

**COMMUNITY HOMELESSNESS ASSESSMENT,
LOCAL EDUCATION AND NETWORKING
GROUP (CHALENG) FOR VETERANS**

**THE FOURTEENTH ANNUAL PROGRESS REPORT ON
PUBLIC LAW 105-114**

**SERVICES FOR HOMELESS VETERANS
ASSESSMENT AND COORDINATION**

February 28, 2008

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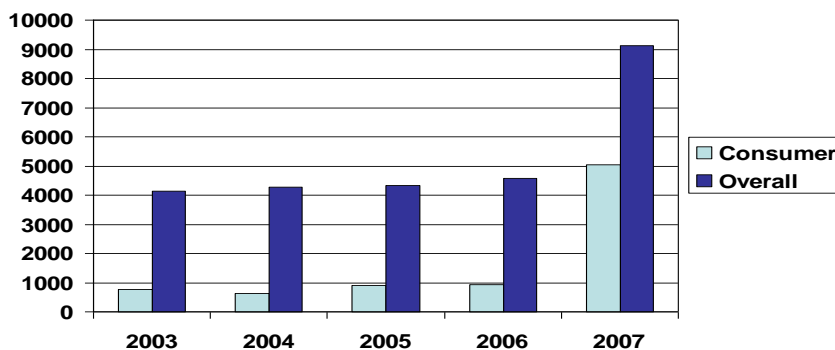
Fiscal Year (FY) 2007 Community Homelessness Assessment, Local Education and Networking Groups for Veterans (CHALENG) Report

Executive Summary

Since 1993, the Department of Veterans Affairs (VA) has collaborated with local communities across the United States in Project CHALENG for Veterans. The vision of CHALENG is to bring together consumers, providers, advocates, local officials and other concerned citizens to identify the needs of homeless veterans and then work to meet those needs through planning and cooperative action.

As in previous years, data collected during the FY 2007 CHALENG process are from questionnaires completed by VA staff, community providers, and homeless veterans. However, this year's CHALENG introduced a consumer specific survey. This effort is designed to empower consumers as active participants in the design and delivery of homeless services. Their involvement is consistent with the VA's recovery oriented approach to the delivery of mental health services. Judging by the level of participation in this year's CHALENG process, this change has been greeted enthusiastically. The following are highlights of the FY 2007 CHALENG report:

Year-to-Year Participation Changes



- *Participation was excellent.*
 - There were 9,132 respondents to the FY 2007 Participant Survey, a 99 percent increase from the previous year, which had a total of 4,578 participants.
 - Over half (55 percent) of the 2007 participants (n=5,046) were homeless or formerly homeless veterans. Consumer involvement went from 927 participants in 2006 to 5,046 participants in 2007, a four-fold increase.

- *Need remains high.*
 - It is estimated that on any given night there are approximately 154,000 homeless veterans. This is based on point-in-time estimates reported by the CHALENG points of contact (POCs). POCs are usually local VA homeless program coordinators from around the country.
 - The number of accessible beds increased between FY 2006 and FY 2007 from 72,196 to 73,430 emergency beds; 40,599 to 47,891 transitional beds; and 31,724 to 35,941 permanent beds (these beds are often not veteran specific and are also open to the general homeless population). The estimated number of additional beds required to meet existing needs decreased for emergency and transitional housing, but increased for permanent housing.

- *VA/Community partnerships continue to yield outcomes.*
 - 87 percent of POC sites that had a nearby Department of Housing and Urban Development (HUD) Continuum of Care planning group participated in it.
 - 543 new interagency collaborative agreements between VA and community agencies were developed in FY 2007. Veterans received dental care, eye care, and mental health/substance abuse treatment as a result of these agreements.
 - 377 new outreach sites were served in FY 2007.
 - 98 POC sites (71 percent of all sites) reported seeing a total of 1,038 homeless veteran families. This was a 5 percent increase over the previous year of 989 families served.
 - Preliminary data from the VA Northeast Program Evaluation Center from FY 2005 through FY 2007 suggests that the overall rate of homelessness among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans is 1.8 percent (unpublished data, NEPEC). Since OEF/OIF veterans represent about three percent of the overall veterans' population, they appear to be underrepresented in the homeless veteran population. However, as CHALENG POCs have prioritized services to this group, they indicate that more outreach, housing, and services are needed to help homeless veterans who recently served in Afghanistan and Iraq.
 - POCs reported on their successes with their FY 2007 action plans. Several local housing projects are increasing capacity for homeless veterans.
 - CHALENG POC action plans for FY 2008 addressed priority needs such as permanent, transitional, and emergency housing, job finding, transportation, job training, re-entry services for incarcerated veterans, VA disability/pension, psychiatric services, and dental care.
 - Dental care, which was cited by homeless veterans as one of the top 3 unmet needs for the past 4 years, *dropped to 12th place*. It seems reasonable to conclude that the Homeless Veterans Dental Program (HVDP), begun in 2006, has had a major impact. In FY 2007, it is estimated that HVDP provided treatment to 7,666 eligible veterans at 129 CHALENG sites.

Introduction

In 1993, VA launched Project CHALENG for Veterans. CHALENG is a program designed to enhance the continuum of services for homeless veterans provided by the local VA medical center and regional office and their surrounding community service agencies. The guiding principle behind Project CHALENG is that no single agency can provide the full spectrum of services required to help homeless veterans reach their potential as productive, self-sufficient citizens. Project CHALENG fosters coordinated services by bringing VA together with community agencies and other Federal, state, and local government programs to raise awareness of homeless veterans' needs and to plan to meet those needs. This helps improve homeless veterans' access to all types of services and eliminate duplication of efforts.

The legislation guiding this initiative is contained in Public Laws 102-405, 103-446 and 105-114. The specific legislative requirements relating to Project CHALENG are that local VA medical center and regional office directors:

- assess the needs of homeless veterans living in the area,
- make assessments in coordination with representatives from state and local governments, appropriate federal departments and agencies and non-governmental community organizations that serve the homeless population,
- identify the needs of homeless veterans with a focus on health care, education, training, employment, shelter, counseling, and outreach,
- assess the extent to which homeless veterans' needs are being met,
- develop a list of all homeless services in the local area,
- encourage the development of coordinated services,
- take action to meet the needs of homeless veterans,
- inform homeless veterans of non-VA resources that are available in the community to meet their needs.

At the local level, VA medical centers and regional offices designate CHALENG POCs who are responsible for the above requirements. These CHALENG POCs, usually local VA homeless program coordinators, work with local agencies throughout the year to coordinate services for homeless veterans.

CHALENG was designed to be an ongoing assessment process that described the needs of homeless veterans and identifies the barriers they face to successful community re-entry. In the current report, data was compiled from 9,132 respondents including, 5,046 survey responses that were completed by homeless or formerly homeless veterans. The CHALENG process is the only ongoing comprehensive national effort to poll VA staff, community providers and consumers about the needs of homeless veterans. The results have assisted VA to identify specific interventions needed to effectively assist homeless veterans. In recent years, there have been several new VA initiatives based in part on input from CHALENG, including:

- The Homeless Veterans Dental Program (HVDP) that has greatly expanded access to care and ending dental services as a top 10 unmet need among homeless veterans.
- The Healthcare for Re-Entry Veterans Program (HCRV), that is designed to help transition former veteran inmates back into the community.
- A demonstration project to help homeless veterans obtain eyeglasses.
- Continued expansion of the VA Grant and Per Diem transitional housing program.
- A major expansion of the HUD VA Supported Housing program (HUD-VASH), which will make thousands of new permanent housing vouchers and case management services available to homeless veterans.

The annual CHALENG report is an important source of information on homeless veterans for policymakers. Copies are routinely distributed to Members of the House and Senate Veterans' Affairs Committees and Appropriation Committees. The report is also used by VA Central Office to respond to media inquiries about homeless veterans. The report helps to keep homeless veteran issues present in the minds of federal officials and the general public.

Finally, the CHALENG process has helped build thousands of relationships with community agencies, veterans groups, law enforcement agencies, and federal, state, and local government. Local annual CHALENG meetings, where attendees complete the Participant Survey, represent important opportunities for VA, and public and private agency representatives to meet, network, and eventually develop meaningful partnerships to better serve homeless veterans.

Results from the Annual CHALENG Survey

This *Fourteenth Annual Progress Report on Public Law 105-114* (Project CHALENG) is based on data collected from two surveys:

1. The CHALENG POC Survey:

This survey, distributed to POCs only, is a self-administered questionnaire requesting information on the needs of homeless veterans in the local service area, development of new partnerships with local agencies, and progress in creating/securing new housing and treatment for homeless veterans.

