



Points of Concern in the Five-Year Plan to End Veteran Homelessness

The Service Providers' Perspective

Concerns Identified by Service Providers at the 2012 NCHV Conference Session with the VA Secretary's Advisory Committee on Homeless Veterans

August 2012

Executive Summary

The National Coalition for Homeless Veterans (NCHV) held its 15th Annual Conference and Membership Meeting in the nation's capital from May 30 through June 1. The event was the largest in the organization's 22-year history, with more than 529 community-based organization and government agency representatives participating in 38 instructional workshops and special focus sessions at the Grand Hyatt Washington.

One of the most talked-about focus sessions took place on the conference's final day. Titled "Critical Issues for the VA Advisory Committee on Homeless Veterans," the meeting drew more than 60 service providers and homeless program staff from federal and local levels of government. These attendees conveyed their varying concerns – covering policy, program and leadership issues – to more than three-quarters of the VA Secretary's Advisory Committee, including Chairman George Basher, who moderated the session.

The NCHV Annual Conference kicked off on a note of measured optimism. During the opening session, VA Secretary Eric Shinseki told attendees: "We do have movement, but it's too early to begin 'high-fiving' one another. Neither should any of us take a knee as we approach the summit. Lean into the hill— keep climbing."

The "Critical Issues" session was notable, in part, for its noticeably sharper tone. The open forum facilitated this by offering service providers the opportunity to level criticisms and voice their biggest concerns in the company of their peers. A great deal of solidarity was realized, and by the session's close, participants deemed that a follow-up report was needed to develop their shared concerns.

Eighteen primary concerns were identified during the conference session. This list (available in its entirety in Appendix A) was distributed to session participants who volunteered to help produce the follow-up report. A total of 16 of these participants representing 12 states responded to NCHV's outreach. These respondents categorized their organizations' top concerns in descending order.

The top seven most-cited concerns by respondents are presented in detail in this report. Individual sections of the report were drafted by subgroups of different service providers, thereby

representing a multitude of voices and perspectives. While this approach does not provide a scientific measure of the issues at hand, it provides a continuation of the frank, unprecedented discussion held at the NCHV Annual Conference.

Most-cited concerns among respondents:

1. VA's long-term planning to serve homeless and at-risk veterans is not properly informed by service providers' inputs. One of the results of this disconnect is that VA policies give more weight to national data than to the intangibles that add value to programs at the local level.
2. VA's data on the Grant and Per Diem Program (Only 53% of participants move into their own apartment or room upon leaving the program.) neither accurately depicts the program's successes in most communities, nor explains why veterans were not able to achieve independent living.
3. VA does not contract enough of its work with veteran service providers, especially that which focuses on placement in permanent housing.
4. Existing VA performance measures are obstacles to accomplishing the true goals of VA's homeless programs.
5. VA national offices have not successfully communicated with local service providers about the department's strategies to end veteran homelessness.
6. HUD-VA Supportive Housing (HUD-VASH) case management is currently unable to address the complex needs of chronically homeless veterans.
7. Homeless women veterans, especially those with military sexual trauma, are likely to need more than 90 days to stabilize in transitional housing before potentially moving on to the HUD-VASH Program.

The respondents who helped produce this report cite numerous opportunities for more meaningful communication and collaboration between VA and its community partners. Recommendations for these actions take on multiple forms in this report, including consultations prior to instituting program modifications and issuing funding notices, and contracting a greater number of functions to experienced service providers.

NCHV presents this document to VA Homeless Initiatives leadership in hopes that it will illuminate some of service providers' deep-seated concerns, and ultimately reinforce the bond between federal and local systems of care. We are deeply appreciative of all parties involved in this project, and dedicated to help VA implement and improve the Five-Year Plan to End Veteran Homelessness.

Participating organizations and agencies:

Representatives from the following organizations and agencies contributed to the overall exercise that produced this report. They are listed alphabetically by the states in which they are headquartered:

Swords to Plowshares

California

U.S. VETS

California

Veterans Village of San Diego (VVSD)

California

Denver Human Services, City and County of Denver

Colorado

The Transition House, Inc.

Florida

Boise VA Medical Center

Idaho

Hoosier Veterans Assistance Foundation (HVAF)

Indiana

Alliance Veterans Housing Outreach and Assistance Metro-Baltimore

Maryland

Veteran Homestead, Inc.

Massachusetts

Minnesota Assistance Council for Veterans (MACV)

Minnesota

Women Veterans Assistance and Resource Corporation

New York

St. Vincent de Paul Society of Lane County

Oregon

Impact Services Corporation

Pennsylvania

Philadelphia Veterans Multi-Service and Education Center (PVMEC)

Pennsylvania

Center for Veterans Issues

Wisconsin

Concern #1

VA's long-term planning to serve homeless and at-risk veterans is not properly informed by service providers' inputs. One of the results of this disconnect is that VA policies give more weight to national data than to the intangibles that add value to programs at the local level.

