



homeless

Interagency Council on the Homeless

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*TOM,
what
homeless
services
will look
like*

**NATIONAL SYMPOSIUM ON HOMELESSNESS RESEARCH
 INFORMATION FOR INVITED AUTHORS**

I. Background

In the decade since the passage of the Stewart B. McKinney Homeless Assistance Act of 1987, a wide range of programs and services have been developed by various ~~government~~ agencies at three levels: U.S., state, and local. During this period of time, a considerable reservoir of research and experience has been accumulated. Thus, this is a good time to review and reflect on what has been learned, consider how it can inform practice, and determine directions for future research.

Two complementary initiatives are underway to synthesize the lessons and implications of research that has been done on topics related to exemplary practices for people who are homeless. One initiative, sponsored by the U.S. Department of Health and Human Services, is a small, invitational workshop entitled **Workshop on Exemplary Practices: Addressing Homelessness and Health Care Issues** and focuses on service delivery strategies and current policy questions. The second initiative, **National Symposium on Homelessness Research**, is a national-level invitational event sponsored by the U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services. It will emphasize how research can inform components of the continuum of care, accountability, and directions for future research. Papers developed under both initiatives will be presented at the National Symposium on Homelessness Research.

Seven papers will be developed under each initiative as shown below:

Research Synthesis Papers	
Workshop on Exemplary Practices: Addressing Homelessness and Health Care Issues July 9 - 10, 1998 Washington, DC	National Symposium for Homelessness Research October 29 - 30, 1998 Washington, DC
Outreach and Engagement	Demographics and Geography: Estimating Needs
Case Management Models and Approaches	Prevention
Transition to Mainstream Services	Emergency Shelter and Services
Systems and Services Integration	Transitional/Supportive Housing and Services
Clinical Intervention	Community Reconnections
Emerging Policy Challenges (Welfare Reform, Managed Care, and Other Issues)	Accountability
Changing Practices at the Agency and Community Levels	Special Population Needs

II. Suggested Paper Structure

Each paper developed for the National Symposium for Homelessness Research will address questions unique to the assigned topic. However, each author will be expected to begin their paper with a brief summary of the characteristics of the research or practice upon which the paper is based, and to conclude with recommendations on policies and practices that need further exploration with suggested research. Each author's first assignment will be to consider the illustrative questions shown in the following exhibit, consider whether additional questions are appropriate for the topic, and propose an outline for the synthesis paper.

Purpose: to synthesize the lessons and implications of research and leading practices for consideration by practitioners and policy makers.

Length: 15 to 25 single-spaced pages, excluding an appendix for footnotes, bibliography, etc.

III. Time Line:

Consulting agreement from Abt	May 22
Bibliography with abstracts, as available, to authors	May 29
Authors' outlines with focus questions to Abt	June 5
Planning team comments on authors' outlines	June 19
First drafts of papers to Abt	July 22
Planning team comments to authors	August 14
Second drafts of papers to Abt	September 16
Abt ships papers to symposium participants	October 15
HUD/HHS Symposium	October 29-30
Planning team final comments to authors	November 16
Final papers to Abt	November 30

Topic Area	Issues to Address
Demographics and Geography: Estimating Needs	What do we know about homelessness characteristics and needs, predictors of homelessness, geographic distribution, mobility and service utilization? How can local providers use this type of information to improve continuum of care planning? What additional information is needed to improve services and efficacy at all stages of the continuum of care?
Prevention	Who is eligible for prevention services? What do we know about effective practices and policies for homelessness prevention, e.g., what is known about effective discharge planning strategies from the criminal justice system, psychiatric institutions, etc.; what is known about strategies for preventing evictions or maintaining housing? What strategies work best under which circumstances? How is effectiveness measured? What are appropriate outcome standards?
Emergency Shelter and Services	What are the key program models? What is the role of each? What set of policy and programmatic assumptions are operative? How are housing and supportive services coordinated? What are effective practices? How is effectiveness measured? What are the expected outcomes?
Transitional and Supportive Housing	What are the key program models, e.g. differing models for coordinating housing and supportive services; role of eligibility criteria? What is the role of each? What set of policy and programmatic assumptions are operative? What are effective strategies? How is effectiveness measured? What are the expected outcomes?
Community Reconnections	What has been learned about reconnecting homeless people to the community in terms of continuing support networks, job preparation and work, utilizing mainstream services? What are the lessons from permanent housing and services for the disabled homeless? What are effective practices? How is effectiveness measured? What are the expected outcomes?
Accountability	What are the appropriate client-level and program-level outcomes? How are individual needs assessed? How is personal change monitored longitudinally? What does a program need to do to put a system in place to monitor outcomes? Who is responsible for monitoring outcomes? How are outcomes likely to differ among the sub-populations being served? How can outcomes be used to inform policy? How does a program measure cost-effectiveness? How cost effective are homeless shelter and services compared to the approaches offered by other community infrastructures, e.g., soup kitchens, jails, emergency rooms, psychiatric hospitals, etc.?
Special Population Needs	Special populations include: youth, domestic violence victims, mentally ill, substance dependent, HIV/AIDS, multiply diagnosed, veterans and other distinct sub-populations. What are the unique needs of special homeless populations and the implications for housing and service responses? What are effective practices? How is effectiveness measured? What are the expected outcomes?



Interagency Council on the Homeless

OVERVIEW

1996 NATIONAL SURVEY OF HOMELESS ASSISTANCE PROVIDERS AND CLIENTS

Background

The 1996 National Survey of Homeless Assistance Providers and Clients (hereinafter "survey") was designed to provide information about the providers of homeless assistance and the characteristics of homeless persons who use services based on a statistical sample of 76 metropolitan and nonmetropolitan areas. Data for the survey were collected by the Census Bureau between October 1995 and November 1996. Analysis of the data is underway. The survey is being sponsored by 12 Federal agencies¹ under the auspices of the Interagency Council on the Homeless, a working group of the White House Domestic Policy Council.

The survey is important because no national studies have been conducted to produce information on the characteristics of persons participating in homeless assistance programs since a 1987 study by the Urban Institute. The 1996 survey used a methodology that was similar to the 1987 study. However, it used a larger sample, included nonmetropolitan areas, and collected more comprehensive information. The 1996 survey also included a wider variety of locations than the 1987 study in order to more accurately and fully reflect the characteristics of homeless people who use services nationwide. The 76 geographic areas that were included in the national sample in 1996 were comprised of the 28 largest metropolitan areas, 24 randomly selected medium and small metropolitan areas, and another 24 randomly selected nonmetropolitan areas (small cities and rural areas).

The survey *will not* provide a count of the number of people who are homeless. The survey *will* provide information about the providers of homeless assistance, the characteristics of the homeless population who use services, and how this population has changed in metropolitan area since the 1987 study. This information is critical for developing effective public policy responses needed to break the cycle of homelessness.

For example, the survey will:

1. Provide information on the types of programs and services (e.g., housing, food assistance, health care) available to homeless persons in both metropolitan and nonmetropolitan areas, including population groups primarily served (e.g., veterans, people with mental

¹The 12 Federal agency sponsors include the Departments of Housing and Urban Development, Health and Human Services, Veterans Affairs, Agriculture, Commerce, Education, Energy, Justice, Labor, and Transportation as well as the Social Security Administration and the Federal Emergency Management Agency.

illness); days of operation; occupancy levels; and sources of funding.

2. Provide a comprehensive profile of the homeless population who use services and allow comparisons of the characteristics of this population with the findings of the 1987 study.
3. Collect additional information related to prevalence of drug use, mental illness, HIV/AIDS, tuberculosis, and previous episodes of homelessness.
4. Provide information on issues not addressed by the last national study in 1987 such as: What are the triggering events that precipitate homelessness? Where were homeless people living before they became homeless?

Methodology

The national survey involved two phases. The first phase--the "provider survey"--was conducted from October 1995 through October 1996. It involved telephone interviews and a mail survey of assistance providers in the 76 geographic areas. Included were providers administering 16 categories of programs, including those that are specifically targeted to homeless people (e.g., shelters, soup kitchens, and outreach programs), as well as certain "mainstream" assistance programs which offer programs targeted to homeless persons. The purpose of this survey of service providers is to identify the types of programs and services available to homeless persons in metropolitan and nonmetropolitan areas and assess emerging continuums of care.

The second phase--the "client survey"--was conducted over a four-week period in late October and early November 1996. It included interviews with a sample of approximately 4,000 persons who were using services in emergency shelters, soup kitchens, outreach programs, and other locations where assistance is provided. In addition to providing data on characteristics of the portion of the homeless population who use services, this phase of the survey will identify population subgroups and help determine their use of various types of assistance programs. It will also provide limited comparative data on housed persons with very low incomes who also rely on soup kitchens and other emergency assistance.

The client survey will produce data on client characteristics at the national level and for metropolitan versus nonmetropolitan populations. The sample size is not large enough to produce estimates of client characteristics at the regional or local levels, nor was it designed to produce a count or other estimates of the number of homeless people.

Data Analysis

The sponsoring agencies have retained the Urban Institute to analyze the data collected through the survey. A panel comprised of nationally recognized researchers and other experts on issues related to homelessness will review and comment on the analysis plan and draft reports. There will be a set of core analyses of the provider data that will examine factors such as geographic level (e.g., national, central city, Metropolitan Statistical Area, and region), program type, and the types and levels of services delivered. The client data will be analyzed to identify patterns based on a number of characteristics, including, but not limited to, such factors as age, race/ethnicity, gender, household composition, history of homelessness, employment, education, veteran status, and use of services and benefits.

Reports

Data from the survey will be released to the public in several stages from the summer of 1997 through mid-1998. The sponsoring agencies plan to offer several reports and data products, including:

Lists of providers (Completed Fall 1997). Lists containing the names, addresses and telephone numbers of the providers in each of the 76 survey areas who reported in 1996 that they met the criteria for inclusion in the survey are currently available. (Domestic violence facilities are not included on the lists for security reasons.) The lists for each of the individual areas are available in a printed, hard copy format or in an electronic file in ASCII or Lotus format. The lists are sorted by sampling area and by ZIP Code. (See information on ordering below.)

Report on Provider and Client Data. Fall 1998 (planned). This report will summarize key findings from the provider survey and the client survey. It will be distributed through the Interagency Council on the Homeless or one or more Federal agency clearinghouses and via Internet.

Public Use Data Tapes. Fall 1998 (planned). The Census Bureau will release public use data tapes in conjunction with the release of the final report. The tapes can be purchased from the Census Bureau.

To be included on the mailing list for information about how to order reports as they become available, mail or fax your name, address and telephone number to Survey Results, c/o Interagency Council on the Homeless, HUD Building, Suite 7274, 451 Seventh Street, S.W., Washington, D.C. 20410, Fax: (202) 708-3672. Requests may also be addressed to NSHAPC_Results@hud.gov.

For additional information on the design and implementation of the survey or for other questions of a technical nature, contact the Population Division, Room 2320, Building 3, U.S. Bureau of the Census, Washington, D.C. 20233, (301) 457-2378 [Fax: (301) 457-2644]. For all other questions, contact the Interagency on the Homeless at (202) 708-1480 or the address indicated above or write to NSHAPC_Results@hud.gov.

DETAILED ANALYSIS PLAN FOR THE NSHAPC CLIENT DATA

Draft Date: April 13, 1998

Primary Goals of the Analysis

As with the analysis of the service provider/program portion of NSHAPC, the goals for analyzing the client portion of the NSHAPC data are consistent with the objectives of the twelve federal agencies sponsoring NSHAPC, agencies which are responsible for one or more homeless assistance programs. Specifically, the goals are:

- To describe the universe of people who use the services of NSHAPC programs in terms of the many topics covered by the survey, namely: current living conditions (including whether they are currently with or without regular housing); detailed housing history (including places they have stayed, episodes of homelessness, contacts with shelters, drop-in centers, and outreach programs); demographic characteristics (e.g., race/ethnicity, age, education, marital status, family structure, etc.); food intake (including detailed history of program contacts); employment history and income sources; veteran status and related information; physical and mental health and chemical dependency; victimization and imprisonment; and current service needs.

Basic descriptive information will be presented both nationally and by central city/balance of MSA/rural locations. In addition, the data will be used to identify similarities and differences among clients who are currently homeless, previously homeless, or never homeless.

- To describe the patterns of service use by NSHAPC clients and the services that may help them avert or leave homelessness.
- To understand pathways to homelessness and the duration and patterns of homelessness among the NSHAPC client population.
- To compare findings from NSHAPC to those of other data sets where possible.
- To explore relationships between local conditions and characteristics of local populations of homeless persons.

Basic Information About the Data

Over 4,200 individuals were interviewed for NSHAPC between October 18 and November 14, 1996. Several sampling stages occurred between identification of the provider universe in each PSU through CATI. In addition, list update procedures took place before sampling to assure the most accurate information about existing programs.

Selection of Provider Programs for Client Interviews

The CATI identified and collected data from the universe of programs serving homeless people within each of the 76 PSUs included in NSHAPC. However, the CATI took place between October 1995 and March 1996, and the client data were not collected for another 6 to 12 months. Because the provider universe was likely to have changed during that time period, the Bureau of the Census updated their lists in each area between May and July 1996. This update eliminated programs that had closed for good or would not be open during the client interview period. It also identified many new programs that needed to be added to the list. The final updated program list was the starting place for client sampling.¹

The following types of programs were eligible to be sampled for the purposes of the NSHAPC client interviews: emergency shelters; transitional housing; permanent housing programs for homeless persons; migrant workers camps used to house homeless people during the off-season; distribution of vouchers for shelter; soup kitchens;² food pantries (only in nonmetropolitan areas); drop-in centers; mobile food programs; and

¹ For a detailed description of the NSHAPC data collection, see Steven Tourkin and Dave Hubble, "National Survey of Homeless Assistance Providers and Clients: Data Collection Methods," U.S. Bureau of the Census, 1997.

² For soup kitchens, each meal (breakfast, lunch, and dinner) was treated as a separate program.

street outreach programs. Because they were unlikely to improve coverage of homeless persons, the following programs were *not* included: food pantries in metropolitan areas, and programs that distribute food stamps or vouchers or deliver food to people's homes; outreach programs that primarily serve clients from other programs (e.g., a health program operating in shelters and soup kitchens). Programs that "accept vouchers in exchange for housing" and health programs (including physical health, mental health, alcohol and drugs, and HIV/AIDS) were also eliminated from the program sampling frame as their clients were mostly covered in other frames.

Within each of the 76 PSUs, all remaining programs were sorted by program type and size (the size measure was "number of service units in a 28 day period," based on information obtained by providers through the CATI and list update procedures). The Census Bureau then sampled the programs using a probability of selection proportional to program size. Because of their size, larger programs may have been selected several times, but Census limited the number of visits to any given program to two.³ Finally, to handle programs that were unable or unwilling to participate in the survey, lists of randomly selected substitute programs were developed and provided to field staff.

For sampled programs, the Census Bureau obtained provider estimates of the number of clients expected at the program for an average day during the October-November interview period. If a sampled program expected fewer than 4 clients it was dropped and another randomly sampled program was substituted. For most programs, Census selected a skip interval that would yield 6 completed interviews. Exceptions to this, for which the skip interval was set to yield 8 completed interviews, were: (a) all programs outside of MSAs (more respondents from each program were needed because there were fewer such programs), and (b) nighttime outreach and mobile food programs. For these programs, interviewers sometimes had to arrange to meet clients at a

³ The sample weights will adjust for those programs that were selected more than twice.

designated location on the following day. Because of concerns that many of these clients would not show up, the Census Bureau established a higher targeted number of completed interviews. Interestingly, this expectation proved to be wrong; virtually everyone with an appointment on the following day showed up and was interviewed.

Client Response Rate

As is common with surveys that are able to compensate respondents for their time, the NSHAPC achieved a high response rate. In all, 4,207 interviews were conducted and in only 6.2 percent of these cases (261 individuals) was the interview conducted with a substitute sample client. Another 108 individuals were classified as non-interviews either because no substitute client was available or because the substitute was unable or unwilling to participate. Finally, another 45 people were found to be out of scope by virtue of having already participated in the survey or being an accompanied minor child. In the end, the survey achieved a response rate of 97.5 percent if we include both original and substitute clients, and a response rate of 91.5 percent if we include original sample clients only.

Core Analyses

The most basic analyses will consist of cross-tabulations, running essential sample breaks against all the survey responses: current and past housing and homelessness history, family information including children, employment, education, mental and physical health and nutrition, veteran status, substance abuse problems, history of victimization, and use of services and benefits. We propose the following as essential sample breaks, but the Working Group and/or panel of experts can modify or add to this list:

- Racial/ethnic identity;
- Household composition, subsuming gender (single men, single women, women with children, unaccompanied youth, other);

- Currently homeless/formerly homeless/never homeless;
- Service use pattern (e.g., shelter only, soup kitchen only, outreach only, any combination of two, or all);⁴
- Central city/balance of MSA/non-MSA;
- Veteran/non-veteran;
- Age (categories meaningful to sponsoring agencies will need to be developed).

