House Committee on Veterans Affairs
Subcommittees on Health and Economic Opportunity
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Testimony by Stephen Peck, President/CEO U.S.VETS

Good morning. My name is Stephen Peck and I'm the President and CEO of U.S.VETS. I'm also a Vietnam veteran. I served with the First Marine Division near Danang in '69-'70, and I've been working for homeless veterans since 1991. U.S.VETS has been in the fight against veterans' homelessness since 1993 when we started our first program in Inglewood, California. Since then we have grown into the largest veteran-specific non-profit housing and service provider in the country, providing housing and services to 3300 veterans every night, and providing homelessness prevention, employment, and mental health services to an additional 5,000 veterans annually in the communities we serve.

I'm also the president of the California Association of Veteran Service Agencies, seven veteran non-profits that collectively provide housing and care to more than 25,000 veterans each year from Eureka to San Diego.

Despite hundreds of millions of dollars spent, numerous government policies, and the best efforts of hundreds of communities, there are still more than 40,000 veterans living on our streets – and the number is rising across the nation. In California, which has 25% of the nation's homeless veterans, the number of homeless veterans has risen nearly 20% this past year, and in Los Angeles, the number rose 57%! This is no time to be taking our eye off the ball.

The five-year "Getting to Zero" effort, launched by the Obama Administration in 2009, was always an aspirational political goal. Federal estimates say the number of homeless veterans dropped by more than half from 2010 to 2016, a significant accomplishment. But faced with an intractable homeless veteran population that refused to drop further, the administration moved the goalposts.

"Functional Zero" was the new goal, a complicated formula that basically said that if there were enough homeless beds in each community to house every veteran who wanted (and asked) to get off the street, then the goal was achieved. But it has been difficult for communities to achieve even this reduced goal because the number of veterans falling into homelessness every month, is outstripping communities' efforts to keep up.

Because that five-year effort was not completely successful, there is a sense that the government is moving on to other problems. There is no longer an emphasis and determination to get every veteran off the streets. This shift in focus is evident in two ways:

First: The proposal by the VA to take permanent housing supportive service dollars out of the special projects category, where is it protected, and placing these dollars into the general fund, where medical directors can redirect it at will. While they have said that they will not shift these dollars, the VASH funds remain in the general fund line item.

And second: VA's overall management of the HUD-VASH program. It is plagued by lack of accountability, insufficient data collection, and inadequate outcome measures.

Together, these two factors represent a direct attack on our ability to get veterans off the street and into permanent housing, and provide the case management and supportive services that will keep them there.

We are talking about a population that is extremely vulnerable. Study after study confirms this and I have included references in my written testimony. 37% of HUD-VASH participants have mental or behavioral health issues, including PTSD, depression, psychoses and substance abuse. Other issues include situational factors such as unemployment and the breakup of relationships, social isolation, and a lifetime of poverty and adverse events. All of these factors, coupled with their homelessness, make these veterans much more vulnerable to suicide, which I will talk about in a minute.

These factors confirm our belief that the support services provided along with the permanent housing in the HUD VASH program are essential to its success.

The Housing First model that the VA professes to follow requires a client/case manager ratio of 25 to 1. Additionally, it requires access to assistance, with a simple phone call, 24 hours a day.

That is not what's happening.

We have project based VASH beds at 5 of our sites and our clinical directors report that VA social workers are, at best, providing minimal coverage. 75 VASH vouchers require 3 full-time case managers in the Housing First model – we never have three, rarely have two, and our clinical staff picks up the slack. This is true of many communities across the country.

I've attached 3 letters to my written testimony from three different communities that have been awarded HUD Vouchers, Kern County and San Francisco, CA, and Miami, Florida (Attachments 1,2,3). In each case, the VA is indicating that it does not have the resources to provide adequate case management coverage for the number of HUD vouchers awarded. The result is many of the vouchers go unused, while veterans languish on the streets.

If I understand correctly, funding that congress has appropriated to the VA, specifically for VASH case management positions, is for some reason not available

Vulnerable veterans still living on our streets need every dollar of this funding. If the VASH program were turned into a grant program, experienced veteran non-profits would assume full responsibility, would spend every dollar appropriately, and could be held to outcome measures

that we are already used to assuming. Because our programs are residential, we have staff 24/7 and are used to responding to client issues day and night. We provide case management for 423 beds of permanent supportive housing with a 92% retention rate. By contrast, a recent Inspector General Study reports a 70% success rate of the HUD-VASH program. This study also states that the reason the vast majority of those veterans exited the program was unknown "as HUD's systems do not have the capacity to track this information."

If a non-profit provided that level of coverage while contracted with the VA, we would lose the contract.

I have heard various reasons why the HUD VASH money is being put into the General Fund category. One of them is so that Medical Directors are free, if necessary, to redirect funds to one of the Secretary's 5 main priorities, one of which is suicide prevention. Let me give you some statistics:

An estimated 9.3 million adults (3.9% of the adult U.S. population) reported having suicidal thoughts in the past year. This compares to 12.1%-18% of the homeless veteran population who have had suicidal thoughts in the past 30 days.

A study by the VA National Center on Homelessness Among Veterans stated that the rate of suicide attempts among homeless veterans was 20 times higher than the rate of suicide attempts among all veterans.

So I think it's safe to say that the effort to end homelessness among veterans is part of that suicide prevention effort. It is part of that effort not just because these veterans have been housed, but because they are supposed to be provided knowledgeable, compassionate case management on a regular basis which gives veterans the skills and reliable support that will fend off the despair that threatens to overcome their will to live.

We all have been at this for a long time and you might ask what is your return on investment – you've put a lot of money into this and still haven't solved the problem. My 25 years of experience in helping homeless veterans tells me that if you pull back now, the number of homeless veterans on the street will continue to grow, and those veterans, in their desperation, will fall back on the only services available to them, which are the very expensive emergency mental health and medical services that are available in communities. They will spend time in jail, they will use emergency homeless shelters – and they will continue to die, having been abandoned by the country they fought for.

Solving homelessness is not a one-time fix, it is an ongoing effort to mitigate the inequality that exists in our system for veterans, who through lack of opportunity, lack of education, mental illness, combat trauma, or other deficits, end up on the margins of society. We are paying for this tragedy one way or another so we simply have to make the decision that these veterans' lives are worth saving.

References

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