National Alliance to
End Homelessness

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CAN HUD-VASH HELP END VETERANS' HOMELESSNESS?
WHAT WE HAVE LEARNED AND RECOMMENDATIONS FOR THE FUTURE

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SUMMARY: President Obama and Secretary Shinseki have committed this Administration to ending homelessness for veterans within five years. In the larger homelessness community, similar goals – in a resource-constrained world – are accomplished by carefully targeting resources based on individual needs. Evidence and our experience confirm that permanent supportive housing models, such as HUD-VASH – while perhaps capable of ending homelessness for all – vastly oversupply resources to a population that largely does not need them. The most effective programs target resource-rich interventions, such as HUD-VASH, to chronically homeless individuals. Therefore, HUD-VASH reform should proceed along two distinct lines:

- VA should ensure that HUD-VASH is closely targeted to chronically homeless veterans. Reform of this nature will require Congressional support, as well as explicit targets.
- VA should effect administrative improvements, identified during the initial round of vouchers, which will improve performance. These reforms include efforts to lower client-to-case manager ratios, as well as hiring and training procedures.

Reform of HUD-VASH is a down payment on the Administration's promise without which VA cannot end veteran's homelessness within five years.

EFFECTIVELY TARGETING RESOURCES TO NEEDS: HOW TO TARGET HUD-VASH

Best practice would suggest that HUD-VASH be tightly targeted to chronically homeless veterans, but experience has demonstrated decreased targeting in practice. If HUD-VASH is to be an effective part of a strategy to end homelessness among veterans, VA and Congress will have to explicitly – and deliberately – target HUD-VASH.

A. Congress has opened HUD-VASH to all veterans, regardless of impairments.

B. In Explanatory Notes, the Appropriations Committee has requested that HUD-VASH vouchers "be made available to all homeless veterans, including recently returning veterans."[i]

C. Current VA policy, while supportive of the expectation that *most* HUD-VASH users will be chronically homeless, contains latitude for local medical centers to employ HUD-VASH for other populations.

D. Our research has suggested that – often under extenuating circumstances – medical centers have awarded vouchers to veterans and their families for whom short or long term rental assistance would suffice.

E. *Medical centers often use HUD-VASH to assist those with less acute needs due to a lack of other options.*

RECOMMENDATIONS:

Targeting 1: **Committee and Congressional language should explicitly state that at least 85 percent of HUD-VASH vouchers will be used to assist *chronically homeless* veterans.** Additional legislation should clarify interventions targeted to prevention and transitional housing *and resource them for success.*

Targeting 2: To meet a five year goal to end homelessness, the Secretary and Congress should explicitly commit the VA to annual reductions of 20 percent in the population of chronically homeless veterans. Targets should address population effects and not program outputs.

IMPROVING HUD-VASH ADMINISTRATION: IMPROVING STAFFING

The first round of vouchers revealed weaknesses in client-to-case manager ratios, as well as staffing experience, which imperil the effectiveness of HUD-VASH for chronically homeless veterans.

A. HUD-VASH client-to-case manager ratios, as established by regulation, are currently set at 35:1. In the larger community, ratios of 15:1 or 10:1 for chronically homeless clients are standard practice.

B. Given the array of additional VA resources, HUD-VASH likely does not require ratios of 15:1 or 10:1. However, our investigation has revealed universal agreement that 35:1 is too high.

C. Case managers hired in the initial round of HUD-VASH often came with little training in housing search procedures. These limitations delayed lease-up for veterans in the program.

D. In the rush to introduce HUD-VASH, VA internal deadlines – often falling due shortly after hire – created incentives to assign vouchers to the first available veteran instead of targeting them to the chronically homeless.

RECOMMENDATIONS:

Staffing 1: Congress should appropriate additional funds to decrease client-to-case manager ratios, as identified by need, and commission the new *National Center on Homelessness Among Veterans* to study appropriate ratios and strategies to extend the reach of each case manager. Additional VA resources and outside models such as ACT Teams may reveal ratio expansion strategies.

Staffing 2: VA should provide existing and future staff with housing search training. This training is likely best administered by outside organizations. As requested by VA, contracting may be appropriate.

Staffing 3: VA should evaluate the process of voucher assignment and determine bottlenecks which incentivize staff to inefficiently target vouchers. Our experience indicates that to the extent VA builds on current capacity with future vouchers, HUD-VASH programs should develop a "pipeline" of clients appropriate for future vouchers.

IMPROVING HUD-VASH ADMINISTRATION: IMPROVING CAPACITY

HUD-VASH has experienced delays in lease-up due to inadequate resources and individual micro-problems encountered in local VA Medical Centers. Reform should address resource shortcomings and enable improved communication.

A. For homeless veterans granted a voucher, expenses for deposits, furniture and transition, and numerous other costs are oft-reported obstacles to HUD-VASH success. No monies for these expenses currently exist.

B. HUD-VASH program structure is inherently decentralized. Problems encountered, as well as solutions identified, will necessarily be as diverse as the communities in which VA is involved.

RECOMMENDATIONS:

Capacity 1: VA should identify monies to provide case managers with flexible funding to meet program needs. In the short term, the Homelessness Prevention and Rapid Re-Housing Program (HPRP), funded by the American Reinvestment and Recovery Act, could provide case managers with such funding. VA staff should immediately coordinate HPRP resources; perhaps by expanding partnerships with community based organizations.

Capacity 2: National VA staff should continue to fund and encourage interaction amongst local HUD-VASH staff to share best practices and successful strategies. Staffing at the national level should be increased to aid the identification and communication of multiple best practices. Efforts to encourage staff to interact, such as through conferences or a blog, should be employed along with increased staff to encourage the dissemination of solutions.

[i] HUD-VASH began as an interdepartmental Memorandum of Understanding between HUD and VA. Subsequent legislative action removed the limitations on veterans. VA published its guidelines for HUD-VASH in the Federal Register on May 8, 2008. These refer to the Explanatory Note for the 2008 Appropriations Act and can be found online at http://edocket.access.gpo.gov/2008/pdf/08-1220.pdf