Explanation:

Service providers generally agree that housing, employment and health care alone cannot transition a veteran from homelessness to stability. Effective program design is a combination of these elements, intended to take advantage of the capacities of community-based organizations and collaboration with local resources. Restrictive timeframes and funding categorizations established at the national level limit service providers in their ability to provide the truly comprehensive service that is necessary to help each veteran transition successfully. Proper treatment takes time and often multiple resources and interventions for effective rehabilitation and reintegration.

Too many policy decisions, including grant awards, are based strictly on the numbers. While these outcome measures are certainly crucial for evaluating programs, the data lacks specific details that explain why they are effective or not. The VA's data on the Grant and Per Diem (GPD) Program – that only 53% of participants move into their own apartment or room upon leaving the program – is a good example. This data neither accurately depicts the program's successes in most communities nor explains why veterans are not able to achieve independent living.

A dramatic shift in strategy without input from successful programs can have a tremendous impact on the veteran. For example, many of the community-based organizations (CBOs) that now operate successful GPD programs may not have the capacity or the local resources to effectively operate a Transition in Place program. Due to limited housing stock in many areas, CBOs may require capital grants to bring a traditional GPD housing unit up to Department of Housing and Urban Development (HUD) standards for permanent housing in order to make this model practical. Without capital funding, the shift to this model could feasibly eliminate quality services for thousands of homeless veterans.

Another example of the concern cited above: Categorical spending restrictions in the Supportive Services for Veteran Families (SSVF) Program grant has actually made it easier for veterans in some areas to become homeless in order to become re-housed than it is to keep the person in housing. This, in effect, creates homelessness in order to cure it. Conversations with service providers could help to solve this contradictory practice.

Recommendation:

Instead of concluding that a program is failing to produce the desired numerical outcomes nationally, the VA needs more discrete data, indicating which of its programs are working so those models can be supported and replicated, and which of its programs are underperforming so they can be re-evaluated and potentially eliminated. In this way, we would build on the strengths of the GPD program, rather than relegating and disparaging the whole program.

The local providers are the experts when it comes to identifying regional capacities for services, as well as identifying those services that produce quality results. Numbers alone don't reflect the service to the veteran. Organizational "best practices" should be shared across provider networks, both regionally and nationally, and those best practices should include peer provider input. Peer review combined with customer feedback regarding these services is essential to ensuring that effective organizations, and effective programs, are awarded funding. In the spirit of interagency collaboration, the input of local organizations providing services to homeless veterans and their evaluation of what works in their communities should carry significant weight in both policy and grant-award decisions.

Ending homelessness among veterans is a noble goal and a vision through which every service provider should direct their services. However, as most service providers are acutely aware, the problem of homelessness does not have a "silver bullet" solution that can be directed from the highest levels. What works in one region of the country may not work in another. Similarly, what works in one region of a state may not work in another. National policies often obscure variables that are important at the local level. Accordingly, national policies should create a framework within which there exists flexibility to address local issues.

Concern #2

VA's data on the Grant and Per Diem Program (Only 53% of participants move into their own apartment or room upon leaving the program.) neither accurately depicts the program's successes in most communities nor explains why veterans are not able to achieve independent living.

Explanation:

The GPD Program is not and has never been a "Housing First" program. Based on the current program description, "The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination." The GPD Program is not and should not be evaluated based upon a Housing First philosophy. Rather, the GPD Program provides "a transition" from homelessness to a stable way of life. Many of the current GPD programs are highly successful at helping homeless veterans achieve stability in their lives— stability defined as much by a job or increasing skill levels as by achieving permanent housing.

Should the GPD Program be reformed? Yes.

Should the GPD Program be rigorously evaluated? Yes.

Should GPD providers be accountable to standards set by the VA for program performance? Yes.

But please do not throw the baby out with the bathwater. Every year since its founding the GPD Program has helped thousands of homeless veterans to stabilize their lives. This most often includes providing veterans with a place to live while they work on their recovery from drug and alcohol addiction, mental health issues, employment problems, and finding and maintaining permanent housing.

Recommendation:

A study should be immediately commissioned on the current success of the GPD Program based on its current (non-Housing First) guidelines. This study should include statements by formerly homeless veterans about the impact GPD has had on their lives. Finally, this study should feature case studies describing NCHV member organizations that operate successful GPD programs.

