

**TESTIMONY OF SCOTT MCNEILLY
WASHINGTON LEGAL CLINIC FOR THE HOMELESS
BEFORE THE COMMITTEE ON HUMAN SERVICES
DHS OVERSIGHT HEARING
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Good morning Chairperson Graham and members of the Committee. My name is Scott McNeilly and I am an attorney with the Washington Legal Clinic for the Homeless. I'm also the co-chair of the Executive Committee of the Interagency Council on Homelessness.

Over the past few years, we have by necessity focused significant resources and attention on responding to the crisis number of families in need of emergency shelter and affordable housing. It had to be that way but it wasn't without a cost for the individual men and women who also have had to turn to emergency services.

During our last hypothermia alert on March 8th, the daily shelter census showed the men's system to be 43 over the total system capacity. The Department of Human Services (DHS) complied with the Homeless Services Reform Act's hypothermia provisions by going 22 over the stated capacity at the Sacred Heart shelter, 9 over the capacity at St. Luke's, 11 over at the Kennedy Recreation center and 16 over at Banneker. There are some extra cots at some of these facilities but there's a pretty good chance some of these men spent the night trying to sleep in chairs or on the floor.

Part of the problem on the men's side of the system is that the District hasn't provided the men's beds required by the Winter Plan. The Plan calls for a total of 1331 beds but only 1296 are actually available. The Winter Plan calls for the use of the DC General cafeteria as the overflow location for men but that space was converted for use by families so there is no overflow capacity for men.

On the women's side, we haven't seen the same strains on hypothermia nights but we continue to see every bed full on non-hypothermia nights. The Winter Plan called for additional "seasonal" beds to address that problem but again, the District failed to deliver the total required by the Winter Plan.

A telling statistic is the "turn-away" number monitored by the Capacity subcommittee of the ICH. That number tracks the number of individuals who present at a facility seeking a bed but can't be served because no beds are available at that location. We only have information through January but last year in January, we had 110 turn-aways. This year in January the number was nearly double, 215.

I can't tell you I know all of the reasons for this upsurge in need but the defunding of Interim Disability Assistance is probably one of them. As a result of budget cuts and

apparent confusion about the amount of money available, the IDA caseload at one point dropped to 383. To shrink it down to that size, DHS didn't move anyone from the wait list to pay status for well over ten months, effectively closing the program. The IDA caseload peaked at 2900 in 2009, probably the nadir of our economic troubles. That year, 6639 District residents applied for SSI based on disability. In 2011, the most recent year for which statistics are available, 6281 District residents applied for SSI, about a 5% decline from the peak year in 2009. A corresponding 5% decline in the IDA caseload would be about 2755. A caseload of 383 clearly does not reflect the real need.

We know that IDA is an important piece of the shelter diversion strategy for individuals. It allows those individuals to at least contribute something toward household expenses which allows them to remain doubled up with friends or family. The strategy to address the crisis numbers of families seeking shelter has included extremely aggressive diversion efforts where families have in some instances been required to demonstrate that there is no family, friend or acquaintance the applicant can double, triple, etc. up with. The Virginia Williams Family Resource Center has used money in some situations to facilitate the applicant family staying in place or doubling up in someone else's household. It's a strategy we apparently believe in, and IDA is probably the best existing diversion mechanism for disabled individuals who find themselves on the brink of entering emergency shelter.

Finally, the other critical strategy for addressing the singles shelter capacity problem is to increase the availability of permanent supportive housing. We know that the chronically homeless individuals who would be appropriate for permanent supportive housing utilize a disproportionate share of shelter resources and, therefore, moving them to permanent housing would have a disproportionate impact on our capacity problems.