

VIRGINIA FAMILY IMPACT SEMINAR

The Virginia Family Impact Seminars are a series of seminars, briefing reports and discussion sessions for state policymakers. The seminars provide non-partisan, solution-oriented research on family issues.

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- Michelle Schmitt, Ph.D., Director, The Center for School-Community Collabo-

ration, School of Education, Virginia Commonwealth University

For further information contact: Dr. Ann Nichols–Casebolt, Associate Vice President for Research Development , Virginia Commonwealth University at acasebol@vcu.edu, or Dr. Mary Secret, Associate Professor, VCU School of Social Work at mcsecret@vcu.edu, or Dr. Janet Hutchinson, Professor, VCU Department of Gender, Sexuality and Women’s Studies at jhutch@vcu.edu. This seminar is co–sponsored by the Virginia Commission on Youth and the Virginia Department of Veterans Services, Virginia Wounded Warrior Program.

The Virginia Family Impact Seminar has convened the following seminars:

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| May 2013 | Military and Veteran Families: Focus on Strategies for Sustainable Housing and Family Well–Being |
| May 2011 | Employment Opportunities and Workforce Development: Policies, Programs and Strategies for Virginia’s Families |
| Sept 2009 | Substance Abuse Prevention: Policies, Programs and Strategies for Virginia's Youth |
| Oct 2008 | Truancy and Dropout Prevention Policies: Strategies for Virginia's Youth |

Part I: Basic Information

Commonwealth of Virginia Military and Veterans Support: A Summary¹

ACTIVE GOVERNMENT SUPPORT

Governor's Executive Orders

The Governors of Virginia have issued Executive Orders (currently, Executive Order 29) setting forth the policy of the Executive Branch for improving services to Virginia's veterans that pertain to all executive branch agencies and enjoins them to assist the Department of Veterans Services in meeting veterans' needs.

Virginia Cabinet level Veterans Affairs Secretary

The Secretary of Veterans Affairs and Homeland Security is responsible for the delivery of veterans' services in the Commonwealth and provides oversight to the Department of Veterans Services (including the Virginia War Memorial), the Veterans Services Foundation, the Virginia Military Advisory Council, and the Secure Commonwealth Panel. This organizational structure places services to veterans at the highest level of state government with a dedicated focus on veterans' issues. The Virginia National Guard is under the cognizance of the Secretary of Public Safety.

Virginia Department of Veterans Services (DVS) (www.dvs.virginia.gov)

- The Department is responsible for the establishment, operation, administration, and maintenance of offices and programs related to services to meet the needs of Virginia-domiciled veterans of the armed forces of the United States and their eligible spouses, orphans, and dependents. DVS is headed by a Commissioner appointed by the Governor, subject to confirmation by

¹ This summary was obtained from the offices of The Honorable Kirk Cox, Delegate to the Virginia General Assembly. No attribution is given.

the General Assembly. DVS connects with local governments and community service boards, and other stakeholders through various programs set forth in this summary. The Department falls under the cognizance of the Governor's Secretary of Veterans Affairs and Homeland Security.

- The Commission of Veterans Services is responsible for a compact with Virginia's veterans that has a goal of making Virginia America's most veteran-friendly state. The compact has been established in conjunction with the Board of Veterans Services and supported by the Joint Leadership Council of Veterans Services Organizations. The compact (i) includes specific provisions for technology advances, workforce development, outreach, quality of life enhancement, and other services for veterans and (ii) provides service standards and goals to be attained for each specific provision in clause (i). The compact is reviewed and updated annually and the Commissioner includes in the progress of veterans services established in the compact in his annual report which normally is submitted in December of each year. It includes legislation that has been enacted during the year and proposed legislation for the coming year.

Virginia Board of Veterans Services

This policy board, established in the *Code of Virginia*, consists of citizen members appointed by the Governor (11), legislators (5), and *ex officio* members (3) with standing committees for veterans benefits, veterans care centers, and veterans cemeteries. It advises and recommends policies and procedures to the Commission of the Department of Veterans Services that relate to the efficient and effective delivery of services to veterans and their dependents and survivors. Most of its current members, both citizen and legislators, are veterans or related to them.

Virginia Joint Leadership Council (JLC) of Veterans Services Organizations

This advisory council, established in the *Code of Virginia*, consists of representatives of 23 veteran's services organization. It advises the Governor through the Department of Veteran Services on matters of concern to veterans and their families and advocates on behalf of the military and veterans' community. The JLC has been active in supporting the quality of life for Virginia's military, veterans, and their families.

Virginia War Memorial Board (www.vawarmemorial.org)

The Virginia War Memorial is a division within the Department of Veterans Services whose mission is to honor patriotic Virginians who rendered faithful service and sacrifice in the cause of freedom and liberty for the Commonwealth and the Nation in time of war, honor all of Virginia's veterans, preserve their history, educate the public, and inspire patriotism in all Virginians. The Virginia War Memorial Board, which consists of citizen members appointed by the Governor (10), legislators (10), and *ex officio* members (4), advises the Commissioner on all matters related to the operation of the Memorial.

Virginia Veterans Services Foundation Board of Trustees (www.vvsf.org)

This independent board, established in the *Code of Virginia*, has supervisory duties and is responsible for : (1) administering the Veterans Services Fund (containing donations to support Virginia's veterans); (2) providing funding for veterans services and programs in the Commonwealth; and (3) raising revenue from all sources including private source fundraising to support Virginia's veterans through allocation of revenue to the Department of Veterans Services. All of the current Foundation trustees are veterans. The Foundation falls under the cognizance of the Governor's Secretary of Veterans Affairs and Homeland Security and consists of citizen members appointed by the Governor (8), citizen members appointed by the General Assembly (8) and *ex officio* members (3).

Virginia Military Advisory Council (VMAC)

This council, established in the *Code of Virginia*, maintains a cooperative and constructive relationship between representatives of the Commonwealth of Virginia and the installation and military command leadership stationed in Virginia. VMAC strives to encourage regular communication on issues affecting military facilities, command operations and quality of life initiatives. The council falls under the cognizance of the Governor's Secretary of Veterans Affairs and Homeland Security.

Virginia Commission on Military and National Security Facilities

Governor McDonnell issued Executive Order 22 in 2010 establishing a Commission on Military and National Security Facilities. Commission members are retired military, political, business, and community leaders dedicated to advancing

Virginia's resident military activities and protecting/growing the Commonwealth's defense industrial base. The Commission falls under the cognizance of the Governor's Secretary of Veterans Affairs and Homeland Security.

BENEFITS

Claims Agent Program

Department of Veterans Services (DVS) claims agents assist Virginia veterans and eligible dependents applying for federal and state veterans benefits. The agents are located at 22 offices throughout the state and provide services at these offices and at other locations on a scheduled basis. Under a pilot program, DVS will work with the Department of Medical Assistance (DMAS) and the Department of Social Services (DSS) to identify Virginia veterans who are eligible for disability and compensation benefits and for medical care through the U.S. Department of Veterans Affairs but who are currently receiving Medicaid benefits.

Automated Claims Processing

The Department of Veterans Services has developed and deployed an automated claims processing system for the electronic preparation of veterans' disability claims that ensures the collection of all the necessary information to expedite the processing of veterans' claims.

Serving our Service Member Families "SOS" (www.sos.virginia.gov)

First Lady Maureen McDonnell launched Serving our Service member Families "SOS" following Governor McDonnell's inauguration in 2010. The SOS partnership network is focused on serving and supporting service men and women and their families. SOS connects these families with businesses, churches, and civic and volunteer organizations to meet their needs while a service member is away on duty or wounded while serving.

Fort Monroe Freedom Support Center

The Center is a highly collaborative, one-step service facility for families of deployed military personnel and military personnel transitioning to civilian life. The state's Transition Assistance Program Coordinator is based at the Center. The Fort

Monroe Freedom Support Center is an initiative by the office of the Governor related to the First Lady's "SOS" program.

State Issued Veteran's ID Card

The Department of Motor Vehicles offers a special Virginia Veterans ID card that is available to all veterans with an honorable discharge. The card enables Virginia's veterans to proudly show their veterans status and to more conveniently access a wide range of discounts and services available to them through various businesses.

Veterans Care Centers in Virginia

Virginia operates two veterans care centers in Richmond and Roanoke. The centers offer affordable, high-quality, comprehensive nursing, domiciliary, and Alzheimer's care, as well as short-term rehabilitation. Additional care centers are planned for Hampton Roads, northern Virginia, and southwest Virginia.

Veterans Cemeteries

Virginia's three veterans cemeteries in Amelia, Dublin, and Suffolk, provide a dignified final resting place for veterans and eligible dependents.

Unclaimed Veteran Cremains

Honorable burials in one of the Commonwealth's veterans cemeteries are provided through the Department of Veterans Services to veterans whose cremated remains (cremains) are unclaimed.

Disabled Veteran Hunting and Fishing Licenses

Virginia provides a discounted lifetime hunting, fishing or combined license for disabled veterans.

Free Vital Records

Veterans and their survivors may receive a free certified copy of vital records, such as birth, death, and marriage certificates, from the Virginia Department of Health, Division of Vital Records.

License Plates

The Virginia Department of Motor Vehicles (DMV) offers a variety of veteran and military related license plates with some at reduced or no fees.

BUSINESS AND EMPLOYMENT

Disabled Veteran Owned Small Business Preference

This initiative provides certification to businesses that are owned and operated by service disabled veterans for the purpose of promoting usage of these vendor firms by the Commonwealth, as well as by private industry, which may rely on the certified status. Further, state procurement officials and their agencies receive credit towards their goal attainment based on procurement amounts with these firms.

Handling Fee Exemption for Veterans

Veterans are exempt from paying the Department of Business Assistance's handling fee when establishing a small business through the one-stop small business permitting program.

