

# **When Johnny Comes Marching Home, Where Is Home?**

A Look at Where Homeless Veterans are Finding Housing and Implications for HUD-VASH

by

JESSICA BRANDES

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Approved by:

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## **Abstract**

Jessica Brandes

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The HUD-VA Supported Housing Program was initially implemented in 1992 as a pilot program that combined VA supportive services with Housing Choice Vouchers for homeless veterans. Expanded in scope and numbers in 2008, the HUD-VASH program has begun to allow homeless veterans to move into permanent housing around the country. This study begins to look at where these veterans are finding housing, and concludes that most veterans are moving to areas of relatively high poverty, high renter-occupancy rates, high rates of families headed by females, and low median incomes. In particular, the majority of veterans in the sample moved to areas with high neighborhood indicators for violent crime and poor mental health. Several recommendations are put forward to improve outcomes for the program.

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## Table of Contents

Introduction.....	1
Background.....	2
Research Question and Hypothesis .....	9
Data.....	10
Methods and Findings.....	10
Discussion and Implications.....	17
Bibliography.....	20

# Introduction

Support Our Troops. Bumper stickers everywhere echo this message. Our leaders repeat the government's commitment to honoring the sacrifice of military personnel. Despite this atmosphere and these well-intentioned messages, we have all encountered or heard about a homeless veteran - living under a bridge, waiting in line at an emergency shelter, or asking for change on a street corner. The plight of our nation's homeless veterans is so morally disturbing because it runs contrary to our cultural values of sacrifice and reward. We expect that if someone risks their safety in service to our country, that we will reward them with, at minimum, a dignified life where their basic needs are met. The failure to meet veterans' basic needs for quality healthcare at Walter Reed Army Medical Center sparked nationwide outrage, and I believe it is this same sense of moral unfairness that causes us to feel outrage over the ongoing problem of homeless veterans.

The Veterans Administration (VA) is the government department charged with providing services to all veterans. The VA has developed many programs and funding mechanisms to assist homeless veterans. In 1992, the VA decided to try a new strategy designed to permanently house homeless veterans who had disabling conditions which made them difficult to house. The department partnered with the Department of Housing and Urban Development, and created the HUD-VA Supported Housing Program, or HUD-VASH. For three years, this pilot program linked veterans with medical, psychological, and other supportive services, while at the same time working with public housing authorities to keep veterans in permanent housing through the use of rental vouchers. The HUD-VASH program was found to be very effective in dramatically decreasing homelessness for participating veterans.

Despite these outcomes, the HUD-VASH program was not expanded until 2007 when Congress allocated funding for 10,000 more vouchers. Veterans began finding housing and receiving services through the program in 2008, and results so far seem to be encouraging. What has not been evaluated, either during the 1992-1995 pilot program or currently, is the quality of the neighborhoods into which these veterans are moving. While physical housing and supportive services are crucial for the participant's well-being, so is the environment in which he or she lives. From the planning perspective, questions remain unanswered about where veterans are going, what the conditions are like there, and how the program might be structured to ensure that veterans are moving into healthy, safe communities that will nurture their long-term success.

These questions form the basis of this paper. I begin with a brief summary of the state of homeless veterans in our country. I then discuss in further detail the mechanics of the HUD-VASH program, and the evaluation of it so far. My last area of background is about the use of vouchers in general, and I specifically discuss the location and character of the neighborhoods where voucher-holders normally find housing. After explaining my research questions and sources of data, I summarize the findings of my analysis. Lastly, I conclude with implications of this research, and policy suggestions for ensuring that HUD-VASH better achieves, and even exceeds, its objectives.

# Background

## *The Problem of Homeless Veterans in the US*

On any given night in the streets of the United States, between 150,000 and 200,000 veterans are homeless (US Department of Veterans Affairs, 2009, Cunningham, Henry, & Lyons, 2007). Of all homeless persons in the US, approximately one in three is a veteran (US Department of Veterans Affairs, 2009). In fact, the number of veterans from the Vietnam War who are homeless is greater than the total US casualties for that war (Ibid.). Politicians, military support non-profits, and homeless activists have repeatedly pointed to our country's homeless veterans as an example of the worst of our nation's disrespect and disregard for its veterans. Yet this problem persists.

Veterans, as a group, are more likely to become homeless than Americans who are non-veterans (Cunningham, Henry, & Lyons, 2007). Male veterans are 1.3 times more likely to experience homelessness and female veterans are over three times as likely. The reasons explaining this are several. As with many persons of moderate or low wealth, veterans have trouble finding affordable housing. Since the draft ended in 1973, moreover, veterans tend to come from poorer backgrounds and to have limited transferrable work skills. This causes many to struggle with poverty and un- or underemployment upon their return to civilian life. Health issues also exacerbate veterans' struggles to lead mainstream lives. One in every ten veterans has a physical disability. Nearly one in ten veterans returning from Afghanistan is coping with a mental illness; for the Iraq War, that number is one in every five (Hoge, Aushterlonie, & Milliken, 2006). The presence of a disability is not only costly and emotionally injurious, but it often leads to discrimination in jobs and in housing. Veterans also grapple with trying to reconnect to social networks that may have weakened during long periods of time away. Some veterans who have trouble readjusting to life back at home may strain these bonds further. These factors of social isolation and lack of support were found in a 2003 study to be the key explanatory factors of why veterans experience longer periods of homelessness than non-veterans. The authors concluded that those who experienced the longest periods of homelessness were "those who were lacking in social bonds to civilian society that are normally conferred by employment, marriage, and support from family of origin" (Tessler, Rosenheck, & Gamache, 2003).

To cope with all these struggles, the Veterans Administration (VA) has a variety of services and programs. Yet these are unable to meet the needs of all veterans because of limited VA staff and funding, and because of the difficulty to connecting to all those who need help, especially when those in need are reluctant to accept or unaware of the help available. Some of this observed reluctance may come from the training military personnel receive, and the principles of pride and self-reliance instilled in them. Pete Dougherty, Director of Homeless Programs for the VA, states that "[chronically homeless veterans] are much better prepared than nonveterans. They seemingly have a higher tolerance and a certain degree of pride and toughness that they, more than the rest of us, can endure tough circumstances" (Ending Homelessness, 2006).