2. The CHALENG Participant Survey:

This survey is distributed by each POC at his or her local CHALENG meeting to: various federal, state, county, city, non-profit and for-profit agency representatives that serve the homeless in the POC's local service area; local VA medical center, Vet Center, VA regional office staffs; and to homeless and formerly homeless veterans. The self-administered survey requests information on the needs of homeless veterans in the local service area, and rates VA and community provider collaboration. There are two versions of

the CHALENG Participant Survey: one for VA staff and community providers, officials, and volunteers, and a new homeless veteran version for 2007. The homeless veteran version is tailored for homeless veterans and includes only those questions pertinent to consumers and omits those questions appropriate only for providers.

CHALENG Survey Respondents

CHALENG Point of Contact Survey Respondents

Point of Contact survey questionnaires were mailed to all designated CHALENG POCs. Out of 138 POC sites, 138 (100 percent) were returned.

CHALENG Participant Survey Respondents

There were 9,132 respondents for the 2007 Participant Survey, nearly double (a 99 percent increase) the 4,578 respondents in 2006. Of the 9,132 respondents, 1,331 were VA providers (staff) and 3,409 were community providers/advocates (agency staff, local officials, interested individuals), and 4,392 respondents indicated no agency affiliation (many of these respondents were homeless veterans). Twenty-one percent of community providers who represented an agency said their agency was “faith-based.”

There were 4,666 Participant Survey respondents who identified themselves as homeless veterans (51 percent of all participants) and 380 participants identified themselves as formerly homeless veterans (4 percent of the total sample). Collectively, consumers (homeless and formerly homeless veterans) represented 55 percent of all Participant Survey respondents. Consumer involvement went from 927 participants in 2006 to 5,046 participants in 2007, an increase of 447 percent.

Community provider respondents were asked to designate their organizational titles in the survey (see Table 1). As in prior years, survey respondents represented a range of service functions from top-level executives and policymakers to line-level service providers.

Table 1. CHALENG Community Provider Respondent Function, FY 2007.

	Community Participants (n=3,409)
Local service agency top managers (executive directors, chief executive officers)	17%
Mid-level managers, supervisors and advocates (program coordinators, veteran service officers)	34%
Clinicians and outreach workers (social workers, case managers, nurses)	30%
Elected government officials or their representatives	1%
Board Members	2%
Other (financial officers, attorneys, office staff, planning staff, etc.)	16%

VA representation in the Participant Survey was mainly through VA Medical Centers (see Table 2 below).

Table 2. VA Providers (staff), FY 2007.

VA Agency	VA Staff (n=1,331)
VA Medical Center/Healthcare System staff	75%
VA Regional Office staff	4%
Vet Center staff	8%
VA Outpatient Clinic staff	12%
VA Other (National Cemetery Administration, Central Office and VISN staff)	1%

Community provider respondents were asked how long they had been personally involved in CHALENG (see Table 3). Over one-third (35 percent) of the participants had been involved with CHALENG for at least 2 years or more. This suggests the maintenance of long-time relationships between VA and community providers.

Table 3. Years of Community Provider Involvement in CHALENG, FY 2007.

Involved in CHALENG...	Community Participants (n=3,409)
Since first local CHALENG meeting (12 years ago)	5%
Two to eleven years ago	30%
One year ago	10%
First time today	55%

Homeless veterans who participated in CHALENG came from many different stages in their recovery process (see Table 4 below). Over one-fifth (21 percent) were literally homeless (many of these veterans were contacted in initial outreach and Stand Down events). Nearly three-quarters (72 percent) were in a transitional housing program such as the VA Domiciliary or a VA Grant and Per Diem program. Seven percent were maintaining themselves in permanent housing (e.g., apartment, single room occupancy) in the community.

Table 4. Consumer (Homeless Veteran) Status.

Where Homeless Veteran CHALENG Participant is Living	Homeless Veterans (n=4,666)*
Literally Homeless (on streets, in shelter, care)	21%
In VA Domiciliary	26%
In VA Grant and Per Diem or other Transitional housing program	46%
In Permanent Housing (including Section 8 Housing)	7%

*753 of the homeless veteran participants did not indicate a residence

Many homeless veteran CHALENG participants have been chronically homeless. Over half of the veterans (53 percent) had experienced homelessness at some time in their life for over a 1-year period. Over one-third (38 percent) had suffered four episodes of homelessness in the past 3 years.

Needs of Homeless Veterans

Rankings of Needs by All Participant Survey Respondents

Participant Survey respondents were asked to rate how well pre-identified homeless veteran service needs were met in their community, using a five-point scale ranging from “Not Met” (1) to “Met” (5). Table 5 shows the results for the entire sample of respondents for 2007 (n=9,132) as well as the previous year.

Table 5. Met and Unmet Needs of Homeless Veterans (All individuals who completed 2007, 2006 CHALENG Participant Surveys).

Need of homeless veterans		Average Score 2007 (n=9,132)	Average Score 2006 (n=4,578)	2006 Rank	Need is <u>met</u> = score of 5
1	TB testing (highest “met” need score)	3.97	3.68	3	↑ Need is <u>unmet</u> = score of 1
2	Medical services	3.93	3.76	1	
3	Food	3.89	3.73	2	
4	Treatment for substance abuse	3.79	3.50	8	
5	Hepatitis C testing	3.76	3.60	4	
6	Help with medication	3.71	3.44	9	
7	Personal hygiene (shower, haircut, etc.)	3.68	3.42	11	
8	AIDS/HIV testing/counseling	3.67	3.50	7	
9	Clothing	3.64	3.59	5	
10	TB treatment	3.61	3.54	6	
11	Detoxification from substances	3.60	3.32	14	
12	Services for emotional or psychiatric problems	3.59	3.43	10	
13	Spiritual	3.53	3.37	13	
14	Emergency (immediate) shelter	3.48	3.25	16	
15	Help getting needed documents or I.D.	3.43	3.28	15	
16	Treatment for dual diagnosis	3.39	3.25	18	
17	Transitional living facility or halfway house	3.31	3.02	25	
18	Help with transportation	3.24	3.01	26	
19	Help with finding a job or getting employment	3.22	3.20	19	
20	Eye care	3.18	2.93	30	
21	VA disability/pension	3.16	3.38	12	
22	Women’s health care	3.14	3.25	17	
23	Glasses	3.12	2.92	31	
24	Education	3.10	3.05	24	
25	Drop-in center or day program	3.06	2.98	29	
26	Help managing money	3.03	2.86	32	
27	Job training	3.03	3.09	20	
28	Family counseling	3.01	2.98	28	
29	Elder health care	2.99	3.07	21	
30	Discharge upgrade	2.97	3.01	27	
31	SSI/SSD process	2.93	3.07	22	
32	Dental care	2.84	2.64	36	
33	Welfare payments	2.81	3.05	23	
34	Legal assistance	2.80	2.78	34	
35	Guardianship (financial)	2.77	2.83	33	
36	Re-entry services for incarcerated veterans	2.76	2.71	35	
37	Long-term, permanent housing	2.57	2.46	38	
38	Child care (highest “unmet” need score)	2.48	2.47	37	
					Need is <u>unmet</u> = score of 1

For FY 2007, Table 5 indicates that child care, long-term, permanent housing, re-entry services for incarcerated veterans, guardianship (financial), legal assistance, welfare payments, dental care, Supplemental Security Income/Social Security Disability (SSI/SSD) process, discharge upgrade, and elder health care were the ten highest unmet needs for homeless veterans as determined by all participants combined. It is important to note that there are significant differences between survey responses from homeless veterans and other participants. These differences are discussed on page 11, "Consumer versus Provider Views on Homeless Veteran Needs."

Child care has been one of the highest unmet needs for several years. While large numbers of veterans do not need child care, when the need for child care is present, it is a particularly compelling and difficult-to-meet need and thus has consistently ranked high among unmet needs identified through CHALENG. Also, even though most homeless veterans are non-custodial parents, they remain deeply concerned about their children's care. In many cases, these veterans struggle with the knowledge that their absence has contributed to their children living in single-parent households, under the care of extended family, or being placed in foster care. As VA cannot directly serve a veteran's children, arranging family services is necessarily split between multiple agencies. Coordinating such care may prove difficult. However, with the recent expansion of the cooperative program between VA and HUD, thousands of Section 8 vouchers will soon be made available to veterans *and their immediate families*. CHALENG will track the impact of this program not only for its effect on permanent housing as an unmet need, but also for its potential impact on child care concerns.

The need for long-term, permanent housing still remains high. This is not surprising, since developing this type of housing is expensive and time consuming, although local communities have been successful in creating permanent beds for homeless veterans. (Please see the 11th annual CHALENG report section "Special Focus: Addressing Long-term, Permanent Housing Need in 2004 Action Plan" for more discussion.)

Guardianship (Financial), SSI/SSD) process, discharge upgrade, and welfare payments represent a cluster of needs. Those needs, if addressed adequately, can make a homeless veteran more economically viable and able to transition out of homelessness. Recent literature supports the need for more and better management of financial resources. In 2006, the national average rent of studio/efficiency apartments of \$633 (O'Hara et al., 2006) was beyond the means of a disabled person whose primary source of income was SSI or a VA pension. Income assistance either through entitlements, subsidized housing, or vocational training will continue to play an important part in keeping veterans out of homelessness.