Virginia Veterans Employment Initiatives

- The Virginia Values Veterans (V3) program is designed to help employers who are dedicated to hiring veterans. The program provides for a certification process which includes developing a pipeline to recruit veterans, completing a pilot program and setting goals for hiring veterans as well as retaining them. This program was established to train employers on how to find and hire veterans.

- The Virginia Employment Commission (VEC) provides job referral and placement resources to assist veterans in finding jobs. Local Veterans Employment Representatives and Disabled Veteran Outreach Program staff are available in most VEC offices to assist veterans with employment services. They also provide recommendations for additional training and education to qualify for particular jobs or professions.
- A VEC website <http://www.vaworkconnect.com> has the capacity to have veterans enter their military training, experience, military occupation specialty, and any certifications they may have received on active duty and provide related job opportunities.
- The Department of Health Professions Military Credentialing Assistance website provides an online tool for military members who want to make the transition to Virginia's civilian healthcare work force. The website provides a full list of professions regulated by the Department of Health Professions, along with a reference of the statutory and regulatory requirements for initial licensure and relevant statutes for deployed active military personnel and their spouses.

Hiring Preferences in State Government

Veterans are granted a hiring preference for state government jobs. The Commonwealth of Virginia extends its veterans hiring preference to active members of the Virginia National Guard. The surviving spouses and dependents of service members killed in action also are entitled to the hiring preference.

Professional Licenses for Spouses of Service members as well as activated Guard and Reserve Members.

This program extends the expiration date of certain licenses, certifications, registrations or other documents held by the spouse of a service member when stationed overseas in order to allow more time to meet continuing education requirements.

Troops to Trucks Program

This program puts veterans and serving National Guard and Reserve members to work in transportation jobs. It is the first program of its kind in the nation. *Troops to Trucks* will make it easier for military personnel to obtain a Virginia commercial driver's license (CDL) and ease the transition into civilian employment by waiving CDL skills testing for service men and women with appropriate experience operating large vehicles as part of their duties. It will also provide for on-base commercial motor vehicle training for those without this experience as well as provide on-base opportunities for completing the written and skills test portions of the CDL application process.

Unemployment Compensation for Military Spouses

Spouses of service members who must quit their jobs to follow their military sponsor on military relocation orders are, under the *Code of Virginia* eligible for unemployment compensation while seeking jobs at their new locations, provided the federal government funds for such unemployment compensation are available.

EDUCATION

The Virginia Military Education Advisory Committee (MEAC)

MEAC implements and monitors military-related education policies and facilitates communication regarding military education. The Committee is comprised of representatives from two- and four-year public institutions with liaisons from various interested state and military-related agencies. The Committee is responsible for advising the State Council of Higher Education for Virginia regarding statewide military-friendly policies for public institutions of higher education in Virginia.

Education Compact Membership

Virginia is part of the Interstate Compact on Educational Opportunity for Military Children. A large number of active duty service members and their families reside in Virginia. The Interstate Compact helps these military families with the transition between school systems in different states, affords military children better opportunities for educational success, and ensures they are not penalized or delayed in achieving their educational goals.

In-State Tuition for Military, Dependents, Veterans, and Guard Members

Virginia grants immediate in-state status for tuition purposes to military active duty, dependents, veterans and certain members of the Virginia National Guard. In addition, the Commonwealth insures that a Virginia-domiciled military spouse or dependent will not forfeit domicile status for in-state tuition due to accompanying the active duty service member while stationed outside Virginia.

Education Benefits for Dependents of KIA, MIA and POW

The Virginia Military Survivors and Dependents Education Program provides education benefits to spouses and children of military service veterans from Virginia killed, missing in action, taken prisoner, or who became at least 90% disabled as a result of military service in an armed conflict. Virginia waives tuition and fees at public institutions and provides a stipend, based on available funds, for other educational expenses.

Honorary Diplomas

Veteran Honorary High School Diplomas recognize the life experience of veterans who were unable to complete their high school education because of service in the armed forces during World War II, the Korean War, and the Vietnam War.

GOVERNMENT PARTICIPATION

Absentee Ballot Access for Overseas Uniformed Military

This program achieves four main goals: It allows the Secretary of the State Board of Elections to develop pilot programs for secure electronic ballot delivery and return in cooperation with the Federal Voting Assistance Program; it allows secure electronic return of Federal Post Card Applications for registrations and absentee ballot requests (codifying an administrative directive); it authorizes secure electronic return of voted ballots; and, it requires expedited delivery in the event that absentee ballots are sent late (codifying an administrative directive.)

HEALTH CARE

Virginia Wounded Warrior Program (www.weareviriniaveterans.org)

The Virginia Wounded Warrior Program (VWWP), part of the Virginia Department of Veterans Services, was the first of its kind in the nation and provides a network of community-based services designed to help veterans and their families overcome the challenges of stress-related traumatic brain injuries. It operates in coordination with the Department of Behavioral Health and Development Services and the Department of Rehabilitative Services. VWWP monitors and coordinates mental health and rehabilitative services support for Virginia veterans, members of the Virginia National Guard and Virginia Residents in the Armed Forces Reserves not on active duty. These services are coordinated through local regional VWWP consortia consisting of community providers, including community services boards, brain injury services providers, VA Medical facilities, and other public and private providers. VWWP also has cognizance over special treatment procedures for veterans and active duty service members in the criminal justice system and the Homeless Veterans Initiatives.

Homeless Veterans Initiatives

A coordinated state effort led by the Department of Veteran Services, in partnership with the Department of Housing and Community Development and other state agencies, is designed to help Virginia communities maximize new and existing resources to reduce veterans homelessness. As part of the program, the Department of Motor Vehicles is working to finalize a process that will allow homeless veterans to use the address of one of Virginia's three Veterans Affairs Medical Centers as their address for residence verification purposes in order to help them attain an identification card.

TRICARE Supplemental Health Coverage for State Employees

Virginia now offers voluntary TRICARE supplemental health coverage as a benefit to qualified state employees.

HOMESTEAD/PROPERTY TAX EXEMPTION

Special Judicial Procedures

Localities may establish special treatment procedures in the criminal justice system for veterans and active military service members (e.g., special veterans dockets or “veterans courts”).

Other Property Tax Exemptions

The Constitution of Virginia allows counties and municipalities to have separate property tax relief programs.

PUBLIC SAFETY/LEGAL

Special Judicial Procedures

- “A Re-Entry Roadmap for Veterans Incarcerated in Virginia” is a guide with accompanying CD that was provided to all correctional facilities, local and regional jails and Probation and Parole District Offices.
- Department of Corrections operating procedures are being revised to require staff to afford an offender in custody or on supervision the opportunity to apply for his/her DD214, the standard separation document of the U.S. Military.
- The Veterans Expectations to Transition Successfully (VETS) re-entry program is designated for veteran offenders who have an Honorable Discharge and military service verified by a DD214. The VETS program participants, typically within 24 months of release, will live in a structured environment and take part in programming geared toward self improvement and release preparation.

SERVICES

DMV2GO Mobile Site Visits

The Department of Motor Vehicles (DMV) has transformed five RV-style vehicles into Customer Service Centers on Wheels. To date DMV has visited all military facilities in Virginia will to host the mobile units, including the Defense Supply Center Richmond, Fort Lee, Langley Air Force Base, Marine Corps Base Quantico, Norfolk Naval Base, and Fort Belvoir, with many more scheduled.

Military Base Partnerships with DMV

The Department of Motor Vehicles (DMV) is in the final states of opening a Customer Service Center on post at one of Virginia's major Army installations (to be announced soon) with the goal of expanding to all installations. The center will bring DMV services, and thus more convenience, to thousands of military and civilian personnel on post and their dependents.

TAXES

Income Tax Exemptions

- Virginia law exempts Social Security and Tier 1 Railroad Retirement benefits from taxation.
- The lesser of the income derived from 39 calendar days of service or \$3,000 for active and inactive members of the Virginia National Guard whose rank is O-3 or less.
- All military pay and allowances for service in a combat zone or qualified hazardous duty area.
- The first \$15,000 of military basic pay reduced dollar for dollar y the amount of military pay that exceeds \$15,000.
- All military retirement income for individuals awarded the Congressional Medal of Honor.

- The military death gratuity payment to a survivor of deceased military personnel killed in the line of duty.
- Retired military personnel, along with others, who were born on or before January 1, 1939 may claim a \$12,000 income tax deduction. For those who are 65 and born after July 2, 1939, the amount of the deduction allowed for those whose income exceeds \$50,000 for single taxpayers and \$75,000 for married taxpayers is reduced \$1 for every \$1 that the taxpayer's federal adjusted gross income exceeds these thresholds.
- Military Disability Retired Pay for retirees who entered the military before Sept. 24, 1975, and members receiving disability retirements based on combat injuries or who could receive disability payments from the VA are covered by laws giving disability broad exemption from federal income tax. Most military retired pay based on service-related disabilities also is free from federal income tax, but there is no guarantee of total protection.
- VA Disability Dependency and Indemnity Compensation from VA benefits are not taxable because they are disabilities and are not subject to federal or state taxes.

Part 2: Focus on Research

RESEARCH STUDIES

Military and Veteran Families' Well-Being: Focus on Spouse Employment

Mady W. Segal, Ph.D.