## ***The HUD-VASH Program***

### *Development of the HUD-VASH Program*

Housing voucher programs, like the Section 8 voucher program and the Housing Choice program, are policy tools that have been used to combat homelessness for decades now. More recently, “Housing First” models of care, which combine partially or fully subsidized housing with intensive case management without being contingent on sobriety or treatment participation, have been increasing in popularity as a tool for housing the nation’s homeless.

In 1992, the Department of Housing and Urban Development and the Department of Veteran Affairs partnered to create the HUD-VA Supported Housing Program, or HUD-VASH. This pilot program combines the two approaches described above by providing “fast-tracked”, or lower-barrier, Housing Choice vouchers to homeless veterans, as well as providing intensive case management and medical treatment through VA Medical Centers. 1,753 vouchers were issued to nineteen different VA medical centers (VAMCs) around the country during the pilot program. Research evaluating the success of the program for veterans indicated the program caused homeless veterans to decrease their incidence of homelessness and remain in housing longer. The HUD-VASH program is significant because it is the only program of the VA that addresses permanent housing for homeless veterans. The VA has funding available for transitional housing and even for blankets and supplies for homeless veterans, but only HUD-VASH for permanent housing.

In spring of 2008, the HUD-VASH program was expanded to 10,150 vouchers for homeless veterans in all fifty states, the District of Columbia, and Puerto Rico. 132 VAMCs are participating in the program and approximately \$75 million dollars of federal funding are allocated to its implementation. The funding for the program was authorized by section 8(o)(19) of the US Housing Act of 1937, 42 U.S.C. 1437f(o)(19), and monies came from the 2008 Appropriation Act, enacted on December 26, 2007 (HUD, 2008). The 132 VAMCs participating were identified by the VA and selected based on the population of homeless veterans in the area, the number of homeless veterans served by the VAMC during 2006 and 2007, geographic distribution, and the resources available from VA case management (Ibid.). Once the VA selected the VAMCs, HUD selected the Public Housing Authorities (PHAs) that were eligible to participate based on location within the VAMC jurisdiction and the administrative performance of the PHA. HUD then invited these PHAs to apply for HUD-VASH vouchers.

The program was expanded in 2008 not just in volume and geographic reach, but in terms of those homeless veterans who are eligible through even lower barriers and further relaxation of typical Housing Choice voucher requirements. Eligibility for the HUD-VASH program is straightforward. Qualified participants are those who are homeless, received an honorable discharge from the armed forces, have shown a demonstrated commitment to the program, are able to live independently, and who are not registered sex offenders. Furthermore, veterans are eligible whether or not they are in treatment for substance abuse or for a mental illness. The pilot program had stricter rules that excluded

participants who did not maintain sobriety, but in keeping with the model of Housing First, this exclusion was eliminated. Veterans are eligible even with a criminal record, and even with a criminal record that includes arson or manufacturing methamphetamines. This too is a change from the 1992 pilot program. Furthermore, family members of the voucher-holder who constitute the HUD-VASH eligible family are only able to be denied because of presence on a sex offender registry. In terms of income limits or requirements, the program is aimed at very low-income and low-income homeless veterans (Section 8, 2008).

### *How Does HUD-VASH work?*

The HUD-VASH program works by VAMCs partnering with local PHAs. The VAMC receives their allotment of HUD-VASH vouchers, which then work basically like regular Housing Choice vouchers: HUD provides funds to the PHA for housing assistance and administration of the program, while the VA pays the rental subsidy to a private landlord from whom the family is renting. Certain requirements (including those for eligibility described above) which must be met by regular Section 8 Housing Choice voucher holders are not required for a HUD-VASH voucher. In fact, the PHA agrees to relinquish its authority to screen families by administering the HUD-VASH program; the VAMC does the screening process (HUD, 2008). Other requirements that are waived under HUD-VASH include the requirement that a voucher recipient find housing within 60 days; HUD-VASH participants receive 120 days. HUD-VASH voucher holders are also allowed flexible lease arrangements that may be for less than 12 months. These changes are all designed to minimize barriers to housing. Furthermore, an individual PHA, in order to meet the needs of a homeless veteran it is trying to serve, may request additional statutory or regulatory waivers from the Secretary of HUD in order to deliver services to the client (HUD, 2008).

Once in the program, the HUD-VASH participant then develops a customized treatment plan with their VAMC case manager. This plan may include a medical component, substance abuse treatment, education and employment goals, or plans to manage a mental or emotional issue. The VAMC's responsibilities are 1) to screen homeless veterans for HUD-VASH eligibility 2) to provide "appropriate treatment and supportive services to potential HUD-VASH program participants, if needed, prior to PHA issuance of rental vouchers" 3) to help participants search for housing 4) to identify and provide for medical and social service needs of participants; and 5) to report information for evaluation (Section 8, 2008). The only cause for termination from the HUD-VASH program is a failure of the participant to comply with the requirement for regular case management. In cooperation with their case manager, however, a participant is allowed, and even encouraged, to eventually decrease their reliance on the case manager and move towards as fully independent living as possible.

### *Evaluating the Success of HUD-VASH*

The major evaluative study of the 1992-1995 HUD-VASH program was conducted by a team of researchers from the Veterans Affairs Northeast Program Evaluation Center, Yale University, and the University of Connecticut (Rosenheck, Kaspro, Frisman, & Liu-Mares, 2003). This study divided 460 homeless veterans, all of whom reported a mental



illness, substance abuse problem, or both, into three groups: those who participated in the HUD-VASH program, those who received intensive case management and regular access to Housing Choice vouchers and those who received standard care. Over the 3-year study period, the HUD-VASH group experienced fewer days of homelessness and more days housed than the case management group. The case management group also experienced fewer days of homelessness and more days housed than the standard care group. No substantive changes were noted in terms of health or social outcomes between the three groups, and the cost of the HUD-VASH program was slightly greater per participant than either intensive case management or standard care alone. The study went on to state that the outcome differences between the three groups were most evident during the beginning of the study period, but that towards the end of the three-year study period, some of these outcomes were becoming less divergent. (See Figures 1 and 2)