Clearly stated program objectives and guidelines for the GPD Program should be developed at a national level, and these objectives and guidelines should be instituted and evaluated rigorously over the next three years. Poorly performing programs should be de-funded and successful programs should be supported and maintained.

In addition, the supply of permanent supportive housing could and should be greatly increased by funding project-based HUD-VA Supportive Housing (HUD-VASH) vouchers, which can be awarded to developers of affordable housing for homeless veterans early in a development process that can take up to four years. Awards of project-based HUD-VASH vouchers should be contingent upon the award of Low Income Housing Tax Credits for development, thus leveraging the operating support.

Concern #3

VA does not contract enough of its work with veteran service providers, especially that which focuses on housing.

A. Opportunities to contract case management services

Explanation:

Community-based service providers have many of the skills, resources and relationships necessary to implement programs that VA tries to implement in-house. They possess unique knowledge of the housing and social service landscapes in their communities. VA's internalizing approach, however, often delays the implementation of critical programs due to hiring needs and the learning curve for new and inexperienced staff.

The HUD-VASH Program provides an example of this phenomenon. Instead of contracting out case management to service providers or independent contractors, VA decided to hire social workers from within its mental health system. This delayed program implementation and resulted in under-assigned units to the chronically homeless population. As a result, Congress questioned demand for the program, leading to some mismatch in the subsequent allocation of vouchers. The true demand in a given area for these vouchers may not have been reflected due to the delay in hiring social workers, caused by VA's internalization.

This approach impacts veterans directly as well. In one major city, two HUD-VASH case managers have been assigned to work with 50 project-based tenants as well as all scattered-site tenants in the community, giving them caseloads of more than 50 veterans each. When immediate intervention is needed for these veterans, their case managers often are not available. Property staff and local nonprofit service providers are left to provide assistance and prevent eviction,

although they are not being reimbursed for furnishing these services. These issues are even more pronounced in rural areas.

Several other areas and programs would benefit from contracting with VA, including the Readjustment Counseling Service (RCS) Program, the delivery mental health services, housing specialists, and employment training and assistance.

Recommendation:

By contracting HUD-VASH case management to local nonprofits – those with cultural competence and experience working with veterans – VA could improve the case management ratio, thus providing more comprehensive services to veterans in the program. The recently enacted Public Law No. 112-154 states that the VA Secretary “shall consider entering into contracts or agreements” in the provision of HUD-VASH case management but makes no requirement for him to do so.

Additionally, VA must consider the range and severity of issues for individual HUD-VASH clients when assigning case managers their caseloads. Case managers must be able to provide adequate care to the veterans who have been entrusted to them.

B. Overlap of employment services for homeless veterans

Explanation:

In early 2011, the Veterans Health Administration (VHA) hired 21 full-time employees across the country for the new Homeless Veteran Supported Employment Program (HVSEP), designed to improve employment outcomes for homeless and at-risk veterans. This did not appear to be coordinated with the Department of Labor-Veterans’ Employment and Training Service (DOL-VETS), which administers the Homeless Veterans Reintegration Program (HVRP).

Our organization heard about HVSEP one day when the program’s new case manager introduced himself in a meeting and said, “I help homeless veterans get employed.” My HVRP case managers were more than perplexed by this.

If these positions had been placed on VHA campuses with no HVRP grantees in the surrounding area, then the HVSEP rollout might have made sense. In most cases unfortunately, these positions were co-located in communities with HVRP grantees. Most of us still do not understand exactly how to interface with these positions without appearing to compete for numbers and confuse the veteran about who is their employment case manager.

Why didn’t VA refer homeless veterans to HVRP programs and save funding on HVSEP positions? Was there some defined gap that HVRP grantees were not filling? The answers to these questions remain unclear.

As an HVRP and SSVF grantee, of course we have reached out to our HVSEP counterparts and are attempting coordination, but we still do not see the driving need for this program. If we had been asked to collaborate early on, we could have strengthened the design of HVSEP and enabled it to enhance what we do as HVRP grantees. We would have welcomed this, especially since our HVRP grant caps have remained constant for years.

Recommendation:

If there was truly a defined gap that HVRP grantees were not filling, VA could have contracted or established agreements with experienced community-based service providers to perform this work.

At present, coordination may take precedence over contracting. Best practices of both HVRP and HVSEP should be highlighted to allow VA and its community partners to make the most of these resources and minimize any duplication of effort.

Concern #4

Existing VA performance measures are obstacles to accomplishing the true goals of VA's homeless programs.