Professor Emerita and Distinguished Scholar Teacher

University of Maryland, College Park

E-mail: msegal@umd.edu

The well-being of military personnel, veterans, and their families is strongly affected by the employment outcomes for civilian spouses of military personnel and veterans. Virginia is home to large proportions of military personnel, veterans, and their spouses. Indeed, many civilian spouses of military personnel and veterans are themselves veterans. Whether or not spouses of military personnel have served in the military, research shows that they are disadvantaged with higher unemployment rates and lower earnings than their counterparts married to civilians and lower returns to education (even when they work full-time and year round). This paper presents data compiled from the American Community Surveys and other sources for comparisons between civilian and military wives to address the following topics:

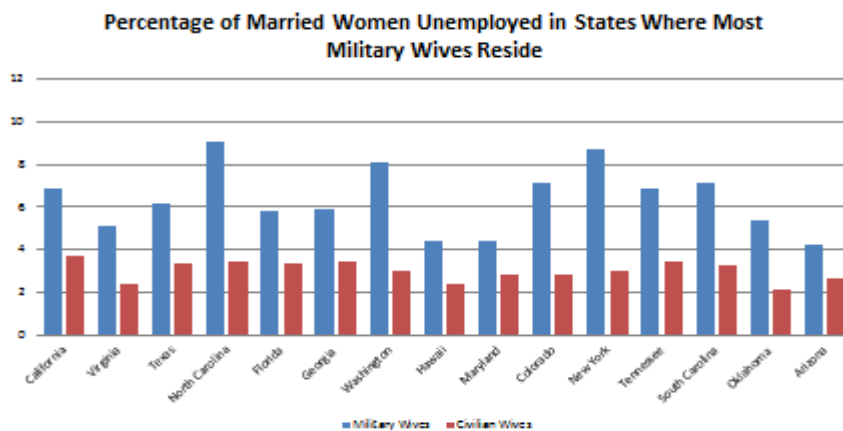
- Why Virginians should be concerned with military and veteran spouse employment
- Percent of military spouses who reside in each state, including Virginia
- Labor force participation of married women in the U.S.
- Military and civilian wives' unemployment rates (U.S. and by state, including Virginia)
- Military and civilian wives' earnings
- Effects of high military presence in local labor market on women's earnings
- Employment of civilian husbands of military women
- Negative effects of moving on military spouse employment
- Military spouse employment programs – existing and proposed

- Other recommendations

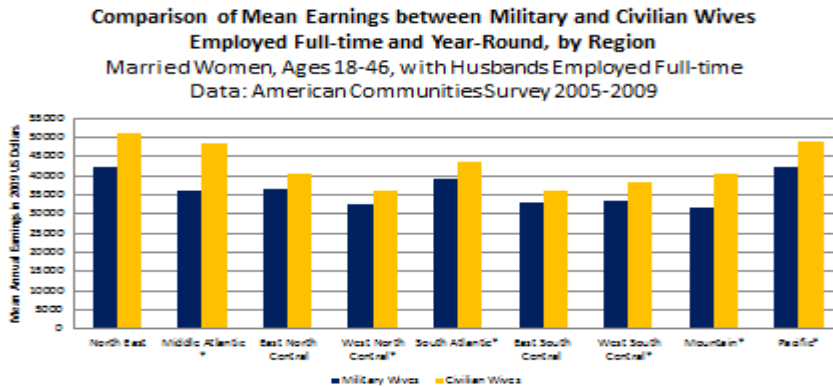
Research comparing civilian wives of military men to civilian wives of civilian men (employed full time and year round) consistently shows that the military wives are less likely to be in the labor market, more likely to be unemployed, and more likely to be employed part-time. Moreover, even for those wives employed full time and year round, military wives earn lower wages than civilian wives. Even when controlling for variables that affect earnings (such as education and years of job experience), military wives are disadvantaged. These findings apply to the U.S. as whole and individual states, including Virginia.

Many military wives live in Virginia. Virginia is home to more than 10% of all military wives in the U.S. Only California has more military wives than Virginia. We need to put this into the perspective of the relative size of the states' populations: California, with more than 38 million residents, ranks first in population, compared to Virginia's 8 million residents and 12th ranking. Thus, military wives constitute a much larger percent of Virginia's population than they do of California's.

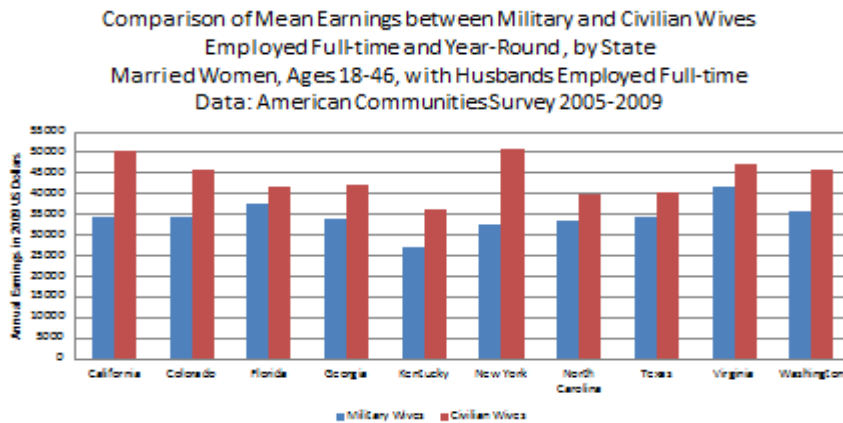
In Virginia, whereas 2.4% of women married to civilian men are unemployed (not employed and looking for work), 5.12% of women married to active duty military men are unemployed. (See chart below.)



Military wives are at a disadvantage in earnings in every region of the country. The Middle Atlantic region provides relatively high earnings for civilians' wives (3rd highest among 9 regions). However, military wives earn significantly less than the civilian wives in the region. (See chart by region below).

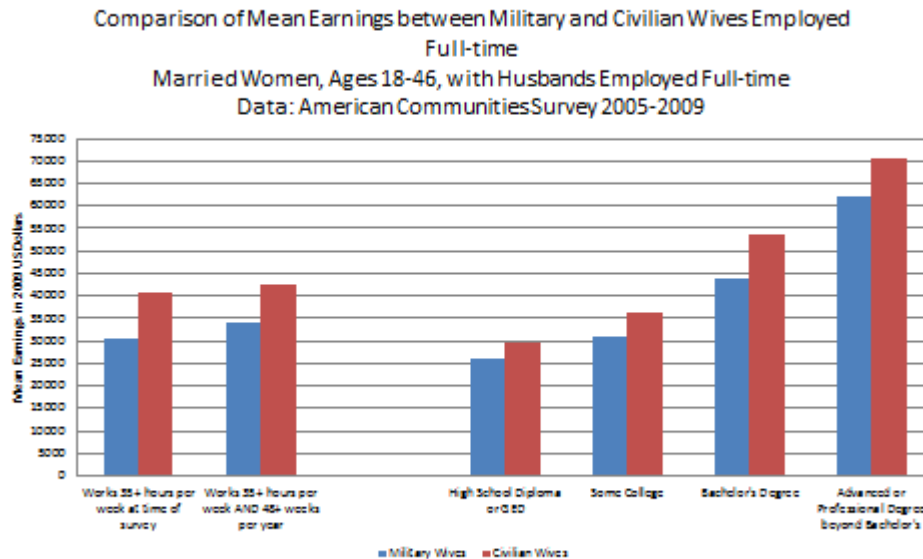


This disadvantage holds in each of the states with the highest percentages of military wives, including Virginia. (See chart by state below.)



The higher a married woman’s education, the higher her earnings are likely to be.

The disadvantage for military wives persists within each educational level. Supporting educational attainment is an effective way to increase military and veteran families’ well-being. (See chart below.)



12

The overall wage gap between civilian and military wives is 42%. This gap represents both substantially lower labor force participation by military wives, and lower earnings for employment. Among households that moved during the year prior to survey, the wage gap is over 47%. Among employed wives, civilian wives earn 27% more than military wives. The overall earnings gap between civilian and military wives employed full-time is 25%.

A high military presence in local areas depresses all women’s employment and earnings. The greater the percentage of people in a local labor market who are active duty military, the lower the earnings of women in the area (Booth 2003). This result holds even controlling for other characteristics of women, including age, education, race, years of job experience, and numbers and ages of children. Women married to military men earn less than women married to full-time employed civilian men.

Most research on military spouses is on civilian wives of military men, who comprise more than 85% of civilian spouses of military personnel. Some research has compared civilian husbands of military women to civilian wives of military men. Male military spouses (civilian husbands of military women) earn more than their female counterparts, but these husbands are more dissatisfied with their employment than are civilian wives of military men (Cooney, De Angelis, and Segal 2011).

Geographic mobility decreases labor force participation and earnings from employment through difficulty finding employment in the new location and decreased job tenure. Measures of geographic mobility include the number of moves the spouse has made, the time between moves, and the time at the current location. Each of these has effects on spouse employment, though the effects vary for different categories of military spouses (such as by race/ethnicity and gender).

For example, Cooney, De Angelis, and Segal (2011) found that 28.5% of spouses were dissatisfied and 17.2% were very dissatisfied with employment opportunities (for a total of 45.7% dissatisfied). Black spouses were 42.2% more likely than Whites to be dissatisfied. Enlisted spouses of all rank categories were significantly more likely to be dissatisfied with their employment opportunities than spouses of senior officers (and this was controlling for education and other variables known to be associated with employment outcomes). For each additional year at the current location, the likelihood of being dissatisfied with employment opportunities decreased by 5.6%, but the effect was stronger for minorities than for Whites. It seems that it takes African American and Asian military spouses a longer time to find satisfactory employment than Whites.

With regard to income, research shows substantial and significant differences by gender and race/ethnicity. For example, Cooney De Angelis, and Segal (2011) found that Black men did not differ significantly from White men, Black women earned 28.4% more than White women, White women earned 23% less than White men, and Black men did not differ significantly from Black women. (These results control for many other variables associated with income, such as education.)

Various programs have been developed to help military spouses in their quest for employment. Early efforts at the federal level focused on teaching the spouses how to write résumés, how to dress for job interviews, and how to behave at job interviews. While these programs helped some spouses, they are not effective if there are not enough jobs in the area, the jobs that are available do not match the skills of the spouse, and/or state licensing requirements hinder employment (especially after moving).

Recommendations

There are many actions that are likely to help ameliorate the negative effects on military spouse employment. Some of these can benefit military veterans and military children of working age. One general approach is the development of partnerships between the public and private sectors to create jobs. For example, the government can erect (or rent) buildings on installations for use by private employers in exchange for training and/or hiring veterans and military family members.

