REPORT:

Human Resources Administration-
CUNY Sustaining Veterans’ Success Initiative

A Formative Evaluation

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Executive Summary

The HRA-CUNY Sustaining Veterans’ Success Program (the program) was launched in December 2015 by the City University of New York (CUNY), HELP USA, and the Human Resources Administration (HRA) as part of the de Blasio administration’s commitment to end veteran homelessness in New York City. The program provides 120 permanent supportive housing units to homeless veterans and low-income community members, in addition to voluntary on-site services such as case management, benefits coordination, counseling and clinical support, education, and employment advisement.

In collaboration with the CUNY Office of Continuing Education and Workforce Programs (CEWP), the Office of Research, Evaluation, and Program Support (REPS) conducted a formative evaluation of the program that consisted of a literature review and a site staff focus group (n=6). This report is structured to address five questions:

1) What is the existing research on homeless veterans? What are the unique health, education, and employment challenges of homeless veterans?
2) What is the research on supportive housing programs for homeless veterans?
3) How is long-term success defined for homeless veterans? What can we expect regarding outcomes for homeless veterans?
4) What are the education and employment benchmarks for homeless veterans in the research literature?
5) What are the barriers to the uptake of supportive services in the program?

A review of the literature revealed that homeless veterans experience substantial problems with physical and mental health, substance abuse, and employment. Although most housing programs that serve homeless veterans focus on self-sufficiency and social integration, evidence on the effectiveness of permanent supportive housing is only moderate. The literature revealed no research evidence to inform benchmarks for employment or education. Lastly, the site staff focus group noted that the two tenant populations in the program face unique but substantial challenges to engaging in services and achieving intended employment and education outcomes.

Four key implications for the program emerged from this formative evaluation:

1) There is little research evidence to guide education and employment services in permanent housing programs for homeless veterans.
2) Despite efforts to offer a range of services by well-trained staff, services do not match staff-identified tenant needs.
3) Tenant engagement in the array of voluntary services offered in the program is likely to remain a challenge despite staff efforts.
4) Given the challenges facing tenants, participating in higher education is likely out of reach for most tenants.
Introduction

In 2009, the Obama administration initiated a national effort to eliminate veteran homelessness in the United States. Five years later, in June 2014, Michelle Obama announced the Mayors Challenge to End Veteran Homelessness to engage mayors and local leaders and to reinforce the goal of ending veteran homelessness. While these efforts contributed to a 47% decrease in the number of homeless veterans between 2009 and 2016, the issue of veteran homelessness remains unresolved. According to a nationwide point-in-time count conducted by the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Veterans Affairs (VA), an estimated 39,471 veterans were homeless in January 2016, and approximately one-third of them were unsheltered (U.S. Department of Housing and Urban Development, 2016). The same count found that an estimated 1,248 veterans in New York were homeless, 7% of whom were unsheltered.

The HRA-CUNY Sustaining Veterans’ Success Program (hereafter the program) was launched in December 2015 as a partnership between the City University of New York (CUNY), HELP USA,¹ and the Human Resources Administration (HRA) as part of the de Blasio administration’s commitment to end veteran homelessness in New York City. The program places homeless veterans and low-income community members² in 120 affordable housing units and offers voluntary on-site wraparound services such as case management, benefits coordination, counseling, and clinical support. Access to comprehensive education and employment services such as job training and placement is offered by CUNY’s Office of Continuing Education and Workforce Programs (CEWP) and clinical support is provided by HELP USA. As of May 2017, 118 units in the apartments were filled, two-thirds by veterans and the remaining one-third by low-income community members.

In collaboration with CEWP, the Office of Research, Evaluation, and Program Support (REPS) conducted a formative evaluation of the program that consisted of a literature review and a site staff focus group (n=6). The purpose of this formative evaluation was to examine five questions:

1) What is the existing research on homeless veterans? What are the unique health, education, and employment challenges of homeless veterans?
2) What is the research on supportive housing programs for homeless veterans?
3) How is long-term success defined for homeless veterans? What can we expect regarding outcomes for homeless veterans?
4) What are the education and employment benchmarks for homeless veterans in the research literature?
5) What are the barriers to the uptake of supportive services in the program?

This report summarizes findings from the literature review, provides an overview of focus-group methods and key insights, and concludes with four key implications for the program.

¹ HELP USA provides housing and supportive services for the homeless and others in need in New Jersey, New York, Pennsylvania, Nevada, and Washington, DC.
² In a departure from the original program objective to serve only homeless veterans, 40 housing units were assigned to low-income community members who were already residing in Hollis, Queens.
Overview of the Program Model

As proposed by the initial HRA-CUNY housing program contract, the objectives of the program were to:

- identify 100 – 120 homeless veterans who were not receiving Supplemental Security Income (SSI) and, subsequently, were good candidates for training, education, and employment opportunities;
- place them in affordable housing units in which they would be responsible for paying up to 30% of their income toward rent;
- offer the opportunity to receive case management services, clinical services, and participate in high-quality education and workforce development initiatives provided by CUNY; and
- ensure that by the fifth year in the program, veterans would be able to sustain their housing without a housing voucher or rent subsidy, integrate into the labor market, and become more economically stable through participation in the voluntary education and job training opportunities.