Legal issues can often play a role in a veteran's finances. Credit problems and obligations stemming from debts, fines, and child support can prove especially burdensome, particularly for those recently released from prison. The typical incarcerated parent owes \$20,000 in child support when released from prison, with payment schedules averaging \$225 to \$300 per month (Turetsky, 2007). Minimum wage workers have little hope of making these payments while supporting themselves in independent community living. Unresolved debts can result in liens against bank accounts, denial of credit, inability to secure a lease, failure in background checks

commonly a part of job applications, forfeiture of driver's licenses, and ultimately re-arrest. In order to generate income without having funds garnished, these workers may enter the underground economy where income is often generated by involvement in illegal activities. Hence, legal assistance is one key to helping veterans meet their obligations to society, while still having the means to avoid relapsing to homelessness.

Re-entry services for incarcerated veterans was a needs category introduced in the FY 2005 report and has made it to the top ten unmet needs list the past 3 years. Providing pre-release planning and after-release services for incarcerated veterans is receiving increasing attention throughout the VA system. In FY 2007, VA launched its Healthcare for Re-entry Veterans (HCRV) Program. VA has designated a national HCRV Coordinator and has funded a Re-entry Specialist for each Veteran Integrated Service Network (VISN). The HCRV Coordinator and the Re-entry Specialists will establish working relationships with correctional institutions, to provide outreach services and follow-up linkages to VA and non-VA social, medical, and psychiatric services to veterans within 6 months of release to the community. In FY 2008, an additional 17 Re-entry Specialists have been funded to expand this effort.

Dental care was the seventh highest unmet need, as identified by **all** survey participants, for homeless veterans this year. This marks a continued decline as it had been ranked second in 2004 and third in the previous 2 years. (NOTE: Homeless veterans surveyed no longer rate dental care as a top ten unmet need). VA medical centers have reported that more dental care services have been provided for homeless veterans. The HVDP offers medically necessary treatment to homeless veterans who have been in a VA-approved transitional housing or residential program for at least 60 consecutive days, and has had a significant impact. For FY 2007, 93 percent of CHALENG sites (129) indicated the HVDP was operational at their local VA medical center (some sites do not have qualifying VA transitional housing or residential programs). These CHALENG sites reported a total of 10,507 veterans who needed dental care and were eligible for care because they had fulfilled residential treatment requirements. Of these 10,507 individuals, 7,666 received care (73 percent of total) either through VA Dental Services or a community provider.

For the first time, elder health care made the top ten list of highest unmet needs for homeless veterans. This may reflect the aging of the homeless veteran population. In FY 2007, 5 percent of all veterans accepted in VA homeless programs nationwide were 65 or older (U.S. Department of Veterans Affairs, 2007). Currently, the average age of homeless veterans who receive VA services is 51 and this mean age has increased slowly over the past few years.

Highest Met Needs

Turning to *highest met* needs as rated by the provider sample, many of the top ten categories were health services-related: Tuberculosis (TB) testing, medical services, substance abuse treatment, Hepatitis C testing, help with medication, HIV/AIDS testing/counseling and TB treatment. Most of these services are routinely offered by VA medical centers. Food, personal hygiene services, and clothing are basic needs addressed at virtually all homeless shelters and programs.

Consumer versus Provider Views on Homeless Veteran Needs

Past CHALENG reports routinely compared need rankings of VA staff and community partners (i.e., local agency staff, public officials, volunteers, and community leaders). Due to the unprecedented number of homeless veterans involved in this year's CHALENG survey, however, it was believed it would be more meaningful to focus on comparing the need rankings of consumers (current and former homeless veterans) and providers (i.e., VA and community participants).

In Tables 6 and 7, the ten highest unmet needs of homeless veterans as ranked by homeless and formerly homeless veterans are compared to the rankings by VA and community providers.

For 2007, there are differences between homeless and formerly homeless veterans identification of highest unmet needs compared to service provider participants. Providers rank dental care as the third highest unmet need, homeless veterans – who for years identified dental care as a top ten unmet need – now rank it at #12 (not shown in the table). This suggests that rankings by providers may sometimes be “trailing indicators,” reflecting beliefs that are no longer experienced by consumers.

Unlike other respondents, homeless and formerly homeless veterans placed welfare payment, SSI/SSDI process, VA disability/pension and discharge upgrade in the top ten list of highest unmet needs. Thematically, this suggests the personal desire of veterans to secure financial resources in transitioning off the streets. Also, homeless and formerly homeless veterans placed elder health care in the list of top ten unmet needs, which may reflect a growing awareness of about the impact of the aging process.

Homeless and formerly homeless veterans agreed with the CHALENG community participants that the following were among the top unmet needs: permanent housing, re-entry services for incarcerated veterans, and financial guardianship.

A Multi-year Overview of Needs

Reviewing Tables 6 and 7, there is some concurrence between the views of homeless and formerly homeless veterans and other CHALENG participants across years. Long-term permanent housing, legal assistance, and child care rank among the top ten unmet needs for all participants from FY 2005-2007.

It is noteworthy that homeless and formerly homeless veterans differ from providers in naming financial and legal needs as a major concern. They rate these needs more highly than the providers surveyed during the 2007 CHALENG process. Further, many of these needs have risen in rank on the consumer's list of top ten unmet needs between FY 2006 and FY 2007. Consumers rank five financial and legal issues in the top ten: welfare payments (the number two unmet need), financial guardianship at four (up from five in 2006), SSI/SSDI at five (up from seven), legal assistance at seven (up from eight), and VA disability/pension at the eighth ranked need (not on the top ten unmet need list for FY 2005 or FY 2006).

Broadly, it suggests that consumers believe that having more personal resources is important in leaving homelessness. By contrast, providers are more likely to rank services such as eye care, glasses and help managing money among the top unmet needs. These results reflect an interesting difference in perspective between consumers and providers.

In terms of highest met needs, homeless and formerly homeless veterans and other participants placed medical services, TB testing, Hepatitis C testing, substance abuse treatment, and food in the top ten list in FY 2005, FY 2006, and FY 2007 (see Tables 8 and 9). As mentioned previously, such medical and basic need services are usually addressed by VA or community providers.

3-Year Comparison - Consumer and Provider (VA and Community) Assessment of Homeless Veteran UNMET Needs

Table 6. Top Ten Highest *Unmet* Needs Identified by Homeless Veterans, FY 2005 - FY 2007.

2005	2006	2007
1. Child care	1. Child care	1. Child care
2. Dental care	2. Welfare payments	2. Welfare payments
3. Welfare payments	3. Dental care	3. Long-term, permanent housing
4. Legal assistance	4. Long-term, permanent housing	4. Guardianship (financial)
5. Long-term, permanent housing	5. Guardianship (financial)	5. SSI/SSD process
6. Re-entry services for incarcerated veterans	6. Re-entry services for incarcerated veterans	6. Re-entry services for incarcerated veterans
7. Guardianship (financial)	7. SSI/SSD process	7. Legal assistance
8. Discharge upgrade	8. Legal assistance	8. VA Disability/Pension
9. SSI/SSD process	9. Discharge upgrade	9. Discharge upgrade
10. Job Training	10. Family counseling	10. Elder health care

Table 7. Top Ten Highest *Unmet* Needs Identified by VA and Community Providers, FY 2005 - FY 2007.

2005	2006	2007
1. Long-term, permanent housing	1. Long-term, permanent housing	1. Long-term, permanent housing
2. Child care	2. Child care	2. Child care
3. Dental care	3. Dental care	3. Dental care
4. Re-entry services for incarcerated veterans	4. Re-entry services for incarcerated veterans	4. Re-entry services for incarcerated veterans
5. Legal assistance	5. Legal assistance	5. Legal assistance
6. Help managing money	6. Help managing money	6. Help managing money
7. Glasses	7. Guardianship (financial)	7. Guardianship (financial)
8. Eye care	8. Glasses	8. Glasses
9. Guardianship (financial) Transportation	9. Eye care	9. Eye care
	10. Transitional living facility or halfway house	10. Transitional living facility or halfway house

3-Year Comparison - Consumer and Provider (VA and Community) Assessment of Homeless Veteran MET Needs

Table 8. Top Ten Highest *Met* Needs Identified by Homeless Veterans, FY 2005 -FY 2007.