Some states have created tax incentives for employers to train and hire veterans. Similar legislation would also be helpful if aimed at hiring military and veteran family members. States could also use state property to erect buildings (or offer low rent for building on state property) for employers who hire/train veterans and military/veteran family members.

Education plays a vital role in improving quality of life, directly as well as indirectly through greater employment satisfaction and income. Offering in-state tuition for veteran and military family members can be an effective way to improve families' quality of life and increase the human capital in the state.

More research is needed to determine the needs of military personnel, veterans, and their families. Such research can help to determine what kinds of programs are likely to fulfill those needs. All program plans should have evaluations built into the design to measure the effectiveness of the program.

It is critical to measure the awareness of existing programs on the part of veterans and military/veteran family members, especially spouses. Research has often found that the target populations for such programs do not know about the programs (e.g., Booth et al. 2007).

In determining program needs and evaluation, it is important to analyze differences by education, race, age, gender, time at current location, etc. Programs that are effective in meeting the needs of some people may not be effective for all people. Studying what is predictive of success for different people can help planners to design and market more targeted programs to improve quality of life outcomes.

References and Additional Resources

American Community Surveys. These surveys are one of the best sources of data to compare military and civilian spouses' employment outcomes.

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Service Models for Assisting Homeless People with Mental Health Problems: Cost-Effectiveness and Policy Relevance²

Robert Rosenheck MD
Northeast Program Evaluation Center (182)
VA Connecticut Health Care System
950 Campbell Ave.
West Haven, CT 06516
TEL:203 937-3850; FAX: 203 937-3433
Robert.Rosenheck@yale.edu

Abstract

This paper reviews research on the effectiveness, cost, and policy relevance of five types of intervention for housing and otherwise assisting homeless people with mental health problems.

1. System Integration. Fragmentation is widely regarded as a major impediment to the functioning of service systems for homeless people. In 1992, a 5-year, 18 site-effort was initiated to integrate homeless service systems and overcome fragmentation. The ACCESS program did improve system integration in the targeted communities but these gains did not improve housing outcomes or reduce psychiatric symptom over a 12-month follow-up study of over 7,000 homeless people with serious mental illness.

2. Supported housing. Supported housing programs, in contrast, integrate housing and clinical case management services directly at the level of individual clients. Two experimental studies have attempted to differentiate the impact of the housing subsidy from that of intensive case-management and suggest that the active ingredient in supported housing is the housing subsidy rather than the intensity of case management. Annual costs tended to be greater in supported housing by several

² VA New England Mental Illness Research, Education and Clinical Center, West Haven CT.; Yale Medical School, New Haven, CT and Rosenheck RA. Service Models for Assisting Homeless People with Mental Health Problems: Cost-Effectiveness and Policy Relevance in Ellen IG and O'Flaherty B (Eds.) How to House the Homeless. New York: Russell Sage Foundation, 2010.

thousand dollars and housing gains are modest in magnitude. Gains were larger in a study of the Housing First model, perhaps because it better targeted high-cost, high-risk clients.

3. Case management alone. Clinical case management programs have proved capable of improving psychiatric symptoms but are less likely to improve housing outcomes in the absence of specific housing resources. These programs remain costly at up to \$7,000–\$9,000/client/year but when targeted at high-cost hospitalized homeless patients they can realize short term savings sufficient to offset their cost. When delivered on a time-limited basis as in the Critical Time Intervention, costs can be contained sufficiently to allow cost-savings after program completion without loss of benefit.

4. Benefits outreach. Since income support is a key to housing, some programs have focused on facilitating access to Social Security or VA disability benefits. These initiatives show modest improvements in access to benefits but intervention costs are substantial and impact on housing outcomes and well-being are modest. Apprehensions that receipt of benefits increases expenditures on alcohol and drugs have not been confirmed among participants in treatment programs. Although assignment of a payee does not seem to reduce substance use, behavioral money management interventions show promise.

5. Supported Employment. Finally, a study of supported employment for homeless veterans showed increases in both employment and days housed in comparison to a control group. But the effect size of these gains was small and must be weighed against costs of several thousand dollars per client annually.

Conclusion. The effectiveness of diverse programs for homeless people with mental health problems has been well demonstrated. But effect sizes are typically modest in magnitude and primarily center in one outcome domain (for example, housing, symptoms, income, or employment) without spreading to others. Program costs can be substantial and are only offset by savings when high-cost, high-risk populations are targeted, or when the duration of treatment is limited. Progress has thus been incremental, and a comprehensive, cost-effective and widely applicable service approach to ending homelessness among people with mental health problems has yet to emerge.

Service Models for Assisting Homeless People with Mental Health Problems: Cost-Effectiveness and Policy Relevance

A recent analysis of data from the National Co-morbidity Study Replication, a representative national epidemiological survey, found that 5 percent of US adults reported a past episode of homelessness lasting a week or more. In comparison to other adults, those who had been homeless were 6 times more likely to have ever had an alcohol or drug problem and 3 times more likely to have had a psychiatric illness (Greenberg and Rosenheck, under review). While it is thus clear that many homeless people have mental illnesses or problems with alcohol or drug use, the link between housing homeless people with such problems and providing them with mental health or social services is not self-evident. One common sense response would be that, just like any other group of homeless people, the central need of homeless people with mental health problems is for a place to live. Mental health care might be needed to address the mental health problems of some homeless people but housing is the logical solution to their homelessness. A logic that could support a more medical treatment model, would argue that effective treatment of psychiatric or addictive disorders would allow recovery and subsequent employment with housing through the private market. Certainly if someone was found on the street having seizures or infected with pneumococcal pneumonia, they would receive treatment for their acute medical crisis before their housing needs would be considered.

In fact, few service initiatives for homeless people with behavioral problems have focused on employment, and most assume that the mental health and addiction problems of homeless people are long term conditions that are not likely to be well enough resolved in the immediate future to allow them to become economically self-sufficient. Rather than a medical model, most specialized service programs for people with mental health or addiction problems follow a tacit social rehabilitation model which assumes that such people suffer from impairments in judgment and in social skills and need active assistance coping with the world around them. Such assistance ranges from: 1) offers of moral support, for example encouragement to make their own choices; to 2) advice on where to seek material assistance; to 3) more active assistance negotiating with landlords for apartments, with public bureaucracies for income supports or housing subsidies, with criminal justice officials for release from jail; or with health systems to obtain medical or mental health services.

Even though rehabilitation models emphasize personal choice, there is also a surveillance or social control function in these services. Judges are more likely to release arrestees to the community, and landlords to accept tenants of questionable reliability, if they “have” a case manager, or rather a case manager “is assigned” to them to “keep an eye on things” and provide assistance if it is needed.

Regardless of the underlying logic, a substantial body of research has attempted to test various service models for homeless people with mental health and addiction problems over the past 20 years with mixed results. This chapter reviews evidence for the effectiveness of five types of intervention: service system integration, supported housing, clinical case management, benefits outreach and supported employment. Because the primary intention of this research is to guide public policy and identify programs capable of solving the social problem of homelessness, emphasis will be placed both on the effectiveness of such services in helping homeless people obtain housing, and on the cost of such services to society. Public programs are ultimately judged by the cost-effectiveness standard, whether benefits and savings together exceed costs, and we will try to address how various initiatives fair by this standard. But first four limitations to the overall enterprise need to be addressed: 1) the constraints imposed by the equipoise standard in human subjects research (the need to avoid depriving comparison subjects of services that meet current standards for adequate care); 2) the generalizability of data from research samples to the general population, 3) the generalizability of findings from research sites to real-world service systems, and 4) need for credible, preferably randomized, control groups.

1. Human subjects constraints. A major limitation of almost all of the research reviewed below is that ethical constraints on human investigation preclude ever testing whether current service models are better than a model of no services at all or sub-standard services. Bare neglect, while regrettably practiced in real-world service systems, violates the demand for equipoise in human research, that no subject should suffer disadvantage as a result of their participation in a study. The only evaluation/research option, therefore, is to test one acceptable service model against another. As a result the apparent magnitude of program benefits is diminished and the question of what minimal set of services should be available to all who need them can never be tested. Serendipitously the national evaluation of the Collaborative Initiative on Chronic Homelessness, discussed below, provides a small window past this barrier.

2. Client generalizability. Second, homeless people with mental health and addiction problems are very diverse, among many other things, in 1) how long they have been homeless, 2) how serious and chronic their mental health problems are, 3) how serious their ancillary problems are (for example, criminal justice system involvement, poverty or employability), and 4) their preference for various mental health services. As a result the generalizability of research on one sample to others is usually unknown. One of the major determinants of the cost-effectiveness of policies is the population to which they are targeted (Schuck and Zeckhauser, 2006). The potential for cost-effectiveness of health care interventions is dependent on the potential for cost offsets which is largely shaped by the baseline costs of the target population (Rosenheck and Neale, 1998; Rosenheck et al., 1999). Programs targeted to high-risk high-cost sub-populations are more likely to pass the cost-effectiveness tests than others, but their results are also less generalizable to the population as a whole.

3. Site generalizability. Third, most studies have been conducted at single site under the auspices of the proud progenitor of the program being evaluated. If such programs were implemented through a broad public policy initiative there would likely be an attenuation of fidelity to the original program model as its implementation passed into less experienced (and less loving) hands, with concomitant attenuation of program effectiveness, as well. At a minimum, the generalizability of a single-site programs to other locations is typically unknown.

4. Credible (randomized) comparison groups. Finally, most studies of services for homeless people, and the most positive and most often publicized studies, are pre-post, or uncontrolled studies in which the effect of regression to the mean can not be distinguished from true program impact. Evaluation of program impact requires random assignment to treatment or identification of a well-matched control group. Peter Rossi long ago pointed out that the more rigorous the study design the less likely human service interventions are to show positive benefits (Shadish et al., 1990). Accordingly, this review is limited to studies with reasonably well-designed comparison groups, especially those based on random assignment.