The final report will be done in a format similar to that used in presenting analyses of the 1990 Street and Shelter Night enumeration from the 1990 Census (which was never released). There will be an introductory chapter and a chapter explaining (and defining) different groups of interest (all service users, homeless service users, ever-homeless service users, etc.) and presenting basic demographic characteristics of the sample (see attached report outline). These will be followed by chapters summarizing major findings accompanied by appropriate graphics. Results will be presented by topic (e.g., current living situation, service needs and service use patterns, food and nutritional issues, employment and work history, etc.) looking at all sample breaks *within* a given topic before going on to the next topic. Summaries of findings from the special focus papers (see below) will be included in various chapters as appropriate. In addition, we propose devoting a single focused chapter to findings related to children who accompany their homeless parents. This moderate-sized and readable report will be accompanied by an appendix containing detailed tables and an executive summary.

Other Analyses: Special Focus Papers

⁴ "Service use pattern" refers to the pattern of service use revealed by survey responses, *not* the program sampling frame through which the respondent was selected. The categories listed are illustrative only. More (or different) patterns may emerge and be used for the analysis.

The NSHAPC client data will clearly support a wide range of specialized studies. The Urban Institute plans to undertake a number of these following the basic analyses described above. These papers are presented in the order in which they will probably be done, with those analyses requiring the development of other data bases such as the Urban Institute's 1987 survey data, contextual data for the PSUs, or shelter tracking data bases coming last on the list. As we proceed with the analysis we may decide to integrate two or more of the topics listed. The first two are the most likely candidates for combining, depending on how the analysis turns out.

Length of Homelessness Analysis

A detailed examination of alternative "length-of-homelessness" estimates will be carried out using data from the basic question (When was the last time you had a home of your own or a permanent place to stay?) and from information on where the respondent has slept in the past month and his/her use of different potential places to live or stay in the time since leaving the last permanent place. The implications of different ways to determine length of homelessness from cross-sectional data will be discussed.

Methods of Classifying the Homeless and Factors Associated with Each Group

This paper will present the results of discriminant analysis to understand differences among people who might be classified as crisis (first-time), intermittently, and chronically homeless on the basis of the timing of their homeless episode(s). The never-homeless may also be included as an additional group.

Pathways to Homelessness (will need to be done at Census for data confidentiality reasons)

This paper will examine pathways to and patterns of homelessness, including an analysis of where people first experienced homelessness, why they left that place (if they did), and why they came to the place where they were interviewed for NSHAPC. We will test the hypothesis that non-urban areas generate homelessness among people who subsequently migrate to urban areas in search of jobs, services, or both.

Predictors of Major Statuses and Conditions

This paper will present the results of multivariate analyses (e.g., logistic and other regression analyses) of factors derived from the client interviews that are associated with various patterns of interest, such as: homeless status; length of homelessness; age at first homeless episode; level of food intake/hunger; health conditions and use of health services; mental health/chemical dependency status and service use; victimization; children's educational and health status; service needs.

Understanding Variations in Homeless Provider Systems and Client Characteristics (will need to be done at Census because it must be done at the PSU level)

These two papers will investigate the geographic variations in provider systems (characteristics, capacities, and gaps) and homeless clients using geographic contextual data. This work involves extracting data from available data sources about each PSU on potentially relevant contextual factors and adding these descriptors to the provider and client data bases. Such factors might include local economic circumstances, housing density and pressures, health, mental health, income and other benefits, household structure, population growth and change, and labor market growth and change. The Working Group and panel of experts can suggest other factors and potential data sources that are available for all PSUs. Analyses will seek to answer the questions of what contextual factors seem to affect the structure and availability of services for the homeless, including shelters for battered women, and what contextual factors seem to affect the characteristics of the homeless population in each PSU (e.g., more families with children or more singles, more or fewer severely disabled people; more or fewer people of each gender, age group, racial/ethnic group, people with particular work and housing histories, etc.).⁵

⁵ One question for the April 22 meeting is whether or not the NSHAPC data will support an analysis of *clients at the PSU level*, given that there are only 50 clients per PSU.

Comparisons to 1987 UI National Homeless Survey and Possibly Other Data Sets

This paper will compare the characteristics of service providers and clients in this survey to service providers and clients in the 1987 Urban Institute data. To be comparable to the 1987 data, this will require extracting from the NSHAPC data only those providers and clients who are within the city limits of cities over 100,000. After making the 1987-1996 comparison for these major urban areas, we could also compare this subset of the NSHAPC to the suburban and rural respondents of the NSHAPC to see who was missed by the 1987 study and how they differ from who was included. Other possibilities include comparisons to the findings from the Philadelphia and New York data bases constructed by Dennis Culhane, or the DC*MADS data from Michael Dennis.

Tentative Outline of :

**1996 National Survey of Homeless Assistance Providers and Clients:
Findings from the Client Survey**

April 13, 1998

Executive Summary

I. Introduction, purpose, methods of data collection, road-map to rest of report

II. Who are we talking about

A. Homelessness can be defined in a number of ways, and once defined, sample can be grouped in a number of ways. Different analyses will call for comparisons using different groupings. Here we explain what the basic groupings are, and how we arrived at them.

1. Many groups to characterize: service units, service users, homeless service users (variously defined), service users on an average day/week/month, etc.
2. Broader versus narrower definitions of homelessness
3. Homeless Status: ever/never; currently/formerly/never, one-time/episodic/chronic

B. Presentation of basic demographics by one or more groupings of current living situation: age, race/ethnicity, education, marital status, veteran or not, household structure (single male/female, female with children, youth, other), description of children with/not with respondent.

III. Current living situation and how people got there

- A. Where sleeping currently (in what type of accommodation or location).
- B. Situation prior to current/last episode of homelessness (type of unit, who lived with, who owned/name on lease, local or not, if not here, who come here and why leave there).
- C. *Summary of special paper on residence patterns since last homeless episode, number of homeless episodes, patterns of homelessness.*

IV. Reported service needs (end of questionnaire) and service use patterns (shelter, housing, outreach, drop-in, food pantry, soup kitchen, veterans homeless programs)

V. Food sources, adult hunger (kids' hunger in chapter on kids)

VI. Employment and minimal work history

VII. Income, income sources, and participation in public benefit programs, including special services for veterans (although the vets program participation might also go under Chapter 4, service use patterns for services specifically directed toward homeless people)

VIII. Physical health status and medical/dental service use

IX. Special needs

A. Mental health status, incidence/prevalence, use of OPD and inpatient, timing in relation to homelessness

B. Alcohol abuse status, incidence/prevalence, use of OPD and inpatient, timing in relation to homelessness

C. Drug abuse status, incidence/prevalence, use of OPD and inpatient, timing in relation to homelessness

D. Incidence of victimization while homeless

E. Prior history of incarceration

F. Patterns of co-occurrence; timing in relation to each other and to homelessness (to the extent possible)

X. Children Homeless with their Parents (Having already described, in Chapter 2, the number, ages, and genders of children born to respondents, and whether they are with their parents or not, this chapter will present more detailed information about the children who are actually with their parents at the service location)

A. Children's educational situation and issues/barriers

B. Children's health condition and access to/use of medical services

C. Children's hunger

XI. Reported Risk Factors for Homelessness in Respondent's Childhood

A. School problems (dropout, truancy, expulsion or suspension, low grade completion)

B. Parental physical or sexual abuse/neglect

C. Foster care

D. Runaway, throwaway, homeless before age 18

E. Time in detention

F. Analyze MH and CD treatment for first time before age 18 (if yes, include)

G. Multiple occurrence

H. *Summary of special paper on relation of risk factors to length, patterns of homelessness.*

XII. *Possible summaries of (a) special paper on contextual effects and (b) special paper on comparisons to 1987 Urban Institute and other data sources (e.g., DC*MADS for DC metro area)*

XIII. Summary/Conclusions/Final Thoughts [policy implications/recommendations]

Appendices Our expectation is that as much as possible of the data presentation in the body of the report will be in graphic formats, with full tables reserved for appendices. We may also want to put additional methodological stuff in appendices.

Homeless

DRAFT

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Fiscal Year 1997 End-of-Year Survey of Homeless Veterans

April 2, 1998 Draft

by

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Executive Summary

This report presents findings from a national end-of-year survey of homelessness among 18,910 veterans hospitalized in acute inpatient, psychosocial residential rehabilitation treatment programs (PRRTP) and domiciliary care bed sections at Department of Veterans Affairs (VA) medical centers at midnight on September 30, 1997. Altogether 4,364 veterans (23.1%) had been homeless at the time of their admission: 2,984 (15.8%) were "literally" homeless, residing in shelters, the streets or similar circumstances, while 1,380 (7.3%) were temporarily doubled-up with family or friends. Rates of homelessness varied from a high of 55.3% in domiciliary beds, to 46.3% in PRRTP beds, to 44.2% in acute substance abuse beds, to 22% in acute psychiatry beds, and 3.2% in acute medicine and surgery beds. In addition, 5.9% of all veterans (N=1,113), although not homeless at the time of admission, had lost their housing since they were admitted, and were therefore at high risk for *projected* homelessness after discharge.

Substantial numbers of homeless veterans were treated in each of VA's 22 Veterans Integrated Service Networks (VISNs). Although there is notable regional variation in the proportion of homeless veterans identified in the survey, ranging from a high of 42.5% in the Pacific Northwest (VISN 20), 32.9% in Southern California (VISN 22) and 32.5% in Ohio (VISN 10) to a low of 11.6% in VISN 2 (Upstate New York), substantial numbers of homeless veterans are treated in every VA medical center in the system.

As compared to domiciled veterans (i.e., those living in an apartment, room or house) homeless veterans were younger than domiciled veterans (47.9 years vs. 61 years), more likely to be black (34.8% vs. 21.7%), less likely to be married (7.9% vs. 42.8%) and had lower annual incomes (\$6,034 vs. \$12,100). They were less likely to receive VA compensation benefits (23.8% vs. 40%) and pensions (5.5% vs. 11.3%). They were far more likely than other veterans to have substance abuse disorders (54.8% vs. 11.2%) and psychiatric disorders (28.2% vs. 19.8%).

Overall, the proportion of homeless veterans has remained essentially stable. In both FY 1995 and FY 1997 23.1% of veterans in all bed sections were homeless at admission, representing no change. Within bed sections, however, there was variability in the proportion of veterans who were homeless upon admission to VA. Mental health beds (acute psychiatry, acute substance abuse and PRRTP beds) and acute medicine and surgery beds experienced slight decreases in the proportion of homeless veterans; mental health had a 4.1% drop (32.9% in FY 1995 to 28.8% in FY 1997) and medicine and surgery had a 2.9% drop (6.1% in FY 1995 to 3.2% in FY 1997). Domiciliary beds, however, experienced a 9.2% increase in the proportion of homeless veterans from 46.1% in FY 1995 to 55.3% in FY 1997.

In contrast to the *rates* of homelessness remaining essentially stable for the two survey periods, only 63.4 percent as many homeless veterans were being treated during FY 1997 as compared with FY 1995 (4,364 in FY 1997 vs. 6,880 in FY 1995). Of the 2,516 fewer homeless veterans surveyed in FY 1997, the overwhelming majority (70%, n=1,749) were explained by

fewer veterans surveyed in mental health beds. The reduction in the number of homeless veterans may be related, primarily, to the closure of substance abuse and general psychiatry beds and the shift within VA from inpatient treatment to outpatient treatment.

Of the 4,364 veterans identified as literally homeless or doubled up upon admission to VA, 2,844 veterans were determined to be discharged prior to December 1, 1997 and of these 2,844 veterans, 1,948 veterans (68.5%) had an outcome assessment form completed upon their *actual* discharge from treatment. Nearly one out of ten veterans (9.6%) remained homeless after discharge, while 43.4% had housing arrangements (13.6% own apartment, room or house; 31.0% an apartment, room or house of a family or friend) and 35.6% were discharged to another institutional setting. Independent of other factors, literally homeless veterans at admission (living in a shelter or outdoors) were 2.5 more likely than other patients discharged to be homeless (Chi square =60.95, $p < 0.0001$, $df = 2$) and 1.6 times as likely to be transferred to another treatment institution (Chi square =74.76, $p < 0.0001$, $df = 2$) upon their *actual* discharge from treatment. Homeless veterans with an alcohol diagnosis were 1.3 more likely to be discharged to institutions (health care institutions, prisons, halfway houses, or transitional living programs) (Chi square =17.69, $p < 0.0001$, $df = 2$). Finally, independent of other factors, homeless African American veterans were 19% less likely to be homeless at their actual discharge from treatment (Chi square =5.19, $p = .0227$, $df = 2$).

These data show that VA continues to treat many homeless veterans and retains a unique role among health care institutions in its investment of resources in services for the medically indigent. The extensive closure of substance abuse beds and, to a lesser extent, psychiatric beds in VA during the past two years, not surprisingly reduced the availability of these services to numbers of homeless veterans that had used them. While VA's bed closures were based, in part, on recent clinical studies that indicated little differences in outcome for patients treated in inpatient or outpatient settings, it should be noted that these studies did not include homeless patients. VA is concerned that homelessness may affect treatment outcomes and, for this reason, the Northeast Program Evaluation Center (NEPEC) continues to monitor care provided to homeless veterans throughout the VA Healthcare System.

To the fullest extent possible, VA is committed to providing appropriate forms of community-based treatment and residential alternatives to acute inpatient care. This includes VA's ongoing commitment to work closely with non-profit organizations and State and local governments who are recipients of VA grant funds and are developing supported housing programs for homeless veterans.

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Introduction

It has been estimated that one-third of all homeless adults and 40% of homeless men are veterans of the United States armed forces (Rosenheck, Frisman and Chung, 1994), and that on any given night there are 150,000-250,000 homeless veterans living in shelters or on the streets of American cities. In response to this tragedy the Department of Veterans Affairs (VA) has established more than 100 specialized programs across the country that reach out to homeless veterans in community settings; link them with health care, social services and other benefits; and bring them back into the mainstream of life in their communities (Kaspro, Rosenheck and Chapdelaine, 1997; Seibyl, Rosenheck, Corwel and Medak, 1997). In addition, VA implemented the CHALENG (Community Homelessness Assessment, Local Education, and Networking Groups) Veterans program mandated by Public Law 102-405 (the Veterans Health Care Amendments Act of 1992) through which every VA medical center in the country joins forces with community agencies to plan new initiatives to strengthen and expand efforts to help homeless veterans, and conduct an annual one-day census to capture the number of homeless veterans being cared for in VA inpatient settings (Burnette, 1994).

This report presents the results of the third national survey of homeless veterans in VA as of midnight, September 30, 1996 -- the last day of Fiscal Year 1997. This year acute care, Psychosocial Residential Rehabilitation Treatment Programs (PRRTP), and domiciliary care bed sections participated. The survey was designed and coordinated by the Northeast Program Evaluation Center (NEPEC) at the VA Connecticut Healthcare System in West Haven, Connecticut in collaboration with the Office of Quality Assurance, the Mental Health Strategic Health Care Group and Social Work Service in VA Headquarters and the Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG) for Veterans program in Dublin, Georgia. Although not a formal part of the annual VA inpatient census, the FY 1997 End-of-Year Survey of Homeless Veterans focused on veterans hospitalized on September 30, 1997 to take advantage of procedures that were in place for the annual VA inpatient census and to allow linkage of survey data on homelessness with annual census data.

This annual survey was designed: (1) to identify the number and proportion of veterans in VA acute care, PRRTP and domiciliary care bed sections who were homeless at the time of admission, (2) to *project* the number and proportion of veterans whose residential status may change during their VA stay such that they would lose their access to housing, (3) to compare homeless and non-homeless VA system users on sociodemographic and clinical characteristics, service utilization and resource consumption, (4) to examine changes in the proportion, and number, of homeless veterans from fiscal year 1995 to fiscal year 1997, and; (5) to examine selected outcomes upon the *actual* discharge among those veterans identified as homeless at admission.

Organization of the Veterans Health Administration

The Veterans Health Administration (VHA) is organized into 22 semi-autonomous Veterans Integrated Service Networks (VISNs). These 22 VISNs are charged with developing cost-effective health care programs that are responsive both to the national mission of VA, and to local circumstances and trends in health care delivery (Kizer, 1995). Although autonomous, the VISNs are also accountable through centralized monitoring of performance and health care outcomes. Because VA has made a major commitment to help homeless veterans, this report will offer information for program managers at the national level, VISN level, and at the level of the local medical center.

Methods

Sample

All patients occupying an acute inpatient, PRRTTP or domiciliary bed at 143 VA health care facilities (systems) at midnight on the last day of Fiscal Year 1997 (September 30, 1997) were included in the sample. Specific programs excluded from the survey were nursing home care units, intermediate medicine, spinal cord injury, blind rehabilitation, respite care and hospice programs. Acute inpatients were chosen as the focus of this survey because of the high cost and intensity of their care, and because limited resources make extending the census to all outpatients, intermediate medicine or nursing home patients impractical. Inpatients are also more accessible to clinical staff, who were responsible for conducting the survey. This year PRRTTP and domiciliary bed sections were included because of the loss of acute psychiatry and acute substance abuse beds in VA during the past two years. We suspect that many homeless veterans that would have been in these bed sections may now be receiving treatment in a PRRTTP or domiciliary bed.