Figure 1: Days housed over 3-year evaluation period (Rosenheck, Kaspro, Frisman, & Liu-Mares, 2003)

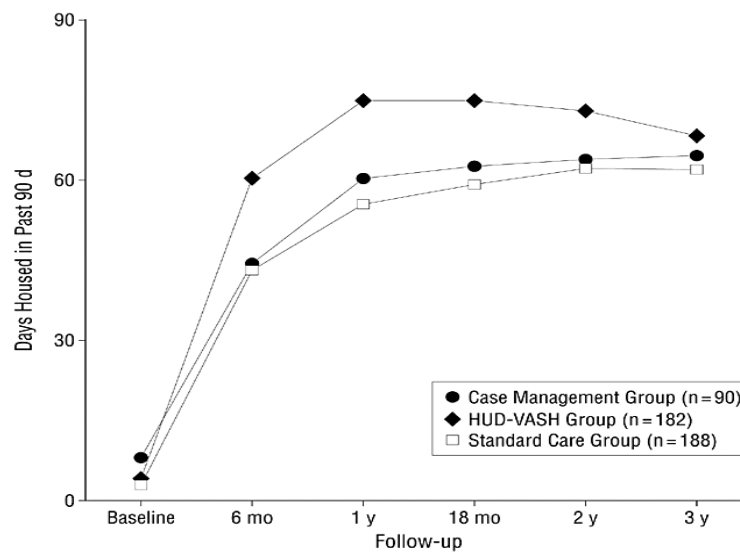
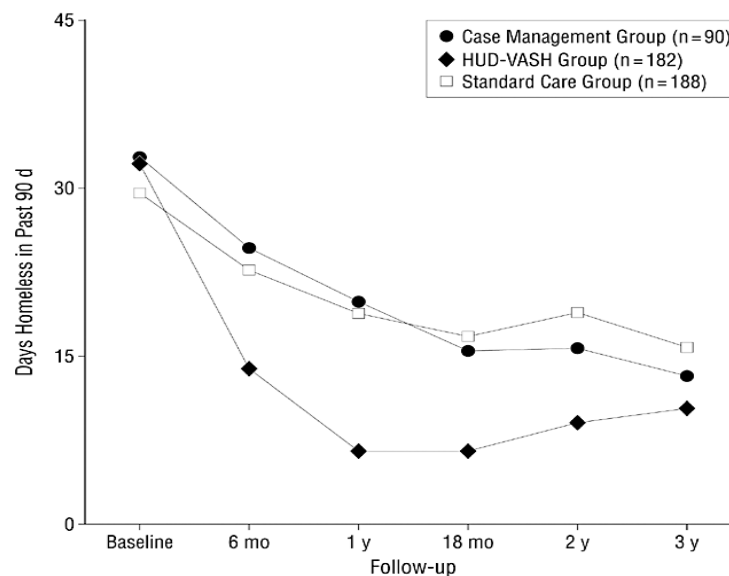


Figure 2: Days homeless over 3-year evaluation period (Rosenheck, Kaspro, Frisman, & Liu-Mares, 2003)



A follow-up to this study conducted in March of 2008 (O'Connell, Kaspro, & Rosenheck, 2008) looked at a five-year period following participation in the study. This analysis showed that while 44% of all participants experienced an episode of homelessness at least once since successfully being placed in housing, the HUD-VASH group had “significantly longer periods of continuous housing” than the other two groups. In 2007, several members of this same research team conducted further analysis of the HUD-VASH outcomes, this time using imputation methods to take into account the loss of some data because of participant drop-out (Cheng, Lin, Kaspro, & Rosenheck, 2007). By using this method, the researchers found that they did see decreased rates of substance abuse among the participants in the HUD-VASH program compared to the other two groups.

### ***Housing Vouchers – Current State of Use and Effects***

In order to analyze the HUD-VASH program, there needs to be a clear understanding of “regular” Housing Choice voucher programs (HCVPs): what is the theory behind these programs, who participates in them, and what are their housing outcomes. In other words, the question of “how successful are HUD-VASH participants in moving to better neighborhoods?” needs to be answered in the context of how successful *all* Housing Choice voucher holders are at moving to better neighborhoods. Specifically, this section will answer the following questions in broad terms:

- What are the theoretical underpinnings of voucher programs?
- How many HCVP vouchers are currently in use and who is using them?
- How fast are HCVP voucher holders finding housing and what impacts this?
- Where are HCVP voucher holders finding housing?

Though there is a great deal of variation across geographies and to some extent across other defining characteristics, this section will focus on the general findings of these questions.

#### *What are the theoretical underpinnings of voucher programs?*

The introduction of housing vouchers as a government policy tool in the first place is the result of the thinking that “seeding of poor households in nonpoor areas” results in, among other things, “access to better jobs and schools, reduced fear of crime, greater residential satisfaction among the poor, and enrichment of the lives of white, middle-class residents through exposure to more diverse populations” (de Souza Briggs, 1997). Theories for believing that moving poor households to more affluent areas is beneficial to the poor are many, and include the notion that non-normative behaviors that are routinely observed tend to be emulated and so the presence of mainstream neighbors can serve as role-models. Another theory is that when comparing themselves to their more well-off neighbors, poor individuals will raise their standards for themselves (Ibid.).

### *How many HCVP vouchers are out there and who has them?*

In 2003, there were 1.8 million vouchers being used across the country (Housing and Demographic Analysis Division, 2008). In 2007, over 2 million households received vouchers (Rice, 2007). As vouchers are depended on federal funding, the number of vouchers available changes frequently. Furthermore, Congress renews vouchers every year but, since 2003, “new” vouchers funded by Congress are actually “tenant protection” vouchers which are limited to tenants living in public housing that has been demolished or sold, or to tenants in housing that has lost some other federal subsidy (Center on Budget and Policy Priorities, 2007). On the whole, then, the only way for new households to get into the system is for other households to give up or lose their voucher.