A. Consequences of a restricted "homeless" definition

Explanation:

One serious concern regarding performance measures as obstacles to accomplishing the true goals of VA's homeless programs is the definition of homelessness. The SSVF Program has been promoted extensively as a prevention program. However, the limited amount of temporary financial assistance (TFA) directed towards prevention is a barrier to keeping veteran families from becoming homeless. This will be exacerbated by a more restrictive homeless definition in the upcoming grant cycle, which VA has stated that it will use.

Currently, the following groups are considered homeless for the purposes of TFA: veteran families that are doubled up and must leave that situation within 14 days or will lose their housing; veterans in transitional housing; or veterans who are otherwise homeless under the HEARTH Act definition. By restricting the definition of "homeless," many veterans will no longer be homeless— not because their emergent crises have been resolved, but because their situations have been redefined. It seems this move is driven by performance measures, as veterans in shelters or counted in unsheltered counts are easier to measure.

In many rural areas, there are no shelters for miles, and many rural areas have cold winters that prohibit veteran families from camping or living in vehicles. These veterans are much more likely to be doubled up out of necessity— yet their family's situation is no more stable than that of veterans with shelter that is available in urban areas. VA's data seems to be driving policy as homeless veterans who are more difficult to count are redefined out of homelessness, while veterans who can be more easily re-housed are emphasized to prop up the department's data outlining its reduction of homelessness.

The SSVF Program is often portrayed as a much-needed prevention resource. Yet in practice, the program has steered away from that emphasis by limiting the percentage of TFA available for homelessness prevention. In most cases, prevention is the least expensive and best option for a veteran family. It costs less than paying moving fees and security deposits, and is cheaper (from the locality's perspective) than a shelter stay. It is best for households with children so that they can avoid being uprooted and experience homelessness. In many communities, especially those in

rural areas, there may not be available affordable housing within a school district, causing even more upheaval in the lives of veterans' families.

It seems again that the move away from prevention is due to the lack of effective ways to capture data showing that prevention methods effectively prevent homelessness. By redefining rapid re-housing, VA is putting a greater burden on the already-too-thinly stretched TFA resources allowable for prevention. The department's performance measure is based on what can be counted, not on addressing the way to create the most effective outcome for veteran families.

Recommendation:

A primary corrective action for this situation would be to let service providers use the entire HEARTH Act definition of homelessness. It is difficult to explain to a veteran family of four, whose cousin has allowed them to stay in her living room for a week, or whose landlord has given them three days to pack and move, that they are not homeless. By utilizing the full HEARTH Act definition, resources will be more readily available for this family. By allowing more TFA to be spent toward prevention, perhaps this family could avoid leaving their original residence in the first place.

By continuing to look closely at SSVF providers' service records and housing stability and supportive service plans, VA can ensure that the program's funds are not being used only for those easiest to serve, but for those in crisis situations without resources and support. This will allow us to truly address VA Secretary Eric Shinseki's mission to end veteran homelessness.

B. Performance measures can be weakened by VA culture and at times seem incompatible with certain realities

Explanation:

Performance measures established by VA are often driven by its culture. As observed by this writer over many years, that culture has been one of internal program development; internal decision making; and internal administration to address issues affecting the veteran population, as opposed to collaboration with service providers, consensus-building among stakeholders and soliciting broad input from the field. Addressing veterans' issues internally could be considered commendable for a federal agency because it demonstrates its concern for a targeted population. But due to the layers of bureaucracy within VA, the flexibility and nimbleness in decision-making that is often required to assist veterans is sacrificed.

One example of VA performance measures being weakened by the department's culture is the recent tightening of GPD rules that apply to female veterans over safety concerns. The concern for this population's safety and security is commendable. However, implementation of some measures lacked thoughtful input from service providers, and may negatively affect the socialization processes needed by some female veterans to fully reintegrate back into mainstream society. Additionally, by isolating females from services being provided at a gender-neutral location, organizations may be forced to take on increased costs to provide the same services on a gender-specific basis. As a result, new performance measures related to female veterans will negatively affect the ability of service providers to stabilize homeless female veterans and place them into permanent housing.

Some VA performance measures, meanwhile, simply do not make sense. For example, if a veteran dies while he or she is in the program, this is considered a negative outcome, thus skewing the numbers. Similarly, if a veteran is hospitalized for more than three days, the veteran is discharged from the program and this is considered a negative outcome. If he or she is released from the hospital any day after being discharged, the veteran must be re-entered into the program or released onto the street, in many cases nullifying weeks or months of progress.

Recommendation:

Some cite national data as showing that transitional supportive housing has poor results. However, if we look deeper into the numbers, we see that some operators have excellent outcomes while others do not. We cannot base national, blanket programming on these numbers alone.