Data Collection Phases

The procedures for conducting the fiscal year 1997 survey were similar to the previous two surveys (Rosenheck, Leda, Sieffert and Medak, 1996; Seibyl, Rosenheck, Sieffert and Medak, 1997). Data was collected in two phases. The first phase was the **Survey Phase** that occurred Tuesday, September 30, 1997. Each veteran in an acute, PRRTTP or domiciliary bed section was classified on a census log sheet (see Appendix A) as to his or her: (1) housing status at the time of admission to the VA medical center, and; (2) *projected*, or hypothetical, housing status if their medical or psychiatric problems were resolved and they could, from a medical point of view, be discharged immediately. The second phase of data collection was the **Outcome Phase**. An outcome assessment form (see Appendix B) was completed at the time of *actual* discharge from acute care treatment at the VA medical center if the veteran were in an acute inpatient bed at midnight on September 30th and was identified as literally homeless or doubled up at the time of their admission to the VA. An outcome form was also completed at the time of actual discharge from a PRRTTP or domiciliary if the veteran were in that program at

midnight on September 30th and was also identified as literally homeless or doubled up at the time of their admission.

Data Collection Procedures

Survey phase. Survey data were obtained from VA clinicians (primarily unit social workers) who were directly familiar with the circumstances of each patient targeted for inclusion in the survey. At each facility a senior staff person was designated as the survey coordinator by the Medical Center Director to assure that the survey protocol (see Appendix C) was implemented as designed. For the most part, the designee was either the Chief of the Social Work Service (or designated contact), the Chief of Domiciliary Care (or designated contact) and/or the coordinator of VA's CHALENG program. Survey procedures were reviewed during the Social Work Service's and Domiciliary Chief's national conference calls. In addition, each survey coordinator submitted a plan that included a list of all medical center acute inpatient, PRRTTP and domiciliary bed sections (based on a sample Gains and Losses sheet from each facility). Bed sections to be included in the survey were identified in each plan. These plans were reviewed by NEPEC staff in individual telephone conference calls with the survey coordinator to assure clear understanding of the protocol.

At large medical centers where the residential status of hundreds of patients needed to be assessed, plans were made to begin data collection several days before Tuesday, September 30th to assure sufficient time to obtain data on all veterans. Wednesday, October 1, 1997 survey coordinators obtained a list from the Medical Administration Service (MAS) of all veterans who had been in the hospital at midnight on September 30, 1997. This list was reviewed and data were obtained on any newly admitted veterans. Data were sent to NEPEC by Friday, October 10, 1997 and each sheet was reviewed individually to assure that the information was complete. When gaps were identified, survey coordinators were contacted and efforts were made to obtain missing information.

Outcome phase. Each survey coordinator developed a system by which those veterans identified as literally homeless or doubled up at admission during the survey data collection phase would have an outcome assessment form completed upon their discharge from VA acute inpatient bed section or discharge from a PRRTTP or domiciliary bed section. At the end of each week, beginning October 10, 1997, until November 29, 1997, survey coordinators mailed completed outcome assessment forms to NEPEC. As with the census log sheets each form was reviewed individually to assure that the information was complete and accurate.

Data Collection Instruments

Census Log Sheet (Appendix A). The census log sheet recorded data on residential status along with each veteran's social security number and date of birth. Information on residential status was obtained from the clinician most familiar with the social service needs of each patient, from the chart, or from questioning the patient directly.

Data were recorded for each veteran regarding: (1) housing status at the time of admission to the hospital; and (2) *projected* (or hypothetical) housing options if their medical or psychiatric problems were resolved and they could, from a medical point of view, be discharged immediately. Residential status at admission was coded into one of five categories: (1) *literally homeless* if the veteran lacked a fixed, regular, adequate night time abode and was living in a shelter designed to provide temporary living accommodations or a public or private place not designed as a regular sleeping accommodation for human beings (e.g., cars, bus station, abandoned building, streets, etc.); (2) *doubled up* if the veteran was staying temporarily with family members or friends in an apartment, room or house; (3) *institution* if the veteran was residing in a staffed transitional residence (e.g., a halfway house), a health care institution (e.g., nursing home or other hospital) or other institutional setting (e.g., jail, prison); (4) *domiciled* if the veteran was living in an apartment, room or house or (5) *unknown* if information was not available. The veteran's *projected* housing options were coded using the same categories with wording modified to the hypothetical nature of the question. Veterans were classified as having lost their housing during the admission if they were not coded as literally homeless or doubled up for their admission status, but were so coded for their current status.

Outcome Assessment Form (Appendix B). For those veterans identified on the census log sheet as literally homeless or doubled up upon admission to VA, an outcome assessment form was completed at the veteran's *actual* discharge from acute care treatment if the veteran was in an acute inpatient bed at midnight on September 30th and at the time of actual discharge from a PR RTP or domiciliary if the veteran was in that program at midnight on September 30th. This simple one-page check format data form documented the veteran's residential and employment status, and arrangements for follow-up treatment. This information was obtained through clinical background knowledge or by direct questioning of the veteran. Only those homeless veterans who were discharged before December 1, 1997 were expected to be included in this phase of the data collection.

Merging Databases

Merging survey data with annual census data. Data on sociodemographic, clinical characteristics, length of stay and bed section were obtained by merging data from the survey with data from the national end-of-year census. The social security number was used as an identifier and the birth date as confirmation of the match. Data on veterans who were discharged before midnight September 30, 1997 and who were not in an acute inpatient, PR RTP or domiciliary bed section were dropped and excluded from further analyses and reports.

Data were thus obtained on gender, age, race, marital status, annual income, VA compensation and pension status, primary diagnosis (ICD-9 codes were recoded into 120 categories using a standard VA algorithm), length of stay at the time of the census, current bed section (the program in which the patient was being treated).

Merging outcome data with survey data. To examine changes in residential status and arrangements for employment and follow-up treatment among veterans identified as homeless at admission, data from census log sheets and the annual census data were merged by social security number and VA facility code with data from the outcome assessment forms.

Outcome Analyses

Outcome analyses were conducted in two stages. First, an examination of the relationship between admission characteristics and veteran housing status at the time of *actual* discharge from acute VA treatment was evaluated using correlations. Admission characteristics were drawn from survey data (housing status at admission) and annual census data (sociodemographic information and clinical diagnoses). Next, to identify those admission factors predictive of housing status at *actual* discharge independent of other admission factors, multinomial logistic regressions were conducted¹.

Findings

Survey Phase

Data gathering procedures. Residential status data were obtained through the survey on 22,717 unduplicated veterans. Of these records' 19,495 (85.8%) matched on social security number with records in the end-of year annual VA census. Non-matches were presumably due either to: (1) patients being discharged before the census date (midnight on September 30, 1997) or (2) miscoding of social security numbers.

Analysis of official VA census data showed 22,604 patients in acute inpatient, PR RTP and domiciliary beds targeted for the census. Complete residential survey data were obtained on 18,910 veterans (83.7% of the total) in these targeted bed sections². Data were obtained on 87.1% of veterans in acute psychiatry beds (n=3,563 of 4,089); 85.4% of veterans in acute substance abuse bed sections (n=812 of 951); 81.1% of veterans in acute medicine and surgery bed sections (n=9,123 of 11,259); 83.2% of veterans in PR RTP beds (n=683 of 821), and; 86.1% of veterans in domiciliary beds (n=4,729 of 5,493).

Homelessness in VA acute inpatient bed sections. Table 1 presents a simple summary of

¹ Admission characteristics selected for inclusion in the regression models were those that were significantly correlated ($p < 0.05$) with housing status at the veteran's *actual* discharge from VA treatment.

² There were 585 veterans for whom residential data were collected as part of the annual survey, however, these data were not included in this report because the veterans were in a bed section, as identified by the Annual VA census, as non-acute (i.e. intermediate care).

admission rates of homelessness. Altogether 23.1% of all veterans had been homeless at the time of their admission: 15.8% (N=2,984) were "literally" homeless, residing in shelters, the streets and similar locations, while 7.3% (N=1,380) had no residence and were temporarily doubled up with family or friends. Rates of homelessness varied from a high of 55.3% in domiciliary beds, to 46.3% in PR RTP beds, to 44.2% in acute substance abuse beds, to 22% in acute psychiatry beds, and 3.2% in acute medicine and surgery beds. In addition, 5.9% of all veterans (N=1,113), although not homeless at the time of admission, had lost their housing since they were admitted, and were therefore at high risk for *projected* homelessness after discharge.

Table 2 presents a summary of overall homelessness (including both veterans who were literally homeless and those doubled up) by VISN and by bed section, within each VISN. Substantial numbers of homeless veterans were treated in all of the VISNs. On average, VISNs reported that 22.1% of veterans were homeless at the time of admission. Although there is notable regional variation in the proportion of homeless veterans identified in the survey, ranging from a high of 42.5% in the Pacific Northwest (VISN 20) and 32.9% in Southern California (VISN 22) and 32.5% in Ohio (VISN 10) to a low of 11.6% in VISN 2 (Upstate New York), substantial numbers of homeless veterans are treated in every VA medical center in the system.

Table 3 presents data by residential status at admission on a variety of veteran sociodemographic and clinical characteristics: age, gender, race, marital status, annual income, current compensation and pension status, clinical diagnosis and length of stay. As compared to domiciled veterans (i.e., those living in an apartment, room or house) homeless veterans were younger than domiciled veterans (47.9 years vs. 61 years), more likely to be black (34.8% vs. 21.7%), less likely to be married (7.9% vs. 42.8%) and had lower annual incomes (\$6,034 vs. \$12,100). They were less likely to receive VA compensation benefits (23.8% vs. 40%) and pensions (5.5% vs. 11.3%). They were far more likely than other veterans to have substance abuse disorders (54.8% vs. 11.2%) and psychiatric disorders (28.2% vs. 19.8%). These differences between homeless and domiciled veterans are quite like those found in community surveys that have compared homeless and domiciled Americans (Tessler and Dennis, 1989; Susser, Moore and Link, 1993). Tables 4-6 presents data, by bed section, on age, income and length of stay.

Tables 9-20 present a complete breakdown of all survey residential data, including both admission residential status and *projected* residential status (i.e., if discharged today) and data on those who became homeless during their hospitalization. These data are presented by VISN (Table 9-14) for all bed sections together and then for each major bed section category, and by VA medical center (Tables 15-20) for all bed sections together and then for each major bed section category.

Comparisons in proportion and number of homeless veterans from FY 1995 to FY 1997.

Table 21 compares the residential status of veterans by all bed sections as determined by the FY 1995 and FY 1997 End-of-Year Surveys of Homeless Veterans (Rosenheck, Leda, Sieffert and Burnette, 1996). Data from FY 1995 were chosen as a comparison with FY 1997 because the FY 1995 survey was conducted prior to the reduction in VA inpatient beds. The top half of the table

reports the proportion of veterans in various residential categories for FY 1995 and FY 1997, and the change between the two survey periods. The bottom half of the table reports the number of veterans in each residential category by bed section for FY 1995 and FY 1997 and the change between the two survey periods. Overall, the proportion of homeless veterans remained essentially stable for the two survey periods. In FY 1995 and FY 1997 23.1% of veterans in all bed sections were homeless at admission, representing no change. Within bed sections there was variability. Mental health beds (acute psychiatry, acute substance abuse and PR RTP) and acute medicine and surgery beds experienced slight decreases in the proportion of homeless veterans; mental health had a 4.1% drop (32.9% in FY 1995 to 28.8% in FY 1997) and medicine and surgery had a 2.9% drop (6.1% in FY 1995 to 3.2% in FY 1997). Domiciliary beds, however, experienced a 9.2% increase in the proportion of homeless veterans from 46.1% in FY 1995 to 55.3% in FY 1997.

In contrast to the *rates* of homelessness remaining essentially stable for the two survey periods, only 63.4 percent as many homeless veterans were being treated during FY 1997 as compared with FY 1995 (4,364 in FY 1997 vs. 6,880 in FY 1995) (Table 21). Of the 2,516 fewer homeless veterans surveyed in FY 1997, the overwhelming majority (70%, n=1,749) were explained by fewer veterans surveyed in mental health beds (Table 21). Table 22 shows the rates of homelessness, the number of homeless veterans and change for the two survey periods by VISN for all mental health beds (acute psychiatry beds, acute substance abuse beds and PR RTP beds). On average, a VISN had 80 fewer homeless veterans (range is from -196 to 2) in mental health beds during the FY 1997 survey as compared with the FY 1995 survey. The VISNs with the greatest losses of homeless veterans were observed in VISN 12 (n=196) and VISN 7 (n=195).

The reduction in the number of homeless veterans may be related, in part, to the closure of substance abuse and general psychiatry beds and the shift within VA from inpatient treatment to outpatient treatment (see data presented in the following section entitled Implications).

Outcome Phase

Data gathering procedures. Of the 4,364 veterans identified as literally homeless or doubled up upon admission to VA, 2,844 veterans were determined to be discharged prior to December 1, 1997 by merging survey data with the national VA Patient Treatment File (PTF) in Austin, Texas. Of these 2,844 veterans, 1,948 veterans (68.5%) had an *outcome assessment* form completed upon their *actual* discharge from acute VA treatment if the veteran was in an acute inpatient bed at midnight on September 30th and at the time of actual discharge from a PR RTP or domiciliary if the veteran was in that program at midnight on September 30th. Table 23 presents a summary of residential and employment outcomes and arrangements for follow-up treatment outcomes by major bed section for these 1,948 veterans. Overall, 75.3% of veterans had a medically approved discharge. Nearly one out of ten veterans (9.6%) remained homeless after discharge, while 43.4% had housing arrangements (13.6% own apartment, room or house; 31.0% an apartment, room or house of a family or friend) and 35.6% were discharged to another institutional setting. The majority of veterans either were unemployed (31.8%) or retired/disabled (24.1%), while 30.9% had arrangements for competitive employment or a

constructive activity (e.g. VA's Compensated Work Therapy, school, vocational training). Seven out of ten (70%) veterans had arrangements for follow-up VA outpatient treatment, with over half having arrangements for psychiatric treatment (50.2%) and substance abuse treatment (60%).

Tables 24-55 present a complete breakdown of all outcome data. The tables are presented first by VISN (Tables 24-39) for all bed sections together and then by acute mental health beds (acute psychiatry and acute substance abuse beds), PRRTTP beds and domiciliary beds and finally by VA medical center (Tables 40 - 59) for all bed sections together and then for acute mental health, PRRTTP and domiciliary beds³.

Predicting homelessness at actual discharge from VA treatment. Results of bivariate and multinomial logistic regression analyses showed that there were three admission characteristics which significantly predicted housing status at the veterans' *actual* discharge from VA treatment. Independent of other factors, literally homeless veterans at admission (living in a shelter or outdoors) were 2.5 more likely to be homeless (Chi square =60.95, $p < 0.0001$, $df=2$) and 1.6 times as likely to be transferred to another treatment institution (Chi square=74.76, $p < 0.0001$, $df=2$) upon their *actual* discharge from treatment. Homeless veterans with an alcohol diagnosis were 1.3 more likely to be discharged to institutions (health care institutions, prisons, halfway houses, or transitional living programs) (Chi square=17.69, $p < .0001$, $df=2$). Finally, independent of other factors, homeless African American veterans were 19% less likely to be homeless at their actual discharge from treatment (Chi square=5.19, $p=.0227$, $df=2$).

Implications and Conclusions

Implications

Data from the national survey reported here suggest that 23.1% of all VA patients in acute inpatient, PRRTTP and domiciliary beds are homeless at the time of their admission to VA; 28.8% of those in mental health (psychiatry, substance abuse and PRRTTP) beds, 3.2% in medical-surgical beds and 55.3% in domiciliary beds. In addition, 5.9% of veterans, although not homeless at the time of admission, lost their housing after admission, and are therefore at high risk for homelessness after discharge. These findings demonstrate that the treatment of homeless veterans is a major activity in standard VA health care programs, and in the more than 100 special programs established to reach out to them in community settings.

The finding that many homeless veterans are treated in VA inpatient, PRRTTP and domiciliary care beds comes at a time of major change for the Veterans Health Administration and for US health care and social welfare systems, more generally. Substantial reductions in funding for Medicare, Medicaid, General Assistance and other social programs are a virtual

³ Outcome data from acute medicine and surgery beds were not included in breakdown by VISN or by medical center since the "n" was so small, $n=215$.

certainty, although the magnitude of those reductions has not yet been decided. State mental health agencies, facing similar budgetary restrictions are also expected to be forced to cut back on the services they provide.

Responding to the same budgetary climate, VA is in the process of shifting the emphasis of care from costly hospital-based treatment to community care wherever appropriate (Burns and Santos, 1995; Rosenheck and DiLella, 1998; Rosenheck, Neale, Baldino and Cavallaro, 1997; Rosenheck, Neale, Leaf, Milstein and Frisman, 1995). Indeed, comparison of FY 1995 and FY 1997 end-of-year VA census data shows that during the recent VHA reorganization, 2,024 substance abuse beds were closed (68% of the FY 1995 total) and 2,428 general psychiatry beds (26.8% of the FY 1995 total). Unfortunately, it is not clear whether any of the resources that had supported these beds were redirected to fund alternative services for homeless veterans. The data presented here on homeless veterans are particularly important to consider when plans for rapid downsizing of inpatient or domiciliary care capacity are proposed. Although most mental health care can be provided on an outpatient basis, veterans who are homeless are more likely to need a brief inpatient admission to get their treatment started. The data alert us to the importance of developing both residential alternatives to hospitalizations and community-based case management programs.