### *How fast are HCVP voucher holders finding housing?*

Success rates for voucher holders finding housing appear to vary widely by PHA. A 2000 survey of 48 PHAs from around the country revealed that, on the low end, 15% of PHAs had success rates under 50% (success being defined as voucher holders finding suitable housing within the specified time limit). At the other end of the spectrum, about the same percentage of PHAs had success rates over 90% (Finkel & Buron, 2001). Nationally, 69% of voucher recipients succeeded in using them. This percentage is a decrease from 1993 when 81% of households were successful (Ibid.). This decrease is usually attributed to a tighter rental market in 2000 than in 1993. A 1994 study found that many voucher-holders sought housing in a “Section 8 submarket”, where landlords are aware of the program and already have Section 8 tenants (Kennedy, 1994).

Success rates differed noticeably based on certain criteria including household type and income type. The most successful group was those whose income was above zero but below 30% of area median. One of the least successful groups, however, were those whose income was zero and who tended to be male-headed (also who tended to received preference for being homeless). For homeless veterans, perhaps their success rate will break along these income parameters as well.

For those who cannot successfully use a voucher, the reasons are generally that not enough landlords in a particular area participate, the housing that is affordable is of poor quality, or that administrative procedures of Public Housing Authorities are inefficient and discourage participation (Sard, 2001). There is also the argument that rent burdens are still too large for some families and individuals, even with the vouchers (McClure, 2005). Tightness of the housing market has also been shown to decrease the level of success for voucher holders. Tightness was determined by vacancy rates in those areas with rents geographically and economically feasible for voucher holders (Finkel & Buron, 2001). Despite increased subsidy allowances in certain areas, housing continued to be out of reach for many voucher holders during the late 1990s and most of 2000s (Turner, 2003).

Finally, in terms of PHA procedures that influence success rates, PHA outreach to landlords was the most positively influential, followed by briefings for voucher holders (Finkel & Buron, 2001). Causation is unclear for these factors, as is knowledge about

whether successful voucher holders took advantage of these PHA services. A 2003 study of the Washington, DC area also indicated that increased accountability for client's search activity was a positive factor for success (Metropolitan Washington Council of Governments, 2003).

### *Where are HCVP voucher-holders finding housing?*

In terms of the type of units into which HCVP voucher holders are likely to move, about 65% of HCVP occupied units in 2003 were multifamily rentals with the rest being single family homes or manufactured housing (Housing and Demographic Analysis Division, 2008). Most of these renters reported being satisfied with their neighborhood, giving an average rating of 7.7 on a scale of 1 to 10, 1 being worst and 10 being best (Ibid.). In terms of neighborhood safety, 26% reported crime in their neighborhood, but only 11% described it as "so bothersome they want to move" (Ibid.).

HCVP vouchers can only be used where there are affordable rental units – affordable in this case meaning below fair market rent for voucher holders unable to pay the difference. In most locations, these rental units are predominantly located in central cities as opposed to the suburbs, which have a higher proportion of owner-occupied units than do cities. Though HCVP voucher users occupy a relatively constant proportion of affordable units (about 6%), because of the location of affordable units, these voucher-users tend to be located within central cities (Devine, 2003).

At the level of census tract, affordable housing was found in virtually all tracts, and HCVP voucher users were found to reside in 83% of those tracts with affordable housing, suggesting a relatively dispersed population of HCVP voucher users within an MSA (Ibid.). This research, however, was conducted using voucher data from 2000 and census data from 1990 which may reflect more optimistic trends seen in the 1990s. Despite its finding of a dispersion of HCVP vouchers throughout the census tracts within an MSA, however, the research also finds that the share of voucher users present in each tract is unequal to the share that would be expected if voucher users had the same preferences as other low-income households without vouchers, and if there were no market barriers for voucher users. In many neighborhoods that have affordable rental housing, the HCVP voucher share is lower than expected, suggesting that barriers exist for voucher users that do not exist for renters without vouchers (Ibid.).

Building upon this finding, a 2008 study of "hot spots" of HCVP voucher use in eight metropolitan areas in 2000 and in 2005 shows a correlation between high levels of voucher use and areas with high levels of rental units, which tend to be central cities (Wang, X., Varady, & Wang, Y., 2008). This is not surprising, and corresponds to what is described above. The prevalence of hot spots, areas defined by a highly concentrated presence of voucher users, and the percentage of voucher users residing in hot spots, however, increased for all but two metropolitan areas between 2000 and 2005 (Ibid.). In other words, though hot spots fluctuated over time, more hot spots were generally found in 2005 than in 2000, and the hot spots were growing more highly concentrated. For most cities, furthermore, the hot spots that were "disappearing" between 2000 and 2005 tended to

have lower concentrations of poverty, while those that were on-going or were emerging during that same time tended to have higher concentrations of poverty. The opposite (that more low-poverty areas are emerging while high-poverty areas are disappearing) is what would be expected if the HCVP program were deconcentrating poverty. Finally, this study indicated that the clustering of HCVP households in hot spots was the norm regardless of the nature of the housing market, be it “hot” or “cool”.

Racial segregation may further concentrate voucher holders in distressed neighborhoods. Research into housing preferences of African-Americans, for example, concludes that while blacks would most prefer a mixed-race neighborhood to an all-black one, they would rather be in an all-black neighborhood than a mostly white one (Farley, Fielding, and Krysan 1997; Farley et al. 1993). Rolf Pendall’s research, which looked at nation-wide 1990 census data, concluded that the wider the disparity between the percentage minority of the whole community and the percentage minority of voucher holders, the higher the concentration of voucher holders in distressed neighborhoods (Pendall, 2000). Additionally, since landlords are not required to accept vouchers, many will avoid renting to voucher-holders who they may deem more risky or more likely to cause problems. Under these assumptions, only those landlords desperate to fill vacancies will accept these tenants of last resort, and these landlords likely own units in distressed, neglected areas (Ibid.).

For voucher users who move to the suburbs, the likelihood that they will be in a community of high poverty is lower than for those users who move to a central city. “In central cities, when the Housing Choice Voucher share reaches between 10 percent and 25 percent of a neighborhood’s occupied housing stock, poverty levels cross the 30 percent threshold for moderate-poverty concentration. However, in suburban areas, even neighborhoods at the 25 percent or greater share level remain below the moderate-poverty threshold (Devine, 2003, 66)”. This is probably because central city neighborhoods tend to be higher-poverty to begin with, so the impact of a clustering of voucher users would have a more destabilizing and negative effect than it would in the suburbs.

