UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C.

FOR RELEASE ON DELIVERY
EXPECTED AT 9:30 A.M., EDT
WEDNESDAY, OCTOBER 3, 1984

STATEMENT OF

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BEFORE THE SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS

AND HUMAN RESOURCES

COMMITTEE ON GOVERNMENT OPERATIONS

HOUSE OF REPRESENTATIVES

ON

THE HOMELESS

Mr. Chairman, we are pleased to appear today before the Subcommittee to discuss the work you asked us to undertake to identify the factors which contribute to poverty in the United States. To respond to your request, our study concentrates on four groups which we believe cover the vast majority of persons in poverty. Specifically, these groups are the single female heads of households, the elderly, the working poor, and the homeless. Our work is still ongoing and our presentation today will be limited to the results of our study of the homeless population.

In conducting our study of the homeless we reviewed over 100 studies and surveys conducted by federal, state, and local government agencies, as well as service providers and academicians. Interviews were held with government officials, poverty experts, and persons who work with the homeless on a regular basis.

Our testimony is organized around three issues: 1) trends in the incidence of homelessness, 2) factors which may be contributing to these trends, and 3) programs and policies affecting the homeless.

TRENDS IN THE INCIDENCE OF HOMELESSNESS

The homeless population is a group that has been the focus of increasing interest and concern in the 1980's. There is no commonly accepted definition of homelessness; however, a basic

working definition (condensed from definitions developed by federal agencies and groups which work with the homeless) is as follows: those persons who lack resources and community ties necessary to provide for their own adequate shelter. They live in public and private emergency shelters, in the streets, in subways, in bus terminals, under bridges and in abandoned buildings.

A major obstacle in determining the extent of the problem is the lack of a definitive count of the number of homeless. State and local governments and advocacy organizations have tried to estimate the number of homeless persons within their boundaries. They have concluded that a reliable count cannot be produced because homeless persons try to avoid appearing homeless in order to escape threats, violence, and other forms of harassment. The homeless who come to shelters can be counted; however, not all homeless use shelters and it is difficult to locate all of the places where they go to sleep.

We are aware of two attempts to estimate the number of homeless on a nationwide basis. The estimates, however, vary a great deal. For example, the Department of Housing and Urban Development (HUD) reported that on an average night in December 1983 and January 1984 between 250,000 and 350,000 persons were homeless.[1] In contrast the Community for Creative Non-Violence (CCNV), a Washington, D.C. based advocacy group and shelter provider, estimated that during the winter of 1983-84 between 2 million and 3 million persons were homeless each night.[2]

Neither of these estimates is based on an actual physical count of homeless persons.

For the reasons mentioned earlier, it is extremely difficult to locate all homeless persons. As a result, the HUD estimate is based on previously published local estimates, telephone interviews with local shelter providers and public agencies, and three local physical counts performed by local organizations. The HUD methodology relied primarily on opinions of individuals who come in contact with homeless persons but who have themselves not conducted actual counts.

The CCNV based its number on a sample of local shelter providers, who estimated that an average of 1 percent of the total population of their locality was homeless. The 1 percent homeless ratio was extrapolated to cover the entire U.S. population and rounded to between 2 million and 3 million. CCNV neither conducted a physical count of the homeless nor asked local groups to conduct one to derive their local total.[3]

Although no one knows the exact number of homeless persons, the over 100 studies we reviewed and the interviews we had with shelter providers, experts and government officials were consistent in reporting that homelessness has increased in the last several years. For example, city officials reported in a series of surveys by the U.S. Conference of Mayors that the average number of people seeking emergency shelter increased 38 percent from 1982 to 1983.[4] Based on estimates from local interviewees, HUD adjusted 1980 data on the homeless to reflect a 10 percent per year increase between 1980 and 1983.[5]

The studies also indicate that there is agreement that the composition of the homeless population has changed. Until the 1970's, the homeless were mostly single white males who were alcoholics or drug addicts. Service providers report that they are now seeing more homeless who do not fit this description.[6] HUD found the homeless now are younger (average age 34), include more minorities (44 percent), and more families with children. Although single men continue to dominate the homeless population, family members comprise 21 percent and single women 13 percent.[7] Overall, the homeless population is viewed today as heterogeneous and composed of numerous subgroups; it includes, however, a high number of persons with serious alcohol and drug abuse problems and individuals with mental health disorders.