Alternative residential programs. In anticipation of current fiscal circumstances and clinical demands, VA Bed Control Policy and Procedures were changed in FY 1992 to establish a new type of administrative VA category: the Psychiatric Residential Rehabilitation and Treatment Program (PRRTP)(see VHA Directive 10-92-060, June 3, 1992, VHA 10-95-099, October 11, 1995 and VHA 10-95-099, September 8, 1997). This new administrative residential option provides VA administrators, clinicians and planners with maximum flexibility in developing non-hospital approaches to the development of effective and efficient residential care and rehabilitation, besides the well-established options provided by the VA Domiciliary Care and Community Residential Care programs. The Compensated Work Therapy/Transitional Residences (CWT/TR) program is one type of PRRTP that has been effective (Leda, Rosenheck and Medak, 1994; Leda, Rosenheck, Medak and Sieffert, 1996; Rosenheck and Seibyl, 1997). Although it is not yet clear to what extent PRRTPs will provide a less expensive substitute for hospital care, many facilities are exploring this option (Rosenheck, Medak and Seibyl, 1997).

Case management. The second major alternative to hospital care is intensive case management. In such programs intensive community-based service delivery (a "hospital without walls") is used to substitute for residential care. Such programs have been more efficient than conventional hospital care in both non-VA and VA contexts (Burns and Cents, 1995; Rosenheck, 1997; Rosenheck, Neale, Baldino and Cavallaro, 1997; Rosenheck and Neale, in press; Rosenheck, Neale, Leaf, Milstein and Frisman, 1995; Weisbrod, Test and Stein, 1980) and more cost-effective than residential care (Rosenheck, Frisman and Gallup, 1995). Intensive case management programs can only do their job, however, when services are directed at the appropriate target population (Rosenheck, Massari and Frisman, 1993) and when the commitment to intensive community-based treatment is sustained over an extended period (Stein and Test, 1980).

Conclusion

The care of homeless veterans has been a prime responsibility of national governments since the fifteenth century, if not before (Adkins, 1968; McNeil, 1982; Tilley 1992). Since the time of Homer, military service has been known to attenuate ties to family and friends, and to generate emotional turmoil of a deep and sometimes crippling nature (Kulka et al., 1990; Shay, 1994). Although the care provided to homeless veterans has changed immensely during the past five hundred years, the results of the FY 1997 End-of-Year Survey of Homeless Veterans suggest that here, at the end of the twentieth century, the United States Department of Veterans Affairs still bear major service responsibilities to this population. Ours is a time of rapid change, when old ways of delivering health care services are being transformed and in which some experts are, with reason, announcing the end of the hospital as we have known it (Stoeckle, 1995). The data presented in this report show that VA continues to treat many homeless veterans and retains a unique role among health care institutions in its investment of resources in services for the medically indigent. The extensive closure of substance abuse and, to a lesser extent, psychiatric beds in VA during the past two years, not surprisingly reduced the availability of these services to numbers of homeless veterans that had used them. While VA's bed closures were based, in part, on recent clinical studies that indicated little differences in outcome for patients treated in inpatient or outpatient settings, it should be noted that these studies did not include homeless patients. VA is concerned that homelessness may affect treatment outcomes and, for this reason, the Northeast Program Evaluation Center (NEPEC) continues to monitor care provided to homeless veterans throughout the VA Healthcare system. To the fullest extent possible, VA is committed to providing appropriate forms of community-based treatment and residential alternatives to acute inpatient care. This includes VA's ongoing commitment to work closely with non-profit organizations and State and local governments who are recipients of VA grant funds and are developing supported housing programs for homeless veterans.

We must proceed with the shift to new, more efficient methods of health care service delivery as rapidly as possible, but must take care not to lose valuable features of the system whose time is passing. Homeless veterans are young and appropriate rehabilitative services can allow them to return to full participation in their communities. At a Senate hearing on the problems of homeless veterans, in February 1994, the former Secretary of Veterans Affairs, Jesse Brown, said that homelessness among veterans, "is an American tragedy -- and it must not be allowed to stand . . . The way a society treats its veterans is an indication of who we are as a nation." Our ability to care for homeless veterans during the coming years will also be a test of how creative, conscientious, and caring we can be as a health care system.

NATIONAL ALLIANCE TO END HOMELESSNESS ♦ NATIONAL COALITION FOR THE HOMELESS
NATIONAL COALITION FOR HOMELESS VETERANS ♦ NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
NATIONAL LAW CENTER ON HOMELESSNESS AND POVERTY ♦ NATIONAL NETWORK FOR YOUTH

October 14, 1998

The Honorable Bruce Reed
Assistant to the President for Domestic Policy
Executive Office of the President
Washington, DC 20503

Dear Mr. Reed:

We are writing as leaders of the six national organizations that share as their vision an end to homelessness in this country to urge the Clinton Administration to request significantly increased funding for the homeless assistance programs of the U.S. Department of Health and Human Services (HHS) in its Fiscal Year (FY) 2000 budget submission. As you know, HHS manages the following homeless assistance programs: Health Care for the Homeless, Projects for Assistance in Transition from Homelessness, and the Basic Center, Transitional Living, and Street Outreach programs for runaway and homeless youth. In addition, we urge the Administration to request FY 2000 funds to enable the Department to establish a targeted homeless addiction disorder treatment program.

The need for health care, housing, income maintenance, and social services for the nation's homeless adults, children, youth, and families far outpaces the availability of services available to them in these program areas. That homelessness is a living condition for an increasing number of our neighbors places even greater pressure on the range of homeless assistance programs. Presidential leadership—demonstrated in part through a meaningful FY 2000 budget request for HHS's current homeless assistance programs and the establishment of a new addiction disorder treatment program—would serve to redress this gap between services and increasing need.

Health Care for the Homeless

The Health Care for the Homeless (HCH) program (one of the programs within the consolidated health center cluster), within the Health Resources and Services Administration, ensures that homeless people have access to health care services through integrated systems of care. As well as providing primary care, diagnostic, preventive, emergency medical, pharmaceutical, addiction disorder and mental health services, HCH projects also conduct intensive outreach, case management, and housing, income, and transportation linkage activities. HCH projects are designed and managed at the community level. HHS estimates that HCH projects serve only about one quarter of persons experiencing homelessness within a given year.

HCH projects and other health centers are overwhelmed by a burgeoning demand for services associated with increasing numbers of individuals without health insurance. This reality places an enormous burden on HCH projects and other community health providers, who are obligated to provide services regardless of the individual or family's ability to pay for them. Furthermore, an increase in the number of homeless people, brought on by recent changes to the Supplemental Security Income (SSI) program, which terminated income and health benefits for individuals with drug addiction and alcoholism disabilities, and other socioeconomic factors, presents an expanded population of patients whom HCH projects and other community health providers are responsible to serve. The phase-out of Medicaid cost-based reimbursement to HCH projects and other health centers and the increased enrollment of Medicaid beneficiaries in managed care programs are reducing the amount of Medicaid funds available to HCH projects, thus presenting an additional major challenge to their ability to provide indigent care.

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Increased federal funds will allow the HCH program to expand services to the three-fourths of the homeless population still without basic health care—both in the way of capacity increases of current projects and the establishment of new projects—and enable HCH projects to remain financially viable in the increasingly market-oriented, rather than care-oriented, health service environment. Accordingly, **we urge the Clinton Administration to request at least \$1 billion for Consolidated Health Centers (which would likely result in approximately \$86 million for the HCH program) in its FY 2000 budget submission.** The \$1 billion funding level, while below the amount ultimately necessary to serve the individuals in need, would be a major step forward.

Projects for Assistance in Transition from Homelessness

The Projects for Assistance in Transition from Homelessness (PATH) program, within the Substance Abuse and Mental Health Services Administration (SAMHSA), makes funds available to states to assist them in providing outreach, screening and diagnosis, habilitation and rehabilitation, community mental health services, substance abuse treatment (for people with serious mental illnesses and co-occurring substance use disorders), case management, residential supervision, and limited housing services for homeless people with serious mental illness. PATH funds are allocated to all fifty states, the District of Columbia, and the U.S. territories, which then distribute the funds to a broad range of service providers—approximately 350 in number—who then deliver actual services.

While PATH has enabled many homeless people to return to secure and stable lives, limited funds preclude the program from reaching the universe of homeless people with serious mental illness. This group continues to grow as a result of a new wave of deinstitutionalization of patients from mental health facilities and the denial of services or premature and unplanned discharge brought about by managed care arrangements.

Additional federal funds are necessary for PATH to reach the substantial number of homeless mentally ill people still not receiving mental health services or losing mental health services. **Accordingly, we urge the Clinton Administration to request at least \$40 million for PATH in its FY 2000 budget submission.** The \$40 million funding level, while below the amount ultimately necessary to serve the individuals in need, would be a major step forward.

Runaway and Homeless Youth Act

Runaway and Homeless Youth Act (RHYA) programs, within the Administration for Children and Families, support cost-effective, community-based services that protect youth from the harms of life on the streets and either reunify them safely with family or find alternative placements. The Basic Center Program provides grants to support temporary shelter for youth and counseling for youth and their families. The Transitional Living Program provides grants to support longer-term shelter as well as independent living services for youth. The Street Outreach Program provides grants to support street-based outreach and education to runaway, homeless, and street youth who have been sexually abused or are at risk of sexual abuse.

RHYA programs provide crucial housing, education, life skills, and support services to vulnerable youth at a pivotal juncture in their lives—when they will be either plunged into chronic homelessness and poverty or achieve stability and independence. Regrettably—for both the youth themselves and for the nation at large—the need for comprehensive services continues to outpace the ability of RHYA programs to provide them. **Accordingly, we urge the Clinton Administration to request at least \$115 million for RHYA programs in its FY 2000 budget submission.**

Targeted Homeless Addiction Disorder Treatment

HHS does not currently administer an addiction disorder treatment program targeted to homeless people, as it does for primary care and mental health. Instead, it is assumed that homeless adults and youth with addiction disorders will obtain treatment services through the mainstream substance abuse treatment system.

But, the mainstream treatment system does not adequately reach the homeless population. Homeless people, who are difficult to contact, are readily dropped from extensive waiting lists for mainstream treatment services. Further, community-based mainstream programs often refuse to accept homeless people. And community-based health care providers, such as HCH projects, lack the fiscal or programmatic capacity to provide addiction disorder treatment services to all in need. For those homeless people who are lucky enough to enter the treatment system, lack of housing frequently renders the treatment less effective. Successful addiction recovery requires the stability of continuous access to needed health care, social services and income support, and a place to live. Homeless people, however, are lacking these necessities and are therefore likely to participate only in the detoxification phase of the treatment cycle. They then are typically discharged back into the environments in which their addictions took hold—streets or emergency shelters—where they are at far greater risk of relapse than if they had been discharged to a stable living situation. Many return multiple times to detoxification programs. Thus, a “revolving door” emerges, resulting in a waste of precious human and financial capital.

Alternative models for delivering addiction disorder treatment services to homeless people that address these flaws in the mainstream system exist and have been proven effective in demonstration projects sponsored by the National Institute on Alcohol Abuse and Alcoholism. Unfortunately, federal funding has not been made available to build on these findings in a concentrated way—a problem that a targeted homeless addiction treatment program would address.

Establishment of a targeted homeless addiction treatment program within HHS is consistent with the intent of Congress, as reflected in FY 1999 Senate Labor-Health and Human Services-Education appropriations report language, which encourages HHS to establish a targeted treatment program; and FY 1999 Senate Veterans Affairs-Housing and Urban Development (HUD)-Independent Agencies report language and the House-passed reauthorization (H.R. 217) of the Stewart B. McKinney Homeless Assistance Act, which require HUD to spend a greater percentage of its homeless assistance funds on permanent housing, and in so doing limit its ability to fund supportive services such as addiction disorder treatment. Establishment and funding of a homeless addiction disorder treatment program would enable HHS to partially satisfy this Congressional expectation.

Accordingly, we urge the Administration to request at least \$100 million for an addiction disorder treatment program targeted to the unique needs and life circumstances of homeless people in its FY 2000 budget submission.

As you know, Congress has signaled its support for HHS homeless assistance programs by providing funding for them in the FY 1999 Labor-HHS-Education appropriations bills approved by appropriations committees in both the House and Senate at levels that surpass the Administration's FY 1999 request. We urge the Administration to “set the bar high” in its FY 2000 budget submission and recommend significant increases for the few health and human services programs designed specifically for homeless children, youth, families, and adults. We are confident that when put to the challenge, Congress will respond favorably to the Administration's recommended investment levels.

The Honorable Bruce Reed
October 14, 1998
Page Four

We look forward to working with the Clinton Administration to assure growth in the Department of Health and Human Services' homeless assistance programs. Please have your staff contact our organizations if we can be of further assistance as the Administration prepares its FY 2000 budget.

Sincerely,



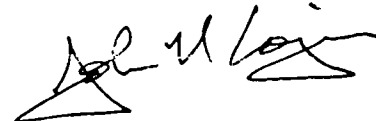
Paula Van Ness
Executive Director
National Alliance to End Homelessness



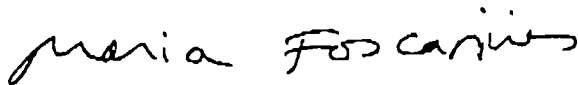
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From the Offices of:
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Resident Counsel

POSITION PAPER

DISPARITY AND INEQUALITY OF INCOME
AND WEALTH IN THE UNITED STATES;
RESULTING INCREASE IN HOMELESSNESS;
THE HAYES NATIONAL PLAN TO END HOMELESSNESS.

INTRODUCTION

The purpose of this paper is to address basic macroeconomic causes of Homelessness, such as disparity and inequality of income, wealth and opportunity in America, and to illustrate the resulting necessity of instituting a National Plan to End Homelessness, as proposed by Homeless Activist **Ted Hayes**, Los Angeles. The basic features of the National Plan are incorporated into a pending request for the President's Executive Order, which was submitted to the White House several months ago.

The request is also pending with the Department of Housing and Urban Development. It will soon be presented in Congress in the form of a House Resolution. **Ted Hayes'** concept for a National Plan is rapidly gaining support in governmental, economic and legal sectors.

Hayes and his organization have long since observed that Homelessness is increasing in direct proportion to the growing inequality of income and wealth in the U.S. In this observation, they are supported by the statements of Alan Greenspan, Chairman of the Federal Reserve Board, in his testimony to Congress, March 5, 1997:

“[T]here has been, as we know and discussed over the years, a significant opening up of income spreads, largely as a function of technology and of education with the increased premium of college education over high school, and high school over high school dropouts becoming stronger. The whole spread goes right through the basic system. It is a

development which I feel uncomfortable with. There is nothing monetary policy can do to address that, and it is outside the scope, so far as I am concerned, of the issues with which we deal.”

Although the reduction of disparities of income, and the corresponding reduction in numbers of Homelessness, may well lie outside the scope of authority of the Federal Reserve Board, Chairman Greenspan remains quite concerned about the ultimate effects, nationally and globally, of that growing problem. That concern was shown by the meeting of Asian and European central bankers, convened by Alan Greenspan, at Jackson Hole, Wyoming, on August 27 and 28, 1998. Although many central bankers understandably wanted to focus the discussions on the Russian economic disaster, Greenspan insisted that they concentrate on the planned agenda, “Income and Wealth Disparity and Inequality, Resulting Problems for U.S. and Global Monetary Policy” (*Financial Times*, August 29/30, 1998, at p.1). ~~The meeting reflected responsible concern for the causal connections~~ between monetary policy and growing poverty and Homelessness.

It is Ted Hayes’ view that the longer mass impoverishment continues and expands, and the more misery and Homeless are created, the more danger to American democracy will be the inevitable result. Not surprisingly, that conclusion is shared by a growing number of economists, jurists and political scientists, as is shown *infra*.

At this time, over half of all financial assets are owned by the wealthiest one percent of American families. Over 85 percent of assets are owned by the top ten percent. See Edward N. Wolff, *Top Heavy: The Increasing Inequality of Wealth in America and What Can Be Done About It*. New York: New Press, 1996; cited in James K. Galbraith, *Created Unequal: The Crisis in American Pay*, Twentieth Century Fund Publ., Free Press, New York, 1998, p. 294.

Increasingly, legislation and political power rewards equity owners (investment) to an unprecedented extent. That same political process excludes or downgrades the estimation of value of less-educated, less privileged workers.

Today, the top one percent of wealthy Americans “earn” half their income from interest. As they get richer, the poor get poorer. *Galbraith, op.cit.supra*, at p. 296; See also Joanne B. Ciulla (Prof., Univ. of Richmond), in *Los Angeles Times*, Sept. 6, 1998, Book Review, at p. 8. As the rich become more secure, the poor become hopeless. As the shrinking middle class is being squeezed by their heavy tax burden, they share less and less compassion for the poor. The middle class is more reluctant to allow their tax dollars to go to the destitute and the Homeless. Inequality weakens people’s willingness to share. *Galbraith, Ciulla, op.cit.supra*.