Key program components include voluntary case management and clinical services provided by two full-time licensed HELP USA clinicians, education and training opportunities provided by the CUNY Education Specialist, job training and employment assistance provided by the CUNY Employment Specialist, benefits coordination provided by the HELP USA Benefits Coordinator, and health services provided by the part-time nurse.

Finding 1. The literature on homeless veterans documents substantial problems with physical and mental health, substance abuse, and employment.

Homeless veterans are a uniquely vulnerable population that experiences a complex combination of challenges. Risk factors for veteran homelessness, which rarely occur in isolation, include mental illness, chronic mental health conditions associated with combat exposure, alcohol and substance abuse, low social support, and structural factors such as unemployment rates and stagnant wages (Tsai, Mares, & Rosenheck, 2012).

Prevalence and Demographic Characteristics

Homeless individuals, as defined by the McKinney-Vento Homeless Assistance Act of 1987, are people who lack “fixed, regular, and adequate nighttime residence,” people whose primary nighttime residence is a “public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground,” or people who live in publicly or privately operated shelters designated to provide temporary housing.

Veterans are at an increased risk of becoming homeless compared to non-veterans and, as a result, are overrepresented in the homeless population (Tsai & Rosenheck, 2015). One study reported the rate of homelessness among veterans is approximately double the rate of homelessness among non-veterans (Chinman, Hannah, & McCarthy, 2012). Older veterans are most vulnerable to becoming homeless: More than half of all veterans in the United States are over the age of 62, and veterans in the 45-54 age group are at the greatest risk of becoming homeless (Fargo et al., 2012).
Nationally, the number of homeless veterans has decreased in the past six years. Data from a January 2016 count included 39,471 homeless veterans, reflecting a 47% decrease since 2010. Although the number of homeless veterans increased in some states during this period, New York posted one of the largest decreases (79%), representing 4,631 fewer homeless veterans. In terms of demographic composition, a large majority of homeless veterans were male (91.1%). Consistent with historical trends, a disproportionate number of the homeless veterans were African-American: They made up 33% of the 2016 count, whereas they comprise 11% of the veteran population (U.S. Department of Housing and Urban Development, 2016).

Risk Factors for Veteran Homelessness
The research literature converges on three major risk factors for veteran homelessness: overall mental health status, co-occurring substance abuse issues, and chronic illness (Creech et al., 2015). Self-reports by homeless individuals have identified alcohol or drug abuse, financial issues, unemployment, and psychiatric problems as key reasons for homelessness (Tsai & Rosenheck, 2015).

Pathways into veteran homelessness, outlined in Figure 1, are distinct from those among non-veterans. While homeless veterans and non-veterans have shared risks, such as psychiatric illness, substance abuse, and family dysfunction, some risk factors are unique to veterans due to combat exposure.

Dunne et al. (2015) compared self-reported causes of homelessness among homeless veterans and non-veterans. Veterans ranked unemployment first, followed by alcohol and drug problems, then mental-health issues. Non-veterans also ranked unemployment first, followed by physical and medical problems, then incarceration. These findings suggest veterans may experience higher rates of substance-related and mental health problems than non-veterans; however, the findings are restricted to self-report attributions.

Health Challenges
Homelessness has been associated with a wide range of physical and psychiatric health problems, such as malnutrition, premature aging, chronic health conditions, substance and alcohol abuse, and exposure to violence (Dunne et al., 2015). In addition to physical health problems linked to homelessness, homeless veterans are prone to challenges stemming from combat exposure, such as posttraumatic stress disorder (PTSD) and military sexual trauma (MST) (Schnurr et al., 2009). As compared with homeless non-veterans, veterans face twice the rate of hospitalization (Kushel, Vittinghoff, & Haas, 2001) and have more severe and more prevalent mental and physical health needs (O’Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003).
Mental health. The high prevalence of mental health issues and substance abuse disorders among homeless veterans is well-documented. Surveys reflect high rates of self-reported psychiatric problems, alcohol or drug abuse and dependence, and chronic health conditions (O’Connell et al., 2010; O’Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003). Recent clinician-reported rates of mental health issues found that roughly 70% of homeless veterans have a substance use disorder and 45% suffer from a mental illness, predominantly PTSD (Fargo et al., 2012).

Most studies that have examined the prevalence of psychiatric illness, substance abuse, and chronic mental illness among homeless veterans have relied on self-reports, which often yield inconsistent results compared to standard instruments administered by researchers or clinicians (Balshem, Christensen, Tuepker, & Kansagara, 2011). Despite inconsistencies in methods and instruments, the evidence consistently shows a high prevalence of mental health issues, substance abuse, and medical problems among homeless veterans (Shelton et al., 2009; Johnson, Freels, Parsons, & Vangeest, 1997; O’Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003). Not surprisingly, veterans who experience housing instability are at greater risk of mental distress and suicidal thoughts compared to veterans who have stable housing (Bossarte, Blosnich, & Piegari, 2013).
High rates of co-occurring mental health and substance abuse issues among homeless veterans (Dunne, Burrell, Diggins, Whitehead, & Latimer, 2015; O’Connell et al., 2010) further signal the challenges faced by this population. Co-occurring problems can have implications for the duration of homelessness because veterans with comorbid disorders have been found to have more extensive homeless histories compared to homeless veterans with only alcohol or drug use disorders (Tsai, Kasprow, & Rosenheck, 2014).