FACTORS AFFECTING TRENDS

Because of the difficulties in counting and surveying the homeless population, it is not surprising that there are no studies which provide a scientifically accurate description of the number, characteristics, and service needs of the homeless or the reasons contributing to the recent increases in this group. The information we will present on factors which are believed to be contributing to this increase is derived from our review of surveys representing a national cross section of the country. Generally these surveys present findings from shelter providers and city officials who deal with the problems of the homeless in specific geographic areas. For example, one study-- "Homelessness in the Southwest"[8] asked service providers from seven large cities to rank the causes of increases in

homelessness in their cities. Another, sponsored by the U.S. Conference of Mayors,[9] asked city officials from 10 large cities throughout the country to specify the causes of homelessness.

After reviewing over 100 surveys and studies we found the results consistent; they reported that there are multiple and interrelated factors contributing to increases in homelessness including: increased unemployment, decline in the low-income housing supply, deinstitutionalization of mentally ill persons and the lack of available community-based services for individuals who are mentally ill, increases in personal crises, and cuts in public assistance programs.

Unemployment

Unemployment was considered to be a problem because it rose dramatically between 1979 and 1983. The 1979 unemployment rate was 5.8 percent; however, by 1983 the annual rate had increased to 9.5 percent, having reached a monthly high of 10.8 percent in December 1982. Not only were more people unemployed during that time but more were unemployed for a long time. To illustrate, in 1979, 460,000 individuals were unemployed longer than 26 weeks. By 1982, that figure had more than tripled to 1,404,000. No one has documented how many individuals became homeless because of these high unemployment rates.

After April 1983 unemployment dropped considerably to a 7.5 percent rate in August 1984. What effect this drop will have on homelessness is also unknown, particularly since many homeless people acquire new problems from living on the streets (e.g. medical and mental health problems) and may not be able to

hold a job even if a job becomes available. The difficulty in finding a job for homeless persons is compounded when they do not have a fixed address or home telephone number.

Low Income Housing Supply

Another frequently cited reason for the rise in homelessness is the decline in the supply of low-income housing. The studies indicate that this decline is due to such factors as downtown redevelopment, condominium conversion, decreased construction, and more demand from higher income renters. The estimates of the size of the decline vary, but all point toward a significant loss of low income housing. One study found that nationwide 1 million SRO (single room occupancy) units were lost during the 1970's, representing nearly one-half of the total supply.[10] New York City, for example, lost 81 percent of its SRO units during the 1970's.[11]

Deinstitutionalizing the Mentally Ill

A third major reason cited for more homelessness has been the increasing trend toward deinstitutionalizing mentally ill people combined with unavailable community-based services for these individuals. In the last two decades many mentally ill people have been released from institutions to receive treatment in the community at places like community mental health centers. However, according to the National Institute of Mental Health (within the Department of Health and Human Services) and others, hundreds of thousands of people have been released

without available community services and training to cope with the job market.[12]

To illustrate the nature of the problem, between 1955 and 1980 the population of state mental institutions shrank by more than three-fourths, from 559,000 to 138,000, even though the total U.S. population increased significantly.[13] With the decline in state mental institutions a system of community mental health centers was established to serve the mentally ill including those being deinstitutionalized. However, less than 800 of the estimated 2,000 community mental health centers needed to provide community care were ever established.[14] Another aspect which compounds this problem is that criteria for admitting the mentally ill to state hospitals have been tightened. This, coupled with an inability or unwillingness of people to enroll in the existing community programs, means that many mentally ill people have no contact with either a state hospital or a community program.[15] For example, psychiatric exams were performed on 179 persons who were admitted to a Philadelphia shelter during the first 2 months of 1982. Although 151 of them were found to have a mental illness, only 68 reported previous professional psychiatric care.[16]

The extent of mental illness among the homeless is difficult to measure. According to surveys by the National Institute of Mental Health, 50 percent of the homeless may have severe and persistent mental disorders, 10 to 15 percent

abuse drugs, and 40 to 45 percent abuse alcohol, with a "great deal of overlap between these categories."[17]

Personal Crises and Cuts in Public Assistance

Another important cause cited in the studies has been the increase in personal crises which lead people to become homeless. People who have experienced a severe personal crisis include runaways and victims of domestic violence.