## **Research Question and Hypothesis**

The evaluation of the 1992 HUD-VASH pilot program described in the earlier section focused on the amount of time the participant remained housed and did not experience homelessness. While moving from the immediate, physically perilous situation of homelessness into housing is undoubtedly a major step forward towards improved life opportunities for homeless veterans, the *neighborhoods* into which these veterans move will have an impact on their quality of life as well. Are the types of neighborhoods just described, the types where HCVP voucher-holders tend to find housing, the same types of neighborhoods into which HUD-VASH participants move? My research question, therefore, is what kinds of neighborhoods are HUD-VASH participants moving to, and what might this mean for their immediate and future quality of life.

My hypothesis is that HUD-VASH participants' chances of success in maintaining housing and improved life circumstances will be hindered by their relocation to neighborhoods with strong indicators for high crime and poor mental health, characteristics that are not indicative of enhancing long-term stability and health and are particularly high-risk environments for vulnerable populations like the chronically homeless.

## **Data**

The data for this analysis comes from a Freedom of Information Act request to the Department of Housing and Urban Development, which tracks data on the issuance of HCVP vouchers. The data represents a sample of 208 HUD-VASH participants out of the total 1,026 who were issued vouchers and who found housing between May 6, 2008 and January 16, 2009. These 208 participants come from 114 zip codes in 7 states which were randomly selected: North Carolina, Arizona, Ohio, Georgia, Colorado, Massachusetts, and Tennessee. Zip codes are the only geographically identifiable unit of data that HUD keeps track of and that is available to researchers; specific addresses of where these veterans moved are protected information.

Demographic data about the areas into which these 208 veterans have moved was obtained by using 2000 Census data at the zip code tabulation area geography. The zip code tabulation area, or ZCTA, is the closest approximation of actual zip code areas in the census. Drawbacks to using ZCTAs as a proxy for actual zip code areas are that the boundaries of ZCTAs do not always line up exactly with zip code areas, and zip code areas change over time, with new zip codes being put into use as populations grow. The other main drawback to using ZCTAs is that demographic and particularly income data are not evenly geographically distributed throughout a zip code and so do not necessarily reflect the circumstances of the veteran's immediate neighborhood.

## **Methods and Findings**

To test my hypothesis, I looked at neighborhood indicators for the two criteria mentioned above: high violent crime and poor mental health.

### ***Methods: Neighborhood indicators that suggest high violent crime***

I based this analysis on two studies. The first, by Martinez, Rosenfeld, & Mares, looked at the connection between social disorganization and violent crime – specifically aggravated assault and robbery – in Miami. To describe social disorganization, the researchers used three indices initially described by Shaw and McKay in their 1969 book, *Juvenile Delinquency and Urban Areas*: socioeconomic deprivation, residential instability, and population heterogeneity. The Miami team based their hypotheses on the idea that the “classical theory of disorganization and community social control (Bursik and Grasmick 1993) suggests that deprivation, instability, and heterogeneity produce crime by impeding

the effectiveness of so-called private, parochial, and public social controls” (Martínez, Rosenfeld, & Mares, 2008).

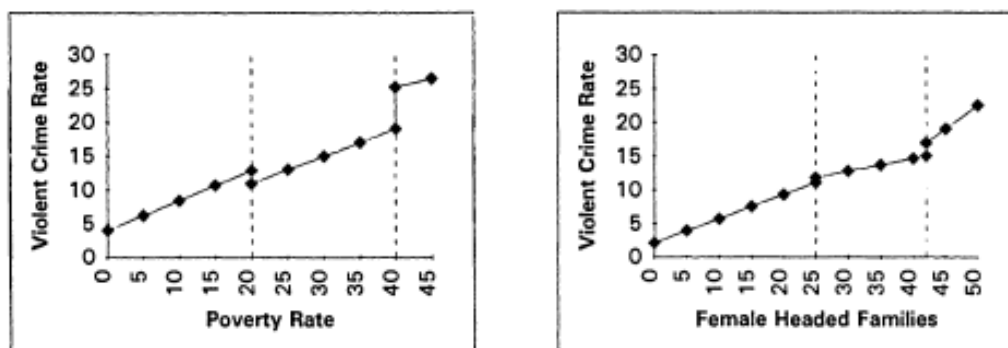
Martinez and his colleagues measured socioeconomic deprivation by looking at percentage of female heads of household with children under eighteen, the unemployment rate, and the poverty rate. They measured residential instability through the percentage of renter-occupied housing, vacant units, males between ages 18 and 24, and the percentage of persons who had moved within the past five years. Heterogeneity was measured by Latino presence, percentage of recent immigrants, and percentage of the population that is defined as linguistically isolated. The researchers found that residential instability and socioeconomic deprivation both had “significant and positive direct effects on rates of aggravated assault, as predicted by social disorganization theory.” For robbery, however, the researchers found that only residential instability had a direct effect. Population heterogeneity had no direct effect on either crime category, and so I did not measure it for my analysis.

I defined three possible levels of measurement for each indicator of socioeconomic deprivation and for each of residential instability:

1. The indicator is not present, meaning the area exhibits tendencies at or below the state average.
2. The indicator is moderately present, meaning the area exhibits tendencies above the state average, but less than 1.5 times the state average.
3. The indicator is highly present, meaning the area exhibits tendencies at least 1.5 times the state average.

The second study on which I based my indicators for violent crime was conducted by Krivo and Peterson in 1996 and is based on data from Columbus, Ohio (Krivo & Peterson, 1996). This study measured neighborhood disadvantaged through a variety of factors including the percentage of female-headed households, the male jobless rate, the poverty rate, and the percentage of non-professional employees. The researchers determined that most of these measures did not display a linear relationship to the presence of violent crime, but that certain thresholds were evident that greatly increased the likelihood of violent crime in a given census tract. They found increased crime when the female-headed household rate was above 45%, and also found increased crime in areas with a poverty rate over 40%. (See figure 3).

Figure 3: Predicted Violent Crime Rates across Levels of Disadvantage: Census Tracts in Columbus, 1990 (Krivo & Peterson, 1996).