2005	2006	2007
1. Medical services	1. Medical services	1. TB testing
2. Substance abuse treatment	2. TB testing	2. Substance abuse treatment
3. TB testing	3. Substance abuse treatment	3. Medical Services
4. Food	4. Food	4. Food
5. Help with medication	5. Help with medication	5. Help with medication
6. Hepatitis C testing	6. Hepatitis C testing	6. Personal hygiene
7. Detoxification	7. Personal hygiene	7. Hepatitis C testing
8. Personal hygiene	8. Detoxification	8. Detoxification
9. Services for emotional or psychiatric problems	9. Services for emotional or psychiatric problems	9. AIDS/HIV testing/counseling
10. TB treatment	10. AIDS/HIV testing/counseling	10. Services for emotional or psychiatric problems

Table 9. Top Ten Highest *Met* Needs Identified by VA and Community Providers, FY 2005 - FY 2007.

2005	2006	2007
1. Food	1. Medical services	1. Medical services
2. Medical services	2. Food	2. Food
3. TB testing	3. TB testing	3. TB testing
4. Clothing	4. Clothing	4. Clothing
5. Hepatitis C testing	5. Hepatitis C testing	5. Hepatitis C testing
6. TB treatment	6. TB treatment	6. TB treatment
7. VA disability/pension	7. AIDS/HIV testing/counseling	7. AIDS/HIV testing/counseling
8. AIDS/HIV testing/counseling	8. VA disability/pension	8. VA disability/pension
9. Substance abuse treatment	9. Substance abuse treatment	9. Substance abuse treatment
10. Services for emotional or psychiatric problems	10. Services for emotional or psychiatric problems	10. Help with medication

Homeless Veterans with Families

CHALENG sites continue to report increases in the number of homeless veterans with families (i.e., dependent children) being served at their programs. Ninety-eight POC sites (71 percent of all sites) reported a total of 1,038 homeless veteran families seen. This was a 5 percent increase over the previous year's 989 homeless veteran families.

Homeless veterans with dependents present a challenge to VA homeless programs. Many VA housing programs are veteran-specific. VA homeless workers must often find other community housing resources to place the entire family or the dependent children separately. Access to family housing through the distribution of the thousands of new Section 8 vouchers that will be made available through the HUD-VASH, will offer an important new resource allowing VA staff to assist the veteran and his family.

Homeless Veterans Returning from Afghanistan and Iraq

For the first time, CHALENG asked POCs about the coordination and provision of services to homeless veterans who have served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). Ninety-five percent (95 percent) of the POCs said they have coordinated the care of OEF/OIF homeless veterans with their local VA medical center Transition Patient Advocate. The Transition Patient Advocate is usually a social worker case manager assigned to work with recently-returning veterans.

Eight-five percent of sites said they could provide same-day housing (emergency or transitional) to homeless OEF/OIF veterans. The most common reasons for those sites not able to provide same-day housing included: insufficient emergency or transitional housing available, long wait lists (33 percent of sites that could not provide same-day housing), or no housing available on site (also 33 percent).

CHALENG POCs were asked how VA could improve services for OEF/OIF homeless veterans. The most mentioned themes included: outreach, housing, and services. The following lists specific suggestions:

Outreach: Greater use of the Internet to inform returning veterans about VA services; outreach to National Guard, reserve units, armories and Vet Centers; general community outreach (including American Indian reservations); more welcome home events; hiring of OEF/OIF veterans to serve as peer outreach workers; and use of outreach workers to follow-up with OEF/OIF veterans to help ensure they come to their initial VA appointments and get “plugged into” the system.

Housing: Specific housing programs targeting OEF/OIF veterans were frequently suggested. Such programs would be less restrictive, more short-term, and emphasize quicker reintegration into the community through mental health outpatient counseling, vocational rehabilitation and job-finding assistance. Some sites have noted that many OEF/OIF homeless veterans cannot relate to current housing programs targeting chronically homeless and mentally ill veterans in their 50s and 60s. It is expected that the influx of thousands of veteran specific permanent housing units made available through the HUD-VASH program will have an impact on this need.

Services: More case management, mental health, and employment services; more programs targeting women and veterans with families; more rapid eligibility determination; and greater coordination between homeless programs and the local VA medical center OEF/OIF specialist.

Site Estimates of Numbers of Homeless Veterans and Housing Capacity

Introduction: Challenges to Estimating the Number of Homeless Veterans in America

Counting the number of homeless people, specifically the number of homeless veterans is a difficult task. There have been few systematic, national efforts to count the homeless. Prior to 2005, the most highly regarded effort took place in 1996, the National Survey of Homeless Assistance Providers and Clients (NSHAPC). At that

time, the NSHAPC estimated that 23 percent of the homeless population was composed of veterans (Burt, 1999).

In 2005, HUD began organizing comprehensive, national counts of homeless persons. This major endeavor requires local Continuums of Care, to conduct point-in-time counts of homeless persons. Continuums of Care are local bodies composed of agencies addressing homelessness. These point-in-time counts not only tally the number of homeless persons, but also seek to determine a homeless person's veteran status. HUD's point-in-time count now occurs every 2 years and is the only nationwide process to estimate homeless individuals in the U.S. This process began because HUD is required by the McKinney-Vento Act to produce "statistically reliable, unduplicated counts or estimates of homeless persons in sheltered and unsheltered locations at a one-day point in time (HUD, 2008)."

In conducting the point-in-time, Continuums of Care must rely heavily on local organizations and volunteers. It has been observed that the precision of local counts varies. In 2005, over half of the point-in-time counts of unsheltered homeless individuals did not collect information on veteran status (HUD, 2007). Also, some CHALENG POCs reported that their local point-in-time count missed certain places or areas (e.g., transitional housing programs, encampments) that homeless veterans are known to reside.

Another challenge is the transience of homeless persons. Even over a short period of time, significant changes in the homeless population can occur due to seasonal variation and natural disasters. As the most recent Annual Homeless Assessment Report from HUD acknowledged: "There is no evidence that the size of the homeless population has changed dramatically over the past 10 years. However, given the limitations of the Annual Homeless Assessment Report as well as the limitations of earlier studies, it is not possible to make a definitive conclusion on the change of the homeless population" (U.S. Department of Housing and Urban Development, 2007).

CHALENG FY 2007 Homeless Veteran Estimate and Sources

Despite procedural problems in counting homeless people, it is believed that a good-faith effort is made through the CHALENG process to estimate homeless veterans annually. Such estimates are important to guide the allocation of existing resources and services for veterans. HUD's notable work in developing a more accurate count of the assessment of homeless veterans has allowed the VA to improve its CHALENG estimate.

For this CHALENG report, each POC was asked to estimate the number of homeless veterans in her or his service area. For the 2007 CHALENG survey, instructions emphasized that POCs were to provide a point-in-time estimate. A point-in-time estimate asks for how many homeless veterans are in the service area during a *given day* of the year. A point-in-time estimate is different from estimating how many homeless veterans are in a service area during the year. For example, a POC may say there are 200 homeless veterans in her service area on any given day (point-in-time), but there are 400 homeless veterans total who are in the service area sometime during

the year.

This year, for the first time, CHALENG POCs were asked to provide a point-in-time estimate of the homeless veterans in their service area on any day during the last week of January 2007. This time period was selected so CHALENG estimates would coincide with the homeless point-in-time counts executed by HUD Continuums of Care nationwide. It is believed that CHALENG should make every effort to base their estimates on the local point-in-time count, as it is the only nationwide homeless count conducted on an ongoing basis. *For the first time, all CHALENG point-in-time estimates were compared to local HUD point-in-time estimates from 2005*, the most recent data readily available. If there was a major difference between the estimates, the CHALENG POC provided an explanation of why there were differences, such as the local HUD point-in-time not canvassing areas with known concentrations of homeless veterans, or utilization of data from a local, non-HUD homeless count.

Findings

The 2007 CHALENG Report estimates that on any given night, approximately 154,000 veterans are homeless* (see NOTE below). This figure is a decrease of 21 percent from the estimate of 195,827 given in the 2006 CHALENG report. Individual site estimates are presented in Appendix Table 5.

***NOTE: The CHALENG estimate includes approximately 8,000 veterans currently residing in VA supported transitional housing. VA, as does HUD, counts residents of transitional housing in the estimates of homelessness. In addition, approximately 2,000 homeless veterans included in the count are currently receiving treatment in VA residential care programs. The vast majority of all of these veterans are placed in housing when discharged from these VA residential services.**

The reduction in the reported numbers of homeless veterans may be a result of improved methodology. As described above, CHALENG homeless veteran estimates were compared to local HUD point-in-time estimates. As a result, many sites adjusted their homeless estimates to be more consistent with the local HUD point-in-time count. When adjusted upward to account for gaps in its unsheltered count, the 2005 HUD point-in-time still only indicates that on any given night approximately 15 percent of the homeless population or 112,000 people are veterans.