The chaotic global economy has transformed the nature of work in the United States, reducing the number of good wage jobs for people with limited educational backgrounds. Elliott Currie, *Crime and Punishment in America*, Metropolitan Books, New York, 1998. At the same time, “Welfare-to-Work” legislation nationwide combines with low-

wage jobs to produce a rising class of destitute, nearly Homeless millions. For those who manage to locate borderline employment, 65-70% are again jobless within one year. Those persons are now arriving on our urban streets in great numbers, joining the miserable millions already there.

Only a diminishing minority of the newly poor will be able to maintain sufficient employment to keep a roof over their heads. The shrinking middle class is being replaced by a new, permanent underclass; and by new masses of Homeless.

Once the new Homeless, having fallen into the abyss created by the relentless widening of inequality, arrive at the bottom, they are then outlawed. They then become subject to the increasing *Criminalization of Status* of the Homeless. (Note: *Ordinances outlawing Homeless for their status are the subject of a companion Memorandum of Opinion, Justiceville/Homeless-USA, August-24, 1998*).

The foregoing factors, taken alone, more than justify the call for a National Plan to End Homelessness. In addition, it is now recognized that the growing disparity in distribution of wealth and income is endangering national and global monetary stability. See Greenspan, *supra*; David Friedman, (MIT), *Greed and Spin, Op-Ed Article, Los Angeles Times, Sept. 6, 1998, at p. M3; The Economist, Sept. 6, 1998, at p.19*.

Thus, there is finally a convergence of civil and democratic compassion, on the one hand, and monetary stability and sound economic good sense, on the other. It is in this context that Ted Hayes has launched the call for a National Plan.

Homelessness cannot be solved without a resolution of the problem of wealth and income disparity in the U.S. and worldwide. In turn, the wealth and income gap problems cannot be solved without specific focus on their political causation. Homelessness is not the inevitable side effect of the operations of market economies. It is, instead, the cumulative result of many and complex causes, including governmental socio-economic policies over an extended period of years.

As polarization of wages, incomes, opportunities and wealth develops, the common interests and common social programs of a society fall into decline. Galbraith, *op.cit., at p. 265*. Hence, the assault on the poor leading up to the Welfare Bill of 1996. Hence, the new social retrogression taking the form of "Welfare to Work to Homelessness".

It has become virtually impossible to measure or quantify reliably and accurately the relative values of capital vs. labor. Ted Hayes has long argued that the wealthy and powerful control political and economic events so completely that, at this point, the powerful need not care any longer about a civil society, nor about the constraining voice of democracy. His concern is now shared by a growing number of prominent economists and others. See Galbraith, *op.cit., at p. 265-66; Friedman, supra*.

National and global monetary policy, indeed the entire world economy's foundation and future, is imperiled. This concern is shown by recent statistics developed by the Organization for Economic Cooperation and Development (OECD), Paris, France; See Nickell and Bell, "*Changes in the Distribution of Wages and Unemployment in OECD Countries*", from J. Hills, Ed., *New Inequalities*, Armonk/M.E. Sharpe, New York, 1996. The scope and extent of this worldwide economic *misere* is caused in good part by the growing discrepancy between rich and poor. The resulting impact on the functioning of democracy and market economies is also the subject of a new report developed by the United Nations.

In its *Human Development Report 1998*, released on September 9, 1998, the United Nations Development Programme (UNDP) finds that in total, the world's richest nations are home to more than one hundred million who are homeless. Sadly enough, the leader among the OECD countries, in both material wealth and deprivation, is the United States, with the highest per capita income and almost 16.5 per cent of the population living in poverty as measured by the Human Poverty Index. Out of this study of 17 richest nations, the U.S. ranks seventeenth --last-- in terms of wealth and income distribution.

GLOBAL CONCERNS CALL FOR LOCAL ACTION.

On Monday, September 14, 1998, President Clinton addressed the Council on Foreign Relations on the urgent challenges now facing the global economy. In that talk, he emphasized the social aspects necessary to any coherent program, viz., *Assisting Families in Recovering Nations*. "The President is calling the World Bank and Asia Development Bank to double their aid through a Social Compact Initiative -- focusing on job assistance, and basic needs during transition..."

It is **Ted Hayes'** firm conviction that in view of the startling increase in Homelessness in the United States and throughout the industrial world, and in view of the threat to economic and political/social stability this poses, that the President's call for a Social Compact Initiative is closely parallel to Hayes' own proposal for a National Plan to End Homelessness. President Clinton should consolidate that progressive planning nationally and internationally to achieve a global result. The aims and methods to be used in ending Homelessness in the U.S., as well as in preventing global financial depression, are in fact one and the same.

THE MORAL HAZARD

In recent years, public support for ending or reducing Homelessness has decreased even as their numbers increase dramatically. The prevailing winds are those of *Compassion Fatigue* nationwide. At the same time, municipal governments, strapped for funding, have resorted to a primitive sort of *social triage*: leaving it up to local officials and even police to distinguish the deserving from the undeserving Homeless.

The flaw in that logic is the same as the flaw in global economic planning: Separating the deserving from the undeserving. On September 16, 1998, Secretary of the Treasury Robert Rubin appeared, together with Chairman of the Federal Reserve Board, Alan Greenspan, at a hearing of the House Banking Committee. The topic was the global economic and financial crisis. Secretary Rubin noted that, in Russia and in Asia, the U.S. is helping persons and even countries who took risks, and perhaps do not deserve our aid. Yet, we help and support them because their plight impacts us. Helping them is in our own enlightened self-interest.

Chairman Greenspan added that we must, simultaneously, maintain a global economy at a certain level, while we continue supporting people, companies, banks, and nations who do not deserve our help. If we let them perish, then we punish the innocent along with the guilty. ~~We must enter into a certain~~ *Moral Hazard*. Our task is to eliminate the crisis without adding unduly to the hazard.

We submit that the same principle applies to eradicating Homelessness in the United States. In achieving that goal, we will probably have assisted people who have irritated us in one fashion or another. Yet, if we do not address the problem swiftly and comprehensively, we run the far greater risk of social and economic instability of a magnitude that will undermine civil society.

Once again, the cures for global economic crisis are closely similar to the program we urge President Clinton to adopt for ending national Homelessness.

THE HAYES PLAN

The Hayes National Plan to End Homelessness calls for formation of a Commission, created by Executive Order and supported by a consensus of Congress. Initial reports and recommendations would presumably be solicited from the following departments and groups:

1. The Federal Reserve Board: As mentioned *supra*, the Federal Reserve advocates a number of measures to build monetary stability while reducing rich/poor disparities worldwide. The National Plan to End Homelessness contains close parallels to those measures. For that reason, the recommendations of the Federal Reserve Board, while obviously exceeding their relatively narrow scope of authority, would be indispensable. The Board would submit a study or position paper on the topic of income inequality, structural poverty and Homelessness, covering monetary policy; interest rates; minimum wages; measurement of capital/labor value ratios; projection of successful and stable monetary policies through reduction of disparities, elimination of Homelessness;

2. Department of State: Because the problem of Homelessness in the U.S. and throughout the industrial countries of the OECD is a human rights issue, the U.S. Department of State should be invited to submit a report to the President covering U.S. human rights efforts and policies worldwide. It should analyze and evaluate growing resistance to American foreign policy on human rights based on perceptions among allies of the increasing disparity between the wealthy and the poor, the powerful and the weak in U.S. society; the consequences for U.S. foreign policy and credibility. It is important to demonstrate that the world media and judiciary, and especially democratic governments of high social awareness, are increasingly observant of U.S. social inequities.

3. Justice Department: To submit a report to the President regarding the new wave of anti-Homeless ordinances nationwide. The report would discuss the criminalization of status of the Homeless. *See Companion Memorandum of Opinion on Anti-Homeless Laws, August 24, 1998.*

Justiceville/Homeless USA already acknowledge the recent efforts of the Justice Department in this judicial arena, e.g., in filing of *Amicus Curiae* briefs in Homeless class actions in state and federal courts across the nation in recent years. We suggest that Justice Department can synergize all participants by combining their litigation support and test case efforts into the National Plan;

4. Housing and Urban Development: To submit an analytical report to the President on the creation of incentive-based communities for Homeless as mandated by the Hayes National Plan; to provide for direct allocation of federal funding to permanent solutions to the complex causes, and increasing incidence, of Homelessness.

5. Associations of Employers and of Manufacturers, organizations in business and industry: To submit reports to the President and to the Hayes Commission recommending concrete steps for remedying the wealth and income gap, together with the causes of Homelessness. In those deliberations, to utilize the private sector's unprecedented access to information technology, human resource expertise, and sheer Yankee Ingenuity. The private sector can provide the keys and the methods of ending Homelessness in the United States,

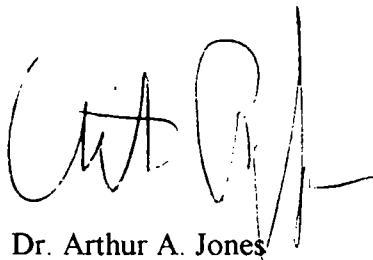
6. Universities throughout the United States should be invited to participate, especially their faculties of Social and Urban Planning, Law, Economics, and Political Science.

The National Plan to End Homelessness, and the Commission to be created in its initial phase, will confront one of the world's greatest human rights causes, taking place on the streets of this, the world's greatest democracy. In its deliberations, it will tackle unpleasant, deeply-imbedded truths about life in America today.

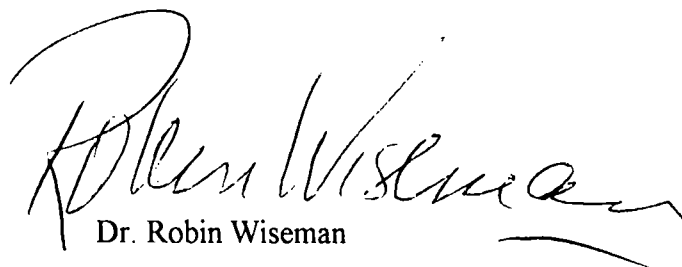
It is our firm conviction, shared by responsible leaders in every sector, that this thorough self-analysis and critical self-inspection is absolutely necessary to our survival as a civil society and effective democracy at this crucial juncture in our history.

If adopted and implemented swiftly and comprehensively, the National Plan to End Homelessness will engender a progressive spirit in America that will strengthen us as a people. It will also ensure that we, as a unique nation, can successfully meet the global and domestic challenges now facing us.

Respectfully submitted, Los Angeles, California, and Washington, D.C., the 23rd day of September, 1998:



Dr. Arthur A. Jones



Dr. Robin Wiseman

JUSTICEVILLE/HOMELESS USA

847 Golden Avenue

Los Angeles, CA 90017

From the Offices of Ted Hayes

cc: Mary Smith
Homeless

F A X C O V E R S H E E T

DATE: October 9, 1998 TIME: 2:25 PM
TO: Andrea Kane PHONE:
Domestic Policy Counsel FAX: (202) 456-7431
FROM: Ted Hayes PHONE: (213) 892-9011
JHUSA FAX: (213) 892-9068
RE: Expanded National Campaign to End Homelessness
cc: [Names]

Number of pages including cover sheet: three

Message

Los Angeles City Councilwoman Rita Walters introduced our Resolution for a National Plan in Council last Tuesday. We will appear for the hearings on Tuesday, Oct. 13.

The exciting aspect is that Los Angeles, as the city with one of the largest --if not the largest-- Homeless populations in the USA, is assuming a role of leadership among municipalities.

Therefore, take courage as you move forward! Our vision of partnership, our nonpartisan and non-adversarial approach to eradicating Homelessness throughout our country, will work and work well. It is a plan whose time has arrived.

Many thanks again for your support.

Ted Hayes

Fax

Recd

Name: Ted Hayes
Organization: Dome Village
Fax: 213/892-9068
From: Delpha Hacker Flad
Date: August 5, 1998
Subject: Homeless Plan Motion
Pages: 2

Delpha Flad

Attached is a copy of the motion that Council Member Walters introduced in Council yesterday.

As you will see, it does not go quite as far as the motion you drafted. Having given her several choices, including yours, this is one she is most comfortable with.

We believe this will be on next Tuesday's agenda. You can check with Rodney in our office on Friday, as we should have Tuesday's agenda by then.

Delpha Hacker Flad
Chief of Staff
Council Member Rita Walters
City Hall, Room 508
200 No. Main Street
Los Angeles, CA 90012
213/473-2302
FAX: 213/473-5848

RESOLUTION

WHEREAS, the number of homeless, throughout the United States, is increasing at an alarming rate; and recent statistics show that there are nearly 230,000 homeless in Los Angeles City and County alone, although numerous other urban areas in the United States are at least equally affected; and

WHEREAS, Los Angeles is in the forefront of cities worldwide in formulating and activating new, working solutions to the problems confronting urban citizenry in our era; and

WHEREAS, neither Los Angeles nor any other major United States city possesses the financial resources to solve the problem of homelessness in the country, nor to eradicate its numerous and complex causes; and

WHEREAS, a national plan to end homelessness is urgently needed, and must be a well-organized, concerted program at federal governmental level; municipal and state efforts, alone, would lead to mere temporary progress and to regional imbalances; and

WHEREAS, the City Council of Los Angeles is also mindful that, lacking the necessary resources, Los Angeles and other cities nationwide have had no alternative but to address behavioral aspects of urban homelessness by means of police enforcement of a wide variety of municipal ordinances; and

WHEREAS, it is becoming increasingly apparent that certain of those ordinances not only contribute to greater human misery among the homeless, but may also create crimes of status, of questionable constitutionality, both California and Federal;

NOW, THEREFORE, BE IT RESOLVED, that the City Council of Los Angeles endorses and supports a comprehensive national plan to end homelessness, and that it urges the President of the United States, the United States Congress, and other relevant federal agencies to develop and implement a comprehensive national plan to end homelessness.

PRESENTED BY _____

RITA WALTERS
Councilwoman 9th District

SECONDED BY _____

Federal Grants to Back Housing For Region's Disabled, Elderly

By BROOKE A. MASTERS and ROBERT E. PIERRE
Washington Post Staff Writers

Maryland, Virginia and the District will share \$40.4 million to build, rehabilitate or subsidize the rent on more than 1,350 apartments for elderly and disabled people as part of a federal affordable housing push that President Clinton announced yesterday.

Three programs in the Department of Housing and Urban Development are awarding a total of \$822 million to nonprofits and housing agencies nationwide to provide affordable housing for 30,000 low-income senior citizens and disabled people, HUD Secretary Andrew M. Cuomo said in a telephone news conference. None of the programs is new, but each has been significantly expanded this year, he said.

"Americans should never have to choose between putting a meal on the table and putting a roof over their heads," Clinton said in his weekly radio address.

The bulk of the funds—\$696 million nationally—will go to nonprofit agencies that applied for federal funding to build and rehabilitate housing units for the elderly and mentally and physically dis-



Housing Secretary Andrew M. Cuomo says the grants will help house the nation's aging population.

abled. Local governments and housing authorities will get the remaining \$126.8 million for vouchers that pay up to 70 percent of the rent on privately owned apartments for low-income disabled people.

Maryland will receive \$16 million in assistance for the elderly and disabled. The largest grant—about \$6 million—will go to Asso-

ciated Catholic Charities Inc. to build 72 one-bedroom apartments for independent elderly in Reisterstown, near Baltimore.

Seven nonprofits in Baltimore, Howard, Prince George's and Montgomery counties will receive grants ranging from \$400,000 to more than \$1 million to support housing for people with disabilities. ReVisions Inc. in Howard will get \$400,000 to build a group home for six people with chronic mental illness.

And Family Services Agency Inc. of Montgomery is slated to receive \$950,000 in capital and operating money for three group homes for nine mentally ill patients.

Montgomery's Housing Opportunities Commission will receive \$2.2 million to subsidize the rents of low-income people with disabilities. And Howard, Charles and St. Mary's counties will share \$1.4 million for similar rent vouchers.

During the last year, disability advocates in Maryland successfully petitioned state lawmakers to set aside \$50 million over the next five years to eliminate a waiting list of 5,300 disabled residents needing

See GRANTS, A11, Col. 1

HUD Grants To Support Housing for Disabled

GRANTS. From A10

group homes, day programs and job training.

But nationally, advocates said, there is never enough money to meet the need. HUD statistics show that more than 1 million disabled adults pay more than 50 percent of their income as rent.

The supportive housing program for people with disabilities is an important program, but it's grossly underfunded in comparison to money that goes out for elderly housing, said Kathy McGinley, assistant director of government affairs for the ARC of the United States, an advocate for the mentally disabled.

Most of Virginia's \$17.2 million will fund the construction and rehabilitation of 193 apartments outside the Washington area, including a 64-unit home for poor elderly people in Gloucester and a 60-unit project in Norfolk.

But Fairfax County will get \$672,000 for 100 rent vouchers. There is a substantial waiting list for housing for the disabled. This grant is certainly needed, said county Board of Supervisors Chairman Katherine K. Hanley (D).