### ***Findings: Neighborhood Indicators that Suggest Violent Crime***

#### *Miami model*

For the percentage of households with children that are headed by females, 172 of the 208 HUD-VASH participants sampled moved to ZCTAs where the percentage of female-headed households are greater than the state average. 92 veterans (44% of the sample) moved to areas with a moderate presence of this indicator, while 80 veterans (39%) moved to areas with a high presence of the indicator, meaning the percentage of families headed by single females is at least 1 and a half times the state average. The unemployment indicator shows a similar pattern. 78 veterans (38%) moved to areas of moderate unemployment, while another 48 veterans (23%) moved to areas with high unemployment. 39% of all HUD-VASH participants moved to areas with unemployment below the state average. Nearly 7 in 10 veterans moved to an area where the poverty rate is worse than the state average. 33% moved to moderately poor areas, while 36% moved to highly poor areas (See Figure 4).

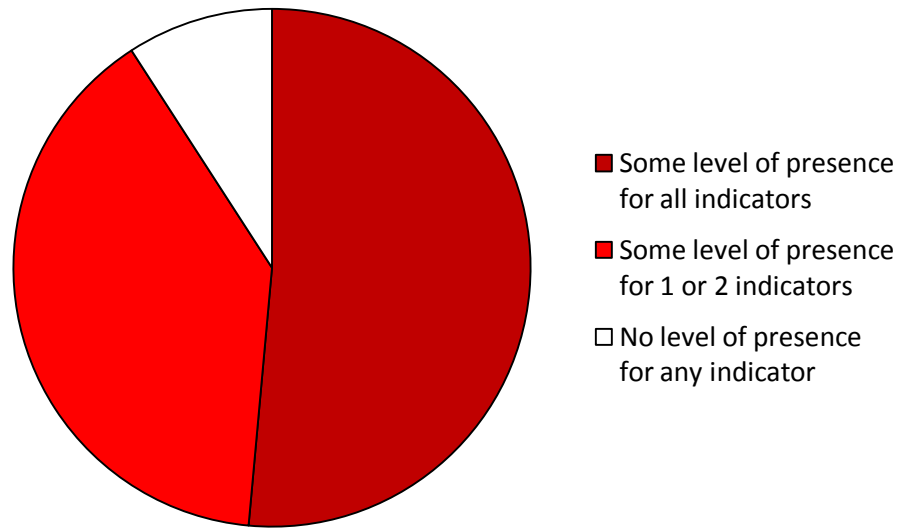
Figure 4: Number of veterans in area of indicator presence for socioeconomic deprivation

	Indicator not present	Indicator moderately present	Indicator highly present
Female-headed Families	36	92	80
Unemployment	82	78	48
Poverty rate	66	68	74

107 of the 208 veterans in the sample moved to areas that had either a high or moderate presence for all three indicators. Only 19 veterans, or 9% of the total sample, moved to areas that had no indicators of socioeconomic deprivation using the Miami model (See Figure 5).



Figure 5: Number of veterans by number of indicators present for socioeconomic deprivation



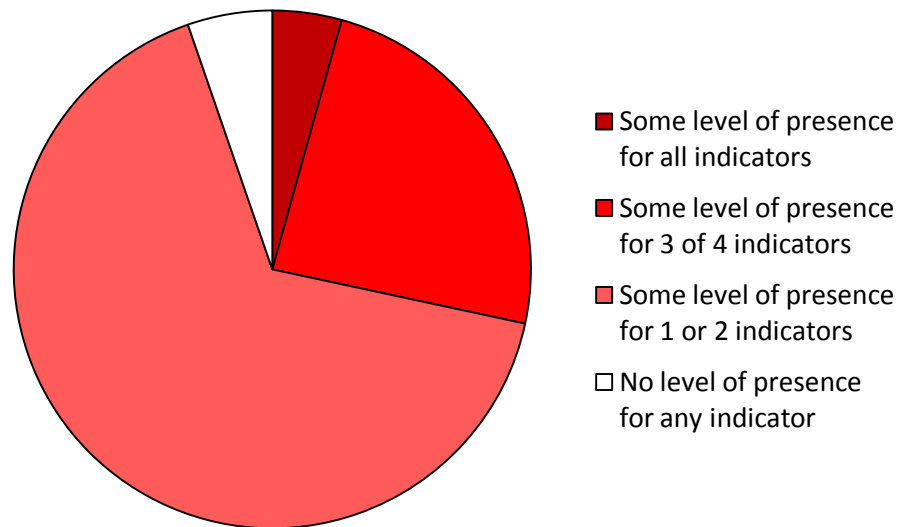
Turning to the second measure of social disorganization, residential instability, I compared the percentage of renter-occupied housing, vacant units, males between ages 18 and 24, and the percentage of persons who had moved within the past five years for the 208 samples. 176 of the 208 veterans (85%) moved to areas with rental percentages above the state average, with 75 of them in areas of high rental presence, meaning rental rates are at least 1.5 times the state norm. 164 veterans (79%) moved to areas where the measure of households who moved within five years was greater than the state average, the vast majority (153) to areas with a moderate presence of this indicator. The other two indicators were less present. Only 58 veterans moved to areas with higher-than-state level vacant units, and just 19 to areas with higher concentrations of young males (See Figure 6).

Figure 6: Number of veterans in area of indicator presence for residential instability

	Indicator not present	Indicator moderately present	Indicator highly present
Renter occupancy	32	101	75
Vacancy rate	150	17	41
Males 18-24	189	17	2
Moved within 5 years	44	153	11

No veteran relocated to an area that had a high presence of all four residential instability indicators, though 9 did move to areas with a moderate or high presence of all four. 50 (24%) moved to areas with high or moderate presence of three of the four indicators, while just eleven (5%) moved to areas with no presence of any indicator of instability (See Figure 7).

Figure 7: Number of veterans by number of indicators present for residential instability



Only four veterans, out of the 208 examined, moved to ZCTAs that had no indicators for residential instability or for socioeconomic deprivation. 135 veterans, or 65% of the sample, moved to areas with at least two indicators of instability and at least 2 of socioeconomic deprivation. This analysis suggests, then, that 65% of HUD-VASH participants moved into areas that are strongly associated with increased violent crime.