Physical health. In addition to mental health challenges, homeless veterans often experience a range of untreated chronic physical health problems, such as infectious diseases, traumatic brain injury, chronic pains, HIV/AIDS, tuberculosis, skin and foot orthopedic problems, and hepatitis C virus (Goldstein, Luther, & Haas, 2009; Snyder & Eisner, 2004). As with mental health problems, substantial comorbidities in physical ailments are common among homeless veterans, who often suffer from multiple medical illnesses (Goldstein et al., 2008). In a study of 2,733 homeless veterans and their medical histories, Goldstein et al. (2008) reported the four major clusters of physical conditions: dental and orthopedic problems, generalized illness, hepatic (or liver-related) disorders, and cardiopulmonary disease.

Health Care Service Utilization
The physical and mental health needs of homeless veterans, then, are substantial. However, health care services provided to homeless adults have frequently been characterized as reactive in nature, rather than preventive, resulting in high rates of emergency room use and hospitalization. Previous research on health-seeking behaviors of homeless adults have found that the propensity to seek health care is especially low among this population because of additional barriers to access, such as feeling unwelcome based on previous health care encounters, feeling stigmatized, and being indifferent to health-related issues (Wen, Hudrak, & Hwang, 2007).

Some evidence suggests outreach to homeless veterans should be clinic-oriented and integrate direct involvement. Results from a randomized control trial study of an intervention designed to increase the health-seeking behaviors of homeless veterans suggest traditional outreach strategies—in which social workers collected information, recommended appropriate services, and provided directions on how to access care—were not as effective as more direct approaches. Direct approaches included transporting homeless veterans to a clinic and introducing them to a clinical team that gave them explicit instructions about the check-in procedure, and interviews with nurses who took their medical history, administered standard intake questions, and conducted a cursory physical exam on the spot. Both these approaches led to significantly higher rates of accessing primary care in subsequent weeks (O’Toole, Johnson, Borgia, & Rose, 2015).

Employment Challenges
Research shows employment plays a valuable role in providing a sense of meaning among individuals with psychiatric diagnoses. According to Drake et al. (2012), “most people with serious mental illness want to work. Like others, they want the responsibility, status, dignity, regular activity, income, challenge, social connections, opportunity to contribute, satisfaction, and all of the other things that employment provides” (p. 3). As a result, facilitating opportunities for employment has been considered an important element of mental health treatments for homeless veterans with psychiatric diagnoses (Goodwin & Kennedy, 2005). However, studies have found that only a small percentage of veterans with mental health
issues access employment services through the Veterans Health Administration (VHA) (Abraham, Ganoczy, Yosef, Resnick, & Zivin, 2014). Although several different types of employment programs for homeless veterans exist, research is inconclusive on the most effective program design for this particular population.

Supported employment (SE), one of the four major vocational services provided through the VHA, has been considered the gold standard for improving employment outcomes among veterans with severe mental illness (Davis et al., 2012). SE is offered in community-based settings in which an employment specialist provides intensive individualized assistance in obtaining and maintaining employment. Although research has shown SE is typically more effective than other VHA employment programs, more intensive onsite training and performance monitoring might be needed for the SE model to produce significantly better employment outcomes (Rosenheck & Mares, 2007).

The Homeless Veteran Reintegration Program (HVRP), the only federal program fully targeted at providing employment assistance to homeless veterans, helps 16,000 homeless veterans annually secure and maintain jobs that will allow them to fully reintegrate into society. Although each HVRP-funded program is unique in its design, universal program components include strong community partnerships to provide veterans with the entire continuum of care, comprehensive assessments and reports for individualized support and planning, and the development of employment opportunities that ensure homeless veterans secure gainful employment.

In an evaluation of twelve HVRP-funded programs conducted by the U.S. Department of Labor (2016), administrators of HVRP programs reported a range of difficulties in identifying and recruiting homeless veterans interested in working. In particular, homeless veterans receiving SSI or SSDI (Social Security Disability Insurance) benefits were unwilling to risk losing benefits as a result of obtaining employment. Eight of the twelve programs studied reported challenges recruiting eligible homeless veterans who were interested in potentially losing their benefits and obtaining employment.

Another difficulty that HVRP program administrators noted was placing candidates in jobs where there was a reasonable match with the required education or skill level. In addition, “even those that met skill requirements for job vacancies might have substance abuse, mental health issues, or criminal records that made it impossible or challenging to place the homeless veteran into some occupations” (U.S. Department of Labor, 2016, p. 47).

While the research on the importance of work for psychiatrically vulnerable populations is well-established (Drake et al., 2013; Tsai, Klee, Remmele, & Harkness, 2013), there is a lack of evidence on how such programs can be successfully implemented within the current system of public supports.

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3 Such as transitional work, incentive therapy, and vocational assistance.
Finding 2. Evidence on the success of supportive housing designed to assist homeless veterans is mixed.