However, some VA sites were able to successfully document why their estimates were not the same as the HUD point-in-time count. For example, after consultation with community providers, some sites reported that their local HUD point-in-time count missed particular areas or transitional residences where homeless veterans are known to congregate. Some sites had data from local non-HUD homeless counts which they felt were more accurate. Homeless veteran estimates by CHALENG POCs included the following non-HUD sources: U.S. Census data (10 percent); VA low-income population estimates (7 percent); local homeless census studies (state, county, local university, etc.) (42 percent); VA client data (36 percent); estimates from local homeless community coalition/providers (59 percent); and VA staff impressions (52 percent). (Note: of the sites that used staff impressions in their estimate, 94 percent used at least one additional source.) Seventy-one percent of POCs used more than one source.

In summary, it is believed the HUD point-in-time data has resulted in a revised CHALENG count that is more aligned with the most extensive homeless estimate methodology currently available, while allowing for adjustments of local estimates based on VA staffs first-hand knowledge of their service areas.

Other Possible Factors Related to a Drop in Veteran Homelessness

In addition to changing methods of estimation noted, two significant factors have likely contributed to a continuing decline in the estimate of homeless veterans:

1. VA Program Interventions

Reductions in veteran homelessness may be due in part to the effectiveness of VA's programs that serve homeless veterans. In the past decade, major VA homeless initiatives on outreach, treatment, residential services and vocational rehabilitation have served tens of thousands of veterans. For example, VA's Grant & Per Diem program, which had just begun in the mid-1990s when the NSHAPC estimated that veterans composed 23 percent of the homeless population, has over 8,500 operational beds today. In the past year alone, 15,000 veterans were provided Grant and Per Diem homeless residential services and an additional 5,000 plus veterans were treated in specialized VA homeless domiciliary residential care programs.

These programs have demonstrated remarkable success at placing and keeping veterans in community housing. A recent study of VA discharges determined that 79 percent of those leaving Grant and Per Diem and homeless domiciliary programs remained housed 1 year after discharge (McGuire, Kaspro, & Rosenheck, 2007).

2. Changing Demographics

The overall population of veterans continues to decline as World War II and Korean War-era veterans age. In 1990, there were 27.5 million veterans, a total that has decreased to 23.5 million today. Similarly, there has been a substantial reduction in the number of poor veterans, decreasing from 3 million in 1990 to 1.8 million in 2000. Since most homeless veterans are poor, it is believed there has been a corresponding drop in the number of homeless veterans as well.

Homeless Veteran Estimate Summary

It is not possible to determine the relative impact of these causes (VA program interventions, changing demographics, or methodological refinement) upon the reported number of homeless veterans. Despite recent changes in methodology, when comparing current HUD and VA surveys to the 1996 NSHAPC data, it does appear that a significant, long term reduction in the numbers of homeless veterans has occurred.

Bed Accessibility and Need

To aid in determining the need for housing for homeless veterans, POCs were asked to include an estimate of the number of beds, emergency, transitional, and permanent beds that are *accessible* to homeless veterans in their local area. It did not ask whether the beds are veteran-specific. POCs were also asked to report the number of beds *needed* beyond the present capacity to meet the local needs of homeless veterans. (Asking only about bed *capacity*, how many beds that can be accessed, would provide an incomplete picture of bed *need* for homeless veterans. For example, there may be several homeless beds in a community, i.e. capacity, but if they are always full and there is a lengthy waiting list, extra beds would still be needed to meet homeless veteran demand.)

Table 10. Bed Capacity (**these beds are often not veteran specific and are also open to the general homeless population**) and Bed Need Assessment.

Type of Bed	Available in FY 2007	Available in FY 2006	Needed Beyond Present Capacity (est.) FY 2007	Needed Beyond Present Capacity (est.) FY 2006
Emergency	73,430	72,196	8,712	14,753
Transitional	47,891	40,599	10,328	11,067
Permanent	35,941	31,724	25,662	24,364

Comparing the data from FY 2006 and FY 2007, it appears that existing bed capacity has increased for all three housing types. This increased capacity may impact on the drop in estimated need for emergency and transitional housing.

Estimated need for permanent housing, however, increased slightly. This may reflect the maturation of VA homeless programs nationwide. As more veterans transition out of emergency and transitional housing programs, which emphasize stabilization and rehabilitation, there is a growing need to place them into permanent housing. The need for permanent housing is being addressed through the Consolidated Appropriations Act of 2008 which provided funding for HUD to expand the HUD-VASH Program. Section 8 vouchers available through HUD-VASH will be utilized to provide housing and supportive services for homeless veterans. The Consolidated Appropriations Act also directed VA to provide sufficient funding for case managers to accommodate the increase in vouchers for this program. This initiative has the potential to reduce permanent housing demand in future CHALENG reports.

Assessment of VA and Community Partnering

As stated in the introduction, the CHALENG mandate is to bring VA and community service providers together in partnership to encourage the development of coordinated services for homeless veterans. For this year's report, we examined three indicators of VA and community partnership. These are: (1) partnership integration and implementation measures; (2) VA involvement in community homeless coalitions; and (3) interagency collaborative agreements.

Partnership Integration and Implementation Measures

Since FY 2000, CHALENG has used two sets of questions to ascertain the level of VA/community partnering as perceived by community (non-VA) providers: (A) *Integration* measures, and (B) *Implementation* measures. The questions were adapted from the nationwide Access to Community Care and Effective Services and Supports study of service system integration for homeless clients with severe mental illness (Randolph et al., 1997).

For this year's CHALENG report, the *Integration* measures consisted of two questions asking community providers from the Participant Survey to rate the following:

1. *VA Accessibility*: accessibility of VA services to homeless veterans.
2. *VA Coordination*: the ability of VA to coordinate clinical services for homeless veterans with the community provider respondent's agency.

A five-point scale was used for each item (1=not accessible, not committed etc. to 5=highly accessible, highly committed, etc.).

Implementation measures consisted of 12 items pertaining to concrete activities associated with VA and community partnering. Community provider respondents were asked to rate the level of implementation of the following strategies between their agency and VA:

1. *Regular Meetings*: Formal, regular meetings of VA and the community participant's agency to exchange information and plan.
2. *Service Co-location*: Provision of services by VA and the community participant's agency in one location.
3. *Cross-training*: Training of VA and the community participant agency's staff on each others' objectives, procedures, and services.
4. *Interagency Agreements*: Agreements between VA and the community participant's agency regarding collaboration, referrals, client information sharing, and/or coordinating services.
5. *Client Tracking*: Computer tracking system enabling VA and the community participant's agency to share client information.
6. *Joint Funding*: Combined/layering funding between VA and the community participant's agency to create new resources or services.
7. *Standard Forms*: Standardized forms that clients fill out once to apply for services at the local VA and the community participant's agency.
8. *Joint Service Teams*: Service teams comprised of staff from both VA and the community participant's agency to assist clients with multiple needs.
9. *Combined Programs*: Combined programs from VA and the community participant's agency under one administrative structure.
10. *Flexible Funding*: Flexible funding to promote service integration between VA and the community participant's agency: for example, funds to pay for emergency services not usually available to clients.
11. *Special Waivers*: Waiving requirements for funding, eligibility, or service delivery to reduce service barriers, promote access, and/or avoid service duplication.
12. *System Coordinator*: Creation of a specific staff position focusing on improving system integration between VA and the community participant's agency.

All implementation items used the same four-point scale: 1=none (no steps taken to initiate implementation of the strategy), 2=low (in planning and/or initial minor steps taken), 3=moderate (significant steps taken but full implementation not achieved), and 4=high (strategy fully implemented).

Table 11 shows the results of the integration ratings by community providers (mean scores of aggregated sites). We compared the aggregated integration scores of each VA facility for FY 2006 versus FY 2007. Using paired t-tests, we found no statistically significant difference in the integration scores between FY 2006 and FY 2007.

Table 11. Community Providers Respondent Ratings of Partnership Integration in CHALENG Participant Survey, FY 2006 and FY 2007.

Integration Items	Community Respondents FY 2006 (134 sites)	Community Respondents FY 2007 (134 sites)
VA Accessibility (1=not accessible...5=highly accessible)	3.64	3.57
VA Service Coordination (1=not able to coordinate...5=highly able)	3.63	3.58

Implementation scores for FY 2006 and FY 2007 were also reviewed. Again, data were aggregated by site and paired t-tests were conducted (see Table 12). There was one significant difference ($p < .01$): the implementation score for cross-training *decreased* from 2006 to 2007.

Table 12. Community Provider Respondent Ratings of Partnership Implementation in the CHALENG Participant Survey, FY 2006 and FY 2007.

Implementation Items ^a	Community Respondents FY 2006 (133 sites)	Community Respondents FY 2007 (133 sites)
Regular Meetings	2.57	2.56
Service Co-location	1.95	1.89
Cross-training	1.97	1.86**
Interagency Agreements	2.30	2.26
Client Tracking	1.65	1.59
Joint Funding	1.66	1.67
Standard Forms	1.79	1.75
Joint Service Teams	2.19	2.15
Combined Programs	1.97	1.94
Flexible Funding	1.64	1.61
Special Waivers	1.67	1.62
System Coordinator	1.88	1.83

^a 1=none, 2=low, 3=moderate, 4=high
 $p < .01$

There was no change in the two integration items which measure community provider perception of VA's accessibility to homeless veterans and VA's ability to coordinate homeless services with community partners.