A final major reason identified as contributing to the increase in homelessness was the cuts in public assistance programs. The Urban Institute estimated in a recent report that federal spending for social programs will be about 9 percent--$38 billion--less in FY 1985 than it would have been prior to legislative changes in 1981.[18] There has been some analysis showing the link between these federal budget cuts and poverty on a national basis. In one of the most recent studies on this issue, Mathematica Policy Research (in an analysis for the Congressional Research Service published in July 1984) estimated that 587,000 more people were in poverty in 1982 as a result of the federal budget cuts included in the Omnibus Budget Reconciliation Act of 1981.[19]

While no one has quantifiably demonstrated the effect of budget cuts on the increase in homelessness, many service providers have reported that homeless individuals interviewed in shelters stated that they had received public benefits (both federal and state assistance) but that these benefits had been terminated. In one survey, officials in New York City, Denver,

and Columbus, Ohio, attributed some of the increase to the termination of benefits (often to individuals with mental illness) due to reexamination of the eligibility of persons for Social Security Disability Insurance (SSDI). New York reported that 20,000 to 25,000 people had been dropped from SSDI in New York State since April 1980.[20] Nationwide, an estimated 491,300 people have been dropped from SSDI; however, more than 200,000 of those dropped have been reinstated upon appeal.

PROGRAMS AND POLICIES TO SERVE THE HOMELESS

In response to the increase in the homeless population, cities and counties, in conjunction with voluntary organizations, have taken steps to expand the supply of shelter beds. According to HUD's survey, 110,000 persons can be housed nationally on any given night in emergency shelters including "approximately 12,000 beds for runaway youths and another 8,000 for battered or abused women." The remaining 90,000 beds serve all other homeless persons including single men, single women, and parents with children.[21] We are not aware of any other nationwide bed estimate or shelter inventory.

No matter which estimate is used to describe the total homeless population, a large majority of homeless persons do not have access to a shelter bed on an average night. Using HUD's estimate of the homeless population, 31 to 44 percent of these

individuals can be sheltered on a given night. Using the CCNV estimate, only 4 to 6 percent have access to a shelter bed.

Our review of actions which federal agencies have taken in response to the increase in the homeless population identified several departments with responsibility to provide assistance to this population: the Federal Emergency Management Agency (FEMA) and the Departments of HUD, Defense, and HHS.

Federal Emergency Management Agency

The Job Stimulus Act of 1983 (P.L. 98-8) established the first national program specifically designed to aid the homeless. This act authorized FEMA to distribute $100 million to groups providing emergency food and shelter services during FY 83 and FY 84 ($50 million went to state and local governments and another $50 million for distribution to volunteer groups, chaired by a National Board). The National Board, which consists of representatives of national voluntary organizations and FEMA, was set up to determine how the funds should be distributed to individual localities. Supplemental appropriations have been made to the National Board; $40 million in November 1983 and $70 million in August 1984, which extended the program into FY 85. The grants were intended for purchasing food and providing shelter to supplement and extend current available resources. The funds could not be used to reimburse shelters or food kitchens for ongoing programs.

At this time, FEMA has not received its complete report on how the funds were spent by state governments. Of the initial $90 million provided to the National Board, approximately

one-third was spent on shelter and two-thirds on food. According to National Board estimates, the funds bought an additional 13 million nights of shelter and 85 million meals.[22] FEMA did not request any funds to extend the emergency food and shelter program into FY 85.

Department of Housing and Urban Development

While not supporting the concept of a separate shelter program, HUD has encouraged state and local grantees to serve homeless persons through existing programs. On February 14, 1983, the Secretary of HUD announced an "expediting of the use of Community Development Block Grant (CDBG) funds" to meet the needs of the homeless as identified by local communities.

Subsequently, HUD regional staff contacted local community development directors to identify amounts of CDBG and state and local governments and private funds being used to help the homeless in CDBG entitlement cities. HUD identified over $20 million in CDBG funds and nearly $60 million in state-local-private funds. Over one-half of the state-local-private funds were being spent in New York City ($35,500,000).[23]

Department of Defense

The Department of Defense has an FY 84 appropriation of $8 million to renovate or adapt facilities on military installations for use as shelters for the homeless and pay for some operating costs. No funds have been spent to date. However, a total of $300,000 has been obligated by four agreements for projects to be initiated this fall. While DOD has offered

facilities at hundreds of installations nationwide, local communities have generally not participated because (1) they had no funds to operate the shelters, (2) the shelters offered were in remote areas, and (3) local installation commanders imposed conditions on the use of potential shelter sites which providers felt were too restrictive.

Department of Health and Human Services

While not specifically operating a program for the homeless, HHS has benefit programs and block grants that can provide assistance to this population. Also, HHS has set up a task force designed to identify federal resources to aid the homeless.

One HHS initiative was an attempt to survey impediments to homeless people receiving benefits from certain programs. Secretary Heckler asked all HHS agencies to identify impediments--such as the lack of a fixed address--which do not allow the homeless to participate in benefit programs for low-income persons. HHS found that there is no federal requirement for a fixed address to be eligible for these programs. Some states and localities, however, require applicants to supply a fixed address to qualify for entitlement programs, such as AFDC and Medicaid. This occurs apparently out of concern by the states that the federal government will penalize them if the state approves fraudulent applications of homeless recipients. This requirement also exists in at least some states' General Assistance programs.