This goes directly to the point that positive outcomes require collaborative planning and local input. With this input, VA should be able to readily address questions such as the following:

- Does the GPD Program work in community X and not community Y?
- Can or should VA or its contractors provide technical assistance to the GPD provider in Community X?
- Should VA pull funding from specific providers?

Accordingly, VA should re-evaluate its internal culture, recognizing that many issues are better addressed on an outsourced basis with performance measures relating to goal attainment. Nimbleness and responsiveness within a broad framework of performance measures are the keys to success.

Concern #5

VA national offices have not successfully communicated with local service providers about the department’s strategies to end veteran homelessness.

A. Community planning should be more inclusive

Explanation:

After receiving criticism from community-based service providers about the lack of opportunities for input, VA made a national push to have mini “summits” at each VA medical center (VAMC). Many of these summits were not planning sessions, but rather three-hour information sessions without any opportunities for actual community input into VAMCs’ respective five-year plans, nor any vetting of those plans once they were developed.

Additionally, CBOs were blindsided by a decrease in GPD applications and an emphasis on Transition in Place (TIP) without recognition of the financial risk associated with existing plans or the viability of the TIP model in high-cost housing markets or areas with highly vulnerable clients.

One NCHV member who attended the “Critical Issues” conference session provided the following testimony:

“Since we were unaware of the pending changes during the past two years, our agency raised millions of dollars of local construction funding to house and serve homeless veterans with the expectation that the VA would provide us the opportunity to compete for operating funding in 2011 and 2012. While the merits of the new TIP program are debatable, the poor communication from the VA to providers seems beyond dispute.”

The lack of collaboration with CBOs has led to much unease and confusion with regard to the transition to a TIP model. Many members object to a freeze in GPD funding and fear it will be slashed. Others embrace the TIP model but believe that it is contraindicated for the most vulnerable veterans, who will fall back into chronic homelessness, and for those who have challenging transitional obstacles. For example, homeless women veterans, especially those with military sexual trauma, are likely to need more time to stabilize in transitional housing before potentially moving on to the HUD-VASH Program.

We recognize that Veterans Integrated Service Networks (VISNs) and VAMCs have a lot of autonomy in administering programs in their localities. Such autonomy is necessary to address unique local challenges—local employment rates, housing stock, available services, etc. However, VA has not engaged in true community planning in the development of the Five-Year Plan to End Veteran Homelessness.

Recommendation:

VA should bring community partners to the table, including existing operators, local government housing and behavioral health policy and program staff, and the Continuum of Care (CoC). These partners have the experience and local knowledge to most appropriately deploy resources in their localities. National staff should be present in these discussions to ensure that relevant local factors are incorporated into national strategic planning. In this way, local issues are addressed, the duplication of services is reduced, and existing (non-VA) government, corporate and nonprofit resources are leveraged.

Furthermore, we suggest the national VA mandate a progress report from VAMCs or VISNs to gauge the results of true community planning processes. This report should include an analysis of local challenges; an assessment of the local deployment of relatively new programs, including SSVF and HUD-VASH; and a revision or approval of the existing strategies as informed by this analysis and assessment. This process should require VA to work with the community of veteran housing operators where they exist; full participation of CoCs; and, where they exist, regional steering committees on homelessness and poverty to ensure that homeless assistance plans are harmonious and best leverage community and federal resources while responding to local needs.

Recent “rapid results boot camps,” supported by national HUD and VA in 15 cities, illustrate the fact that challenges in deployment of federal resources vary considerably by locality, calling for locally generated solutions. It is only through incorporating all relevant stakeholders at the local level that efforts to end veteran homelessness will succeed.

Local providers should be included in conversations before VA national offices publish their Request for Proposals (RFP) design, eligibility and reporting requirements. Incorporating the experience of local providers who actively work in the field, assess needs and implement solutions would make the requirements more realistic within the context of each community.

An ombudsman or arbitration process on the VA federal level is another potential solution to help institutionalize coordination between and among community-based service providers, local VA facilities and national VA programmatic leadership.

B. Discerning the differences between data

Explanation:

Some NCHV members have reported that they pay little attention to the VA's Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) report as it does not meaningfully collect or analyze its survey data. VA's overall measurement of veteran homelessness, meanwhile, mischaracterizes the reality in some communities. An NCHV member who attended the "Critical Issues" conference session stated the following: "We are constantly told that the numbers of veterans who are homeless is drastically decreasing. Here at ground zero, all our beds are occupied and we have a waiting list of over 75 veterans just waiting for an opportunity to enter our programs."