Models of Supportive Housing

Of the supportive housing models that have been designed and implemented to assist homeless veterans, consensus has grown around the effectiveness of Housing First, a model that prioritizes rapid placement in permanent housing and offers voluntary treatment and support services⁴ (O’Connell, Kasprow, & Rosenheck, 2013). In 2012, the VA adopted Housing First as the official model of HUD-VASH (Housing and Urban Development-Veterans Affairs Supportive Housing), a joint program run by HUD and the VA that provides veterans with housing vouchers, voluntary case management, and clinical services.

Despite the growing support for Housing First, research evidence on model effectiveness is not robust. A review of studies published between 1995 and 2012, including seven randomized controlled trials, revealed only moderate evidence for the model (Rog et al., 2014). Although Housing First participation has been associated with, for example, reduced emergency room use, reduced hospitalization, and increased tenant satisfaction, research has yet to identify the most effective model elements for different subpopulations of homeless people with mental and substance use disorders (Rog et al., 2014).

The evaluation of the VA’s Housing First implementation is in its early stages and initial results have been mixed. A pilot evaluation of 14 HUD-VASH sites found high rates of housing retention and reductions in acute hospital utilization and emergency room use (Montgomery, Hill, Kane, & Culhane, 2013). On the other hand, an earlier study of about 3,000 homeless veterans found that only a few veterans received rehabilitation services and employment assistance through HUD-VASH, service delivery dwindled over the years, and 75% of the veterans were terminated from the program within five years (O’Connell, Kasprow, & Rosenheck, 2010). An important area of future research is whether Housing First is as effective for individuals who suffer from substance abuse and mental health issues, which can hinder the engagement process (Montgomery et al., 2013).

While the research on permanent supportive housing as a model for homeless veterans is moderate, several elements of permanent supportive housing programs have been identified as integral components of successful programs (see Table 1).

⁴ Such as case management, health care, mental health treatment, vocational assistance, and job development.
### Table 1. Key Dimensions of Permanent Supportive Housing Models

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Indicator</th>
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<tbody>
<tr>
<td>Choice of housing</td>
<td>• Housing options&lt;br&gt;• Choice of living arrangements</td>
</tr>
<tr>
<td>Separation of housing and services</td>
<td>• Service staff have no housing role&lt;br&gt;• Location of service providers</td>
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<tr>
<td>Decent, safe, and affordable housing</td>
<td>• Affordability of rent&lt;br&gt;• Housing quality standards</td>
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<tr>
<td>Housing integration</td>
<td>• Integration of community</td>
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<tr>
<td>Rights of tenancy</td>
<td>• Tenant rights</td>
</tr>
<tr>
<td>Access to housing</td>
<td>• Housing readiness not required&lt;br&gt;• Privacy (tenants control entry to unit)</td>
</tr>
<tr>
<td>Flexible and voluntary services</td>
<td>• Tenant service preferences&lt;br&gt;• Service options&lt;br&gt;• Availability and adequacy of services&lt;br&gt;• Caseload size</td>
</tr>
</tbody>
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*Note. Key dimensions and indicators of permanent supportive housing. Adapted from “Fidelity Scoresheet and Fidelity Scale,” by U.S. Department of Health and Human Services, 2010, Permanent Supportive Housing: Evaluating Your Program, p. 15. Copyright 2010 by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.*

**Finding 3. Definitions of success for homeless veterans include reducing homelessness, achieving self-sufficiency, and social integration.**

**Defining Success for the Homeless Veteran Population**

The Housing First model and its focus on rapid placement into housing have been found to significantly reduce the number of days of homelessness for veterans, but the research is unclear on the risk of returning to homelessness (O’Connell, Kasprow, & Rosenheck, 2010). Exits from permanent supportive housing programs sometimes represent positive outcomes for some veterans, but, more often, they indicate a return to homelessness (Cusack, Montgomery, Blonigen, Gabrielian, & Marsh, 2016). One criticism of Housing First has been that while it is highly effective in reducing the number of days veterans spend unsheltered and homeless, it often leads to only minor improvements in clinical and social adjustment outcomes. The only way to maintain the status quo is to continuously provide ongoing intensive clinical support and services (O’Toole, Pape, & Kane, 2013).

Long-term success for homeless veterans in supportive housing programs is difficult to define but self-sufficiency and social integration have been two prominent areas of focus (Tsai, Klee, Remmele, & Harkness, 2013). A barrier to self-sufficiency is the issue of dependency on public support systems: Studies have found that subsidized housing programs sometimes undermine internal and external incentives to seek employment or obtain self-sufficient private housing (Tsai, Kasprow, & Rosenheck, 2011; Messenger, 1992). Regarding social integration, studies have found that while it is important for homeless veterans to manage mental health symptoms and achieve clinical stability, many homeless veterans are interested in improving other aspects of their lives, such as developing connectedness to the community and building social capital (O’Toole, Pape, & Kane, 2013; Tsai, Klee, Remmele, & Harkness, 2013).
Finding 4. The literature review revealed no research evidence to inform benchmarks for employment or education.

While there are anecdotal examples of service-delivery programs that have been successful in enrolling a high number of homeless veterans and placing them in employment, the review of the research literature did not identify evidence-informed education and employment benchmarks for homeless veterans.