Many of the homeless population would qualify for medical and financial assistance under current HHS programs, including SSDI, SSI, and Medicaid. However, in addition to not having a fixed address, many individuals would need extensive assistance and supportive services to establish eligibility and residency where they could receive these benefits. In response to a New York City initiative, HHS regional staff have participated with state and city personnel in outreach efforts at shelters to identify homeless individuals who appear eligible for SSDI or SSI. These teams then help to review and process the applications. Other cities are now requesting this help from HHS.

Community Services Block Grant (CSBG) funds can be used to fund a range of antipoverty programs, including emergency food and shelter. According to HHS, local governments reported that they budgeted one-fifth ($60 million) of their FY 83 funds on emergency services, which would include, among other activities, efforts to aid the homeless.[24] The Alcohol, Drug Abuse, and Mental Health (ADAMH) Block Grant can be used by states and localities to fund community mental health centers. All persons, including the homeless, who live within a center's geographical jurisdiction may receive services. There is no data on whether homeless persons use these services.

Finally, HHS chairs the Federal Interagency Task Force on Food and Shelter, which was created in 1983 to cut red tape and act as a "broker" between the federal government and the private sector when an available federal facility or resource is

identified which could be used to establish or continue a food or shelter project. The task force includes representatives from the Departments of Agriculture, Commerce, Defense, HUD, Interior, Labor, and Transportation, as well as GSA, FEMA, ACTION, the Veterans Administration, and the Postal Service.

The task force has cited both accomplishments and setbacks. For example, it reports that it has linked hundreds of federal food-dispensing units, primarily military commissaries, with local food banks and shelters. On the other hand, since the task force lacks the authority to require federal agencies to deliver excess resources to food or shelter providers, some resources have gone unused. This has been particularly true of vacant federal buildings, both civilian and military, whose agency tenants have set stringent rules for their use as shelters, or vetoed their use outright.

Overall, while there are federal resources for which the homeless should be eligible, there is currently no nationwide coordinated outreach effort to bring federal, state, local and private resources to bear on the homeless problem. Also, because there is no one agency responsible for monitoring and documenting the allocation of federal resources to states and localities, it is difficult to determine what the current level of support actually is and where the most urgent needs are.

SUMMARY

In summary, while there is large disagreement on the exact number of homeless persons, there is a consensus in the over 100 studies that we reviewed and among the government officials,

experts, and shelter providers we interviewed, that homelessness has increased in the last several years. There is also agreement that while this group still has many persons with serious alcohol, drug abuse, and mental health disorders, its composition has changed. Today's homeless include more young people, women, and children.

Surveys conducted in cities across the country also consistently reported that multiple and interrelated factors appear to be contributing to the trend in increased homelessness: high unemployment during the period of 1979 to 1983; the decline in the supply of low-income housing; deinstitutionalization of mentally ill persons combined with unavailable community-based services; increases in personal crises; and cuts in public assistance programs.

There is also agreement that at present, facilities and services are insufficient to meet the needs of the homeless for shelter. Even using the most conservative estimate of the size of the homeless population still leaves between 140,000 and 240,000 of these individuals without access to shelter on a given night. In addition while there are federal resources for which the homeless should be eligible there is currently no federal agency which has the authority to marshall these resources toward addressing the needs of the homeless.

Though supplying food and shelter does respond to the immediate needs of the homeless, long-term solutions are more problematic and likely to be very expensive because they will have to address the issue of how to most effectively assist

individuals with financial and often chronic mental health and medical problems. Experts have concluded that the homeless will not only need low-income housing, they will need support services, such as medical and mental health care and vocational training (where appropriate) to improve their chances of self-reliance. Some of the financial and medical services the homeless need are available in current HHS programs, including SSDI, SSI, and Medicaid. However, as demonstrated in New York City, because of the many problems of the homeless, outreach efforts are often needed to help these individuals prove eligibility, receive benefits, and obtain needed medical care.

Mr. Chairman, this concludes our prepared statement. We will be happy to answer any questions at this time.

Notes

[1]Department of Housing and Urban Development, A Report to the Secretary on the Homeless and Emergency Shelters, May 1984, pp. 8, 9 and 18.

[2]Mary Ellen Hombs and Mitch Snyder. Homelessness in America: A Forced March to Nowhere. (Washington, D.C.: Community for Creative Non-Violence), 2nd ed., September 1983, pp. xvi.

