

Testimony of
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Hearing on the Status of Homeless Assistance Programs for Veterans
Before the
Subcommittee on Health
Committee on Veterans' Affairs
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I am Dr. Ned Cooney, a clinical psychologist and Director of Mental Health and Substance Abuse at the Newington Campus of the VA Connecticut Healthcare System, and Associate Professor of Psychiatry at Yale University School of Medicine. My area of expertise is substance abuse treatment and clinical research. I was asked to testify because I manage treatment programs that provide care for veterans, many of them homeless, in the northern half of Connecticut. I will speak as a VA clinician and clinical administrator sharing my first-hand experience with the daily challenge of promoting recovery for homeless veterans with substance use disorders.

The Mental Health Care Line at the Newington Campus provides standard and intensive outpatient services for veterans with psychiatric and substance use disorders. Our intensive substance abuse clinic is fairly typical of VA clinics, with 43% of our clients classified as homeless on admission.

Treating homeless patients in an outpatient setting is difficult. Homeless patients often stay in shelters or on the streets where many of their cohorts actively abuse alcohol and drugs, or where alcohol and drugs are readily available. Few homeless patients have supportive family or friends, and few are employed. Most have concurrent severe and persistent mental illness. They have limited skills to cope with drinking and drug situations and urges to use. They are often in imminent danger of relapse, with dangerous medical, emotional, and legal consequences and need 24-hour structure to help them apply recovery or coping skills. When we try to treat homeless veterans without residential supports, they often continue to use alcohol or other drugs, and deteriorate psychiatrically with imminent serious consequences. Therefore, programs that first address the clients' subsistence needs and then provide long-term treatment in progressive stages are necessary for homeless substance abusers (Drake et al. 1994; Oakley & Dennis, 1996).

Using criteria developed by the American Society of Addiction Medicine (2001), 22 out of 29 substance abuse patients recently admitted to our intensive program needed residential support during treatment. That's 76% of patients meeting ASAM criteria for residential treatment.

Brief residential support is provided to patients enrolled in our intensive treatment programs by concurrent admission to a unit known as the Quarterway House at the West Haven Campus. Patients from the Newington area ride a daily 45-minute VA shuttle

from the Q-house to the Newington Campus. Bed capacity is limited, so most patients are allowed only a 14-day stay at the Q-house during the beginning of intensive treatment. The Q-house could be called a “housing first” program because it provides safe and substance-free residential support for homeless patients without requiring a period of sobriety prior to admission.

Because most homeless patients need more than two weeks of residential intensive treatment to stabilize and to be connected to a longer-term safe and sober residence, we must rely on referrals to other programs outside of VA Connecticut. These include the Western Massachusetts Shelter for Homeless Veterans in Leeds and the veterans domiciliary operated by the State of Connecticut at Rocky Hill. These facilities provide stable and substance-free housing for our patients, and opportunities for them to receive needed rehabilitation including continuing care, and employment. Although the Leeds shelter is further away, their eligibility criteria match those of the VA, while the nearby Rocky Hill domiciliary accepts only wartime veterans, excluding many of the veterans that we serve. In the past few months, 25 out of 54 veterans that were treated in the Newington intensive substance abuse program were referred to Leeds (7 veterans) or Rocky Hill (18 veterans). A shuttle provides daily transportation from these facilities. To date, this residential support arrangement has been effective, with 43 out of 54 veterans (that’s 80%) successfully completing the intensive phase of substance abuse rehabilitation in the Newington program. It is notable that prior to establishing these community housing and transportation supports, only 5 out of 12 homeless veterans successfully completed the substance abuse intensive treatment program.

Funding cuts often loom at the Leeds shelter and at the Rocky Hill State Veteran’s Home, and greatly threaten our ability to provide the residential support necessary to our homeless veterans. Although there are a few smaller facilities that also provide residential support, none have the capacity to handle the number of referrals generated by our program. Local area homeless shelters, while supplying emergency shelter, do not provide the structure and substance-free environment needed to support abstinence and recovery in these patients.

Supported housing and residential case management are also critical after the acute phase of treatment. The VA Connecticut’s Health Care for Homeless Veterans (HCHV) Program oversees our VA Grant and Per Diem Program. With funding support from this program, VA provides longer-term transitional housing services through partnership with several community-based agencies. While this is a good program, currently only 10 beds are funded in northern Connecticut. One facility with 4 G&PD beds recently lost funding, but 9 beds are expected to open up at another facility in the near future. According to the Connecticut Department of Social Services, there were 544 veterans in homeless shelters in northern Connecticut last year, so the number of transitional housing beds is far short of the need.

The HCHV program at VA Connecticut has developed a larger network of transitional housing options in south central Connecticut, providing 51 transitional housing beds for

homeless veterans where stay is allowed for up to 2 years, and 16 treatment beds where veterans may remain for up to 90 days.

The HCHV Program also operates an outreach team that serves veterans who are homeless, and who may not come to the VA medical center on their own. The team works in urban, suburban and rural areas, traveling the daily pathways of homeless individuals. The team has established strong linkages with emergency shelters, soup kitchens, churches, local mental health and substance abuse providers, veterans' service officers, and VA Community Based Outpatient Clinics, and works to bring homeless veterans into the VA system.

In summary, VA Connecticut Healthcare System is committed to providing high quality, accessible mental health and substance abuse treatment to homeless veterans. We have led the effort to create a seamless, one-stop continuum of care for homeless veterans throughout northern Connecticut. This is accomplished with minimal residential support provided directly by VA Connecticut. We rely heavily on partnerships with State and not-for-profit agencies. When our community partners lose financial support, it threatens our ability to provide quality care to homeless veterans. Furthermore, such losses may ultimately mean that fewer veterans will break the cycle of homelessness, addiction and mental disorder.

I want to thank Congressman Simmons and Staff Director John Bradley for giving me the opportunity to address this Subcommittee. This concludes my prepared testimony.

REFERENCES

- American Society of Addiction Medicine (2001). ASAM patient placement criteria for the treatment of substance-related disorders (2nd ed-revised). Chevy Chase, MD: American Society of Addiction Medicine
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