With regard to education benchmarks in particular, there appear to be no large-scale programs with the objective of enrolling homeless veterans in higher education initiatives. Examples of education services provided in other programs for homeless veterans, such as the Maryland Center for Veterans Education and Training (MCVET), include behavior modification/self-improvement courses and financial literacy/planning courses (U.S. Department of Labor, 2003). It is worth noting that these courses are not college-level coursework5.

Finding 5. The two tenant populations in the program face unique but substantial challenges to engaging in services and achieving intended employment and education outcomes.

Focus Group Background

To understand more about the case in point—the HRA-CUNY Sustaining Veterans' Success program—REPS reviewed administrative data and conducted one site-staff focus group. Whereas the literature review focuses on adjustment and services for homeless veterans, data in this section pertains to the tenants, which include both previously homeless veterans and low-income community members.

Data from an assessment survey that tenants complete before meeting with a program clinician indicates that 43% of all assessed tenants (38% of assessed veteran tenants and 27% of non-veteran tenants) reported previously receiving treatment for a mental health issue/losing their housing because of their mental health. Despite these numbers, service records reflect low utilization of voluntary case management and social services. As of July 2017, 16 tenants were receiving clinical services, 17 tenants were receiving benefits counseling, three tenants were enrolled in degree programs, and four tenants were enrolled in non-degree programs. Among the 12 tenants who were currently employed, one tenant was earning more than $13 per hour.

With support from CEWP, REPS researchers conducted a focus group with all six program site staff members: the employment specialist, education specialist, benefits coordinator, and three clinicians. The purpose was to better understand the experiences of program staff and to examine factors associated with participants’ service utilization. Four key questions were addressed in the focus group:

1) What roles do the staff members play and what are their experiences to date?

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5 While there are some employment benchmarks from the federally-funded Homeless Veterans Reintegration Programs (HVRP) (https://www.dol.gov/vets/programs/hvrp/hvrp-bp.htm), these programs focus exclusively on employment in non-residential settings and, as a result, may not be comparable to the HRA-CUNY program.
2) What are the community and tenant characteristics? What are the greatest areas of need among tenants?
3) What is the program’s model of supportive housing and how does the programming meet or not meet the needs of this population?
4) What are the levels of service utilization and the barriers to the uptake of voluntary services offered in the program?

REPS evaluators developed a focus group guide and protocol based on the key questions and the research literature on veteran homelessness and supportive housing (see Appendix A). The focus group, which was conducted in June 2017 at the Queens Library in South Hollis and lasted for 1 hour and 45 minutes, was recorded and transcribed. The transcription was analyzed by two REPS research analysts using a thematic coding method.

Key Themes
Four key themes emerged from the focus group data, each of which was extracted from patterns of ideas that were discussed by more than one focus group participant. Given the preliminary and exploratory nature of the focus group, these observations are limited to the staff participants’ experiences and viewpoints. Where applicable, the themes are tied to evidence from the literature review on homeless veterans, given that the program participants are recently homeless. In this report, unless specified, tenants refers to both veterans and community members (non-veterans).

Key Theme #1: The program’s on-site voluntary services meet some, but not all, veteran tenants’ needs.

The program’s model of permanent housing was described by staff as community housing with voluntary onsite supportive services. Having an onsite support team that works collaboratively together to provide the most appropriate combination of services to interested tenants was commonly cited as an important feature of the program model. This approach of providing direct services is supported by research on direct—instead of indirect—services to engage homeless veterans in care (O’Toole, Johnson, Borgia, & Rose, 2015).

While the wraparound nature of the on-site supportive services was designed to provide individualized care and case management, staff comments suggested one shortcoming of the model could be that the services are not fully wraparound in practice. Wraparound services are defined as “psychosocial and treatment programs that facilitate access, improve retention and address co-occurring problems,” and provide tailored services to meet the specific needs of individuals (Etheridge & Hubbard, 2000, p. 1762). Staff reported that some veteran tenants would benefit from more easily accessible psychiatric services and medication management, two services that are currently not offered in the program. As examined in the literature, homeless veterans are an extremely vulnerable population with high rates of psychiatric problems and low rates of health care service utilization (Dunne, Burrell, Diggins, Whitehead, & Latimer, 2015; O’Connell et al., 2010). Easy access to psychiatric and medication management services might be better aligned to the needs of some tenants.
Staff reported that an important feature of the program design was the different levels of care (or tiers) that are provided based on the needs of the tenants. One staff member commented,

*I think it’s a very well-designed program... we have tiers, so the people that really aren’t ready are in the first tier, and then people that are ready but still need clinical support are in the next, and then folks that need less clinical are ready to go right to school and work.*

**Key Theme #2: The program serves two distinct tenant groups—veterans and non-veterans—with distinct needs.**

Other staff members agreed that “meeting [tenants] wherever they are” was a priority.

Of the 120 housing units, approximately two-thirds of the units are occupied by formerly homeless veteran tenants and their family members, while the remaining third of the units are occupied by low-income non-veterans.

The low-income non-veterans, who moved into the apartments several months after the veterans, were characterized by staff members as generally being older and less inclined to engage in activities designed to help tenants rejoin the workforce. This sentiment was expressed by another staff member who described many non-veteran tenants as wanting to be “… retired. They just want to kick back and not be involved, and, with most of them, they don’t really need services.”