### *Columbus Model*

The Columbus model is simpler than the Miami model, and suggests that violent crime is markedly more prevalent in areas where female-headed families represent 45% of all households, and in areas where the poverty rate is above 40%. Only ten veterans moved to ZCTAs with female-headed household rates above 45%, and just six to areas with over 40% poverty. Using the Columbus model, it appears at first that very few veterans are locating to these high-crime neighborhoods, but I believe the reason for this is in the geographies examined. The Columbus model looked at tract-level census data, and tracts of concentrated poverty and social disruption would have high rates for these two indicators. Looking at the much larger ZCTAs, as my analysis does, statistically disperses these concentrations so that the overall percentages tend to be lower. My prediction is that if Krivo and Peterson had done their analysis at the ZCTA-level, their threshold percentages would be lower.

### ***Methods: Neighborhood Indicators that Suggest Poor Mental Health***

High poverty is the most obvious neighborhood indicator of poor mental health, an area of concern for many homeless veterans and those who work with them. A 2003 study by Leventhal and Brooks-Gunn looked at Moving to Opportunity families in New York City and found that those who moved to areas of increased median income, lower poverty rates, and lower rental rates yielded better mental health outcomes. Those who relocated to areas of high poverty showed higher rates of stress and depression (Leventhal & Brooks-

Gunn, 2003). Another study based on 1995 data from Detroit surveyed residents in low and high poverty areas on their level of life satisfaction. Predictably, those in higher poverty areas reported less life satisfaction, and higher levels of stress (Schulz et. al., 2000).

For this analysis, I continued to consider moderate poverty as those areas with a poverty rate above the state average, and high poverty as areas at least 1.5 times the state average. I used the same scale for rental rates. For median income, I defined a moderate presence of this indicator if the median income in the ZCTA is lower than the state median, and a high presence if median income in the ZCTA is less than 60% of state median income.

### ***Findings: Neighborhood Indicators that Suggest Poor Mental Health***

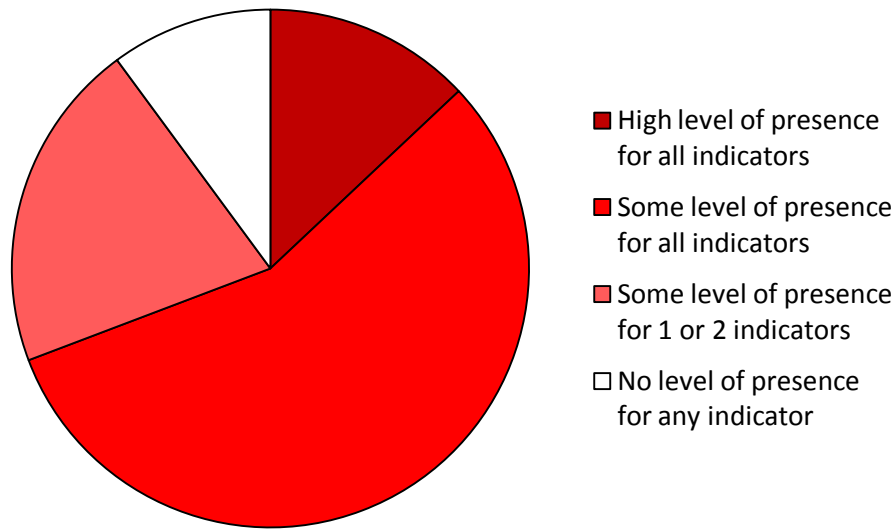
In terms of the three indicators, I have already stated that 33% of veterans moved to moderately poor areas, while 36% moved to highly poor areas. 85% of veterans moved to areas with rental percentages above the state average, with 75 of them in areas of high rental presence, meaning rental rates are at least 1.5 times the state norm. 169 veterans (81%) moved to areas where the median income was less than the state median. 28 of these veterans, 14% of the total sample, moved to areas with median incomes less than 60% of the state median (See Figure 8).

Figure 8: Number of veterans in area of indicator presence for poor mental health

	Indicator not present	Indicator moderately present	Indicator highly present
Poverty rate	66	68	74
Renter occupancy	32	101	75
Median income	39	141	28

27 veterans (13%) moved to areas with a high presence of all three indicators for poor mental health. Another 117 veterans (56%) moved to areas with high or moderate presence of all three indicators, meaning that 69% of all veterans are in areas where all three mental health indicators are present. Just 21 veterans, or 10% of the sample, moved to areas where no indicators are present (See Figure 9).

Figure 9: Number of veterans by number of indicators present for poor mental health



It is important to note here that mental health indicators such as the three examined above are found to suggest poor mental health for those who are not otherwise mentally ill. For those, like many homeless veterans, already struggling with mental illness and substance abuse, these indicators might not operate the same way. As Carol Wilkins of the Corporation for Supportive Housing states,

“In research and focus groups with tenants and mental health consumers, consistently we hear that people want high quality housing (which is mostly a characteristic of the building or apartment unit - not the zip code) with access to community amenities (shopping, recreation, parks, transit) and opportunities for social integration. For homeless people with mental illness or substance abuse problems, I am not aware of any research that links mental health well-being to the indicators you have selected (poverty rate, renter occupancy, median income)” (Carol Wilkins, personal communication, April 10, 2009).

A valid argument remains, however, that the mental health of the community members living around the veteran still makes a difference in quality of life, even to the homeless veteran already experiencing poor mental health.

## Discussion and Implications

In summary, the findings of this research suggest that 65% of the veterans sampled located in areas strongly indicative of high violent crime, and that 69% located in areas with indicators for impaired mental health. HUD-VASH participants were, on the whole, locating in areas with high rates of female-headed households, high poverty and unemployment rates, high rates of rental occupancy, high resident turnover and low median incomes. With this understanding, we are able to draw some conclusions and suggest directions for future actions.