These four caveats in fact compound one another, because once we limit ourselves to controlled studies that include cost data, we increase the chances that the samples are not representative, that the comparison treatments will be of above average intensity and quality, and that generalizability to routine real-world care

will be limited. Nevertheless, as Fitzgerald wrote in *Gatsby*, “.we beat on, boats against the current...”

System Integration

One of the most widely voiced complaints about mental health systems in general and about services for homeless people, in particular, is that they are fragmented, that communication between providers is poor and that service system integration is much needed (New Freedom Commission on Mental health, 2003). HUD’s Continuum of Care initiative (Burt et al., 2002) was designed to reduce fragmentation and increase coordination in such systems. Studies of the impact of service integration initiatives are difficult to conduct because the unit of intervention is the service system and the locus of presumed benefit are the individuals served by the system.

In 1993, the Center for Mental Health Service’s initiated the ambitious Access to Community Care and Effective Services and Supports (ACCESS) program. This 5-year demonstration program, evaluated the impact of efforts to enhance service system integration in 9 communities that received \$250,000/year and extensive technical assistance to bolster system integration through 11 distinct strategies (Randolph et al., 2002). The study also included a matched sample of 9 comparison sites that did not receive funds or technical assistance to implement such strategies. Housing and clinical outcomes of over 7,000 homeless persons with serious mental illness were tracked over 12 months of program participation in 4 annual cohorts (Rosenheck et al. 2002). The results of this study showed that: 1) intervention sites showed greater use of system integration strategies; and 2) greater improvement on measures of system integration (Morrissey et al. 2002), and that 3) many clients successfully exited from homelessness for 30 days or more (Rosenheck et al., 2002). Nonetheless clients at integration sites showed no greater improvement in exiting homelessness or in symptom outcomes across the four client cohorts, as their system became more integrated, than did control sites (Rosenheck et al. 2002). The virtually identical slopes of improvement across all cohorts at both integration and control sites reflect no impact of changes in service system integration on client outcomes. Although ACCESS is just one study, it seems likely that to improve housing outcomes integration needs to occur in the direct provision both housing resources and clinical services to individual clients.

Cost-Effectiveness of Supported Housing

Programs offering such proximal integration of clinical or case management services and augmented housing resources are often called supported housing programs. Although there are many variations, all combine dedicated housing resources or subsidies with human services that represent a combination of community based mental health services and practical assistance of the kind often associated with the social work profession. It is widely believed that these services need to be: 1) intensive representing contact one or more times per week, 2) to be flexible, practical, and community-based rather than office-based, and 3) to be sustained for many years. Only two studies have sought to tease out the specific contribution of housing subsidies and intensive case management: the HUD-VA Supported housing program (HUD-VASH)(Rosenheck et al., 2003) and the San Diego McKinney Demonstration (Hough et al. 1997).

The HUD-VASH program is perhaps the largest of these programs implemented at 34 sites across the country and serving almost 5,000 veterans with access to almost 2,000 Section 8 housing vouchers from 1992 to the present. The program has recently been expanded to 10,000 vouchers that will be linked to more than 200 case managers at over 120 VA facilities.

Four sites in the original 1992 demonstration conducted a cost-effectiveness evaluation in which N=460 homeless veterans were randomly assigned to: 1) HUD-VASH (involving both Section 8 vouchers and case management, N=182); 2) intensive case management provided by the HUD-VASH case managers, but without special access housing subsidies (N=90); and 3) standard, time-limited VA case management service for homeless veterans (N=188).

Over a three year follow-up period the HUD-VASH group was housed 65 percent of nights as compared to 57 percent for case management alone, and 53 percent for the standard care group ($p < .05$)(Rosenheck et al., 2003). The case management-only condition thus had only 4 percent more days housed than the standard care group. The HUD-VASH group also experienced 14 percent total days of homelessness while the control groups each experienced 22 percent days of homelessness ($p > .05$), again with no difference between case management only and standard care. Therapeutic alliance (a measure of treatment satisfaction) was stronger in the HUD-VASH group than the other, groups, and a special analysis that addressed differential data attrition with a technique called multiple imputation,

showed that substance use outcomes were superior in the HUD-VASH group than in the other two (Cheng et al., 2007). These results suggest a significant benefit of modest magnitude associated with the integration of case management and vouchers, but no independent benefit from intensive case management by itself.

On the cost side, from a societal perspective, including all VA and non-VA health costs as well as shelter use, incarceration, administrative costs of transfer payments, *annual* costs for HUD-VASH clients over the three years were \$2,067 greater than standard care, while costs for case management control clients were \$1,167 greater than standard care reflecting both direct case management services and greater use of other health services.

Cost effectiveness-analysis using Incremental Cost-Effectiveness ratios showed increased costs of \$45 per additional day housed (95 percent confidence interval = -\$19-\$108) for HUD-VASH clients as compared to controls. Since societal willingness to pay for a day of housing for a homeless person is unknown, cost-effectiveness acceptability curves can be used to show the likelihood of achieving cost-effectiveness under various shadow prices for a day of housing from the societal perspective (including VA and non-VA health costs, criminal justice system costs, homeless shelter costs, transfer payments and productivity through employment) (Figure 1). Benefits are likely to outweigh costs with a probability of 56 percent if a day of housing is valued at \$50; with a probability of 80 percent if valued at \$75/day; and at 92 percent a \$100/day of housing.

The HUD-VASH study was based on random assignment, included a cost component, included a mixture of clients with psychiatric and addiction problems and represented a broad real-world dissemination effort, albeit within the VA system. It showed significant housing benefits, specifically tied to the use of vouchers, but increased costs that would make the intervention less appealing to policy maker. However, with the war in Iraq pushing services for homeless veterans higher on the Congressional agenda, the program is now undergoing a major revival and expansion. It is clear that the increased costs of case management could have been reduced by either lowering the intensity of the case management intervention or shortening its duration. In the new iteration case load expectations are being increased from 25 clients to 35 clients per case manager. What is unknown is whether such cost savings on the delivery of case management services would reduce benefits or, most intriguingly, whether homeless people with mental health and/or

addiction problems could benefit from dedicated vouchers even without any case management.

The second supported housing study that tried to differentiate the benefit of intensive case management from that of housing vouchers was the San Diego Housing Demonstration which used a two-by-two design crossing access to housing vouchers by two levels (high and low intensity) of case management (Hurlburt et al., 1996; Hough et al., 1997). Clients who received rent subsidies were more likely to be independently housed at the end of the 18 month follow-up period but housing outcomes were no better among clients who received high intensity case management than among those who received low intensity case management either with or without vouchers. These findings did not represent clear superiority of either the housing or case management intervention because there were no significant differences between any of the conditions in the number of days of homelessness, and the high intensity case management was, in practice, not as much higher than the standard case management as had been planned. No cost data were obtained but the lack of robust reductions in homelessness would make the results from San Diego less than attractive from a policy perspective.

Housing First is a third, very well-known supported housing initiative which puts a high emphasis on client choice and emphasizes rapid placement in housing severely mentally ill, often dually diagnosed clients, who would otherwise be unlikely to find housing or would find delayed access through multi-stage continuum of care programs (Tsemberis et al., 2004). Housing First has among the most robust improvements in housing in comparison to its randomly assigned control group (60 percent –80 percent of time housed over 6–24 months vs. 12 percent –30 percent time housed for controls ($p < .001$) with similarly robust differences in days of homelessness. Active maintenance of housing units directly by the program, as contrasted with making referrals to Public Housing Authorities, may also facilitate more rapid housing explain the robust findings. There were no benefits in psychiatric or substance abuse outcomes for Housing First clients as compared to controls, although they experience more choice in their programs.

About one third of clients in the Housing First trial entered the program while they were in a psychiatric hospital bed (Gulcur *et al.*, 2003) creating a substantial opportunity for cost savings. There is clear evidence that Housing First clients experienced significantly less use and lower institutional costs during the first 24 months of treatment (Gulcur *et al.*, 2003), although by 24 months there were no

longer significant group differences. A full cost-effectiveness analysis which would include the costs of the of the Housing First intervention itself, has yet to be published, but targeting a high cost sample to begin with increased the chance that Housing First would generate enough savings in institutional care to pay for its own expenses, at least during the first two years. By targeting severely ill clients with dual disorders including many psychiatric inpatients Housing First maximized the opportunity for substantial housing improvements as cost savings, but these findings may not be applicable to less severely impaired populations.

Supported Housing Summary

These studies clearly show the potential benefit of housing subsidies but do not provide distinct evidence for the effectiveness of intensive case management, although they certainly do not rule out a critical role for such services. It is notable that even in the HUD-VASH study, and to a lesser extent in Housing First, clients who did not receive targeted housing services showed decided improvements in their housing status over the follow-up period in both access to independent housing and in reciprocal declines in days of homelessness. Thus in some studies in which interventions improved housing outcomes, difference were not starkly different, although they were most robust in Housing First.

Cost-effectiveness of case management

A review of intensive case management services for homeless people with mental illness identified 10 experimental studies only 3 of which included cost analyses (Morse, 1998). Seven of the ten studies showed fewer days homeless day for case management clients, many of whom received poorly defined housing assistance, as compared to controls but only two showed reduced symptoms. Four studies have been designed to support cost-effectiveness analysis.

A study conducted in St Louis compared two models of intensive case management for homeless people with mental illness (one which included community-workers on the team and one which used only professionals). The intensive case management models cost about \$9,000 per client over 18-months of treatment and were compared with a more standard broker case management model. While the intensive case management conditions showed greater symptom reduction and consumer satisfaction than standard care, there were no differences between groups in days of homelessness, most likely because no specific housing resources

were dedicated to clients in either intensive case management condition. Costs were lowest for the intensive case management program that used community workers (\$39,913/18 months), highest for intensive case management that relied on professionals (\$49,510) and in the middle for standard, brokered case management (\$45,076). The high cost of this program and lack of any greater exit from homelessness does not argue for its policy appeal. It more directly raises doubts about the value of even effective mental health interventions in addressing the problem of homelessness without specific housing resources.