In the District, the nonprofit Community Preservation and Development Corp. will get \$6.5 million to rehabilitate 73 District apartments. The city will receive an additional \$671,771 to subsidize the rent on 100 apartments for disabled people.

Cuomo said the expanded programs are part of HUD's effort to address the aging of the American population. The construction projects feature apartments tailored for seniors—they generally are smaller than those geared for families and include grab bars in the bathrooms and wider doors that can accommodate wheelchairs.

"This is a cost-effective alternative for a wave that is about to break," Cuomo said. "We want to provide alternatives to medical facilities [and] assisted-living communities, which are very expensive."

Staff writer Cheryl W. Thompson contributed to this report.

The second program will provide an additional \$126.8 million to be distributed among disabled people in the form of rent subsidies.

Administration officials predict that the new apartments will accommodate 12,400 people through projects managed by 166 private groups that competed for the grants. The money will cover development costs and does not have to be repaid so long as the new housing is available for 40 years to low-income elderly residents or people with disabilities.

More money is available to the project owner to cover differences between the rent and operating costs.

Those receiving the assistance must be classified as "very low income," which means that a household cannot earn more than 50 percent of the area's median income. On a national average, Administration officials say that amounts to less than \$8,000 a year.

The second program is expected to provide affordable housing for more than 17,000 low-income people with disabilities so that their rent does not exceed 30 percent of their income.

"This is going to be a priority for the President," Andrew M. Cuomo, Secretary of Housing and Urban Development, said in an interview.

"We're all getting older, not only individually, but as a society, and the numbers are alarming," Mr. Cuomo said. "The graying of America is going to have significant impact on the nation's housing and will be one of the greatest challenges we face over the next 10 years."

Currently, the country has about 34 million citizens 65 or older, compared with about 3 million at the turn of the 20th century. Mr. Cuomo said that the figure is expected to reach 53 million within 25 years, putting additional strain on the need for affordable units.

As a result, Mr. Cuomo said, the department and the private organizations that are building new units are redesigning them with older and disabled people in mind, focusing on communal facilities for health and recreation.

Mr. Clinton said that despite the benefits most Americans are accruing through the prosperous economy, too many elderly and disabled people are trapped in substandard housing, where broken plumbing, inadequate heat and hazardous hallways are a dangerous fact of life. And too many spend more than half of their modest incomes on housing, often sacrificing basic needs like food and medical care just to pay the rent.

Promoting the Administration's efforts, he added, "At this moment of unparalleled prosperity, we must not do less."

U.S. Bolsters Housing Aid For the Elderly

New Programs Offer Millions to Disabled

By MICHAEL JANOFSKY

WASHINGTON, Nov. 28 — With Thanksgiving weekend as a backdrop, President Clinton today highlighted two new housing programs that will provide \$222 million for low-income people who are elderly or disabled.

In his weekly radio address, Mr. Clinton said that the money would benefit 29,400 people living in 48 states, and the District of Columbia, Guam and Puerto Rico. Montana and North Dakota, sparsely populated states, are the only two that are not slated to receive any of the money.

For millions of struggling senior citizens and people with disabilities, the peace and security of a decent home is a distant dream and the threat of homelessness an ever-present nightmare. Mr. Clinton said, discussing the programs, which are included in the new budget for the Department of Housing and Urban Development. "Too many of these hard-pressed Americans are warehoused in sterile nursing homes — not because they need to be, but because they can't afford to live anywhere else."

He added, "Americans should never have to choose between putting a meal on the table or putting a roof over their heads."

The Administration's \$25 billion housing budget for the 1999 fiscal year was one of the few appropriation requests that met with little opposition in the Republican-led Congress this year. It included \$1.8 billion in new spending for vouchers, which reflected the first major increase in housing spending in four years and also the department's efforts to rid itself of wasteful programs and mismanagement that characterized it in the past.

The larger of the programs Mr. Clinton cited in his radio address generates \$690 million in grants to nonprofit organizations around the country to build and rehabilitate 8,200 apartment units for older people and the disabled who fall below certain income levels.

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THE PHOTO

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12/1/98
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SUNDAY, NOVEMBER 29, 1998

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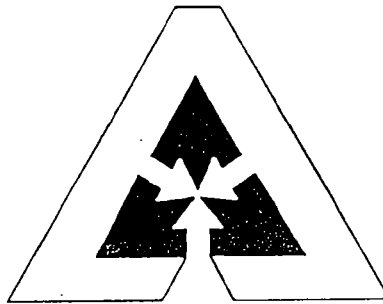
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homeless

THE PREVENTION OF HOMELESSNESS

A Report of



THE NATIONAL ALLIANCE TO END HOMELESSNESS

September, 1992

The Prevention of Homelessness

A Report of The National Alliance to End Homelessness

Thanks to
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for Printing this Report

Copies of this report are available for \$3.00/Alliance members, \$5.00/non-members from: The National Alliance to End Homelessness, 1518 K Street, N.W., Suite 206, Washington, DC 20005, 202-638-1526.

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The Alliance wishes to acknowledge the assistance of Eric Lindblom and Becky Sherblom in the preparation of this report. Its contents, however, are solely the responsibility of the National Alliance to End Homelessness.

Introduction

Homelessness is a modern American tragedy with devastating social and economic costs. We know the solutions to homelessness. They lie in affordable housing, adequate incomes, and comprehensive social services for those who need them. But implementing these solutions is costly, and we as a nation have not made the commitment to bear this cost. As long as we do not, the problem of homelessness will continue to grow.

Prevention holds hope as a sensible and cost effective way to stop the growth of homelessness. Given scarce public and private resources, the continual entry and re-entry of people into the homeless population makes it difficult to move beyond an emergency response to the problem. Were we to stop this flow, we could more effectively provide assistance to those who are currently homeless and begin to reduce the size of the homeless population. Only when this is done will the end of homelessness truly be in sight.

Prevention programs, when well run and properly targeted, have several advantages. There is every indication that they can be cost effective. They save the cost of shelter, often a very expensive form of housing. They prevent people from entering the homelessness system, becoming progressively "dysfunctional," and requiring more and more expensive services and supports. And, they make it easier for people to maintain steady employment and self sufficiency. Prevention requires an up-front investment that can result in substantial future savings.

Prevention also avoids the human and social costs of homelessness. Homelessness is a

cruel condition. The human benefit of saving even one person from the experience of homelessness is difficult to assess, but substantial. And homelessness has serious social consequences. Although many homeless people struggle valiantly to hold together families, maintain jobs and contribute to their communities, homelessness is a formidable opponent of these goals. Homelessness signals our failure to realize the potential of all of our nation's citizens. Our investment in their potential will yield real social benefit in communities, in schools and in the work place -- just as our failure to invest has resulted in deterioration in these areas.

For these reasons then -- economic savings, human savings and social savings -- prevention presents itself as a workable, sensible, and humane way of confronting homelessness.

What is Prevention?

Homelessness prevention means many things to many people. Broadly, it means that someone who is threatened with homelessness does not become homeless. That is, someone who is domiciled (i.e., not living on the street, in a shelter or transitional facility, not doubled up with a relative or in some other form of shelter not designed to be permanent or long-term) does not lose that residence or some equally acceptable residence.

There are many programs and efforts which accomplish this. Basically, they can be divided into three types.

Intervention Programs. These programs assist people who are literally about to become homeless because of eviction (most commonly), mortgage foreclosure, institutional release, foster care emancipation, family break-up or other reasons. Examples of this type of prevention program include emergency rent or utility payments, landlord/tenant mediation, legal aid to forestall eviction, and family counselling.

Stabilization Programs. These programs are directed to people who are at risk of homelessness because they are precariously housed, paying too high a percentage of income for rent, living in a volatile domestic environment, underemployed, plagued with alcohol or substance abuse or other illnesses, etc. The aim of these programs is to stabilize the household before it reaches the brink of homelessness. Examples include

case management, foster care counselling, budgeting assistance, treatment for illnesses including drug and alcohol abuse, and family counselling.

Infrastructure Programs. The goal of these programs is to build strong, stable communities in which there is no threat of homelessness. This is the most complete solution to the problem. Such programs provide a range of affordable housing options including supportive housing for those who require it; adequate incomes from employment and/or benefits; and comprehensive social, health and other services.

It is our contention that a full range of all of these programs is necessary for prevention to be successful.

Prevention Programs

Intervention Programs

Rent assistance
Mortgage assistance
Tenant/landlord mediation
Domestic violence counseling
Family counseling
Legal aid
Case management
Emergency utility payments

Stabilization Programs

Institutional transition (prisons, hospitals, jails, etc.)
Foster care emancipation
Community agencies
Drug/alcohol treatment
Family counseling
Domestic violence programs
Tenant education
Case management
Budgeting assistance

Infrastructure Programs

Housing Assistance:
Section 8
Single Room Occupancy
Housing and mortgage insurance
AFDC housing grants
Public housing
Tax credits
Supported housing

Income Assistance:
Veterans benefits
Aid to Families with Dependent Children
Emergency Assistance
General Assistance
Food Stamps

Service Assistance:
Health care
Case management
Counselling
Children's programs
Job training and placement
Enrichment
Building self esteem
Drug/alcohol illness treatment
Mental health care

Who Is the Target for Prevention?

The most difficult task of any prevention effort -- particularly intervention efforts -- is to identify who is likely to become homeless. The truly cost effective prevention program will accurately target its assistance to people who would be homeless without it. (This is not to say that those who are in a crisis, the result of which is not likely to be homelessness, do not deserve assistance. However, assistance to such people is best not called homelessness prevention, or it deceives the public purpose and can divert our attention from the pressing problems of homelessness.)

In order to target our resources and programs, we must describe, then, who is likely to become homeless. In general, those most at risk of homelessness, and therefore those to whom we should first target assistance, are those among the very poor who spend a large (over 30%) portion of their income on housing or who have a temporary or unstable housing arrangement (e.g., are doubled-up). Within this pool of precariously housed, very poor people we can further say that those most at risk are those who:

- ◆ have been homeless before;
- ◆ have no support networks (friends or family) which can help them with housing or finances, or who have exhausted such networks;
- ◆ have an institutional history (prison, jail, hospitals, etc.) and whose institutional stay was not immediately followed by steady employment, stable housing, and sobriety;
- ◆ have been in foster care; or

- ◆ are victims of domestic violence.

And, to further refine the targeting effort, amongst people who fall into any of the above categories, the people most likely to become homeless are:

- ◆ single men;
- ◆ female-headed households, particularly ones with no experience of independent living;
- ◆ people with chronic mental illness;
- ◆ people with substance or alcohol abuse illness; and
- ◆ people with serious health problems.

If prevention efforts are to succeed, it is people from these groups, and those with these characteristics, that must be affirmatively targeted. Programs which fail to target these groups, or which exclude them, will not make a substantial contribution to preventing homelessness.

At Risk of Homelessness

Current Situation

Very Poor

Doubled Up

Spend Too Much on Housing

History

History of Homelessness

No Support Network

Institutional History

Foster Care

Domestic Violence

Characteristics

Single Male

Female-Headed Households, especially young

Chronic Mental Illness

Substance/Alcohol Abuse

Health Problems

Recommendations

There are in operation today many excellent prevention programs, particularly intervention programs. The design and operation of these existing programs are an essential primer for anyone interested in establishing a prevention program, and the programs are thoroughly described in two sources: The American Affordable Housing Institute report, Preventing Homelessness: A Study of State and Local Homelessness Prevention Programs and Eric Lindblom's paper, "Toward a Comprehensive Homelessness Prevention Strategy," (Housing Policy Debate, vol. 2, No. 3., pp. 957-1025). Readers are referred to these two papers for detailed information on programs in operation.

There has been a great deal of discussion about what an ideal prevention effort could and should be and how one can best be implemented. It is generally agreed that a truly successful prevention effort would address emergency intervention, stabilization for those most at risk, and most broadly, the creation of an infrastructure of housing, income and service supports which would keep people from reaching the brink of homelessness. There is somewhat less, although still substantial, agreement that prevention efforts should be well targeted to those most at risk, and rigorously evaluated as to their success both in identifying and reaching that population, and in removing them from the cycle of homelessness.

Following is a discussion of some of the elements involved in the establishment of a comprehensive prevention effort including: 1) infrastructure; 2) stabilization programs; 3) intervention programs. It is followed by a discussion of ways to implement such programs.

While it is the case that a truly effective prevention effort would be comprehensive and encompass infrastructure, stabilization and intervention, it should be noted that less comprehensive efforts are also desperately needed.

Infrastructure

Imagine a community with an adequate supply of decent affordable housing. In this community, all those able to work are adequately trained to do so and are able to find jobs that pay a decent wage and provide a full package of benefits. Those who cannot work are supported by a safety net that holds them above the poverty line and guarantees them food, shelter and health care. People who confront personal problems can readily access service assistance, and a supportive environment of friends and family is encouraged and nurtured. In such a community there is unlikely to be homelessness. Such a community is the ultimate homelessness prevention infrastructure.

However, even in the absence of the perfect community, much of this infrastructure exists and can be built upon to improve its ability to prevent homelessness. Unfortunately, at present, federal state and local budget cuts are actually causing the deterioration of the existing prevention infrastructure. In the long term, such cut-backs are likely to cost more money in the form of emergency assistance to the homeless and also of law enforcement, prisons, health care, unemployment, and the like. Prudent and carefully planned up-front investment in our communities prevents the virtually uncontrollable cost of such emergency measures as shelter, foster care and prisons.

As mentioned, there is an existing infrastructure of support that can be built upon to prevent homelessness. In the housing area the existing programs include Section 8 vouchers and certificates, housing assistance, single room occupancy (SRO) preservation programs, the Low Income Housing Tax Credit, mortgage insurance and other low income housing programs. Although there are many excellent programs, only a fraction of those eligible for housing assistance currently receive it. Accordingly, it is recommended that the federal government increase the supply of affordable housing and expand any and all existing housing and tenant assistance programs to meet the need. The following suggestions are also offered.

- ◆ Provide technical assistance to increase the capacity of nonprofits to develop affordable housing.
- ◆ Permanently extend the national Low Income Housing Tax Credit.
- ◆ Provide the Veterans Administration with a substantial number of new Section 8 certificates or otherwise increase its access to housing so that homeless veterans who are assisted through its service programs can be concurrently stabilized in housing.
- ◆ Take steps to reduce the number of Veterans Administration and Federal Housing Administration foreclosures, particularly those likely to result in homelessness.
- ◆ Make available a full spectrum of housing to those suffering from AIDS and AIDS-related illnesses. This should range from independent housing to hospices. No one should become homeless because of AIDS, nor should anyone with AIDS be homeless.

State and local governments are also encouraged to invest in affordable housing, directly and through incentive programs such as tax abatements, density bonuses and the like. Additionally, there are steps that states and localities can take to encourage development of affordable housing without public spending.

- ◆ Remove zoning barriers which are exclusionary, forbid shared housing or in-law

apartments, or otherwise directly or indirectly inhibit the production of affordable housing.

- ◆ Take steps to preserve existing affordable housing, including moratoria on the destruction of SRO units, requiring replacement of converted affordable units, and so on.
- ◆ Amend building codes to encourage development of SROs and other low cost housing, still consistent with basic health and safety requirements.

In the income area, there are numerous federal employment and benefit programs that can properly be regarded as part of a prevention infrastructure when adequately funded, properly utilized, and coordinated with other prevention efforts. These include Social Security Insurance, Aid to Families with Dependent Children, unemployment compensation, Emergency Assistance and veterans benefits among others. At the federal level much can be done to make these programs more useful as prevention tools including the following.

- ◆ Check all relevant federal programs, such as Emergency Assistance, to make sure that regulations optimize their availability for prevention efforts.
- ◆ Establish a national minimum AFDC benefit.
- ◆ Index income supports to ensure that they maintain recipients above the poverty line.
- ◆ Extend outreach to the at-risk population (particularly those who are about to be released from institutions, emancipated from foster care, etc.).
- ◆ Coordinate with local service agencies (community action agencies, community development agencies, mental health agencies, etc.) to reach those at risk.
- ◆ Develop a one-stop shopping method of benefit enrollment.
- ◆ Remove disincentives to the earning of supplementary employment income for those on benefits.
- ◆ Generally re-design income programs to encourage rather than discourage the accumulation of assets that can provide a safety cushion, however meager.

- ◆ Replace a precipitous withdrawal of benefits with a phased or gradual withdrawal for those making it on their own.
- ◆ Recognize that earned income can fluctuate over time and develop a system that evens out this fluctuation by reducing waiting periods for benefits.
- ◆ Eliminate regulations that require that crisis assistance (such as emergency rent payment) be counted in income tests.
- ◆ Increase use of local nonprofit organizations as representative payees and reimburse such agencies for administrative costs.
- ◆ Make undocumented residents eligible for prevention assistance.

Local and particularly state governments also have income support responsibilities (e.g., general assistance) as well as employment and training programs. They might enhance their homelessness prevention effectiveness in the following ways.

- ◆ Resist efforts to cut general assistance and AFDC amounts, steps which often throw adults -- and in the case of AFDC, children -- into homelessness.
- ◆ Create job opportunities in public works and other public benefit areas such as child care.
- ◆ Encourage home care programs, micro-enterprises and other efforts which allow low income people to maximize the resources available to them while moving toward independence.
- ◆ Give tax credits or other incentives to businesses which hire and train homeless people.

