public sources to facilitate and hasten project development.

- Requires the Secretary of Veterans Affairs to submit a comprehensive plan to end veterans' homelessness. Not only would this plan list the current programs offered to assist homeless veterans, it would also lay the groundwork for evaluating the effectiveness of those programs.

- Creates a program, authorized at \$10 million through FY 2014, to provide employment assistance and child care to women veterans and veterans with dependent children. This would allow the growing number of women veterans to have access to employment and training opportunities that they are currently lacking.

- Expands the Grant and Per Diem Program by including male homeless veterans with minor dependents as a new category. Community-based organizations continue to see the number of male veterans with dependent children growing; by expanding the GPD to serve this population directly, many more veterans and their families could be assisted.

IN SUMMATION,

As we move forward on this effort to end veterans homelessness, I want to thank you for your support helping those men and women who have served this country in their time of greatest need. The progress we made has been commendable but our work will not be done until there are no veterans left on the streets.

The Homeless Veterans and Other Health Care Authorities Act of 2010 lays the foundation of the work that lies ahead. From the increase in the number of HUD-VASH vouchers, and the ability to provide supportive services for low-income and women veterans, to the improvement and expansion of the GPD program and reimbursement process, this bill provide real opportunities to move the PLAN into ACTION and fulfill the historic mission to end homelessness among America's former guardians in five years.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO PATRICK RYAN, VICE CHAIR, BOARD OF DIRECTORS, NATIONAL COALITION FOR HOMELESS VETERANS

Question 1. You mentioned in your written testimony that VA and its community-based partners cannot—address gaps in the availability of transitional and permanent housing—in communities with homeless veterans—without an immediate legislative change to the Grant and Per Diem Program. Can you please tell us specifically what particular legislative changes you are referring to?

Response. As currently written, 38 U.S.C. section 2012(a) sets a maximum payment to a provider at a little over \$34 per day, which is slightly more than \$1,000 per month. VA estimates this amount is not more than 30% of the cost of providing care in most areas of the country. Because the current formula provides such a low level of financial support, there is inadequate VA presence in many large cities where tens of thousands of homeless veterans live. Rural homelessness is more difficult to track, but it's easy to see that few VA-supported programs exist in rural locations. The best way to address this gap would be to authorize the Secretary to

provide payments to eligible organizations on a program cost basis rather than a per diem basis, and authorize the Secretary to provide differing levels of support to programs in high cost areas and in areas where there are significant gaps in services for veterans.

Although the per diem program was never intended to reimburse for the full cost of care, a "percentage of cost" based reimbursement formula would give the Secretary greater flexibility and could lead to the establishment of transitional housing programs where none exist today. The language contained in section 3 of H.R. 4810, 111th Congress, is one way of addressing this issue.

A second problem with the current formula is the effect it has on smaller community-based organizations. In order to provide services, these organizations incur certain fixed costs, especially employee salaries. However, if the planned number of veterans is lower than the program's maximum, its funding from the VA is reduced. This result is perceived as unfair by service providers, who are used to grant programs that use a "percentage of cost" reimbursement funding formula.

Question 2. Can you help the Committee reconcile the excellent testimony of our first panel of witnesses with the statements of this panel about the distinctly different approaches to ending homelessness among seriously mentally ill veterans?

Response. While each of these agencies focus on their different areas, it is key to remember that all of the programs administered by these agencies (DOL, HUD, and VA) relate to a person's ability to get and maintain housing. However, the veteran's need for health care (including mental health services) and employment services must also be addressed if we want to achieve lasting change in the lives of veterans who were homeless.

Question 3. In your testimony, you touched on several steps necessary to enable the Federal Government to end homelessness among veterans in five years. Based on your experience on the issue of homeless veterans when you were with the House Committee on Veterans' Affairs, what do you see as the major roadblocks that need to be overcome to make real progress?

Response.

A. VA could be more open and collaborative. There is a basic lack of current, publicly available data about the number of programs serving homeless veterans. VA should develop and post this information on a public Web site and solicit suggestions on how to address gaps in services. If VA clearly identified gaps in the availability of transitional and permanent housing in communities with homeless veterans, it would be easier for communities and local organizations to take action to build capacity. Large cities such as New York, Boston, Chicago, and Los Angeles have significant gaps between the demand for transitional housing and the number of facilities available. Gaps also exist in many small and medium-sized communities and on Indian tribal lands. Focusing on those gaps and addressing them is the only way to end homelessness. For FY 2010, VA received an additional \$50 million in construction funds to make vacant building available to house homeless veterans, but there has been little consultation with veterans' advocates about how this money can be spent most effectively.

B. HUD, Labor, and other Departments need to work with a far greater sense of urgency to eliminate seams and build bridges between the various Federal programs that serve homeless veterans. It is remarkable, for instance, that money provided to HUD in the 2009 appropriation process for homelessness prevention pilot has still not been made available. Several NCHV members have been urging HUD to take immediate steps to stimulate the creation of additional permanent housing for homeless veterans, including project basing for Section 8 rental housing vouchers, but HUD has not affirmatively issued guidance on this subject. VA should adopt an immediate action plan to eliminate roadblocks and procedural delays in the award of enhanced-use leases to groups seeking to house homeless veterans. If HVRP is as successful as Labor claims, why aren't even more funds devoted to it? The Inter-agency Council on Homelessness (ICH) needs to be far more action-oriented.

C. The Office of VA Homeless Programs needs additional resources to more closely monitor outreach, referral, and admission policies at every VA medical center to ensure that these policies are collaborative and consistent with the goal of ending homelessness.

D. To demonstrate its commitment to ending homelessness, VA and the other members of the ICH should convene an open meeting with community-based organizations serving homeless veterans no later than the end of May 2010 to discuss ideas about how these Departments could immediately alter program rules and policies to permit greater flexibility in the use of grant funds to serve homeless veterans.

E. It is clear that mental illness is a significant contributor to veteran homelessness, and that early intervention can dramatically reduce the effects of traumatic stress and subsequent PTSD among servicemembers. The Congress or some other impartial body should monitor closely the Defense Department's capacity to respond to servicemembers with incipient mental illness in a timely fashion.

Question 4. Based on your experiences, do you believe there are any simple changes that can be done immediately to improve the services and programs available to assist our homeless veteran population and what are they?

Response. In my opinion, the VA's Office of Homeless Programs is well-led, but its resources are stretched. It would be useful if it had additional resources so that it could be more proactive. For example, additional resources could be used to provide more extensive employee awareness training so that all VA employees understood how they can play a role in ending homelessness among veterans. The Office also needs internal authority and additional resources to more closely monitor outreach, referral, and admission policies at every VA medical center to ensure that these policies are collaborative and consistent with the goal of ending homelessness.