Two more promising intervention studies, one from Baltimore (Lehman et al., 1997, and 1999); and one from New York (Susser et al., 1997; Herman et al., 2000; Jones 2003) illustrate program elements that can improve cost-effectiveness profiles. The Baltimore Assertive Community Treatment study linked a costly case management intervention (\$8,000/year) with section 8 vouchers and found significantly greater improvements in symptoms, life satisfaction and health status and a greater proportion of days in stable housing over a 1-year follow-up period (59 percent vs. 43 percent).

Total health costs were \$50,748 for the experimental condition and \$66,480 for the controls, representing net savings of \$15,732/year. This difference largely reflects 30 fewer inpatient days for the experimental condition during the year generating \$24,519 lower inpatient costs. A key to the favorable cost results was that almost one-third of the sample (29 percent) were recruited from an inpatient unit, thus guaranteeing a high-cost sample, with considerable opportunity for savings. Presumably the availability of housing resources prevented unnecessary extensions of hospital stays. As noted in our summary of study caveats, targeting current inpatients can have an important impact on cost-effectiveness results. While limiting study generalizability, it also illustrates that thoughtful targeting of policy initiatives can improve their cost-effectiveness, at least during the early phase of treatment.

The third program, the New York-based Critical Time Intervention (CTI) represents another modification of the supported housing case management model that improved cost-effectiveness. Unlike most intensive case management interventions discussed above, CTI is a time-limited, 9 month intervention, designed to facilitate the transition from shelter living to community residence, but it did not direct services over the long-term. In an experimental study of CTI and standard care, both groups had access to community housing and thus housing rates were

very high for both over an 18 month follow-up period. CTI clients spent 94 percent of nights housed while controls spent 79 percent of nights housed, a difference of 58 days over 18 months. CTI clients also had lower scores on one measure of psychiatric symptoms.

Total costs from the societal perspective were \$725 greater for CTI clients than for controls during the 18 month follow-up period. However, because CTI is a time-limited intervention, while costs were \$2,263 greater during the first 9 months (similar to HUD-VASH) they were \$1,613 lower during the second 9 months, after the intervention was over. Thus while the incremental cost-effectiveness ratio was \$94/night housed during the first nine months of the study, it was only \$13/night housed during the entire study period. Cost-effectiveness acceptability curves showed that CTI was 95 percent likely to be cost effective if a day of housing is valued as \$457 during the first 9 months, \$120 during the second nine months and \$152 over the entire study period. CTI cost-effectiveness results are thus similar to those of HUD-VASH, except that costs dropped sharply after the supported housing intervention ended, and overall housing rates are higher for both experimental and control groups.

In this review of cost-effectiveness studies three points deserved further emphasis. First, that it appears that the availability of dedicated housing resources appears to be a critical ingredient for housing homeless people with mental illness and that intensive case management by itself does not seem to improve housing outcomes. Second, the differences between experimental and control conditions in the studies reviewed are not very large, 66 percent vs 53 percent of days housed in HUD-VASH, no difference in the San Diego or St. Louis projects; 59 percent vs 43 percent in Baltimore and 94 percent vs 79 percent in CTI but with larger differences in Housing First. Third while some models were associated with increased costs others showed cost savings, largely reflecting variability in the baseline costs of the target population and the duration of the intervention. Finally, while these interventions all generate some benefits, from the policy perspective they are not robustly cost-effective and do not provide an exceptionally appealing case for comprehensive implementation.

As we noted in our preliminary caveats, differences between experimental and control conditions may be minimized in random assignment studies because of the ethical equipoise requirement that no treatment group be deprived of effective services. To bracket this possibility we present preliminary data on housing out-

comes from the Collaborative Initiative on Chronic Homelessness (CICH)(Mares and Rosenheck, 2007), a demonstration program jointly funded by HUD, HHS and VA. The CICH evaluation is a non-experimental study primarily focusing on consumers who received CICH services, a rich array of housing and health care services using a diversity of case management models. Five of the 11 participating sites voluntarily recruited samples of chronically homeless people from a different part of the city, where the enriched services were not available. Baseline data suggest that the CICH sample had more serious health problems than controls and adjustment was made for these using regression models. These data show more robust differences in housing outcomes (68 percent –90 percent of days housed vs. 31 percent –55 percent days housed over the first 12 months of service)(Figure 2) and modest differences in health costs (Figure 3) and suggest that the impact of supported housing may, in fact be greater, than observed in experimental studies, although the risk of selection biases in the absence of random assignment is, of course greater.

Case Management Summary: Case management programs alone, are capable of improving mental health symptoms but seem less likely to improve housing in the absence of specific housing resources. These programs remain costly at up to \$7,000–\$9,000/client/year but when targeted at high cost hospitalized patients can realize short term savings sufficient to offset their cost. When delivered on a time limited basis, costs can be contained sufficiently to allow cost-savings after discharge.

Benefits Outreach, Payeeship and Behavioral Money Management

It is well established that diminished access to public support payments increases the risk of homeless among people with mental health and addictions problems and is a more important risk factor than lack of access to mental health treatment (Sosin and Grossman, 1991). While facilitating access to income supports is regarded as one of the services routinely provided by case management teams, several initiatives have been developed improve access to VA income benefits and have shown that 15 percent –22 percent of veterans contacted through outreach programs received new benefits over 12 months (Chen et al., 2007, Greenberg et al., 2007). However, in the absence of comparison groups it is difficult to know how much to attribute these gains to the outreach efforts, since many clients would have received their benefits on their own initiative.

A joint benefits outreach project conducted by VA clinical staff in collaboration with co-located Social Security field office staff did obtain data that allowed for such a comparison. The adjudication of benefits claims can be time consuming and complex, requiring assertiveness at multiple levels of appeal and deft knowledge of how to develop medical evidence of disability. Project staff included both outreach workers, to organize claims, and doctoral level professionals who could develop necessary medical evidence (Rosenheck et al., 1999). The evaluation design compared receipt of social security benefits at VA homeless program sites that were involved in the joint project and comparison sites that were not. Comparing applications for SSA benefits at the demonstration sites in the years before and after the project was initiated shows a sharp increase in applications from 8–10 percent of homeless veterans in the years before the project was initiated to 23 percent in the years after, with a small secular upward drift to only 10–12 percent at the control sites. Since the rate of award remained the same over these years at both types of site, the net award rate increased modestly from 5 percent to 13 percent of veterans (Figure 4) while the rate of award among homeless veterans entering VA homeless programs at control sites drift upward from 6 percent to 7 percent . This net increase in the proportion of awardees attributable to the program by about 8 percent, came at an estimated cost of \$1,700 – \$3,200 per award (Rosenheck et al., 1999).

A further study of outcomes in the same initiative compared a subgroup of veteran applicants for SSI or SSD payments who received benefits (N=50) and those who did not (N=123). In the 3 months after the awards, beneficiaries reported significantly higher total incomes (\$735 vs. \$458 $p<.001$), higher quality of life (2.96 vs. 2.67 on a 1–7 terrible to delighted scale, $p<.004$) and marginally fewer days of homelessness (9.37 vs. 31.8, $p=.11$) but also lower employment earnings (\$19 vs \$108, $p=.013$).

Since receipt of benefits can be a trigger for substance use (Shaner et al., 1995; Phillips et al., 1999) it is notable that new beneficiaries reported no expenditures on alcohol or drugs while non-recipients reported only \$5 expenditure ($p=ns$), although beneficiaries did spend significantly more money on tobacco products (\$31.77 vs \$20.28, $p<.007$)(Rosenheck et al., 2000).

Whether the benefits in quality of life and housing are worth the not insubstantial investment in benefits outreach is unclear from these data and would require follow-up information well beyond the first three months after the award.

Concerns about misuse of income benefits for substance abuse have also been widespread and studies have clearly demonstrated a substantial “check effect” with increased use of illegal drugs after receipt of benefit checks (Shaner et al., 1995; Philips et al., 1999). However, several studies of participants in VA homeless programs (Rosenheck and Frisman 1996; Frisman and Rosenheck 1997) and in ACCESS (Rosen et al., 2005) have failed to find such effects among clients involved in treatment. A common intervention to curtail such risks, assignment of a representative payee does not seem to have a significant beneficial effect (Rosenheck et al., 1997; Rosen et al., in press). However, a recently developed behavioral intervention called Advisor–Teller–Money Manager (ATM) that is designed specifically to enhance abstinence among drug users by teaching them to better manage their funds, shows some promise in reducing substance use (Rosen et al., 2003; Rosen et al., in press).

Benefits Outreach Summary. Benefits outreach to facilitate access to entitlements has been subject to only one controlled study which revealed some evidence of at least short term benefit but at substantial cost. Additional research is needed of this intuitively appealing area, but the evidence is too thin to support policy action at present.

Supported Employment

We turn, finally, to supported employment, an approach that seeks to return homeless people, many with addiction problems, directly to the labor market. The model of supported employment that has been most carefully evaluated is the Individual Placement and Support (IPS) model (Becker and Drake, 2003). IPS emphasizes rapid job placement, a focus on competitive jobs, ongoing support without a time limit, client choice of jobs, integration of vocational support and clinical care, and openness to all who want to work, regardless of clinical status or past work experience.