Staff were in agreement about the range of needs and level of functioning among the veteran tenants; some formerly homeless veteran tenants were described as being high-functioning and actively engaged in the community and programming, while others were characterized as isolated and less inclined to partake in any activities, possibly due to mental or physical health challenges.

Staff reported minor tensions between veteran and non-veteran tenants when the non-veteran tenants first moved in to the apartments. “Once we brought in the [non-veteran tenants], it kind of stirred things up and it’s a strange mix and wasn’t one that we were intending to have happen.” With time, however, staff reported the divide has mostly dissipated and there is growing rapport among all tenants. As one staff member expressed, “[the tenants] support each other, in need, banding together for an issue, helping each other on a day to day basis.” Another staff member added,

*I think there was a barrier in the beginning because the veterans moved in in January and the [non-veteran tenants] in May, and so it took some time to kind of get past that. I think actually our activities, the classes, and groups have helped with the mingling... and they [have] come to know each other on a more personal level, which is helpful to a degree.*

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6 The average age of veteran tenants is 52 years old. For community members, it is 60 years old.
Overall, the staff members described the community as one that is slowly growing, despite challenges that arise due to tenants who are unready or, as of yet, unwilling to be engaged. As one staff member expressed, “[the] tenants haven’t had a community in a long time” and “many of them have just been surviving... they didn’t even have a roof over their head so creating community and finding meaning and pursuing a future has really been out of the question until now.”

**Key Theme #3: Despite varied and targeted outreach to tenants, service utilization has been lower than anticipated.**

In order to engage more tenants in programming and services, staff reported experimenting with various outreach methods, such as texting, calling, emailing, distributing flyers, going door-to-door, distributing monthly community calendars, extending the hours of events and services to accommodate more tenants, and walking around the vicinity of the apartments before an event to notify tenants about the event. Additionally, one staff member created a Facebook group in an effort to reach tenants through an online platform.

Despite these efforts, staff unanimously agreed the levels of participation in the activities and programs were lower than they anticipated. Low service utilization is a common theme in the research literature about homeless veterans (Tsai, Link, Rosenheck, & Pietrzak, 2016). On average, staff reported fluctuating caseloads of between zero to six tenants at a time. Despite expressing interest in some activities, engaging tenants has proven challenging. As one staff member described,

> If we put out a survey or if we, say, at a tenant meeting have a sign-up sheet [to see] who’s interested, people will show interest and then not follow through. So there’s a lot of not following through and some folks will not follow through for a while and then all of a sudden they will be following through... people have their patterns but sometimes they break out of them.

Another staff member expressed frustration that tenants do not engage in the voluntary services, which are located in the temporary offices across the street from the apartments: “Most of the tenants who should be utilizing [services], and have said on the survey that they would, have not utilized them at all.”

**Key Theme #4: Personal and programmatic barriers resulted in low service uptake among tenants.**

Five clusters of barriers to the uptake of services emerged from the site staff focus group.

Structural disincentives to pursue employment. Staff members reported that at least one tenant was no longer eligible for the benefits he was receiving due to his employment and salary, which put him over the threshold for that particular benefit. One staff member explained, “the majority of people in that situation, or [who] could potentially be in that situation, they usually go the route of, ‘let’s decrease the income so I can maintain where I’m at now.’"
Thinking about the future, one staff member worried that the rising minimum wage would serve as an even steeper barrier for tenants considering gainful employment because higher projected incomes that put tenants at risk of losing any benefits might deter them from pursuing employment:

> I fear that in the future we'll be seeing a lot more of those [who do not seek employment] as the minimum wage changes to $15. In terms of maintaining the housing here, the subsidies that most candidates have, it's about $11 or so that they [can earn and still remain eligible for housing in the program].

Another staff member added,

> We look at projected incomes for folks when we're looking at either, you know, to pursue a degree or pursue a job. And a lot of these entry level jobs, they are like $26 to $30 [per hour], which is okay but that's really hard to live in New York City if not impossible... A few people do have the vouchers where they can continue to work up to a point where they can afford the full rent, but most don't.

Mental health issues, alcohol and substance abuse. Mental health issues, alcohol abuse, and substance abuse were consistently discussed as the major barriers to tenant engagement. According to one staff member, “some of them have really serious barriers that prevent them from participating, whether it's alcoholism, you know, mental health issues that they're struggling with, that they just can't [participate] until they're stabilized.” Co-occurring mental health issues and substance abuse issues were also cited as a major challenge for some tenants.

Additionally, the lack of continuity in the mental health and substance abuse treatments that tenants receive off-site was reported as a major obstacle for making progress with some tenants. One staff member reported,

> What ends up happening a lot of the times with mental health issues and substance abuse issues is that they get referred out and then they just, there's no continuity of care and they end up, for whatever reason, they stop going.

Physical ailments and premature aging. Symptoms associated with early aging and physical ailments were reported to be barriers to service utilization for some older tenants. Staff reported that physical ailments sometimes prevent tenants from accessing the services they need. One staff member explained, “There's a lot of tenants, their health is really, really failing, and they can't get to doctor's appointments and they can't figure out transportation because it's a really tough system to figure out... a lot of our tenants are older, and, even if they're not that old, they're in their 60s [and] they've lived hard lives.”