In the service area there are a plethora of mainstream programs which contribute to a homeless prevention infrastructure. Medicare and Medicaid, Health Care for the Homeless, community health centers, alcohol and drug treatment programs, veterans hospitals and other programs serve the health needs of the poor, Federal programs support child care, education, case management, drug and alcohol abuse treatment, legal aid, mental health services and much more. State and local funds also support these health and social services, and others including domestic

violence programs, special assistance to homeless children, self-esteem and enrichment programs, etc. In general, these programs need to be made available to more people and at more intensive levels to help people deal with personal problems before they become so debilitating that they result in homelessness. Specific suggestions include the following.

- ◆ Make alcohol and drug abuse treatment facilities, including facilities for patients' families, available to those who need them. Those who obtain treatment also need assistance to retain their housing, jobs, etc. while under care.
- ◆ Make a full spectrum of services available to those suffering from AIDS and AIDS-related illnesses.
- ◆ Fulfill our responsibility to those with chronic mental illness through the establishment of community mental health programs that include a range of appropriate housing options.
- ◆ Increase the outreach capacity of existing programs so that those who need them know of their existence. Make service programs easily available in the community.

Of course, other ways to strengthen the homeless prevention infrastructure abound -- from improving the education of poor children so that they can eventually get decent jobs, to promoting inner city economic development. The important point is that the absence or reduction of infrastructure programs can lead to the need for less acceptable and even more expensive emergency programs such as emergency shelter.

Stabilization

Stabilization programs are not necessarily different in nature from infrastructure or intervention programs, but they are targeted to those most at risk of homelessness. Such programs seek to identify those most at risk and then help stabilize them in their current home,

or help them successfully make the transition to a new living arrangement. Stabilization programs include prison pre-release planning, pre-emancipation planning for foster care youth, budgeting assistance, drug and alcohol abuse treatment, case management, etc.

The key to the success of stabilization programs is identifying who is at risk of homelessness. The general risk factors have been discussed above. In particular, stabilization efforts can successfully find clients amongst very poor people in the following locations:

- ◆ prisons or jails
- ◆ hospitals for mentally ill people
- ◆ community and service organizations that assist the poor
- ◆ buildings or projects being foreclosed upon or converted from low income use
- ◆ domestic violence programs
- ◆ programs for youngsters with runaway or throwaway histories
- ◆ drug or alcohol abuse treatment centers
- ◆ housing for people who were once homeless

In the absence of a comprehensive homelessness prevention infrastructure, at-risk groups should be targeted for assistance to prevent their homelessness. In addition to the general housing, income and service supports discussed above, the following are suggested.

- ◆ Design stabilization efforts based upon the underlying cause of homelessness in an area. For example, while evictions may be the primary apparent cause of homelessness, the evictions themselves may be caused by plant closings or a precipitous rise in drug abuse in an area. An eviction prevention program will not address these underlying issues nor, ultimately, prevent homelessness.
- ◆ Create a national, state or local rental emergency insurance program (similar to the national flood insurance program) whereby renters would pay a small amount into an insurance fund that could be drawn upon in an emergency.

- ◆ Monitor all institutional releases. It is not enough simply to require that those being released from jails, hospitals, prisons, residential treatment programs and other institutions have a place of residence. They must be able to reach this place of residence. It must not be temporary. It must be affordable. Assistance and follow-up to those being released from institutions should span several years, since most people do not become homeless immediately upon leaving an institutions.
- ◆ Plan for foster care emancipation. Foster care youth are frequently emancipated with no plan of how or where to live and with no support network of family and community upon which to rely. In some areas of the country as many as 60% of homeless people have a foster care history. Programs that help foster youth find a firm footing can prevent their future homelessness.
- ◆ Those most likely to become homeless are those who have been homeless before. Track and provide follow-up services to formerly homeless families and individuals, including those exiting transitional programs and shelters. This can effectively prevent homelessness.
- ◆ Cities receive the preponderance of attention when it comes to homelessness, but rural and small town homelessness is equally devastating and is exacerbated by the lack of available housing and services. Target stabilization efforts not only to farming areas, but also to small towns that lose light manufacturing, mining, food processing or other industries.
- ◆ Tenant education is an important stabilization tool. Well informed tenants with clearly defined legal right are less likely to find themselves fighting illegal evictions by their landlords.
- ◆ Stabilize buildings and even whole neighborhoods with incentive programs that encourage landlords to keep rents low. States and localities could grant tax credits in the amount of foregone rent increases, for example.

Intervention

A final type of program -- emergency interventions -- signals the failure of the infrastructure and stabilization programs to keep people from the brink of homelessness. Although it is emergency intervention programs such as rent assistance and landlord/tenant

mediation, that are most often identified as homelessness prevention programs, it is the conviction of many that these are largely band-aid efforts with little long term impact for most clients. They are most effective as a part of a more comprehensive prevention effort.

Nevertheless, intervention programs are important and the two major issues surrounding them are: 1) targeting -- would those people helped, no matter how needy, have become homeless without program assistance; and 2) follow-up and evaluation -- is the assistance effective in preventing homelessness in the long term?

In a world of unlimited resources, everyone who claimed public assistance could receive it and no thought would be given to how effectively one program performed compared to another. Needless to say, we do not live in such a world, but in one of scarce resources in which assistance is targeted to those most in need, and in which different methods of delivering assistance must compete with each other. Therefore, homelessness prevention programs must not only target accurately, but be proven effective in order to compete for funds with prevention and a myriad of other programs.

Homelessness prevention can never be perfectly targeted because it can never be known if someone would have become homeless without assistance. But an effort can be made to screen possible clients based on the characteristics of those most at risk, as described above. Clients for intervention programs should be:

- 1) very poor and with effectively no assets;
- 2) at immediate risk of losing their homes; and
- 3) without access to alternative housing.

People who meet these criteria and who, in addition, have personal problems or histories of

homelessness, institutionalization or illness, can be further prioritized. Without such screening, a program may call itself homelessness prevention and may in fact do great good for deserving people, but its impact on homelessness will be negligible.

The next question is whether the program prevents homelessness or merely postpones it. Rental assistance, for example, in the absence of case management, job training and other forms of assistance may simply postpone homelessness for those who require a greater degree of help. While postponing homelessness may be beneficial from social, human and economic standpoints, prevention is obviously the greater good. In order to evaluate a prevention program's effectiveness there is a building consensus that long term follow-up contact with clients is necessary. Programs must be planned based upon what is known will end homelessness for individuals.

Following are recommendations pertaining to intervention strategies.

- ◆ While families are the most frequent target of intervention programs, single adults are more likely to become homeless. Intervention efforts should not fail to target this population.
- ◆ To maximize their impact, intervention efforts should be well coordinated with other housing and service programs so that they can link their clients to all needed sources of assistance.
- ◆ Administer intervention programs through existing community multi-service organizations. They can leverage additional public and private resources to assist clients, and provide on-going assistance in the community.
- ◆ Public and private nonprofit agencies should work to coordinate their efforts in regard to homelessness prevention.
- ◆ Introduce a free-standing federal homelessness prevention program that gives localities flexibility in designing and implementing prevention programs. Part of this program might be a revolving loan fund and/or grant program for emergency rent assistance.

- ◆ While revolving loan funds are attractive, the people who receive prevention assistance are so poor and hard to keep track of, and the loan amounts so small, that it is often impractical to expect or obtain repayment. An alternative is a program that provides loans for higher income people and grants for lower income people.
- ◆ Ensure adequate due process for people being evicted from public housing. Mistakes are often made due to bureaucratic bungling of changing income/rent amounts (rent in public housing is based on income -- people are often evicted for nonpayment of rent that should have been reduced due to income loss).
- ◆ Eviction assistance should also be offered to those not living in their own apartment, but doubled up with family or friends. When forced to leave they, too, need deposit and rent funds.
- ◆ Link people being evicted for non-payment of rent with social service agencies that can provide immediate assistance. This can be done automatically by the courts, or nonprofits can take the responsibility to contact people immediately upon their eviction (including setting up offices in the courthouse).
- ◆ Make certain that there are strong laws of due process for eviction to minimize illegal evictions.
- ◆ Encourage more pro bono legal assistance in cases that would result in homelessness by giving lawyers who work on such cases a tax credit worth 50% of their fee.
- ◆ Look at real effectiveness when analyzing cost benefit. Legal aid may look like a bargain compared to case managed comprehensive care. But if it does not address underlying problems that may lead to repeat emergency episodes, the apparent "savings" may not be real.
- ◆ Design intervention programs so that they include money for follow-up and evaluation.

The Politics of Prevention

The comprehensive homelessness prevention effort described above is clearly an expensive one, addressing in effect a system of support for the very poorest Americans. It is based upon the conviction that as a nation we must become pro-active in dealing with this devastating problem. It is put forth under the premise that the investment of new monies in a comprehensive prevention program at the local, state and federal levels will yield economic, as well as human, savings in the long term. (Evaluation of intervention programs such as legal aid and rent assistance show a savings of up to \$5 for every \$1 spent on prevention.) In order to make the most of our nation's precious human resources, we must invest in such comprehensive prevention efforts.

There are, however, pressing political tasks involved in the establishment and operation of prevention programs. Every prevention program, from a comprehensive prevention infrastructure to a small emergency rent assistance program, must seek community and funding support. With the exception of individual programs operated by nonprofit organizations, prevention programs are designed at the local, state or federal level. Most must, therefore, receive design and funding approval from city councils or county governments, state legislatures or the U.S. Congress. They are then administered by public administrative departments and operated by these same departments or by nonprofits. All of these bodies must be persuaded of the effectiveness of prevention, including targeting, evaluation and coordination. The following recommendations address these concerns.

Nonprofits

- ◆ In the current political climate, programs that assist working people and the middle class are more attractive than those that assist the very poor. Despite this political reality, it is not generally recommended that homeless prevention programs reduce eligibility criteria to attract such clients and thus become more palatable to lawmakers.
- ◆ Create model homelessness prevention legislation and submit it to the state legislature.
- ◆ Learn how to impact the federal, state and local administrative and regulatory processes in order to improve the prevention aspects of existing laws, regulations and programs.
- ◆ Educate and lobby administrative branches of government as well as the legislative branches. This ranges from presidents, governors and mayors to relevant political appointees and career bureaucrats. Administrative and legislative staff members are another influential group to contact.
- ◆ Programs that can demonstrate cost savings are attractive to budget offices; but sometimes legislatures are more affected by the advocacy community. Both strategies are needed.
- ◆ As potentially homeless people are not a well organized constituency for prevention programs, program operators and advocates must fill this advocacy role.
- ◆ Nonprofit organizations and advocates of prevention programs should involve themselves in the development of state and local Comprehensive Housing Assistance Strategies (CHAS) to ensure that the underlying causes of homelessness and prevention solutions are adequately addressed.
- ◆ Create homelessness prevention coalitions made up of interested organizations and agencies such as those working on homelessness, poverty, housing, etc. You may want to include government agencies such as state and local departments of social services.
- ◆ Network with prevention organizations and coalitions in other fields (e.g., groups trying to prevent juvenile crime, family dissolution, domestic violence, etc.) to learn about how to assess prevention benefits, to consolidate prevention data, and to create broader prevention strategies.

- ◆ The private sector can be a partner in prevention efforts. Extend coalition work to foundations, corporations and the like.
- ◆ Service organizations should coordinate on two levels: first, on a service level with other organizations to improve their delivery and work better with public agencies; and second on an advocacy level to press for more prevention programs.

Public Agencies

- ◆ Where no prevention strategy exists, the following steps can be taken to initiate one.
 - inventory available resources that contribute to infrastructure, stabilization and intervention;
 - identify inadequacies and gaps;
 - strengthen existing resources;
 - design programs to fill gaps; and
 - provide case management to ensure maximum utilization of all prevention resources.
- ◆ Government and public agencies can improve coordination with nonprofits and among nonprofits by requiring such coordination and cooperation as a condition of funding. Additionally, they can stimulate the formation of such coalitions with grants.
- ◆ States and localities should have homeless coordinators to collect data and coordinate prevention and assistance efforts.
- ◆ Those seeking to establish support for a prevention program are advised to give homelessness a face. Show who a prevention program would help. Show the damage homelessness does to people. Present real examples of the savings that prevention can entail.
- ◆ Use homelessness prevention as a tool to persuade the general public that something can actually be done to end homelessness.

Conclusion

Homelessness is a tragic and complex problem, and yet it is not insoluble. Its solutions cannot be effective, however, unless we can break into the cycle of homelessness and stabilize the size of the homeless population. This can be done with prevention programs.

If we are to stop the growth of the homeless population and begin to reduce it, we must be rigorous in how we address prevention. We must target assistance to those most likely to become homeless without it. We must test program effectiveness -- short and long term. We must assess program cost and choose to implement only those efforts which serve us -- and those on the brink of homelessness -- best. If we fail to do these things, we may still do good for many people, but we will not begin to end to homelessness in this nation.

APPENDIX I

For more information on prevention:

"Toward a Comprehensive Homelessness Prevention Strategy," Housing Policy Debate, Vol 2, No. 3, pp. 957-1025 (1991) can be obtained free from Fannie Mae by calling 202/752-7000.

The American Affordable Housing Institute's report, Preventing Homelessness: A Study of State and Local Homelessness Prevention Programs can be obtained by contacting the Institute at P.O. Box 118, New Brunswick, NJ 08903, 908-932-6812.

APPENDIX II

PREVENTION PROGRAMS

The following are primarily intervention programs

COUNSELING

Chicanos Por La Causa
1525 North Oracle
Tucson, AZ 85705
(508) 226-5722

Northbay Single Parents for Independence
P.O. Box 466
Novato, CA 94948
(303) 296-6686

CO Housing Assistance Corporation
Foreclosure Prevention Program
938 Bannock, Rm 300
Denver, CO 80204
(303) 572-9445

Neighbor to Neighbor
424 Pine Street, #102
Fort Collins, CO 08524
(303) 484-7498

Dekalb/Fulton Housing Counseling Center
42 Spring Street, S.W.
Atlanta, GA 30303
(904) 726-2611

Housing Services Program
MA Executive Office of Communities and
Development
100 Cambridge Street, Room 1103
Boston, MA 02202
(202) 232-6748

Somerville Community Corporation
1 Sumner Street
Somerville, MA 02143
(617) 367-695

Consumer Credit Counseling Service of
Delaware Valley
1211 Chestnut Street, Suite 411
Philadelphia, PA 19107
(212) 533-2541

RENTAL ASSISTANCE

Division of Health and Social Services
Division of Public Assistance
Rental Assistance
PO Box 24029
Anchorage, AK 99524
(602) 229-2736

Shelter, Inc.
Rental Deposit Guarantee Program
1070 Concord Avenue, #200
Concord, CA 94520
(415) 827-3598

Dept. of Social Services, Office of Children
and Community Agencies
Homeless Family Case Management and
Eviction Prevention Services
1000 So. Main Street, Suite 108
Salinas, CA 93901
(408) 755-4710

Office on Homelessness
Housing Crisis
1070 Concord Ave. Suite 270
Concord, CA 94520
(415) 827-3598

Department of Housing and Community
Development
Emergency Shelter Program
630 I Street
Sacramento, CA 95814
(916) 327-3652

Sacramento Housing
and Redevelopment Agency
Tenant Relocation
630 I Street
Sacramento, CA 95814
(916) 440-1327

Department of Social Services
Emergency Assistance under AFDC
744 P Street, Room 1650
MS 16-31
Sacramento, CA 95814
(916) 322-5330

Eden Council for Hope and Opportunity
Regional Rental Assistance Program
770 A Street
Hayward, CA 94541
(415) 581-9380

CO Affordable Housing Partnership
CO Rental Assistance and
Self Sufficiency Program
1981 Blake Street
Denver, CO 80202
(303) 297-2548

CO Department of Social Services
Homeless Prevention Activities Programs
1575 Sherman Street
Denver, CO 80203
(802) 241-2903

City and County of Denver
Department of Social Services
Eviction Prevention
2200 W. Alameda
Denver, CO 80223
(303) 937-2934

Catholic Community Services
Josephine Street
Denver, CO 80206
(303) 388-4435

House of Neighborly Services
Eviction Prevention
830 Bridge Street
Brighton, CO 80601
(303) 659-2316

Dept. of Human Resources
CT Eviction Prevention/Rent Bank Program
1049 Asylum Avenue
Hartford, CT 06105
(207) 623-2981

Action for Bridgeport Community
Development
1287 East Main Street
Bridgeport, CT 06608
(202) 624-7525

FL Department of Health
and Rehabilitative Services
Emergency Financial Assistance Program
for the Homeless
1317 Winewood Blvd.
Tallahassee, FL 32399
(202) 483-8412

Metropolitan Foundation
Metropolitan Emergency Assistance Fund
50 Hurt Plaza
Atlanta, GA 30303
(303) 866-5928

DeKalb Economic Opportunity Authority
3597 Covington Highway
Decatur, GA 30032
(215) 874-8451