In 2000, a demonstration was implemented at 9 VA programs serving homeless veterans that were provided with educational support and funds to hire and train an employment specialist who would provide IPS services (Rosenheck and Mares, 2007). Individual client outcomes were assessed with a pre–post non–equivalent control group design. From 6–12 months before IPS became available, a cohort of 30 homeless veterans newly entering the program and who expressed an interest in employment, was recruited at each site, and followed through quarterly interviews for two years (Phase 1 cohort: N=308). Once the employment specialist

was hired and trained, a second cohort of 35 veterans was recruited and also followed for two years (Phase 2 cohort: N=322). As noted above this kind of comparison, involving real-world, large scale dissemination without randomization, more closely follows the situation of actual policy implementation (albeit with human subjects committee approval and written informed consent).³

Controlling for significant baseline differences veterans in Phase 2 had 13.7 percent more days per month of competitive employment on average (least square means =8.4 vs. 7.4 days; $F=16.5$, $p<.0001$). Among workers in either group there were no significant differences in hourly wage (\$8.51 vs \$8.08; $f=3.2$; $p=.07$) or monthly earnings (\$1,238 vs \$1,142; $F=3.1$, $p=.08$). Average annualized employment income among all participants was \$1,299 greater for those in the phase 2 group (\$8,889 compared with \$7,590; $F=4.5$, $df=1$ and 596, $p=.01$). There was only one significant difference in any non-employment outcome: veterans in Phase 2 had a significant, if modestly, greater average numbers of days housed in the previous 90 days (least square means=34.0 vs. 29.6; $F=4.5$; $p=.03$) for an annualized difference of 16 days housed or only 4 percent per year (Figure 5).

This intensive, highly individualized intervention was not inexpensive with annualized costs for employment specialist services averaging \$2,063/client month (site range=\$1,400-\$2,700), although this was partially offset by greater annual earnings (social productivity) of \$1,299.

This study suggests that IPS can be implemented in an organization with no previous experience with this model through a modestly intensive, but sustained, training effort guided by a single outside expert (Rosenheck and Mares, 2007). Increases in days of competitive employment were observed at eight of nine sites and were statistically significant overall. However, these gains are substantially smaller than those reported in other studies. In Bond's (2007) review of research on IPS, almost 2.9 times as many clients in the IPS groups were employed, as compared with those in the control groups (56 percent compared with 19 percent), while in another large study, the Employment Intervention Demonstration Program (Cook et al, 2005), 1.6 times as many clients in the supported employment group (experi-

³ Because the Phase 2 comparison group was not identified through random assignment participants in the two phases were compared on baseline measures revealing that participants in the IPS phase had fewer lifetime years of homelessness, were more likely to have worked in the previous 3 years (but not in the previous 30 days), had fewer psychiatric symptoms and better physical health, but did not differ on major psychiatric diagnoses or in substance abuse problems. Adjustment for these characteristics was made in subsequent analyses.

mental model) were employed as clients in the control group (55 percent compared to 34 percent). These are much larger effects than the 15 percent gain in days competitively employed found in this study. It is possible that group differences were small in this study because training was insufficiently intense; because the focus was on a homeless sample that included many clients with substance abuse problems rather than on domiciled people predominantly with severe mental illness; or because effectiveness was attenuated in this fairly large-scale real-world dissemination.

Supported Employment Summary

As in our consideration of other interventions for homeless people with special needs, we find evidence of modest effectiveness for supported employment but also for increased costs. Rough calculation of incremental cost-effectiveness ratios suggests \$129/night housed for the supported employment intervention, but only \$48 per night housed if we consider productivity gains as offsetting intervention costs. These incremental cost-effectiveness ratios are similar to those observed in HUD-VASH (\$45/night housed) and during the active treatment phase of CTI (\$94/night housed), but are not likely to be especially attractive to policy makers with tight budgets.

Conclusion

Controlled research has evaluated the effectiveness and cost of several types of program intended to meet the needs of homeless people with psychiatric and addictive disorders. While significantly superior to control treatments, their effects are most often modest in magnitude and primarily center on a single outcome domain such as housing, symptoms, benefits, or employment. No single intervention seems to spread substantial benefit across multiple life domains. Program costs can be substantial but may be offset by more refined specification of high-cost target populations or in limiting the duration of active treatment, albeit with some risk of loss of effectiveness and applicability to the broader population of homeless people with mental health problems.

While these programs provide meaningful, if incremental, benefits they do not yet offer a service armamentarium which can be deployed on a large scale in expectation of efficiently eliminating the problem of homelessness among people with mental illness. While incremental progress is clearly in evidence in these stud-

ies, progress remains to be made to improve their effectiveness, their efficiency, and their potential for widespread dissemination.

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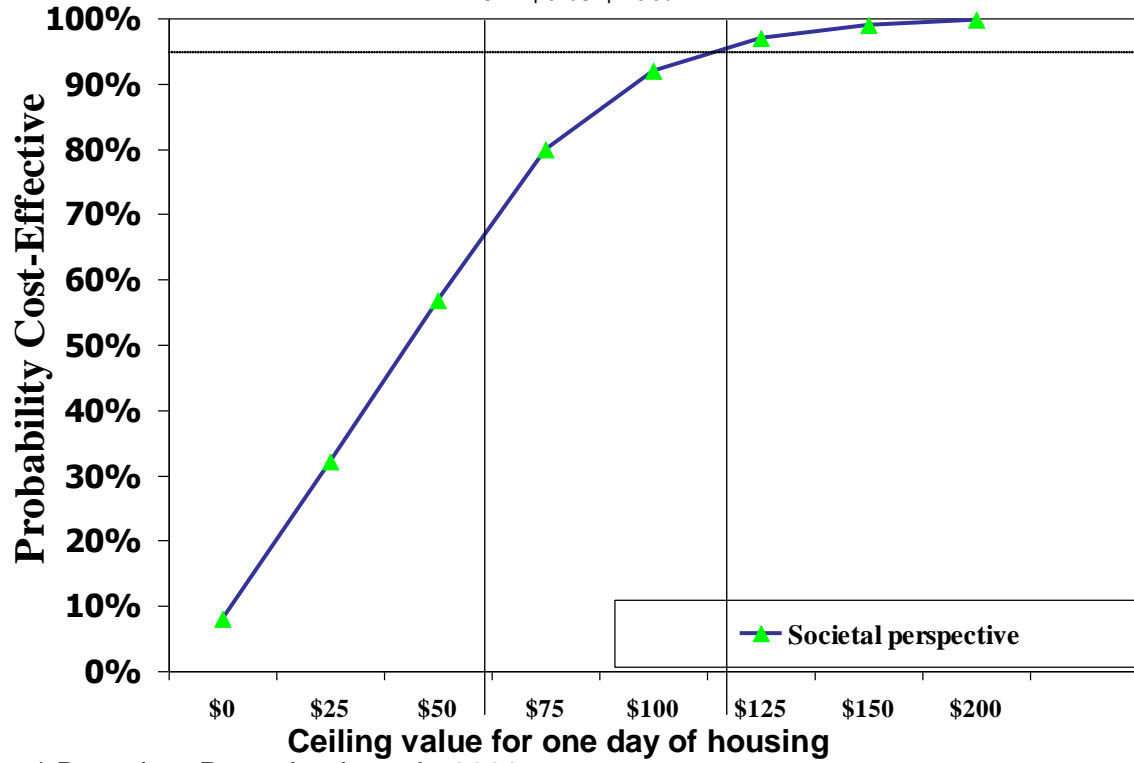
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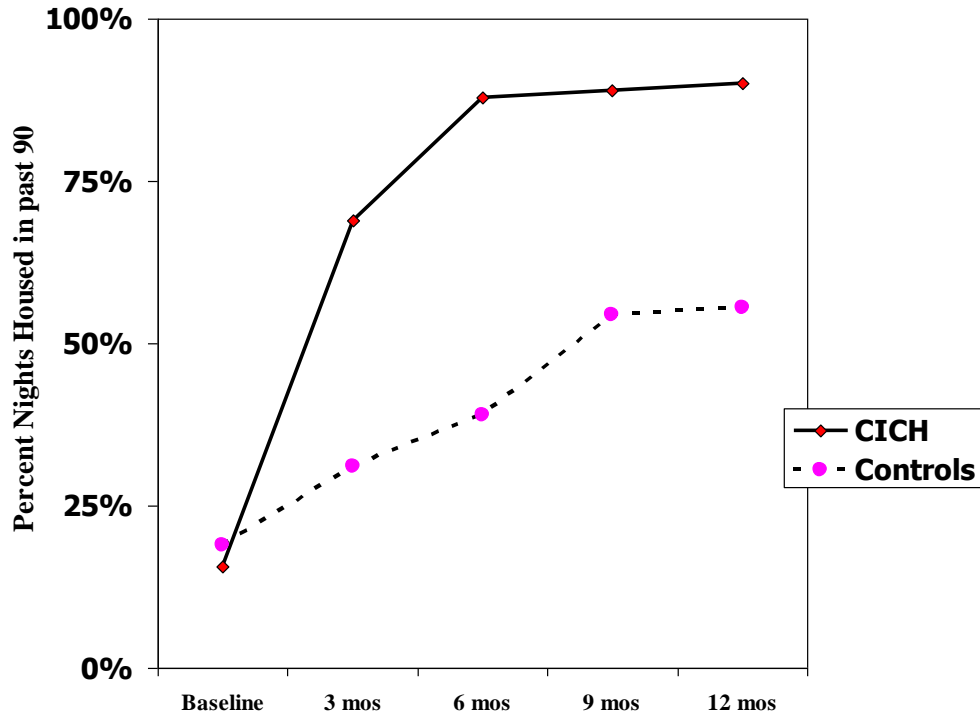
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**Figure 1. Cost Effectiveness Acceptability Curve:
HUD-VASH vs Standard Care at ceiling values for one day of housing
from \$0 to \$200.***