Overall, there has been no increase in community rating of the 12 partnership implementation activities. Generally, there has usually been an increase in one or more activity scores. This suggests that VA and community progress in implementing

partnership activities may have leveled off. (Note: It was reported in last year's CHALENG report that there were no significant changes between 2005 and 2006. It will be interesting to see if this leveling off in partnering is seen in next year's CHALENG report as well.)

VA Involvement in Local Homeless Coalitions

Involvement in local homeless coalitions has been identified as a useful way for VA staff to network with local homeless service providers and develop partnerships. Ninety-six percent of the POC Surveys indicated participation in a local homeless coalition.

As noted previously, the HUD sponsors local planning groups called Continuums of Care to help address the needs of the homeless. VA homeless programs are encouraged to participate in their local Continuum of Care. In FY 2007, 88 percent of POC sites that had a nearby HUD Continuum of Care planning group (111 of 127) participated in the local Continuum of Care planning efforts.

Interagency Collaborative Agreements

Existing Interagency Collaborations Agreements: CHALENG POCs reported on VA efforts to serve homeless veterans through arrangements with local community agencies. CHALENG POCs were asked to identify whether they currently had interagency collaborative agreements with: correctional facilities; psychiatric and substance abuse inpatient programs; nursing homes and faith-based organizations. Table 13 shows the prevalence of current interagency collaborative agreements.

Table 13: Percentage of POCs (n=138) Indicating Interagency Collaborative Agreements with Select Program Types.

	Formal 2007	Informal 2007	Formal or Informal* 2007
Correctional Facilities (jails, prisons, courts)	13%	59%	67%
Psychiatric/substance abuse inpatient (hospitals, wards)	17%	60%	75%
Nursing homes	28%	19%	45%
Faith-based organizations	62%	56%	88%

*Note: Some sites had both a formal and informal agreement with a program type.

Eighty-eight percent of POC respondents indicated their VA medical care facility had an interagency collaborative agreement with a faith-based organization. This is not surprising given the fact that many faith-based organizations have a long history of serving the poor and homeless. Seventy-five percent of sites reported ties with a psychiatric and/or substance abuse inpatient program, an indication of the link between mental illness and homelessness and the need to coordinate services between mental health and homeless agencies.

Two-thirds (67 percent) of POCs had relationships with a local correctional facility. Incarcerated veterans are at high-risk for homelessness upon leaving jail or prison. Several VA homeless programs provide information to homeless veterans in local jails and prisons to help them arrange transitional housing and substance abuse or mental

health treatment after their release. With the recent implementation of the HCRV program, including the hiring of a National HCRV Coordinator and HCRV specialists for every VISN, the percentage of medical centers which have agreements with correctional facilities should increase in the coming years.

Forty-five percent of POCs had arrangements with a nursing home, usually through VA nursing home contracts. This reflects the aging of the homeless population and the need for facilities to address the multiple medical needs of older homeless veterans and chronically ill homeless veterans.

New Interagency Collaborative Agreements and Outreach Efforts: VA staff continue to establish new interagency collaborative agreements and to identify and serve new outreach sites. Table 14 displays figures for new agreements (formal and informal arrangements) and outreach sites, broken down by VISN. Compared to 2006, there were increases in the number of agreements and outreach sites in 2007.

Table 14. New Interagency Collaborative Agreements and Outreach Sites for FY 2007.

VISN	Formal Agreements	Informal Agreements	Agreements (total)	Number of New Homeless Outreach Sites
1	11	31	42	8
2	5	13	18	8
3	6	24	30	28
4	7	19	26	33
5	4	10	14	24
6	3	21	24	19
7	1	14	15	27
8	2	26	28	16
9	1	18	19	16
10	5	14	19	15
11	5	6	11	2
12	1	10	11	9
15	5	10	15	12
16	10	17	27	18
17	4	12	16	14
18	2	20	22	17
19	4	9	13	6
20	54	58	112	21
21	3	15	18	15
22	6	17	23	42
23	8	32	40	27
Totals, All VISNs (FY 2007):	147	396	543	377
Totals, All VISNs (FY 2006):	81	352	433	343

Nature of New Interagency Collaborative Agreements: 113 out of 138 reporting POC sites (82 percent) had at least one new agreement with a community agency. The most frequent topic of the new agreements was transitional housing (see Table 15 below). Nearly half (49 percent) of the POC sites which reported a new agreement indicated that securing transitional housing for veterans was a focus. The other two of the top three topics of interagency collaborative agreements were emergency (immediate) shelter (27 percent) and re-entry services for incarcerated veterans (24 percent).

Table 15: Subject of New Interagency Collaborative Agreements Between VA and Community Providers, FY 2007.

Need	Percentage of POCs with New Collaborative Agreement who Indicated Need was Addressed in Agreement*
Transitional living facility or halfway house	49%
Emergency (immediate) shelter	27%
Re-entry services for incarcerated veterans	24%
Services for emotional or psychiatric problems	22%
Food	21%
Long-term, permanent housing	21%
Help with finding a job or getting employment	21%
Job training	20%
Help with transportation	20%
Clothing	19%
Dental care	18%
Help managing money	15%
Help getting needed documents or identification	13%
Treatment for substance abuse	11%
Glasses	11%
Personal hygiene (shower, haircut, etc.)	9%
Detoxification from substances	9%
Medical services	9%
Eye care	8%
VA disability or pension	8%
Treatment for dual diagnoses	7%
Help with medication	7%
SSI/SSD process	7%
Legal assistance	7%
Spiritual	7%
AIDS/HIV testing/counseling	6%
Family counseling	3%
Women's health care	3%
Welfare payments	3%
Drop-in center or day program	2%
TB testing	2%
Guardianship (financial)	2%
Education	2%
Discharge upgrade	2%
Child care	1%
Elder health care	1%
TB treatment	0%
Hepatitis C testing	0%

*Multiple needs addressed in the new interagency collaborative agreements may be identified by POCs

Veterans Served due to New Collaborative Agreements: CHALENG POCs were asked to report how many veterans received key services (mental health and/or substance abuse treatment, dental care, and eye care) as a result of new collaborative agreements in FY 2007 (see Table 16).

Table 16. Number of Veterans Served Through New Interagency Collaborative Agreements, FY 2007.

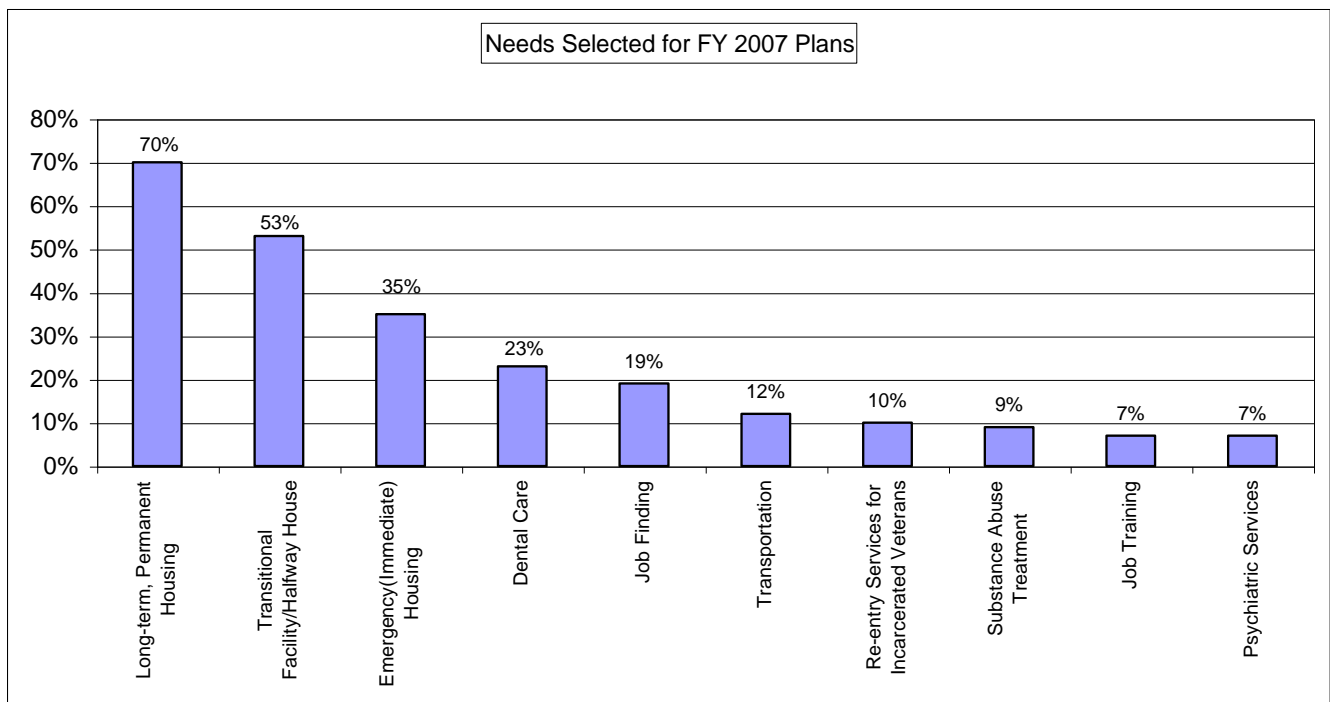
Service	Number of Veterans Served as result of New Interagency Collaborative Agreement
Mental Health/Substance Abuse Treatment	344
Dental Care	1,131
Eye Care	500

POC Action Plans

POC Success in Executing FY 2007 Action Plans

As part of the CHALENG survey in FY 2007, POCs were asked to select the three highest priority needs in their areas and to indicate how they would address these needs in FY 2007. The most frequently selected needs included: permanent, transitional, and emergency housing; dental care; job finding; transportation; re-entry services for incarcerated veterans; substance abuse treatment; job training and psychiatric services.