First, there are some obvious caveats to consider. Primarily, the data examined is showing where formerly homeless veterans have found housing – that this data exists is evidence of the HUD-VASH program's success at housing homeless veterans. The suggestion that the program might be further examined and improved is not a dismissal of the gains that have been and are being made. Secondly, as was already mentioned in the background section, voucher programs necessitate rental units that are at or below fair market rent. These, as we have seen, are mostly located in urban centers and in other areas that tend to have higher poverty rates, lower incomes, and other indicators which have been described in detail for violent crime and for poor mental health. In order to function, voucher programs also need landlords willing to rent to voucher-holders. One would think a voucher-holder, particularly one that has identified special needs such as a HUD-VASH participant, would be less desirable a tenant than other tenants competing for limited units. We would expect, therefore, that HUD-VASH participants are often tenants of last resort and so are filling less desirable units. On the other hand, a landlord may be more likely to rent to a HUD-VASH voucher-holder that has a case manager and is receiving extensive supportive services than to a "regular" HCVP voucher-holder. More research needs to be done comparing rates of rental success by HUD-VASH participants with rates by all HCVP participants.

Furthermore, it should be kept in mind that HUD-VASH voucher holders select their neighborhoods for a variety of reasons that may have a lot, a little, or nothing at all to do with indicators of neighborhood quality which are described here. Much has been written about the value found in social capital and support systems that are often very strong and very critical to the livelihood of low-income families in poor neighborhoods. Fracturing these social ties by moving to an area deemed "better" by my standards or by the standards of VA evaluation methods might not translate to "better" for the veteran. The potential feelings of isolation and marginalization that a formerly homeless veteran might experience if he moves to a more affluent neighborhood in which he does not feel he "fits" might be a significant factor in his housing location choice. Sandra Newman's research supports this assertion. She found that neighborhoods with a certain level of "disorder" may be *better* suited for persons with mental illness because their unusual behaviors or relapses would be less glaring (Newman, 1994).

Bearing all this in mind, it remains a troubling issue that so many HUD-VASH participants have located in areas of high poverty, high residential instability, high

socioeconomic deprivation, and probable high violent crime and high levels of stress and depression. Regardless of the likelihood that this is the case for all voucher-holders, homeless veterans are particularly burdened by prevalent mental illness, substance abuse, and feelings of isolation, and therefore warrant special consideration. The case management and services provided through the HUD-VASH program are designed to aid the veteran in his or her ability to live independently and in better mental and physical health, yet the environments into which many are moving appear detrimental to these goals. One area of research that might illuminate this issue would be a cost-benefit analysis comparing intensive case management in a low-functioning neighborhood with less intensive case management in a healthier neighborhood.

In the National Alliance to End Homelessness's publication *Vital Mission*, the researchers found that "veterans make up a disproportionate share of homeless people. They represent roughly 26 percent of homeless people, but only 11 percent of the civilian population 18 years and older. This is true despite the fact that veterans are better educated, more likely to be employed, and have a lower poverty rate than the general population" (Cunningham, Henry, & Lyons, 2007). Professor Charles Daye, with the UNC Center for Civil Rights, further pointed out that it might be easy to assume that veterans experience homelessness on a more frequent basis than civilians because the military attracts a higher proportion of "dysfunctional people", were it not for the particularly high numbers of homeless veterans from the Vietnam War (Daye, personal communication, April 7, 2009). As Daye notes, the draft pulled people into military service from all walks of life, and so self-selection was not the only force at play. Both of these facts support the assertion that the nature of being a veteran, separated from the circumstance of being homeless, already makes this population one that is particularly vulnerable. This is why relocating homeless *veterans*, not just all homeless persons, into the most supportive and safe environments possible is so important.

Several recommendations might be offered to address improvements to the HUD-VASH program.

- 1) *Increase the supply of permanent, affordable rental housing.* This supply needs to be increased in terms of sheer numbers, but also in its more even distribution through all areas. As Carol Wilkins of the Corporation for Supportive Housing states, "although people like to think of housing vouchers as offering a wide range of choices, in reality there are limitations in the availability of rental units at or below the fair market rent and landlords willing to accept housing vouchers" (Carol Wilkins, personal communication, April 10, 2009). An increased and more diverse supply of affordable rentals means increased choice for voucher-holders. Local planning tools such as inclusionary zoning policies, affordable housing requirements, and scattered site policies can all be used to achieve this aim.
- 2) *Exempt VA benefits payments from a veteran's income calculation when determining his or her rental payment.* This provision is included in the Homes for Heroes Act of 2009, H. R. 403, pending legislation introduced in the House of

Representatives earlier this year (Cheryl Beversdorf, personal communication, April 10, 2009). Doing this would essentially leave the veteran with more income to save, spend, or to pay towards rent for a unit above fair market rent. Again, the veteran has more options which could result in improved neighborhood location.

- 3) *Ensure the effectiveness and motivation of HUD-VASH case managers.* This could be accomplished through increased funding to the VA for training or for salaries. The supportive services are such a critical component to this program, and so much of this depends on the quality and the initiative of the case manager. To give the veteran access to the fullest range of residential choices, the case manager must know the local resources, have a positive relationship with landlords, be able to navigate the rental market, and pro-actively advocate for his or her client. With the introduction of HUD-VASH nationwide, many VAMCs are hiring new case managers, so additional funding to ensure their proper training and commitment would be timely.
- 4) *Expand HUD-VASH as well as other housing voucher programs.* In order to increase the supply of affordable housing through market mechanisms, there must be an unmet demand. Housing vouchers will only act as a true force of demand in the housing market if there are many, many more of them. If vouchers do not succeed at increasing supply, they will simply increase demand for limited units and rents will increase (Susin, 2002).
- 5) *Pursue urban policies that minimize the factors which may lead to high crime and poor mental health.* Enact mixed-income zoning so that homeownership neighborhoods and rental neighborhoods are not distinct, mutually exclusive choices. Increase education and job-training resources to minimize unemployment and poverty. Develop an aggressive policy towards dealing with vacant properties. Increase economic development and job opportunities to decrease violent crime. It is obvious that many urban problems are interconnected, and addressing as many of them as comprehensively as we can will help to improve outcomes in all these areas.
- 6) *Expand and improve VA programs to prevent homelessness.* The HUD-VASH method of using intensive case management and supportive services is the result of having homeless veterans with a wide range of severe problems which need frequent and intense interventions. Case managers are forced to deal with substance abuse, mental illness, unemployment, poor physical health, social isolation and other issues – all of which are exacerbated by homelessness. Interventions could be easier and could be achieved faster (or arguably might not be needed at all for problems that developed as a result of homelessness) if veterans never became homeless.

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