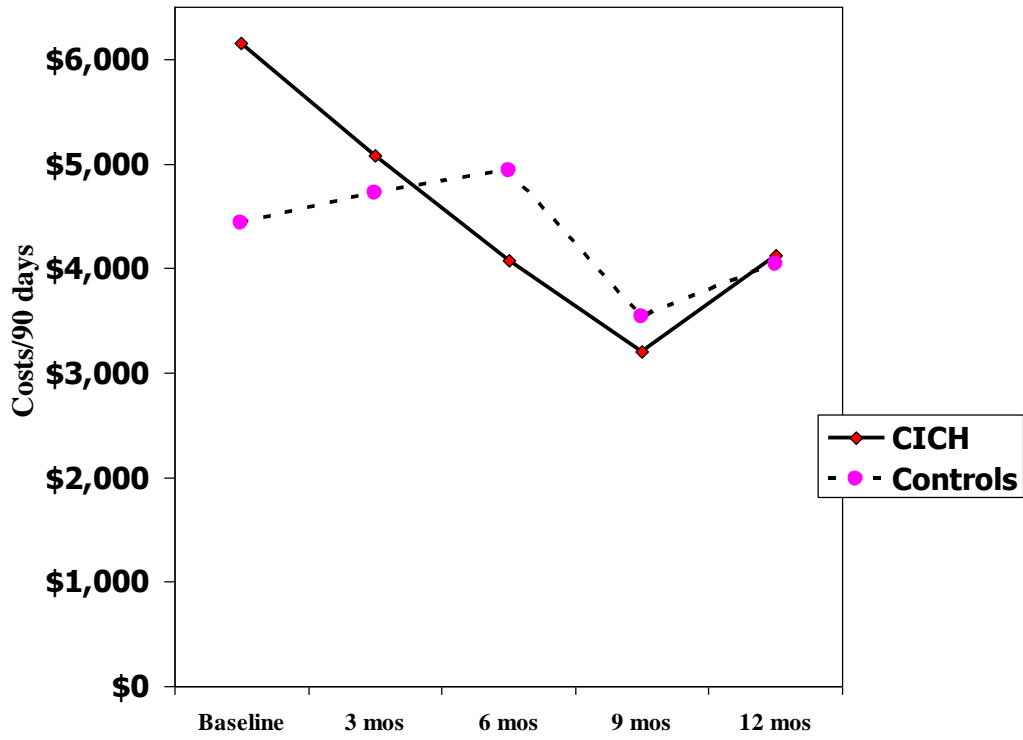
* Based on Rosenheck et al., 2003.

**Figure 2. Outcomes in the CICH Supported Housing Program:
Percent Nights Housed in Past 90***



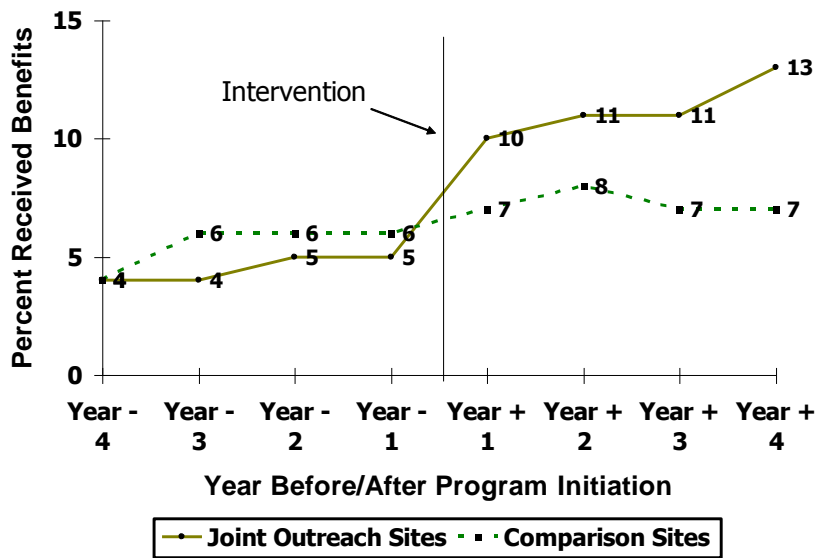
* Based on Mares and Rosenheck, 2007.

Figure 3. Health Costs for Past 90 days in the CICH Supported Housing Program*



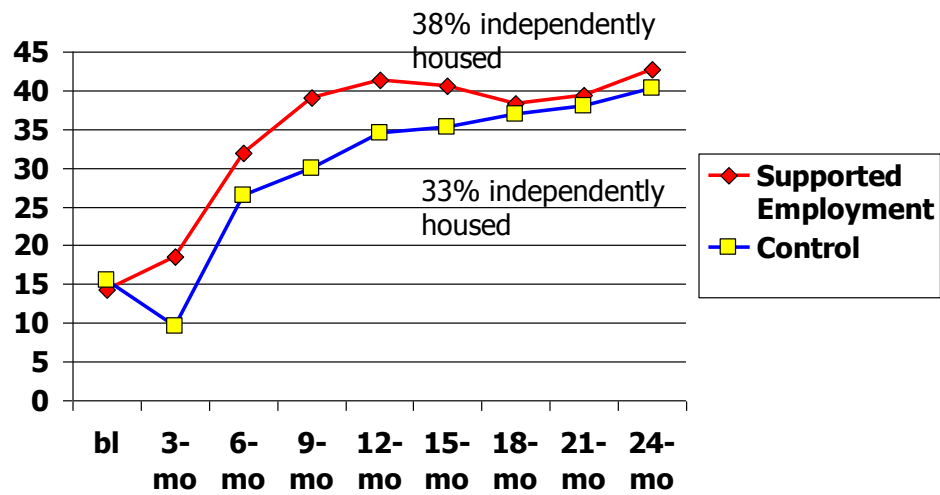
* Based on Mares and Rosenheck, 2007.

Figure 4. SSA-VA Joint Outreach: Rates of Award Among All Outreach Veterans (N=34,431).*



* Based on Rosenheck RA, Frisman LK, KasproW W, 1999

Figure 5. Days Housed in past 90 (Least Square Means)*



* Based on Rosenheck and Mares, 2007.

Part 3: Speaker Vitae

Dr. Bradford Booth has 15 years of experience designing and conducting social science research and evaluations focused on military personnel, military families and veteran populations and the programs designed to support them. During his 11 years at ICF International, where he currently serves as Vice President, he has led or overseen more than 25 research and evaluation projects for the Department of Defense (DoD), Department of Veteran Affairs (VA) and the military services. Dr. Booth has served as the principal investigator and/or project director for studies on the impact of deployment on soldiers and military families, the post-deployment reintegration of service members, the effectiveness of military support services, military spouse employment, organizational change in the military, recruitment and retention, and the effectiveness of VA and DoD programs. Dr. Booth has considerable experience conducting both qualitative and quantitative research using a wide variety of methodologies, including focus groups, personal interviews, literature review, and large-scale surveys using varied modes of administration. He is a member of the Inter-University Seminar on Armed Forces and Society, the major professional organization for social scientists studying the military, and he serves frequently as peer reviewer for the Inter-University Seminar's journal, *Armed Forces and Society* as well as other journals including *Military Psychology*, *Social Psychology Quarterly*, *the Journal of Military and Political Sociology*, and *Race, Gender and Class*. His most recent publications include: Booth, B., and Lederer, S. (2012). Supporting military families in an era of persistent conflict. Chapter 25 in *The Oxford handbook of military psychology*. Laurence, J.H. and Matthews, M.D. (eds.) New York, NY: Oxford University Press; Booth, B., Lederer, S. and Falcone, A. (2011) *Evaluating the Effectiveness of Deployment Reintegration Programs for the National Guard and Reserves*. Presentation at the annual meetings of the American Sociological Association, thematic session on Adjustment and Reintegration of Combat Veteran. Las Vegas, NV. Aug 19-22. Dr. Booth earned his PhD in Sociology from the University of Maryland.

Dr. Robert Rosenheck is Professor of Psychiatry and Public Health and at the Child Study Center at Yale Medical School where he is also Director of the Division of Mental Health Services and Outcomes Research in the Department of Psychiatry, and Senior Investigator at the VA New England Mental Illness Research and Education Center. He is a nationally known mental health service researcher who is leader in cost-effectiveness studies of behavioral health interventions, especially those for homeless people with mental illness, and in monitoring quality of care and other aspects of the performance of large health care system. As founding Director of the Department of Veterans Affairs Northeast Program Evaluation Center he has 22 years of experience evaluating, disseminating, and monitoring innovative programs for homeless veterans with mental illness treated in over 1000 programs across the VA system. He has been a prime architect of national VA collaborative programs with both the Department of Housing and Urban Development and the Social Security Administration. He also directed the client-level evaluation of the ACCESS program for homeless mentally ill Americans, for the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services, which examined the effect of service systems integration on outcomes for homeless persons with severe mental illness in 18 sites and led the evaluation of the joint HUD-HHS-VA multi-site initiative to end chronic homelessness. He has published more than 600 scientific papers on topics such as performance evaluation of large homeless services systems, the causes of homelessness, the cost-effectiveness of programs for homeless persons with mental illness and has received awards for his research from the American Psychiatric Association and the American Public Health Association among others.

Dr. Mady Wechsler Segal earned her Ph.D. at the University of Chicago. She is Professor Emerita of Sociology at the University of Maryland, where she has been Distinguished Scholar Teacher, faculty affiliate of the Women's Studies Department, Associate Director of the Center for Research on Military Organization, and Associate Dean for Undergraduate Studies. She has been a guest scientist at the Walter Reed Army Institute of Research and a Distinguished Visiting Professor at the U. S. Military Academy, West Point. She has served as chair of the Scientific Advisory Committee for the U.S. Army Research Institute's Army Family Research Program, as a Human Resource Consultant to the Secretary of the Army, as a Special Assistant to the U.S. Army Chief of Staff, as a member of the Board of Visitors of the U.S. Military Academy, as a member of the Congressional Commission on Military Training and Gender-Related Issues, and as a member of the Naval Research Advisory Committee Panel on Quality of Life. Her research has focused on military women, military families, and race/ethnicity in the military. Her publications include "The Military and the Family as Greedy Institutions" (*Armed Forces and Society*, 1986) and (with Richard Cooney and Karin De Angelis) "Moving with the Military: Race, Class, and Gender Differences in the Employment Consequences of Tied Migration" (*Race, Gender and Class*, 2011). Dr. Segal is an author of various reports for military leaders and policy makers, including *What We Know About Army Families: 2007 Update* and *How to Support Families during Overseas Deployments: A Sourcebook for Service Providers*.