Recommendation:

A "weight factor" could be applied to reports submitted to VA. For example, the first question for the CHALENG report could read: "In the past year, how many homeless veterans and family members have you provided services to?" If one organization served 2,000 homeless veterans and another organization served 200, this ratio should be taken in to consideration. Many of the VA's statistics are reported in percentages. Ten percent of 2,000 is obviously a lot more than 10 percent of 200. This would establish a reality to the numbers and give a more adequate picture of the "on-the-ground" issues facing providers and homeless veterans and their families.

C. Community engagement around permanent supportive housing models

Explanation:

Many service providers report that "Housing First" models are highly effective and immediately solve the homelessness issue on a particular day. Yet those organizations that work with a large number of homeless veterans know that the key to housing is to ensure it is affordable, safe and maintainable. If the veteran is unable to keep his or her housing because of substance abuse, mental health issues or other issues, it just doesn't work. Warehousing them without appropriate supportive services sets them up for failure, which may, at a later date, cause additional barriers to housing and employment. It may look good on paper to permanently house a veteran within 90 days or so. But if the veteran is only able to stay in his or her new apartment until the rent is due, this does little to solve the issues and barriers confronting him or her. Rehabilitation procedures and employment issues can sometimes take a long time to resolve.

Recommendation:

Environmental factors associated with the provision of supportive housing vary a great deal across this country. Without engaging local governments, community providers and CoCs in the planning process, federal resources are poorly deployed, failing to leverage the local resources and expertise necessary to meet the goal of ending veteran homelessness in specific communities.

In terms of permanent supportive housing, scattered-site HUD-VASH vouchers may be ideal for relatively stable veterans and may even be a path out of supportive housing to independent living. For many, however, including our aging veterans and those with serious or co-occurring disabilities, it is much more of a challenge. In those cases, site-based HUD-VASH would provide a dignified, safe environment.

Concern #6

HUD-VA Supportive Housing (HUD-VASH) case management is currently unable to address the complex needs of chronically homeless veterans.

A. The HUD-VASH Program should offer veterans stronger opportunities to rise out of poverty and provide case managers with real-life experience

Explanation:

The current problems with HUD-VASH result from misinformation and poor training. It is difficult for anyone to get copies of the actual program manual from HUD, and different housing authorities have different interpretations of regulations. Responsibility for the vouchers is constantly being transferred from town to town, and no one seems to know what is going on. While some VA staffers work effectively, the department tends to pile more work on them in particular, causing eventual burn out.

Case managers for the most part are poorly trained and very inexperienced. Young, mostly female college graduates know what is in the book, but they have no real-life experience and are tasked with visiting the residents. In most cases, this works out to about one visit every four weeks— if that. No one is even sure what it is that they do.

Another problem noticed by our organization is that the HUD-VASH Program keeps people at poverty level. If you have children and want to save for education, or if you would like to save for a home, it is not possible. As soon as you have 10 dollars over the cutoff numbers, you lose the voucher.

Housing courts vary from state to state, and most small programs can't afford lawyers to handle evictions while HUD-VASH residents are destroying the housing provided to them through the program. When a resident decides to stop paying his or her share of the rent, the program is stuck with the problems. This creates a financial handicap for the program, and is problematic for landlords as well.

Recommendation:

First, VA needs to admit that young people just out of college have not hit the learning curve with substance abuse. Both VA and HUD should develop an easy-to-read curriculum explaining the rules and implications of the HUD-VASH Program, and how this relates to substance issues. This should be used by the cities and towns that are responsible for issuing vouchers as well.

Second, the HUD-VASH Program needs more support for scenarios when residents refuse to pay their portion of the rent. Taking away the voucher is one step, but then the program is left with a court case and financial issues. Many landlords will not take HUD-VASH vouchers any longer due to these issues. An enforcement process must be established.

Third, there should not be a penalty on families trying to save for a goal. These families should be allowed to earmark an account for college funds or to secure housing.

B. Scattered-site HUD-VASH has drawbacks for case management

Explanation:

The HUD-VASH case management model traditionally used by VA is not a Housing First model and is therefore insufficient and ineffective with chronically homeless and mentally ill veterans. Housing First is ideal for these populations because it requires little from the participants, wrapping services around them to create stability and help them progress to independent living.

The HUD-VASH case management model, however, assigns one case manager to at least 25 clients, often in scattered-site housing. The best a case manager can hope to do is touch a client for one hour once a month— as cited by dozens of VA case workers around the country. Chronically homeless and mentally ill veterans cannot hope to achieve stability with such limited contact. Experience shows that given these conditions, they deteriorate rapidly and end up losing their HUD-VASH vouchers to eviction. This is not helpful for the veteran or the system of care that works so hard to get these veterans off the streets.

Recommendation:

Project-basing HUD-VASH has the potential to be a positive solution to this dilemma. If you have 50 of these tenants in a building, two case managers can share an office and be available on a daily basis to set up regular appointments, coordinate groups, develop community resources, and respond to crises. However, the experience of housing developers with project-based vouchers has been anything but effective.