The Christian Council of Metropolitan Atlanta
Arthur L. Montgomery Building
465 Boulevard, SE Ste 101
Atlanta, GA 30312
(313) 335-2462

Polk County Dept. of Social Services
Polk County General Relief Fund
City View Plaza
1200 University, Second Floor - Suite A
Des Moines, IA 50314
(207) 626-4600

Jefferson County Department
for Human Services
Family Assessment and Support Program
810 Barret Street
Louisville, KY 48204
(502) 625-6410

MA Department of Public Welfare
Housing Resources Division
MA Emergency Assistance
and Homeless Prevention
180 Tremont Street
Boston, MA 02111
(206) 329-4111

Relocation and Emergency Housing Services
Baltimore Rental Assistance Program
417 E. Fayette Street, Suite 356
Baltimore, MD 21202
(410) 962-2144

The Abell Foundation
Revolving Rental Loan Program
Fidelity Building
210 North Charles Street
Baltimore, MD 21201
(702) 687-4715

Department of Housing
and Community Development
Rental Allowance Program\Housing
Subsidy Programs
Community Development Administration
100 Community Place Peoples Resource
Center
Crownsville, MD 21032
(410) 514-7490

NJ Department of Community Affairs
NJ Homelessness Prevention Program
363 S. Broad and Front Streets
Trenton, NJ 08625
(206) 352-5268

OK Department of Commerce
House Bill 1566 Pilot Program
PO Box 26980
Oklahoma City, OK 7312
(202) 591-7211

DE Community Action Agency
Government Center
2nd & Orange Street
Media, PA 19063
(302) 891-5101

Philadelphia Urban Coalition
121 N. Broad Street, 6th Flr
Philadelphia, PA 19107
(608) 266-0073

RI Housing and Mortgage Finance Corporation
Emergency Housing Assistance Program
60 Eddy Street
Providence, RI 02903
(509) 765-9206

School of Community & Public Affairs
VA Commonwealth University
Homeless Intervention Program
919 W. Franklin Street
VA 23284
(404) 288-0923

VA Department of Housing
and Community Development
SHARE: VA Housing Partnership Share
Homeless Intervention Program
205 N. 4th Street
Richmond, VA 23219
(515) 682-8714

Portsmouth Area Resources Coalition Inc.
P.O. Box 1183
Portsmouth, VA 23705
(202) 332-8800

Emergency Assistance Office
P.O. Box 1183
Portsmouth, VA 23705
(804) 397-5208

VT Dept. of Social Welfare
Agency of Human Services
Emergency Assistance: Back Rent
or Mortgage Arrearage
103 S. Main Street
Waterbury, VT 05676
(212) 382-6629

Salvation Army
925 E. Pike Street
Seattle, WA 98012
(215) 563-5665

MORTGAGE ASSISTANCE

The Urban Housing Foundation Inc.
Comprehensive Housing Counseling
2416 Lake Street
Omaha, NE 68111
(402) 492-3100

PA Housing Finance Agency
Homeowner's Emergency Mortgage
Assistance Program
2101 North Front Street PO Box 15530
Harrisburg, PA 17105
(607) 776-4126

Housing Opportunities, Inc.
133 Seventh Street, PO Box 9
McKeesport, PA 15134
(717) 783-8391

MEDIATION

San Francisco Housing Consortium
Clearinghouse
Landlord-Tenant Mediation
25 Taylor Street
San Francisco, CA 94102
(415) 441-7713

Eviction Prevention and Mediation
CT Department of Human Resources
1049 Asylum Ave.
Hartford, CT 06105
(802) 241-2646

Community Mediations
126 Grand Avenue
New Haven, CT 06513
(303) 294-0241

LEGAL AID

The Western Center on Law and Poverty
2000 O Street Suite 230
Sacramento, CA 95814
(916) 442-0753

Legal Aid Foundations of Los Angeles
Eviction Defense Center
1550 West Eighth Street
Los Angeles, CA 90017
(213) 387-9038

American Bar Association
State and Local Bar Association
Homeless Programs
3535 West Sixth Street, Suite 100
Los Angeles, CA 90020
(213) 385-2977

San Francisco Bar Center
Volunteer Legal Services Program
685 Market Street Suite 700
San Francisco, CA 94105
(415) 382-2535

Washington Legal Clinic for the Homeless Inc.
1800 Massachusetts Avenue N.W. Sixth Floor
Washington, DC 20036
(502) 585-3556

Mandel Legal Aid Clinic
6020 S. University Avenue
Chicago, IL 60637
(503) 823-3200

Legal Services
145 State Street
Springfield, MA 01103
(413) 781-7814

Homeless Persons Representation Project
520 W. Fayette Street
Baltimore, MD 21201
(609) 633-6204

St. Louis University School of Law
3700 Lindell Blvd.
St. Louis, MO 63108
(202) 872-3589

Monroe County Legal Assistance Corporation
111 Westfall Rd.
Rochester, NY 14620
(617) 523-6400

Brooklyn Legal Services Corporation
105 Court Street
Brooklyn, NY 11201
(206) 513-0190

Brooklyn Legal Services Corporation
260 Broadway
Brooklyn, NY 11211
(301) 514-7490

Legal Action Center for the Homeless
220 East Fourth Street
New York, NY 10009
(203) 566-4369

MFY Legal Services, Inc.
41 Avenue A
New York, NY 10036
(301) 396-4253

The Legal Aid Society
15 Park Row, 22 Floor
New York, NY 10038
(609) 633-6303

Bronx Legal Services
579 Courtlandt Avenue
Bronx, NY 10451
(216) 574-9393

Queens Legal Services Corporation
8902 Sutphin Blvd.
Jamaica, NY 11435
(513) 879-5867

Onondaga County Department
of Social Services
Legal Services of Central New York, Inc.
421 Montgomery Street
Syracuse, NY 13202
(203) 566-4369

Ontario County Department of Social Services
Legal Assistance of the Finger Lakes
3871 County Road, #6
Canandaigua, NY 14425
(412) 281-2102

Orange County Department of Social Services
Mid-Hudson Legal Services, Inc.
Box Z, Quarry Road
Goshen, NY 10924
(412) 281-2102

Rensselaer County Department
of Social Services
Legal Aid Society of Northeastern NY
133 Bloominggrove Drive
Troy, NY 12180
(804) 786-7891

Seneca County Department of Social Services
Legal Assistance of the Finger Lakes
2226 County House Road
Waterloo, NY 13165
(302) 891-5101

Rockland County Department of Social
Services
Legal Aid Society of Rockland County
Building L
Sanatorium Road
Pomona, NY 10970
(215) 351-9551

Nassau/Suffolk Law Services Committee
Box 2000
11 Oval Drive
Hauppauge, NY 11788
(402) 444-7921

Low-Income Housing Development
University at Buffalo School of Law
Legal Assistance Program
507 John Lord O'Brien Hall, North Campus
Buffalo, NY 14260
(206) 684-8085

Evergreen Legal Services
401 Second Avenue South, Suite 401
Seattle, WA 98104
(206) 464-1422

FOSTER CARE & PRISON EMANCIPATION PLANNING

Foster Youth Connection
729 South Windsor Blvd. Apt. 1
Los Angeles, CA 90005
(213) 936-4009

Samaritan House
2301 Lawrence
Denver, CO 80203
(212) 568-9166

Safe Harbor/Salvation Army
2136 Champa
Denver, CO 80205
(303) 2295-3366

Dismas, Inc.
2400 Twenty-First Avenue South
Nashville, TN 37212
(615) 383-6393

Philadelphians
4531 Old Broadway
Knoxville, TN 37918
(615) 689-5833

MULTI-SERVICE PROGRAMS

AZ Emergency Services Delivery System
Emergency Services Network
Community Services Administration
AZ Department of Economic Security
1789 W. Jefferson
Phoenix, AZ 85005
(314) 771-2273

ARCH Family Services
4247 Martin Luther King Jr. Avenue S.E.
Washington, DC 20032
(202) 610-2957

St. Vincent De Paul, Inc.
26 Third Street, N.W.
Atlanta, GA 30303
(203) 566-8776

Metro Human Needs Alliance
P.O. Box 2377
Louisville, KY 40201
(617) 776-5931

MD Dept. of Housing
and Community Development
Homeowners Emergency Mortgage
Assistance Program
45 Calvert Street
Annapolis, MD 21401
(518) 473-1182

Housing Resource Center
2627 Ohio
St. Louis, MO 63118
(203) 787-9586

Northern Manhattan Improvement Corporation
549-559 W. 180th Street
New York, NY 10033
(609) 633-6202

Community Action Agency Delaware County
Community Energy Assistance Center
Government Center
2nd & Orange Streets
Media, PA 19063
(612) 297-2590

Central Area Motivation Program CAMP
722 18th Street
Seattle, WA 98122
(717) 780-3940

South King County Multi-Service Center
155 S. 356th Street
Federal Way, WA 98003
(617) 727-7004

The Multi Service Centers
of North and East King County
18220 96th Avenue
Bothell, WA 98011
(413) 584-4577

Martin Luther King Ecumenical Center
1424 Tacoma Avenue S. Suite A
Tacoma, WA 94802
(206) 393-784

Fremont Public Association
3601 Fremont Ave.
Seattle, WA 98103
(215) 563-5665

VA Homeless - VA.

Infrastructure Disposal

Parameters

- Establish a five year pilot, which expires September 30, 2005;
- Limit project to 30 disposals;
- Provide resources and transfer authority from the working reserve to cover administrative start-up costs in the FY 2000 budget; and
- Evaluate the pilot in the fifth year to assess goal achievement and effectiveness.

Distribution of Proceeds

- *90 percent to VA divided among the following:*
 - local VA medical center,
 - Veterans Integrated Service Network (VISN) to benefit veterans in the regional area, and
 - VA Capital Asset Revolving Fund to pay costs associated with future property sales.
- *10 percent to benefit the homeless-* Currently, homeless groups may obtain surplus Federal property at no cost under the Stewart B. McKinney Act. This pilot would direct property sale proceeds to HUD's Homeless Assistance Grant account for distribution to Continuum of Care grantees in the local area where the sale takes place. These funds would supplement the community's continuum of care for veteran-specific and general homeless population projects. The Interagency Council on the Homeless (including VA, HUD, GSA, and HHS) would issue guidance, reporting criteria, and ensure that veteran populations are served by the funds.

Disposal Process

- Thirty days prior to disposal, VA would notify OMB and GSA of a property sale and notify Congress if the sale exceeds the threshold for major construction projects (currently \$4 million).
- VA would conduct hearings to address local-area concerns associated with the disposal.
- VA would participate in GSA's government-wide property database management system and would have the option to pay for their expertise to facilitate property disposals.
- Federal agencies would have the first chance to pay fair market value for VA's excess property before it would go to the public for sale.
- If after thirty days, no federal agency elects to purchase the asset, VA would have the authority to sell, transfer, or exchange property to State, local, or private institutions for fair market value.

Goal: Pilot a change to the Property Act that gives government agencies an incentive to eliminate unnecessary infrastructure while supporting the intent of the Stewart B. McKinney Act.

Current Homeless Law:

Under Section 501 of the McKinney Act (42 U.S.C. sec 11411), (recently amended by section 2824 of the National Defense Authorization Act for FY 1993), the Interagency Council on the Homeless works with HUD and HHS in coordinating the conveyance of surplus properties at no cost to homeless assistance groups in local areas. One of the primary purposes of the McKinney Act is to coordinate public assistance to the homeless.

Recommendation:

- 10% of property sale proceeds would go to the Homeless Assistance Grants account in HUD for homeless populations.
- HUD would distribute funds to local Continuum of Care grantee.
- The local homeless assistance grantee would use the funds to supplement their awarded funding for the community's continuum of care plan, for veteran-specific and general homeless population projects.
- The Interagency Council on the Homeless (including VA, HUD, GSA, and HHS) would issue guidance, reporting criteria, and ensure that veteran populations are served by the funds.

12/1

Howard 53

TO: Paul Weinstein
Lyntina Rice
Mary Smith
Rose Cerda
Chris Jennings

FROM: Andrea Kane

Here are ^{unofficial} excerpts from HUD pressback
on issues you may be interested in.
I've attached table of contents if there are other
items you want to see.

Cliff G.
Nathan

FOR INTERNAL
USE ONLY

Department of Housing and Urban Development
FY 2000 Budget Passback
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CC: Marc Smith

Department of Housing and Urban Development

FY 2000 Passback

Homeless Assistance Grants

Budget Authority
(dollars in millions)

	FY 1998 <u>Actual</u>	FY 1999 <u>Enacted</u>	FY 2000 <u>Request</u>	FY 2000 <u>Passback</u>
Homeless Assistance Grants	823	975	1,439	1,020

Policy Guidance

- Provides at \$1.020 billion: \$975 million in emergency shelter and competitive grants (same as 1999), and a \$45 million increase for a demonstration of new ways to help the homeless with housing linked to mainstream services.
- The FY 2000 Budget would build on the success of HUD's continuum of care strategy to close gaps in assistance and permit communities flexibility to design their own solutions. A large percentage of HUD's funding has gone to supportive services: 55 percent of the 1997 awards, while only 18 percent went to permanent housing. The concerns of interest groups and many in Congress that HUD's assistance should focus more on permanent housing is evidenced by 1999 enactment of a requirement that 30 percent of funds go to permanent housing.

HUD is the primary provider of permanent housing to reduce homelessness. To the extent that homeless persons are eligible for mainstream program but are not connecting with those programs, this needs to be corrected. To the extent cost shifting takes place from the mainstream programs to HUD homeless assistance program for supportive service funding, funding for permanent housing is decreased.

The Passback includes \$45 million in FY 2000 for a demonstration project to be developed by HUD in conjunction with HHS and other agencies that provide mainstream services for the homeless.

Additional Passback Guidance:

- The FY 2000 Budget should continue the requirement that no less than 30 percent of Homeless Assistance Grants go to permanent housing.
 - Continue the 1999 provision requiring that funding for services be matched by 25 percent in grantee funding.
 - The Interagency Council on the Homeless is to provide OMB with a paper evaluating the feasibility and impact of HUD and HHS issuing a joint NOFA (Notice of Funding Availability).
 - HUD is asked to provide further analysis of how best to make local and State programs accountable to clients, funders, and the public, including recommendations for additional performance measures corresponding to the long-term goals of the program.
 - The technical assistance language is to be clarified to include tracking systems.
 - The budget model for this program has been improved to more accurately estimate outlays.
- Performance Measure. The first two outcome indicators cited in the revised Annual Performance Plan measure increases from 1998 to 1999, but text does not mention why the indicators do not increase from 1999 to 2000. The last two indicators do measure the increase between 1999 to 2000. All indicators should be addressing performance levels in 2000. Add a performance measure for average length of homelessness.
- If the Department chooses to appeal the number and/or policy guidance for this account, then the following information must be provided, at a minimum, to allow proper evaluation of the appeal:
- offset within HUD to fund any increase above passback level; and,
 - documentation of the effects of alternative funding level or uses in achieving the program's goals.



Interagency Council on the Homeless

Handwritten notes:
125-
What's
K...?
K...
Homeless

FAX COVER SHEET

DATE 11-18-98

NUMBER OF PAGES (INCLUDING COVER) 3

MATERIAL SENT TO: Mary Smith

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Interagency Council on the Homeless

November 18, 1998

MEMORANDUM FOR: NSHAPC CONTACTS (See List Below)
FROM: GEORGE FERGUSON
SUBJECT: NEXT STEPS AND KEY DATES IN THE REVIEW PROCESS OF THE DRAFT NSHAPC REPORT

Thank you for your comments on the draft consolidated report that we sent you before the last meeting of the NSHAPC working group on October 5. Marti Burt is now revising the draft to address the group's comments and concerns, including distinguishing more clearly the findings on the currently homeless from those of the "formerly" and "never" homeless.

Marti has promised to send us a new, complete draft for review by Tuesday, November 24. We will make it available to the full working group as soon as we receive it, with comments due by Monday, December 7. The working group will meet on Thursday, December 10 to develop a consolidated set of comments to send to Marti. Marti will then make necessary revisions and send it simultaneously to us and the panel of experts on or about Monday, December 21. The working group would then meet with Marti and the expert panel on Wednesday, January 13. The schedule after that depends on the extent of revisions needed after this meeting. Our goal is to complete the necessary clearances and issue the report by the end of March.

This is an ambitious schedule given the amount of material to review. Because the full report is so voluminous and because we need to maintain tight control on the number of copies in circulation, we ask, as before, that you affirm your interest in obtaining a copy of the next draft that will be available for delivery to you on or about November 25. Please call me (202/708-1480, ext. 4517) or send me an e-mail note (george_a_ferguson@hud.gov) if you would like to receive a copy, and I will send it to you at the address you indicate as soon as it is available.

This will be your only opportunity to provide input at this important stage of the survey. We received very few comments on the "program" chapters of the previous draft of the report distributed in September. Please be sure to review that section of the report if you have not done so already.

ADDRESSEES:

USDA/FNS Kate Hine
Gary Bickel
USDA/RECD John Pentecost
Amy Donoghue
Census Annetta Clark Smith
Steve Tourkin
Education Pat McKee/Shawn Mussington
Joanne Wiggins
David Cleary
Robin Bouckris
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