Although a part-time nurse was hired to address some of the issues related to tenants’ physical ailments, one staff member expressed that some tenants might require more than on-site support from a part-time nurse. A staff member explained,

> Transportation around here is not great... as you know, [the town] is a little isolated... so people's physical problems, where maybe you know, it's great for them to visit [the nurse] but they have a doctor and need to go see a doctor for maybe some specific
thing that [the nurse] can’t help with onsite... so people are often always trying to juggle multiple things.

Another staff member added,

[The nurse] has been going in and out of the buildings checking in on them and letting them know she’s here Monday and Friday... Maybe it’s a fear that they don’t want to know what’s going on with their bodies after being in the shelter for so long, because they probably didn’t pay attention to it.

Issues of privacy. Staff members reported the proximity of the program office to the apartments was one of the merits of the program. However, one potential disadvantage of the location of the temporary office is that it may make some tenants uncomfortable that other tenants can see them visiting the office for services. As an instance that illustrated the possibility that some tenants may be sensitive to the issue of privacy, one staff member reported,

Another area that we could use more support around is substance abuse... that’s been kind of a tricky one because we’ve had a lot of feedback from tenants that they wouldn’t attend substance abuse groups here onsite because... they don’t want all the other tenants to know their business. They’d rather go off somewhere, but a lot of them don’t go off somewhere.

Fit between tenant needs and program design. Staff reported some tenants simply do not need the services offered in the program because the services were designed with a very specific population in mind: homeless veterans from the shelter system. One staff member described the departure from the original program recruitment criteria that took place during the implementation process:

So the population we thought we were going to get were veterans in the shelter system who are ready to go to school and work and might just need some clinical support... a third of those turned out to be people from the community that were not veterans, not from the shelter system, and tend to be older and don’t necessarily need or want our services... then the folks that we got from the shelter system, a lot of them were not and are not and may never be ready for school or work.

In a similar vein, a staff member explained,

Sometimes it’s just that like [the tenants] might have already had a job, or maybe they go to a program, like they’re very... locked in to something outside of here, you know. So they’re going to a job every day or going to a program every day or some combination thereof, I mean they’ve got their benefits and this is just their housing, you know, this is only housing for them.
Conclusions

Four implications for the program emerged from this formative evaluation.

1) There is little research evidence to guide education and employment services in permanent housing programs for homeless veterans.

Despite the existence of education and training programs for homeless veterans such as the MCVET (U.S. Department of Labor, 2003), research has not identified best practices for employment and education services within permanent supportive housing. Additionally, the extant evidence from employment programs, such as those funded by HVRP, is of little use to the program due to the difference in program models. As previously discussed, national programs that support homeless veterans typically target a single issue, usually housing, education, or employment/reintegration. In fact, a key dimension of permanent supportive housing programs is separation of housing and supportive services (Table 1).

2) Despite efforts to offer a range of services by well-trained staff, services do not match staff-identified tenant needs.

Services in the program are voluntary, with tenants opting to enroll in one of four tiers: Tier 0 (no services provided); Tier 1 (mental health services only); Tier 2 (mental health and education/work services provided, with team meeting in weekly collaborative case conferences); Tier 3 (education/work services only). However, staff felt that, for tenants who are “always in crisis and are actually causing crises around them because of it,” there is not an appropriate level of care in the program. Specifically, these tenants would benefit from psychiatric medication management and/or drug and alcohol abuse treatment. As noted in the literature, alcohol and drug problems and mental health issues were some of the most significant risk factors for homelessness among veterans (Tsai & Rosenheck, 2015). Program staff have observed these problems persisting among veteran tenants. Tenants with the highest level of need may require more intensive services (i.e. psychiatric care and medication management) than this particular model can provide.

3) Tenant engagement in the array of voluntary services in the program is likely to remain a challenge despite staff efforts.

Site staff members have utilized a variety of engagement strategies, varying them to reach each individual tenant (p.13). However, based on the literature regarding low health care service utilization for homeless adults (Wen, Hudrak & Hwang, 2007) and the issue of population mismatch/program design identified in the site staff focus group (p. 16), engagement in the voluntary services is likely to remain low for both veterans and community members. More direct approaches to service provision may increase engagement, for example, by accompanying tenants to the psychiatrist, signing them in, introducing them to the doctor (in what is known as a “warm hand-off”), and assisting them in scheduling a follow up appointment (O’Toole, Johnson, Borgia, & Rose, 2015).

4) Given the challenges facing tenants, participating in higher education is likely out of reach for most tenants.

The program was designed under the assumption that high-functioning homeless veterans would receive shelter, pursue education, receive employment, and eventually become self-sufficient, allowing them to re-integrate into society. However, the program expanded to
include low-income community members in addition to homeless veterans. Both groups of tenants tend to face mental and/or physical health challenges and structural disincentives to pursue higher education and employment, including risk of losing current benefits and approaching eligibility for social security benefits.

Other programs provide support for the specific challenges facing the homeless veteran population. For example, some education and training activities offered in programs for homeless veterans teach behavior modification and financial literacy. These courses truly meet veterans where they are at and are distinct from the program’s educational goal of enrolling homeless veterans in CUNY’s degree and non-degree programs.