In one major city, an office for HUD-VASH case managers has remained unoccupied for months. When the program liaison was recently called by the housing developer, the voice mailbox was full and not accepting messages. Case managers tend not to answer their phones after hours and on weekends when emergencies often arise for veterans with more serious problems.

One Sunday morning, one of these veterans jumped to his death after trying to reach his case manager. Property staff and local nonprofit service provider staff were on site within half an hour and remained there into the night to work with the veterans. VA staff did not return phone calls.

Concern #7

Homeless women veterans, especially those with military sexual trauma, are likely to need more than 90 days to stabilize in transitional housing before potentially moving on to the HUD-VASH Program.

A. Consultations should be held to determine if the 90-day threshold is sufficient

Explanation:

The total disintegration of the “Housing Ready” model could well be an outcome of the Housing First model. Many believe this must be avoided in order to truly address the needs of all veterans, otherwise we are requiring all homeless veterans to meet a pre-determined, inflexible, unrealistic set of goals and ultimately denying them the opportunity to reach attainable and successful permanent housing.

VA Secretary Eric Shinseki has stated that no door out of homelessness should be eliminated. There continues to be a need for a variety of entry points to independent housing, and a true individualized assessment of capabilities should be utilized in order to produce the most successful outcomes for our veterans.

In the HUD-VASH Program, a veteran’s complexity and severity of need—debt, safety, medical and mental health issues—are individually addressed by case managers and clinical staff. The program’s policy that veterans should not receive vouchers if they have resided in a transitional facility for more than 90 days is extremely shortsighted.

These veterans’ issues are of such a magnitude that they often require more than 90 days to resolve. This is especially true for veterans who have been homeless for an extended period, carry debilitating debt, or have serious mental health issues. Any GPD service provider can attest to this and provide specific documentation of this reality. This 90-day ruling eliminates some veterans from access to the HUD-VASH Program, which was designed to bring advantage to them.

Sexual trauma is a situation of a devastating degree. In fiscal year (FY) 2011, the Department of Defense reported 3,192 reports of sexual assault, up one percent from FY 2010. The department estimates that one in five women and one in 100 men are affected, approximating that more than 19,000 were raped or assaulted in 2010. The U.S. Military Academies report an increase in these incidents of 63 percent for FY 2011 over FY 2010. This is not affecting only women— according to the VA, 45.7 percent of veterans who screened positive for military sexual trauma (MST) in 2010 were men and 39 percent of veterans receiving MST treatment were men.

It has been identified that women veterans have a high incidence of sexual assault, childhood sexual assault and trauma, domestic violence, and MST. With these issues alone comes the burden of addressing the mental health/psychiatric diagnoses that interfere with their very ability to function. Many live in the dark places of shame and guilt that can at times be paralyzing.

Self-harm is also a reality for many of these women. One GPD women veterans program reports that of the 205 women admitted, specific mental health conditions were present in the following percentages:

- Military sexual trauma – 44 percent
- Sexual trauma – 54 percent
- Childhood abuse – 55 percent
- Domestic violence – 53 percent
- Non-combat PTSD – 46 percent
- Bipolar disorder – 31 percent

- Depressive disorder – 57 percent
- Self-harm – 19 percent
- Personality disorder – 11 percent
- Adjustment disorder – 6 percent
- Schizophrenia – 8 percent

These women are often debilitated to the point of requiring therapy several times a week, and need admission to a VA residential intensive therapeutic program specializing in MST before returning to GPD Program to treat their other outstanding problems. All of this individualized assistance for successful community integration can take longer than 90 days. Truthfully, the VA is often not staffed to provide the level of case management that the veteran will require in order to maintain and sustain independent living.

Recommendation:

Many GPD service providers feel that more of their feedback and suggestions should be considered in the process of setting VA policy that affects the veterans with whom they are entrusted. We certainly realize the importance of studies and data, but these are statistics without names or emotions or the scars of life. If attention isn't given to the uniqueness of the individual, we have, in a way, dehumanized him or her as a statistic in a column on a page in a book.

HUD-VASH case managers should confer with local GPD program directors and case workers, in concert with the veteran's mental health clinician, to determine if that veteran is appropriate for housing before 90 days.

Pushing the veteran out before he or she is reasonably capable of surviving in the community is only setting them up for failure. This serves no one— least of all the veteran, who ends up back in the system again.