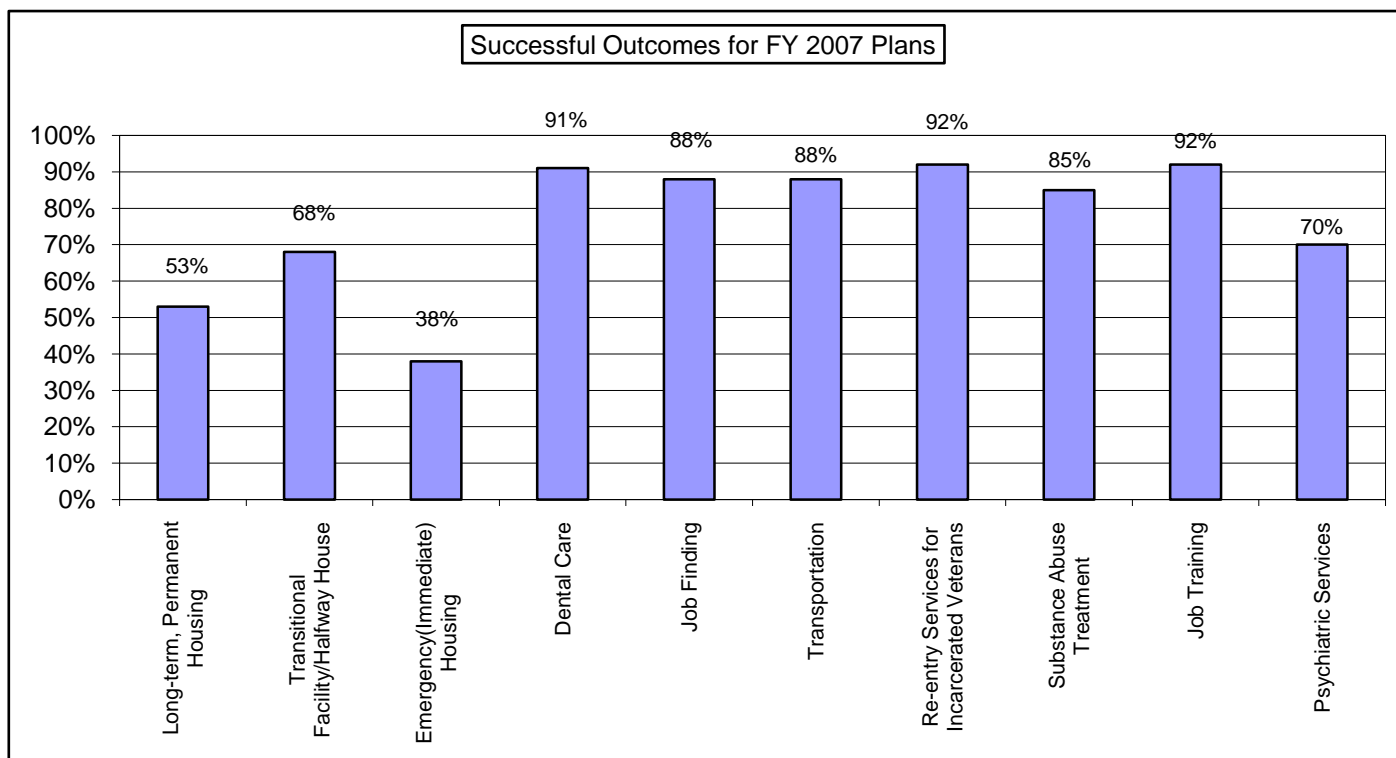
Figure 1. Top Needs Selected for Points of Contact to Address.



For this CHALENG report, POCs were asked to indicate their success in implementing their plans to meet the top three needs that were identified. (See Appendix Table 6 for all POC progress reports.) For the purposes of this report, success was defined as achieving tangible outcomes such as securing additional transitional housing beds, negotiating a reduced or free bus fare for homeless veterans, or receiving grant funding for a project. Success did not include the beginning of processes such as starting initial planning or submitting a grant for funding.

Figure 2 shows the percentage of sites that were successful in obtaining an outcome for the ten most frequently selected needs to address in FY 2007.

Figure 2. Outcomes for Top Ten Action Plan Topics with Percentages of POC Sites that were Successful.



Listed below are some examples of how POCs achieved success in addressing their priorities for FY 2007. This summary does not reflect the total level of CHALENG partnership activity in addressing these needs -- only the activity from the sites that identified the need as one of its top three.

Long-term, permanent housing: Community agencies opened new permanent housing (20 sites); VA used HUD Section 8/Shelter Plus Care vouchers (20 sites).

Transitional housing: Community agencies opened VA Grant and Per Diem-funded beds or received VA Grant and Per Diem funding (39 sites); VA accessed non VA-funded transitional housing (two sites); new VA Domiciliary opened (one site).

Emergency housing: Shelter opened/expanded (ten sites), new agreements made with existing shelters (six sites), local motel used as temporary shelter (one site), new shelter database or directory facilitated better placement (two sites).

Dental care: VA provided services under VHA Directive 2002-080 (eight sites); local dental providers offered care (some being paid with special VA dental funding) (21 sites).

Job finding: VA Compensated Work Therapy/Supported Employment programs started or expanded (11 sites); local Department of Labor Homeless Veterans Reintegration Program utilized (two sites); VA partnered with local private and public agencies for job finding (15 sites).

Transportation: VA or local transit authority offered new lines and services to accommodate veterans (nine sites); bus passes and tokens distributed (four sites); local agency purchased a van or hired a driver (two sites); veterans re-assigned to a VA clinic closer to their residence (one site).

Job training: New VA employment program begun or vocational rehabilitation staff hired (five sites); job training provided through local community agencies (five sites).

Substance abuse treatment: Added VA substance abuse staff (six sites); new VA Grant and Per Diem program serving dually diagnosis patients (one site); community agencies offered substance abuse treatment (three sites).

Re-entry services for incarcerated veterans: New outreach worker/discharge planner hired (nine sites); local task force of VA and community agencies coordinated services for formerly incarcerated veterans (five sites).

Psychiatric services: New programs started and new staff hired (two sites); existing VA mental health services restructured to improve treatment access and care (three sites); veterans referred to local community mental health program (two sites).

Most commonly, POC sites that did not achieve success with their FY 2007 plans mentioned lack of funding (grant proposals denied, loss/reduction of existing program funding) as a factor.

The least successful action plan topic was emergency housing or immediate shelter. Only 36 percent of all sites reported success in addressing this FY 2007 action topic. Many sites indicated they were in the early planning and development stages of creating shelters. Also, unlike transitional and permanent housing development, there has been difficulty in locating funding sources for the development of additional emergency shelters. For example, the VA Grant and Per Diem program has funded and maintained several transitional housing programs throughout the country; similarly HUD, through its Section 8 and Shelter Plus Care programs, has created permanent housing resources in many local communities.

Similarly, some of the more successfully met needs were tied to specific funding and initiatives. Many sites mentioned the implementation of VHA Directive 2002-080 in addressing dental needs. VA Compensated Work Therapy and Supported Employment programs and Department of Labor Homeless Veteran Reintegration Programs addressed job training and job finding needs. New VISN HCRV program specialists provided a boost for local efforts to serve recently released incarcerated veterans.