The program serves the important purpose of providing homeless veterans the care they deserve. Given the many challenges that homeless veterans experience and the lack of established best practices, the work being done in the program is inevitably challenging. Site staff, tenants, and data should continue to identify areas of need and inform quality improvement for the program and other initiatives serving homeless veterans.

In sum, results from this formative evaluation suggest the program would benefit from a re-examination of the model in light of the existing tenant population. Between the high level of need among previously homeless veterans and the characteristics of the community-member group, expected outcomes for the model should also be revisited. Despite the appealing goal of employment and self-sufficiency, earnings may pose a strong disincentive because they could imperil program eligibility. Finally, challenges faced by both tenant groups make enrollment in higher education unlikely in all but a few cases.
References


Johnson, T., Freels, S., Parsons, J., & Vangeest, J. (1997). Substance abuse and homelessness:


Appendix A

Focus Group Guide

HRA-CUNY Sustaining Veterans’ Success Program

Purpose: To explore the experiences of program staff, the barriers to the uptake of voluntary services for tenants, and the experiences of tenants receiving services through the HRA-CUNY Sustaining Veterans’ Success Program (hereafter referred to as the program).

Sample:
6 program staff members- Employment Specialist, Education Specialist, Benefits Coordinator, LMSW-Clinician, LMHC-Clinician, and Part-Time Clinician

Primary areas of interest:
1. An overview of staff’s roles and experiences
2. Community and tenant characteristics: unique strengths and challenges, greatest areas of need
3. Programming: nature of services offered and suitability/appropriateness
4. Participation: level of participation and any barriers to the uptake of voluntary services, including employment, education, social services and case management.
Introduction & Context

1. Purpose

Thank you for agreeing to participate in this focus group discussion today. I’m [name and title]. I assist with the evaluation of the program. [name and title] will be assisting me with facilitating the discussion and taking notes.

The purpose of this focus group is to learn about your experiences working on the program and your overall opinions about the program.

2. Confidentiality

- We are going to be recording the discussion and taking notes. The recordings and notes of these focus groups will only be reviewed by the REPS evaluation team.
- Real names will not be identified nor will remarks or comments be attributed to a specific individual.
- Once all of the analysis for the focus groups is completed, the results will be aggregated and will be incorporated with other data.
- If we choose to highlight someone’s individual response to a question, we will not use that person’s real name.
- We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other’s confidentiality.
- Does everyone agree to being recorded today?

3. Consent forms

- The consent form is required to participate in this focus group. The information you give us will only be used for evaluation.
- You may refuse to answer any question or withdraw from the study at any time.
- I’m passing out a consent form, please read the form and sign to show you agree to participate in this focus group and have it recorded.

4. Logistics

- Because we are taping and taking notes, I may remind you occasionally to speak up and to talk one at a time so that we can hear you clearly.
- There is no need for everyone around the table to respond to every question. You don’t have to go in a circle.
- It is important that a wide range of ideas are expressed. Please feel free to add to the conversation in agreement or disagreement with your colleagues.
- Are there any questions before we get started?
Focus Group: Topic Guide

General
1. What is your role and how long have you been in this role?
2. Can you tell us about your background, training, or any previous experiences working in a similar role or with a similar population?
3. Can you tell us about your overall experience working with tenants?
   a. Probe for rewarding and challenging experiences.

Community and Tenant Characteristics
4. How would you describe this community?
5. What is unique about the community?
   a. What are the unique strengths within this community?
   b. What are the unique challenges within this community?
6. How would you describe the relationship between tenants?
   a. Probe for nature of relationship between veteran and non-veteran tenants.
7. How would you describe the relationship between tenants and staff members?
8. What are some of the greatest areas of need among tenants?
   a. Probe for health, mental health/substance use, education, and employment.
   b. Probe for any differences between veteran and non-veteran tenants.

Programming
9. In your own words, can you describe the program’s model of permanent housing for this population? What are the most important characteristics?
   a. Probe for differences between model in design and actual implementation.
10. How are the programs and services that are available to tenants meeting (or not meeting) their needs? (Reference question 8 answers)
    a. Are there any specific activities, programs or services that stand out to you as being particularly helpful or unhelpful to tenants?
11. Are there any programs or services currently not being offered that would benefit members of this community?
12. Do you use other resources or informal networks to meet the needs of community members? If so, what are they?
    a. Are there any resources that you might find helpful in working with community members?
13. Can you tell us a little bit about the weekly case conferences? The monthly staff meetings?
    a. Probe for topics of discussion, utility, how they have been helpful or how they can be improved.
Participation
14. Can you tell us about the levels of participation in the voluntary services offered to tenants?
   a. Probe for education, employment, case management, and social services.
   b. What engagement strategies have you used to actively support participation in these services?
15. Have you noticed any patterns in the types of tenants who participate?
16. What goals do you typically work towards with your clients?
   a. What progress do your clients make towards these goals?
   b. What supports or hinders this progress?
17. Have you noticed any patterns in the types of tenants who decide not to participate?
18. Can you share any feedback that you’ve received about why tenants chose to/not to participate in the voluntary programs and services offered in the program?
19. Based on your interactions with tenants, are there any significant barriers that prevent their ability or willingness to participate in these programs and services?
20. If you could change anything about the program, what would it be?
   a. Probe for education, employment, case management, and social services.