B. Thoroughly dealing with women vets' trauma can compound other time-consuming issues

Explanation:

In our area, many of the women need multiple services, and coordinating and attending the variety of referrals, consults and needed appointments takes time. Until they receive these services, many of these women are not ready to transition out of the structured environment provided by transitional housing. Also, many of our female veterans are involved in multiple treatment programs with a list of requirements and time-sensitive goals. Being an individual suffering most often with a mental illness, substance abuse disorder, socialization issues, budgeting issues, estrangement, etc. and trying to attend the multiple, varied weekly appointments while completing required paperwork for each type of appointment increases stress and reduces motivation to move forward.

These women can become even more overwhelmed in the beginning processes of trying to put their life back on a track that makes them healthy and happy. If they're no longer able to stay where they're at, we have to request extensions or locate new housing altogether— this creates issues as well. When these women finally get used to a place or feel safe, they have to move again. This requires updating demographic information of the parties involved, moving belongings, learning a new bus route, etc.

Ninety days is not long enough to coordinate and successfully complete what is necessary for these women to move out of transitional housing into a more independent housing situation. Their MST history also plays a major role in their readiness to address an array of requirements. A female veteran with MST is typically in therapy, which helps them process the traumatic event(s). Just the act of processing trauma can result in a variety of issues surfacing, which become barriers to move forward with their rehabilitation.

For example, if a woman veteran is feeling severely depressed the day of an appointment that took two weeks to get into, she may not get out of bed. Therefore she misses the appointment, and it now takes another two or more weeks to reschedule. Multiply that situation by a handful of appointments, and 90 days can be eaten up quickly. All the while we're not much closer to her achieving the goals that would allow her to move out of transitional housing in the allotted timeframe.

Recommendation:

The ability to request 60- to 90-day extensions to maintain transitional housing placement would be helpful. A decision matrix could be created, based on the severity of situations and needs to determine the needed length of stay for these veterans.

APPENDIX A

The following 18 statements of concern were initially identified during the “Critical Issues” conference session. This list was circulated to participants who volunteered to help produce a follow-up report on the session.

The order in which these concerns are presented is not the original order in which they were distributed. Rather, they are ranked by popularity among respondents to NCHV’s post-session outreach.

Note: Due to their similarities, the first and third statements in the below list were later combined into a single statement of concern: “VA’s long-term planning to serve homeless and at-risk veterans is not properly informed by service providers’ inputs. One of the results of this disconnect is that VA policies give more weight to national data than to the intangibles that add value to programs at the local level.”

Primary Concerns Identified during “Critical Issues for the VA Advisory Committee”

1. VA’s long-term planning to serve homeless and at-risk veterans is not properly informed by service providers’ inputs.
2. (tie) VA does not contract enough of its work, especially that which focuses on housing, with veteran service providers.
2. (tie) VA policies give more weight to national data than to the intangibles that add value to programs at the local level.
2. (tie) VA’s data on the Grant and Per Diem Program (only 53% of participants move into their own apartment or room upon leaving the program) neither accurately depicts the program’s successes in most communities nor explains why veterans are not able to achieve independent living.
5. Existing VA performance measures are obstacles to accomplishing the true goals of VA’s homeless programs.
6. (tie) HUD-VASH case management is currently unable to address the complex needs of chronically homeless veterans.
6. (tie) VA national offices have not successfully communicated with local service providers about the department’s strategies to end veteran homelessness.
6. (tie) Homeless women veterans, especially those with military sexual trauma, are likely to need more than 90 days to stabilize in transitional housing before potentially moving on to the HUD-VASH Program.
9. (tie) Service providers need an arbitration process on the VA federal level to respond to and help resolve their issues with local VA officials.
9. (tie) VA homeless programs should re-establish their focus on rehabilitation as opposed to simply housing or employment.

- 11.** The Housing First model is not a good fit for the HUD-VASH Program.
- 12.** (tie) Given the rapid expansion of the SSVF Program, it is important that grantees prove they have significant community partnerships and experience working with at-risk veteran populations.
- 12.** (tie) VA needs to be able to determine which of its GPD programs are underperforming and whether they should be eliminated.
- 12.** (tie) Homeless veterans' dental care needs are not being adequately met by VA.
- 15.** (tie) The requirement for communities to use their HUD-VASH voucher allocation by year's end should be extended, given the time needed to properly target vouchers to and successfully house chronically homeless veterans.
- 15.** (tie) The SSVF Program does not adequately incorporate the input of local service providers/grantees.
- 17.** (tie) The SSVF Program is currently inhibited by a lack of coordination with other local VA homeless programs.
- 17.** (tie) A large number of veterans who fall between the Vietnam and Gulf War eras will reach pension age in the next few years— due to their ineligibility for service-connected pension and potentially other VA benefits, there may not be enough preventive resources available to address their needs.