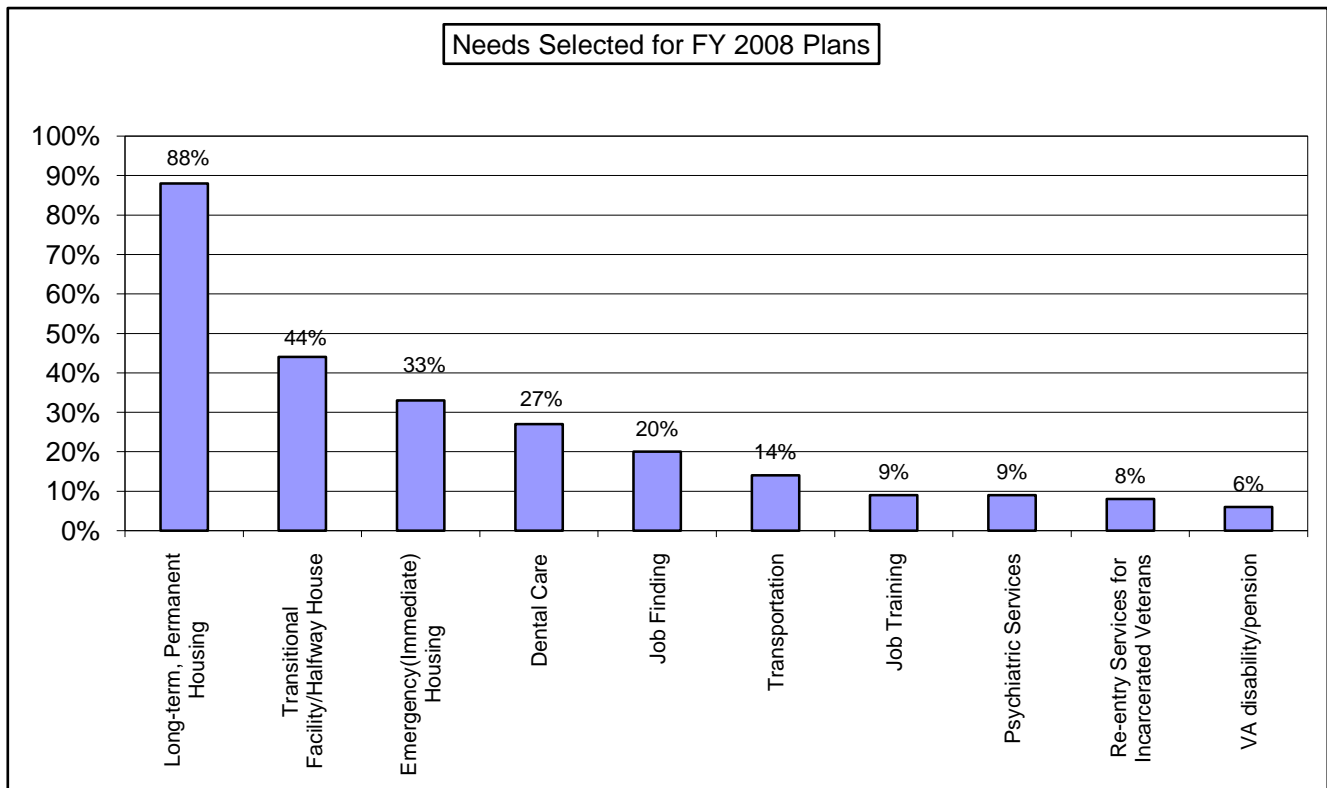
Important CHALENG Partners

CHALENG POCs were asked to identify community partners who helped them address their past year's action plan. Appendix 7 highlights and acknowledges the accomplishments of these partners in FY 2007.

POC Action Plans for FY 2008

The 2007 POC survey requested that POCs outline their action plans for addressing top unmet needs of local homeless veterans in FY 2008. These unmet needs included: permanent, transitional, and emergency housing; dental care; job finding; transportation; psychiatric services; job training; re-entry services for incarcerated veterans, and VA disability and pension.

Figure 3. Needs Selected For Plans.



In the CHALENG Participant Survey, respondents were asked to name the top three greatest unmet needs in their communities that they would like to address in FY 2008. Importantly, nine of the ten needs they wished to work on the most were on the top ten list for VA POC action plans for FY 2008.

The CHALENG 2008 top ten list of needs to address is consistent with recent thought

on addressing homelessness. A variety of reports have attempted to define the program elements necessary to end homelessness. Although these descriptions tend to be more general and may lack detailed input from consumers, they offer a framework for planning a comprehensive intervention. One important effort was made by The Federal Task Force on Homelessness and Severe Mental Illness (1992), which identified five critical service components essential to resolving homelessness: housing; employment; psychiatric and substance abuse treatment; medical care; and social support. Relatedly, the 2008 CHALENG action plan top ten list includes housing, employment and psychiatric care. As noted earlier, CHALENG participants rate medical care as a high met need for homeless veterans. VA currently provides a broad range of medical services for these veterans.

While acknowledged as an important component of recovery, social support has never been officially listed by CHALENG as a specific, pre-identified need to be ranked. Related to the report from The Federal Task Force on Homelessness, a recent Canadian survey (Russell, Hubley, & Palepu, 2005) of homeless persons concluded that in addition to access to basic necessities, relationships, self-respect, the respect of others, and having choices all influenced the quality of life of homeless persons. It is not known whether such quality of life indicators impact directly upon homelessness, but they are certainly clinically relevant to those veterans we treat. Social support will be measured in the 2008 CHALENG survey.

Update on CHALENG Activities

Individualized CHALENG reports by POC site are now available on the Internet in draft form. Each report includes: an estimate of homeless veterans in the service area; an estimate of homeless veterans who are chronically homeless; bed counts; FY 2008 action plan, and need and integration/implementation rankings. The Web site address is: <http://www.va.gov/homeless/page.cfm?pg=17>.

Also on the site is the 14th Annual Progress Report on Public Law 105-114 in its entirety. The current report and site profiles are useful for sites that are undergoing Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation or have community partners that are applying for VA Grant and Per Diem funding. CARF requires programs to provide feedback from external stakeholders such as community partners and clients. As part of their VA Grant and Per Diem application, community agencies must document the local needs of homeless veterans in their area. Much information from stakeholders and their perception of homeless veterans needs is available in the annual CHALENG report.

Summary

Trends In Veteran Homelessness

Over the short-term, the combination of demographic changes decreasing the overall veteran population and the increase of VA resources for the homeless should continue to reduce homelessness among veterans. At some point, changes already apparent in the active military force structure will likely be mirrored in the profile of homeless veterans. Although only 4 percent of all homeless veterans are women, this proportion will likely increase as currently 15 percent of all US troops are women. The extensive use of the National Guards and Reserve units in Iraq and Afghanistan means that in addition to the typical influx of new, younger veterans expected from any conflict, a greater proportion of “new” veterans will be older and have families. VA will face significant challenges in addressing the needs of these veterans if they become homeless, unless it can meaningfully address their homelessness in the context of the family unit. The continued prominence of child care as an unmet need highlights the potential impact of this concern. Recognizing this need, the Consolidated Appropriations Act of 2008 provided funding for HUD to expand the HUD/VASH Program. Section 8 vouchers available through HUD/VASH will be utilized to provide housing and supportive services for homeless veterans *and their families*.

VA's success in reducing homelessness brings new demands. Although housing is obviously a critical step in ending homelessness, it is not a sufficient intervention to restore health and quality to life. Through CHALENG, VA continues to assess the needs of homeless veterans so that we may identify areas where the overall quality of life for these veterans may be improved. We believe this approach is not only the humane one, but the one most likely to result in long term solutions to homelessness. VA will continue to work to establish a continuum of care that meets the full spectrum of economic, vocational, legal, social, and spiritual needs identified by veterans and providers in this report.

Final Thoughts

The annual CHALENG Survey documents the needs of homeless veterans identified by veterans, community agencies and VA staff. CHALENG also records how VA and community agencies work together to plan and meet those needs.

Constructively, housing capacity increased between FY 2006 and FY 2007 with emergency and transitional bed need decreasing. POC actions plan updates have documented many success stories in developing housing, particularly through the use of VA Grant and Per Diem funding for transitional housing and HUD Section 8/Shelter Plus Care funding for permanent housing.

There is also evidence that non-housing initiatives have been successful. About 7,600 veterans received dental care through the HVDP in FY 2007. Ninety-two percent of sites that selected re-entry services for incarcerated veterans as a priority need in FY 2007 reported some success coordinating care with new VISN HCRV Program liaisons, prisons, and other community agencies.

The estimated need for affordable permanent housing continues to increase even as capacity increased. Although growth in partnership activities as indicated by the report's 12 implementation measures remained flat, that may mask increasing collaborative activities through the expansion of existing partnerships. This will be a focus for assessment in future CHALENG reports. Significant new national initiatives, particularly the major expansion of the HUD-VASH program, are expected to make a marked difference in the coming year.

In summary, there has been significant accomplishment in serving homeless veterans with our community partners, although the information obtained through CHALENG indicates that much work still remains. CHALENG will continue to examine the progress of VA and the community toward that goal.

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