[3]Hombs and Snyder, p. 11. Mitch Snyder, testimony at the May 24, 1984 hearing before the Subcommittee on Housing and Community Development of the Committee on Banking, Finance, and Urban Affairs and the Subcommittee on Manpower and Housing of the Committee on Government Operations, U.S. House of Representatives, on HUD Report on Homelessness, Banking Committee Serial No. 98-91, p. 33.

[4]U.S. Conference of Mayors, Status Report: Emergency Food, Shelter, and Energy Programs in 20 Cities, Washington, D.C., January 1984, p. 1.

[5]HUD (1984), p. 16.

[6]Ellen Baxter and Kim Hopper. Private Lives/Public Spaces: Homeless Adults on the Streets of New York City. (New York: Community Service Society), February 1981, pp. 32-33. Mario Cuomo, 1933/1983 - Never Again: A Report to the National Governor's Association Task Force on the Homeless, July 1983, p. 33. Roger Sanjeck, Federal Housing Programs and Their Impact on Homelessness, New York City: Coalition for the Homeless, October 1982, p. 3.

[7]HUD (1984), p. 28.

[8]Peggy Jane Gearan and Louisa R. Stark, Homelessness in the Southwest: A Survey, Transient Aid Center, St. Vincent de Paul Society, 1984.

[9]U.S. Conference of Mayors, Homelessness in America's Cities: Ten Case Studies, June 1984.

[10]Cynthia B. Green, "Housing Single Low Income Individuals," Paper prepared for the Conference on New York State Social Welfare Policy, New York, October 1-2, 1982, p. 6.

[11]Green, p. 6.

[12]U.S. Department of Health and Human Services and the Department of Housing and Urban Development, Report on Federal Efforts to Respond to the Shelter and Basic Living Needs of Chronically Ill Individuals, February 1983, pp. 1, 3-5 and 13-15, Irene Shifren Levine, Alcohol, Drug Abuse, and Mental Health Administration, Department of Health and Human Services, Homelessness: Its Implications for Mental Health Policy and Practice, August 30, 1983, pp. 4-7, Hombs and Snyder, pp. 6, 43-52, Laurence Appleby, Nancy Slagg and Prakash N. Desai, "The Urban Nomad: A Psychiatric Problem?" Current Psychiatric Therapies Vol. 21, 1982, pp. 253-254 and 260.

[13]Howard Goldman, "The Demography of Deinstitutionalization". Deinstitutionalization, Leona L. Backrack, (ed), (San Francisco: Jossey-Bass, Inc.), p. 35.

[14]National Institute of Mental Health, History of the Community Mental Health Centers Program, April 30, 1980, p. 71. Jack Zusman, "The Philosophic Basis for a Community and Social Psychiatry." An Assessment of the Community Mental Health Movement, (Walter E. Barton and Charlotte J. Sanborn eds., (Lexington, MA.: Lexington Books), 1977, p. 37.

[15]HHS/HUD, pp. 3, 4; Appleby, et al, pp. 255, 257, 258.

[16]Department of Health and Human Services, Alcohol, Drug Abuse and Mental Health Administration, Alcohol, Drug Abuse and Mental Health Problems of the Homeless: Proceedings of a Roundtable, March 31 and April 1, 1983, pp. 10 to 11. "Technical Assistance Project," covering October 1, 1982, to January 31, 1984, pp. 1, 6.

[17]Levine, p. 2.

[18]John L. Palmer and Isable V. Sawhill, eds., The Reagan Record: An Assessment of America's Changing Domestic Priorities, 1984, The Urban Institute, (Cambridge, Massachusetts: Ballinger Publishing) p. 13.

[19]Congressional Research Service and Mathematica Policy Research, Effects of the Omnibus Budget Reconciliation Act of 1981 (OBRA) Welfare Changes and the Recession on Poverty, Committee Print WMCP: 98-33 for the House Committee on Ways and Means, July 25, 1984, p. 12.

[20]U.S. Conference of Mayors, Homelessness in America's Cities, pp. 5, 30, 36, 44, and 63.

[21]HUD, (1984), p. 34.

[22]Emergency Food and Shelter National Board, Fact Sheet, "Emergency Food and Shelter National Board Program," p. 2.

[23]Stephen J. Bollinger, HUD, Memorandum on "HUD Assistance to the Homeless," March 3, 1983, pp. 2-5.

[24]National Governor's Association, "Final Report to the Office of Community Services, U.S. Department of Health and Human Services on Grant Number CS-82-TA-0005, the CSBG Training and Technical Assistance Project," covering October 1, 1982, to January 31, 1984, pp. 1, 6.